“Methodological and epistemological challenges for the chiropractic profession in health care – a study of the history, status quo and future of research and clinical practices.”

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Declaration

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature ……..

Date ……..

Abstract

Although a legitimate provider of manipulative therapy, chiropractic largely functions outside mainstream health care in South Africa. A narrow research focus, poor institutional representation and inadequate professional integration all contribute to its undetermined role in health care.

This study exploratory, qualitative study sought to investigate the state of the art of chiropractic with respect to beliefs, philosophy, research methods and clinical practices.

Semi-structured, interviews were used to extract responses from ten chiropractors, six patients and four researchers.

The results were interpreted on three levels; thematically, in relation to chiropractic's discipline and profession and as a function of the '3 worlds' framework.

The thematic analysis revealed that:

1. Beliefs and philosophical traditions play an active role in the practice and science of chiropractic.
2. The chiropractic investigative paradigm has started to mature.
3. The contextual role of research methods is being clarified.
4. Contemporary chiropractic practice is not as evidence-based as it should be.
5. The chiropractic model of practice is significantly different to the perceived standard medical model.
6. Chiropractic clinical practice has a fuzzy identity.
7. Chiropractic's professional status is unclear.
8. The professional and disciplinary components of chiropractic are still institutionally immature.
9. Chiropractic's legitimacy is questionable.

Themes 1-3 indicated that beliefs and philosophical traditions affect the way in which chiropractors conduct themselves clinically, the way patients view the world of health care and the manner in which researchers study clinical phenomena. Themes 4-6 suggest that the state of the art of chiropractic clinical practice is different from medicine, however the exact nature of its model of practice seems quite fluid. Themes 7, 8 and 9 suggest that the degree of professional and institutional maturity provide chiropractic with only partial legitimization.

With regards to the discipline it seems that science and education have an important buffering role to play between the patient and the practitioner, in order to curb metaphysically motivated practices. Furthermore, chiropractic's investigative paradigm is progressing atypically and hence the view of it conforming to a standard view of science is questioned.

With regards to professional matters, our study indicates that chiropractors function on a spectrum which runs between "technicians" and "physicians". Whilst patients have holistic health care beliefs it seems they are pushed toward chiropractic, through negative allopathic health care experiences and are drawn to the profession by its integrated model of practice. However, the lack of mainstream healthcare integration counter balances this worth and reduces chiropractic's professional legitimacy.

Two cross over themes were revealed. Firstly, chiropractic's investigative paradigm has started to narrow the gap between applied science and clinical practice and secondly chiropractic's legitimacy cannot lie in the opinion of medicine.

The 'three worlds' framework indicated that the first three themes are meta-scientific (W3) reflections on beliefs, philosophical traditions and research methodology. The fourth theme reflects the relationship of research and practice (W2 and W1), and the remaining five themes are reflections clinical practice (W1 activities).

Our study contends that chiropractic has the potential to develop into a mainstream health care provider through the implementation of a multi-leveled development strategy.

Opsomming

Alhoewel chiropraktyk ’n geoorloofde verskaffer van manipulasieterapie is, funksioneer dit grootliks buite hoofstroomgesondheidsorg in Suid-Afrika. ’n Eng navorsingsfokus, swak institusionele verteenwoordiging en ontoereikende professionele integrasie het tot die onbepaalde rol van chiropraktyk in gesondheidsorg bygedra.

Hierdie verkennende kwalitatiewe studie het gepoog om chiropraktiese praktyk ten opsigte van oortuiginge, filosofie, navorsingsmetodes en kliniese praktyke te ondersoek. Semi-gestruktureerde onderhoude is gebruik om response van tien chiropraktisyns, ses pasiënte en vier navorsers te verkry. Die uitslae is op drie vlakke geïnterpreteer: (i) tematies; (ii) met betrekking tot die chiropraktiese dissipline en beroep; en (iii) as ’n funksie van die “drie wêrelde”-raamwerk.

Die tematiese analise het die volgende blootgelê:

1. Oortuiginge en filosofiese tradisies speel ’n aktiewe rol in die praktyk en wetenskap van chiropraktyk.
2. Die chiropraktiese ondersoekende paradigma is besig om verder te ontwikkel.
3. Die kontekstuele rol van navorsingsmetodes word duideliker gemaak.
4. Hedendaagse chiropraktiese praktyk is nie soveel op bewyse gegrond as wat dit behoort te wees nie.
5. Die chiropraktiese model van praktyk verskil aansienlik van die aanvaarde standaard- mediese model.
6. Die identiteit van chiropraktiese kliniese praktyk is vaag.
7. Chiropraktyk se professionele status is onduidelik.
8. Die professionele en dissiplinêre komponente van chiropraktyk is steeds institusioneel onderontwikkel.
9. Die legitimiteit van chiropraktyk is betwisbaar.

Temas 1 tot 3 het daarop gedui dat oortuiginge en filosofiese tradisies die wyses beïnvloed waarop chiropraktisyns klinies handel, waarop pasiënte die wêreld van gesondheidsorg sien, en waarop navorsers kliniese verskynsels bestudeer. Uit temas 4 tot 6 kan afgelei word dat chiropraktiese kliniese praktyk van geneeskunde verskil; die presiese aard van die praktykmodel kom egter heel onbestendig voor. Uit temas 7, 8 en 9 kan afgelei word dat die graad van professionele en institusionele ontwikkeling chiropraktyk slegs gedeeltelik legitimeer.

Dedication

I dedicate this work to the patients, practitioners and scholars of the chiropractic profession.

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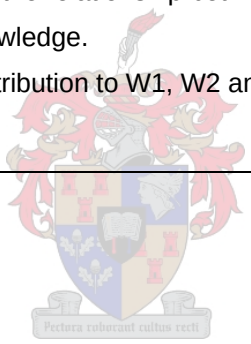

Chapter 1
Introduction

1.1. Study context and background

As both a clinician and an academic, I have been privy to some of the debates and developments within the chiropractic profession. One such issue is its "split personality" with regard to clinical management and research.

Journal articles in this field create the impression that the profession is a manual healthcare "sub-specialty". Chiropractic scholars tend to focus on the use of spinal manipulation as an intervention to treat various clinical musculo-skeletal syndromes. Clinical experimental and quasi-experimental designs to this effect abound in the literature and although a great many tend to focus on back pain and headaches, various extremity studies are also a feature. From time to time areas traditionally thought to lie in the domain of allopathy are investigated, for example colic and asthma. However, these more organically oriented studies tend to make up only a small portion of studies.

In the clinical setting, a similar trend is evident with patients consulting chiropractors mainly for a cure for or relief from back pain and headaches, and every now and again reports of successful organic condition management are heard. The profession's practice therefore seems to be congruent with its biomedically oriented mode of inquiry. Considering the history of the profession, particularly its battles with mainstream medicine, one is left asking what all the fuss was about. However, when one looks deeper, an undercurrent of scholarly debate and clinical discord exists, which questions this apparently stable status quo.

From a professional perspective, chiropractic has claimed and maintained its independence from mainstream medicine through a history of fierce professional and medico-legal warfare. It claims links with philosophical traditions that at times place it in opposition to allopathic medicine. These traditions seem to influence the nature of the chiropractor's approach to management and the relationship that exists with his/her patient. Chiropractors tend to develop close professional relationships with their patients, which lead to the management of issues far removed from mechanical symptoms, such as stress management.

Secondly, scholarly discourse criticising reductionist thinking and warning scholars of the limitations of controlled, intervention studies is frequent in chiropractic literature. The common theme of these commentaries is the stunted and unbalanced development of the profession should all aspects of the profession's activities not be investigated. Furthermore, scholars argue that the profession will encounter the same problems as their allopathic counterparts if they use similar approaches to problem solving.

Consequently, I found myself asking whether these commentators have a point and if they do, what the origins of this duality of chiropractic were,, what purpose(s) it serves and what the complications associated with it are.

Relevance and importance of the study

Chiropractic seems split with respect to its professional and disciplinary identity. It is important that the factors that influence it are considered systematically so that they can be integrated into the larger academic discourse related to these topics.

It may not be the best option for the welfare of chiropractic merely to borrow the approaches used by biomedicine to question its own practices. This is mainly because the priority in chiropractic may not necessarily be to separate and observe individual management factors, but rather to view the entire process in its natural setting.

The scope of practice that currently exists for chiropractors in South Africa puts them in a position to play a significant role in South African healthcare. Chiropractors are primary contact physicians with a host of management tools at their disposal. However, the professional exposure often does not span this range, in particular with respect to primary healthcare management in the public sector. If the profession does not achieve integration in this regard, its scope of practice is at risk of being reduced, and the professional domain may become similar to that of manual therapy.

Against this background, I undertook to develop a discourse for the South African setting, which could begin to address the "Jekyll and Hyde" persona of chiropractic in such a manner that it could lead to the meaningful development of the profession in the future.

1.2. The topic of investigation

A preliminary overview of the chiropractic literature for evidence of clinical management efficacy, particularly for lower back pain, revealed that the majority of investigations conducted in chiropractic have been of an experimental or quasi-experimental research design, often in the form of clinical trials, comparing spinal manipulation with other interventions (Meade *et al*., 1990; Manga *et al*., 1993; Hendler, 1995; Paton, 2000 Muller and Giles 2003 and Assendelt et al. 2005).

The traditionally accepted clinical outcomes have revolved mainly around measurement outcomes, such as the quantification of pain and disability, from an objective and subjective perspective (Jensen, 1986; Fischer, 1986; Triano, 1993). As with other predominantly quantitative paradigms, scientific rigour was attempted through methodological techniques aimed at enhancing control, whilst keeping reactivity at acceptable levels (Mouton, 1996: 141-143). Factors such as attention effects, researcher confounding and the placebo effect were seen as decidedly negative and eliminated as far as possible (Koes *et al*., 1992).

Despite the significant body of evidence suggesting the efficacy of chiropractic manipulative therapy particularly for acute idiopathic low back pain, the profession is still dogged by reductionist methodological criticism in the area of clinical research (Ernst & Assendelft, 1998). Even though authors like Rosner (1999) successfully counter many of these critiques, the misleading impact of manual therapy related literature on clinical practice has not contributed to unifying management protocols.

The practical nature of the profession compels doctors in the chiropractic field to impart not only safe, effective and individualised manual therapy, but also to integrate pertinent lifestyle issues into a management protocol aimed at producing and maintaining a state of optimum health (Kotze, 1995). The non-physical component of care can therefore often include certain activity modifications, patient education and counselling (Kotze, 1995). According to Jamison (1996), this holistic approach to patient care attributes the return to wellness to the interactive “healing encounter” between doctor and patient, rather than to isolated manual therapies. Furthermore, Jamison (1999, 2000) and Meenan (2001) illustrate and argue, respectively, that alternative measures are required to evaluate the process of the doctor-patient interaction, rather than merely its outcome, and they therefore maintain that other qualitative outcomes should be pursued.

Both Mouton (1996: 107) and Jamison (1996) emphasise that the research question(s) should always precede the method applied to answer it/them. If this is the case, one could reasonably argue that valid management protocols could have been ignored due to the lack of consideration given to qualitative research questions within the chiropractic profession, and to the question whether bio-psychosocial, instead of or along with biomedical outcomes, would provide more complete scientific data.

A number of authors have argued that the reason why modern medical science (including chiropractic) has been unable to ameliorate conditions such as chronic non-specific lower back pain results from the biomedical approach to testing clinical efficacy. They suggest that the bio-psychosocial (info-medical) paradigm could provide a viable inclusive alternative for the evaluation of clinical efficacy, particularly for conditions with significant physical, psychological and social components (Firman & Goldstein, 1975; Vernon, 1991; Symonds *et al.,* 1996).

There is some evidence to suggest that the current investigatory practice in chiropractic does not adequately consider the practical, methodological or philosophical elements present in its research paradigm in order to accommodate possible biological, psychological or social influences on a particular research problem.

Examples of qualitative indicators for success, which might be utilised in study designs, have been identified and utilised in other professions, particularly in the nursing sciences. Sherwood *et al*. (2000) concur with Jamison (1991; 1999; 2000) that patient satisfaction with care can be used as a critical indicator for successful outcome in the management of painful syndromes. Sherwood *et al.* (2000) maintain that it is only through the use of qualitative data that the subjective, multidimensional nature of pain can be captured. Furthermore, according to Dowswell *et al*. (2000), the degree of congruence between patients' lives before and after a traumatic episode can be used as a qualitative indicator of recovery.

Although the above-mentioned qualitative indicators have not been fully tested as to their applicability in the chiropractic paradigm, they seem to represent a reasonable point of departure from which appropriate qualitative research methodologies could be developed.

Chiropractic scholars might be tempted to superimpose qualitative designs derived from nursing onto existing ones and to develop hybrid approaches. The problem with this is that professional and disciplinary concerns would not be adequately addressed and the *status quo* would remain unchanged. Merely staying within this narrow focus of discussion would at most answer questions related to the empirical aspects of the topic of interest.

To investigate the theoretical components it is also necessary to ground the discipline and profession of chiropractic in a discourse that could establish their respective characteristics and roles. Specifically, this means considering aspects like the development of chiropractic as a profession and discipline, the role of beliefs and philosophy, and paradigms in the chiropractic field.

It was evident that understanding the views of various stakeholders representative of the profession and discipline about the current and future role of chiropractic in South African healthcare would be required to deal with the practical priorities. Therefore, what initially started out as a narrow clinically oriented topic, focusing on methodologies only, developed into a study covering a cross-section of philosophical, methodological and practical issues related to the science and practice of chiropractic in South Africa.

1.3. Establishing the empirical research niche

Against this background, the aim of this study is to explore the state of chiropractic in South Africa with respect to its professional and disciplinary components and to relate these to the role envisioned by stakeholders in the local healthcare setting.

The specific objectives of the study were as follows:

a) To review the main beliefs, philosophical paradigms and modes of inquiry that underpin chiropractic practice;
b) To describe the process of professionalisation and institutionalisation of chiropractic; and
c) To undertake an empirical study aimed at establishing how the profession is currently viewed and interpreted.

1.4. The research design and methodology in brief

Objectives one and two made use of secondary data. Specifically, a literature study was conducted to review the dominant beliefs, paradigms and methodologies in

chiropractic research. Furthermore, a discourse was developed with respect to chiropractic's unique process of professionalisation and institutionalisation as a means to clarify its current position in local healthcare.

Objective three was addressed through primary research. This took the form of an exploratory, qualitative study aimed at extracting important perceptions or views from in-depth interviews with selected practitioners, researchers and patients.

1.5. Outline of the thesis

Chapter 2 provides a historical context for the development of chiropractic as an antagonist to mainstream medicine, emphasising the history and development of chiropractic practice and its philosophical discourse.

In Chapter 3, the notion of a "chiropractic paradigm" is discussed against the work of Ian Coulter. In addition, the institutionalisation of chiropractic as a discipline and profession, and the role of the chiropractic profession in healthcare are discussed.

Chapter 4 concerns itself with chiropractic research methodology. This discussion takes place within the context of low back pain and a case is made for the development of general principles pertinent to research methodology within the larger chiropractic research paradigm.

Chapter 5 is devoted to a discussion of the methodological issues pertinent to this study.

Chapter 6, 7 and 8 present the empirical results from the interviews conducted with practitioners, patients and researchers, respectively. The results present an overview of the state of chiropractic as a profession and discipline with regards to many of its general aspects and characteristics that constitute the day-to-day running of the profession in the South African context.

Finally, in Chapter 9, the study results are triangulated and conclusions are presented.

Chapter 2
An historical view of the practice and philosophy of chiropractic

2.0. Introduction

The chiropractic profession has had a colourful history, full of interesting personalities and practices that are even more interesting. Despite a number of developmental problems, it has developed rapidly over a relatively short one-hundred-year history into a significant contributor to modern, conservative healthcare (Humphreys, 1994). Chiropractic has moved from being a marginalised healthcare tradition to one that is said to be verging on being mainstream (Wardwell, 1992: 42; Meeker & Haldeman, 2002). The profession hence finds itself at a crossroads about how to define itself in the future with respect to its scope of professional practice, academic discourse and traditions of research (Meeker & Haldeman, 2002).

It is the broad aim of this chapter to present a view of how chiropractic as a discipline and a profession has defined itself and where it might look to maintain and develop a position of relevance in the South-African healthcare system.

To this end, the chapter will focus on the following two themes:

a) The history and development of chiropractic practice and philosophical discourse, as an alternative to mainstream medicine; and
b) The concept of “paradigms” as a key notion relevant to chiropractic.

2.1. The historical basis for chiropractic and medical discord

2.1.1. Introduction

It is no secret that orthodox medicine and chiropractic developed in antagonism to one another from the latter’s inception until late in the 1970s. Although the rifts of many philosophical, academic and medico-legal differences are being healed in a positive and systematic way, the differences between these two groups of healthcare providers are still visible (Chapman-Smith, 2000: 17).

It is the aim of this section to illuminate the origins of the divide between allopathic medicine (from this point on referred to as “medicine”) and chiropractic. This will be done to inform the concept of opposing paradigms, which will be elaborated upon in

a subsequent discussion, in order to provide contextual grounding for the trends chiropractic has followed in its development.

2.1.2. The origins of early chiropractic and medical antagonism

A number of authors have described the relationship between chiropractors and medical practitioners during the early days of chiropractic history (Gibbons, 1992 in Haldeman, 1992: 15; Chapman-Smith, 2000: 11; Keating, 2003) as a period of polarity and antagonism, which led to feuds spanning the greater part of the twentieth century.

In the early part if the nineteenth century, a popular medical protest movement arose in response to the rampant misuse of medical treatments prevalent at the time. As little or no rational foundation existed in medicine, purging of the patient became a popular practice that motivated a host of potentially life threatening, ”heroic” interventions such as bloodletting, surgery and the administration of various poisons and heavy metals. The rate of iatrogenically induced injuries was therefore phenomenally high (Waagen & Strang, 1992 in Haldeman, 1992: 30). To counter these practices, a medical reform movement was established to introduce a coherent, rational approach to healthcare. It turned to the only established principles of the day and started promoting lifestyle change and professional alternatives to orthodox medicine. These recommendations included improving personal hygiene, eating uncooked fruits and vegetables, and exercising regularly in the fresh air. All of these were either scoffed at or opposed by orthodox medical practice. Professional alternatives such as homeopathy, osteopathy, naturopathy and magnetic healing gained popularity at this time and the reform movement argued that even if they did not benefit the patient directly; their interventions did not result in substantial harm and they were thus tolerated as minor stakeholders in the field of healthcare.

By the late 1800s, medicine, although by this stage not quite as organised as what it would become after the 1910 Flexner Report,[1] had embarked on a particular model of practice that was steadily moving it away from manual interventions and towards practices which did not require the laying on of hands (Gibbons, 1992 in Haldeman, 1992: 16; Keating, 2003). This move was probably related to medicine’s growing

[1] Arbaham Flexner is considered to be the man directly responsible for the wholesale inclusion of medicine in the university structure of America, as well as its link to government funding of basic science research (Keating, 1992: 339, 427; Gibbons, 1992 in Haldeman, 1992: 15, 17).

alignment with a (more reductionist) scientific method, which was oriented toward the development of new technologies for the cure of physical disease. At this time, medics had once again lost interest in the role of healthy lifestyle factors because of the advent of medical pharmaceuticals. This coincided with a growing professional ego within medical ranks, which deemed the practice of manipulative therapy as inferior to its standards. Manual therapy was therefore aggressively discouraged within its ranks and those caught practicing in this manner were soon ostracised (Keating, 2003).

Furthermore, even though the social milieu was probably still suitable for the development of a new unorthodox form of healthcare characterised by drug-free intervention and relative harmlessness (Waagen & Strang in Haldeman, 1992: 30), medicine had by that time assumed the role of watchdog against inappropriate healthcare practices. These were seen to be all practices not generated from within medicine itself. It is clear that the motivation for limiting non-medical practitioners from entering the healthcare market at the time had less to do with the benevolent care for society than with keeping the lion's share of the financial profit (Chapman-Smtih, 2000: 12, 13). By the time chiropractic originated, the anti-medical *zeitgeist* of approximately forty years earlier had changed dramatically. The climate that had fostered the development of the aforementioned alternative professions now worked against chiropractic. In addition, chiropractic itself added a third compelling reason for the frosty start to relations.

Shortly after its "discovery"[2] in 1895, chiropractic found itself in the grip of an aggressive medical inquiry bent on stamping out what was seen as a new version of "bone setting". In a bid to develop a rationale for its own existence as separate and distinct from mainstream medicine as quickly as possible, D. D. Palmer turned to metaphysics for salvation (Waagen & Strang in Haldeman, 1992: 31-32; Coulter, 1999: 35-36). Schooled in a number of esoteric healing practices of the day such as faith cure, Christian Science and magnetic healing, he realised that no such grounding could be developed over night. Palmer cleverly countered his lack of evidence by proposing a vitalistic theory as an explanation for the nature and effect of chiropractic.

[2] Although the profession of chiropractic in its present form originated from this point, D. D. Palmer did not claim to be the first to make use of spinal manipulation to treat the infirm (Coulter, 1990).

His theory, called the theory of “universal and innate intelligence”, postulated that the universe is a reflection of an intelligent life force, and that this life force finds its expression in the human body through the concept of *vis medicatrix naturae*, the innate tendency of the body to heal itself. He argued that the vessel of energy flow through the body was the nervous system and that it could become disturbed for a number of reasons, with disease at the common outcome. A further postulate was that this ill-fated process could be reversed by spinal manipulation, which could restore the flow of the life force through the body.

His argument proved to be a shrewd move because it initially grounded the chiropractic profession and is considered to be the primary reason for its survival in the early days of its existence. However, this stance positioned the two camps virtually as polar opposites in terms of philosophical views, since medicine was growing more firmly aligned with science based in materialism (Coulter, 2000). This polarity was widened by the vocal anti-science rhetoric used by a number of the profession’s early representatives, particularly Bartlett Joshua Palmer, son of D. D. Palmer (Chapman-Smith, 2000: 14).

The rift between early chiropractic and medicine was primarily based on the following three factors: a) the dislike of manual approaches to healthcare practice; b) the dislike of competition by the dominant healthcare occupation; and c) the confrontation between two old metaphysical foes, vitalism and materialism/reductionism.

Having aligned themselves with a decidedly anti-mainstream worldview and using techniques that were unfashionable, the early chiropractors firmly entrenched themselves as anti-establishment and, although temporarily safe to practice, quickly found themselves labelled as the “quacks” of the healthcare world. Morris Fishbein, an early secretary and editor of the American Medical Association, made a number of remarks to this effect, labelling chiropractors as both an “unscientific cult” and a group of “rabid dogs” (Chapman-Smith, 2000: 14).

Thus the era of conflict with medicine started which, according to Chapman-Smith (2000: 12-15), would span the next seventy- five years. The two camps clashed on a number of different fronts. Four of these areas were domain issues, namely educational standards, economics or law and politics, nomenclature and spinal

manipulation.. The others resulted from the competitive spirit, excesses and over-enthusiasm of some of the personalities in the opposing camps.

However, it was the economic or legal and political domain that produced overt conflict in the early days. It was clear that medicine no longer saw chiropractic as a harmless group of fringe practitioners, but as serious competition for the patient pool. Chiropractors were being trained faster than their medical counterparts were and many medical practitioners were choosing to bolster their education with a chiropractic qualification. It was in the best interest of medicine to curb or put an end to these developments. The strongest action available to medicine was the legal route and, between the 1920s and 1930s, they exercised this option with great vigour. At the height of the chiropractic witch-hunts, no fewer than 450 of the 600 chiropractors in the United States were prosecuted for practicing medicine without a license. A common situation during these times was the chiropractor and his/her patients opposed by the medical profession. The winner in every instance was the chiropractor because he/she received the powerful public vote because they were seen to be the martyr. It was a lesson that medicine took a long time to learn and one that would ultimately turn the tide once again in favour of the beleaguered profession (Chapman-Smith, 2000: 12-15).

Medicine may have failed to remove chiropractic quickly from American healthcare through outright legal action, but this was only the start of a protracted battle of attrition. Whilst chiropractic won the high profile court battles, medicine secured two important, but insidious victories. It succeeded in segregating chiropractic educationally and politically. By focusing all its attention on the medico-legal issues in the early days, chiropractic education never became an entrenched part of mainstream education and the profession never sought to achieve representation in the public healthcare sector. The impact of this on chiropractic is becoming increasingly evident as contemporary chiropractors are still trying to penetrate mainstream healthcare (Chapman-Smith, 2000: 153).

2.2. Chiropractic's internal strife; the development of competing philosophies and practices

2.2.1. Introduction

If early chiropractic exponents had developed a coherent and unified model of chiropractic practice, the profession may have found it easier to organise itself into a coherent body. However, as will be shown in the next section, not only did

chiropractors develop very different theories for the nature and effect of spinal manipulation, they also proceeded to teach and practice very different clinical approaches. The lack of agreement between scholars about the interpretation of the clinical art (technique), science and philosophy of chiropractic divided the profession and slowed its development as a profession considerably.

2.2.2. The "straights" and the "mixers"

The first two decades of the internal development of chiropractic were marked by feverish debates over the nature and effect of spinal manipulation, as well as over how to identify the functional lesion known as the "subluxation"[3] that chiropractors aimed to reduce.

During the period 1897 to 1914, D. D. Palmer advocated three different theories. His theories ranged from energy flow concepts (vitalistic) on the one hand, to spinal "impingement" theories (mechanistic) on the other, each of which he taught as a fundamental truth at its zenith. Palmer was not the only developer of the philosophical-theoretical discourse of the time. His son, B. J. Palmer, and a number of early graduates from Palmer's school of chiropractic also aggressively contributed to this discourse. However, Palmer's view that spinal manipulation or chiropractic (he often used the two interchangeably) was the only intervention patients required to be rid of disease remained constant.

It did not take long for this fundamentalist view to be challenged. Less than a decade after the first spinal "adjustment", graduates from Palmer's school of chiropractic started proselytising for a mixture of manipulation and naturopathic remedies. This was, of course, in complete opposition to Palmer's philosophical views. According to Keating (2003), it appears to have been the origin of the "mixer-straight" split still evident in the twenty-first century chiropractic context.

Although there is a sad irony in the fact that chiropractic's first success also caused its first major intra-disciplinary conflict, it was in a sense inevitable. Too many exponents of chiropractic identified philosophically with biomedico-reductionism and could not accept the vitalistic tenets upon which Palmer's esoterically oriented theories were based (Waagen & Strang, 1992 in Haldeman, 1992: 33-37).

Two distinct practice approaches developed from this historical split. The innatists or vitalists gave rise to the "straight" (purist) chiropractor who only treated the spine and made use of his/her hands only. The reductionists gave rise to the "mixer" (eclectic) chiropractor who was informed by a more mechanistic or rationalistic approach, based on the consideration of what was biologically reasonable and the use of whatever modality seemed clinically most appropriate.

2.2.3 Chiropractic "techniques"

The early chiropractic exponents were affected by a profound sense of ownership of the skills that they possessed and were not prepared to relinquish these without handsome remuneration (Keating, 2003). Consequently, the development of brand name, patented techniques quickly became big business. These techniques incorporated not only the application of the treatment modality, namely the adjustment or manipulation, but went further to incorporate systematic approaches to identifying the subluxation. Keating (2003) has identified upward of thirty of these techniques in chiropractic, with some of them sporting elaborate diagnostic devices and treatment apparatuses that assist the practitioner. A number of these so-called "brand name" techniques still exist today. This practice led to unhealthy competition, with practitioners slating their opposition as being "un-chiropractic" (whilst at the same time extolling their own virtues), and it generated a high degree of secrecy about techniques and approaches. The result of this type of practice was the development of rival factions within the developing profession with little cross-pollination of ideas.

The one notable exception is the "diversified technique" (Keating, 2003). This term has developed over time to encapsulate a range of eclectic chiropractic techniques that do not aspire to belong to any particular brand name technique (Bergman *et al.*, 1993: 747). They are essentially a compendium of manipulative procedures, which are value free with respect to links with theoretical effects other than the mechanistic ability to induce movement in a joint. This technique is the cheapest and it is the dominant one because it belongs to the public domain and is continually added to by contemporary chiropractors (Keating, 2003).

2.2.4. The development of chiropractic science and education

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[3] Subluxation nomenclature in medicine and chiropractic differ- in medicine this means a partial dislocation, in chiropractic it refers to a functional lesion.

Chiropractic has had its fair share of innovative thinkers who sought to apply emerging technologies to the science of chiropractic (Keating, 2003). This was particularly true from the 1930s onward. However, if one were to evaluate these "tools of measurement and management" critically, the overwhelming majority had no empirical basis for their application (Keating, 2003). Much the same can be said for chiropractic theories. These were often developed in secret isolation and hence did not link effectively with established disciplinary traditions like philosophy and sociology.. Most significantly, they provided little empirical testability. Evidence for this was the popularisation and continued use of nonsensical terms like "chiropractic philosophy" and "chiropractic manipulations" (Coulter, 1999: 1-3). The debate around the two concepts is essentially that the former implies that chiropractic has somehow spawned a unique branch of philosophy, while the latter implies that spinal manipulation somehow gains an extra quality merely because it is applied by a chiropractor (Coulter, 1999: 1-3). Chapter 4 will elaborate on these issues in more detail.

The development and format of early chiropractic education is largely responsible for this state of affairs because chiropractic colleges developed outside mainstream tertiary education (Chapman-Smith, 2000: 15; Meeker & Haldeman, 2002). Even though the technical education of chiropractors, which was not dependent on development in the natural sciences or humanities, went ahead largely unaffected, core theories and philosophical and social issues relevant to the budding profession had little chance of developing as part of larger institutional disciplinary schools of thought (Wardwell, 1992: 3).

In the closed system of the profession's early education, candidates received their chiropractic education with no prior qualifications or after they had received a first degree. A number of early graduates were also medical practitioners. Therefore, with no internal collaboration between colleges concerning minimum standards and scope of curriculum, and with the assumption that students would get their basic education elsewhere, the lack of development in areas important, but not pivotal, to the practice of chiropractic, like philosophy, does not surprise.

No traces of concern in this regard are detectable in the profession's history until 1944, when a manifesto entitled *The Basic Principles of Chiropractic Government* appeared. Developed by the National Chiropractic Association (NCA), it spelled out the need to introduce the study of philosophy of science and clinical research

methods appropriate to chiropractic in American colleges of the day. The NCA had a strong motivation for the development of a greater degree of coherence. Not only would this help the scientific discipline of chiropractic due to a greater degree of communication among its scholars, but it would also allow the profession to approach government organisations to further legitimise the young profession (Keating, 2003).

Government recognition also provided access to public funding. Seeing that chiropractic holds little interest for pharmaceutical companies, no mechanisms were available for chiropractic scientists to secure significant research grants through either the public or the private sector (Chapman-Smith, 2000: 17). This may have been the driving force behind the founding of another important organisation, because in the same year the non-profit Chiropractic Research Foundation (1944) was established. This Foundation was and still is intent on underwriting chiropractic research, education and hospital development, and to disseminating chiropractic scientific knowledge (www.fcer.org 2004).

Notwithstanding these two significant developments in the organisation of chiropractic, not enough interest was sparked to produce any major reform in the teaching institutions of the day. Real development in this critical area of the profession's disciplinary existence only came approximately twenty years later with the successful efforts at upgrading and standardising chiropractic education during the 1960s of a more potent controlling body, the American Chiropractic Association (ACA).

It took a further decade for chiropractic to develop enough internal coherence in the administration of its education in order to approach the United States Federal Government to stand as the official referee for its educational standards. To this end, the Council for Chiropractic Education (CCE) was established in 1974 and is still the governing body charged with controlling chiropractic standards of education across the United States.

Wardwell (1992: 260-262) argues that, although American colleges have succeeded in establishing a core curriculum, they still differ greatly in philosophic emphasis. The lack of integration of traditional chiropractic philosophical constructs with the larger body of philosophy, according to Wardwell, has had the following two influences: a) chiropractic continues to distance itself from the useful mainstream discipline of

philosophy; and b) a lack of philosophical grounding produces variability in approaches to practice.

2.2.5. In summary

Considering the development of chiropractic, particularly in its first three decades, one can hardly blame the predictions made regarding the inevitable demise of this form of healthcare (Gibbons, 1992 in Haldeman, 1992: 15). For both the internal and external reasons mentioned, chiropractic had a particularly poor grounding for the development of a constructive, self-critical and transparent philosophical and applied scientific discourse to inform the development of a profession. Nevertheless, it exists today and has never been more vibrant. Therefore, chiropractic must have developed in a unique manner as a profession to where it is today. To understand a profession that instantly challenged the established orthodoxy of the day and itself without self-destructing requires further understanding of its unique characteristics.

2.3. Chiropractic as a profession: An exception to the rule?

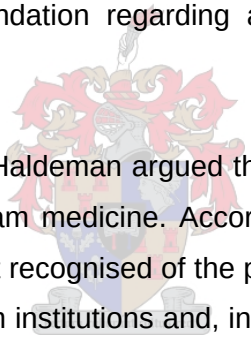
The sociologist Walter Wardwell has commented on professionalisation in relation to chiropractic since the 1950s. His interest in this dissenting school of medicine stemmed from its resistant stance to the dominance of mainstream medicine. He found in the chiropractors a group who shared his criticism of orthodox medicine because of its tendency to treat symptoms, its affinity for the use of pharmaceuticals and the level of iatrogenesis associated with it because of surgery and toxic drugs. In 1951, he labelled the chiropractic profession as marginal in the United States, with a plight similar to that of the African Americans of the day. To Wardwell, chiropractors were marginalised because they were denied their rights and responsibilities, namely to contribute to conservative healthcare (Wardwell, 1992: 42). Chiropractors were considered marginal for the following five reasons: a) their professional training was less than a medical doctor's training; b) their scope of practice was more restricted than that of a medical doctor; c) they had a poor legal status; d) their income was often so low that it forced them out of practice; and e) their overall social standing was lower than that of a medical doctor.

Besides the marginal professions of the day such as chiropractic and osteopathy, he also identified three other types of professions. These were ancillary (auxiliary), for instance nurses and pharmacists, limited (or limited medical), for instance optometrists and psychologists, and quasi-professions, for instance faith healers and shamans.

Wardwell considered each of these categories with respect to chiropractic professionalisation and presented the following view:

The ancillary model is inappropriate for chiropractors because it would mean that they would have to accept a dependency on medicine and they would essentially lose their status as primary contact practitioners. At the time, he suggested that chiropractic work towards becoming a limited medical profession. This would mean that chiropractors, through their own choice, would limit their practice to only certain areas, for instance the musculo-skeletal system. The implication of this was that chiropractors would have to tone down their claims for the effects of spinal manipulation to the level of the physiological only.

Wardwell continued to comment on the progression of the profession, without much change in the status quo until the 1980s. By 1992, he still argued for a certain amount of marginality in the profession, particularly in the context of the “straight” chiropractor, and his recommendation regarding a limited medical approach still stood (Wardwell, 1992).



However, in 2002, Meeker and Haldeman argued that chiropractic was on the verge of becoming a part of mainstream medicine. According to them, chiropractic is the largest, most regulated, and best recognised of the professions that have traditionally functioned outside of mainstream institutions and, in the new lexicon, have fallen into the category of “complementary and alternative medicine”. In 1997, 11% of the American population made use of chiropractic services, which translates to 190 million office visits per year.

Besides evidence for its continued growth, chiropractic remains a system of healthcare that does not limit itself to the musculo-skeletal system and, although some practice it in a conceptually limited capacity, the profession has not declared itself as a limited medical profession.

Authors now recognise that taking the trait approach to describing professions followed by Wardwell is not the best way to describe the process of professionalisation, because this view relies on established professions as a point of reference. In the case of chiropractic, it is clear that Wardwell used medicine as the standard against which chiropractic, amongst others, was measured and classified. From a traits perspective, chiropractic can only ever be a minority anomaly in the

classical healthcare profession of medicine, whose terms of reference as a system of healthcare must change in order to conform to mainstream thought. This view is not unique to chiropractic, as has been demonstrated in psychology (Louw, 1991).

Furthermore, Wardwell's interpretation of a limited medical profession is problematic when applied to chiropractic. According to his classification, the limited medical practitioner would restrict his/her practice to part of the human body. This would clearly be inappropriate because chiropractors do not limit their practice by means of areas or systems, but by the conservative nature of interventions that they are prepared to apply. It is true that a significant proportion of chiropractors see manipulation, in particular, as having a local effect on joint-related structures. However, it is possible that wider effects congruent with holistic philosophy could become apparent in the future. For example, the management of chronic low back pain and infantile colic point both point to central nervous system processes far removed from the point of physical intervention.

In summary

Chiropractic was studied as a marginal "minority" group from the perspective of medicine. This seems to have led scholars to make a number of assumptions and consequently to reach some misguided conclusion about the paths to chiropractic professional maturity. This statement will be defended in section 3.3 as part of a discussion of an alternative approach to viewing the process of professionalisation in chiropractic.

2.4. Positive change after the 1970s; further development in the science and practice of chiropractic

2.4.1. Introduction

It took the chiropractic profession seventy years to establish an infrastructure, which allowed it to practice legally, achieve sound educational standards and develop a credible research agenda. It did so against great odds with no public funding and no significant private funding, in relative isolation from the mainstream healthcare system and education, and in spite of its own internal strife.

2.4.2. The "Golden Age" of chiropractic

The 1980s and 1990s saw rapid changes in chiropractic worldwide. These changes included a progressive acceptance by medicine, its integration into the American private healthcare system, acceptance of its peer-reviewed journals by *Index*

Medicus (e.g. *Journal of Manipulative and Physiological Therapeutics* and *Spine*), and the establishment of an ongoing agenda for chiropractic research funded by the US Federal Government. Furthermore, chiropractic education was systematically integrated into publicly funded institutions in a number of countries outside of the US, for example Australia, Brazil, Canada, Denmark, England, South Africa and Wales.

However, according to Chapman-Smith (2000: 17), this change in attitude would not have occurred had it not been for the following three pivotal forces:

a) The wide public acceptance and use of chiropractic services;
b) A large US national survey by Stanford University confirmed that chiropractic patients generally use both chiropractic and medical services and want cooperation between their chosen healthcare providers; and
c) The medical profession acknowledged that their approach to the management of back pain driven by a mechanistically oriented research engine was, as patients had demonstrated with their choices, largely ineffective.

The common denominator was once again the patient, chiropractic's oldest ally. The profession was found to be socially relevant and desirable by the consumer of healthcare, but this time it was not a legal issue. The public had voted with their hard-earned dollars for the inclusion of chiropractic in the healthcare system of the future.

The chiropractic profession of the twenty-first century finds itself in the previously unimaginable position where it can finally start to expand its sphere of influence both institutionally and professionally. The respite is sure to be short lived because the competition for the consumer intensifies once again in a healthcare industry in which patients demand high quality evidence-based healthcare. The debate is no longer about whether manipulation is an option in the conservative management of back pain, but about who is perceived to be the best exponent thereof.

2.4.3. The South African story-have we seen the last of the conflict?

Published literature describing the historical development of chiropractic in South Africa is somewhat scant. However, it would seem that a rather coherent view of chiropractic's development exists and therefore I shall use these resources to provide a synopsis of the profession's development from the 1920s to the late 1980s (Engelbrecht 1992, Brantingham & Snyder, 1999, and www.chiropractic.co.za 2005).

Chiropractic's story in South Africa is believed to have started in the early 1920s when four or five of American-qualified practitioners settled around the country and began to practice as informal members of the healthcare community.

