An Analysis of the General Chiropractic Council's Policy on Claims Made for the Vertebral Subluxation Complex

Christopher Kent D.C., J.D.

ABSTRACT

The United Kingdom's regulatory body for the chiropractic profession recently issued a document on claims made for the vertebral subluxation complex (VSC), which states that the VSC is an historical concept not supported by any clinical research evidence that would allow claims to be made that it is the cause of disease or health concerns. The document goes on to provide "must" statements regarding beliefs, values, evidence based practice and advertising.

The GCC has resorted to a "straw man" fallacy in their Guidance document thereby misrepresenting others' positions on the topic. Clinical research evidence exists to support a nexus between vertebral subluxation and health concerns and evidence-based practice (EBP) is not limited to those interventions supported by randomized controlled trials (RCTs). Despite allusions to the contrary, subluxation-centered care and patient-centered care are not mutually exclusive and the suggestion that subluxation-centered chiropractors do not or cannot practice in an evidence-based model is another "straw man" fallacy.

The practice of imposing a more burdensome evidence standard on subluxation-centered chiropractors than on musculoskeletal/pain treatment oriented chiropractors, or medical practitioners, is unacceptable, discriminatory, and an application of the fallacy of "special pleading." Despite the GCC's contentions, vertebral subuxation is recognized by the World Health Organization and major chiropractic organizations worldwide, and manifestations of vertebral subluxation may be assessed utilizing reliable and valid examination procedures. Finally, and perhaps most importantly, the management of vertebral subluxation is the chiropractic profession's unique contribution to the healthcare system.

Key Words: *Chiropractic, Vertebral Subluxation, Evidence based Health Care, Regulatory Boards*

Introduction

The General Chiropractic Council (GCC) is the United Kingdom statutory body with regulatory powers established by the Chiropractors Act of 1994. The GCC states that they have three main duties:

- To protect the public by establishing and operating a scheme of statutory regulation for chiropractors, similar to the arrangements that cover other health professionals
- To set the standards of chiropractic education, conduct and practice
- To ensure the development of the profession of chiropractic, using a model of continuous improvement in practice

In May of 2010 the GCC issued a document titled:

GUIDANCE ON CLAIMS MADE FOR THE CHIROPRACTIC VERTEBRAL SUBLUXATION COMPLEX

The document states:

The chiropractic vertebral subluxation complex is an historical concept but it remains a theoretical model. It is not supported

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by any clinical research evidence that would allow claims to be made that it is the cause of disease or health concerns.

Chiropractors are reminded that

- they must make sure their own beliefs and values do not prejudice the patients' care (GCC Code of Practice section A3)
- they must provide evidence based care, which is clinical practice that incorporates the best available evidence from research, the preferences of the patient and the expertise of practitioners, including the individual chiropractor her/himself (GCC Standard of Proficiency section A2.3 and the glossary)
- any advertised claims for chiropractic care must be based only on best research of the highest standard (GCC Guidance on Advertising issued March 2010)

Critical Analysis of the GCC Guidance

The General Chiropractic Council (GCC) has resorted to a "straw man" fallacy in their "Guidance on Claims Made for the Chiropractic Vertebral Subluxation Complex" (VSC Guidance).

A straw man argument is based on misrepresentation of an opponent's position. To "attack a straw man" is to create the illusion of having refuted a proposition by substituting a superficially similar yet weaker proposition (the "straw man"), and refuting it, without ever having actually refuted the original position.[1] A handful of chiropractors representing the radical fringe of the profession, and a self-described cadre of "skeptics," are suggesting that the term and concept of vertebral subluxation be abandoned. They erroneously claim that subluxation-based chiropractic is based on the antiquated monocausal theory espoused by early chiropractors, or the limited model of intraforaminal nerve-root compression. Anyone with even a passing knowledge of the literature knows this is not true.[2]

The VSC Guidance document states, *inter alia*, that the vertebral subluxation complex "is not supported by any clinical research evidence that would allow claims to be made that it is the cause of disease or health concerns." Chiropractors do not claim that VSC is ***the*** cause of disease (emphasis added). Had the sentence ended with "the cause of disease," there would be no issue. However, by using the term "any," and adding "health concerns," the statement is falsified. Furthermore, the inference that a chiropractor who acknowledges VSC believes that it is ***the*** cause of disease is untrue.

