

Chiropractic Identity in the United States: Wisdom, Courage, and Strength



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ABSTRACT

Objective: The objective of this paper was to discuss the chiropractic profession's identity and 3 contentious issues related to identity.

Discussion: The various clinical specialties and independent groups in the chiropractic profession are so different in their beliefs, practice styles, and political agendas that a common identity is unlikely to be created. Areas of disagreement, including advanced practice, vertebral subluxation, and the philosophy of chiropractic, continue to separate those in the profession. Doctors of chiropractic should accept that differences within the profession will remain for the foreseeable future and that the profession should allow each group to live peacefully and supportively alongside each other.

Conclusions: If the profession embraces the ideals of truth, respect, and tolerance, it can continue to grow and provide diverse health care services well into the future. (J Chiropr Humanit 2016;23:29-34)

Key Indexing Terms: *Chiropractic; History*

INTRODUCTION

In the course of the last 120 years, the chiropractic profession has had scores of political and legal victories and provided successful treatments to millions of grateful patients.¹ These accomplishments have created prosperity and fame for many in the profession, but despite these successes, or maybe partly because of them, the profession in the United States is still no closer to having an agreed-upon identity than when it began. Certainly, there have been attempts to define the profession, and these have resulted in some generalized descriptions of chiropractic. Three of these descriptions were developed over a decade ago through the position paper created by the Association of Chiropractic Colleges (ACC)² and the survey reports of McDonald³ and the World Federation of Chiropractic (WFC).⁴ These initiatives brought forth some measure of understanding, but what also emerged was the acknowledgement that there were divisions within the chiropractic profession. In particular, McDonald and the WFC classified subgroups within chiropractic by scope of practice (broad, middle, and narrow), and more recently, authors have observed that these separations persist.^{5,6} A unifying

identity has not been established in spite of continued advances in research and scholarly activity, education, licensure, public and interprofessional attitudes, and integration into mainstream health care institutions.¹ Given its successes, the chiropractic profession has made some gains in improving its authority, but in my opinion, this is the result of individuals and small groups establishing their niches, with the rest of the profession benefiting from this passively. Therefore, as the history and the current state of affairs indicate, the creation of a single unifying identity will not happen in the foreseeable future, if ever. However, considering that the profession's successes continue to accrue and that doctors of chiropractic (DCs) continue to thrive in many diverse ways, achieving a unified identity, perhaps, does not matter. Therefore, the objective of this paper was to review the history of the profession's identity, discuss 3 contentious issues, and offer suggestions to improve matters.

DISCUSSION

Beyond being known as highly effective "bonesetters," part of the chiropractic profession's identity has been created by patient conditions that have seemed to improve the most, the myriad therapies offered to the public, and the ability of individuals and groups to promote their specific style or brand of chiropractic. There are multiple scope-of-practice identities within the profession, and even within these groups, there are divisions. This creates a number of subgroups that are identified by a characteristic or issue, such as by specialization involving additional training (eg,

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Table 1. *Examples of Chiropractic Subgroups*

| Certification Based | Practice Style Based | Technique Based |
|---------------------|--------------------------------------------------|---------------------------|
| Advanced Practice | Alternative Medicine Practitioner (Neovitalists) | Activator Methods |
| Diagnostic Imaging | Neuromusculoskeletal Specialist | Active Release Technique |
| Internal Medicine | Primary Care Physician | Applied Kinesiology |
| Nutrition | Spinal Care Specialist (Condition Based) | Chiropractic Biophysics |
| Neurology | Subluxation-Based Family Practitioner | Diversified |
| Orthopedics | | Gonstead |
| Pediatrics | | Network |
| Rehabilitation | | Sacro-occipital Technique |
| Sports Practitioner | | Thompson Technique |
| Wellness | | Upper Cervical Specific |

sports medicine, clinical nutrition). Others are identified by the conditions treated or the type of practice (eg, spinal care specialist, primary care physician (PCP), wellness care practitioner). Yet others are grouped by “philosophical” beliefs (eg, vitalism, neovitalism), choice of chiropractic technique (ie, with or without certification), or political agenda (eg, wanting to change scope of practice laws) (Table 1).