However, it seems that although the field may have changed, the players and the game remained the same because within a decade (in 1928) chiropractors were under fire. Prompted by mainstream medicine to ban the practice as illegal, the profession faced potentially dooming legislature put forward by the Ministry of Health. To counter this move, the South African Chiropractic Association, the first in a long line of chiropractic associations, was formed in the early 1930s. The embryonic profession survived by remaining legal and avoiding inclusion under the umbrella allopathic control body, the Medical Council. Chiropractors were, however, unable to secure legal registration and licensure.

Between the late 1930s and 1950s, many associations were formed to represent chiropractors in South Africa. The first (in 1940), presumably in a move to gain strength through numbers, was called the South African Manipulative Practitioners Association (SAMPA). It was dominated by chiropractors, but it included an eclectic group consisting of naprapaths, naturopaths and osteopaths. This was followed a few years later by the establishment of the South African Health Practitioners Association (SAHPA). It is not clear why a second association was formed, but it is possible that geographic location (Natal and the then Transvaal) may have been the cause.

The two groups merged in 1947 under the SAMPA banner to square off with medicine for a second time. This time the tack had changed somewhat; the then Minister of Health suggested a "Supplementary Health Services Bill" that would see this group registered under the Medical Council as "auxiliaries". However, once again through successful lobbying, this move was avoided.

In the 1950s, the largely coherent single association fragmented into three factions. The Pan African Chiropractic Association (PACA) was formed, presumably because of philosophical and practical differences amongst the professions represented. This group catered exclusively to chiropractors and accepted both "straight" and "mixer" philosophies. A group of fundamentalist chiropractors, however, found the eclectic form of practice unacceptable and consequently formed an association for "straight" chiropractors, the South African Chiropractic Association (SACA).

This fragmentation helped little to further the cause of the profession as it faced further criticism in the early 1960s. Termed the “Report of the Commission of Inquiry into Chiropractic” (1962), the published document stated that there was no scientific basis to chiropractic. The commission comprised entirely of allopathic medical practitioners and the rationale for the determinations made without a single visit to a chiropractic practice or college remains a mystery to this day. Paradoxically, however, the report suggested that physiotherapists and orthopaedic surgeons should be given the opportunity to incorporate any manipulative techniques of patient value present in the corpus of chiropractic techniques into their educational programmes. Remarkably, the minister of health at the time elected not to act on the findings of the commission and instead simply tabled it.

An uncomfortable seize fire prevailed until 1970, when the chiropractic profession made a further attempt to gain legislation. Despite initially being denied recognition, based on the findings of the 1962 report, the first legislation licensing chiropractors was passed in 1971 after successful lobbying and active support by practitioners and patients.

There was still one bridge to cross, however. No provision had been made for registration of new chiropractors except for those who were then chiropractic students or already practitioners. The rest of the 1970s was spent attempting to change this situation. The Minister of Health finally agreed to re-visit chiropractic legislation with the proviso that under a united banner (CASA) the profession had to provide three documents:

a) A memorandum on the “State of the Art of Chiropractic”;
b) A rebuttal to the “Report of the Commission of Inquiry into Chiropractic” of 1962; and
c) Answers to questions raised in parliament during the reading of the Chiropractors Bill of 1971.

According to Dr. H.O. Mönning (1971) (the then advisor to the minister of health), these documents were requested so that three fundamental issues could be debated:

> (a) whether their (chiropractors) work may be a useful and essential addition to ordinary medical services; (b) whether their work may otherwise constitute any danger to the health of the public; and (c) if it does in fact have definite advantages, whether the recognition of chiropractors as a

professional group is justified and on what conditions, if any, such recognition is to be given.

By 1982 it was clear that the chiropractic profession had established its relevance in all three the above named areas. Consequently in a final bid to control chiropractic, medicine attempted to place chiropractic under what had by that stage become the Medical and Dental Council. This bid narrowly failed and what resulted instead was a body termed the South African Associated Health Professions Board, which was to exercise control over various health disciplines not covered under the Medical and Dental Act of 1928.

The story has a further twist, however. The chiropractic roll could not be re-opened until the profession had established an educational programme of acceptable standard. Between 1984 and 1988, a six-year professional qualification was developed and implemented. What was then Technikon Natal had the first group of chiropractic students commence classes in 1989 and its first graduate was produced in 1994. Interestingly, the move to Technikon Natal was facilitated by none other than FW De Klerk who at that stage was serving as minister of health for the Nationalist government (Engelbrecht 2005).

According to Engelbrecht (2005) the similarities between the North American and South African scenarios are undeniable. However, for him chiropractic in South Africa, perhaps having learnt from ‘big brother’s mistakes’, negotiated a somewhat more favourable position for itself initially. This is mainly due to the following:

a. The smaller number of practitioners allowed the formation of a cohesive body, which was able to set aside philosophical differences in order to further a shared cause. The small number of practitioners meant that fringe practices and ‘technique peddling’ was of an insignificant size and therefore unable to cause dissonance within the ranks. This remains a major stumbling block for chiropractic in the US.
b. A critical mass of moderate spokesmen allowed for successful political positioning. In the US scenario, much of the disagreement between chiropractors and allopaths can be ascribed to overzealous personalities.
c. The chiropractic profession, from the outset, negotiated a state funded institution to qualify new practioners. Chiropractic in the US to date, has still not managed to secure a government funded training programme.

A further key factor, which the two countries do share, is the role, or lack thereof, for chiropractic in the public health care arena. It would seem that in both scenarios the profession was happy enough just to be a legal entity in the private health care setting and consequently neglected to negotiate mechanisms for chiropractors to serve in institutions such as government hospitals and the military. In South Africa, where this forum serves as the smelting pot for health care integration and exposure to South Africa's diverse ethnic and cultural groups, one can reasonably argue that exclusion would be a distinct disadvantage. Perhaps this represents the final hurdle in establishing chiropractic as an accepted, rather than tolerated profession. With the level of control allopathic medicine exerts over this sector, could denying chiropractic access to this domain be medicine's 'ace in the hole' with which to starve the chiropractic profession of exposure and hence limit its development?

2.4.4. In summary

Chiropractic's first century of existence can be described as the history of an outsider, both locally and in North-America. Despite the many factors stacked against it, the profession has managed to stake a claim in the hostile waters of healthcare. However, it would seem that in both instances the role of the chiropractor in the public health care system was overlooked. This brief historical sketch whilst by no means a complete view of chiropractic history around the world, perhaps points toward the folly of the wholesale adoption of foreign healthcare practices, particularly in a developed versus developing country setting. Chiropractic has traditionally relied heavily on its societal appeal, however without this commodity in the South African context the profession may once again find itself in a survival crisis. Although mainstream medicine may once again take on its role as antagonist, the real enemy might simply be chiropractic's lack of perceived societal relevance. The consequent local priority of increasing awareness amongst black South Africans therefore cannot be overstated as this group is a major societal stakeholder which currently cannot be considered as informed, much less positive, towards chiropractic.

2.5. The notion of "paradigms" relevant to chiropractic

2.5.1 Introduction

Since his seminal work, *The structure of scientific revolutions* (1962), Thomas Kuhn has been synonymous with the notion of "paradigms". His text, which is essentially a critique of the positivist theory of growth through accumulation of theory, irrevocably altered the manner in which science views its own development. Although his work has drawn much critique and heated debate, the term is widely used in scientific

literature, particularly in philosophy and the methodology of the social sciences to describe the development of different schools of thought or reference frameworks (Mouton, 1996: 203; Coulter, 1999: 6). In fact, the impact of his work has been so profound that the temptation exists to assume that the theory of scientific revolutions is applicable to any scholarly tradition or school of thought.

This has also been the case in chiropractic, which has been compared to medicine in this manner as an alternative paradigm (Coulter, 1990c).

It is the aim of this section to clarify the classical application of Kuhn's work and then to discuss its application as it may pertain to the chiropractic context as an example of a key academic debate relevant to chiropractic.

2.5.2. Kuhn in a nutshell

According to Kuhn (1962), scientific disciplines develop through the alternation of periods of normal practice and revolutions. During the period of normal science, scientists function within a certain framework, tradition or school of thought known as a paradigm. They go about answering paradigm-driven questions in much the same way as one would piece together a puzzle. They strengthen the central theory or theories that support it and do not question the validity of the central hypotheses the paradigm is based on. However, from time to time scientists may discover new empirical facts that are not predicted by the paradigm. These are termed anomalies. Scientists will then attempt to adapt the paradigm to this occurrence in order to further the paradigm. However, when the number of anomalies becomes too great to accommodate and they start to cast doubt on the validity of the core theory, the discipline is moved into a state of crisis. Initially all sorts of *ad hoc* measures are employed to counter the crisis, but inevitably the existing paradigm is rejected as inadequate. During the crisis, the scientific community will debate questions relating to the nature of the entity of interest to them and a number of alternative theories will vie for position. However, it is only when a new theory that supersedes the existing one and demonstrates empirical testability becomes known, that a scientific community will undergo a revolution. During this time, ever-greater numbers of scientists will start to support the alternative paradigm, until a critical mass has moved away from the old paradigm. At this point, the discipline starts to move once again into a phase of normal scientific practice using the new paradigm as its grounding.

2.5.3 The definition and characteristics of a paradigm: A Kuhnian curse?

Although Kuhn spent much time discussing the functions of a paradigm, he left us with the legacy of an ill-defined term, which has been a source of much criticism on his work (Mouton, 1993: 62 in Snyman, 1993). No less than 22 different meanings were ascribed to the term by Kuhn himself and the definition changes depending on the context of usage, i.e. metaphysical, sociological or as an application of a model or exemplar (epistemic context). It has been speculated that Kuhn purposely defined the concept loosely so that it could be used in different contexts.

Pajares (2004), in a synopsis of the original text, postulates that it is due to the priorities of a paradigm that a clear-cut definition is problematic. He states the following:

> The paradigm of a mature scientific community can be defined with relative ease. The "rules" used by scientists who share a paradigm are not so easily determined. Some reasons for this are that scientist can disagree on the interpretation of a paradigm. The existence of a paradigm need not imply that any full set of rules exist. Also, scientists are often guided by tacit knowledge – knowledge acquired through practice and that cannot be articulated explicitly. Further the attributes shared by a paradigm are not always apparent. Paradigms can determine normal science without the intervention of discoverable rules or shared assumptions. In part, this is because it is very difficult to discover rules that guide particular normal-science traditions. Scientists never learn concepts, laws and theories in the abstract and by themselves. They generally learn these with and through their application. New theory is taught in tandem with its application to a concrete range of phenomena (Pajares 2004 accessed online).

Therefore, with the ever-changing boundaries of the entity called a paradigm, the closest we can get to a definition is that the term can be applied to whatever allows science to accomplish something, whether it is a framework, tradition, school of thought or whether it is of a metaphysical, sociological or epistemic nature (Mouton, 1993: 62-63).

2.5.4. Applying Kuhn to chiropractic

With no specific definition, it is easy to see why the term has found such varied interpretation. Therefore, in the absence of a definitive character, Kuhn's application

of the concept should be considered as the next best option before it is accepted that paradigms can be appropriately applied to the chiropractic context.

According to Kuhn (1996: 92-110), in the development of science, the crisis is a key phase where scientists can no longer deny the possibility that existing paradigms may have become inadequate to ground their field of endeavour. This time of relative confusion and discord continues until an explanatory theory appears whose explanatory potential supersedes the central theory of the previous paradigm and also exhibits significant empirical testability. Once this has been achieved and a critical mass of scholars embraces the new framework, a period of normal science can once again be entered. Even if we assume for a moment that chiropractic and medicine can be classified as opposing paradigms, there exists a key deviation from Kuhn's formula, which is that no such crisis was associated with its development. The dominant school of healthcare was not in crisis, therefore one cannot make the argument that chiropractic arose as a single paradigm due to a revolution in theoretical thinking or due to a need for change in the practice of orthodox medicine.

Secondly, Kuhn intended the notion of paradigms to be employed when considering the development of scientific disciplines. Although early postulates about spinal manipulation hinted at the development of a discipline associated with chiropractic, it is clear that chiropractic was to be established as an independent healthcare profession. Therefore, based on the argument that the classical Kuhnian paradigm is reserved for scientific disciplines (Friedrichs, 1972: 9; Gatting, 1980: 123), it cannot be applied to chiropractic because it contains both a discipline and a profession.[4]

These two deviations from the classical view of paradigms therefore imply that Kuhn can only be applied to the chiropractic profession as a framework, which it has in common with other professions, and not in the classical application of his work. This approach would not be irregular because other hybrid professions and disciplines have been discussed in this manner in the relevant literature, for instance in psychology.

[4] An academic discipline can be defined as a branch of instruction or learning within which a number of scholars function, and which possesses its own knowledge that it is able to distinguish and differentiate from the knowledge of other disciplines. A profession, on the other hand, is defined as a division of expert labour supported by official and sometimes public belief that it is worthy of some special status. Although discipline-specific knowledge is characteristic of a profession, the reverse is not necessarily the case and hence a discipline does not necessarily constitute a profession.

2.5.5. In summary

If we follow through on the issues raised above, it can be concluded that chiropractic did not develop as a superseding paradigm offering a more plausible basis for the management of disease, but rather as a healthcare tradition, which may have contained and still contains paradigms, some of which stood and stand in opposition to paradigms prevalent in medical orthodoxy.

The next section in this chapter will consider chiropractic at the level of paradigms in order to understand its development.

2.6. Metaphysical and philosophical concepts prevalent in chiropractic

2.6.1. Introduction

In some literature, the chiropractic profession is related to the Kuhnian paradigm. However, before chiropractic can be viewed within the discourse of paradigms, some background information is required concerning its ontological (metaphysical) positions and the key philosophical reflections prevalent in its theoretical discourse. Therefore, the following section will briefly outline their origins and relevance in contemporary chiropractic. (Although some historical context is provided, the aim of this section is not to provide an exact chronological account of the history of philosophy in the profession.)

2.6.2. Metaphysics in chiropractic as grounding for philosophical traditions

The metaphysical principles in chiropractic are essentially those fundamental tenets that are accepted as beliefs without evidence. These *a priori* assumptions are used to construct an ontological view from which further theories may develop. For the most part, these assumptions are not amenable to proof, although it may at times change if these views can somehow be operationalised and studied (Coulter, 1990c).

Historically, the metaphysical view most strongly associated with chiropractic can be summarised as follows: Illness is as an energy block preventing the movement of energy between molecules. Treatment simply consists of removing such a block, after which the body has the capacity to self-heal. The block is termed “subluxation” and the energy is termed ”innate” (Coulter, 1990c; Coulter, 1999: 13; Gatterman, 1995).

The important *a priori* assumption in chiropractic essentially revolved around two notions. The first is the presence of a restorative life force or energy, Innate

Intelligence, which pervades the body and imparts a self-healing ability and a tendency to establish harmony (homeostasis). This life force is a local representation of a universal essence, which is omni-present. Secondly, disease is found when there is a reduction in the flow of energy throughout the body and not primarily due to invasion by germ agents. These are always present and can only affect an individual who is already compromised. Thus the body, when functioning normally, is able to combat disease naturally. (Coulter, 1990c; Phillips & Mootz, 1992: 46-47 in Haldeman, 1992; Gatterman, 1995).

However, as noted above, some of chiropractic's early thinkers were strongly influenced by bio-medical traditions and therefore the ontological assumptions of determinism and causation are also part of metaphysics in chiropractic. These individuals had a more mechanistic view of chiropractic and challenged D. D. Palmer's views from the outset (Coulter, 1990c).

Various authors argue that Palmer's early principles can be interpreted as either all-pervading energy or the presence of some "universal essence". The energy concept is ultimately measurable mechanistically (for instance psycho-neuro-immunology), whereas the intelligence concept implies being and consciousness and therefore cannot be quantified (Gatterman, 1995; Baum, 1998).

Consequently, Phillips and Mootz (1992 in Haldeman, 1992: 31) argue that early chiropractic belief systems emphasised the following two fundamental characteristics: (1) a testable principle suggesting that the structure and condition of the body function and heal; and (2) an untestable metaphor that asserts that the mind-body relationship is instrumental in maintaining health and in healing processes.

Figure 2.1 is a tabular flow diagram, which illustrates the difference between the testable principle and the untestable metaphor of chiropractic.

The Testable Principle:	**The Untestable Metaphor:**
Spinal manipulation(adjustment)	Universal Intelligence
↓	↓
Restoration of structural integrity	Innate Intelligence
↓	↓
Improvement in Health Status	Body Physiology
↓	↓
Materialistic Philosophy:	Vitalistic Philosophy:
• Operational definitions possible	• Origin of holism within chiropractic
• Lends itself to scientific inquiry	• Cannot be proven or disproven

Adapted from Phillips and Mootz (1992).

Authors (Phillips & Mootz, 1992 in Haldeman, 1992: 31; Baum, 1998) agree that this dichotomy (energy versus intelligence) lies at the heart of the "mixer" or "straight" debate and is responsible for the two major philosophical traditions in chiropractic, namely vitalism and materialism.

2.6.3. Philosophical traditions identifiable in chiropractic

2.6.3.1. Introduction

Besides the two primary philosophies (vitalism and the mechanistic world view), four other philosophical traditions are identifiable in chiropractic, namely holism, naturalism, therapeutic conservatism and humanism. Vitalism and materialism will be presented first as the contrasting philosophical traditions in the profession, followed by holism, which, although considered a stand-alone philosophical tradition, finds its roots in vitalism. Naturalism, therapeutic conservatism and humanism will be discussed last under a single heading due to their function not so much as philosophical traditions, but as principles of practice in chiropractic (Gatterman, 1995; Jamison, 1998a and b; Coulter, 2000).

2.6.3.2. Vitalism

As seen previously, vitalistic theories were most probably the earliest and most intricately developed (through necessity as much as interest, no doubt) of all the tenets voiced by the "founding fathers" of chiropractic. Like many of the spiritual and biological theorists before him, Palmer believed that life was purposive and could be explained in terms of the wisdom and intentions of a higher consciousness. In the

tradition of thirteenth century scholar St. Thomas of Aquinas and Plato long before him, Palmer held the view that the order we perceive in the universe indicates an intelligent planner (Keating, 1992: 28).

According to Waagen and Strang (in Haldeman, 1992: 32), the initial question that perplexed D. D. Palmer was as follows*:* "Why does one man get sick when others who work at the same bench or live in the same house, do not? If they eat the same food and breathe the same air, why does one person contract a disease and another remains healthy?" The answer Palmer came up with was the most significant of the concepts he developed. By extrapolating from his innate intelligence theory, Palmer postulated that the structure most likely to affect the nervous system would be its bony encasing, the vertebra. He inferred that vertebral dysarthria, for which he used the term subluxation,[5] was the most likely reason for the blockage of the nervous system function and, consequently, the flow of innate intelligence. Therefore, Palmer postulated that the subluxation was the answer to his initial question and that as a chiropractor his work would be simply to keep subluxations from occurring. According to Coulter (1999: 13), this discourse placed him in direct opposition to what would later become the "germ theory" in orthodox medicine. Palmer's view was that as long as the body functioned normally (i.e. remained subluxation free), it would be able to combat disease naturally.

According to Waagen and Strang(1992), an interesting feature of Palmer's vitalistic philosophy, was that he described the mind as a dual entity. There was the innate or individual part of universal intelligence and the acquired or educated part of the mind that develops throughout life. Although one can only speculate about Palmer's understanding of dualism, it is clear that his usage of the term was not meant to describe the individual and separate existence of body and mind in a classical Cartesian fashion (Silver, 1998: 11-15).

Although the "innate" part of universal intelligence became the cornerstone of the vitalist philosophy, Haldeman contends that it is impossible to describe the philosophy of D. D. Palmer as favouring either vitalism or reductionism as he clearly thought them both important and inseparable. This seems plausible because Palmer, despite his best efforts, was influenced by the *a priori* assumptions of medicine as is

[5] Palmer described a subluxation as a vertebral segment that is not frankly dislocated, but is out of normal anatomical relationship to the adjacent segments (Waagen & Strang in Haldeman, 1992: 32).

evident in the later revisions of his theories (Keating, 2003). Gatterman (1995) agrees with this view because he argues for individual and universal application of vitalism in chiropractic. The universal metaphysical construct suggests that biological forces are directed by a supernatural force, universal intelligence, which is a concept that falls in the realm of religion and not science. However, in the local sense, the vital functioning of each individual is directed through the body's innate intelligence, which is ultimately measurable. Although Palmer suggested that innate intelligence is a manifestation of the universal presence, Gatterman (1995) argues that one does not have to question the origins of life whist attempting to find evidence for universal regularities. Phillips and Mootz (in Haldeman, 1992: 46-47) suggest that it is vitalism in the local or individual sense that gave rise to holism in chiropractic (see Figure 2.5.1).

Incidentally, one gets a sense that although the early philosophers acknowledged the mechanical-physiological effects of manipulation, that the "vitalistic" ideal was considered to exist at a higher level than any basic science endeavour;[6] the reason presumably being the perception that this theory dealt with the essence of chiropractic.

Palmer conceptualised a set of principles, which later formed the basis of the term "chiropractic philosophy". However, there appears to be no evidence that it was developed as anything more than a further vitalistic interpretation of the early metaphysical concepts (Keating, 1989). Several vitalist philosophers attempted to use biological principles to explain the life force principle, which by the 1920s had progressed as far as the untestable metaphor (Phillips and Mootz in Haldeman, 1992: 46-47). (See Figure 2.5.1.) However, by the late 1970s, what had developed from "chiropractic philosophy" can only be described as a form of dogma distinctly devoid of critical reflection and no closer to establishing empirical potential than the original untestable metaphor had been (Coulter, 2000).

Although the *status quo* at the start of the twenty-first century does not seem very different, some interesting and useful debates have occurred within this area recently.

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[6] Keating (1992: 35) is of the opinion that the term refers specifically to subjects such as body mechanics, neuro-physiology and pathology.

As an introduction to a discussion on the roles of philosophy and belief systems in complementary and alternative healthcare (CAM), Coulter (2000) argued that “what has actually been philosophy in the profession has seldom been uniquely chiropractic and what has been uniquely chiropractic has seldom been philosophy”.

In his discussion, Coulter re-examined the role of a number of fundamental metaphysical principles prevalent in complementary and alternative medicine (CAM) in order to foster further critical debate about philosophical concepts in these fields. Since chiropractic is a major stakeholder in the ranks of CAM, this has obvious relevance for it. Coulter discussed vitalism, holism, naturalism, humanism and therapeutic conservatism to demonstrate that these metaphysical principles imply a particular philosophy of health, which if nurtured could give rise to a unique practice paradigm.

Coulter (2000) concludes that chiropractors may finally have to concede that vitalism may be a failed metaphysical belief.

Peters (2000), in an article entitled ”Vitalism, holism and homeostasis: To what extent are they unique to chiropractic“, comments on the notions of “vitalism”, “holism” and “homeostasis” in a discussion that focuses on the extent to which these concepts are unique to chiropractic. According to him, “vitalism” is a term that evolved in order to describe certain developments in the field of applied natural philosophy during the latter portion of the eighteenth century. At a time when the newly emerging field of the scientific method was growing ever more powerful in its mechanistic view of the world, and in particular of the human body, a number of mainstream natural philosophers resisted this paradigm. They maintained that whatever its material nature, some kind of “vital force” must (literally) *animate* living substance. According to Peters (2000),:“These early Vitalists had different names for it, but all agreed that this vital force was the very source not only of life, but of health and healing too”. Unfortunately for individuals like Mesmer (animal magnetism) and von Reichenbach (the odic force), the more successful biomedicine[7] became in explaining life and treating disease, the more marginalised vitalism became.

[7] Conventional medicine is often described as “biomedicine”, because it emphasises the link between medical intervention (technology) and biological understanding (science).

Peters (2000), contrary to Coulter (2000), argues that vitalism is in fact not a failed metaphysic, but one that we simply have not had the tools to begin to fathom until very recently. Peters provides evidence for his argument on two levels.

Firstly, he states that from a philosophical perspective, the cultural shift from modernist principles to post-modernist[8] thinking has meant that there has been a growing acceptance that healthcare should be based on bio-psychosocial principles in order for it to address the epidemic of stress and lifestyle related disease. Peters postulates that the growing body of literature around mind-body medicine and the effect that consciousness has on the body is more likely to be rooted in vitalistic rather than materialistic thinking.

Secondly, on a more tangible level, a number of events in recent times have breathed new life into vitalism. According to the Peters, these are the relative success of CAM in which vitalistic principles are evident, the inability of medicine to show that scientific understanding necessarily increased our technological control of the world and the increased awareness of the "connectedness" of the mind and body in other fields of healthcare, such as humanistic psychology. Furthermore, with the growth of the number of research studies suggesting that attitude and social support influence health outcomes, the empirical basis for vitalist thinking increases.

Peters (2000) therefore concludes that vitalism is alive and well and, although central to the origins of chiropractic, it is by no means unique to the profession.[9]

Although chiropractic's particular brand of vitalism was and still remains a source of heated discourse within the profession, it did provide a legally defensible distinction between medicine and chiropractic (Keating and Mootz, 1989; Coulter; 1990b). Furthermore, "vitalism" was historically never meant to be in competition with science. Therefore, contemporary chiropractic scholars should not hasten away from

[8] In health, modernism can be described as a set of beliefs, generally implicit, that scientific understanding will increase our technological control of the world. Such control often takes the form of a dramatic intervention, like transplant surgery, and is thought to lead to progress in terms of increased happiness and well-being. The opposing philosophical construct of post-modern thinking starts from the premise that the world cannot be understood from a single framework. Understanding is believed to come from examining and juxtaposing multiple perspectives and from accepting a disjointed plurality of values and beliefs. Therefore, post-modern thinkers cannot accept the underlying assumption that progress is implicit in technological advance, or that the "modern" scientific worldview is the defining characteristic of progress.

their vitalist roots as the metaphysical principle of innate intelligence may yet prove to be a valuable ally in the future as the science of chiropractic enters the twenty-first century. However, chiropractic is still to contribute to this philosophical tradition, which can be recognised as self-critical, constructive and meaningful.

2.6.3.3. *Materialism (mechanistic view)*

As was stated earlier, chiropractic scholars aligned with ontological and philosophical traditions quickly started having an effect on the science of chiropractic. It was impossible for those who espoused the vitalistic view to develop a philosophical tradition that could lead to empirical consequences as the concept was by its very nature untestable. Therefore, the story of the development of chiropractic's materialistic or mechanistic[10] position essentially runs parallel with the development of philosophical traditions associated with the science of medicine, barring a few contextual differences (Waagen & Strang in Haldeman, 1992: 37-42).

After the "mixer" or "straight" split, the materialist or mechanistic thinkers associated with chiropractic were responsible for developing the science of chiropractic from a reductionist or positivist perspective (Phillips & Mootz in Haldeman, 1992: 46). They divorced themselves philosophically from their vitalist counterparts and focused on what was later to become the "testable principle" in the philosophy of chiropractic (Figure 2.5.1). Their theory, related to joint physiology, was developed to the point where manipulation could be operationally defined and measured. This in turn led to scientific inquiry through the scientific process.

It is not clear from the literature whether the "testable principle" has the same intended meaning as the Popperian testability principle. However, it does seem to have the same function, which suggests that this theory is testable and therefore also falsifiable. This assumption is supported in the literature because of the scientific method scholars followed to develop and test this theory (Mautner, 1996: 433; Silver, 1998: 18). Therefore, elements of critical rationalism are identifiable in chiropractic scholarly activity, even though they may not have been explicitly labelled as such or even noted.

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[9] Vitalism is recognised as a large topic for discussion, but falls outside of the scope of this review.

[10] Mootz and Phillips argue that materialism is mechanistic, because all explanations of life-matter relationships are based on natural laws.

There is no doubt that this philosophical tradition has produced the most fertile ground for chiropractors to produce rigorous evidence supporting their claims. The empirical evidence developed through mechanistic thinking was key in persuading legislators and healthcare funders to support chiropractic services to the extent that they do today (Meade *et al*., 1990; Manga, 1993). At least three different themes currently exist in chiropractic as major areas of theory building aimed at further describing the nature and effect of spinal manipulation. These are neuro-physiological, biomechanical and anatomical (Haldeman, 1992: 165, 185, 225; Vernon, 2000).

However, as with all science built on positivist traditions, there are limits. Phillips and Mootz (in Haldeman, 1992: 46) acknowledge that the framework of materialistic thinking precludes the scientist from investigating the nature of chiropractic. This realisation is reflected in their statement that, although of lasting philosophical interest, the answers regarding the essence and purpose of life are not readily found with the tools needed for basic and clinical research. Therefore, chiropractic's mechanistic principle is merely a way in which the clinician and scientist can describe and investigate that which is observed in his or her patients.

It is perhaps in this area that materialism in chiropractic lost its way to some extent. Towards the latter half of the twentieth century, more and more criticism has been levelled at studies designed in the positivist and reductionist tradition when scholars started to trespass on the sacred grounds of the nature of chiropractic. As will be discussed in Chapter 3, this change has been insidious and at times apparently only semantic.

Chiropractic has a lot to thank materialistic thinking for; it has served the profession faithfully during its tenuous past. However, one cannot help but wonder what could have happened if chiropractic vitalists and materialists had developed their views in an open academic environment.

2.6.3.4. *Holism*

Holism is a philosophical tradition that seeks the integration of body, mind and spirit. Phillips and Mootz (in Haldeman, 1992: 46) argue that holism is rooted in the philosophy of teleology, which asserts that there is a design and purpose in nature and that the purpose of or justification for a phenomenon lies in its final purpose. Teleology exhibits somewhat of an idealistic or vitalistic character because of it

application in arguing for the existence of God. Teleologists oppose mechanistic interpretations of the universe as being solely reliant on organic development or natural causation (www.levity.com 2004). Therefore, the concept of a ”universal intelligence” that manifests in living things as ”innate intelligence”, providing purpose, balance and direction to all biological function is strictly speaking a teleological metaphor. The classic medical concept of homeostasis also has its roots in the teleology of holism and is equated with Palmer’s innate intelligence concept (Gatterman, 1995).

The problem with holistic philosophy in the chiropractic context is obvious. It is in a sense an offshoot of vitalism and in the chiropractic context is associated with the unpopular untestable metaphor (Figure 2.5.1). It is viewed as not having been developed past the point of a pre-scientific concept (Vernon, 2000). Therefore, the interpretation of holism in chiropractic precluded it from making any significant contribution to the science of chiropractic.

Baum (1998) agrees with this view and states that practitioners who fall under the banner of complementary and alternative medicine must make an attempt to break from the vitalist interpretation of the concept in order to gain a new perspective on it. In contrast to Phillips and Mootz (in Haldeman 1992: 46), Baum states that holism was coined by the South African politician and thinker Jan Smuts, who used the word to describe the tendency of nature to produce wholes from the ordered grouping of units. Arthur Koestler developed this interpretation in *Janus: A Summing-Up*, which essentially espoused the view that organisms have the ability to display the autonomous properties of the whole as well as the dependent properties of its parts. Therefore, as opposed to a closed system, which cannot be studied empirically, it is possible to view holism as an open system amenable to study and experimentation, but not through reductionist principles. Baum (1998) consequently implies that holism should be viewed as neither vitalist nor materialist/reductionist. Baum (1998) does concede, however, that no matter what the interpretation, holistically driven inquiry has for the most part been suffocated due to the great advances of the twentieth century, which have been associated with the mechanistic application of the scientific method.

Besides its problematic philosophical interpretation, holism in chiropractic exhibited another more meaningful application for holism. This is evident in the operationalisation of holistic thinking as interpreted by D. D. Palmer. The founding

father adopted the position that fresh air and exercise, healthy eating and personal hygiene are all early important factors required to maintain the health of the entire human organism, a concept that the medical reform movement had espoused, but one that can be traced back to the famous Descartes. This was somewhat of a juxtaposition for Descartes, because on the one hand he believed firmly in the notion of keeping the body healthy and leaving it to its own devices, yet he never acknowledged its existence.

In a sense then, chiropractors, rather than utilising holistic philosophy as a mechanism for constructing theories with empirical testability, have sought rather to apply holism to their approach to practice (Gatterman, 1995). This tradition in chiropractic has grown to reflect the generally accepted holistic ideal that patient care should be integrated in order to influence all aspects and levels of being in a positive fashion (Jamison, 1998a; 1998b).

Therefore, holistic philosophy in chiropractic essentially circumvented the potential challenge of empirical testability and has been applied to describe approaches to practice. A number of authors have contributed to holistic ideals in chiropractic models of practice (Keating, 1992: 37-39; Gatterman, 1995; Coulter, 1999: 97-107; Coulter, 2000).

According to Keating (1992: 37-39), the notion of holism can best be described as the commitment to considering the “total person” during the process of healthcare, with the total person being defined as that which represents something greater than the sum of his/her organic components. The holistic principle is therefore an undertaking on the part of the chiropractor to place each complaint and problem found within as comprehensive an understanding of the unified individual as his/her training and intellectual capacity will allow. This appreciation of the systems integration of the organism implies the recognition that the individual cannot be healthy in one part and ill or diseased in another; the holistic clinician is charged with seeking the connections between malfunctioning parts and the whole person.

Keating proposes that this conceptual understanding of the term can be applied practically by focusing on the following areas:

a) Recognising the early stages of deviation from health as well as late-stage health crisis symptoms;

b) Paying attention to the patient's experience of his/her own health in an effort to understand the context within which health issues occur;
c) Paying attention to the unique idiosyncratic ways an individual combines biological, psychological and social factors to produce health or distress and disease; and
d) Recognising that novel methods of intervention may be required for the successful intervention in the health problems of each special, singular patient.

Clinically, the holistic directive places a responsibility on the chiropractor to acquire a substantial knowledge of the human body, but also requires an open-mindedness to consider diverse sources of information. It requires caution in the drawing of conclusions, humility in the appraisal of one's own abilities and a willingness to seek assistance and knowledge from others when necessary.

For Keating, individuals who attempt to consider these principles will constantly find themselves poised at the interface between body and mind, and they may consider themselves to be holistically driven.

In describing a patient-centred paradigm for chiropractic education and research, Gatterman (1995) provides a synopsis of a number of philosophical constructs central to chiropractic. In this discussion, the concepts of vitalism, holism, naturalism, humanism, conservatism and rationalism are presented and they inform a discussion on a proposed practice model for the profession.

In this research context, "holism" means seeing human beings as irreducible units, with everything in them related to everything else. The following five interrelated ideas pertaining to organic wholes have been identified:

a) The analytic reductionist approach as typified by the physiochemical sciences has proven inadequate when applied to certain cases, for example to a biological organism or to society;
b) The whole is more than the sum of the parts;
c) The whole determines the nature of the parts;
d) The parts cannot be understood if considered in isolation from the whole; and
e) The parts are dynamically interrelated or interdependent.

Coulter (2000) is in agreement with Gatterman (1995) because he argues that "holism" postulates that health is related to the balanced integration in all aspects and levels of being: body, mind and spirit, including interpersonal relationships to the whole of nature and our physical environment. He re-emphasises that "holism" by its very nature contradicts reductionism, since it holds that the whole is different from and greater than the sum of the parts.

From this application developed a further refinement termed "wellness practice". This concept will be elaborated upon in a subsequent section, but in brief, a wellness practitioner is a chiropractor who is driven by the holistic ideals stated above, and who attempts to engage with his/her patient on as many levels as possible in an attempt to produce and maintain the patient in a state of wellness (Jamison, 1998a). Wellness practice represents the most contemporary interpretation of holism in chiropractic and early indications are that it has significant support from both inside and outside the chiropractic environment, particularly for the management of chronic disease. It seems that its integrative nature may produce higher levels of success in treating conditions that do not respond well to the standard biomedical approach to disease management.

Consequently, it would seem that holistic principles are abundant in the contemporary practice of chiropractic and that this tradition of thinking has contributed positively to approaches or models of practice. There also seems to be very real potential for holistic philosophy to develop theories with empirical potential to support what the profession has been doing from a common sense basis for over a century.

As stated earlier, the last three philosophical tenets (naturalism, therapeutic conservatism and humanism) are expressed as principles of practice rather than distinct philosophical traditions.

2.6.3.5. *Naturalism*

Chiropractic's preference for natural therapies has been explicitly present since its beginning. Its founding father D. D. Palmer stated in 1910 that the chiropractor "Heals as nature heals, in accordance with nature's laws. Compelling the body to do its own healing with its own forces" (Coulter 1991). Coulter (1991 and 1999: 14-15) argues that this view remains central to contemporary chiropractic because of the profession's physical approach to management and, although Palmer's view

predates medicine's lifesaving "wonder drugs", the ongoing issue of iatrogenensis that still remains an important motivator for care providers to provide natural (non-pharmacological) remedies. Therefore, as with holism, rather than sparking off a field of scientific endeavour, naturalism has stood as a principle, which governed the scope of practice of chiropractic.

As part of a modern interpretation of the concept, Coulter (2000) states that most CAM groups express a preference for natural remedies. This preference stems from the premise that the body is built on nature's order, and that it therefore has the natural ability to heal itself. This ability should be reinforced by the use of natural remedies and not tampered with unnecessarily through the use of drugs and surgery.

Clinically, this principle is still widely accepted to hold true within the practice of chiropractic today as only manipulation of the cervical spine has been loosely linked with serious iatrogenically induced side effects (Bergmann, 1993: 134).

From a cost-effectiveness perspective, naturalism has also served the profession well as healthcare insurers have started paying more attention to chiropractic management protocols, which seek to avoid the use of symptom amelioration through palliative medication (Manga, 1993).

2.6.3.6 *Humanism*

According to the historical evidence, D. D. Palmer was known as an individual with a great passion for philosophical and esoteric literature (Waagen & Strang in Haldeman, 1992: 32). He was known to have carried several spiritualist texts in his extensive personal library. He was considered to have an ontological view of the world, which accepts the existence of a supernatural being. This is reflected clearly in his notion of universal intelligence. Although we can only speculate, his view of humanism was not likely to have been in keeping with that of Renaissance philosophers like Erasmus (Mautner, 2000:256). Rather than having an anti-religious interpretation, it seems that Palmer's understanding was more likely to have been linked to individual rights and liberties (Coulter, 1999: 41-42).

Coulter postulates that in the broad chiropractic context this relates to the immutable rights of the individual and that the dehumanising procedures, technologies and institutions that have been created to care for the ill should be reduced. The personal, social and spiritual aspects of health are therefore recognised.

More specifically, according to Jamison (2001), chiropractic's early interpretation of humanism blends well with its other philosophical constructs in order to provide a brand of healthcare that is orientated towards considering the patient as the central focus of care. Therefore, the effect of humanist thinking in clinical practice is very much present in contemporary chiropractic. It manifests as the acute awareness and respect for the patient's values, beliefs and dignity.

However, Coulter reminds us that even though it is present in chiropractic, this philosophical construct is by no means unique to the profession. According to Jamison (2001), the nursing profession is most probably the strongest proponent of humanistic principles in modern healthcare as this profession stands at the forefront of care for the acutely infirm where there is always the danger of becoming anesthetised to suffering.

2.6.3.7 *Therapeutic Conservatism*

According to Keating (1992: 41-42) therapeutic conservatism can be traced back to the Hippocratic principle of "Above all do no harm." This notion refers to the right of the patient to expect to be no worse off for consulting and following the advice of the healer. Keating also argues that the notion of "therapeutic conservatism" is aimed specifically at promoting patient self-healing mechanism (as opposed to drug assisted) and in this respect is closely linked with the notion of "vitalism".

Keating is of the opinion that this principle is very much alive and well in contemporary chiropractic and is specifically expressed in the profession's tendency to follow low technology, hands-on management protocols as well as in its critical view of pharmaceutical agents. In fact the author goes as far as to say that in this respect the chiropractic profession may represent one of the last remaining examples of the Hippocratic tradition.