Use of the adjective "any" in relation to evidence, and failure to define "health concerns" places the GCC in an utterly indefensible position. The existence of a single piece of evidence linking VSC to a perceived health benefit falsifies the statement. The World Health Organization[3] defines "health" as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The Definition has not been amended since 1948. Therefore, ***any*** clinical research evidence supporting a relationship between VSC and "physical, mental, or social well-being" falsifies the statement.

Clinical research evidence exists to support a nexus between vertebral subluxation and health concerns.

A comprehensive review of the literature supporting this relationship is beyond the scope of this paper. Suffice it to say that entire textbooks from mainstream medical publishers have addressed it.[4-7] At least one peer-reviewed journal indexed in CINAHL, MANTIS, and ICL is devoted to the subject.[8] Furthermore, only one citation is necessary to falsify the GCC statement.

A three arm randomized clinical trial with two control groups (one receiving usual medical care, and the other placebo controlled) investigated the effect of subluxation-based chiropractic care on persons undergoing inpatient addiction treatment in a residential addiction care setting.[9] Chiropractic care, consisting of spinal adjustments directed to vertebral subluxations was administered five days per week over a period of 30 days, for a total of 20 care encounters. A total of 98 subjects (14 female and 84 male) were enrolled in the year-and-a-half long study. 100% of the Active (chiropractic) group completed the 30-day program, while only 24 (75%) of the Placebo group receiving a simulated chiropractic adjustment and 19 (56%) of the Usual Care group completed 30 days.

The Active group showed a significant decrease in anxiety while the placebo group showed no decrease in anxiety. The frequency of visits to the Nurse's station was monitored during the course of the study. Of those in the Active care group, only 9% made one or more visits, while 56% of the Placebo group and 48% in the Usual Care group made such visits. This poor performance by the Placebo group suggests that the favorable results obtained in those persons receiving chiropractic care are not attributable to a placebo effect. A 100% retention rate was achieved in a residential care setting using subluxation-centered chiropractic. The possible physical and neurological mechanisms for such a response are described in an earlier paper by Holder et al, in which they describe the Brain Reward Cascade in relationship to vertebral subluxation and its role in resolving Reward Deficiency Syndrome (RDS).[10]

A large retrospective study of subluxation-based chiropractic care on self-related health, wellness and quality of life was published.[11] After surveying 2,818 respondents in 156 clinics, a strong connection was found between persons receiving chiropractic care and self-reported improvement in health, wellness and quality-of-life. 95% of respondents reported that their expectations had been met, and 99% wished to continue care. Furthermore, improvements in health related behavious was noted in subjects under long-term chiropractic care.

In a case-controlled retrospective study, chiropractors collaborating with researchers at the University of Lund found that chiropractic care could influence basic physiological processes affecting oxidative stress and DNA repair.[12] Serum thiol levels were used as a surrogate indicator of DNA repair and oxidative stress. The study examined serum thiols in patients under short-term and long-term chiropractic care. Serum thiols are primary antioxidants, and serve as a measure

of human health status. The test provides a surrogate estimate of DNA repair enzyme activity, which has been shown to correlate with lifespan and aging.

Comparing serum thiol levels in nearly 50 patients receiving short- or long-term chiropractic care with controls, researchers found that independent of age, sex or taking nutritional supplements, long-term chiropractic care of two or more years re-established a normal physiological state in patients. Ability to repair damaged DNA is an important factor in health and longevity. Oxidative stress is now a broadly accepted theory of how persons age and develop disease. Oxidative stress results in DNA damage, and inhibits DNA repair. According to the authors, "it was concluded that musculoskeletal stress discomfort, associated with vertebral subluxation, could induce an in vivo oxidative stress effect estimated by reduced thiol levels in plasma, but it could also be reversed by long term chiropractic care."