Once DCs become part of these subgroups, their allegiance does not shift very readily. It may be that once they have gained a modicum of financial and professional success, they see no reason to change the status quo, or in some cases, they have a deep abiding passion for their cause. Therefore, it would seem that the Institute of Alternative Futures was correct when it suggested that professional unity for chiropractic does not seem possible.⁵ If this is true, and attempting to unify the profession under a single identity is fruitless, would it not be more prudent to try to live in peaceful coexistence and with mutual support? This is quite evident in the medical profession. Essentially, like medicine, which has more than 35 specialties and 50 subspecialties,⁷ chiropractic also has a diverse collection of clinical specialties.¹ Like medicine, which has more than 150 medical societies and more than 400 different medical associations in the United States alone,⁸ chiropractic has associations that are delineated by politics, philosophy, or personal interests.¹ Also, chiropractic is similar to medicine in that differences of opinion exist regarding the scope of clinical practice and preferred treatments. For example, there are differences among medical practitioners regarding sensitive issues, such as abortion,⁹ end-of-life choices,¹⁰ or the use of a specific clinical procedure even when there is better evidence for others.^{11,12}

The chiropractic subgroups have created organizations that hold meetings, have a presence on the Internet, publish reports, and offer educational seminars. Like medicine, although there are occasional squabbles, many of these chiropractic subgroups exist without too much intrusion from each other. Sometimes a squabble grows into a full-blown battle. However, given the deep-seated differences, it is unlikely that either side will have an epiphany and suddenly align themselves with their adversary. It is also unlikely that one side would emerge so victorious that the other side would simply accept defeat and disband. The

strength of conviction in the constituents of the subgroups, the sheer numbers on both sides of the debate, and history suggest that this will not happen. Therefore, it may be time for the chiropractic profession to take direction from the Serenity Prayer, which asks for “the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.”¹³ Instead of arguing about what our single identity should be, would it not be better for the chiropractic profession to accept the things we cannot change and find the courage to change the things we can? This presumes that we have the wisdom to know the difference. The following are 3 examples of chiropractic identity issues that are being debated.

The Advanced Practice Issue

Those supporting the agenda regarding advanced practice promote that broadening the scope of practice laws to include prescriptive rights and minor surgery will result in increased use of chiropractic services and greater authority while tending to the primary care needs of the US population.^{14,15} Supporters of this approach paint a dire picture of the current state of practice for their members and see advanced practice as an opportunity to create a financial boon, especially for new graduates.¹⁶ Currently, chiropractic students in accredited programs are trained at a foundational level in toxicology, which includes instruction on commonly prescribed medications.¹⁷ This makes sense, because undoubtedly DCs manage patients who already are taking or will take drugs while under their care. It is important to know the clinical effects of medications, especially with regard to the chief complaints with which a patient presents. However, if what occurred in the mid-1990s at Western States Chiropractic College is any indication,¹⁸ attempts to broaden the chiropractic degree program to include training on prescriptive authority will continue to meet with rancor and failure.^{19,20} To some in the profession, even the term “advanced practice” is disagreeable, because it suggests that those who do not want prescriptive rights are not advanced in their profession. Others object to this concept because proposed paths mimic the nursing profession or the physician assistant model, which some believe belittles the physician status of DCs.

Currently, there is no reason to believe that members of the subgroup touting advanced practice will stop actively promoting their agenda and attempting to alter scope-of-practice laws. If anything, their numbers are growing. According to a recent review, DCs are decidedly split on the issue of prescribing medications.²¹ However, there does appear to be a trend in survey reports over time supporting some type of pharmaceutical use in practice. Nevertheless, promoters of the advanced practice agenda need to answer the important question: What does “advanced practice” really mean? A limited prescriptive license for DCs focusing on neuromusculoskeletal conditions is very different from full prescriptive authority similar to that of a doctor of medicine or osteopathy practicing as a PCP. In the former case, focused postgraduate educational courses and credentialing could be created and put in place fairly easily, using the example set by the state of New Mexico.²² However, to obtain full prescriptive rights, substantially more education and training would be required before regulatory authorities would allow DCs to practice like allopathic PCPs with their strong focus on internal medicine and infectious diseases. It is evident that practicing as a chiropractic physician focusing on neuromusculoskeletal conditions is different from functioning as an allopathic PCP.