Like Keating, Gatterman (1995) also views therapeutic conservatism in the context of therapy. The author states that this principle falls in the tradition of Hippocrates, whose term "Primum non nocere" (first do no harm) hinted at it. Conservatism favours a minimalistic 'interference' by the practitioner, while active participation on behalf of the patient is promoted. This, along with counseling to encourage positive lifestyle changes, allow the patient to become a partner in health promotion and maintenance, thereby reducing reliance on others for care.

In a slightly broader context, Coulter (2000) views most of CAM as being therapeutically conservative. That is, it uses therapies that have a low level of side effects and it tends to accept that the least care is the best care. This concept is linked with the earlier principles of holism and naturalism, because if the body has the ability to heal itself, the role of therapy is simply to initiate the process. Since continued care may intervene in this process, the intent is for minimal treatment. This principle fosters the practice of involving the patient actively thereby reducing his/her therapeutic dependency.

There seems to be little debate about the meaning of this term, its prevalence in chiropractic and the implications of its practical application. However, Gatterman (1995) and Coulter (2000) both state that therapeutic conservatism is not unique to chiropractic.

2.6.3.8. Systems theory as a potential contributor to chiropractic thinking traditions and models of practice in the future

In an article dedicated to establishing a rationale for chiropractic to consider a systems model to healthcare, Beckman *et al.* (1996) argue that the chiropractic profession finds itself in the dilemma that it exists as a holistic approach to healthcare in a mechanistic, reductionist culture. The authors state that the resolution of this dilemma does not lie in the outright rejection of the reductionist model, but the development of a science of healthcare that takes into account the diversities of the physical and other natural sciences and that finds a reasonable balance between scientific objectivity and human experience (Beckman et al 1996: 208).

Beckman *et al.* (1996) offer the systems paradigm as their grounding for such a model, because they believe that systems theory offers a generic framework that exemplifies an organismic, holistic worldview and can provide direction for the implementation of a wellness-oriented approach to healthcare. This is accomplished because of the nature of systems theory concepts, which are as follows:

1. Multileveled (stratified) structure: The human is thought of as one subsystem within an entire system with a series of mutually dependent and interrelated organisational levels of differing complexity. A change in one level has the ability to affect the rest of the system. Understanding the system is not achieved by dissecting it because the nature of the whole system is always greater than just the sum of its individual parts.

Essentially, this model would be health-oriented and person-centred without rejecting evidence gathered in a reductionist manner. Due to its emphasis on integration, the systems approach attempts to incorporate this information into an expanded understanding of the nature of evidence. In other words, it seeks the unification of biophysical (objective) and the personal (subjective) aspects of the system (holism).

2. Ecological view: The systems view of health is process oriented rather than object or disease oriented. Health is seen as an ongoing process rather than a static state or simply the absence of disease. Thus, there can be no ideal state independent of the natural and social environment.

3. Nonlinear causality (interactivity): Illness and health are the result of a constant interplay between mental activity and physiological processes that are mutually reinforcing through what has been termed self-reinforcing cybernetic feedback loops. Interventions by the doctor or the patient at any level of the system will have effects throughout the whole system.

4. Self-organisation: In the systems view, there is a symbiotic or functional-structural adaptation of the person to his/her environment. Human beings are considered to be self-organising systems that display a great deal of dynamic stability due to a process of constant co-adaptation of the person-environment system. This process is essentially known as homeostasis.

At a glance, a systems approach to healthcare does provides chiropractic with possible mechanisms to resolve the disparity between its research and practice for a number of reasons listed below:

a) It is person-centred, without rejecting the importance of evidence-based practice, but attempts to incorporate these elements within an expanded understanding of the nature of evidence; and

b) The theoretical framework emphasises the organismic, holistic worldview and provides direction for the implementation of a wellness-oriented approach to healthcare that emphasises the human potential for growth and development.

As chiropractic is seeking greater levels of integration, this philosophical tradition should be considered as a possible starting point for empirical research traditions.

2.6.4. In summary

Although six philosophical traditions have been reviewed, the literature suggests that vitalism and materialism are positioned centrally as they have the most direct links to the early metaphysical tenets and the other traditions are somewhat more peripheral, although by no means less important.

Coulter (2000) remains positive about the development of philosophical principles in chiropractic. He concludes that metaphysical principles present in chiropractic still point toward a contemporary philosophy of health. This philosophy maintains that health is a natural state and that the body has the tendency and ability to restore this state. Health is also an expression of biological and spiritual factors, and optimum health is unique to an individual. He maintains that a vibrant and distinct philosophy of healthcare can be established solidly within chiropractic, but warns that the casual use of the term ”chiropractic philosophy” is both ignorant and dangerous. Coulter (2000) stresses that the ongoing use of this phrase could hamper constructive discourse because of its link with earlier dogmatic stances and its lack of meaning within the larger sphere of philosophy.

From this discourse, one can see that although the profession had the potential to develop the philosophy that Coulter (2000) mentioned, the need to establish itself in the rapidly evolving world of the scientific method meant that materialism, mechanistic thinking and ultimately critical rationalism received immediate attention from chiropractic scholars. As the ”mixers” began to run parallel with the emerging powerhouse of biomedicine, they drew further away from the other five principles in their thinking. The vitalists in the profession, on the other hand, did little to open critical discourse further. Therefore, a research or academic culture developed, which assimilated in many ways with that of biomedicine (Jamison, 1995).

However, somehow a number of common sense principles seemed to stick and inform clinical practice, some of which are today proving to be of significant value. In a sense, chiropractic’s research seems to be catching up with its practices from a philosophical perspective.

One must, admit, however, that even though chiropractic has provided some interesting interpretations of philosophical tenets, they are by no means unique to the profession and it will consequently serve the profession well to cease using the term “chiropractic philosophy”.

In conclusion

Chiropractic's first century of existence can be described as the history of an outsider, both locally and abroad. The profession, despite the many factors stacked against it, has managed to stake a claim in the hostile terrain of healthcare. Now, in a relatively secure position, attention must be given to issues of development rather than survival. For chiropractic to integrate successfully into a healthcare system that until recently has tolerated it only because of patient support, chiropractors must consolidate their position with as much professional development as possible. In the following chapter, these issues will be explored.

This chapter revealed the following salient issues:

Chiropractic's anti-mainstream worldview and use of controversial management interventions placed it in opposition to mainstream healthcare thinking. This led to fifty years of strife with allopathic medicine.

The trait approach used by Wardwell to brand the profession as "marginal" did little to improve the position of chiropractic from a sociological perspective.

It is unlikely that chiropractic developed as a superseding paradigm offering a more plausible basis for the management of disease; it is rather a healthcare tradition that held and still holds metaphysical views, some of which stood and stand in opposition to paradigms prevalent in allopathic medicine.

Kuhn cannot be applied to the chiropractic profession in the classical sense because chiropractic is not only a scientific discipline, but also a profession.

The literature suggests that vitalism and materialism are the central metaphysical tenets of chiropractic, whereas the other four tenets seem to be guiding principles in practice.

Materialism has had the greatest influence on chiropractic science and practice.

Chapter 3
Chiropractic: Paradigms, professionalisation and institutionalisation

3.0 Introduction

In Chapter 2, the history of chiropractic practice and philosophy was briefly reviewed in order to provide a rationale for some of the peculiarities associated with the profession's early development, especially around the notion of paradigms.

It is the broad aim of this chapter to develop key issues related to the professional development of chiropractic further. Specifically then, this chapter will focus on the chiropractic paradigm as commented on by Ian Coulter, the institutionalisation of chiropractic as a discipline and profession, and the role for the chiropractic profession in healthcare.

3.1 Coulter's chiropractic paradigm: An argument for the existence of multiple paradigms in chiropractic

3.1.1 Introduction

It has been argued that one cannot consider chiropractic as a singular paradigm and that if one were to do justice to the notion of paradigms, one would have to look for evidence of paradigmatic development associated with the discipline and profession of chiropractic.

As a sociologist, Ian Coulter has been commenting on the development of chiropractic practice for more than two decades (Kelner, Hall & Coulter, 1981). He has not only argued extensively for the existence of a chiropractic paradigm, but believes strongly that chiropractic as a major stakeholder in CAM stands in the unique position of having the potential to influence the development of healthcare beyond the restrictions of biomedicine.

Coulter argues that,

> at the end of the twentieth century, where the major diseases are related to lifestyle and have largely been unresponsive to treatment within the reductionistic, biomedical paradigm, there is an important place for alternative philosophies. The philosophy of chiropractic in this context provides an interesting exemplar for all alternative healthcare (1999: xvi).

3.1.2 Coulter's understanding of the paradigm: Key interpretations of Kuhn

Coulter (1990) defines a paradigm as

> The theories, beliefs, values and techniques, which describe a certain area of speciality, in order to define those questions worth asking. A paradigm furthermore, provides the frame of reference by which, the (research) questions can then be posed and answered.

According to Coulter (1990c), Kuhn first conceived the paradigm as a form of dogma, which implies that paradigms are in a sense restrictive and, although normal science is constructive, it does not encourage extensive leaps through novel thinking.

Paradigms set themselves up to be defeated because no one view can be all encompassing and therefore what presents as an anomaly to one paradigm, might be perfectly acceptable to another. A new paradigm always involves an act of faith (*gestalt* switch) and its spread requires an act of conversion. Therefore, a paradigm is only as successful as the persuasiveness of its proponents. Coulter argues that, although competing paradigms are incommensurable, it does not have to be absolute. However, the problems that exist for communication between theorists belonging to different paradigms are similar to those that confront a language translator. There is no language for translating one theory into another because words embedded in successive theories have different meanings and different conditions of applicability.

Scientific paradigms could be grouped into three distinct categories in order to defuse some of the ambiguity inferred by Kuhn's loose nomenclature. Firstly, metaphysical paradigms exist where one is referring to beliefs, myths, new ways of seeing and so forth. Secondly, sociological paradigms exist where the paradigm is a recognised achievement of a social group. Thirdly, the construct paradigm, where a paradigm is treated like a textbook example, as actual instrumentation, as a *gestalt* switch and so forth. These sub-paradigms are distinguishable, but they often co-exist and all contribute to a research paradigm.

Therefore, the chiropractic paradigm actually consists of a conglomeration of three sub-paradigms that dynamically interact with one another and inform the practice and the type of inquiry of its proponents.

3.1.3 Interpreting the different faces of the chiropractic paradigm

Coulter (1990) argues that if we are to consider chiropractic as a distinct paradigm, we must

> embrace the basic assumptions, metaphysical beliefs and philosophy on which chiropractic is founded, the body of knowledge of chiropractic (theories, research findings, models of reality, etc.), the language and concepts of chiropractic and the therapies. Further, since a paradigm is defined not only by what its followers say about it, but by the behaviour of those who subscribe to it, it is defined by an identifiable group whose behaviour is affected and directed by the adoption of the paradigm as an important framework.

Therefore, it is Coulter's stance that chiropractic's claim to being a paradigm must be judged on whether it meets the criteria of a paradigm. Let us therefore consider Coulter's classification of these different sub-paradigms.

3.1.3.1 Chiropractic as a construct paradigm

The construct paradigm centres around the initial "trick" that brings about a *gestalt* transformation. This event in chiropractic came in the form of the first adjustment by D. D. Palmer when the hearing of a deaf man was apparently restored after a manipulation of the spine. According to Coulter (1990),

> there is general agreement among philosophers of science that science can and does grow out of metaphysics, [but] they have generally ignored the reverse situation where metaphysics arise out of technical "tricks" or achievements.

Therefore, chiropractic seems to contradict this consensus because, despite the claims of the founding father for the existence of theories and principles of chiropractic, no evidence can be found corroborating this claim. In other words, the first manipulation was carried out without any prior speculation about its relation to good health.

Although Coulter argues convincingly that chiropractic may represent a variation from the norm, it must be stated that Kuhn focused on theoretical constructs. The notion of a construct paradigm is not present in the original text and is therefore an adaptation and interpretation by Coulter on Kuhn.

However, what can be said is that the sociological permutation in chiropractic developed last because it was only after these initial events and metaphysical postulations that articulation and development of the paradigm followed.

3.1.3.2 Chiropractic as a metaphysical paradigm

As seen previously, evidence for chiropractic's rapid metaphysical paradigm development is abundant in its history and followed rapidly in the wake of the initial *gestalt* transformation.

Coulter defines metaphysics as the *a priori* assumptions of chiropractic that accompany and inform its theory. These assumptions are of the ontological nature of the universe and are largely not amenable to proof, although this is subject to change.

In the case of chiropractic, the first metaphysical tenet is that the cause of disease is not to be found outside the body, but within. This stands in opposition to medicine's invading organism view. The body, when functioning normally, is able to combat disease naturally. The second is the restorative life force, Innate Intelligence, which is responsible for vitality.

Coulter states that metaphysical tenets tend to give way to empirical ones, but he also argues that it is doubtful whether any paradigm is free of metaphysical elements.

However, these worldviews have shown little development in terms of rational support, logical consistency, conceptual coherence and problem-solving capacity in its brief history. Notwithstanding the strong commitment to this view, the bulk of scientific inquiry within chiropractic does not use these as basic premises and therefore a powerful bio-medically oriented worldview counters it from within the profession.

3.1.3.3 Chiropractic as sociological paradigm

Evidence for this paradigm resides in the social organisation of a recognisable social group around a paradigm. Clearly, this happened in the case of chiropractic. Professional and political associations have been formed, schools founded, research foundations established and journals and indexes published. Furthermore, chiropractors are recognised by statutes in most of the jurisdictions of western society where they practice.

However, Coulter feels that this is perhaps the area where the application of the paradigm concept might be useful to chiropractic, but in a negative sense. Both internal (associations) and external (government legislators) contributors to the sociological paradigm in the United States have failed to formulate a precise definition and a tidy scope of practice for chiropractic. This may come as no surprise due to the history of the profession. However, the result is a hazy, non-unified social identity, which could be detrimental to chiropractic.

Besides the three main categories, Coulter identifies three other paradigmatic contexts relevant to chiropractic. These are chiropractic as a philosophical paradigm, chiropractic as an alternative paradigm (to medicine) and chiropractic as a research paradigm.

3.1.4.1. Chiropractic as a philosophical paradigm

Coulter states that D. D. Palmer's original approach to health was holistically driven. It was based on the notion that the body is an integrated unit, which has the ability to maintain a status of health as long as homeostasis is maintained. Therefore, chiropractic does not treat disease, in the strict sense of the word. It strives to return the body to a balanced state so that it can combat disease. This means that what constitutes a diagnosis in medical terms constitute symptoms for many chiropractors.

This does not mean that chiropractors deny the existence of micro-organisms that can give rise to disease, but that they distinguish between exciting and predisposing causes of disease. Disease is caused by lowered resistance, which is the predisposing factor, whilst micro-organisms taking advantage of this situation are the exciting factors.

Furthermore, it was Palmer's stance that the body was built on nature's order and therefore all interventions applied to the human body should aim to enhance the natural ability to heal. He was therefore against the use of drugs and the natural interventions he chose were hand adjustments.

Although a level of uncertainty will always remain, naturalistic philosophy is very much a part of contemporary chiropractic, if for no other reason than the profession's position taken about health behaviour, for instance good nutrition, good exercise and so forth.

As was discussed earlier, a number of other philosophical infusions have contributed to the development of philosophical discourse within chiropractic. Therefore, a strong argument can be made for the existence of chiropractic as a philosophical paradigm.

3.1.4.2 Chiropractic as an alternative paradigm

According to Coulter (1990), five major paradigms in health existed at the latter part of the nineteenth century in North American healthcare. These were allopathy (medicine), homeopathy, osteopathy, naturopathy and chiropractic. Of these, allopathy based on its germ theory became the dominant view. Of the rest, only chiropractic remained intact and grew significantly.

As was noted earlier, its existence and growth resulted more from social factors than from healthcare research. Nevertheless, it still stands as a general paradigm as opposed to an allopathic specialty like dentistry and podiatry. In other words, chiropractors do not limit themselves to the treatment of one part of the body, nor do they necessarily accept the basic premises of medicine.

Chiropractic was in its early days labelled as deviant or marginal. However, as the profession has developed, it is now described as complementary and alternative. For Coulter, the answer lies in empirical research where patients define how the profession should be utilised. Chiropractic might have been an alternative paradigm in the nineteenth and twentieth century, but is it still so?

3.1.4.3 Chiropractic's research paradigm

Coulter (1990) emphasises that in the area of research chiropractic differs considerably from other health paradigms. For the most part, paradigms are seen to give rise to distinct research traditions in which the paradigm is applied over a wide range of research puzzles. During such a period, the paradigm is not fundamentally tested in terms of its core assumptions, but pushed as far as it can go. (This is Kuhn's notion of "normal science") This did not occur in chiropractic, however, because the profession instead drew from other paradigms to provide rationales for its own. Coulter (1990) is of the opinion that the reason for this can mainly be attributed to the complex history of the profession as it struggled for survival in the face of constant medical antagonism. He furthermore states that it was only recently that chiropractic scholars have begun to engage with the major research questions of the paradigm.

Coulter (1990) is therefore led to the conclusion that chiropractic has a number of the features of a paradigm, but the paradigm has not led to the research tradition generally associated with a scientific paradigm.

Coulter makes the strong claim that chiropractic is no worse and also no better than the other paradigms that have populated science, but that it has yet to demonstrate that it can give rise to a research tradition to equal others.

3.1.5 In summary

Coulter therefore concludes that chiropractic at least warrants consideration as a distinctive paradigm. Compared to medicine, it involves a *gestalt* transformation and a conversion experience. It had an original ”trick”, has theories and philosophical traditions and is supported by a distinctive social structure. There is considerable incommensurability between chiropractic and medicine; chiropractors and medical practitioners pose different clinical questions and have adopted different strategies to solve them.

Although the chiropractic paradigm is currently undergoing rapid change, Coulter’s interpretation of paradigms stands essentially uncontested in the literature and has served as a platform for philosophical debate (Jamison, 2001; Meeker & Haldeman, 2002; Menke, 2003). However, one basic aspect that remains unclear is the issue he alludes to quite early on in his discourse: Is chiropractic a single paradigm with different faces depending on the context, or is it a conglomeration of a number of integrated paradigms that contribute to the chiropractic paradigm? Whatever the interpretation, the point remains that chiropractic can and has been mapped at the level of paradigms.

However, as is often the case in science, one tends to uncover more questions than answers. In the case of chiropractic, a cloud currently hangs over its research paradigm. What are the paradigmatic questions that chiropractic scientists should be concerned with and how will they go about rectifying their methods of inquiry in the future?

3.2 The institutionalisation of the chiropractic profession: an argument for an increase in the presence of chiropractic colleges in mainstream tertiary education

3.2.1 Introduction

Having argued that chiropractic manifests itself at the level of paradigms, we now have to take cognisance of the issue that as a research paradigm the discipline of chiropractic leaves much to be desired.

The business of chiropractic education has succeeded in producing doctors of chiropractic with educational levels comparable to those of their medical peers (Meeker and Haldeman, 2002). However, for the most part, chiropractic still exists outside mainstream tertiary education in North America today and the profession is therefore still prone to isolation (Meeker & Haldeman, 2002).

The ill effects of years of isolated development are still evident in its philosophical traditions or lack thereof, and in the variability in approaches to practice identifiable today. Although the profession has managed to combat these by remaining socially relevant, this position must change in order for the profession to manage its destiny actively (Wardwell, 1992: 260-262; Meeker & Haldeman, 2002).

It has been suggested that one of the hallmarks of professional maturation is the level of institutionalisation exhibited in its discipline of applied knowledge (Louw, 1990: 21). Therefore, although chiropractic has been described in some detail in the literature as a profession (Wardwell, 1992), an argument will be made in this section that the profession must exhibit greater levels of institutional acceptance in order to help itself to secure a position as a significant healthcare provider in the future.

This section will aim to highlight the need for the development of the theoretical grounding of chiropractic's paradigm of inquiry by increasing the level of institutional presence in mainstream tertiary institutions.

The chiropractic profession went through a great deal of trouble to prove that it is distinct and separate from allopathic medicine. Chiropractors were successful in this endeavour; their existence in the face of dogged medical antagonism is testimony to this. However, what the profession also severed itself from in the process was open access to social science discourse related to healthcare as prevalent in the university system (Gibbons in Haldeman, 1992: 15).

In the following section, it is argued that, although the sociological paradigm of the profession has been disadvantaged due to its relative isolation, its progressive institutionalisation points towards social maturation and relevance in the future.

3.2.2 Knowledge, power, professions and universities

In a text dedicated to the institutionalisation of formal knowledge, Freidson (1986: 3-4) develops a view on knowledge, power and professions grounded in the theories of Michel Foucault.[11] The author states that the type of knowledge required for power/knowledge is what is termed formal knowledge, because it is used to create order in human activities and therefore constitutes an exercise of power over those who are the object. For Eliot (1986), formal knowledge is strongly characterised by rationalisation, which is

> the pervasive use of reason, sustained where possible by measurement, to gain the end of functional efficiency and … is intimately associated with the rise of modern science and the application of the scientific method to technical and social problems.

Eliot (1986) argues that for this knowledge to have an impact on the natural or social world, it must be carried by human agents, whose characteristics will influence the impact made by this knowledge. As universities are the source of much of the formal knowledge today, Eliot (1986) argues that a natural consequence is that the knowledge carriers or ”intellectuals” tasked with the dissemination of formal knowledge reside within and conform to its structure and practices in order to acquire it.

Although Eliot (1986) does not conclusively describe the exact nature of the “intellectuals” responsible for transporting and delivering formal knowledge, he recognises that professionals may constitute a part of this corpus, if they are not solely occupied with the pursuits of daily life, but are also concerned with ideas rather than just systematic bodies of knowledge or intellectual disciplines. It therefore comes as no surprise that university education has become synonymous with

[11] Foucault’s view is that power and knowledge are key ingredients in the motivation for scientific endeavour and that the two are so intimately related that the use of the compound power/knowledge is the most appropriate way to describe the nature of the relationship. Foucault challenges the conventional thinking that scientific knowledge is a function of the benevolent search for ”truth”, but rather a vehicle for self-determination and dominance over the object of inquiry, whatever its nature (Mills, 2003).

professions that have strived to align themselves with the vehicles through which facts and consequently knowledge are formally legitimised (Abbott, 1988:196).

3.2.3 The university as a barometer of professional maturity

Besides legitimacy, Abbott (1988: 196) states that universities play a number of other useful roles in professional life, namely providing authoritative grounds for the exclusive exercise of expertise, housing the function of knowledge advancement, enabling academic professionals to develop new techniques outside of practice, training young professionals, often in conjunction with the function of research, and they can become arenas for inter-professional competition.

Once entrenched within the structure of the institution, the profession can start to channel formal knowledge and mould it to its own set of diverse interests (Mills, 2003:69-70). In this text Mills argues that "rather than seeing the production of knowledge as wholly oppressive, Foucault is able to see that the production of information by the marginalised themselves can alter the status quo".

Therefore, if evidence of such development within the chiropractic profession can be found it would indicate a move from relative obscurity and weakness to one of relative security and self-determination with respect to formal knowledge acquisition.

3.2.4 Implications for the chiropractic profession

As the chiropractic profession has become more institutionalised, we can indeed see evidence of its progression from an object of study (Firman & Goldstein, 1975) to an independent body with the ability to create and channel formal knowledge (Kilvaer, 2002; Zolli, 2002). Many chiropractic scholars with post-graduate qualifications up to and including the doctorate level contribute to an advanced level of formal knowledge production and integration within the university system (Carey, 2003). The level of formal knowledge dissemination has become equally advanced. Evidence of this can be seen in the number of indexed *Medicus* journals, which are devoted to chiropractic research activities, and the number of popular texts penned by chiropractic scholars used in universities (Coulter, 1991a).

In South Africa, two state university chiropractic programmes (Durban Institute of Technology and Technikon Witwatersrand) train primary care practitioners at the Master's level, which requires a research component for qualification (Durban Institute of Technology: Chiropractic Departmental Handbook, 2003: 13). This aspect of training sets it apart form the other professions that commonly share its patient

pool. These professions include physiotherapy, biokinetics and general medical practice, and do not require the ability to conduct research as an entry requirement to their respective professions (www.sun.ac.za 2003), which is also the case for the great majority of chiropractic colleges internationally. Although the international Council for Chiropractic Education (CCE) enthusiastically supports this curriculum because of its ability to produce clinicians and researchers, only the University of Southern Denmark currently offers a similar programme (Roodt, 2004). This is mainly because both the South African and Danish programmes enjoy considerable state subsidy and are therefore not tuition driven, which means that smaller student intakes can sustain the programmes and consequently the logistical issues associated with the throughput of high numbers of Master's theses pose less of a problem (Roodt, 2004).

The legitimacy afforded the profession, due to its ability to produce and integrate formal knowledge, has been useful in securing an existence (Jamison, 1991: 1). According to Jamison (1991: 1), chiropractors have been included in the orthodox healthcare system for some time now as the largest exponent of complementary and alternative medicine. However, chiropractors for the most part still find themselves outside the referral loop of mainstream healthcare (Langworthy & Birkelid, 2001). According to Menke (2003), the percentage of medical physicians who referred patients to chiropractors in the previous week ranges between 12 and 18%, and 90% of chiropractic patients still claim to be self-referred, despite a new generation of medical doctors who display curiosity and openness to chiropractic.[12] This implies that merely having access to the creation and dissemination of formal knowledge is not enough to ensure professional status and privilege. Hence, although its carriers of formal knowledge are at least the equivalent of their healthcare counterparts, the integration of chiropractic into the greater healthcare system is less than optimal (Menke, 2003).

3.2.5 *In summary*

Although still hampered by its isolation, it has progressively become more self-aware and its levels of organisation have become more complex (Chapman-Smith, 2003). Chiropractic has succeeded to a certain degree in using its institutional structures to further its cause, but the discipline can at best claim partial institutionalisation when

[12] At the time of this study, no statistical information related the rate of referral in the South African context could be found.

compared to other healthcare professions that are prevalent in universities, for example psychology.

3.3 The professionalisation of chiropractic: A page out the book of psychology

3.3.1 Introduction

There is much controversy in the literature over the definition of a ”professional”. For some, the terms “profession” and “professionalisation” have been used so indiscriminately that as terms they have almost ceased to be useful (Louw, 1990: 1). However, authors agree that to attain the rank of professional is to command status in society. Therefore, due to the impact of professionalisation on modern society, Louw (1990: 1) argues that if an occupation is serious about its claims to this particular division of expert labour, it has to consider its own particular process systematically and critically.

It was argued in section 2.3 that chiropractic professionalisation cannot be viewed using a traits approach. This view is problematic firstly because it judges chiropractic according to the characteristics of medical professionalism. Secondly, the trait approach assumes that the professional ideology of the dominant members will hold for all the members, which cannot be said for chiropractic due to its “mixer” or “straight split”.

The relatively young profession of psychology shares with chiropractic the characteristic of having elements of both an academic discipline and claims of professional standing. Psychologists have developed a significant body of knowledge in this regard in which a number of authors have argued for its successful professionalisation (Freidson, 1986; Louw, 1990). Furthermore, psychology has placed great emphasis on the role of institutionalisation, which, as was argued earlier, is integral to professional existence and is probably incomplete in chiropractic.

Therefore, it is the aim of this section to apply factors considered key in successful professionalisation from psychology as an example of an occupation that exhibits the dual characteristics of discipline and profession and which was traditionally considered to represent the ideal for chiropractic, namely that of a limited medical profession. This will be done in order to form an opinion of the maturity of professionalisation in chiropractic and to indicate areas of possible growth.

3.3.2 The dimensions of professionalisation

According to Louw (1990: 21), Geuter (1984) provides the most satisfactory major study of the professionalisation of psychology, which distinguishes the following dimensions as guidelines for this process:

a) The institutionalisation of psychology as an academic discipline;
b) The development of systematic knowledge within the discipline that could be applied;
c) Institutionalised professional roles and the demands of society;
d) The strategies of the occupational group to gain acceptance for their discipline; e) Regulating qualifications and formulating educational policy;
f) The role of occupational rivals; and
g) The subjective suppositions of the members of the occupational group.

These dimensions will be explained briefly and then loosely applied to the chiropractic context.

3.3.2.1 The institutionalisation of an occupation as an academic discipline

Here two aspects have to be considered, namely cognitive and social institutionalisation. Social institutionalisation describes the processes of internal organisation that take place, like associations and journals, and the integration of the discipline at universities. Cognitive institutionalisation includes the establishment of consensus among scientists about the problem area(s), the concepts and the methods of the discipline.

Chiropractic has demonstrated significant social institutionalisation (Chapman-Smith, 2000: 25-29) with respect to professional bodies and legislation, but it can probably only claim partial institutionalisation at universities internationally and in South Africa (Chapman-Smith, 2000: 54-55; Till & Till, 2000). Furthermore, as discussed in 2.5 and 2.6, there still seem to be different problem solving traditions in the profession. Therefore, from and institutional perspective, the profession is still relatively immature in it process of professionalisation.

3.3.2.2 *The development of systematic knowledge within the discipline that could be applied*

A discipline must possess its own knowledge, which it must be able to distinguish and differentiate from the knowledge of other disciplines. This knowledge is, however, not simply the result of scientific advances at the technological level. In a

study of professionalisation, aspects of knowledge that become relevant at the level of the practical solution of socially defined problems are crucial. At specific times, problems arise in society that make concrete demands on experts. Professionals then have to change the application of that knowledge. According to Louw (1990: 21), new applied knowledge is not only yielded through the moulding of knowledge to changing societal needs. However, some applied knowledge will be of more practical use than others will.

The applied knowledge in chiropractic seems fragmented at present. On the one hand, research is conducted primarily from a mechanistic perspective, whilst other philosophical traditions seem to inform clinical approaches to practice in the profession, on the other hand (Jamison, 1998a).

3.3.2.3 *Institutionalised professional roles and the demands of society*

A professionalising science cannot only be theoretically involved with the problems of society; its experts must also intervene actively in problem areas with their procedures. A range of problems will occur, some more amenable to the applied knowledge of the profession than others. A measure of successful professionalisation can therefore be the extent to which various institutions carry a discipline's expert roles, for instance the defence force, labour and industry, among others.

Chiropractors continue to enjoy great support from their patients. However, chiropractic was only recently accepted into the United States armed forces (2000) and it is not a feature of the hospital environment. This holds true for the South African context, where little or no presence is observable in government institutions or public healthcare systems (Till and Till, 2000). Industry, however, supports chiropractic care and worker's compensation does pay for chiropractic care (www.chiropractic.co.za 2004). The profession can claim only moderate success in terms of institutionalisation in this context.

3.3.2.4 The strategies of the occupational group to gain acceptance for their discipline

Members of a professional group will employ a number of strategies to advance the position of their profession. One such strategy is to lobby parliament to pass laws restricting the practice of the profession to certified people only. This activity is often seen as the driving force behind the process of professionalisation. It must be kept in mind that professions are not monolithic and may often contain rival sub-groups, which may oppose one another on certain matters. These groups may favour

different strategies of professionalisation, which in turn may influence its institutionalisation and professionalisation. However, occupations can only be successful if they succeed in convincing important clients and addressees that their work or performance is useful to the client or the institution. This process is termed legitimation. The strategy of legitimation can be science-oriented or it can be aimed at demonstrating practical usefulness.

It would seem from its research agenda, that chiropractic sought legitimation from medicine and that the profession worked under the assumption that all other areas would follow once medicine gave its stamp of approval. Perhaps there was some wisdom in this, as spinal manipulation gained recognition as an appropriate modality for treating mechanical spinal disorders in particular (Meeker & Haldeman, 2002). However, as will be argued later, the result has been a research culture that suffers from many of the same ailments as medicine and which tends to exclude issues important to the chiropractic profession; issues related to chiropractic's most important addressee, the patient (Jamison, 1998a; Bolton 2001).

3.3.2.5 The regulation of qualifications and formulation of educational policy

Scientific products are largely evaluated and quality controlled by the scientific community itself. When the discipline becomes a profession, however, its consumers become individuals or institutions who cannot judge the competency of the professionals. Thus, the control of competency becomes a concern and a state system of licensing or registration is called into existence. This inevitably involves the problem of the qualifications required to practice the profession. Here universities are of vital importance, because university-based professions always claim a higher status in the market place.

In chiropractic, this has progressed in a similar manner as with most other profession, with state bodies now responsible for controlling these practices (Chapman-Smith, 2000: 30-32; Meeker & Haldeman, 2002).

In South Africa, an interesting situation developed when an entire training programme was established, not so much because of an intrinsic desire from within the profession to have local training, but to allow the chiropractic profession to add numbers to its roll of members (Brantingham & Snyder, 1999).

3.3.2.6 The role of occupational rivals

No discipline can afford to relinquish problems within its own field of competence to others. Often a process of struggle and persuasion has to take place, in which groups of people attempt to negotiate the boundaries of an area of expertise and to establish control over it. Chiropractic is no exception. In the United States, it battled medicine over the right to manipulate for more than half a century, until 1987 when it won the final lawsuit. The case of Wilks and others *versus* the American Medical Association (AMA) found the AMA guilty of an illegal conspiracy of systematic long-term 'wrong doing' and intent to destroy a licensed profession. Locally, chiropractic's critical moment came in 1982, when it was legislatively granted the ability to regulate the practice of manipulative therapy (Brantingham & Snyder, 1999).

3.3.2.7 S*ubjective suppositions of the members of the occupational group*

It has been a general assumption that the members of a profession act in a uniform way in terms of their common interests. This is called into question when one considers whether professionals and academics, for example, all share the same expectations of professionalisation, or have the same requirements. It is possible, on the one hand, to see the growing practical direction as an enlargement of the discipline. It is, however, also possible for academic psychologists to see the increasing professionalisation of the discipline as acting against its scientific interests. Thus, its scientific interests may in fact prevent the discipline from turning its activities towards practical interventions.

The existence of various models of practice indicates that the profession has not developed solely on the strength of its institutional academic advancements. It has been reported by a number of authors that the models of practice prevalent in chiropractic may actually be a better representation of the true nature of the chiropractic profession than what its narrowly focused research paradigm tends to suggest (Gatterman, 1995; Coulter in Lawrence, 1996: 437-439; Jamison, 1998b).

3.3.3 In summary

What is most obvious about this view of professionalisation is that chiropractic, rather than being marginal, appears to share a lot of common ground with psychology, which was never considered marginal to the extent that chiropractic was. Incidentally, the Geuter model was developed in the context of German psychology during the Second World War. For the psychologists of the day, this was a time when the theoretical/empirical advancement of the discipline was severely hampered by the

exodus of Jewish academics. It was also advantageous to avoid links with universities and to dodge involvement with Nazi rhetoric. However, by the time the war ended, psychologists were firmly institutionalised in the German military. Therefore, in the case of psychology, professionalisation took place in the absence of significant input from the discipline aspect of the profession. In this sense, the level of chiropractic professionalisation attained without significant entrance to universities can be readily understood as the profession organised itself around legislative bodies without significant advances in its empirical theory development.

It is also true, however, that in the case of psychology a strong disciplinary tradition had already been established in a much shorter time. Therefore, cognitive institutionalisation, particularly, seems to be where chiropractic requires development.

The inherent danger of the above set of criteria is that they will be used as finite characteristics to be fulfilled, with psychology in this instance providing the yard stick. The next section will consider areas that could benefit from professional development.

The ”dimensions” approach to chiropractic provides an alternative view of the profession, which explains the condition of the profession in 2002 more adequately than Wardwell’s traits view. Most importantly, it does not require that chiropractors declare themselves as limited medical professionals, when they are patently not.

3.4 Issues for chiropractic to consider as part of its professional maturation process

3.4.1 Introduction

In section 3.2, it was argued that no matter how well chiropractic becomes institutionalised in universities, it will not automatically secure a position in the healthcare system. For the same reason, professionalisation will eventually require significant institutional presence in order to strengthen its position. Therefore, chiropractic should consider mechanisms to further its process of professional maturation by finding ways to effectively link practice and academia.

This section will discuss two themes that contribute to this discourse, namely chiropractic’s paradigm of inquiry and models of practice identified in the profession.

3.4.2 A biomedically inspired research paradigm and the practical nature of chiropractic

What is evident from the previous discussion (3.1.4.3) is that, as with medicine, the investigatory paradigm in chiropractic developed from rationalist roots and grew to form the basis of its research paradigm. According to Lafaille and Fulder (1993), its dualistic approach to the patient created a division between an objective body and a subjectively experienced psyche. This promoted causal thinking in terms of a singular stimulus-response scheme and consequently gave rise to a research model that is based upon mechanistic, monocausal and dualistic principles (Gatterman, 1995; Jamison, 1995). The result has been an abundance of evidence in the tradition of the reductionist, biomedical model (Cooperstein *et al*., 2001).

The implication for chiropractic has been two-fold. Chiropractic research has utilised the same marker for intervention as biomedicine, for example the presence of disease as indicated by a diagnosis to initiate management, with the same indicator(s) for successful intervention, namely the amelioration of clinical signs and symptoms.

Scholars have misused clinical intervention studies. Manipulative techniques have been applied erroneously as a controlled, independent variable to comment on the clinical nature of chiropractic as opposed to its effect as an intervention (see 2.5.3.2) (Ernst & Assendelft, 1998). This means that researchers have effectively reduced the entire clinical scope of the profession in many instances by equating it with manipulation (Nelson *et al*., 2000).

A narrow focus of research tends to narrow professional scope of practice, according to Nelson *et al.* (2000), who warn that, if this type of academic discourse continues, chiropractic scholars will be forced to address the question of whether or not the profession should be defined solely by manipulation seriously. If not, then the research paradigm will have to at least have the potential to reflect the nature of the profession from a practical perspective.

The practical nature of the profession compels the doctor of chiropractic to impart not only safe, effective and individualised manual therapy to remove the markers of disease, but also to integrate pertinent lifestyle issues into a management protocol aimed at producing and maintaining a state of optimum health (Kotze, 1995), in other words, keeping the patient well. This non-physical component of care might therefore

often include certain activity modification(s), patient education and at times counselling (Kotze, 1995). According to Jamison (1998b), this integrated (holistic) type of approach to patient care represents a return to wellness due to the interactive "healing encounter" between doctor and patient, which extends beyond the application of isolated manual therapy or therapies.

The practical nature of chiropractic does also incorporate positivist empiricist thinking, but it is not the only area in which chiropractors have influence and are compelled to demonstrate evidence to support utility (Jamison, 2000a).

3.4.3 Diverse chiropractic practice models and their effect on inquiry

At least two practice models have evolved in chiropractic despite a relative dearth of research to support them. Authors seem to agree that these models of practice are better approximations of the true nature of healthcare in the chiropractic paradigm and consequently may provide the conceptual basis for future research endeavours (Gatterman, 1995; Jamison, 1997a; Coulter, 2000).

3.4.3.1 The illness behaviour model and chiropractic

The first model considered by scholars as appropriate to chiropractic is the illness behaviour model (Vernon, 1991; Gatterman, 1995; Coulter, 1996: 434-437). However, it was not, developed specifically with chiropractic in mind. Waddell (1987) developed it as a generic clinical model for the treatment of low back pain because of the ongoing problem with alarmingly high levels of disability associated with the condition.

The notion of illness behaviour can be traced back to the work of Mechanic and Volkart (1960) who coined the phrase in an article, which recognised the necessity for the systematic study of disease in contexts outside and inside the laboratory. The authors recognised that, besides the existence of disease entities, patients experienced disease differently and developed behavioural strategies that are not necessarily linked to the physiology of organic disease, with both psychological and social impact. The authors termed this experience the "sick role". Pilowsky (1969) contributed to the discourse by pointing out that some patients presented with physical complaints for which no adequate organic basis could be found, with the consequence that they were often labelled hysterics. He argued that when the doctor identifies with the sick role, the patient enters the sick role quicker and hence the healing process is fast tracked. Firman and Goldstein (1975), who examined

chiropractic from an early psychosocial perspective, were of the opinion that chiropractors were uniquely equipped to legitimise the entrance of patients into the "sick role". Their statement was based on the following observations:

a) Chiropractors often deal with clinical syndromes that present without direct evidence for their existence, for instance wounds, fever and so forth.

b) They acknowledge the patient's illness and tend to quickly enter into a shared reality with the patient. This tends to establish congruence with the patient and facilitates a more successful management process.