Another study[13,14] looked at the degree to which chiropractic intervention affected a change in a healthy lifestyle. The study found that chiropractic care users do tend towards the practice of a positive health lifestyle, which also has a direct effect on reported improvements in wellness. These empirical links are relative to the sociodemographic characteristics of this population and show that use of chiropractic care is an aspect of a wellness lifestyle.

In a review of literature related to objective physiological changes following chiropractic care, Hannon[15] discussed more than twenty studies documenting objective health benefits in subjects who were specifically described as "asymptomatic," "healthy," "normal," or "free from physical injury." Nearly an equal number of studies were found documenting objectively measured health benefits in subjects in which no symptomatic presentation was described.

In a comprehensive review of over 1200 papers addressing neurovertebral influences on visceral and autonomic nervous system function, Rome[16,17] notes, "Evidential support for the association of a neurovertebral influence upon visceral symptoms, function and dysfunction does exist in the referenced literature. This includes the higher levels of evidential assessments, and would seem to negate claims that there are no formal research studies in the manipulative sciences…The importance of this clinical entity – the VSC, is worthy of separate mention."

Evidence-based practice (EBP) is not limited to those interventions supported by randomized controlled trials (RCTs).

Sackett [18]defines evidence-based practice as: "The conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of individual patients. ... [It] is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions."

EBP is not a revolutionary idea. As Baltzan[19] wrote, "What's new about that? Certainly that is what I learned from my instructors when I went to medical school nearly 50 years ago and what my father told me he learned in medical school 80 years ago. In fact, Hippocrates understood the concept."

The problem is not, as Sackett[20] proposed, "integrating individual clinical expertise and the best external evidence." Every doctor does that. The problem is the cavalier dismissal of evidence that doesn't fit into a rigid hierarchy and the compartmentalizing of the profession into two classes: (1) an oligarchy of researchers; and (2) doctors who are reduced to mere technicians following the flow charts and algorithms promulgated by the elite. There is grave danger that the heart and soul of the healing encounter - the doctor-patient relationship - may be a casualty of the more extreme application of this mechanistic approach.

Although there is some minor variation in evidence hierarchies, the randomized clinical trial (RCT) is usually at the top. Significant problems are inherent in the RCT. Furthermore, for chiropractic, which does not treat specific diseases and emphasizes the individual needs of each patient, RCTs are an expensive exercise in futility.

The randomized clinical trial was first proposed by the British statistician Austin Bradford Hill in the 1930s.[21] Since then, the RCT has received a plethora of praise and a paucity of criticism. The Office of Technology Assessment[22] noted, "Objections are rarely if ever raised to the principles of controlled experimentation on which RCTs are based."

Despite such widespread enthusiasm, A.B. Hill[23] recognized that clinical research must answer the following question: "Can we identify the individual patient for whom one or the other of the treatments is the right answer? Clearly this is what we want to do. ... There are very few signs that they [investigators] are doing so." Herein lies the fatal flaw in RCTs.

As Coulter[24] observed, "We consider the controlled clinical trial to be a wrongheaded attempt by man to subjugate nature. Its advocates hope to overcome the innate and ineluctable heterogeneity of the human species in both sickness and health merely by applying a rigid procedure." Inability of the RCT to deal with patient heterogeneity makes it impossible to use RCT results to determine if a given intervention will achieve a specified result in an individual patient.

There are other problems associated with the application of evidence-based practice. Black[25] listed the following: the lack of generalizability of scientific evidence to individual patients, the lack of attention to third-party interests, the threat to the "art" of medicine, and the dangers of an oversimplistic approach. Although EBM clearly has a place, it does not have all the answers.