There are very different laws across the United States governing the practice of chiropractic, and the trend is toward broadening the scope of practice.²³ At this point, it must be accepted that scope-of-practice laws are going to change in some states, as they historically have, and this may include some form of prescriptive authority. It will take courage, but given the strong sentiments and numbers associated with making this change, the doubters should consider supporting a limited prescription initiative managed by the profession and help establish rigorous postgraduate educational standards and an acceptable name for these newly credentialed chiropractors. Limiting prescription-writing authority to exclude opioids and other narcotics would seem wise and be an easier path to gain legal passage. For those few who want to function in a manner similar to allopathic PCPs with full prescriptive authority, it would be wiser to create advanced standing opportunities in osteopathic and medical colleges than to attempt to change the laws on chiropractic scope of practice in any dramatic way. For the advanced practice agenda, chiropractic colleges that are so inclined should help their fellow DCs by creating articulation agreements with medical institutions.

The Subluxation Issue

It is ironic that the chiropractic profession has not shown more support when it comes to the hypothesis of vertebral subluxation. Subluxation/joint dysfunction (S/JD) is deeply ingrained in the psyche, education, and clinical practices of many within the profession, and its continued relevance is undeniable. Supporters in this subgroup include some of

those who practice brand-named techniques (eg, Gonstead, Thompson, or Activator Methods) and those who state they are “subluxation based.” According to the National Board of Chiropractic Examiners, S/JD is identified as the most common condition treated by DCs,²⁴ and the topic continues to be included in their tests. Physical examination for S/JD is a required training component (meta-competency 1) by the Council on Chiropractic Education (USA).¹⁷ Subluxation/joint dysfunction also continues to be named as part of the scope-of-practice law in various states (eg, New York),²⁵ and remains a clinical entity paid for by Medicare and other forms of insurance.

For the detractors of subluxation, the term itself can be a source of confusion,²⁶⁻²⁸ and the lack of substantial and ongoing quality research is particularly concerning. Although, a few research studies have been done and have been included in chiropractic textbooks^{26,27,29} Recent studies by DCs^{30,31} and physical therapists³² have focused on creating clinical decision rules for the use of manipulation in patients with spinal pain and disability and have found the existence of “segmental dysfunction” to be a key criterion when trying to identify patients who will respond well to care. Unfortunately, textbook information is sometimes outdated, not well organized, or not assessed for quality. Overall, the discussion on the topic is so cluttered by low-quality studies, pseudoscience, and dogmatic proclamations that it has been made impossible for DCs and those outside the profession to access that which is truly the best available research evidence.

It seems that when it comes to bringing rational, evidence-informed understanding to an issue that is central to the profession, few are willing to address misinformation/disinformation and improve access to better research publications. One would expect that a large professional association, such as the ACC, the WFC, the American Chiropractic Association, or the International Chiropractic Association, would organize a publication list that included the best-quality evaluations and research available. Indeed, S/JD is conspicuously absent on the newly created WFC website’s suggested reading list, where commonly treated conditions have their own topic heading.³³ This is curious given that results from the WFC Identity Consultation Survey revealed that 65% of chiropractors wanted the public to identify the profession by “management of vertebral subluxation & its impact on general health.”⁴ However, there are at least 5 peer-reviewed publications with a focus on S/JD that are dispersed under various headings on the WFC website.³⁴⁻³⁸

I feel that there should be a dedicated group of researchers or technique professors who would be willing to be the curators of an S/JD topic list. Making the highest-quality evidence easily accessible to the chiropractic profession may help quell the rancor and improve clinical and professional understanding. It is time for members of the profession to accept that vertebral subluxation will continue to exist as a

construct as long as the chiropractic profession exists. More so, S/JD will be treated as a clinical entity so long as it is a foundational component of educational training. There will continue to be patients who respond quickly and dramatically to motion segment–based examination and adjustments or manipulations. Doctors of chiropractic who found fame and fortune by using a chiropractic technique focused on the detection and removal of S/JD have not been given any particular reason to change their ways. Given their successes, new practitioners will undoubtedly emerge and continue to practice these S/JD methods, especially when they become part of established practices. A group needs to be formed to create a list of the best evidence available concerning S/JD and its treatment. The profession should tell the truth (for better or for worse) about S/JD and have the strength to promote the evidence both within and outside the profession.