Firman and Goldstein (1975) felt that this aspect of the sociology of chiropractic was so important that they concluded, even though the profession was considered marginal at the time, that as long as the chiropractic profession was able to build on this social role in the healthcare system, it would most likely remain stable in the future. At the time, however, chiropractic scholars did not develop this line of thinking any further.

Waddell (1984) demonstrated that patients suffering from chronic low back pain actually suffered from three separate and measurable entities that contributed to the disability associated with the condition. Waddell (1984) demonstrated quantitatively that physical impairment, psychological distress and magnified illness behaviour together constituted 71.2% of disability encountered. The author argued that this percentage was important because, although illness behaviour and distress may have developed secondary to the original physical problem, they could become just as disabling and may persist after all physical traces of injury had disappeared.

Waddell (1987) then developed a clinical model for the management of low back pain, incorporating bio-psychosocial factors, which he termed the illness behaviour model (IBM). He demonstrated both conceptually and quantitatively how chronic low back pain and disability had become increasingly associated with emotional distress, depression, failed treatment and the adoption of a sick role, and conversely more divorced from the original basis of physical findings. Waddell explicitly stated that conventional medical treatment for low back pain had failed; critical introspection would be required to affect the growing pandemic known as low back pain. One of the key concepts of the IBM is therefore the notion that one can be well in the presence of disease and ill without organic dysfunction.

Grounded in the work of Waddell, Vernon (1991) developed a model for the management of low back pain for chiropractors,including holistic principles and wellness practice. He recognised the limitations of the testability principle of chiropractic, formally described by Phillips and Mootz (1992), and saw it as a stumbling block in chiropractic's exploration of its paradigm. Chiropractors were uniquely equipped to provide care for the illness aspects of low back pain and a framework is needed to distinguish between treatment, care and focus inquiry.

Vernon's treatise therefore focused on successful "care giving", in which the non-specific (placebo) effects associated with the process were desirable and to be utilised to improve management. He developed this position further by demonstrating conceptually and operationally how care giving could be structured into a management process in order to address disease, illness behaviour and wellness.

Table 3.1. The conceptual clinical practice milestones achievable through the Vernon Clinical Practice Model.

Stage in healing encounter	Action taking	Conceptual impact	Outcome achieved
1. Initial contact	Acceptance of patient	Validates problem	Dissatisfaction
2. Diagnosis	Based on manual procedures Practitioner delivered Low emphasis on technology Identification of a specific lesion	Communication Secures intact relationship Anxiety related to laboratory procedures Reinforces "fixer" role	Distress Trust Distress Confidence
3. Explanation	Comprehensive with the use of audio-visual aid(s)	Patient satisfaction	Distress
4. Negotiation of plan of action	Immediate and not pain contingent	Patient co-operation	Patient self efficient
5. Treatment	Emphasis on role of movement Intervention aimed specifically at mobilising injured structure(s)	Active role of patient Co-responsibility emphasised, thereby reinforcing fixer role	Patient self efficient Trust
6. Evaluation	Function orientated, i.e. function, symmetry, strength and pain	Multi-factor evidence of recovery	Experience of pain reinforced by linking it to recovery of function.

(Vernon, 1991: 382-384)

From Table 3.1 it becomes apparent that Vernon's clinical model utilises the rational, biomedically acquired evidence for the physiological effect of particularly spinal manipulation. However, the model accepts the validity of the healing encounter described by Jamison (1995) as a critical dimension for the success of overall management. Clear guidelines are given that relate to physical action(s), for instance specific interventions, verbal and non-verbal tools to be taken by the practitioner and a number of non-physical skills, which must be employed to address psychosocial components pertinent to the patient's illness behaviour. The outcome therefore is the movement of the patient into, through and ultimately out of the sick role, with the result being wellness.

The model consists of six stages, which represent different stages of the shared healing encounter. Based on the work of previous scholars, Vernon proposes desired actions to be taken at each stage (which are not necessarily always tangible, for instance "accepting the patient") to achieve a conceptual impact and a desired result. This model highlights the complexity of clinical management and that measurement of the effect of controlled interventions will provide clinicians with a partial understanding of the entire management process. Its clear portrayal of "treatment" in the context of the larger management plan made scholars aware of the one-dimensional nature of their research and of what still had to be done to define the nature of chiropractic completely (Gatterman, 1995).

3.4.3.2 The patient-centred model

Gatterman (1995) incorporated Vernon's model and extended it to the broader, generalised model for chiropractic practice. The model is termed the patient-centred "paradigm", which incorporates the metaphysical tenets of chiropractic and elements of the biomedical and wellness practice mentioned in this review. He argues that the patient-centred paradigm does not propose a radical paradigm shift, but seeks to fit known facts about patient satisfaction into a context of maximum benefit to the patient. It could also generate new facts that had not yet been observed or findings not yet understood as significant.

Using a focus group approach, the characteristics identified were put to an eight-member consensus panel consisting of chiropractic educators, researchers and a sociologist. The characteristics of the paradigm are described as follows:

a) Recognition and facilitation of the inherent healing capacity of the person;
b) Recognition that care should ideally focus on the total person;

c) Acknowledgement and respect for the patient's values, beliefs and healthcare needs and expectations;
d) Promotion of the patient's health through a preference for drugless, minimally invasive and conservative care where indicated;
e) A proactive approach that encourages patients to take responsibility for their health; and
f) The patient and patient-centred practitioner act as partners in decision making, emphasising clinically and economically effective care, based on predictable delivery, documentable outcome and overall quality.

For Gatterman (1995), these characteristics mean that chiropractic will have to develop beyond the randomly controlled clinical trial to involve designs where clinicians can apply patient-centred "real world" assessment. This implies the use of pluralistic designs from both qualitative and quantitative quarters, which rely on triangulation to maintain scientific rigour and are able to draw broader inferences.

Coulter (1999: 51) contends that chiropractic's emphasis on the crucial role of individuals in their own health has resulted in a treatment paradigm that is perhaps overly patient oriented. The aouthor is of the opinion that this model developed to oppose biomedicine on some level. In this instance, the reason was purely pragmatic because, 'like all alternative providers in a culture where the traditional route for illness is medicine, chiropractors have been required to pay attention both to the patient's needs and to getting results. Patients in alternative care have invariably used other forms of care first and, failing to get results, have turned elsewhere' (Coulter 1999: 51).

Therefore, the practice paradigm, which seems to hold sway among chiropractic scholars, has developed in much the same way that Einstein's relativity theory superseded Newton's theories of absoluteness (Silver, 1998: 20). Although positivist-reductionist thinking has been able to solve some of the questions relevant to chiropractic scholars, the biomedical paradigm is just too narrow to solve many others.

In summary

Although some expansion on the two models has been undertaken (Jamison, 1997a; 1997b), the development of the chiropractic practice model is still in its infancy and

has yet to demonstrate a tradition of unique scientific inquiry, which might elevate it to the level of a fully-fledged paradigm.

3.4.4 Views on a balanced development of the chiropractic investigatory or research paradigm

The literature suggests that wellness practice parameters in chiropractic have not only existed in the profession for some time (Vernon, 1991; Coulter, 1996: 434-441), but have been developed significantly over the last 15 years. However, due to the poor integration of practice and research, concern exists among chiropractic scholars over both the appropriate paradigm for educating the student and the appropriate research paradigm for investigating chiropractic (Caplan, 1991; Coulter, 1993; Jamison, 1995). For Coulter (1993), this is tantamount to the same thing, which is the appropriateness of a scientific framework. The ongoing debate between clinical and statistical relevance is providing ever greater, albeit indirect, evidence for the inability of basic science to capture the uniqueness of chiropractic. It only succeeds in distorting its contribution by forcing it into the limiting concepts and categories of basic sciences (Anderson *et al.*, 1992).

Consequently, chiropractic scholars have started debating alternative ways in which to describe the investigatory component of its paradigm. In a discussion dedicated to alternative philosophical and investigatory paradigms for chiropractic, Coulter (1993) focuses on two areas in which chiropractic might look to other paradigms to develop fresh perspectives. These are (a) paradigms that could illuminate the practitioner-patient interaction and (b) paradigms that could provide grounding for the development of a more appropriate research paradigm.

3.4.4.1 Patient-practitioner interaction

The obvious first choice for Coulter (1993) and others (Caplan, 1991; Kleynhans, 1991; Jamison, 1995) was to examine holism's contribution to an alternate paradigm. Holism as a principle stands in radical opposition to the materialist basis of science and a related paradigm would therefore naturally demand the most radical changes in terms of healthcare delivery. According to Coulter (1993), a healthcare practitioner functioning in a holistically driven paradigm would be

> Holistic (nonreductionist) and focus on the total patient; naturalistic (a preference for natural remedies); humanistic; therapeutically conservative (using the least possible intervention and allowing the body to heal itself as much as possible); equalitarian with respect to the doctor-patient relationship,

> which is seen as a partnership; personable (using a low level of technology); caring; and practicing in settings that reinforce the dignity and power of the patient.

Jamison (1995) interpreted this view as a focus on the relationship aspect of chiropractors and their patients. She suggests that the analysis of patient-practitioner interaction as a therapeutic strategy could be one approach to incorporating aspects of holism into a paradigm more suitable to chiropractic. She furthermore argues that this endeavour has the potential to formalise such a paradigm by identifying future research variables, as well as by focusing on the practitioner as an instrument of healing. No specific methodologies are mentioned. However, Jamison (1995) does suggest that the establishment of practice models in chiropractic like those suggested by Vernon (1991) and Gatterman (1995) would allow the specific methods to develop as a natural consequence of their application.

Holism, as demonstrated previously, is not a research paradigm, but a meta-scientific position that resides at the level of metaphysics. Consequently, in an effort to standardise comparative discourse, Coulter (1996) incorporated the work of a number of holistic protagonists in order to produce a refinement in holistic thinking, which could be used at the level of research. According to Coulter (1993; 1999: 39) holism as a generic, philosophical construct refers to the balanced integration of an individual in all aspects and levels of being: body, mind and spirit, including interpersonal relationships and our relationships to the whole of nature and our physical environment.

He argued that in a healthcare setting holism implies the consideration of the individual in the full context of his/her spiritual, psychological, social and biological well-being in order to attain total health. Successful healthcare is therefore a function of an integrated management strategy shared by a number of healthcare practitioners and the finite goal attainable by any one particular practitioner.

Furthermore, the notion of wellness care had come about as a criticism of the predominant biomedical healthcare system rather than because of philosophical discourse at the level of metaphysics, in other words, holism *versus* reductionism. Therefore, Coulter (1999: 61-63) argues that a realistic term to describe a healthcare practitioner who uses holistic principles in order to facilitate wellness rather than cure disease, should be a ”wellness practitioner”. It stands to reason that such a

practitioner would function in a wellness paradigm and this paradigm would stand in opposition to biomedicine.

Although the argument for a wellness paradigm was not refined until the clarification provided by Coulter (1999: 63-65), Jamison (1991) mentioned wellness practice as a specific mode of healthcare delivery several years earlier. She did so within the larger “holistic paradigm”, and stated that, by its nature, wellness care should constructively contribute to a bio-psychosocial approach to health as it affords the practitioner the opportunity to consider variables other than only those linked to the organic disease state (Jamison, 1991).

A further paradigm considered by Coulter (1993) under the relationship aspect was the bio-psychosocial paradigm. This paradigm, attributed to the work of Engel (1977), developed in opposition to biomedicine. Engel argued strongly that biomedicine was in fact detrimental to the best interests of the patient. In 1977, Engel stated,

> The dominant model of disease today is biomedical, with molecular biology its basic scientific principle. It assumes disease to be fully accounted for by the deviations from the norm of measurable biology (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neuro-physiological) processes. Thus the biomedical model embraces both reductionism, the philosophical view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic.

According to Cherkin (1998), a bio-psychosocial model in healthcare can be practically defined as one that focuses on illness rather than on disease, and maintains that a person’s experience of illness is influenced by psychological as well as physical factors. In his essay about the state of the science of primary care of low back pain, he argues that those charged with the management of primary low back pain cannot make progress until they acknowledge patient perceptions and placebo, and the role these play in the healing process. Although Cherkin (1998) argues for the continual refinement of randomised control trials in particular, he strongly criticises the biomedical approach of research by stating that “tinkering with the

current mess" will not provide useful answers for the management of primary low back pain.

Due to its inclusive nature, Coulter (1993) considered this an appropriate model from which chiropractic can develop its own paradigm. Furthermore, Coulter (1993) argues that many proponents of holism considered Engel's model to be appropriate and that the two paradigms were congruent in many ways.

Therefore, as suggested the biopsychosocial (infomedical) paradigm could provide a viable, inclusive alternative for the evaluation of clinical efficacy particularly for conditions with significant physical, psychological as well as social components (Firman & Goldstein 1975, Vernon 1991, Jamison 1991: 4, Symonds *et al*., 1996).

From the patient-practitioner perspective, it would seem that holistic thinking (the wellness paradigm) and the bio-psychosocial paradigm had very similar contributions to make. Their suggestions mainly centred on the development of practice models and healthcare delivery, which could lead to specific modes of inquiry. What is still unclear, however, is whether a wellness paradigm will develop as a separate entity or whether wellness practice will form a part of the bio-psychosocial paradigm. Nevertheless, wellness practice provides an exciting prospect for the profession, as it incorporates many of the basic principles deemed important to chiropractic.

3.4.4.2 Grounding for a research paradigm

Coulter (1993) suggests that both humanism and phenomenology might be useful to chiropractic scholars because of their differences from biomedicine, as well as their established modes of conducting research. Coulter (1993), however, agrees with Kleynhans (1991) that phenomenology most probably has more to offer than humanism does. Humanism in many ways intends to shore up biomedicine by adding new elements from, among others, the social sciences. However, phenomenology clearly follows a non-positivistic philosophy and is therefore more congruent with chiropractic's basic principles.

Bolton (1999) agrees with Coulter (1993), but adds naturalism as grounding for an alternate research paradigm. In an article titled "Research design in chiropractic", a

strong case for the inclusion of naturalistic[13] (qualitative) research methods in the chiropractic research paradigm is made. Bolton (1999) uses the multidimensionality of the pain experience measurement as a case in point to demonstrate that translating outcomes from quantitative data and statistical analyses into the treatment of the individual patient with chronic back pain in a chiropractic clinic raises a number of questions.

According to Bolton (1999), quantitative studies have demonstrated a weakness in their interpretation on the following three levels:

a) Factors like patients' and practitioners' attitudes, beliefs, expectations and preferences are not adequately investigated through quantification;
b) The patient cannot be observed holistically; and
c) Very little can be gleaned from statistical inferences of the patient's social environment in the context of the whole person.

He argues that quantitative research, if poorly understood and applied exclusively, will not only diminish our view of the big picture, but will slant our view entirely to be without context and without application. It is in this respect that qualitatively oriented studies come to the fore because they have the ability to "provide rigorous accounts of treatment regimens in everyday contexts and, from them, can enhance our understanding of how patients act and fall ill".

As the above-mentioned methods involve the immersion of the researcher in the research process, Coulter (1993) states that the relationship aspect of chiropractic, which has gone without investigation, will immediately benefit.

3.4.5 In summary

From the literature review it is evident that there is currently incongruence between chiropractic's model(s) of practice and its underlying research paradigm. The debate in chiropractic about an appropriate paradigm(s) of investigation and practice points for Kuhn either to pre-scientific debate or to a tradition in flux (Mouton, 1996: 203). Chiropractic contains a body of evidence, but its appropriateness to describe the

[13] In the naturalistic research paradigm, it is essential when a complex entity is under investigation that all time and context-dependent realities remain intact. Without these interactions, the investigation becomes artificial and meaningless. This mode of research therefore stands in opposition to the reductionist model and is congruent with phenomenology in that causality is not central to its principles.

nature of chiropractic fully is in question. Therefore, if we follow the Kuhnian "prediction", the healthy scholarly discourse and research activity currently taking place should eventually lead to a point where the disadvantages of the past no longer make a difference; a point where the profession can ask and answer the questions it has always found intriguing.

Perhaps the time has come to move researchers into the natural setting where the practice of chiropractic occurs. The time has possibly arrived to find methods and tools with which to appreciate the effect of clinical rituals and relationships that have always been thought of as important in patient care.

3.5 The integration of chiropractic in South African healthcare based on a systems model of healthcare

3.5.1 Introduction

In section 3.2, it was argued that, although the acquisition and application of knowledge may have been instrumental in ensuring the existence of the chiropractic profession, it is not sufficient to ensure integration into mainstream healthcare. The result of this incomplete integration is that the profession is not supported by the public healthcare and referral system. It therefore attracts patients on a referral basis, which remains an ongoing problem (Freburger *et al.,* 2003).

A number of authors have argued for chiropractors to adopt integrative thinking and practice strategies in order to tap into an evolving healthcare system (Caplan, 1991; O′ Malley, 1995; Coulter, 1996: 443; Mootz *et al.*, 1997). Menke (2003) in particular provides a lucid and up to date view of this topic in a commentary titled "Principles in integrative chiropractic". According to him, chiropractic's public acceptance continues to grow with the profession enjoying ever-increasing levels of utilisation. However, "the ability of chiropractors to respond confidently to integration into the overall healthcare system may be the next step in gaining access to more patients and improving the healthcare quality".

In order to attain this end, Menke (2003) argues that the profession must proactively formulate a blueprint, which maintains the chiropractic identity, and at the same time emphasises their role as primary contact physicians and not musculo-skeletal specialists (limited medical professional). To maintain its identity, the profession must continue to capitalise on high patient satisfaction ratings and therefore must continue to emphasise biomechanics, manual therapy of the spine, good patient rapport and a

strong patient-physician bond. Menke (2003) warns that if the plan is reactive or characterises chiropractors as musculo-skeletal specialists, the profession runs the danger of being passively swept along by the priorities of managed medical care, with the result being a limited role similar to physical therapy.

With this in mind, my intention is to explore, in the final section of this chapter, a position for the chiropractic profession in the South African context, which could provide a base from which to launch such an integrative strategy.

3.5.2 The rationale for a systems model to healthcare in chiropractic

Holism and the wellness paradigm suffer from a practical malady, which is that they contradict mainstream philosophy and thinking. Therefore, chiropractic finds itself in the situation that if it wants to integrate into mainstream medicine it is going to have to overcome the perception of it being anti-establishment. As we have seen earlier, a healthcare model based on systems theory seems conceptually viable due to its inclusive nature. It does not require either chiropractic or medicine to make any concessions, but instead challenges healthcare practitioners to broaden their horizons and to accept as evidence facts that fall outside natural philosophy. In particular, holism/homeostasis can be seen by both sides as a concept that, when interpreted as by Baum (1998), provides an interesting common point of departure in the field of science and not metaphysics.

There is no indication from the literature that the Beckman *et al*. (1996) treatise has any major conceptual flaws, however little has been developed in terms of research and practice using a systems grounding. Therefore, I shall present a conceptual view of chiropractic practice in South Africa based on this stance.

3.5.3 Healthcare for South Africa that considers both illness and wellness makes sense

Jamison states that,

> although influential in healthcare, the definition of health as the absence of disease permits consideration of health only insofar as it involves the absence of detectable disease. Although it is a useful approach to early disease diagnosis and may suffice as a rationale for disease prevention by case finding, it is not a definition that may be operationalised in order to attain optimal health (1991: 13-14).

Therefore, Jamison argues that the WHO's definition of a total physical, psychological and social well-being, whilst not defining the criteria upon which well-being should be based, does represent a paradigm shift from its Cartesian predecessor.

A number of authors from across the healthcare spectrum agree with Jamison on this issue (Kaptchuk & Eisenberg, 1998; Teitelbaum, 2000; Meenan, 2001). Wellness care emphasises active participation on the part of the patient and thus reduces the burden of health provision on the healthcare practitioner. Therefore, if developed optimally, it is more cost effective than its dualistic counterpart, because it places emphasis on costly technology for curative interventions, reduces the routine use of medication and places less of a load on personnel in the healthcare system.

In current-day South Africa, however, we still encounter a healthcare system, which is strongly oriented towards recognition and management of disease (Kenyon *et al*., 2003), and although the notion of holistic practice seems to have spawned some debate,, particularly in the management of HIV/AIDS and corporate health programmes, the evidence for meaningful wellness practice is still scant (Giarelli & Jacobs, 2003; Dugmore, 2003). Therefore, an appropriate point of departure for chiropractic seems to be to create a conceptual view of where chiropractic currently lies in the healthcare system.

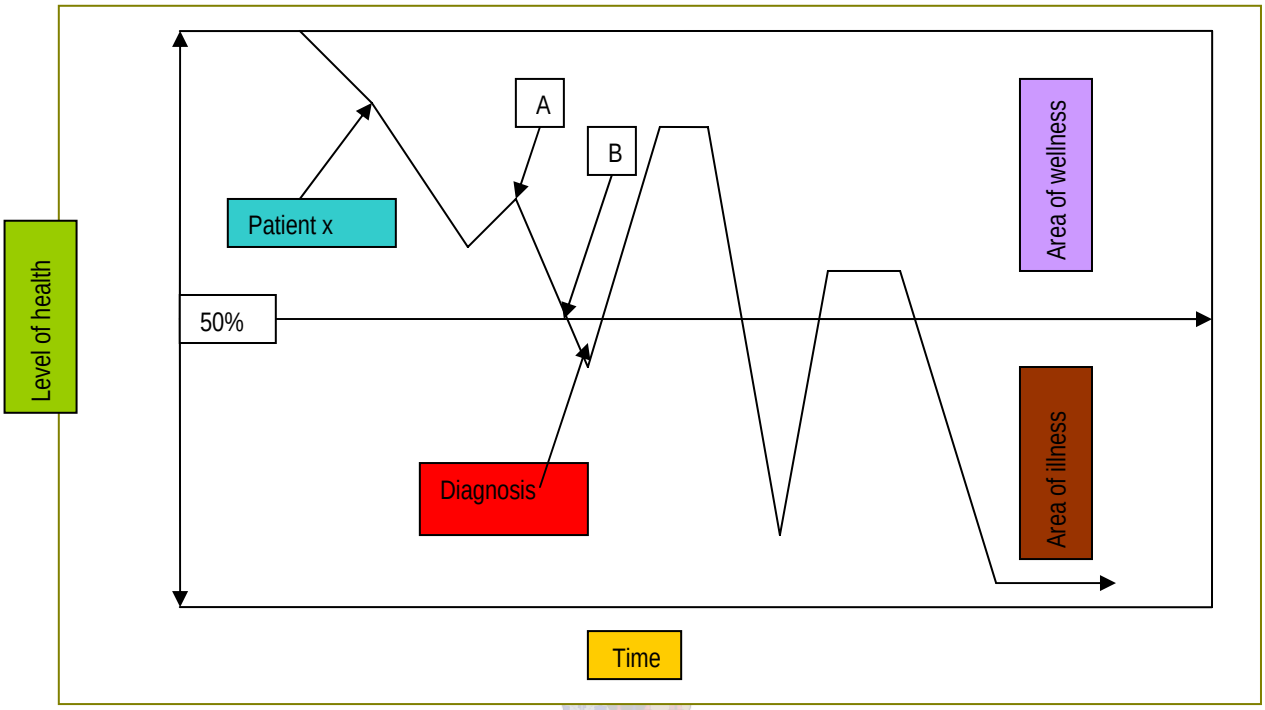
3.5.4 The dilemma for wellness orientated chiropractors

One way of creating such a view is to consider where chiropractors might function in the course of a patient's healthcare history. Let us assume that we are able to map the life line of a hypothetical patient 'x' in terms of the major health related incidences which affect this individual over time. Let us further assume that health is finite and measurable on a scale between perfect health (100%) and death (0%). With these poles established there then has to be a cross-over between 'ease' (wellness or health) and 'dis-ease' (illness or sickness), which is indicated by the 50th percentile. The exact level of the line is arbitrary, but it does indicate a critical cross over between wellness and illness also known as health and disease.

Figure 3.1 then indicates that patient x was born healthy and for the most part resides in the area of wellness. However, at times he/she will experience episodes of reduced wellness. Under the current healthcare system, these reductions for the most part go unmapped e.g. point A, until he/she sinks below a critical level (50%). At

which point (B), he/she would be labelled ‘diseased’ based on a diagnosis made during this period. This arguably represents a run of the mill scenario. However it raises a simple question:” Wouldn’t it be better to recognise the decline in health before it falls below critical levels?”

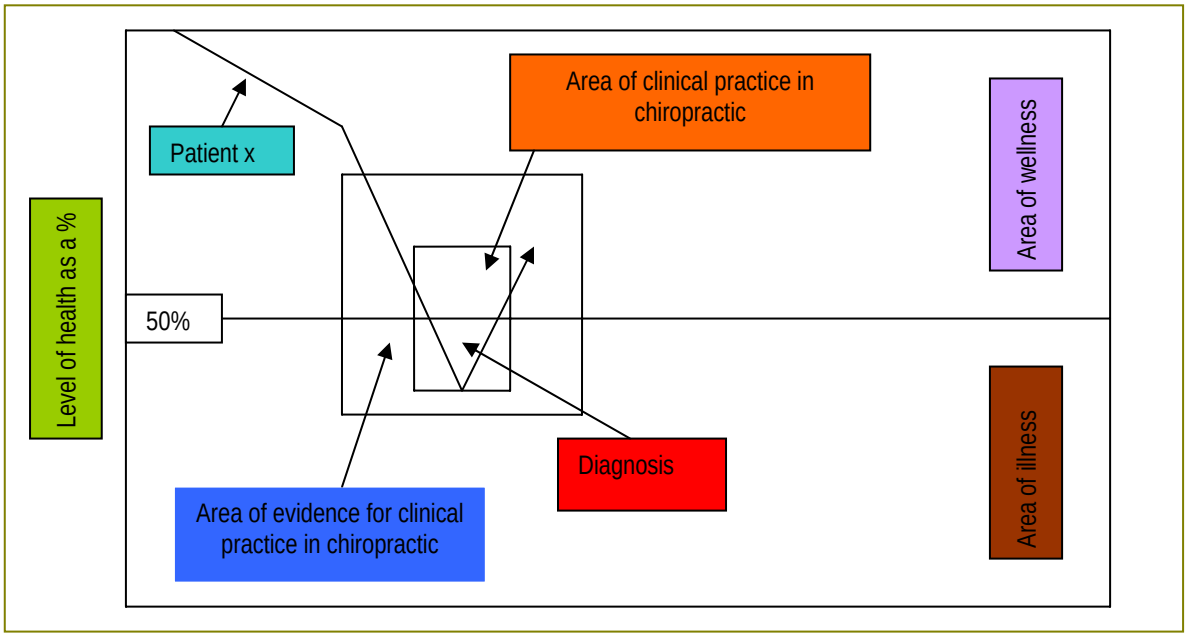
Figure 3.1: The healthcare history of patient x.



From my earlier discussion (section 2.6) it would seem that a significant number of chiropractors answer ‘yes’ to the above question both philosophically as well as in practice and thus function in the relatively un-chartered area of “wellness” practice (section 3.4.2).

However, due to the historical influence exerted by biomedical research traditions on chiropractic, evidence for clinical effect tends to cluster around critical cross-over points where clinically significant pathology is apparent (as illustrated in Figure 3.2). Consequently, the profession’s practical nature may require of the clinician to function in a much broader capacity then what the evidence of practice suggests. This becomes problematic as the profession attempts to influence policy makers, both public and private, who focus heavily on evidence, to underwrite the profession as it attempts to carve its niche (position) in the health care system.

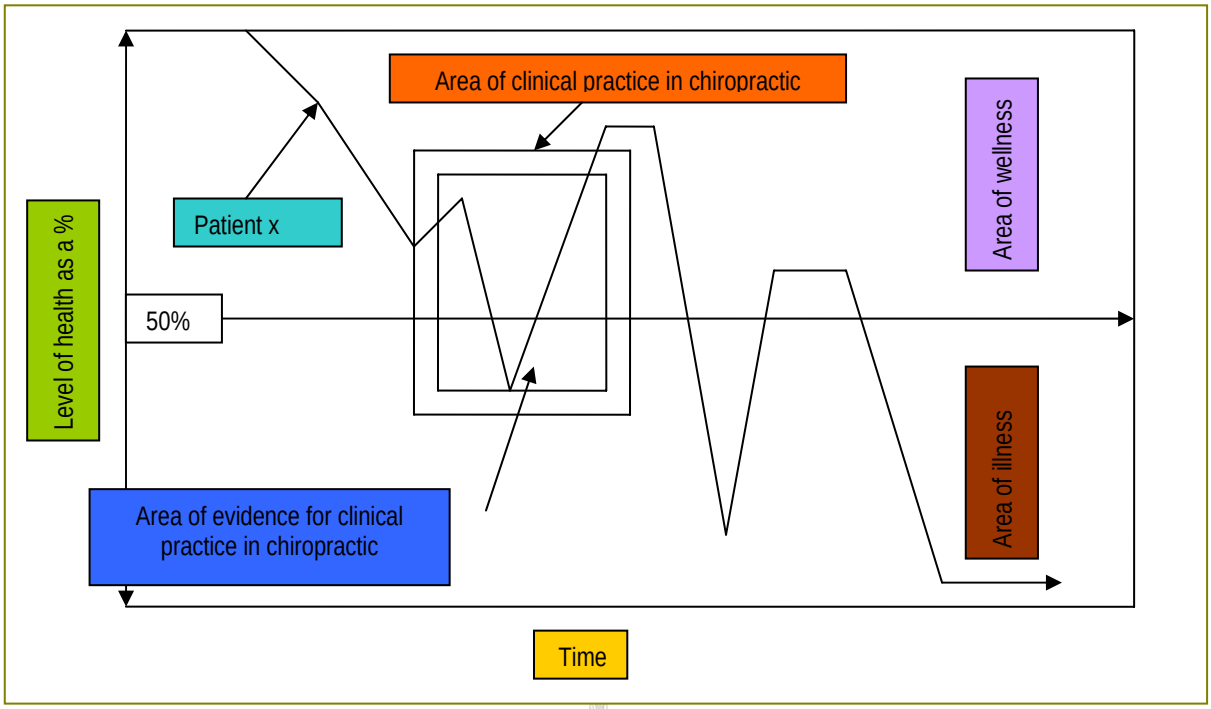
Figure 3.2.The superimposition of the nature of chiropractic clinical practice and its evidence for practice.



If we therefore suppose that the diagnosis made in Figure 3.1 is related to low back pain, the chiropractor should be well equipped to recognise and manage that condition according to wellness-oriented practice principles. However, he/she will not be able to justify professional utility through the evidence provided by a narrowly focused paradigm of inquiry (Figure 3.2).

What these illustrations indicate is that the key to developing an optimal position in the healthcare system is to identify the scope of activities that the profession wants to cover and then to systematically start expanding the paradigm of inquiry to mirror more closely viable models of practice, so that evidence-based utility can be demonstrated (as illustrated in 3.3 below).

Figure 3.3: The ability of the chiropractor to demonstrate utility in the management of patient x.



3.5.5 The effect of a coherent practice and research paradigm on position in the healthcare system

If we were to assume for a moment that three different hypothetical healthcare professions had resolved the dilemma as per 3.3 above, one might see a very different picture of healthcare for the patient developing.

Figure 3.4 below represents three hypothetic healthcare professions with different, but well-demarcated roles in the healthcare system.

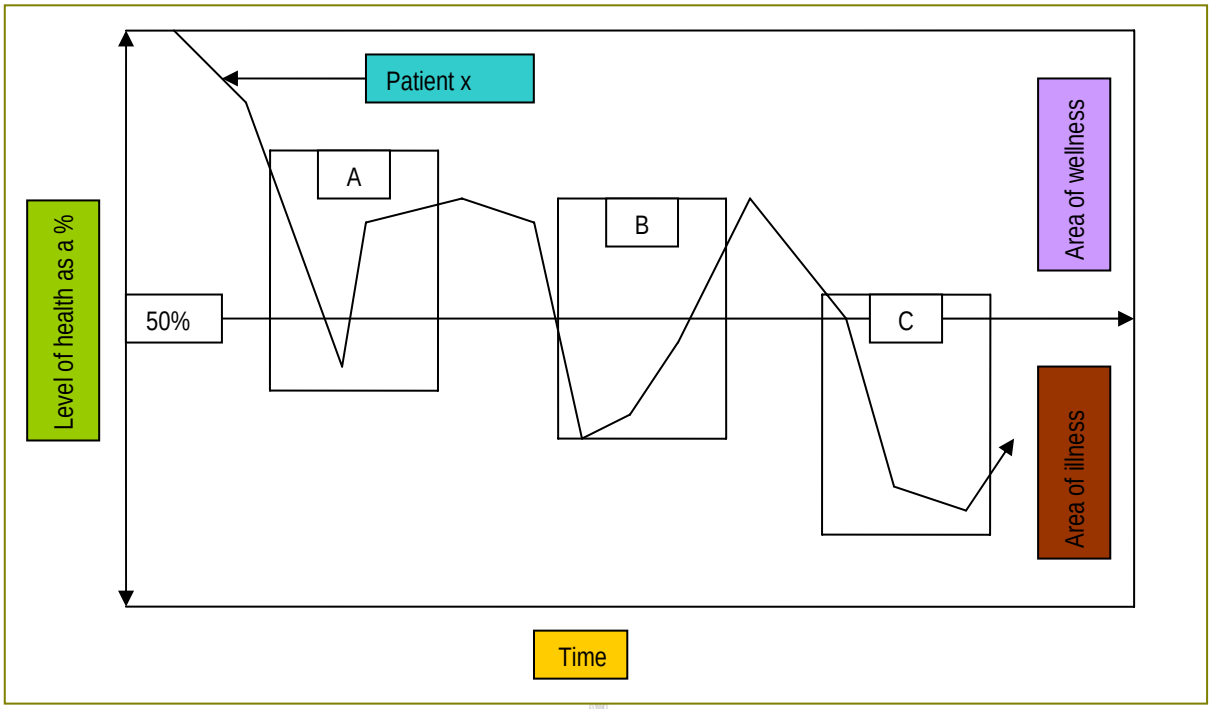


Figure 3.4: The effect of clear role demarcation on healthcare system integration.

Profession (A) functions mainly in the area of healthcare above the 50% mark, whilst (B) has a mixture and (C) concerns itself mainly with heroic interventions below the 50% mark. It stands to reason that one would expect to see a significant level of paradigmatic inquiry from profession (A) in the areas above the 50% mark as this is where it has to demonstrate utility for its interventions to be supported by the healthcare system. In (B) one would have a mixture, whereas (C) would make its inquiries mainly in the area below the 50th percentile.

If we then superimpose the health history of a patient (x) over these professions and make the assumption that the patient and health service administrators are adequately informed, it seems plausible that each profession would be able to assist appropriately in the healthcare needs of the individual during different phases of his/her life, as well as maintain and, in the process, cement their position in the system.

What would then be left is to integrate the three professions in a manner that will maximise the efficiency of the healthcare system.

The chiropractic profession would be hard pressed to place itself in either one of the three categories at present, although its philosophical rhetoric and scope of practice indicate that the profession probably mirrors profession (A) most closely. It therefore seems appropriate that the profession should use this as a conceptual point of departure and establish the position it deems appropriate to hold before moving ahead with plans of integration (Carey *et al.* 2005).

Some of the implications of a coherent view of the profession are as follows:

a) A clear identity to project to the consumer and other healthcare professionals;
b) A clear identity to project to healthcare funders and policy makers;
c) A clear base from which to launch research activities;
d) A clear view of the product required from the education process; and
e) A reduced probability of major internal professional discord.

3.5.6 In summary

A favourable position in the healthcare system of the future will stand as undeniable physical evidence for the paradigmatic maturation of the chiropractic profession. Although positive developmental evidence seems to exist, the profession will have to exhibit even higher levels of organisation in order to sustain itself in the face of rapid changes in healthcare. Of crucial importance to the profession in the future will be the coherence with which it manages institutional as well as professional matters so that these might support its position among the healthcare professions.

In conclusion

At the turn of the twentieth century, chiropractic and allopathic medicine was developing along separate professional lines. Whilst the former was aligning with the world of science and technology, the latter was establishing its clinical identity through the use of metaphysics and a physical management. For some it seems that medicine used the biomedical paradigm first as a vehicle to legitimise itself and then as a tool to control healthcare practice. Chiropractic, because of its ontological and practical deviation from the norm, became an obvious and presumably “soft” target. The chiropractic community, however, proved itself a tough nut to crack and despite a long series of professional, educational and medico-legal face-offs, continued to grow.

Chiropractors entrenched themselves professionally mainly through public appeal and acquired legitimacy through legislation based on social relevance rather than

scientific evidence. As its position became more secure, chiropractic also started appealing to the world of science for its legitimisation. However, paradoxically, despite adopting the tools of biomedical research and developing a body of evidence of some consequence, the profession was not legitimised by mainstream medicine. This lack of acceptance is perhaps most obviously reflected in the profession's continued operation on the fringes of the public and private healthcare system.

The philosophical discourse in the profession has mirrored this struggle with medicine. From establishing itself as separate and distinct to "proving" the effectiveness of spinal manipulation, the development has been distinctly reactionary and often isolated from mainstream thinking. It has only recently been possible for the profession to consider its own "philosophical well-being" critically. Recent inquiry into chiropractic, particularly through the input of social science, has highlighted avenues that the profession can follow in order to maintain its uniqueness, whilst solidifying its evidence base and legitimacy at the same time.

Some of the most encouraging factors for the ongoing development of the chiropractic paradigm are that its patient-centred nature has positioned it well to take advantage of the mainstream shift toward CAM. Although not formally mapped out, the initial stages in the development of a maturing chiropractic investigatory paradigm, which might assist it development in the area of wellness in particular, is evident.

As the chiropractic paradigm and in particular its investigatory segment matures, chiropractic scholars must accept that medicine exists as a paradigmatic opponent and as such can never legitimise the profession. More importantly, however, is the question of to whom they should be appealing. It seems evident that the chiropractic profession should be courting the patient and the institutions funded by them to pay for healthcare. This holds true particularly in the South African context where the entire healthcare system is in flux as private health funders grapple with managed medical care and the public sector prepares itself for a national healthcare service. A key component in this achieving success in this respect is the development of a coherent identity, which chiropractic currently does not seem able to portray.

Therefore, the specific research questions that have come to light from the above discussion and have empirical consequences are as follows:

a) What is the *status quo* with respect to philosophy in practice in a South African context?

b) What are the models of practice prevalent amongst practitioners and what types of management issues do they bring to the fore?

c) How should/could the profession develop within the local healthcare context?

Chapter 4
Methodological issues in the development of the chiropractic research paradigm

4.0. Introduction

In the previous chapter, the following two main themes were identified:

a) The chiropractic research paradigm has developed by adopting the methodologies of biomedicine, which led to an incomplete view of the profession; and

b) The chiropractic research paradigm is in the early stages of development and has only recently started to broaden its perspectives to include the relational aspect of patient management.

This chapter will concern itself with a discussion of these themes in the context of research methodology. Although the discussion focuses on low back pain, the volume of supporting data justifies the development of general principles pertinent to research methodology within the larger chiropractic research paradigm.