Holmes, et al.,[26] are even harsher in their criticism of evidence-based health sciences (EBHS): "EBHS comes to be widely considered as the truth. When only one method of knowledge production is promoted and validated, the implication is that health sciences are gradually reduced to EBHS. Indeed, the legitimacy of research designs comes to be questioned, if not dismissed altogether. In the starkest terms, we are currently witnessing the health sciences engaged in a strange process of eliminating some ways of knowing. EBHS becomes a 'regime of truth,' as Foucault would say - a regimented and institutionalized version of 'truth.' ... The ossifying discourse that supports EBM is the result of an ideology that has been promoted to the rank of an immutable

truth and is considered, in learned circles, as essential to real science."

The authors further note, "The all-embracing economy of such ideology lends the ... disciples a profound sense of entitlement, what they take as a universal right to control the scientific agenda. By a so-called scientific consensus, this 'regime truth' ostracizes those with 'deviant' forms of knowledge, labeling them as rebels and rejecting their work as scientifically unsound."

However, the most damning aspect of evidence-based practice is the lack of scientific evidence that it improves clinical outcomes. According to Haneline,[27] "It should be noted that the process of EBP itself has not been rigorously tested, so we do not know for sure if it actually results in improved health. No RCTs that have compared EBP with standard methods or practice have been carried out in any of the health care professions because of the methodological difficulties and exorbitantly high costs that would be associated with attempting to execute such studies."

With tongue firmly planted in cheek, Smith and Pell[28] probably said it best: "As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomized controlled trials. Advocates of evidence-based medicine have criticized the adoption of interventions evaluated by using only observational data. We think that everyone might benefit if the most radical protagonists of evidence-based medicine organized and participated in a double blind, randomized, placebo-controlled, crossover trial of the parachute."

Sackett[29] stated, "Evidence Based Medicine is the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values

Perhaps Baruss[30] said it best: "If we are serious about coming to know something, then our research methods will have to be adapted to the nature of the phenomenon that we are trying to understand. The purpose of science should take precedence over established methodologies ... Similarly, belief in a universal, inflexible scientific method that can guarantee truth belongs to scientism. If one is authentic, one's effort to develop one's understanding by changing opinions into questions may cut so deeply that traditional research methods themselves are called into question and are replaced by others that serve one's purpose better. One may need to draw on the totality of one's experience and not just on that subset that consists of observations made through the process of traditional scientific discovery."

> ***Subluxation-centered care and patient-centered care are not mutually exclusive. The suggestion that subluxation-centered chiropractors do not or cannot practice in an evidence-based model is another "straw man" fallacy.***

A report by the Economic and Social Research Institute of the W.K. Kellogg Foundation[31] listed the characteristics of patient-centered care:

A. *Welcoming environment*: provide a physical space and an initial personal interaction that is "welcoming," familiar, and not intimidating;

B. *Respect for patients' values and expressed needs*: obtain information about patient's care preferences and priorities; inform and involve patient and family/caregivers in decisionmaking; tailor care to the individual; promote a mutually-respectful, consistent patientprovider relationship;

C. *Patient empowerment or "activation"*: educate and encourage patient to expand their role in decision-making, health-related behaviors, and self-management;

D. *Socio-cultural competence*: understand and consider culture, economic and educational status, health literacy level, family patterns/situation, and traditions (including alternative/folk remedies); communicate in a language and at a level that the patient understands;

E. *Coordination and integration of care*: assess need for formal and informal services that will have an impact on health or treatment, provide team-based care and care management, advocate for the patient and family, make appropriate referrals and ensure smooth transitions between different providers and phases of care;

F. *Comfort and support*: emphasize physical comfort, privacy, emotional support, and involvement of family and friends;

G. *Access and navigation skills*: provide what patient can consider a "medical home," keep waiting times to a minimum, provide convenient service hours, promote access and patient flow; help patient attain skills to better navigate the health care system;

H. *Community outreach*: make demonstrable, proactive efforts to understand and reach out to the local community.

These characteristics are applicable to any healthcare provider, and are appropriate for both musculoskeletal and subluxation/wellness oriented chiropractic practices. To suggest that subluxation-centered care and patient-centered care are incompatible, mutually exclusive, or contradictory is disingenuous.