The Philosophy Issue

Practitioners have the right to embrace a belief system as long as it is legal and ethical. However, the beliefs involving traditional chiropractic philosophy, such as vitalism (and now neovitalism) and some alternative medicine concepts borrowed from others, are controversial. As a profession, our history indicates that we have had a wide variety of eclectic ideas and beliefs.¹ It should be no surprise that, despite the promotion of evidence-influenced education and practice within the profession, these belief systems persist. The profession has historically attracted alternative thinkers, and in my opinion, the attraction remains. However, such a diversity of opinion and practices is no different from that which exists in the world at large. Many people embrace health care beliefs that are unsupported by scientific evidence, and some of these beliefs have profound effects on their choice of treatment interventions.³⁹⁻⁴¹

As members of a health care profession, we consider concerns about safety, effectiveness, and public perception to be particularly important. If what is said and done to a patient is unsafe or creates harm, appropriate professional and criminal investigation and penalties must occur. If treatment effectiveness is in question, patients need to be told what evidence, if any, supports a belief. As for public perception, as with many other forms of alternative medicine that do not have strong evidential support, some people will be fine with a belief-based approach, and others will be repelled by such an approach. If patients know the facts, no laws are broken, and according to the evidenced-based practice model,⁴² the concept of autonomy is maintained,⁴³ then patients have a right to choose their practitioner and treatment on the basis of their personal values and beliefs.

The dissenters to chiropractic philosophy should accept that as long as chiropractic educational programs and subgroups teach “chiropractic philosophy” and promote these concepts, these beliefs will continue to exist. If, at

some point, the evidence shows that these beliefs cause unsafe or ineffective practice methods, the regulating bodies within each jurisdiction have the duty to step in and stop these practices. However, tolerance for differences among practitioners is also mandated by rules regarding professional misconduct. In the meantime, the best the dissenters can do is promote their own belief systems and hope that people are convinced by their logic and persuasion. All chiropractors have the ethical responsibility to accept that their beliefs sometimes can mislead and harm patients or make the profession look bad at a time when mainstream health care is extremely focused on evidence. Supporters must be very clear when their beliefs are metaphysical, are purely speculative in nature, are not amenable to scientific investigation, or have little to no evidential support. They should also be clear if their treatment is unsupported by high-quality data and falls into the realm of care that is merely experimental. Any attempt to blend speculation with scientific evidence would be misleading, and the entire profession must guard against this. Above all else, DCs must take care to do no harm and always act in the best interests of their patients. When it comes to unsubstantiated beliefs, being truthful will benefit the profession, whereas being harmful requires policing by the profession.

In review of these 3 areas, I suggest that we need to accept that most DCs who have aligned themselves with any one of the subgroups will not change their position. Therefore, I recommend that the best course of action is for the profession to have the wisdom to accept the reality of these resolute divisions and the courage and strength to offer suggestions to help guide actions that will lead to the best possible existence for the entire profession. In my opinion, if this approach could be taken, everyone’s personal and financial resources would be better directed, and ultimately the profession could find itself in a more suitable place.

LIMITATIONS

The limitation of this commentary is that it is based on opinion and is not a sociologic or systematic study. The contents are my personal views and may not necessarily have addressed all issues relevant to this topic.

CONCLUSIONS

The chiropractic profession has been trying to define itself since its inception, but no single unifying identity has emerged. Like medicine, a number of clinical specialties, associations, and beliefs with impact on clinical practice exist; however, within the chiropractic profession, there are also a number of independent groups that are so different in their beliefs, practices, and political agendas that achieving

a common identity remains a remote possibility. Until an unequivocally unified position emerges, DCs must accept this reality and have the courage and strength to allow all groups to live peacefully and supportively alongside each other. If the profession has the wisdom to recognize that the best way forward is to embrace the ideals of truth, respect, and tolerance, it can continue to grow and provide diverse health care services well into the future.

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CONTRIBUTORSHIP INFORMATION

Concept development (provided idea for the research): C.G.

Design (planned the methods to generate the results): C.G.

Supervision (provided oversight, responsible for organization and implementation, writing of the manuscript): C.G.

Data collection/processing (responsible for experiments, patient management, organization, or reporting data): C.G.

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Writing (responsible for writing a substantive part of the manuscript): C.G.

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Practical Applications

- The chiropractic profession has not been able to create a single unifying identity for itself.
- Advanced practice initiatives, vertebral subluxation, the role of traditional chiropractic philosophy, subspecialties, and practice styles continue to separate the profession.
- The profession should recognize that the separations will most likely continue and therefore should embrace its diversity.

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