Firstly, the contribution that biomedical methodologies have made to the investigation of low back pain will be examined. The role of spinal manipulative therapy, established through biomedical modes of inquiry, is acknowledged. However, as previously argued, the totality of the chiropractic paradigm appears not to be reflected in its investigatory paradigm, which implies that chiropractic scholars will face the same systematic research shortcomings encountered by their biomedical counterparts. Due to the limitations of the research paradigm, these shortcomings will centre on methodological debates about the “noise” produced by interventions and extraneous variables in manual therapy trials, the use of so-called pragmatic clinical studies and the interpretation of the non-specific (placebo) effect.

Secondly, the contribution of non-clinical or non-experimental studies will be examined. It is argued that qualitative studies allow for investigation in the clinical context that emphasises relational aspects during the clinical encounter. However, as this represents a new area of endeavour for scholars, the body of knowledge underpinning these methodologies is relatively small and conservative.

Finally, questions will be posed that identify the paucity of literature specific to the South-African context.

4.1. The biomedical status quo concerning the management of non-specific low back pain

The drive towards evidence-based healthcare has placed pressure on health professions globally to justify and standardise their therapeutic interventions in order to satisfy both the critical consumer and healthcare policy makers (Coulter, 1996; Bolton, 2001). This, along with the historical pressure to establish legitimacy faced by the chiropractic profession, spawned a research culture, which modelled itself largely on the well-established and accepted modes of scientific investigation utilised by biomedicine (Coulter, 1993).

This has resulted in the generation of a myriad of controlled clinical trials pertaining to the effectiveness of spinal manipulation for the treatment of such complaints as non-specific low back pain[14] (Ernst & Assendelft, 1998). Whilst these studies have done much to entrench the position of chiropractic as the largest profession recognised in the United States under the banner of complimentary and alternative medicine (CAM) (Assendelft *et al.*, 1995; Nelson *et al*., 2000; Meenan, 2001), some authors maintain that this position was attained through volume, rather than the quality and inferential clarity of studies produced (Assendelft *et al.*; 1992, Assendelft *et al.*, 1995; Ernst & Assendelft, 1998).

Their view is particularly relevant in the management of chronic[15] patients, where the outcomes of randomised clinical trials (RCTs) are unstandardised and have not produced clear-cut results. Consequently, a number of authors are of the opinion that these factors have reduced clinical management of the chronic patient to little more than educated guess work (Anderson *et al.*, 1992; Ernst & Assendelft, 1998). This is most conspicuously reflected in the World Health Organisation's policy on low back pain management, in which it endorses spinal manipulation as a valid intervention for patients, but only when the natural history of the condition spans less than thirty days (Chahade *et al*. in Ehrlich & Khaltaev, 1999: 37).

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[14] The term refers to back pain where no underlying pathology can be established and the causes of the complaints remain unknown (Koes *et al.*, 1992).

[15] In this study defined as patients suffering from low back pain for longer than three months.

If one considers the above evidence along with the fact that healthcare professionals are generally losing the economic battle against the disability associated with low back pain, a strong case can be made for some fresh perspectives on the problem (Waddell, 1987; Ehrlich & Khaltaev, 1999: 4).

The question that springs to mind then is why a profession, which seems uniquely equipped to have a positive impact on a condition such as low back pain, has, according to the World Health Organisation, made relatively little impact. Chiropractors are after all clinically well equipped to function within a bio-psychosocial paradigm (Vernon, 1991; Gatterman, 1995; Jamison, 1997a & 1997b), and they have contributed (controversially at times) to the generation of a significant body of scientific literature dedicated to the management of both the acute and chronic variations of the affliction (Assendelft *et al*., 1995; Ernst & Assendelft, 1998; Cooperstein, 2001).

It is the opinion of some that the historical preference for empiricist-reductionist inquiry, and the consequent disregard for appropriate methodologies to provide legitimacy at the cost of scientific validity, has led to the current situation (Coulter, 1996; Jamison, 1997a).

4.2. Biomedical methodologies pertinent to chiropractic[16]

A scanning of the chiropractic literature for evidence of clinical management efficacy, particularly for low back pain, reveals that the majority of investigations conducted have used an experimental or quasi-experimental research design, often in the form of clinical trials comparing spinal manipulation with other interventions (Meade *et al*., 1990; Manga *et al*., 1993; Hendler, 1995; Paton, 2000; Manga, 2000).

The traditionally accepted clinical outcomes have revolved mainly around the quantification of physiological responses, such as pain, strength and range of motion (ROM) (Deyo *et al*., 1998). As with other predominantly quantitative paradigms, scientific rigour was enhanced through methodological techniques aimed at enhancing control, whilst keeping reactivity at acceptable levels (Mouton, 1996: 141-143). Factors like attention effects, researcher confounding and

[16] As stated earlier in the review, the argument made at the paradigmatic level will be reinforced by an examination of the methodological constraints resulting from the adoption of biomedical thinking in relation to the chiropractic paradigm.

the placebo effect are considered decidedly negative and to be eliminated as far as possible (Koes *et al.*, 1992).

Koes *et al*. (1991) published a blinded review entitled “Spinal manipulation and mobilisation for back and neck pain: A blinded review”. Their research objective was to assess the efficacy of spinal manipulation for patients with back or neck pain, with specific emphasis on the methodological quality of randomised clinical trials dealing with the subject matter. According to the authors, spinal manipulation or mobilisation was widely utilised, but remained controversial even though their efficacy had been investigated in randomised clinical trials. The authors argue that a systematic review was justified because the methodological studies cited as empirical evidence were doubtful. In their introduction, Koes *et al.* (1991) state that the similarities and differences among manipulative techniques were not always clear, but certain distinctions or classifications could be made. Manipulation was said to involve a high velocity thrust to a joint beyond its restricted range of movement, whereas mobilisation involved low velocity passive movements within or at the limit of joint range. Curiously, the authors then state that they will refer to these two techniques collectively as “manipulation” for the purpose of their investigation, but they do not explain why this decision was taken. Their search revealed a total of 35 trials comparing manipulation with other treatments. These studies were then subjected to a criteria assessment method, which generated a score out of a possible one hundred points. Thirty trials were related to back pain and five to neck pain. No trial scored higher than sixty points and only four scored higher than fifty, which, according to the authors, suggests a generally poor quality. The most prevalent methodological issues raised were the proper description of dropouts, small sample sizes, a lack of placebo groups, the blinding of patients and the blinded measurements of effect. Koes *et al.* (1991) produce a table in which they give a brief description of each study considered. However, the authors do not elaborate on whether they attempted to establish the type of manipulation used as interventions in each of the studies. However, the authors distinguish between manipulations with respect to their profession of origin, for instance osteopathic.

Their results reveal that eighteen trials reported better results for manipulation than the reference treatment, five trials reported better results in only certain subgroups, whilst eleven studies indicated manipulation to be no more effective than the reference treatment. The results also indicate that most trials reported only

short-term effects; studies that did include long-term effects mostly showed no positive results.

The authors conclude their study by stating that, due to the generally poor quality of studies and the small differences between study outcomes, the evidence for the use of manipulation was at the time unconvincing. They also argue, however, that this type of intervention might be useful for certain patients suffering with low back pain for between two and four weeks.

In the following year, a meta-analysis by Anderson *et al*. (1992) appeared with the objective of assessing the efficacy of spinal manipulative therapy (SMT) in the treatment of back pain. Anderson *et al*. (1992) introduce their review by stating that every society introduce approaches to treatment that it deems acceptable, and that even though these modalities may have a long history of usage they did not guarantee therapeutic value. The authors use manipulation and mobilisation as a case in point. They state that even though scholars agree on the distinct definitions of manipulation and mobilisation,[17] the two are seen to be alternative ways of achieving essentially the same purpose. This, according to the authors, is a "long-accustomed habit", which contradicts differences between them evident in scientific literature. On the basis of this assumption, the authors set out to identify and integrate the results of different randomised, controlled clinical trials, utilising their distinguishing definition of manipulation in the meta-analysis format to assess the efficacy of SMT. A total of 23 RCTs were identified, but, because some trials had more than one comparison group, 34 mutually exclusive, distinct samples were identified. Effect sizes were calculated for nine outcome variables at eight time points following the initiation of treatment. These were pain, global assessments of efficacy by clinicians and patients, flexion, extension range of motion, the straight leg raise orthopaedic test, return to work, activities of daily living and lastly the combination of work and activities of daily living. The time intervals measured were seven, fourteen, twenty-one, thirty, sixty, ninety and one-hundred-and eighty days, as well as longer than six months. The studies collected were furthermore evaluated according to a coding formula, which was applied uniformly across the studies in order to identify characteristics that may have influenced effect size. These included report

[17] In manipulation, the operator applies a manual thrust into a joint in order to cause it to move through a restrictive barrier beyond its passive range and into the para-physiological space. Whilst in mobilisation, the requirement is only that the joint be gently moved within the limits of its passive range of motion.

characteristics, design characteristics and quality characteristics. The coding system was then tested for inter-evaluator consistency on a random sample of nine studies and proved satisfactory. The research tool therefore not only allowed the researchers to compare studies in terms of their objective, which required a statistical pooling, but also allowed them to assess a further sub-problem, which was whether methodological rigour and effect size were related.

The authors acknowledge experiencing problems during coding for diagnostic characteristics, because studies were greatly divergent. This was noted specifically during the process of establishing codes for age categories, symptoms and pathology under treatment, in ranking severity and in dividing the chronological continuum of acute to chronic. Treatment coding was also highly divergent as in some cases the nature of the SMT was unstated. Where possible, the difference between manipulation and mobilisation was identified and a category was created where the two appeared to have been combined. Interestingly, the Anderson *et al.* (1992) coding also reflects the training and experience of the therapist as the authors consider this to be an important indicator of methodological rigour.

The results indicate that SMT demonstrated a consistently greater efficacy over comparison forms of treatment, in terms of the various factors measured, with the highest effect sizes concentrated within the first month. Some evidence was also found for the impact of SMT around six months with respect to pain, which had a positive effect size of 0.48. However, the authors warn that little evidence existed beyond four weeks. Both the positive and negative aspects mentioned seem to correlate with the work of other researchers (Koes *et al.*, 1991). Table 4.2.1 illustrates the specific effect sizes according to the results of Anderson *et al.* (1992).

Table 4.1: Specific clinical effect sizes for the nine outcome measures considered by Anderson *et al.* (1992) as calculated using Cohen's D effect size.

Outcome Variable	**OES**	**SD**
Pain	0.38	0.38
Clinician global assessment	0.38	0.14
Patient global assessment	0.18	0.09
Flexion	0.34	0.39
Extension	0.17	0.34
Straight leg raise	-0.01	0.52
Work	0.40	0.38
Daily activities	0.30	0.23
Work and daily activities	0.70	0.51

SD= standard deviation; OES= overall effect size

As can be seen, all but one of the outcome effect sizes favoured manipulation over either a control or comparative treatment. The authors state that the straight leg raise was marginally negative and was inconsistent over time (week 1 = -0.27; week 2 = 0.46; week 3 = -0.22.). They therefore consider it a poor proxy measure of clinical recovery. The authors, however, also state that, even though a number of the outcome measures displayed face validity, they are in fact proxy measures, which always casts some doubt on measurement sensitivity and specificity.

The second sub-problem related to method quality showed some interesting results because the hypothesis that larger studies would rank higher in terms of quality was proven to be valid (r =.03), although weakly so. What also appeared, however, was that a better methodology tended to yield a lower effect size. This result appears to be congruent with the control-reactivity relationship, according to Mouton (1996: 142-144), as well as with the influence of non-specific treatment effects, according to Cherkin and McCournack (1989).

The final discussion in the article centres on the issue of effect size, or more specifically what should be considered a clinically significant effect size. According to the authors' interpretation of the data, the consistently small to medium effect sizes noted in their analysis are real and indicative of a clinically meaningful difference in favour of manipulation. It is also argued that, although no significant difference in effect sizes could be found, manipulation findings were concentrated at the higher end of the effect size continuum, while those receiving mobilisation were more

randomly distributed and they therefore consider SMT to provide results that are more consistent.

The authors conclude their discussion by stating that only 18 percent of the studies included true placebo procedures. The remaining 82 percent were compared to another treatment. This finding is considered to be a further contributing factor to the deflation of effect size, which, according to them, strengthens the case for the use of SMT.

In the same year, Shekelle *et al.* (1992) published a review article on spinal manipulation for low back pain. The review begins with the argument that, over the previous fifty years, the use of spinal manipulation had been associated with the practice of chiropractic, which is partly why the use of spinal manipulation had been labelled an unorthodox treatment by the medical profession. Therefore, in an attempt to balance and further stimulate the debate, and to be of assistance to clinicians, the authors also decided to review the available scientific literature. They conceptualised spinal manipulation as an intervention that encompassed many different techniques. These techniques were broadly categorised as being one of two types: non-specific, long-lever manipulations and specific, short-lever, high-velocity spinal adjustments. The long-lever manipulations utilise the femur, shoulder, head, or pelvis to manipulate the spine in a non-specific manner, whereas short-lever spinal adjustments use a specific contact point to affect the specific vertebral joint. Shekelle *et al.* (1992) state that the second type is most closely associated with chiropractic practice, although many chiropractors also use long-lever techniques. Consequently, the specific aim of the article was to review the use of lumbar manipulation of all types to treat low back pain.

Studies reporting the use and complications of spinal manipulation and all controlled trials of the efficacy of spinal manipulation were identified and analysed. Of the fifty-eight articles identified, 25 were controlled trials. The studies were then scrutinised for methodological quality according to the criteria suggested by Koes *et al*. (1991). The researchers found that the risk associated with lumbar manipulation was small and that it may vary according to the clinical condition with which the patient presented. The authors estimate the risk to be in the region of less than one per every 100 million manipulations. No firm conclusions could be reached, however, due to the lack of available data.

In their assessment of efficacy, Shekelle *et al*. (1992) first discuss the notion of degree of benefit versus risk to the patient. According to the authors, no survival benefit had ever been shown or claimed, and that assessment would therefore have to be based on relief of pain, time to relief of pain, improvement of functional status, days lost from work, or other similar outcomes. The authors point out that physiologic variables, such as flexibility and number of degrees of straight leg raising, had been used as outcome measures, but that they had correlated poorly with measures of functional status. Furthermore, the authors also state that the studies reviewed had a methodological quality varying between 22 and 62 out of a possible 100 points. The meta-analysis found strong evidence for the effectiveness of manipulation in the management of acute or sub-acute patients with uncomplicated low back pain, as all nine the articles used to analyse this section indicated a significant difference in favour of manipulation. The same could not be said, however, for chronic or complicated cases. The authors conclude their article by stating that manipulation was often used in combination with other therapies in the clinical setting, but that the proportional benefits of combination therapies had not yet been established. It was therefore their opinion that these beneficial components should be investigated individually at first and then in combination in order to optimise treatment strategies.

With the specific aim of addressing methodological quality, Koes *et al*. (1992) investigated the effectiveness of manual therapy, physiotherapy and treatment by the general practitioner for non-specific back and neck complaints. They conducted a randomised trial on a study population of 256 patients diagnosed with and suffering from their condition for six weeks or more. The population was randomly allocated to one of the three above-named categories, whilst a fourth group was created in order to control for the placebo effect. Consequently, 65 patients received manual therapy, 66 physiotherapy, 64 placebo and 61 were treated by a general practitioner. The results of the study indicated that manual therapy and physiotherapy were statistically indistinguishable and both groups were better off than those in the placebo group. More importantly, however, was that subjects in the placebo group were better off than subjects receiving treatment from a general practitioner were.

Although the authors made a significant effort to address methodological issues, such as sample size, patient selection criteria, the refinement of treatment interventions and attention to blinding, they are categorical in their conclusion that non-specific effects (for example, extra attention) could be the reason for intervention success. They conclude that “it seemed useful to refer patients with non-specific

back and neck complaints lasting for at least 6 weeks for treatment with physiotherapy or manual therapy"(Koes *et al*. 1992).

The authors call for further studies in this area, particularly as they consider placebo-related extraneous variables to be poorly understood. However, no suggestions are, made as to what alternative methodologies should be employed to investigate these effects.

In the same year, a blinded review article scrutinising the efficacy of chiropractic manipulation for back pain was published by Assendelft *et.al*. (1992). Their investigation is rooted in the apparent demand for scientific proof of the efficacy of chiropractic manipulation and its link to full acceptance by the general public, third party payers and national governments. The authors state that the demand for the development of RCTs had led to the running of several such trials for back and neck pain, and to a number of reviews. According to the authors, "It is preferable that RCTs involving chiropractors as therapists be used to determine the efficacy of chiropractic treatment" (Assendelft *et.al*. 1992).

The authors include only randomised clinical trials involving chiropractors as therapists. Of the thirty-five studies initially identified (of which twenty-five concerned themselves with low back pain), five studies were identified as being of chiropractic origin. In reviewing these studies, the authors feel that the methodological quality had been generally poor. In fact, no study scored higher than forty-eight out of a possible one hundred, and they therefore, from a methodological point of view, refrain from drawing strong conclusions.

Interestingly, much of the discussion of the results centre on the inability of the review panel to distinguish chiropractic and non-chiropractic studies from one another. It would appear that in the Netherlands both chiropractors and post-graduate physiotherapists and physicians may legally engage in manipulation. They also seem to interpret manipulation in a quite distinct way. Assendelft *et.al.* (1992) state that, because the thirty trials identified were not congruent with the Dutch chiropractor's interpretation, these studies could not be used to shed light on the efficacy of chiropractic. Their interpretation was clearly in conflict with that of Anderson *et al.* (1992) and Shekelle *et al.* (1992), who identified 23 and 25 studies respectively. The authors consequently argue that, in addition to this, the lack of

information regarding the profession of the therapist and their skill in manipulative techniques was a methodological shortcoming.

Nevertheless, the authors conclude that chiropractic appears to be an effective treatment for back pain, but that further studies using rigorous methodologies should be conducted.

Assendelft *et al.* (1995) discuss the relationship between methodological quality and the conclusions reached in randomised clinical trials (RCTs) of spinal manipulation. Of the 51 reviews assessed, 34 made positive statements about spinal manipulation, while 17 were neutral. Of the positive reviews, 44 percent restricted their conclusions to short-term results, six percent to sub-acute and short-term pain and 24 percent made no mention of restrictions. According to the authors, most reviewers did not distinguish precisely between the terms sub-acute and short-term. Assendelft *et al.* (1995) conclude that the overall quality of RCTs on spinal manipulation are of a poor quality, specifically stating that the lack of a uniform classification of prognostically homogenous subgroups are a major concern.

As a follow-on to their 1992 review, Assendelft *et al*. (1996), in an attempt at statistical pooling, re-visited their objective of determining the effectiveness of chiropractic for the treatment of low back pain. The authors justified this second review of eight “chiropractic” RCTs by arguing that previous reviews recommending the use of spinal manipulation for low back pain had evaluated spinal manipulation in general and not chiropractic manipulation specifically. According to the authors, chiropractic approaches to management can only be justified through chiropractic studies. They were unable to perform their planned statistical pooling, and cited the fact that most outcome measures in combination with the various follow-up moments were not adequately covered by the various RCTs to perform a sensible pooling. The authors suggest that the heterogeneity in outcome measures and follow-up timing were the main obstacles. Consequently, the authors are still unconvinced of the effectiveness of chiropractic for the treatment of acute or chronic low back pain.

In a retrospective descriptive study, which investigates the management of chronic non-specific low back pain in primary care, Van Tulder (1997) attempts to describe the diagnostic and therapeutic procedures for patients with low back pain in primary care. According to the author, both the over-use and under-use of diagnostic and therapeutic interventions had been reported in the literature and that there is very

little consensus among experts, specifically concerning the management of chronic cases. The preferred approach has thus been the use of conservative interventions, but once again, little standardisation can be observed. In an attempt to observe general trends, the author sampled twenty-six general practitioners (GPs) and a normally distributed study population of 524 patients suffering from the condition. Both groups were observed by means of a questionnaire, repeated at twelve months.

As GPs are the only practitioners involved in Dutch primary healthcare, they are seen as the "gate-keepers" responsible for channelling patient management to paramedical therapists and medical specialists. It was for this reason that only GPs were used. The GP questionnaire contained items about diagnoses and the frequency of use of diagnostic modalities, therapeutic interventions, and the referrals to paramedical therapists or medical specialists during the previous twelve months. The patient questionnaire included information about visits to complementary therapists, as well as items pertaining to paramedical and medical specialists (it was assumed that patients might visit these practitioners of their own accord and that this information might not be reflected by the GP's files).

The main results of the study indicate that 46 percent of patients received medication, 36 percent non-steroidal anti-inflammatory drugs (NSAIDs), 29 percent went untreated and for 18 percent bed-rest was advised. Thirty-six percent of patients had been referred to a physiotherapist. Interestingly, only 18 percent of subjects reported that they had not visited a paramedical therapist or medical specialist over the twelve-month period. There is very little in the discussion devoted to the utilisation of complementary services, even though it is stated that the role of chiropractic and osteopathy was a minor one in the Dutch healthcare system. According to the author, GPs are reluctant to refer to these practitioners due to their controversial effectiveness. No inferences are drawn from the study due to its retrospective nature, but it is clear that, as "gatekeepers", general practitioners tend not to refer to complementary practitioners other than physiotherapists. The position of the World Health Organisation regarding the conservative management of chronic low back pain is to employ a multi-disciplinary approach, which includes the use of chiropractic services (Nassonova *et al.* in Ehrlich and Kaltaev, 1999: 27). Therefore, the results of this study clearly indicate that the trends in primary care observed are more likely due to the biases of pivotal players in the Dutch medical system, rather than a concern for the patient's best interests. However, the article does not discuss this possibility.

Later on in the same year, Van Tulder *et al.* (1997a) published a comprehensive systematic review investigating the available evidence for the treatment of acute and chronic non-specific low back pain. Working on the assumption that the RCT was the paradigm of intervention research and consequently restricting their research accordingly, the authors reviewed 150 studies (68 on acute low back pain, 81 on chronic low back pain and one study investigating both). In their discussion, the authors emphasise that the overall methodology of the studies is inadequate. Specifically, the authors express concern at the possibility of the existence of co-interventions not mentioned in the studies reviewed (the authors do not specify the nature of these in the article). In addition, Van Tulder *et al.* (1997a) note that the outcome measures and assessment instruments are so varied that it is difficult to compare studies. The authors do, however, conclude that spinal manipulation is a useful intervention, but that there is no evidence to suggest that it is more effective than back schools and exercise therapy for chronic low back pain in the short term. The authors do not reflect on the trends that, according to the Van Tulder *et al.* (1997b), seem to pervade Dutch primary practice, but a divergence in healthcare delivery practice and research trends do seem to exist in the Dutch setting.

In a prospective follow-up study, Van Tulder *et al.* (1998) recruited twenty-six general practitioners and 368 patients in order to gather data concerning the management and course of low back pain in a primary care setting. The authors conclude that the most widely utilised intervention is the prescription of non-steroidal anti-inflammatory medication, and that the majority of referrals were to physiotherapists and neurologists. Furthermore, the course of low back pain seemed stable, with only a slight improvement in physical functioning and pain intensity noted over a twelve-month follow-up period. This evidence seems to indicate that the general approach to primary management for low back pain is not the most appropriate management for the condition as suggested by the previous study by Van Tulder et al. (1997b). One can only speculate whether the course of the condition could have been significantly altered if a multi-method approach had been followed that included interventions like spinal manipulation, exercise and patient education as suggested by Van Tulder *et al.* (1997b).

In a narrative review dedicated to the discussion of methodological issues for the primary care of low back, Bouter *et al.* (1998) focus their discussion on the following four key areas: study designs, the definition of low back pain, the determinants of low back pain and outcome assessment.

The authors maintain that most study designs for back pain research fall within the (clinical) epidemiological tradition and therefore focus primarily on the relationship between the occurrence of low back pain and other determinants, such as diagnosis, prognosis and therapy. These factors are traditionally expressed as categorical or continuous variables of severity of pain or related disability. Similarly, determinants are expressed in quantitative fashion. The authors maintain that largely two types of design are used, namely observation and experimental, the former being further divided into descriptive and analytical. Of the two types, Bouter *et al*. (1998) consider experimental designs, controlled clinical trials or randomised clinical trial as the preferred study design for the evaluation of clinical efficacy and cost-effectiveness. Although they state that the above-named designs are well accepted, they conclude that the prognostic, diagnostic and therapeutic interventions have an impact on one another when they are combined into protocols. Consequently, confounders and effect modifiers always exist and should therefore be considered carefully in design and analysis. The authors do not elaborate on these extraneous factors, but conclude that the design of management trials will prove to be a major methodological challenge in the future.

Under the definition of back pain, Bouter *et al. (*1998) consider the problem of identifying homogenous cases as a major stumbling block. They maintain that, because the former was typically defined by the sensation of pain rather than a patho-physiological or patho-anatomical basis, etiological and prognostic heterogeneity were pronounced among low back pain patients. Therefore, as researcher could not show that subjects suffered from the same condition to the same extent, they could not determine with a great degree of certainty which subjects might really have benefited from experimental interventions. The authors argue that there is an urgent need to identify homogenous subgroups and that these should be studied in an experimental setting. No comment, however, is made about mechanisms that could be employed.

Bouter *et al.* (1998) point out that, in an attempt to quantify determinants, researchers have looked to the identification of risk factors for the occurrence of low back pain or early predictors of chronicity. The general lack of success in this area is partly due to methodological flaws that make it difficult to know which determinants to measure. The authors do not expand on the methods problem, but blame a lack of positive predictive value of determinants and cheap proxy measures, such as questionnaires with doubtful validity and reliability, as culprits.

According to Bouter *et al.* (1998), controlling for extraneous factors was essentially clear, but difficult to realise; clear identification of the appropriate factors, followed by accurate measurement, was what was needed. The authors cite work-related biomechanical risk factors, individual susceptibility, specific psychosocial stressors and the influence of the social security system as examples of these, but do not elaborate on what methods could be employed to decrease extraneous variable bias.

Finally, the authors discuss outcome measures and maintain that intervention research is primarily focused on health-related quality of life quantification. These include generic, low back pain specific and individualised varieties.

Table 4.2. Examples of common outcome measures and instruments used in low back pain research.

Outcome measures	Domain	Instruments
Symptoms	Individualised	Pain intensity (VAS or NRS)
	LBP specific	Presence or absence of radiation
	Generic	Overall improvement (VAS or NRS)
Disability	Individualised	Functional limitations at baseline (VAS or NRS)
	LBP specific	Roland Disability Questionnaire, Oswestry Scale
	Generic	Sickness Impact Profile (SIP) Medical Outcome Study Short Form 36 (SF 36)
Role functioning	Generic	Work absenteeism (number of days), medical consumption, healthcare utilisation
VAS = Visual Analogue Scale; NRS = Numerical Rating Scale; LBP = Low Back Pain		

Adapted from Bouter *et al.* (1998: 2017).

Bouter *et al.* (1998) view some of the popular instruments as useful, but argue that they have escaped scrutiny, citing specifically the Roland and Oswestry Disability Questionnaires as examples. According to them, neither of the two is constructed according to a conceptual approach or empirical methods of item development, analysis and item selection, yet they are the most widely used scales for measuring disability in patients. Furthermore, the authors argue that studies use more than one outcome parameter, but these are not effectively combined to establish hierarchy or limit multiple end points before data was analysed. In addition, competing conclusions are an area of study design that is very unsatisfactory. The Bouter *et al.* (1998) discussion concludes that the "signal-to-noise ratio" of current outcomes is simply too high and consequently responsiveness is another area of concern. They call for methods to identify minimum relevant clinical change and statistical tests to

compare the responsiveness of different outcome parameters. Although most of the methodological problems will be present in the near future, according to Bouter *et al.*, identifying them will be the first step towards overcoming them.

Deyo *et al.* (1998) gathered a focus group of international back pain researchers in an attempt to standardise outcome measures for low back pain research. In considering the history of patient-based intervention studies, the panel confirmed that clinical outcomes aimed at objectively measuring physiological responses such as range of motion (ROM) and strength, were in many cases unsuccessful because of their weak association with factors more relevant to patients and to society. According to Deyo *et al.* (1998), researchers in this field responded to the problem by attempting to fuse clinical expertise and social science, resulting in the rapid evolution of a number of questionnaires aimed at capturing a broader range of relevant outcomes (Table 4.2 illustrates the domains these outcomes were thought to represent). Factors such as symptom relief, daily functioning and work status seem to be more appropriate and, according to Deyo *et al.* (1998), the consensus opinion from the panel indeed still reflects this.

According to the authors, a lack of standardisation in the use of these instruments had led to difficulties in study comparison and consequently little shared understanding concerning the true meaning of results and the comparability of study populations could be found. With this consideration in mind, Deyo *et al*. (1998) argue that a core of six questions, either simply asked or expanded upon in great detail, depending on the focus of the researcher, should appear as consistent outcomes in research protocols to facilitate some universal comparison(s) among studies.

Table 4.3. Six questions recommended by Deyo *et al.* (1998) that should be included in patient-based intervention studies on low back pain to facilitate study comparability.

Domain	Specific question
Pain symptoms	During the past week, how bothersome have the following symptoms been? a) low back pain and b) leg pain (sciatica) Or Conventional visual analogue pain scales.[18]
Function	During the past week, how much did pain interfere with your normal work (including both work outside the home and housework).
Well-being	If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?
Disability	During the past four weeks, about how many days did you cut down on the things you usually do for more than half of the day, because of back pain or leg pain (sciatica)?
Disability(social role)	During the past four weeks, how many days did low back pain or leg pain (sciatica) keep you from going to work or school?
Satisfaction with care	Over the course of treatment for your low back pain or leg pain (sciatica), how would you rate your overall medical care?

Adapted from Deyo *et al.* (1998: 4).

Although this article seems to represent a reasonable progression in terms of unifying outcomes, a number of authors are wary of this type of approach (Vernon, 1991; Jamison, 1995). They argue that the process (context) of care giving may be central to success or failure and considering these factors superficially may therefore not be sufficient to capture relevant issues. Considering that evidence demonstrating the importance of process outcomes is readily identifiable (Deyo & Diehl, 1986; Brody *et al.,* 1989; Meenan, 2001), assessment of the context outcomes deserves further attention.

In an editorial, Ernst and Assendelft (1998) criticised the research evidence supporting chiropractic, stating that clinical trials specific to chiropractic were of poor methodological quality. They argue that the effectiveness of chiropractic as a treatment for low back pain has not been established beyond a reasonable doubt. Rosner's (1999) commentary rebuttal argues that Ernst and Assendelft (1998) based their assessment of chiropractic management on eight clinical trials investigating

[18] Bolton and Wilkinson (1998) and Yeomans (2000) consider the eleven point numerical pain rating scale (NRS) to be more responsive than the visual analogue scale (VAS) as a clinical measure of pain intensity; therefore, the superiority of the VAS is still under contention.

manipulation performed by chiropractors, and that their critique of management was therefore conceptually inappropriate.

Hoogendoorn *et al.* (2000) developed a systematic review, which focuses on the evidence for and against psychosocial factors at work and in private life as risk factors for back pain. They hoped to collate evidence from various studies to identify factors with positive predictive value. Their review consists almost entirely of quantitative studies (one study used semi-structured interviews) and excluded studies considering personality traits. Of the work-related factors considered, strong evidence was found for the coincidence of low social support in the workplace, low job satisfaction and back pain. The association between job satisfaction and back pain was thought to be due to the inter-correlation of psychosocial work characteristics and physical load on the one hand, and job satisfaction on the other.

According to Hoogendoorn *et al.* (2000), there is insufficient evidence for definitive statements about psychosocial factors in private life. They conclude their article by stating that the evidence for the role of specific work-related psychosocial factors had not yet been established.

In summary

Despite the significant and rapidly expanding body of evidence suggesting the efficacy of manipulative therapy for especially acute idiopathic low back pain, chiropractic is dogged by reductionist methodological criticism in the area of clinical research (Ernst & Assendelft, 1998, Ferreira *et al*. 2003, Assendelft *et al*. 2005 and Muller and Giles 2005). Even though authors such as Rosner (1999) successfully counter many of these critiques, the misleading effect of manual therapy related literature on consumers has not contributed to unifying management protocols.

However, authors seem to agree that the measurement of purely physiological responses is inadequate in chronic low back pain research in particular. Perhaps it is time to start taking this suggestion seriously. Scholars clearly consider social factors as important in the management of the chronic patient. One particular application when this is necessary is during the investigation of the clinical context within which healthcare takes place. Therefore, it makes sense that social science research methods should be used at appropriate times, rather than resorting to oversimplified questions that are used simply because they unify avenues of inquiry traditionally considered important.

4.3. A question for meta-analysis?

In the previous chapter, it was argued that, on the paradigmatic level, the nature of chiropractic has been ill-represented through biomedical research and that scholars have erroneously commented on its nature through the use of inappropriate methodologies.

In order to evaluate whether this argument can be defended at the methodological level, a meta-analytical framework, which can comment on the methodological as well as the epistemological dimension of these studies, is required. One such a framework was developed by Mouton (1996) and will be used to assess the articles already discussed in order to present my argument systematically.

Mouton (1996: 109) argues that validity is not a finite goal that can be fully realised at any particular point in the research endeavour, but rather a criterion that, if carefully considered, has the potential to lead to a closer approximation of the "truth". Furthermore, Mouton (1996:109-112) argues that the research process can be deconstructed into a number of categories that, depending on the level of consideration, could either contribute or detract from the validity of the whole.

The framework provides guidelines that can be used to either develop or critically evaluate research methodology, and they can potentially be applied to all types of research. Table 4.3.1 illustrates common pitfalls and solutions. Besides proposing a pragmatic solution to methodological problems, the framework also differentiates between the types of validity-related criteria, allowing the user to distinguish the validity criterion being dealt with from an epistemic perspective.

Table 4.4. Mouton's (1996) validity framework.

Stage in research process	**Sources of error**	**Methodological "move" or "strategy" (objective research)**	**Outcome / goal / end-product**	**Epistemic (validity-related) quality or criterion**
Conceptualisation (Conceptual analysis)	Complex notions Vagueness Ambiguity Abstract concepts	➢ Thorough literature review ➢ Clear and logical definitions	Concepts/ definitions/ unit of analysis	Theoretical validity (clarity/scope)

Adapted from *Understanding Social Research* by Mouton (1996: 111).

Of these, the pivotal category is conceptualisation as it represents the trigger that sets the rest of the method cascade in motion (see Table 4.4). Mouton (1996: 66,109-110) argues that the outcome of a successful conceptualisation process is a clear research question, as well as the identification of the social entity to be studied, termed the unit of analysis.

Babbie and Mouton (2001: 85) elaborate on this term by stating that a "unit of analysis" represents the "what" of the study. Although the unit of analysis is frequently an individual person or people, units of analysis can also be processes, interventions, cultural objects or institutions. This is an important concept to grasp because the authors argue that some units of analysis cannot be observed directly, and therefore have to be investigated in a proxy manner by utilising one or more units of observation.

Therefore, although the unit of analysis represents what the researcher ultimately investigates, he/she may have to consider a number of units of observation to allow him/her to construct summary descriptions of all such units and to explain differences between them. It is therefore self-evident that if the conceptual reasoning of a study is unclear it will not fulfil its epistemological function and therefore cannot be used to comment on the nature of a paradigm.

4.3.1. Methodological comment utilising the validity framework: selected examples of questionable conceptual clarity

In this section, the validity framework will be used as a guide to comment on conceptual issues present in selected examples of the studies reviewed. This will be undertaken in order to motivate the argument that research methodology should start at the conceptual level and that in this particular area of endeavour too little emphasis has been placed on establishing theoretical validity. (The studies used in this discussion were selected based on obvious conceptual issues; it is not the aim to criticise the overall validity of the studies.)

Although Koes *et al*. (1991) draw a conceptual distinction between the mechanisms whereby manipulation and mobilisation are applied, they do not consider the possibility of differences in effect and assumed congruence. At the time they wrote the article, there was already some evidence to suggest that manipulation and mobilisation differ in effect (Ottenbacher & Di Fabio, 1985; Meade *et al*., 1990). By grouping the two together, two distinctly independent variables are conflated.

Manipulation is furthermore classified by profession, rather than by the specific technique used, implying that a difference in variables exists that depends on the profession which applies it. However, no comment is made to clarify whether it is indeed the case or whether an effort has been made to clarify the techniques used. In clinical research, independent variables are as a rule standardised, for example the dosage of experimental medication given. Therefore, the professional orientation of a researcher should have no bearing on the effect of any chosen variable. What was intended to be a study aimed at questioning the effect of certain aspects of manual therapy, in other words manipulation and mobilisation (study title), is interpreted as a study that comments only on manipulation (study objective). Conceptual clarity can therefore be questioned as the researchers in effect consider aspects of manual therapy used in the treatment of back and neck pain as opposed to distinctly considering manipulation. Theoretical validity could have been improved if the variables had been more clearly defined.

The study by Koes *et al.* (1992) can be criticised because of the lack of conceptual clarity, particularly the lack of clarification of key terms like treatment, management and therapy, as well as the definition of units of analysis or observation, like manual therapy, physiotherapy and treatment by the general practitioner.

A strong argument can be made that treatment refers simply to a type of intervention, whereas management and therapy refer to the process that the doctor intends to follow to improve the patient's situation with varying degrees of emphasis on care giving (Vernon, 1991). However, as the interpretation can shift depending on the context of the study, the central issue is that this process does not occur in the study, which makes it difficult for the reader to follow the authors' intention.

In this study, physiotherapy is defined as

> exercise, massage and physical therapy modalities, manual therapy [that] consisted of manipulative techniques (manipulation and mobililsation of the spine) and treatment by the GP [that] consisted of prescription of medication (e.g. analgesics, nonsteroidal anti-inflammatory drugs), advice about posture, home exercises, participation in sports, bed rest and other treatment modalities.

These groups of interventions are also given by three different professionals, a physiotherapist, a manual therapist and a general practitioner. Curiously, the manual

therapist is allowed to apply only one of two interventions, namely manipulation or mobilisation of joints (in this case the spine). However, massage, to name but one, is a manual therapy shared by a number of healthcare professions and therefore should feature among the interventions applied by the manual therapist (Peterson in Bergmann *et al.*, 1993: 123-24; Moore & Jull, 2002).

Nevertheless, the authors draw the reader's attention to the fact that the three groups do not only manage patients by using a different combination of treatment interventions (independent variables), but they also represent three different professional groups.

Therefore, clarify is required about the relevance of this distinction. Is it made just to detect differences in the effect of the interplay of certain independent variables, or is it also to observe differences, which might occur due to the clinical rituals used by three distinct groups? If it is the former, then the professional background of the technician (the individual applying the interventions) should be standardised; if it is the latter, then the conceptual focus of the study changes significantly.

As the study stands, the authors compare more than just treatment interventions with one another since physiotherapy, manual therapy and general practice have different approaches, both physically and non-physically, which could affect overall response during patient management (Cherkin, 1989; Koes *et al.,* 1992; Jamison, 1998a and 1998b). Therefore, in some instances treatment modalities are considered, while in others the entire scope of management is observed. Therefore, the possibility exists for the presence of competing units of analysis.

The lack of clarification is apparent because they admit that extraneous variables, such as non-specific effects related to each of the independent variables studied, were not considered. In the light of the concerns raised at the conceptual level, one has to question the theoretical validity of this study, as well as its comparability to other studies where scope of practice could be very different.

In conclusion, the study's aim to address methodological issues with respect to pragmatic clinical trials was accomplished from the operational stage of the study, but improving methodology must commence from the level of conceptualisation.

Assendelft *et al.* (1992) attempt to reach a conclusion about the role of chiropractic in the management of low back pain. Conceptually, this implies the consideration of the term ”chiropractic”, but what becomes clear from their article is that the term is equated with studies involving spinal manipulation performed by chiropractors. Although patients may form common units of observation for the study of either of these entities, practitioners and patient-practitioner interaction would at least have to be considered in order to consider ”chiropractic” as a unit of analysis (Coulter, 1996).