> ***Imposing a more burdensome evidence standard on subluxation centered chiropractors than on musculoskeletal/pain treatment oriented chiropractors, or medical practitioners, is unacceptable, discriminatory, and an application of the fallacy of "special pleading."***

Special pleading is a logical fallacy where a double standard is applied. One flawed premise that has resulted in a cultural barrier to the broader application of distinctively chiropractic principles and methods is the belief that allopathic interventions universally enjoy strong research support for their safety and effectiveness. Chiropractic, along with other non-allopathic approaches, are dismissed as lacking scientific support. Thus, allopathic medicine has become the *de facto* standard and enjoys largely uncritical acceptance by policy-makers.

According to a 1991 statement by David Eddy,[32] "There are perhaps 30,000 biomedical journals in the world, and they have grown steadily by 7% a year since the seventeenth century. Yet only about 15% of medical interventions are supported by, solid scientific evidence, David Eddy, professor, of health policy and management at Duke University, North Carolina, told a conference in Manchester last week. This is partly because only 1% of the articles in medical journals are scientifically sound, and partly because many treatments have never been assessed at all."

Pelletier[33] wrote, "To provide a baseline against which to measure CAM, it is important to point out that as much as 20 percent to 50 percent of conventional care, and virtually all surgery, has not been evaluated by RCTs." An analysis was published in the journal *Clinical Evidence*.[34] Of 2,404 treatments used in medical practice, 360 (12 percent) were rated as beneficial, 538 (23 percent) likely to be beneficial, 180 (8 percent) as a trade-off between benefits and harms, 115 (6 percent) unlikely to be beneficial, 89 (4 percent) likely to be ineffective or harmful, and 1,122 (46 percent) as unknown effectiveness. In other words, only 35 percent of conventional therapies were found to be beneficial or even likely to be helpful.

Kilo and Larson[35] wrote, "On balance, the data remain imprecise, and the benefits that U.S. health care currently deliver[s] may not outweigh the aggregate health harm it imparts ... it is time to address possibility of net health harm by elucidating more fully aggregate health benefits and harms of current health care."

This isn't gratuitous medical-bashing; it's merely an acknowledgement of the current state of the art. We cannot allow policy-makers to demand a more burdensome standard of safety and effectiveness for chiropractic than is demanded of allopathic medicine. On a level playing field, subluxation-based chiropractic will establish a rightful place in the culture.

Regarding musculoskeletal chiropractic, some chiropractic leaders have suggested that low back pain should be our point of entry into the health care system. They frequently base this opinion on the premise that there is sound, incontrovertible scientific evidence that chiropractic care represents a superior approach to low back pain. In actuality, the evidence is equivocal at best.

First, manipulative therapy is not synonymous with chiropractic care. A growing number of practitioners, particularly physical therapists and osteopathic practitioners, offer this service. While adjustment of vertebral subluxation is a unique service provided by chiropractors, spinal manipulative therapy is a common-domain procedure.

In addition, the scientific evidence supporting manipulation as a treatment for low back pain is equivocal. A review in the Cochrane Database[36] sought "to resolve the discrepancies related to the use of spinal manipulative therapy and to update previous estimates of effectiveness, by comparing spinal manipulative therapy with other therapies and then incorporating data from recent high-quality randomized controlled trials."

What did these investigators conclude? "Spinal manipulative therapy had no statistically or clinically significant advantage over general practitioner care, analgesics, physical therapy, exercises, or back school. ... There is no evidence that spinal manipulative therapy is superior to other standard treatments for patients with acute or chronic low-back pain." And what of the claim that chiropractors offer more effective manipulative treatment for back pain than other providers? The authors note: "[P]rofession of manipulator ... did not affect these results."