Furthermore, the authors devote a considerable section of their discussion to explain why thirty of the thirty-five studies were not distinctly chiropractic. Surely transparent criteria should be provided for defining “chiropractic”, “manual therapy” and “manipulation”? It was never an aim of the study to clarify professional differences in interpretation, and a methodologically driven literature review seems like an inappropriate mechanism to raise this type of question. Theoretical validity therefore becomes an issue in the study due to the lack of conceptual clarity.

Unfortunately, Assendelft *et al.* (1996) did little to elaborate on the conceptual definitions that hampered the theoretical validity of their 1992 review. In fact, it seems that the conceptual errors were reproduced almost verbatim, which is both interesting and unfortunate as the authors specifically thank Paul G. Shekelle, who has a very different conceptual interpretation, for his input regarding systematic reviews on spinal manipulation (Shekelle *et al.*, 1992).

Consequently, although the authors refined their methodology, their review added very little to the academic discourse regarding low back pain other than to re-affirm their previous sentiments. Ironically, the authors argue for a distinction to be made between general spinal manipulation and chiropractic manipulation, but offer little reason for the drawing of such a distinction, or indeed little explanation of what the difference might be. The validity criterion does not shift in this study and therefore remains theoretical.

Bouter *et al.* (1998) acknowledge that the clinical epidemiological perspective represents only one of the stakeholders active in the observation of low back pain care. However, what is absent from their discussion is what role each of these has and where, if at all, they overlap. Therefore, whilst concentrating on methodological issues in the quantitative investigation of low back pain, the valuable conceptual link is discounted as part of their discussion despite the acknowledgement of the multi-

factoral or multidisciplinary nature of low back pain research. The critique is therefore that methodological issues start with conceptualisation and should be considered a routine part of the methodological debate.

Furthermore, the authors do not clarify two important concepts, namely the interventions useful for low back pain and primary care for low back pain. Vernon (1991) and Jamison (1995) have previously demonstrated the differences in meaning. Consequently, this study reflects its results only in terms of point outcomes and does not consider process outcomes, which could have been useful in understanding, as opposed to expressing, the aim of it in quantitative terms (Meenan, 2001).

The conceptual validity of this study is therefore questioned because it prematurely discounts the interaction between clinical experimental research and other disciplines, such as sociology, and because of the vagueness of certain key concepts.

A validity framework table of the above-mentioned articles (Table 4.5) gives the reader a quick visual summary of the methodological errors, as well as possible strategies that could be used to improve on the designs.

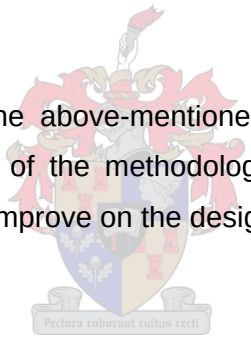


Table 4.5. Articles reviewed according to the validity framework.

Article	Study design	Method issue	Validity criterion	Specific comment	Suggested "move"
Koes *et al*., 1991	Blinded review	Conceptual Conceptual	Theoretical Theoretical	Manipulation and mobilisation both defined as "manipulation". Manipulation defined/classified by profession, e.g. chiropractic, osteopathic.	Consider manipulation and mobilisation as different interventions. Remove professional bias from independent variable definition.
Koes *et al*., 1992	Randomised trial	Conceptual	Theoretical	Vague terms, e.g. treatment, therapy (management), manual therapy unclear. Complex unit of analysis, i.e. professions not considered.	Clarify definitions Consider study focus and units of observation.
Assendelft *et al.,* 1992	Blinded review	Conceptual	Theoretical	Unit of analysis erroneous- Chiropractic vs. spinal manipulation.	Distinguish units of observation and re-consider study focus.
Assendelft *et al.,* 1996	Systematic review	Conceptual	Theoretical	Unit of analysis erroneous – Chiropractic manipulation vs. spinal manipulation.	Distinguish units of observation and re-consider study focus.
Bouter *et. al.,* 1998	Narrative review	Conceptual	Theoretical	Clarify definition of methodological issues. Vague definitions. primary care vs. interventions	Clarify unit of analysis Include process outcomes

In summary

It seems that conceptualisation is an issue that can be legitimately questioned. In the examples chosen, the main area of concern lies in the informal and inconsistent manner in which authors draw a distinction between important concepts, such as management and treatment. Furthermore, units of analysis or observation are often unclear, for example chiropractic *versus* spinal manipulation *versus* manual therapy.

Therefore, the following three salient issues emerging from the previous examples must be considered by scholars when attempting to add to the body of literature, both empirically and non-empirically:

a) Thoroughly conceptualise the study so that the nature of the social entity or units of analysis or observation are clear;
b) Use the unit of analysis as the marker to choose an appropriate design (methodology); and
c) Ensure that variables reflect the nature of the unit of analysis as completely as possible.

In an area of endeavour as keenly observed as back pain, theoretical validity may be the factor that separates studies with real worth from those that merely approximate a hazy truth, currently evident in the management of this condition.

Conclusion: What can be learnt from experimental inquiry?

One could conclude that positivist-empiricist inquiry has succeeded in demonstrating the effectiveness of spinal manipulative therapy for patients suffering from acute idiopathic low back pain. However, this important finding has been nearly overshadowed by a “turf war” over who owns the rights to spinal manipulation. In the process, both chiropractic researchers and their critics have lost sight of the questions they have wanted to answer in order to push their respective points of view.

Authors agree that the randomised clinical trial will remain the standard for clinical inquiry (Pak & Adams, 1994; Scaffner, 2000). However, the design can only provide the answers to appropriately conceptualised questions falling within its scope. The conceptual meta-analysis augments this stance as it points out that at least some of the paradigmatic problems with respect to back pain research have manifested themselves in semi-appropriate biomedical methodologies. It is possible that this has prevented authors from reaching clear-cut inferences and it has consequently created unnecessary opacities in the larger chiropractic research paradigm.

It is a possibility that chiropractic has not yet entered its period of “normal science”, if such a notion exists. However, it is more likely that what we are witnessing is the rapid maturation of a research paradigm, which is looking for other methods to answer broader research questions.

4.4. The contribution of non-experimental research in understanding the patient-practitioner interaction

4.4.1. Introduction

Non-experimentally orientated research is less abundant in the literature than its clinical-experimental counterpart is. In fact, the researcher could not identify a single review article on these types of studies. If one compares this to the 51 reviews on clinical-experimental studies (Ernst & Assendelft, 1998) related to idiopathic low back pain, the low priority accorded to qualitative methodologies becomes immediately apparent.

Coulter (1993) in particular argues that non-experimental (qualitative) methodologies would be valuable to chiropractic scholars in attempts to broaden the research "horizon", as pointed out in the previous chapter. Therefore, in this section I shall discuss some of the methodologies utilised in the study of low back pain, with specific emphasis placed on the patient-practitioner relationship in chiropractic.

4.4.2. The evolution of non-experimental methodologies in understanding chronic back pain

In an effort to gain an understanding of whether patients perceive a difference in the care received from chiropractors as opposed to family physicians, Cherkin and MacCornack (1989) employed a focus group of twenty patients[19] to identify key factors in the care giving process. The term "care" is not clearly defined in the study, but the factors identified by patients in their evaluations are "the perception regarding the providers' concern, understanding, and skill in providing care for low back pain, the information they were given by the provider, and their satisfaction with the process of care" Cherkin and MacCornack (1989).

The sample of completed questionnaires utilised consisted of 215 from family physician patients and 242 from chiropractic patients. The results of the study indicate that patients who received chiropractic care for their low back pain were three times as likely to report that they were very satisfied with the care they received (66 percent *versus* 22 percent respectively). Furthermore, chiropractic patients were also more likely to have been satisfied with the amount of information they were given, to have perceived that their provider was concerned about them and to have

[19] This was a random sample drawn from a health maintenance organisation's enrolees who had either consulted a physician or chiropractor in the twelve-month period preceding the study.

felt that their provider was comfortable and confident dealing with their problem. The authors also found that patients indicated that they were more likely to return to the same chiropractor than physician (87 percent *versus* 60 percent). Although the authors discuss a number of reasons that could account for the observed results, they argue strongly that patient-provider interaction may be a strong contributory factor to the specific benefits of treatment and consequent overall clinical effect. Cherkin and MacCornack (1989) suggest that the philosophy governing practice may constitute the difference between the two groups, but an investigation of this factor does not form part of the study. Although "care" was not elaborated on specifically and therefore must represent a potential threat to theoretical validity, it was clear from the study that the term had a broader meaning than merely "treatment".

In an effort to refine provision of care, Sawyer and Kassak (1993) conducted a study aimed at determining patients' attitudes to the process and results of chiropractic care, and to identify the patient characteristics that might predict satisfaction. The authors' main motivation for conducting the study was that patient satisfaction measured a non-physical outcome dimension that could be utilised as a consumer-generated outcome in the evaluation of health service provision. The authors settled on the use of a pre-tested 32-point satisfaction questionnaire to generate this data. The study results indicate that patients generally expressed a high degree of satisfaction with care. The authors found that patients who experienced no or marginal improvement were predictably less likely to be satisfied with care than those with significant improvements.

In their discussion, the authors point out that they have no way of knowing whether highly satisfied patients had less pain after treatment. However, according to the authors, a decrease in physical discomfort would presumably result in a treated patient reporting a higher satisfaction level. The authors call for further evaluation of the relationship between patients' assessment of treatment outcome, their functional status and how this influences satisfaction. In this study, "care" was also not defined, but the aim of the study was clearly related to satisfaction, which was elaborated upon and related to care giving.

Cedrashi *et al.* (1996) investigated the role of congruence between patient and therapist in chronic low back pain patients. In this study, congruence is defined as the agreement between patient and therapist on aspects such as the causes of the back pain problem, the motive of the consultation, the type of treatment and the prognosis.

The authors' point of departure is that the question of congruence is included in the reflection of the patient-therapist relationship, which can be therapeutic or detrimental to effective therapy. Consequently, the hypothesis of this study is that congruence will positively influence perception and evolution of the back pain problem during treatment, as well as the expectations regarding the evolution of the back pain problem in the future. Seventy-one[20] chronic back pain sufferers and their therapists were interviewed at their initial and final consultations or after six months if treatment had not been completed. The interviews were structured and based on a number of pre-tested questions, which were then formatted in order to represent an index of congruence between patient and therapist.

The results of the study confirmed the initial hypothesis, but a number of interesting discoveries were also made. The authors found that regardless of the level of patient satisfaction, the results of treatment or congruence on the issue, the shared prognosis for the future did not change, namely that back pain will, at best, recur and, at worst, persist or grow worse. The authors state that this seems to indicate that the results of treatment are considered transitory in the long-term evolution of the problem. Therefore, a shared view seems to exist that some basic non-reversible chronic dysfunction of back pain is present that will lead to further episodes in the future. To the authors, this means that congruence will favour "recurrent treatments" aimed at management of a chronic condition rather than a definitive solution of the problem. Although a number of questions arose from this study, what seems to manifest clearly is that non-congruence leads to a less favourable response and a strained patient-practitioner relationship. Furthermore, it seems that successful management for the chronic patient is not measured in terms of a complete resolution of physical symptoms.

Jamison (1996a) conducted what she terms a "preliminary observational study" in order to establish whether a chiropractic practice model could be identified within a patient-centred paradigm. The author drew a purposive sample of 22 chiropractors originating from four different countries.[21] Each chiropractor was asked to identify five patients for observation. A set of criteria aimed at maximising practice variability was applied. At least two to three patients suffered from an acute or sub-acute condition.

[20] Thirty-nine patients came from six chiropractors and 32 from six rheumatologists.

[21] The countries observed were Australia, Canada, the United Kingdom and South Africa.

The remaining two were chronic back pain sufferers. Besides the above-mentioned criteria, the patients also had to represent the following categories:

a) A very satisfied patient;
b) A marginally satisfied patient;
c) A patient with whom the practitioner enjoys interacting; and
d) A patient whom the practitioner finds “difficult”.

Data was collected by means of questionnaires. Practitioners were asked to identify their preferred practice model from a list provided and to indicate the model applied in the management of each patient. They were also asked to indicate the clinical behaviours they thought each of their participating patients would most value. All participants completed questionnaires to establish their preferred behavioural style. Furthermore, patients were asked to rate the clinical satisfaction out of ten and to complete questions on their health locus of control.

The following four dominant behavioural styles are identified: director, thinker, socialiser and relater. Directors and thinkers are seen to be task orientated, the former being outcomes oriented and the latter process oriented. Socialisers and relaters are relationship oriented, the former focused on lively interaction, the latter on maintaining relationships. Furthermore, the following three key practice models are identified: clinical, participant and guided. In a clinical model, the patient recognises the clinician’s expertise and follows instructions; the practitioner therefore makes decisions. In the participant model, the problem is discussed and the patient makes the decision. In the guided model, the patient is an active participant, but is largely guided by the clinician’s advice.

The results indicate that despite a preference for any particular model, at least two different types applied to each patient. Furthermore, the behavioural patterns chiropractors perceived to be appropriate to a particular patient had little effect on patient satisfaction. It was found, however, that chiropractors have a preference for the relational model, but that they tended to apply a clinical approach in acute and sub-acute cases compared to chronic cases. Finally, the results also indicate that chiropractors are aware that patients with an external locus of control[22] are more likely to conform to a clinical model of management. Jamison (1996a) further states

[22] Patients with an internal locus of control have the expectancy of being able to control their life-world through their behaviour; externals perceive their life-world as being more strongly determined by powerful others and/or chance (Jamison, 1987).

that, according to this study, chiropractors favour a relational practice model, regardless of nationality, training or preferred behavioural style, emphasising the importance placed by chiropractors on the active participation of their patients in clinical care.

In the final discussion, the author points out that the extent to which an adaptation of the clinical behavioural pattern may contribute to or maximise the therapeutic benefit of the clinical encounter had not been established. Although not specifically stated, this exploratory study does indicate the presence of a common chiropractic practice model, which appears to be rooted largely in a bio-psychosocial approach to clinical management. This study is important not only because of its results, but because it represents a clinical integration of the models developed by Vernon (1991) and Gatterman (1995). Furthermore, even though the study is relatively small, it suggests congruence between South African and international trends.

According to Jamison (1997a), reductionist biomedical inquiry is currently unable to accommodate the notion of mind-body interaction during the chiropractic consultation, and it consequently cannot shed light on the meaning of the chiropractic consultation experience. The author hypothesises that this is an important area to probe because it will further the debate around enhancing well being. However, it will require a break from the more conservative methodologies that have been employed up to this point.

Jamison (1997a) developed a research question based on interactionist principles and applied it to chiropractic care in order to reconstruct the clinical reality of the chiropractic consultation. She used a constructivist inquiry paradigm based on purposive sampling,[23] grounded theory, inductive analysis and contextual interpretation in order to observe consultations, and subsequently to ascertain whether this framework was compatible with the clinical reality present in chiropractic and to how clinical communication might contribute to healing.

The author's cognitive framework reveals that recent developments in the field of psycho-neuro-immunology have produced empirical evidence to support an interactionist perspective, and demonstrates that mental processes and physical

[23] The author observed 208 consultations generated by 34 chiropractors in geographically dispersed areas of Australia.

functioning are mutually and bi-directionally interactive (Jamison, 1996b; Jamison, 1997a). The author argues that if chiropractic were able to support this type of paradigm of inquiry, notions of mind-body interaction in the clinical encounter will become evident. Therefore, besides the rituals of treatment, practitioners functioning within an interactionist paradigm could address both the patient's cognitive experience (the perception and appraisal of symptoms, its causes and response to therapy) and their emotional response (symptom distress).

During the observational stage, the dominant encounter observed was that of a male practitioner with the preferred behavioural style of a socialiser providing follow-up care to a female patient with a chronic or recurrent back problem. In order to establish rigour in the observed phenomena, the author triangulated her observations with the experience of the practitioner and patient through a description of the observed clinical communication sent to the former and a structured questionnaire, which summarised her observations, to the latter. This procedure reveals that regardless of the duration of time in all cases, hands-on time was spent in verbal and non-verbal communication. Thematic analysis reveals the establishment or reinforcement of a personal relationship between chiropractor and patient, as well as the creation of a shared reality with respect to the diagnosis, current status, progress achieved and therapy for the presenting complaint.

Inductive analysis and contextual interpretation through reflection on practice observation and patient and practitioner comments reveal processes fundamental to the consultation, namely "validation of the patient's complaint[,] . . . establishment of a shared understanding of the condition and reduction of patient uncertainty"(Jamison, 1997a).

The conclusion reached through reflection on grounded theory confirms support for and consequent development of an interactionist model, with the tactile nature of chiropractic care conceptualised as a powerful trigger in the clinical encounter. Jamison (1997a) concludes that an interactionist model is consistent with the fundamental principles of chiropractic, such as wellness, and that it allows for the appreciation of the diverse triggers responsible for a return to wellbeing.

Jamison (1997b) bolstered her theoretical stance with a further empirical study in the same year. In this observational study (1997b), she sought to map the chiropractic practice model present in Australian chiropractic practices. She hypothesised the

presence of a model that incorporates aspects of Vernon's illness behaviour model for chiropractic and Gatterman's patient-centred model.

To observe whether this was the case, the author purposefully sampled 34 chiropractors from cities (8), suburbs (10), rural areas (6) and coastal towns (7) throughout the country. Furthermore, male (28) and female (6) practitioners were observed, including chiropractors who qualified locally and abroad. A total of 208 consultations were observed, which consisted of initial visits, repeat consultations, musculo-skeletal and visceral complaints. The most frequent consultation was between a male chiropractor with a socialiser behavioural style treating a female patient for a chronic or recurrent back problem. The length of each consultation was measured, as well as the time spent on diagnostic and therapeutic interventions. Consultations were also audiotaped. Thematic analysis of the observations and audiotapes were undertaken and the results triangulated.

From this methodology, Jamison (1997b) constructs a model for the *gestalt* of chiropractic practice, which looks as follows:

- Nonverbal and verbal practitioner behaviour that speaks of professional confidence, professional authority and friendliness;
- Validation of the patient's complaint;
- Patient participation;
- Physical interaction;
- Immediate feedback;
- Caring;
- A learning experience;
- An enhanced sense, within the patient, of the ability to cope; and
- Reinforcement of the potency of chiropractic care.

Jamison (1997b) concludes that this chiropractic practice model is compatible with the illness behaviour model and the patient-centred model. As with the former, the practitioners help patients to cope with their problems, and as with the latter, the quality of the patient-oriented relationship is central in successful management. Jamison (1997b) therefore argues that the chiropractic practice model should be considered a variable contributing to patient satisfaction and consequently to the improvement experienced by patients.

Verhoef *et al.* (1997) also recognise the importance of bio-psychosocial outcomes, such as the degree of patient satisfaction investigated by Cherkin and MacCornack (1989). They believe, however, that that this outcome should be combined with other patient outcomes relevant to chiropractic care, such as changes in the pain experienced and functional ability, in order to gain a more complete picture of patient care.

To this end, they designed an observational follow-up study consisting of a questionnaire, which was completed at the onset of treatment and repeated six weeks later. The instrument was applied to 369 patients presenting with back and/or neck pain, who saw one of thirteen pre-selected chiropractors for the first time or who had not seen a chiropractor for a period of six months before the first visit. Their operational instrument was a combination of previously utilised instruments, as illustrated in Table 4.6 below.

Table 4.6. The factors measured by Verhoef *et al.* (1997).

Factor quantified	Outcome utilised	Origin of outcome
Pain experienced	Visual analogue scale	McDowell and Newell (1987)
Functional ability (disability)	• Revised Oswestry Disability Index (ODI) • Neck Disability Index (NDI)	Hudson-Cook *et al.* (1989) Vernon and Mior (1991)
Patient satisfaction	32 Item Questionnaire	Sawyer and Kassak (1993)

The results from the study indicate that acute patients were significantly more likely to experience pain relief or improvement in disability ($p<.01$). Patients who had seen someone other than the chiropractor during treatment were less likely to experience pain relief or an improvement in functional ability ($p<.01$ for NDI and $p = .01$ for ODI). Furthermore, pain relief was significantly greater in those who had completed treatment within the six week period as opposed to those who were still receiving treatment ($p = .01$).

Of the factors associated with satisfaction it was noted that an improvement in disability was significantly related to general satisfaction ($p<.001$) and doctor conduct ($p = .02$), and improvement in neck pain was significantly related to all four types of satisfaction (general satisfaction $p<.001$, access to the doctor $p = .03$, finance $p = .01$ and doctor conduct $p = .03$). Significantly greater satisfaction was reported by acute patients ($p = .04$), those who were still seeing the chiropractor at six weeks ($p = .04$)

and those who had depended solely on the chiropractor during the six-week period ($p<.001$). The number of times the patient saw the chiropractor during the six-week period was also significantly related to general satisfaction ($p = .01$), with a pattern of increased number of visits correlating linearly with increased satisfaction. Lastly, significantly greater satisfaction with doctor conduct was again expressed by those who were still seeing the chiropractor at six weeks ($p<.001$) and by those with an increased number of visits ($p = .01$).

In their discussion, the authors raise some concern as to the sensitivity of both the pain and functional assessment scales for the evaluation of chronic patients. They also state that chronic pain by its very nature is difficult to treat and therefore less likely to improve within a short period of time. They feel that the findings regarding co-intervention by another practitioner may be explained by the impetus for seeking chiropractic care. Two factors were differentiated, namely that patients either had experienced relief through chiropractic care or had seen the chiropractor as a last resort. The investigators find the trend towards increased satisfaction with care and a lengthy duration of treatment to be curious in the light of the fact that a long duration is not associated with pain resolution. This finding is attributed to the development of a more personal relationship between patient and practitioner.

The authors conclude that further studies should be conducted to address factors that may be important to patients in terms of practitioner-patient interactions and how these may be linked to self-reported pain and disability. This is in keeping with the findings of Cherkin and MacCornack (1989), Cedrashi *et al.* (1996) and Jamison (1996a).

The authors acknowledge a possible sampling bias; an area they paid little attention to is the inclusion rationale for the combination of outcomes utilised. Self-reported pain intensity and disability measures are not developed in the context of care giving, but rather as subjective measures of patient response in the biomedical paradigm. Therefore, although these may seem like logical outcomes, the appropriateness of the combination with bio-psychosocial outcomes cannot be assumed.

In a commentary by Jamison (1998b) entitled “Non-specific interventions in chiropractic care”, she argues that the maximisation of an even marginal non-specific gain in a therapeutic encounter may be a useful adjunct to specific care and therefore should be studied rather than excluded. The author links this to the quality of

interaction during the consultation and feels that the specific-approach chiropractor enhances this effect. She states that, regardless of nationality, training or preferred behavioural style, chiropractors seem to favour a relational practice model and that this approach seems to ultimately create positive efficacy expectations. Consequently, she argues that the use of the non-specific intervention or placebo is highly defined. She concludes that placebo is present in all clinical encounters and should be utilised for the betterment of patient care. However, it should not be used to substitute or confuse the effect of specific therapy.

Changing her approach slightly, Jamison (1999) undertook a descriptive study to ascertain the stress perception of chiropractic patients. Purposive sampling was utilised to acquire ten participating chiropractic clinics representing different geographical areas across Australia. One-hundred-and-thirty-eight patients were studied through a structured questionnaire. The questionnaire consisted of sub-scales, which focused on levels of stress with respect to their emotional, cognitive and physical function, a self-screen for evidence of residual tension, a distress and risk assessment method questionnaire (DRAM) and finally three opinion questions regarding stress and stress management skills.

The results revealed that 30 percent of patients considered themselves as moderately to severely stressed. Over half of the participants felt that stress had a moderate to severe impact on their current problem. Furthermore, 71 percent felt that it would be helpful if their chiropractic care included strategies to help cope with stress.

In her conclusion, Jamison (1999) argues that the interpretations and perceptions of patients may be some of the most important dimensions of illness behaviour and that, in this particular study, one in every three patients considered themselves as at least moderately stressed. It would stand chiropractors in good stead to utilise stress management strategies in daily practice. The author's motivation for this is that enhancing perceived control is one of the factors that could enhance non-specific treatment effect (Jamison 1998a and 1998b).

Jamison (2000a) developed the stress management theme further by conducting an exploratory study into the use of stress self-assessment tools, the perceptions of patients regarding stress management as an option in chiropractic care, and to establish which stress management strategies patients perceived as being the most

useful. A study was developed in which data was gleaned through three distinct phases, after which data was triangulated and thematically analysed. Firstly, 48 patients completed a semi-structured questionnaire to ascertain their stress levels and the type of stress management techniques they considered helpful. Two further exploratory studies[24] were conducted in which participants were invited to complete a questionnaire to ascertain their self-perceived stress levels. They were also given information on stress management techniques and asked to indicate which of the stress management strategies they considered useful, which ones that had tried and which ones they believed they would continue to use on a long-term basis. In addition, patients were also asked to complete a DRAM questionnaire to assess their residual tension. Twenty-seven of the interviewees considered themselves to be moderately or severely stressed. The DRAM questionnaire contributed very little data. Based on this, Jamison (2000a) argues that no specific stress testing should be routinely undertaken, beyond asking patients to rate their perceived stress levels as absent, minimal, moderate or severe. A number of patients participating in the study wanted stress management included in their chiropractic care, but a wide variation in preference was evident. The author concludes that no statistical pooling was attempted, but that evidence does seem to "exist" that patients believe they would benefit from chiropractic that includes information about stress management strategies.

Jamison (1999; 2000a) thus provides some evidence that the inclusion of stress management information may enhance the control the patient perceives with respect to their illness. This may affect overall wellbeing positively and it should be considered a part of the chiropractic practice model because it contributes to relationship building and may consequently enhance the non-specific clinical effect of management.

Jamison (2000b) augments the discussion of Cedrashi *et al.* (1996) on congruence by exploring this concept with respect to health-related perceptions between chiropractors and their patients. Nine practitioners and 173 patients provided information to explore patient-practitioner perceptions with respect to "the patient's stress levels, the importance of injury as a causative factor in the presenting

[24] A total of 51 questionnaires were utilised on a selected sample of patients who expressed an interest in the study.

symptom and the responsibility the patient should take “in getting themselves well” Jamison (2000b).

Data was collected from patients by means of a questionnaire, whilst the practitioners completed a questionnaire and were interviewed. The results indicate that congruence of perception was less than 50 percent in each of the three dimensions examined, with the biggest discrepancy in that dealing with the patients’ role in “getting themselves well”. Patient-practitioner congruence was established to be in the region of 29 percent, with patients indicating more often that they should take responsibility for getting well. The author concludes that a shared clinical experience can create an environment in which the expectation of healing is improved. It is therefore important that chiropractors do not assume congruence in order to maximise the non-specific effect of management.

Congruence appears to be an important indicator for success as it is also used in the nursing paradigm, which has a strong tradition of qualitative research (Sherwood *et al.*, 2000). These authors concur with Jamison (1991; 1999; 2000b) that patient satisfaction with care can be used as a critical indicator for successful outcomes in the management of painful syndromes. In fact, according to Dowswell *et al.* (2000), the degree of congruence between patient’s lives before and after a traumatic episode can be used as a qualitative indicator of recovery. Although this aspect of congruence has not been tested in the chiropractic setting, it seems to represent a reasonable adjunct to the already multi-dimensional concept of congruence.

Nyiendo *et al.* (2000) re-visited the line of inquiry of Cherkin and MacCornack (1989), but in a slightly different context. In their study, termed a prospective, observational, community-based feasibility study, they compare chiropractors and family physicians in the management of chronic low back pain in terms of severity of pain, sensory and affective pain quality at one month, and patient satisfaction assessed at seven to ten days and one month. A total of 93 chiropractic patients and 45 medical patients were used in the study. Chiropractors saw their patients on average four times to the one of their medical practitioner. The results indicate that patients treated by chiropractors showed a greater improvement and satisfaction at one month than those treated by medical practitioners. Furthermore, chiropractic patients who suffered from psychosocial impairment were just as likely to show improvement on the primary outcome measures as patients with better psychosocial health were. This was not the case with medical patients, where outcomes were heavily dependent on

psychosocial status at baseline. This observation was once again attributed to the non-specific effect of chiropractic treatment.

In a commentary entitled “Reflections on chiropractic’s patient-centred care”, Jamison (2001a) argues that the clinical practice model, which developed within the biomedical paradigm,

> . . . lent itself to scientific appraisal of clinical outcomes and evidence-based medicine, it has also encouraged practitioner detachment and fostered patient-practitioner alienation. Growing disillusionment with the human face of medicine, the prevalence of chronic conditions in an aging population, and the financial demands of technologically advanced medicine have contrived to change the focus from physician to patient (Jamison 2001a) .

Consequently, the author encourages refinement of a patient-centred clinical model for chiropractic to strengthen congruence between doctor and patient even more. According to Jamison (2001a), no universally recognised definition for patient-centred care exists in the literature, due to a dichotomy of focus. One category interprets patient-centred care as a reorganisation of services around patient needs, whilst the other focuses on understanding the patient’s perception of their health needs, priorities and healthcare expectations. For Jamison (2001a), it is the latter of the two categories that has relevance for chiropractic as it allows for the defining of client preferences, as well as preferred patient outcomes.

The current framework for patient-centred care in Australia, according to Jamison (2001a), suggests the following:

a) It takes place within a relational model;
b) It takes place within a guidance co-operative mode (patients actively participate in their healthcare, but are largely guided by the practitioner); and
c) It is deliberative in nature (the practitioner provides factual information and clarifies types of values embodied in each option) .

Jamison (2001a) contends that communication secures successful chiropractor-patient interaction:

> . . . the quality of interaction between the physician and the patient can be extremely influential in patient outcomes, and, in some (perhaps many) cases, patient and provider expectations and interactions may be more important than specific treatments.

Successful communication does not merely entail the successful conveyance of an intellectual message, but also the application of appropriate non-verbal triggers in order to facilitate a change in the patient. Jamison (2001a) states that making the patient feel better is an area of investigation not yet adequately appreciated.

Jamison (2001a) concludes that the desired outcome of chiropractic care is improved patient function rather than disease cure. Although chiropractors are successful at conveying such understanding, it is unlikely that this is attributable to their verbal messages. Consequently, chiropractic patient-centeredness appears to result more from the impact of its philosophy on clinical demeanour rather than from a conscious attempt to conform to the delivery of patient-centred healthcare.

However, as the studies fall short of being a true survey or a case study, this statement cannot be accepted without question.

4.4.3. In summary

Table 3.5.2 provides a quick summary of the studies reviewed, indicating the method and mode of analysis used.

Table 4.7. Methods and mode of analysis of non-experimental studies reviewed.

Author(s)	Method(s)	Mode of Analysis
Cherkin and MacCornack (1989)	Focus Group and Questionnaire	Quantitative
Sawyer and Kassak (1993)	Questionnaire (Scales)	Quantitative
Cedrashi *et al.* (1996)	Questionnaire (Index of Congruence)	Quantitative
Jamison (1996a)	Questionnaires	Quantitative
Jamison (1997a)	Questionnaire and Participant Observation	Qualitative (Grounded Theory)
Jamison (1997b)	Case Studies	Qualitative (Thematic Analysis)
Verhoef *et al.* (1997)	Questionnaire	Quantitative
Jamison (1998b)	Non-empirical	n/a
Jamison (1999)	Questionnaire	Quantitative
Jamison (2000a)	Questionnaires	Quantitative
Jamison (2000b)	Questionnaire	Quantitative
Nyiendo *et al.* (2000)	Questionnaires (Scales)	Quantitative
Jamison (2001a)	Non-empirical	n/a

This section reveals the conservative nature of non-experimental research. Although some features of qualitative methodologies are evident in some of the studies, the

style of reporting and analysis of results are distinctly positivist in nature. No classic examples of qualitative design, such as participant observation, focus group-based studies, life history or discourse studies, seem evident (Babbie & Mouton, 2001: 53). Therefore, it would seem that although a growing awareness of the potential value of qualitative data is evident, researchers seem reluctant or unable to embrace the naturalistic approach required to optimally utilize qualitative data collection methods. The results being that the data is superficially 'mined' and under analysed.

Nevertheless, this limited quantitative-qualitative hybrid style of inquiry has provided a starting point by which the clinical role of chiropractic can be investigated in its context. It would seem that any specific intervention used by a doctor of chiropractic could be augmented if certain factors are taken into account. A practitioner who aims to be successful whilst functioning in the chiropractic practice model should ensure the following:

a) The patient's satisfaction (Cherkin & MacCornack,1989; Sawyer & Kassak. 1993);
b) Congruence between patient and practitioner (Cedrashi, 1996; Jamison, 2000b; Sherwood *et al.*, 2000);
c) Positive efficacy expectations (Jamison 1997a; 1997b);
d) The patient's perception of an increased level of control over his/her ailment (Jamison, 1999); and
e) The practitioner augments his/her verbal communication through re-assuring non-verbal communication (Jamison, 1996a; 1997a; 1997b; 2001a; 2001b),

This review is by no means exhaustive, but does indicate that research questions, which require an insider perspective, have perhaps not been entrusted to naturalistic (qualitative) research methods. Currently, there is very little evidence in the literature about the potential clinical effect of patient-practitioner interaction in chiropractic and about what might influence it. It is possible for the profession to begin to investigate it because the outcome measures do exist and effective implementation of research question(s) can therefore be undertaken.

Conclusion

The literature review indicated the following salient issues:

- Both biomedical and bio-psychosocial paradigms underpin chiropractic research and practice.
- Biomedical reductionism is the dominant research paradigm in the field of acute and chronic idiopathic lower back pain.
- The biomedical mode of inquiry has shown itself to be of limited value for investigating the clinical management of lower back pain due to the psychosocial factors associated with the chronic version of the condition.
- Conceptual weakness is a methodological weakness evident in the literature discussing the management back pain.
- Chiropractors exert a well-defined non-specific effect on their patients, which has the potential to augment/detract from specific interventions.
- A chiropractic practice model exists and incorporates Vernon's illness behaviour model for chiropractic as well as Gatterman's patient-centred paradigm.
- No classic examples of qualitative designs seem evident in the literature.
- The chiropractic practice model is more amenable to hybrid designs incorporating qualitative and quantitative methodologies.
- A paucity of evidence exist that address the size of this effect and the factors that may influence it.

The dominance of bio-medically oriented research with its associated clinical methods can hardly be considered surprising considering the history of the development of the philosophy of science in the profession. Therefore, the clinical view of research methodology in the profession is a logical development of this limited paradigm.

The criticism voiced in this chapter is not aimed at calling into question the results attained from clinical-experimental inquiry. Indeed, the argument has already previously been made that this research has been vital to the growth and existence of the chiropractic profession. However, it does raise the possibility that the current investigatory paradigm does not readily allow scholars to consider all possible factors relevant to a certain line of inquiry, a principle of particular importance when researchers want to comment on a complex entity such as ”chiropractic”.

This conceptual limitation is reflected in the paucity and interpretation of qualitative or qualitative hybrid designs, which preclude scholars from attaining an insider perspective on research questions (Babbie & Mouton, 2001: 271).

The review therefore suggests that progress in the investigation and management of low back pain will be slow until an appropriate paradigm shift is made, operationalised and applied routinely and rigorously to this problem in the chiropractic setting. Scholars have to face the reality that chronic pain sufferers have both a psychological and a social grounding for their behaviour and therefore they have to be studied in these contexts, as well as in the isolation of research setting. It is quite possible that the clinician will be the most important facilitator in the healing process, not because of the specific interventions he/she chooses to apply, but because of non-physical skill he/she has developed. These non-physical skills may be pivotal in unlocking the individual's inherent capacity to heal and stay well.

In closing, the broad empirical research questions relevant to the development of the chiropractic research paradigm and patient management in the local context are as follows:

a) What is the *status quo* of chiropractic's research paradigm?

b) How has the RCT effected the development of the research paradigm?

c) What is the perception of chiropractic patient management in the local context?

d) Where should research efforts focus in the future?

Chapter 5
Methodology

5.0. Introduction

This chapter discusses the methodological issues pertinent to this study under the following headings:

5.1 Conceptualisation
5.2 Study design (operationalisation)
5.3 Methodology
5.4 Sampling
5.5 Data collection
5.6 Analysis and interpretation
5.7 Limitations and assumptions
5.8 Ethical considerations

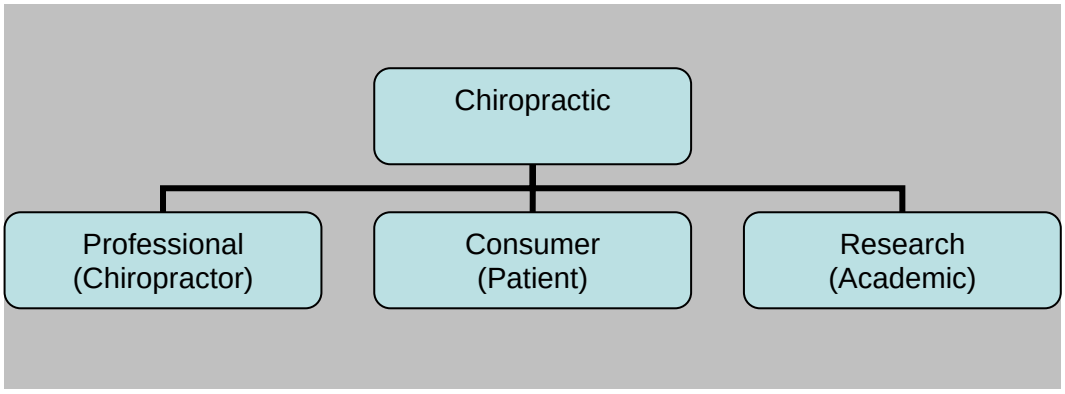
5.1. Conceptualisation

The review of key concepts (for instance basic chiropractic terminology, models of practice and patient management) and theoretical issues (for instance beliefs, issues related to chiropractic as a paradigm, professionalisation and institutionalisation) is of an exploratory nature. Therefore, no specific hypotheses are generated from this review. Instead, the study aims to establish the *status quo* in the local context as a point of departure for the development of chiropractic's disciplinary and profession components.

5.1.1 Units of analysis

In this study, two related units of analysis were investigated, namely chiropractic as a professional institution and a disciplinary institution. In both, the focus is on the conceptions, theories, concepts and practices of chiropractors (individuals).

Figure 5.1. The constituents of chiropractic required in order to comment adequately on the study unit of analysis.



The units of observation deemed most likely to be helpful in the context of this study, considering its philosophical, methodological and clinical management foci, are practitioners, researchers and patients (Figure 5.1) (Mouton, 1996: 48).

The rationale for including these three groups is as follows:

- Practitioners are the professional "product" of the "unit of analysis" under investigation and therefore represent the link between the patient and the formative structures (education and legislation). Therefore, practitioners are in a position to reflect on the operationalisation of philosophy, management and professional development.
- Academics (researchers) are responsible for identifying activities from the social world (world 1) and then investigating them in the world of research (world 2) (Mouton, 1996: 26). Therefore, in the chiropractic context, development of chiropractic from a philosophical, research and management consensus perspective will fall within the area of endeavour of this group.
- Patients are the individuals who are directly affected by the agents of the profession (practitioners) and therefore should mirror their actions. Therefore, patients are in a position to reflect best on the transferral of philosophy and management consensus into practice.

5.2. Study design (operationalisation)

This study is of an exploratory and interpretative or phenomenological nature (Hammersley & Atkinson, 1996: 29). The specific design is best described as a "case study" of a specific profession or discipline as data was collected from selected practitioners, researchers and patients (Babbie & Mouton, 2001: 279-281).

5.3. Methodology

The complex unit of analysis as well as the nature of the research questions necessitated a methodology that would be flexible, yet at the same time capable of capturing the phenomenon under investigation (Babbie & Mouton, 2001: 357). Therefore, the empirical components of the study made use of semi-structured, individual interviews. The semi-structured interview was preferred so that respondents could comment broadly. Consequently, themes important to the respondent were explored during the course of the interview without restricting or leading the respondents with respect to their individual interpretations and understanding of the subject matter (Babbie & Mouton, 2001: 289).

5.4. Sampling

The study was conducted in three phases, with each phase providing some guidance for the subsequent set of interview schedules. The sampling procedure was purposive, as all the respondents were selected by the investigator according to a set of criteria (Babbie & Mouton, 2001: 287). Particularly in the case of the patient responses, the sampling procedure could also be described as theoretical, because the decision to use this group was based on evidence gleaned from the previous two groups of interviewees (Neuman, 2000: 370).

Ten chiropractors were sampled from the Durban metropolitan area. The location was chosen primarily because it was logistically manageable for the researcher as follow-up interviews were anticipated for this group of interviewees (Babbie & Mouton, 2001: 287). A sample size of nine was deemed appropriate in order to allow for data saturation. However, an extra practitioner was sampled to ensure this state was reached (Neuman, 2000: 198; Babbie & Mouton, 2001: 166). The sample was stratified into three subgroups according to the number of years in practice as follows:

Years in practice	No of practitioners
0-5	3
6-10	4
11 and above	3

The stratification process was introduced in order to achieve a balance between practice experience and recent training.

The sampling process yielded the following practitioner profiles to which I assigned pseudonyms in order to maintain confidentiality:

Practitioner 1 a.k.a. Dr. Levine - white male approximately 50 years old, graduated abroad, practice experience more than 15 years. This respondent was also a part-time academic at the time of the study.

Practitioner 2 a.k.a. Dr. Krantz - white female approximately 35 years old, graduated in South Africa, practice experience 5-10 years. This respondent was a part-time academic at the time of the study.

Practitioner 3 a.k.a. Dr. Hussein - Indian male approximately 30 years old, graduated in South Africa, practice experience 3-5 years. This respondent was a full-time academic at the time of the study (full-time academics are encouraged to consult with patients in a limited capacity in order to keep up their clinical skills).

Practitioner 4 a.k.a. Dr. Krause - White female between 25-30 years old, graduated in South Africa, practice experience 5-10 years. This respondent was a part-time academic at the time of the study.

Practitioner 5 a.k.a. Dr. James - White male approximately 35 years old, graduated in South Africa, practice experience 5-10 years. This respondent was a part-time academic at the time of the study.

Practitioner 6 a.k.a. Dr. Black - White male approximately 45 years old, graduated in South Africa, practice experience 3-5 years. The respondent was a part-time academic at the time of the study.

Practitioner 7 a.k.a. Dr. Grant - White male approximately 35 years old, graduated in South Africa, practice experience 5-10 years. The respondent was a part-time academic at the time of the study with a M.Sc. in Sports Medicine.

Practitioner 8 a.k.a. Dr. Manning - White male approximately 35 years old, graduated in South Africa, practice experience 5-10 years.

Practitioner 9 a.k.a. Dr. Rays - White male approximately 50 years old, graduated abroad, practice experience more than 15 years.

Practitioner 10 a.k.a. Dr. Armstrong - White male approximately 45 years old, graduated abroad, practice experience 10-15 years.

Interviews were conducted utilising a schedule developed primarily from the salient issues identified in the literature review (Appendix A). Initially three practitioners were re-interviewed and the interviews coded inductively. A follow-up session was then arranged to clarify and/or elaborate points of discussion. These points were then incorporated into the list of codes and the initial interviews were then re-coded using the new codes. A further seven interviews were subsequently conducted and coded using the coding schema that had been developed in the previous phase. A total of 13 primary documents were developed for coding and interpretation (Appendix B).

Four chiropractic researchers were sampled in order to gain an overview of the issues pertaining particularly to the chiropractic research paradigm and associated methodologies, as well as general paradigmatic development issues. The researchers were all high-profile personalities who have been influential in their various fields of interests.

A brief profile of each of the respondents appears in the table below. These respondents were assigned surnames as pseudonyms.

Pseudonym	Research experience	Areas of interest	Other qualifications	Involvement in policy/politics	Resides in
Hayes	20 yrs or more	Neuro-physiology, philosophy, clinical management	Ph.D., MD-Neurology	High	N-America-U.S.A
Tusker	20 yrs or more	Biomechanics, clinical management	Ph.D.	Medium	N-America-U.S.A
Grover	20 yrs or more	Clinical management	PH.D., MD	Medium	Europe
Goldmann	20 yrs or more	Philosophy, neuro-physiology, clinical management		Medium/High	N-America-Canada

Researchers were selected to attain a broad view of important issues from experienced researchers, both European and North-American. Furthermore, the sample was deemed capable of commenting on specific philosophical considerations.

Three of the respondents were interviewed at an international conference, whilst the fourth was interviewed at his workplace. Due to logistical reasons, the researchers could only be interviewed once. The interview schedule was adapted from the practitioner interviews, as well as some considerations from the literature (Appendix C). Four primary documents were generated from these interviews (Appendix D).

The patients were the final group to be interviewed. The researcher informed practitioners at the onset of the study that they might be requested to provide access to two of their patients for interviewing purposes. The practitioners therefore acted as gatekeepers for the researcher (Hammersley & Atkinson, 1996: 34). Practitioners sampled patients according to the following criteria:

- A low back pain sufferer;
- One chronic patient (symptoms for six weeks or more);
- One acute patient (symptoms for less than four weeks); and
- Prepared to be interviewed and recorded.

Each patient respondent was assigned a false first name in order to maintain confidentiality as follows: Patient 1 – Alfie; Patient 2 – Nazeem; Patient 3 – Jock: Patient 4 – Claire; Patient 5 – Marie; and Patient 6 – Liz.

After the patients had given their verbal consent, their details were passed on to the researcher who then set up appointments accordingly. Respondents were interviewed in the same manner using a semi-structured interview schedule prepared from information gathered from the literature review, as well as the previous rounds of interviews (Appendix E). Six primary documents were generated (Appendix F).

5.5. Data collection

Data was captured with the use of a digital audio recording device. The digital recorder was preferred, due to its superior recording quality and longer uninterrupted recording time. All initial interviews were transcribed verbatim and saved as MS Word files, after which they were exported to Atlas Ti software for coding and interpretation. All initial interviews were coded inductively so that a code list could be generated. Consequent interviews were then coded, using the code list. If a new code was generated, all previous primary documents were re-coded looking for evidence of the new codes. This process was carried out until all primary documents had been coded.

Qualitative research is by nature subjective, but it is important that the researcher consider his/her particular background in order decide whether he/she will be able to effectively filter data without introducing a systematic researcher bias (Mouton, 1996: 151). In this particular study, the researcher is also a chiropractor. This could mean that certain philosophical, management and professional development views might have influenced the investigation. He can be classified as having the following profile:

Years of practice	Philosophical views	Model of practice	Career
6-10	Biomedical	Diagnostically oriented	Academic
	Holistic	Biomechanical	Minor practice
	Anti-vitalist	Limited wellness	

The researcher is a full-time academic who consults with patients in a limited capacity. He has been in practice for seven years and has adopted a biomechanical model of practice, which is somewhat patient-centred. The researcher maintains a limited wellness practice, which involves mainly the development of exercise regimes with patients after symptomatic treatment is completed. Clinical practice is more a mechanism used to stay in touch with treating than a way to earn a living. His

academic responsibilities include clinical teaching and supervision, lecturing in philosophy, research methodology and wellness care.

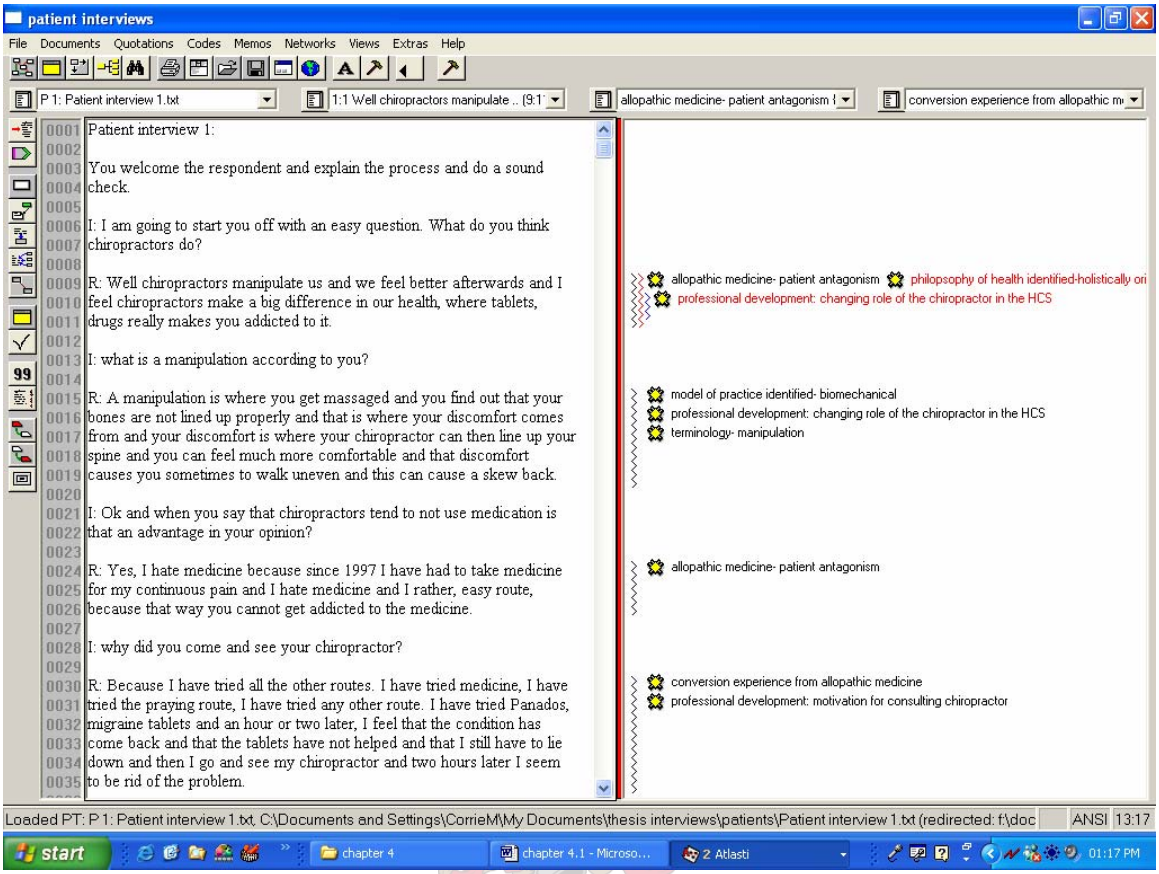
The researcher attempted to overcome possible biases by asking general, undirected questions and allowing respondents to answer at length and in their own terms of reference (Hammersley & Atkinson, 1996: 129). Establishing data as trustworthy is an important component in establishing reliability of data in qualitative research (Babbie & Mouton, 2001: 490-503). Therefore, multiple sources of data are considered preferable to using one only. In this study, the triangulation of data from the three different groups provided the opportunity to establish such trustworthiness.

5.6. Analysis and interpretation

Atlas Ti 4.1 CAQDAS system was used to code and analyse the empirical data. The system is used for the thematic analysis and interpretation of large volumes of textual data. The strengths of the programme lies in the fact that it facilitates organisation (coding) of data, as well as allowing the user to arrange codes into groups (families) and to develop more complex, visual presentations of data (networks). The filtered data can then be exported back to MS Word documents for discussion and interpretation.

Codes are used to sort interesting segments of primary data into meaningful subsets. Figure 5.2 is a screen shot from a patient interview. The verbatim text transfer can be seen in the left hemisphere, whilst the codes assigned appear on the right. As segments of text can have multiple codes assigned to them, different codes are indicated in various colours.

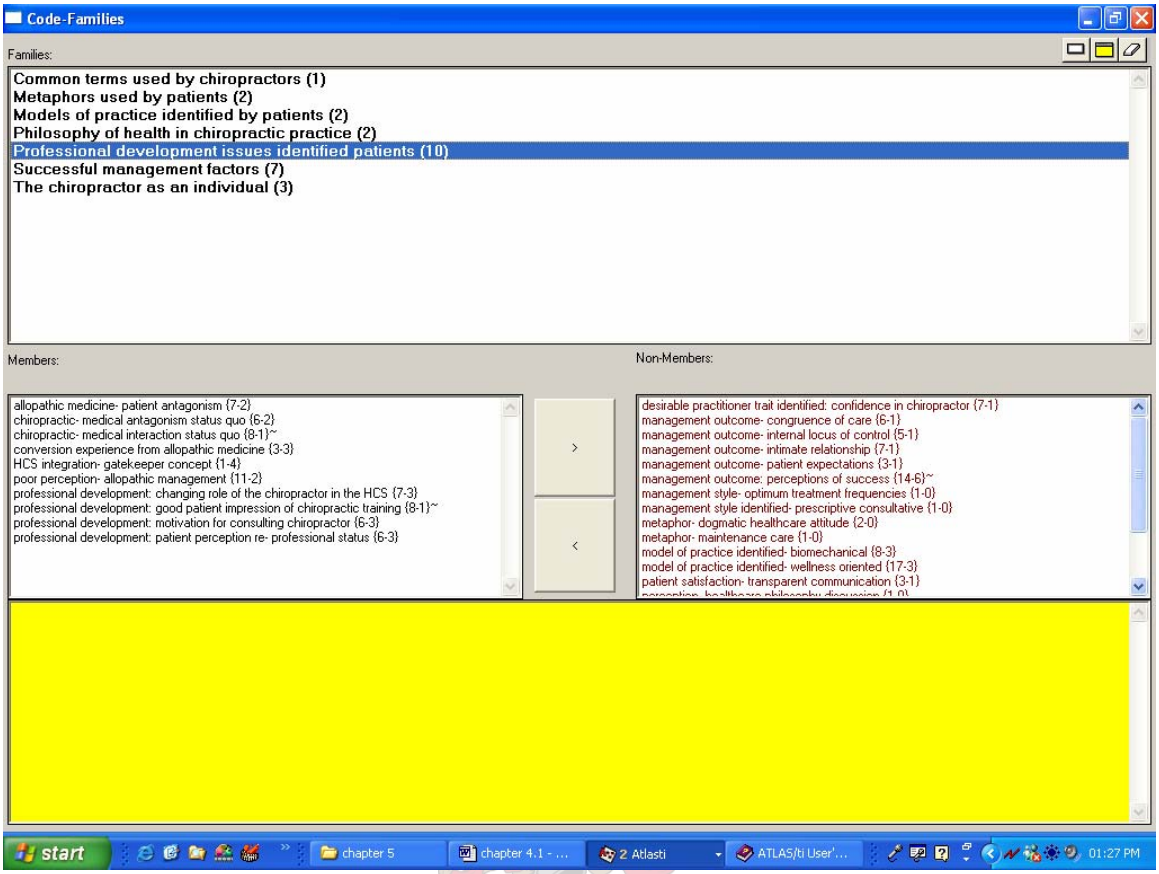
Figure 5.2. Screen shot of a coding page.



Families are devices to form clusters of related entities for easier handling. This becomes especially useful when a large number of these interpretative objects are encountered. Like the objects they host, families are named "containers". In this study, code families had to be created in certain instances to facilitate the reporting of related data (Figure 5.3).

The top half of the page highlights the code family that has been created and selected. The bottom left shows the codes that have been included, whilst the bottom right shows the codes that could still be included if selected by the researcher.

Figure 5.3. Screen shot of a code family page.

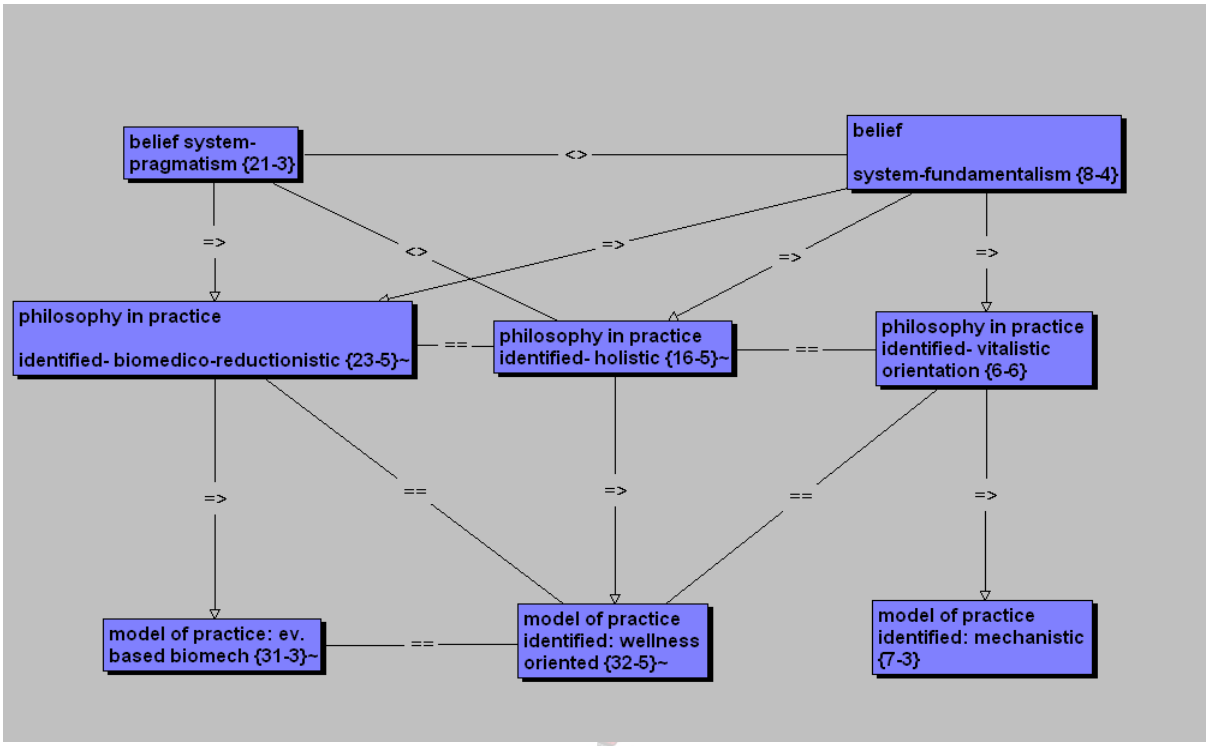


More sophisticated than families, networks allow a stronger structure than just treating sets of elements as similar. With the aid of networks meaningful "semantic" relationships between elements can be developed. Almost everything can be connected in a network.

Networks draw their sophistication from the ability to link the nodes of the network in a variety of ways. For example, in network (Figure 5.4), the desirable practitioner traits (top middle) are considered a part of quality care during the management process. The links that were encountered during the development of networks during this study were:

[ ] ‘is a part of’, = = ‘is associated with’, => ‘is cause of’ and <> ‘is contradictory to’.

Figure 5.4. An example of a network generated from Atlas/Ti.



5.7. Assumptions

Due to the fact that the “chiropractic profession” and “chiropractic discipline” cannot be “observed” directly, one has to rely on “indirect observations” or “inferences” based on data from other variables and sources of data as illustrated in Figure 5.1. Other units of observation could therefore be used to further reflect chiropractic as an institution, for example legislative bodies. However, this study focused on the perspective of the chiropractor and representatives of political and legislative bodies were therefore not considered as part of this study.

It was assumed that younger practitioners would be able to give a greater amount of information with respect to academic or philosophical issues; whereas older practitioners would be more likely to give more information about practice and management issues. I based this assumption on the fact that the younger practitioners would recall more of their academic instruction; whereas older practitioners would have had more time to develop strong views on patient management based on their clinical experiences.

5.8. Limitations

Due to the unstructured nature of the interviews, some variation in emphasis between interviews was expected. It was not the intention of this study to focus too

specifically on one particular issue, but rather to develop a discourse about a number of themes prevalent in chiropractic. Therefore, depending on their level of interest and knowledge, respondents answered questions at various levels, which means that issues raised were not always exhaustively debated.

It was furthermore assumed that practitioners would provide the researcher with the widest spread of data and that the other two groups (researcher and patients) would be used for more specific areas of discussion. However, some patients may have been able to comment on issues reserved for the practitioner interviews.

This study was aimed at obtaining an in-depth insider perspective over a range of issues. Although the sampling procedure was aimed at including appropriate stakeholders, it is possible that other themes could still lie undiscovered, particularly since the sample was drawn from one geographical region of the country only.

5.9. Ethical considerations

As outlined below, there were no specific ethical considerations that could, in any way (I believe) compromise the eventual quality of the findings. The study complied with normal good ethical research practice:

- The study was vetted and approved by the University of Stellenbosch research committee before its commencement.
- This was a non-intervention study.
- The study covered no sensitive material and did not target special groups of any kind.
- Informed consent was sought from each of the respondents.
- A letter of information accompanied the informed consent form and explained the benefits and possible risks of the study that could be anticipated.
- Participants were free to withdraw at any point of the study.

Chapter 6
"State of the art" and developmental issues from a chiropractor's perspective

6.0. Introduction

This chapter presents the results obtained from practitioner interviews, which provide an overview of the state of chiropractic as a profession with regards to many of the general aspects and characteristics that constitute the day-to-day running of the profession in the South-African context.

6.1. A commentary from practitioners with respect to technical terms used during daily practice

In this section, technical terms commonly employed by chiropractors in the course of their professional work will be explored in order to extract the meanings and interpretations attached to them.

I made the assumption here that communication is an indication of the coherence of the shared reality of the paradigm's exponents. Therefore, closely overlapping meanings should indicate a common understanding of the reference framework within which the practitioners practice their profession. I will return to the "plausibility" of this assumption after the results of this section have been presented.

Specifically then, the terms discussed in this section are "chiropractic", "the subluxation", "straights" and "mixers" and "the adjustment".

"Chiropractic" was chosen for fairly obvious reasons, the first being that it presents a reasonable, standardised point of departure for the interviews. The second and more important reason was that it immediately presents a view of the profession that could be developed during the interview.

"The subluxation" is an important term, which has historically been closely associated with the so-called "chiropractic philosophy" debate, particularly with reference to the characteristics of the lesion chiropractors treat. Therefore, the interpretation(s) and understandings of this term by contemporary practitioners will show how this concept is understood in the current practice milieu, and hence also issues related to philosophy in practice.

Similarly, the “straight” *versus* “mixer” debate has traditionally been fairly widely discussed within the chiropractic fraternity. It too carries philosophical connotations, but also provides an indication of the type of approach to practice individual practitioners might follow, depending on how they “describe” or “categorise” themselves. This was considered helpful in developing a view on different approaches to practice.

The “adjustment” is an important contemporary term because it provides a view of the practitioner’s interpretations of modalities (treatment tools) in contemporary practice, as well as an indication of the type of clinical practice individuals might subscribe to.

The reader is reminded that respondents 1, 3 and 4 were interviewed twice in order to clarify certain issues, therefore primary documents 11 (P11), P12 and P13 refer to these respondents, respectively.

6.1.1. Chiropractic

Dr Levine defined chiropractic as ”that healing profession which treats muscular conditions, which primarily involve[s] a joint lesion of some sort, . . . which at times might be associated with concomitant nerve involvement” (P 1: 1:1 (61:64).

Dr Hussein describes chiropractic as “a form of therapy that involves manipulation of the spine as its hallmark to treat musculo-skeletal conditions”. He furthermore states that chiropractic is rapidly evolving and in this is finding more congruence with other manual healthcare professions. As these professions often draw from common basic sciences, many of the modalities applied in practice have become generic (P 3: 3:1 (39:46). Therefore, certain aspects of clinical practice historically not considered as chiropractic are now viewed as appropriate to the profession.

Dr Krause suggests that a chiropractor is:

> . . . a primary contact physician who is able to diagnose any sort of pathology walking in the door – much like a GP would. Almost a gatekeeper in many senses and then referral of those cases, which you cannot treat. Mostly those cases would be outside the parameter of neuro-muscular-skeletal, which is our forte of what we are able to do (P 4: 4:1 (40: 51).

In this response, we find a significant broadening of the domain of chiropractic because, whilst it acknowledges the fairly narrow range of conditions chiropractors tend to treat, it implies that this type of practitioner is potentially a first contact (frontline) representative of mainstream healthcare system. The implication is that patients will consult chiropractors on a wide range of healthcare issues, not necessarily limited to musculo-skeletal complaints, much in the way they consult a general practitioner. The chiropractor, as the first contact practitioner, will then assess and manage the patient according to their clinical judgment, which can entail treating these personally or referring the patient for appropriate treatment by another practitioner. However, in this regard, she further states:

In terms of the treatment approaches – they can vary depending on what type of practitioner you want to be. Obviously I stick more to the scientific as opposed to some kind of fringe developments, but definitely adjusting being the primary focus of what chiropractic is, but it does not only have to be adjusting – it can be tissue work, muscle work, the complex between the muscle and joint interaction, as well as the supplementation, the wellness, the nutrition of the patient – psycho-social factors that would influence the way the patient responds to your treatment (P 4: 4:1 (40:51).

Dr Krause suggests here that the choice of approach to practice will have an effect on what type of chiropractor one might become, and that should one choose the route of science, one will remain in tune with this particular view. However, should a practitioner choose to follow alternate rationales in practice, i.e. non-science/anti-science, the definition will change. The implication is that, should a practitioner not choose the route of science, he/she will most likely forego the role of primary healthcare practitioner.

Dr Krause provides further confirmation of the mainstream view of chiropractic when she states that it consists of “adjustment, the physical manipulation of the patient as indicated. The use of auxiliary soft tissue therapies or massage techniques, and then advise and nutrition” (P 4: 4:2 (82:84).

Dr Krantz described the profession simply as a “hands-on healing profession” (P 2: 2:1 (26:26).

Dr James considers chiropractic to be “a slightly separate branch of medicine” (P 5: 5:45 (190:190), which tends to deal with “nerve, muscle, bone and a combination of any ailment between the three” (P 5: 5:1 (19:20).

Dr Grant views chiropractors as neuro-muscular specialists with close links to other healthcare specialists (P 7: 7:31 (41:45). Furthermore, he contends that chiropractic has three major constituents that contribute to its identity; these are art, science and philosophy. Whilst formulating his definition, Dr Grant asks himself a retrospective question with respect to the role and relative importance each of these aspects plays in formulating the chiropractic identity. He argues that “certainly art and science do, in my opinion, and philosophy, perhaps, is of less importance” (P 7: 7:1 (22:26). The implication of this statement is that the definition of chiropractic should be molded more strongly on the influence of science than on the clinical “art” or philosophical traditions associated with the profession.

Dr Black gave an interesting definition of the chiropractic. Initially, his view that chiropractic is a type of physical medicine, which concerns itself with functional disorders of spinal and extremity joints, seems fairly standard. However, he adds the following:

> I look at it as a holistic approach compared to what I unfortunately see in straight medicine, without being derogatory to our colleagues there, and my definition to my patients is that it is a neuro-musculoskeletal approach. . . I can add to the quality of their life and hopefully reduce pain, and in some rare instances change the physiology of the problems for them as well (P 6: 6:1 (22:27).

For him, chiropractic is a holistically driven approach to managing musculo-skeletal disorders. Therefore, although this view does not directly contradict Dr Krause’s perspective, it does introduce the notion that clinical science is perhaps not the only factor that determines the nature of chiropractic. In this instance, the indications are that philosophical traditions, such as holism, also influence the manner in which a practitioner approaches clinical practice.

Dr Manning’s definition of chiropractic is interesting because he in a sense rejects the standard view espoused by the other respondents as “superficial” and relatively unimportant. For him, the view that should be considered paramount is the one held by chiropractic patients. In his mind, the public views a chiropractor as the

”treater of pain and discomfort” of the back and neck: “Particularly if you have an interest in dealing with something at a causative level and are, as many people are nowadays, more involved with the health movement than just resorting to medication (P 8: 8:1 (25:39).

The implication here is that a contemporary ”health”-care movement exists among patients, who seek out providers capable of providing causal as opposed to symptomatic management, i.e. excluding the use of medication. Furthermore, it would seem that in its defined area of competence, chiropractic is able to provide such a service – a commodity that this group of patients finds attractive.

Dr Rays does not really define chiropractic *per se*, but rather suggests that the definition is fluid, depending on the philosophical views and approach to practice of the chiropractor:

> . . . what chiropractic really is to me isn’t really what chiropractic is to somebody else. So we have a different idea of the philosophy and practices of chiropractic. So that does disturb me, particularly when I hear that people are not adjusting spines and calling themselves chiropractors, because by definition we have to adjust the spine (P 9: 9:1 (34:39).

The indication from his response is, however, that chiropractic’s identity is bound to the administration of spinal manipulation.

For Dr Armstrong:

> . . . chiropractic is a science, it’s a philosophy, it’s a way of life basically of trying to help people self-heal by removing any interference in the nervous system. You know, primarily in the spine. I also look at the cranials and extremities, you know, as interference, basically to assist a normal balance in the nervous system. To help the body and the brain to communicate efficiently (P10: 10:1 (17:22).

Although the basic associations with the spine and nervous system are shared with other respondents, he introduces the notion that the profession’s primary function is to normalise the activity of the nervous system (causal mechanism), which in turn allows recovery from ailments to take place. This definition neither contradicts nor combines well with any of the previous ones. However, “balancing of the nervous

system", like in acupuncture (Chaitow, 1983: 10)**,** hints at energy flow and hence vitalistic principles.

In summary

The quotes above reveal a wide range of definitions and self-understanding of the identity of the chiropractic. The prevalence of a wide range of philosophical views is evident as respondents included elements of biomedical, holistic and vitalist philosophy in their definitions. These then tended to support their view of a chiropractor's activities, which vary from a mechanistic adjuster, to a musculo-skeletal specialist and a primary care practitioner.

The responses indicate that philosophical grounding and cognitive strategies inform the approach to practice used by the individual practitioner. For example, a biomedically orientation tends to translate into a primary contact practitioner (physician), albeit with a limited musculo-skeletal focus. However, a non-science (vitalist) approach may lead to a different identity, which resembles that of a technician or therapist. It is my view that this dynamic could be indicative of the identity these respondents assign to chiropractic.

The definition of what a chiropractor is, is not as clear-cut as it may seem and, depending on the individual view of its identity, may be located on a sliding scale between therapist and physician. On the one end lies the primary contact practitioner, who incorporates a wide range of strategies to manage the health of the patient, and on the other lies the therapist, who is concerned only with the mechanistic removal of spinal dysfunction (subluxation).

6.1.2. Subluxation

Dr Levine presented quite a lengthy discourse with respect to the identity and the nature of the "subluxation" or "subluxation model". Initially, he described it simply as a nebulous term describing an entity which chiropractors treat; one that may or may not have some connection with the nervous system (P 1: 1:4 (54:56). The nebulous nature of the term apparently lies in the role of the nervous system:

> . . . the typical subluxation model says that you should have nerve pressure in order to define something as a subluxation. I do not go along with that at all. I think many of the chiropractic conditions that we treat do have subluxations – they certainly have aberrations in terms of movement – either increased or decreased fixations or hypermobility problems, but without true signs of

> nerve pressure at all. There is no referral pattern and is specific local joint or muscle pain and some people would deny that that is a subluxation. In my understanding, it is bio-mechanically abnormal. And it is a treatable lesion (P 1: 1:7 (42:50).

Dr Levine goes on to make the following statement: “I mean as chiropractors we see the subluxation as the sort of deep foundation of the human being. I am not convinced about that”. However, rather than expanding on this potentially interesting comment, he again reduces the subluxation to a biomechanical lesion, which in the context of healthcare is of lesser importance than a healthy diet or getting enough exercise: “I suspect that a bad diet would kill a person far quicker than subluxations would” (P 1: 1:11 (126:132).

When I discussed this concept with Dr Levine in the second interview, another fairly lengthy explanation ensued. However, in this segment of the response a different dimension of the term came to light. According to Dr Levine, a practitioner can be subluxation based in terms of his/her approach to practice and, although he personally does not consider this as an approach he follows, he “believes” in its presence as a complex term that science has not yet been able to fathom:

> I must say that I don’t particularly think really in terms of subluxations. I don’t for instance think that a subluxation is a diagnosis *per se*. I am more inclined to think of the tissue involved in the subluxation process. I prefer to think in terms of is there an injury to the disc, is there a frank nerve root entrapment, and are there signs of nerve root entrapment? So I am more neurologically and orthopeadically based than subluxation based. But that is not to say that I do not believe in the subluxation, I do believe in it. We might use other terms, but lets just say that it is a quite clear derangement of one sort or another within spinal joints do affect people’s health directly in the sense that they cause pain, probably predominantly and pain will affect people’s well-being (P11: 11:1 (49:67).

It seems as if Dr Levine struggled to articulate his view of this concept clearly and in the process proposes an amalgamation of biomedical terms and thinking with a belief in an entity which science is yet to define adequately. Whilst reluctant to use the term, he does not seem prepared to abandon it. After reaching consensus that a subluxation is as a subtle physiological or patho-physiological entity, I specifically

asked whether it affects the body's energies by reducing nerve flow, to which he responded:

> . . . whether directly or indirectly, I would say yes. The person, who is suffering from the headache, his energy flow, if you want to use that term, is disturbed. There is no question in my mind about that (P11: 11:2 (69:77).

This was an important response, because up to this point the philosophical grounding of the term was still unclear. However, at this point its association with vitalistic thinking became apparent. The "conflict" between Dr Levine's philosophical views and clinical practice approach is evident in his next response:

> . . . subluxation, when it is frankly present, I have no difficulties with at all. It is when it is subtle subluxation that I have difficulty with. It causes no signs and no symptoms and there is a question of whether it is really there and it comes back to does every person need to have a chiropractic adjustment on a regular basis, even though there are no signs and no symptoms? And there is a group of chiropractors, rightly or wrongly, who imply that every person needs to have a regular chiropractic adjustment, because of a disturbance of energy flow. For me, I have difficulty with that concept of subluxation and I am not convinced that every patient must have a chiropractic adjustment. I wonder if it is not a financial thing that they are talking about? Is this not another way to make money? You have this condition that nobody can identify, it is causing no signs, no symptoms, but we think you should pay us a fee and have it adjusted (P11: 11:8 (159:164).

When the subluxation is present as a clinical entity, it poses no problems. However, when it is used to motivate for repeated spinal manipulation based on maintaining energy flow, it becomes problematic for him, particularly because it can be used as an unethical motivation to over-service the patient. Therefore, Dr Levine rejects the subluxation model as an approach to practice due to its lack of scientific support, pragmatic sense and unethical connotations. He continues, "if you treat the subluxation only and the patient has a heart attack and dies, you have failed the patient" (P11: 11:10 (171:173).

This response perhaps also indirectly points toward the clash between the technician and the physician view (see 6.1.1). When the routine biomechanical lesions treated daily in chiropractic offices present in the absence of secondary, organic pathology, a mechanisitic approach of simply removing the restrictions may suffice as

an adequate management strategy. However, when underlying organic pathology demands that the practitioner elaborates on this plan, simply treating a small biomehanical aspect of the patient's health without taking cognisance of and responsibility for potentially life threatening disorders is not only unethical, but dangerous.

According to Dr Krantz, the subluxation is simply a term that describes a joint restriction "somewhere within the joint's normal range of motion" (P 2: 2:4 (159:161). Dr Hussein also suggests that the subluxation is perhaps a clinical entity that chiropractors locate and reduce or remove (P 3: 3:2 (37:39). Dr Hussein dismisses "subluxation" as dated terminology, which describes what is now called "a fixation or as a restriction in movement". The fixation is an entity commonly treated by chiropractors (P 5: 5:2 (89:93).

Dr Grant refers to the medical interpretation of the term, but furthermore states that it is important to refer to the "subluxation complex" in the chiropractic milieu. This term, according to Dr Grant, "involves dysfunction of or restriction in movement of spinal or extremity joints with or without soft tissue Involvement". However, like the previous respondents, he considered it equivalent to more contemporary terms, such as "fixation, dysfunction or restriction in movement" (P 7: 7:2 (99:112).

Dr Grant contends that for "straight" chiropractors, the subluxation may be considered significant in the sense that, depending on the spinal level at which it occurs, corresponding organ function may be affected:

> . . . a straight chiropractor is generally the Palmer or Sherman type graduate who will be entirely focused on establishing subluxation, misalignment, fixation in the spine and treat only that. . . I am not always going to trace glandular or organ involvement from a certain spinal level, whereas I think they will very much use that system (P 8: 8:3 (136:164).

I shall elaborate on the straight/mixer debate in 6.1.3. However, for the moment it would seem from this response that straight chiropractors aim to normalise or improve organ function through improving or normalising nerve flow, by reducing spinal subluxations. A concept that, due to its association with energy flow, seems to have vitalistic roots (as indicated by Dr Levine).

According to Dr Rays,

> On the one hand it refers to a complex entity, which has the capacity to interfere with nerve and organ function and, on the other, to a simple mechanical joint lesion Subluxation to me means that a vertebra is firstly not in its correct position anatomically, secondly it has no proper movement in respect to adjacent vertebra and thirdly it had an effect or is interfering with the nerve root at that level (P 9: 9:15 (59:89).

What makes his response interesting is that he gives further clarity about the link between the subluxation and the "straight/mixer" practitioner debate. According to Dr Rays, the two groups are arguing over two sides of the same coin: the one being a more philosophically driven approach to practice and the other a more science driven approach to practice. The problem seems to lie on the side of the "straight" practitioners who consider spinal subluxations to be the only cause for disease and therefore ignore all other causative mechanisms identified in medical science:

> . . . basically what they are arguing about is not a lot. One assumes that any chiropractor undergoing training will be told about the Palmer theory; they must bear that in mind when they are dealing with the scientific side of what is happening in the body, the physiological, the anatomical etc. etc. that everybody is taught at school. Yes, we have evidence now of tissues becoming inflamed with nerve irritation. The difference is that people are, they become, absolutely focused in that one statement of subluxation causing disease. They seem to disregard all the other evidence that not only subluxation causes disease.

This inability to recognise the importance of both traditional wisdom as well as scientific advancement limits the vision of these practitioners. The modern (mixer) chiropractor should be prepared to balance these two aspects, which in a sense then becomes the "art" of chiropractic. Traditional theories handed down from previous generations, which seem to hold merit clinically, but are not yet confirmed through science, may prove to be useful and therefore should be kept in mind. With regards to this, Dr Rays states:

> . . . if the two camps, the straights and the mixers would just relax a little and accept that both philosophies are working at the same time, then we wouldn't have the problem. People do get stuck and dogmatic and that causes the problem. So I am actually in both camps (P 9: 9:9 (94:118).

He concludes that there is a significant level of misunderstanding within chiropractic with respect to the term subluxation and that it has had the effect of reducing the clarity of chiropractic's identity with respect to patients and legislators. Consequently, he suggests that:

> . . . we could all standardise the term subluxation and make that completely a chiropractic word. In that the nerve is being interfered with when the vertebra is out of place, that is what we deal with. If we could make that our product that's what we deal with, I think that will make it a lot clearer. I think that will clear up a lot of misunderstanding and a lot of confusion. Now, unfortunately, the word subluxation has been grabbed by the straight chiropractors and they disagree that the mixers should be able to use it, so you come into all that sort of crap. But, I firmly believe that if the world knew what a subluxation was, that what chiropractors treat, I think we will be in a much better position. Hopefully in ten years time that will be the situation (P 9: 9:12 (387:401).