Chiropractic Care for Low Back Pain: A Cochrane Review Update[37] concluded, "Combined chiropractic interventions slightly improved pain and disability in the short-term and pain in the medium-term for acute and subacute LBP. However, there is currently no evidence that supports or refutes that these interventions provide a clinically meaningful difference for pain or disability in people with LBP when compared to other interventions."

Regarding cervical and thoracic manipulation, the Cochrane Review[38] was lukewarm at best, noting primarily low quality evidence. The authors concluded, "Cervical manipulation and mobilisation produced similar changes. Either may provide immediate- or short-term change; no long-term data are available. Thoracic manipulation may improve pain and function. Optimal techniques and dose are unresolved. Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate."

Vertebral subuxation is recognized by the World Health Organization and major chiropractic organizations worldwide.

The World Health Organization (WHO) has promulgated guidelines on basic training and safety in chiropractic.[39] This document discusses philosophy and the basic theories of chiropractic, noting that:

> Chiropractic is a health care profession concerned with the diagnosis, treatment and prevention of disorders of the neuromusculoskeletal system and the effects of these disorders on general health. There is an emphasis on manual techniques, including joint adjustment and/or manipulation, with a particular focus on the subluxation.
>
> The concepts and principles that distinguish and differentiate the philosophy of chiropractic from other health care professions are of major significance to most chiropractors and strongly influence their attitude and approach towards health care.
>
> A majority of practitioners within the profession would maintain that the philosophy of chiropractic includes, but is not limited to, concepts of holism, vitalism, naturalism, conservatism, critical rationalism, humanism and ethics. (p. 5)

The core syllabus for full chiropractic education includes the following:

He/she should possess a comprehensive understanding and command of the skills and knowledge that constitute the basis of chiropractic in its role as a health careprofession, as follows:

> achieve a fundamental knowledge of health sciences, with a particular emphasis on those related to vertebral subluxation and the neuromusculoskeletal systems… (p. 10)

Furthermore, in the World Health Organization's International Classification of Diseases (ICD-10)[40] codes, ICD Code M99.1 is assigned to "Subluxation complex (vertebral)."

The "unique paradigm of chiropractic care" has been articulated by the Association of Chiropractic Colleges[41] (ACC), and accepted by major chiropractic organizations, including:

- The Council on Chiropractic Education
- The International Chiropractor's Association
- The American Chiropractic Association
- The World Federation of Chiropractic
- The Congress of Chiropractic State Associations
- The Association of Chiropractic Colleges
- The Federation of Chiropractic Licensing Boards
- National Board of Chiropractic Examiners
- The National Association of Chiropractic Attorneys
- The Council on Chiropractic Practice

The ACC Paradigm states the following concerning the subluxation:

> *4.0 THE SUBLUXATION*
>
> Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation.
>
> A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.
>
> A subluxation is evaluated, diagnosed and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.[1]
>
> ***Manifestations of vertebral subluxation may be assessed utilizing reliable and valid examination procedures***.

Reliable and valid clinical assessments exist for the biomechanical and functional components of vertebral subluxation. These include radiographic mensuration, instrumentation for evaluation of function, and "paper and pencil" instruments to evaluate self-reported quality-of-life.

These technologies are described in internationally recognized practice guidelines, which have qualified for inclusion in the National Guideline Clearinghouse. Council on Chiropractic Practice (CCP) Clinical Practice Guideline No. 1, ***Vertebral Subluxation in Chiropractic Practice*****,** has undergone three revisions. In addition to being included in the National Guideline Clearinghouse (NGC), the guideline is included in Healthcare ***Standards: Official Directory,*** published by ECRI, a Collaborating Center for the World Health Organization, and the official WHO healthcare standards and guidelines archive. The CCP Guideline may be obtained online at no cost at:

http://www.ccp-guidelines.org/guideline-2008.pdf

The NGC summary of recommendations is available at:

http://www.ngc.gov/summary/summary.aspx?doc_id=13617&nbr=006978&string=vertebral+AND+subluxation

Guidelines addressing the use of spinal radiography for biomechanical analysis related to vertebral subluxation have been promulgated by the Practicing Chiropractors' Committee on Radiological Protocols (PCCRP) For Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice. This guideline document may be accessed without charge at: http://www.pccrp.org

> ***The Vertebral Subluxation Complex is the chiropractic profession's unique contribution to the healthcare system.***

Several articles have recently appeared in both the chiropractic trade press and peer-reviewed journals questioning the very existence of vertebral subluxations.[42,43] A comprehensive review of the evidence supporting vertebral subluxation is beyond the scope of this article. Several clinical practice guidelines or "best practices" documents have addressed vertebral subluxation and reviewed the scientific literature supporting objective assessment of vertebral subluxation.[44-46] All major chiropractic organizations including the ACA, ICA and WFC have accepted the Association of Chiropractic Colleges Paradigm,[41] which adopted the following statement concerning subluxation:

"Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation. A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence."

An overwhelming majority of chiropractors (at least in North America) accept the term and the concept. Smith and Carber[78] noted that more than 70 percent of chiropractors surveyed report that subluxation is important to their clinical decisions and guides their clinical care of patients. McDonald, et al.,[48] reported that more than 88 percent of their surveyed chiropractors favor retaining the term *vertebral subluxation complex*.

By bantering about terms such as *integration* and *evidence-based practice*, members of a fringe element have achieved a degree of success in hijacking some colleges and political organizations in an apparent attempt to pander to politics and fit into the medical system.

There is an organization known as the Flat Earth Society[49] whose members stubbornly choose to ignore the

overwhelming evidence contrary to their position and deny the spherical nature of the Earth. Ironically, they use Internet technology to propagate this belief. Apparently the Flat-Earth folks have no problem using orbiting communications satellites to spread the word. The subluxation deniers would fit in splendidly. Dogma over data.

What of the notion that DCs should abandon subluxation and the traditional philosophy of chiropractic? The fundamental issues are simple: Are we a profession with a clearly defined mission or are we a profession simply seeking some niche which offers access to a slice of the health care pie? Are we driven by principles or politics? Does our mission statement define our political position or do we grovel to get whatever crumbs are tossed our way? Do we have an identity defined by our purpose or are we chameleons who change our colors to blend into the existing environment?

Conclusion

Medical anthropologist EA Morinis[50] wrote, "Only the chiropractic philosophy significantly distinguishes the chiropractic practitioner. And yet the philosophy is kept hidden away. It has done so in fear of being labeled quackery, and this was undoubtedly a good strategy to follow at one time. The public knows next to nothing of [the] chiropractic philosophy of healing and its mechanisms: If hospitals offer spinal manipulation, a chiropractor offers nothing else. This distortion of the chiropractic tradition can only be overcome by a reevaluation of the place of theory in chiropractic. ... Dispossessed of its philosophy, chiropractic is dispossessed of its uniqueness, and perhaps its future."

Physiologist I.M. Korr[51] admonished the osteopathic profession to hold fast to its principles: "There are misapprehensions about the source of your strength. Your profession appears to believe that its strength is to be found more in the stamps of approval by self-appointed magistrates of medicine. ... As a result, you often act as though you believed your strength is to be nurtured by mimicry, by cloaks of protective coloration, by compromise of principles, by organized compliance, by appeasement, and by adaptation to what is prescribed for you by organizations of another profession. ... Recent events loudly proclaim the futility of this approach." Korr[52] also stated, "I think we need, in some way, to re-infuse into the profession an appreciation of the immensity of the idea, of the profession's responsibility to it, and of the vast opportunities to serve it."

We must make sure everyone understands vertebral subluxation, wellness, and our unique approach to unleashing human potential. Or, like the Soviet Union, the chiropractic profession as we know it could die with barely a whimper. The alternative is being the champions of a different approach to our health care priorities and playing a major role in the rescue of a failing health care system.

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