There is a clear appeal for a clarification of the identity of chiropractic. However, what I found interesting is that he considers the term to have been annexed by the "straight" chiropractic fraternity, but the unified meaning he suggests for the term and for the nature of chiropractic does not seem too far off from the straight interpretation as stated by other respondents (see Dr Manning).

According to Dr Armstrong, a subluxation is "basically where a joint is out of alignment, but not out of alignment enough to be called a dislocation. So it is partly out of place and it affects the physiological function of the joint, so the joint cannot do its range of motion" (P10: 10:2 (106:108). This view is in keeping with that of most of the other respondents.

In summary

From the above it can be seen that the traditional view of a "subluxation complex", consisting of a restricted joint(s), disturbed nerve flow and consequent organ pathology has seemingly been discarded as an operational term in favour of less value laden terms. Likewise, the word "subluxation", for the most part, is considered a dated term that essentially describes the joint lesions chiropractors treat. Words such as "dysfunction" or "fixation" are now favoured as they are thought to describe the clinical entity that chiropractors deal with more clearly.

It seems that the term's main drawback lies in its association with vitalistic beliefs in the profession and that this coincides with the division between "straight" and "mixer' chiropractors. The perception is that this intra-professional dispute has negatively affected the image of chiropractic.

The issue of confusing nomenclature in confusing professional identity is perhaps the most clearly portrayed in the "tension" Dr Levine experiences due to the dual meaning of the subluxation. Dr Rays also directly contributes to this through his wish that nomenclature be standardised. However, chiropractic nomenclature seems to be only the tip of the proverbial iceberg. It is my contention that the word and associated concepts are symbolic of underlying beliefs with respect to the nature of chiropractic and that these fuel intra-professional discord. Therefore, simply changing terms will have little effect in unifying approaches to practice.

6.1.3. The straight and mixer debate: A further clarification

In the section above, Drs Manning and Rays in particular alluded to an intra-professional debate, which comprises distinct philosophical view points and consequently differences in approaches to practice. When I questioned respondents on this issue, a number of interesting responses emerged.

Dr Krantz considered herself to be a diversified practitioner or "mixer". According to her, this means a chiropractor who accepts that patients "could present in any manner both mentally and physically with different sorts of ailments" and that one cannot "adopt one philosophy" and apply it to all patients (P 2: 2:10 (51:70). Furthermore, a "mixer" tends to follow management protocols with some type of scientific grounding (P 2: 2:11 (163:165), which implies that management can include any of a number of treatment modalities, including advice on posture, nutrition, ergonomics, exercise and even anti-inflammatories, if required. This stands in contrast to a "straight" chiropractic approach, which, according to Dr Krantz, means "that the adjustment is the be-all and end-all of the treatment and getting them in for x amount of adjustments" (P 2: 2:13 (208:221).

Dr Hussein described himself as a "mixer" or diversified practitioner (P12: 12:2 (64:96) and stated, "I adjust and use modalities – I don't mind doing that. I feel that if there is anything that will help the patient in getting better, then it should be carried out" (P 3: 3:13 (55:62).

However, whilst defining straight chiropractic (pure chiropractic) as ”practicing manipulation of the spine”, he asked an important rhetorical question:

> The question arises whether a patient has been treated chiropractically if they haven’t been manipulated in your rooms, and I would say that he hasn’t been treated chiropractically. In other words, if somebody presents with low back pain and all you did was ultrasound and massage and for whatever reason you did not deliver an adjustment, then the patient was not treated chiropractically (P12: 12:12 (137:145).

Therefore, although Dr Hussein considered himself a “mixer” in the sense of applying various modalities, he displayed elements of “straight” chiropractic philosophy in his view of the role of the adjustment. Therefore, I will label this a pluralistic view (I shall elaborate more on this in 6.1.4).

Furthermore, according to Dr Hussein, straight chiropractic is linked to the dated, philosophical school of thought termed ”innate intelligence” and that it is more prevalent amongst older practitioners. He was of the opinion that this philosophy is anti-science and supports Dr Krantz’ view that these practitioners do not use “other modalities in their practice” and choose only to manipulate” (P 3: 3:14 (211:220).

Dr Hussein was clearly critical of “straight” chiropractors as he stated:

> . . . these people that would practice the old school of chiropractic, which believes that, for example, if you adjust the lumbar spine you can treat diabetes or you can treat asthma by adjusting the thoracic spine. Or if someone has cancer of the brain that adjusting the neck is going to get rid of the cancer. All those sub-groups fall under one camp of chiropractic that have the old school of thought that believes that treating the spine releases the innate etc. and that allows the body to heal itself completely of all types of serious organic conditions. . . That camp, are the type of people that the medical doctors or the scientific community look at and say this is hocus pocus.

This comment provides two clear reasons why “mixers” might dissociate themselves from “straights”. The philosophically driven practice approach has the potential of placing individuals with life threatening pathologies at great risk and other healthcare practitioners will view these practices as unacceptable.

Dr James also considered himself to be a “mixer” and made the distinction as follows:

> . . . a straight chiropractor would be someone who wouldn’t do any acupuncture, myofascial trigger point therapy, ultrasound, interferential current or even sometimes massage. A mixer would be someone who takes different techniques, like a Gonstead-type adjustment, a short lever type adjustment, and then use that in conjunction with any of the physiotherapy techniques, that would be a mixer (P 5: 5:7 (95:122).

For him, the key differentiation between the two camps is the eclectic use of treatment modalities by the “mixer”, as opposed to the use of manipulation only by the “straight” (P 5: 5:16 (305:315).

Dr Black agreed with Dr James’ perspective, but added that there are not “too many die hard, straight chiropractors around. There are some, but I think a lot lie in between and don't want to admit it sometimes” (P 6: 6:10 (243:263). Dr Black therefore suggested that on a pragmatic level most chiropractors use an eclectic batch of treatment modalities, but that some practitioners pay the “straight” approach lip service out of loyalty to days gone by.

Dr Grant classified himself as a “mixer” in much the same manner as did Dr James and Dr Black, but added a further distinguishing factor, which is that “straights” ”simply manipulate with very little diagnostic involvement”, whereas “mixers” are trained in diagnosis (P 7: 7:10 (114:128).

Dr Manning provided the first indication of the “mixer/straight” distinction in 6.1.2. He defined the “straight” chiropractor as someone who is “entirely focused on establishing subluxation, misalignment, fixation in the spine and treat only that” (P 8: 8:6 (129:147). In considering which approach is preferable in the South African context, he again considered this question from the perspective of the patient and stated:

> . . . it depends on what chiropractic’s identity is now. There we have to establish which identity, the mixer or the straight, is the strongest one in public opinion and I think if it goes my way in ten years time then the mixer identity will be dominant. . . In the end, there is no way it will ever lose a clear identity as a chiropractor. Patients will still, the public will still have the idea, that for back and neck pain I go to the chiropractor; it works quicker than the

> physio, it's better than taking pills. I know I feel better; I don't need words to tell me that. I know I feel better when I do this . . . and that is the identity that will never be lost (P 8: 8:14 (356:365).

Dr Manning linked the "mixer/straight" debate strongly to the identity of chiropractic. Although he would prefer the "mixer" approach to prevail in time, it seems that there are aspects of the profession inherently desirable to the public. For him, chiropractic will continue to exist as a unique profession, even if public opinion indicates that a straight chiropractic approach should be followed.

Considering Dr Rays' view that the debate about or distinction between the two camps is somewhat technical (see 6.2), and that the different exponents perform more or less the same function (P 9: 9:24 (91:118), Dr Manning and Dr Rays agreed to some extent on their conceptual view of the "mixer/straight". However, whereas Dr Manning is clearly a "mixer", Dr Rays is somewhat torn between the two approaches and shifts between the two schools of thought, depending on the practice scenario. He stated. "I sometimes am a very straight chiropractor and believe that the adjustment will get rid of the symptom" (P 9: 9:25 (125:137).

Dr Armstrong stated that he does not use physical therapy, e.g. ultra-sound, hot packs and massage, in his practice, but did not commit to classifying himself as a "straight" chiropractor: "I don't use physical therapy. I don't use physical therapy for specific reasons, but I don't like using the term straights or . . ."

When I inquired what type of chiropractor he thought he was, the reply was:
"I would probably say more in terms of a wellness-style, where I don't focus on treating symptomotology, I focus on restoring health" (P10: 10:13 (23:42).
I interpret this statement to imply that he is probably more of a "straight" chiropractor, based on the fact that he did not consider himself to be a treater of symptoms. This implies that no diagnosis is required to initiate treatment, which is a characteristic of "straight" chiropractic.

In summary
The difference between "straights" and "mixers" seems clear and the issue separating them speaks to the core of chiropractic identity. On the one hand, there is a group who believe, based on a vitalist view, that the adjustment is central and that the practitioner should apply it to all patients in all circumstances to restore and

maintain health. On the other, there is a group who consider themselves as healthcare practitioners, in tune with the beliefs of the biomedical paradigm, concerned with the management of problems related to the musculo-skeletal system.

The issue is not so much how to “categorise” or “classify” different practitioners, but rather the implications of self-understanding for the profession in the South African context. A technician does not have the responsibility of diagnosing, but the physician claims the position of exercising clinical judgement in the management of the patient. The indications are that a number of practitioners, classified as “straights”, are attracted by the status associated with the physician and yet are content to practice at the level of a technician. In this regard, it would be naïve to expect a profession to thrive in contemporary society, should its practice not be developed on rational grounds and with its proponents avoiding the responsibility of providing evidence-based healthcare.

6.1.4. *Adjustment*

According to Dr Levine, the adjustment is a procedure carried out by the chiropractor to remove subluxations or fixations or dysfunctions and is used when indicated by the presenting symptomotology (P 1: 1:17 (394:409). He considered it an important treatment tool, but did not subscribe to the wholesale application of the modality, especially not when no clinical indication for applying it can be found (P11: 11:15 (85:98).

Dr Hussein provided an interesting interpretation of the term when viewed in the context of his stance on the “mixer/straight” debate. The reader will recall that in 6.3. Dr Hussein identified with the “mixer” stance; however, whilst commenting on the adjustment he stated the following:

> A modality is a way of treating a patient. But if they receive IFC or ultrasound or infra red, they haven`t been treated chiropractically. If they receive all that with an adjustment, then they have been treated chiropractically. And the adjustment is the hallmark of the profession. If somebody has just had a manipulation of the spine, they have been treated chiropractically (P 3: 3:9 (402:407).

He clearly draws a distinction between the relative value of modalities. The adjustment is considered so integral to management that Dr Hussein considered a

patient not to have been treated chiropractically if an adjustment had not part of the management process:

> There are certain types of chronic conditions where manipulation is not advised. The chiropractic adjustment forms a very integral part of patient management, but it is not always necessary to adjustment in the treatment of a particular condition (P 3: 3:11 (413:416).

The incongruence of these two statements lies in the understanding that certain patients are not eligible for adjustment, but can be treated by the chiropractor. However, because they do not receive this special ingredient (adjustment) they would not have been treated chiropractically. This is a view more in tune with “straight” chiropractic.

In the follow-up interview, I attempted to clarify this issue with Dr Hussein. On inquiring about the ““adjustment” again he repeated the above, but added that the following:

> I don’t think it’s correct to say that if someone goes to the GP’s office and he hasn’t given them medication or he hasn’t given them an injection, all he’s done for them is given them advice. I don’t think it is correct to say that he hasn’t practiced medicine. The advice may help to cure some type of organic condition (P12: 12:11 (155:161).

Dr Hussein did not view allopathic medicine in the same manner as chiropractic, because although chiropractors may consult and impart good advice to their patients, they are not considered to practice chiropractic until they have adjusted their patient. For the allopath, no such criteria exist (see also R3 in 6.1.3.).

When I inquired whether he thought a tension existed in his view, he stated that he did not think so. I received no more clarification from the respondent in this regard, but on reviewing the interview, it appears that the reason for this apparent inconsistency may lie in the following comment by Dr Hussein:

> I think the greatest challenge would be to keep ourselves distinct from others. Everybody is turning to manipulation and that is the hallmark of our profession. If people ask what is the difference between a chiropractor and a physiotherapist – all the modalities that I use come from my sister’s office and she is a physiotherapist. But when it comes to adjustment, that is what I do.

> She treats her patients using all those modalities, but she cannot adjust. The hallmark of our profession is manipulation (P 3: 3:12 (479:494).

The motivation for the elevated role of the adjustment is that it is perhaps the only modality that is uniquely chiropractic. Therefore, it once again seems to be about the identity of chiropractic and in this instance the preservation of chiropractic's uniqueness that motivates this pluralistic view.

Dr Black agreed with Dr Hussein concerning the importance of the adjustment for distinguishing chiropractic as unique among other manual medicine practitioners. It may even provide some confirmation of my view that the hybrid "straight-mixer" view is evident in Dr Hussein's responses:

> I think the greatest challenge is going to be for us to identify ourselves as not the sole caretakers of manipulation, because there are many other professions using it, but that we are seen to be best people doing it and that the challenges lies in continuing to show that is what we are: the best providers of manual therapy, because it is not exclusive to chiropractic (P 7: 7:7 (395:413).

In Dr Rays we find further confirmation of the integral role of the adjustment. Dr Rays considered acupuncture not to be a "distinctly chiropractic thing", but rather a different profession. His "first choice treatment is always the adjustment or the manipulation, but when I hear of chiropractors whose first choice of treatment is acupuncture or massage, I go cold, because that is not what we are licensed to do". Dr Rays firmly believes that the public is done a disservice when adjustments are not administered. When I asked why this is the case, he replied:

> I just think it is from history. You know we have battled over the last eighty or ninety years to get the chiropractors out of jail and then into the law books so that we can earn a living and there are practitioners that are doing treatments, and I am not saying that the treatment doesn't work, but they are not doing what chiropractors have fought to do (P 9: 9:21 (336:357).

Further motivation for the key role of the adjustment is the historical hardship the profession endured in order to practice independently.

Dr Black considered an adjustment to be a very specific type of manipulation, which requires significant training and finesse to perform well:

> Any fool can get a crack out of a person, but to get the crack at the right point, takes techniques and knowledge and often I think that people are adjusted where they 'go' easy and not at the right point or as I often hear: 'When so and so adjusts me, I hear a lot go'; now that is not chiropractic to me that's a physio trying to manipulate. But, you know, part of our code is to be specific in our adjustments, so I don't expect to hear six cracks in the neck at a time (P 6: 6:6 (125:136).

Dr Armstrong defined the adjustment quite broadly as “a procedure involving the spine that will restore nerve flow to an area to allow it to start to self generate and to self heal” (P10: 10:10 (307:311). His definition is congruent with his view of chiropractic, which seems to be associated with a vitalistic view of healthcare.

In summary

The most common definition of an adjustment refers to a physical manipulative procedure, usually of the spine, which reduces painful symptoms. It is also defined simply as an action, which restores nerve flow to a targeted area. The first definition describes a specific process, whereas the latter accentuates a desired outcome. There is quite a bit of room for interpretation in these definitions and indeed, the interviewees commented on the fact that practitioners tend to adjust differently and even have different criteria for a successful adjustment.

More important than the technical definition, however, is that the significance of the “adjustment” varies greatly amongst practitioners. For some it forms a part, albeit an unimportant part, of a management process. For others, however, it is the hub around which the profession pivots. An interesting conflict between clinical thinking and belief exists, as practitioners, on the one hand, acknowledge that the adjustment cannot be used in every treatment scenario and is in fact contra-indicated in some situations. On the other hand, however, they strongly hold the belief that a patient has only been treated ”chiropractically” once he/she has received this particular intervention.

The indications are that professionals require an unique procedure, which they can hold up as uniquely chiropractic and can then use as a defining icon for the

profession. This suggests that the identity of the profession is rather fragile in the sense that its identity resides in a “rick” rather than in a well-rounded self-image.

So can chiropractors claim coherence?

In viewing the technical terms used by practitioners, it is my view that these individuals differ substantially with respect to the interpretation of the terminology they use in daily practice. This calls into question more than just a coherence of understanding; it creates the distinct impression that the identity of a chiropractor lies on a somewhat blurry continuum. This spectrum seems to range from a highly integrated, diagnostically driven physician, to a simple mechanist. Due to their distinct characteristics, the models of practice employed along this sliding scale would also necessarily differ, which in turn could create widely varying perceptions of the identity of chiropractic for those external to the profession.

6.2. Philosophical traditions and their influence on clinical practice

The discussion in the previous section shows that basic chiropractic nomenclature can provide an indication of distinct beliefs and philosophical views with respect to clinical practice. It is important to consider these in more detail and to establish with what cognitive strategies and consequently approaches to practice they are associated.

I have subsequently conducted a review of the evidence pertaining to the various views held by the respondents. I first manually coded the interviews according to beliefs and philosophies. I then ran a number of key word searches in the Atlas Ti auto-coding function. These terms included philosophy, holism, vitalism, wellness, innate, science, biomedicine, scientific method and mainstream medicine. I used a mixture of the comments elicited from respondents and philosophical concepts from the literature to develop these key words.

Besides providing a view of the debates that exist at the level of philosophy in the profession, this group of responses also allows the reader to form an image of the ten respondents through the manner in which they deal with issues around philosophy. In this endeavour, I have presented the data in a consecutive manner in order to allow for more continuity. The key debates are summarised at the end of the section.

Dr Levine considered himself to be a holistically oriented chiropractor. His view seems grounded in pragmatism as he explains that the unfortunate experience of a patient who, after presenting with low back pain, died from a heart attack, “had quite a profound influence on the way I practiced, because it reinforced to me that anybody that calls himself a healer has to look at the whole patient – not just see a subluxated spine” (P 1: 1:51 (81:87).

He experienced some doubts about holistic philosophy, however, because he considered holism quite a “cheap” word in contemporary healthcare. It seems that holism, rather than being taken seriously, is paid lip service to and not truly applied in practice. The reason for this seems to be that it is a time-consuming process, which possibly demands too much from the individual. A second reason could be the lack of markers for holistic practice, which makes it difficult to ascertain whether wellness goals are being reached:

> I certainly try to treat the whole patient in so far as I am able. . . I don’t really think I do it as adequately as I would like to. . . I don’t think any of us knows how well we do it and its only in relation to some norm that is not defined anyway. . . so I try for better or for worse to be a holistic chiropractor (P 1: 1:52 (98:104).

Dr Levine considered factors like diet, exercise and psycho-social stress as part of a holistic approach to healthcare; all of which are more important than removing subluxations (P 1: 1:53 (126:132).

Considering and managing these aspects posed a further problem for Dr Levine because, according to him, patients:

> couldn’t be bothered to do exercises; they certainly don’t want to come and pay you money while you are trying to get them rehabilitated and strengthened. They are looking at short-term relief of pain and they cannot see that next year or the year thereafter as equally important (P 1: 1:54 (270:276).

This comment is significant as it identifies the model of healthcare that patients have grown accustomed to as one that requires little foresight or active participation on their part and that procuring patient compliance is consequently problematic.

Along with holism, Dr Levine also considered biomedicine as an important influence because, despite his “belief” in subluxations, he utilises “medical pathology” when considering the “human condition” (P 1: 1:55 (26:30). This indicates an affiliation with biomedical philosophical traditions. However, this view is counter-balanced by Dr Levine’s vitalistic view of a person’s “energy flow” that is disturbed when subluxations are present.

Dr Levine also considered integrated medical practice as part of holism (P11: 11:18 (12:26), which means that practitioners should ask questions that fall beyond their scope of practice, so that appropriate action can be taken.

Dr Krantz agreed with Dr Levine that a responsible chiropractor is compelled to consider more than reducing fixations (subluxations): “How can one believe that when you know that there could be other causes for a fixation and other causes of pain? (P 2: 2:46 (314:317).

However, her motivation seems to be borne out of a sense of duty to ”get the patient well as soon as possible”, which means considering factors such as nutrition, exercise, posture and the treatment in an integrated fashion (P 2: 2:31 (392:400). It seems as if she is influenced by both biomedical and holistic considerations in her cognitive strategy pertaining to clinical practice:

> . . . one tries to keep an open mind about things, especially when you hear about other philosophies and techniques that other people say are 'the thing' and are the bible. One could consider those, but I tend to think that if there is no scientific grounding to or no relatively scientific grounding to the technique or the philosophy then it's actually, what is the point of using it? (P 2: 2:47 (59:74).

She made an interesting comment with respect to the vitalistically oriented chiropractor:

> . . . they so soundly believe what they say and it just, based on one's training, just doesn't make sense at all. It just astounds me that patients can believe them, which means that they must be very, they must come across as very charismatic in what they say and do and believe (P 2: 2:53 (102:117).

The implication here is that passionate chiropractors have the ability to influence patients and earn their support, even when the rationale for clinical interventions is

lacking in evidence. Dr Krantz' unique view of vitalism is important because it indicates that, even though the academic merits of a concept might not be apparent, it does not preclude the concept from making an impression on its audience when it is passionately conveyed as the truth.

Dr Hussein initially exhibited a strongly anti-vitalist stance in criticising the innate intelligence (straight chiropractic) view, as well as subluxation-based practice:

> I have a problem with people who practice with the whole innate philosophy where they believe they can cure ulcers by manipulating the spine . . . they just haven't kept up with the latest developments in the field and they are still practicing the old way of chiropractic and, because they have such large practices, it damages the profession . . . I think that chiropractors that have graduated more recently, would tend to think of things a little more differently compared to the guys that are in the field for a while. The guys who have been in the field for a while have that old type of philosophy that is so much under debate . . . they are not prepared to be mixers or they are not prepared to use other modalities in their practice – just manipulation and that is it (P 3: 3:14 (191:220).

It would seem that his criticism resides at the level of beliefs as well as practice. Firstly, he adheres to the view that chiropractors can affect organ function by means of manipulation and that espousing this as a rationale for treatment is detrimental to the profession. Secondly, he views the (mostly older) practitioners who practice under this pretext as damaging to the profession because their lack of modality differentiation does the profession a disservice. To him, their cognitive strategies have not remained up to date with the development of the profession.

Dr Hussein considered himself to be in tune with positivist (scientific) (biomedical) philosophy in practice and reiterates that he wouldn't call his philosophy of practice, the 'traditional chiropractic hardcore philosophy, 'you know innate and all that', to which he does not prescribe. Rather he considers himself to be grounded in this view, because he only uses those complementary therapies, other than manipulation, that have stood the test of time and that have some scientific background. He contends that he tries to remain as mainstream a practitioner as possible. P 3: 3:47 (102:113).

It is worth pointing out that this same practitioner (6.1.3) also placed a significant level of importance on the manipulation associated with vitalistic thinking. Therefore, the above comments must be viewed in context. It is possible that Dr Hussein is not quite as mainstream as he considers himself to be and that there are still some “vestiges” of a vitalistic philosophy present in his belief system.

Dr Krause described the current chiropractic practice paradigm as too ”interventional” and “doctor-centred” and believed that “it should be based more on holistic patient management”. Her view is that a shift is required to:

> the holistic paradigm and then that determines patient management and how you equate that to patient treatment as opposed to a straight forward ‘I am the doctor and you are the patient’ philosophy – more dictatorial philosophy (P 4: 4:10 (531:546).

At the same time, she would like to see the practice paradigm become more evidence based (more in tune with the scientific method), so that chiropractors take ”time out” with the patients as “opposed to just adjusting”:

> Adjusting, yes, that is the mainstay of what chiropractors do, but that is not the only thing chiropractors are entitled to do. Using the scope of practice more fully as oppose to limiting ourselves to one aspect of that whole scope of practice that we have (P 4: 4:29 (383:388).

It is interesting to note that Dr Krause considered the holistic view to be defendable through a research paradigm that it will lead to an improved quality of practice.

Dr Krause also expresses certain anti-vitalist sentiments:

> . . . someone says that chiropractors can cure all disease, which has been proven to not be the case. But, if the patient comes in to you with cancer or something that you are unable to treat, maybe even hypertension, you will then have to try and explain to the patient that that principle is totally incorrect and that often presents its own problems – especially if the patient is adamant or has had previous successes or perceived successes by another chiropractor or physical therapist that aligns themselves very closely to chiropractic. That in itself presents problems with patient interaction. Also on a global scale – how do you logistically motivate for healthcare funding based on a principle that is not necessarily proven or does not show any sort of moral or rational judgement when it is made (P 4: 4:40 (179:188).

For Dr Krause, it seems, that patients who consult her after having been treated by a vitalistically oriented chiropractor, suffer from a form of “indoctrination”. The vitalist principles that are imparted in a very charismatic manner are used as a rationale to substantiate claims, which cannot be substantiated with empirical evidence. Therefore, when she uses different treatment strategies, she has to address this view and re-educate patients in a manner consistent with her approach to practice. This task is made especially difficult when patients have experienced a “cure” during their time with the previous practitioner.

Dr James provided an interesting response with respect to philosophy of practice. He appeared to be someone who continually attempts to build bridges between himself, patients and mainstream medicine. Dr James’ view of philosophy is that it must contribute directly to integrated patient management and that any view that opposes this process is counter-productive to the profession, especially with respect to its identity and legitimacy. Because Dr James considers himself distinct from allopathic medicine, he uses a “solely scientific approach” to patient management in order to narrow the distance between himself, allopathic healthcare providers and patients. He states:

> . . . what we end up trying to do is fit into a scientific medical model and quite often meeting with resistance on the other side in that mainstream medicine is quite resistant to chiropractic as a whole. They tend to understand very little about what we do. To justify my existence in the area, I have to be solely scientific in my approach to patient and patient management (P 5: 5:34 (209:229).

Therefore, in his aim to justify his existence as a manual medicine practitioner, Dr James follows an overtly “classically” scientific approach:

> I try to explain everything according to a biomechanical model. This model has been researched and is fully understood. It gives me what I feel is a sound foundation to prescribe the different exercises that I do, and to administer the treatment that I do, and without that scientific background I don’t think I could manage my patients as effectively (P 5: 5:47 (241:245).

The benefits to him seem clear:

> . . . it gives the patient more security, so that they know where you are coming from. They understand that chiropractic is a branch of medicine and not a philosophy and I think it gives them confidence in the treatment that you administer (P 5: 5:48 (173:185).

It is therefore fairly predictable and consistent that Dr James would disapprove of anything remotely vitalistic: “there is no or seems to be no scientific background to them, that they haven’t been researched fully. Their diagnostic methodology is not accepted in the scientific world (P 5: 5:46 (69:79).

Furthermore, Dr James considered vitalist philosophical rhetoric as a ploy to ”to get the most out of the patient in terms of follow up visits” (P 5: 5:53 (390:394)).

Dr Black also considered himself closer to the biomedical approach to practice. However, his rationale was very different from that of Dr Krause and Dr James. His inspiration for this view seemed grounded in role modelling as he “realised that the two chiropractors that I had modelled myself on originally were very medically orientated” (P 6: 6:33 (329:335)).

However, Dr Black also portrayed an awareness that he is “a physical doctor and not a physiological doctor to any great extent, although we try and change those sort of things with diet and all that; to be aware of my own limitations I can do so much (P 6: 6:35 (141:155).

This is a significant comment because it implies that, although this practitioner adheres to holistic thinking, he is aware that the primary level at which he exerts an influence is on the local area he is treating. This view is congruent with Dr James’ biomechanical approach.

Drs. Grant and Manning associated themselves with the “scientific method” and from the text the indications are that this means a positivist philosophy in practice (P 7: 7:33 (221:226); (P 8: 8:11 (114:122)).

However, Dr Manning furthermore exhibited a practical form of holism. According to him, not all patients are amenable to holistic management because they are not able or prepared to take on the responsibility of their personal wellness management. This

distinction in patient typology is important because, according to Dr Manning, these two groups will view maintenance care in a different light. The active (holistic) patient will see maintenance care as an attempt to over-service because they are already doing much to manage their problem(s), whereas the passive group might interpret this as a pre-emptive action on the part of the chiropractor to preserve the level of their health and consider it quite acceptable:

> . . . some people will rely on you to take responsibility for their back pain, others won't. They will be very much responsible and I think it is important as a practitioner to establish at what level the patient wants you to be involved with the problem. The patient in control and responsible for their body can take you suggesting maintenance treatment or follow-up treatments on a monthly basis as purely trying to make money out of them. Whereas the other case, which doesn't have the time or inclination to be that involved in their own spine, need that and appreciate that and the lack of trying to get them onto some kind of maintenance programme is seen as you don't care about their spine. So you have to be able to read a patient on that level and be flexible on how you are going to offer control of that problem (P 8: 8:36 (73:84).

Dr Rays' views were more evidently vitalist, which to him implies that all patients should be adjusted, as this is what chiropractors should do:

> I like to follow an approach first written down by the Dr Palmer father and son, where I believe that nerve interference in the spine is achieved when vertebrae in the spine are not sitting in the correct position, and when these mal-positions are there for a long time, I think they can cause chronic states of disease in the body (P 9: 9:50 (54:58).

In this regard, it would seem that Dr Rays is the philosophical antithesis to all the previous practitioners, barring perhaps Dr Levine and Dr Hussein to a limited extent.

Dr Armstrong is also strongly influenced by vitalistic philosophy. He contended that he is both anti-reductionist and anti-mechanistic and considered himself to be an adherent of systems theory. In his explanation, he used an interesting metaphor to explain this view:

> . . . a car, if something is out it, can influence other parts of the car; the same thing with the body. If you have a problem in your neck, with time it is going to affect the entire body; because we are one . . . and the system view, meaning

> every system influences the other system, and that is more the vitalistic or the holographic viewpoint (P10: 10:36 (228:238).

The influence that this has on his approach to practice is that he initially deals with symptoms, after which he embarks on what he terms “wellness practice”. This implies that the patient would come in for regular adjustments that can be “structural” or “non-structural” in nature (P10: 10:39 (61:70).

Dr Armstrong’s response was interesting, because he clearly distinguished between the philosophical poles of vitalism, systems theory and reductionism. However, rather than using this to motivate a purely mechanistic approach to practice, he seemed to believe that he intervenes on an emotional level through management.

In summary

The evidence presented indicates, as one would expect, that practitioners are not influenced by one type of philosophical tradition only. The dominant views evident amongst these respondents indicate that biomedico-postivistism, holism and vitalism are the main philosophical traditions, which inform their beliefs. However, this in itself is not particularly new or unexpected.

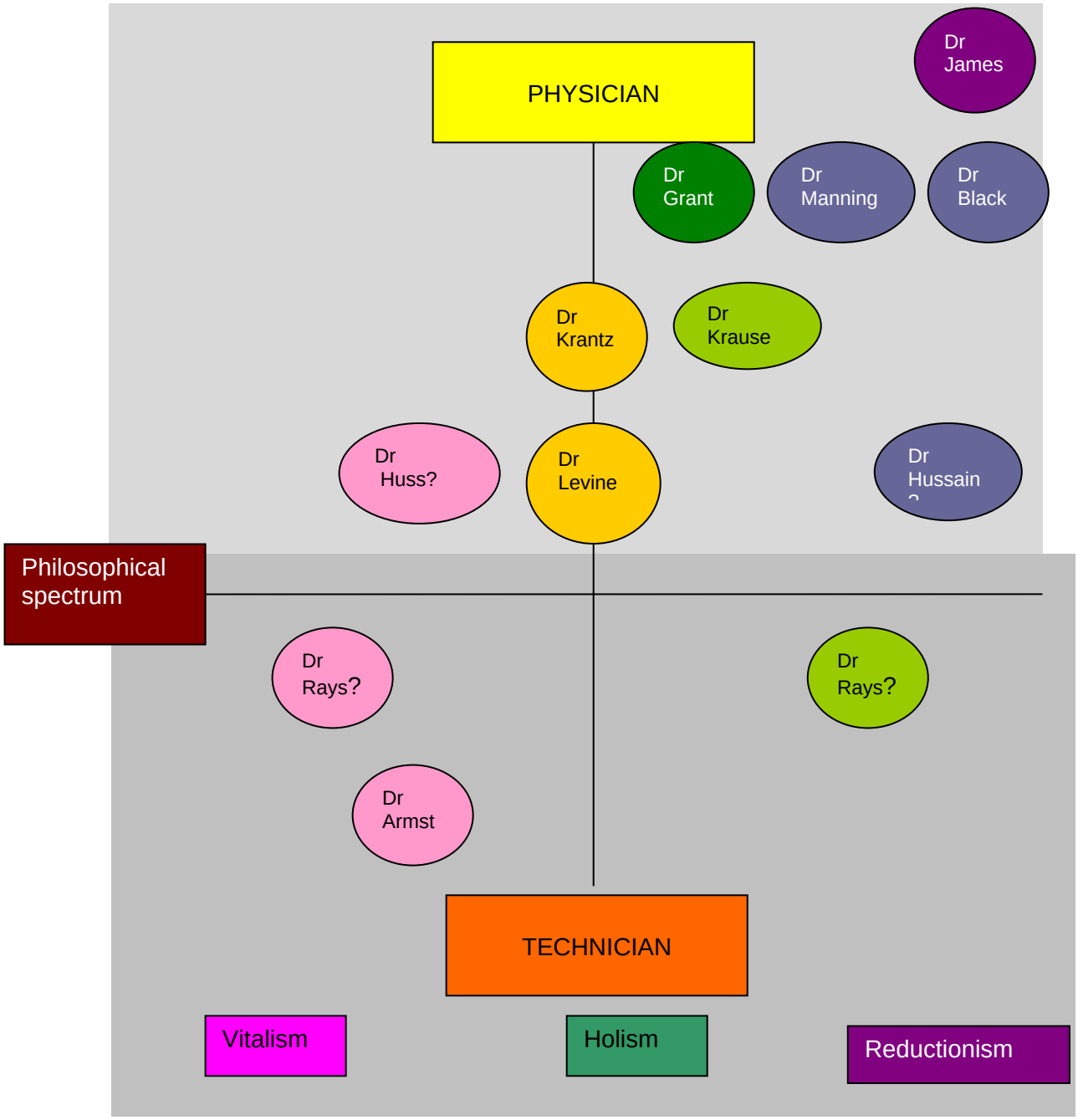
It is evident that practitioners are able to assimilate more than one, in some cases all three, of the philosophical beliefs into their individual perspectives. For the most part, biomedico-reductionism predominates and either stands alone (as in the case of Dr James) or is associated with holistic thinking (Drs Krause, Black, Grant and Manning). Drs Levine and Krantz, however, exhibited a very mixed set of beliefs. An interesting aspect of their views is the internal “tension” over vitalism, which they both criticise and admire. Dr Hussein and Rays both appear to “oscillate” between vitalism and biomedico-reductionism, and it was hard for me to place them in either of the two camps with confidence. Lastly, Dr Armstrong’s beliefs appeared to be shared between vitalism and holism.

These relative positions are presented on the horizontal axis of typology 6.1 below. The continuum I used, i.e. vitalism to holism to biomedico-reductionism, is based on the indications that vitalism and biomedico-reductionism stand on opposite ends of the philosophical spectrum, with holism located somewhere in between, but probably closer to biomedico-reductionism.

In 6.1.1 and 6.1.3, I argued that two approaches to practice could be identified from this group of respondents, i.e. the physician and the technician or therapist. Placing a practitioner into either one of these categories depends largely on the role he/she accept or avoid with respect to patient management and the level of importance they place on spinal manipulation. I used these two criteria to place practitioners on either side of the vertical axis of typology 6.1. It was easy to place Drs Rays and Armstrong because their actions in practice clearly indicate a technician or therapist approach. Similarly, Drs Krantz, Krause, James, Black, Grant and Manning are clearly located in the mould of the physician. Drs Levine and Hussein were more difficult to "place" due to the tension that they exhibited between the importance of the adjustment, on the one hand, and the role of the practitioner, on the other. In the end, I placed both in the physician category as I judged the sense of responsibility both exhibited toward their patients as more important than their "fixation" with subluxations and adjustments.

When we consider typology 6.1, an interesting picture emerges. It would seem that practitioners "use" philosophical views to rationalise their actions rather than alter their behaviour in order to be more consistent with the essence of a philosophical perspective. Practitioner behaviour cannot be determined or predicted through beliefs, because there are too many combinations that might be employed to justify existing behaviour. One could argue that our results show that the (reported) behaviours of practitioners are indeed "over-determined" by their beliefs about the profession and chiropractic discipline.

Table 6.1. A typology of practitioners with respect to philosophical influence(s) and approaches to practice.



6.3. The practitioner-patient interface

In this section, I discuss the views and responses of the respondents with regard to the clinical doctor-patient interaction. This will be done in order to present a *status quo* view of chiropractic at the level of clinical practice. The level of clinical practice in the context of this study pertains to the operational procedures practitioners undertake during patient management. I address this topic under four headings, which are aimed at providing a sequential view of the clinical management process. To this end, I define and/or discuss four sub-headings (depending on the

responses), namely patient management and care, management approaches, the acute and chronic setting and modalities used in chiropractic practice. Management and management approaches would have implications for patients in general, whereas the setting and modalities used would be more dependent on individual scenarios. Therefore, one could say that this data is represented in a "general to specific" manner.

6.3.1. Patient management and care

Dr Levine considered patient management as the plan of action he follows in order to improve the patient's condition. This plan usually "starts with a diagnosis" and it involves the various phases of treatment from "getting the patient out of acute pain" to "looking at the patient's habits and posture". Management, according to him, encompasses various treatment protocols, as well as the setting of treatment frequencies.

According to Dr Levine, this is the easy part of patient management. He considered the next part, which he terms "your plan for their restoration and their health", to be the more difficult aspect because it means getting them to comply with, for example, exercise;

> They couldn't be bothered to do exercises; they certainly don't want to come and pay you money while you are trying to get them rehabilitated and strengthened. They are looking at short-term relief of pain and they cannot see next year or the year thereafter as equally important (P 1: 1:37 (258:308).

The implication here is that symptom reduction is a relatively simple undertaking, but wellness practice is a more complicated process. Wellness is dependent on patient compliance and on his/her understanding of the long-term benefits in adopting health maintenance practices.

Similarly, Dr Black simply viewed patient management as "my protocol and how I am going to set about fixing my patient". In developing this protocol, he considers various treatment modalities, but also associated factors pertinent to them, such as nutrition, stress and exercise. To him, management is an individualistic process, which differs from patient to patient (P 6: 6:21 (272:304)).

According to Dr Hussein, management entails putting patients ”onto the road to recovery or helping them to cope with their condition, if no further progress can be made”:

> They shouldn’t be advised in the way in which you send them on a wild goose chase where they feel that they are going to get cured. They must be informed that you will achieve a certain level of relief for this condition, but that this condition is not going to be reversed. They should be informed that we try as much as we can to get the best outcome and the most amount of relief as we can (P 3: 3:37 (352:357).

Here we note the first distinction drawn between management in the acute and chronic setting, and that management differs, depending on the presenting scenario. The importance of clear communication with respect to expected outcomes from management is also emphasised.

Dr Hussein returned to the importance of the adjustment, but stipulated that it may not always be indicated (P 3: 3:10 (409:416). Furthermore, Dr Hussein did not consider management to be a well-differentiated term within the profession, with the majority of practitioners considering the term to mean setting treatment frequencies. According to him, this practice is termed “patient maintenance” (P 3: 3:35 (234:268)).

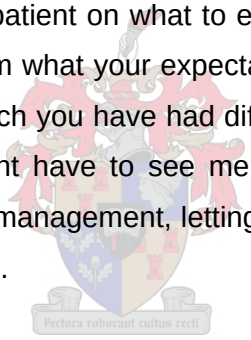
According to Dr Krause, a patient manager is the individual who is responsible for any one patient’s well-being. She described that individual as the one “in charge of managing that case or keeping tabs on whatever that patient is progressing through”. She did not consider management to be a term that is correctly interpreted by chiropractors, but contended that practitioners use treatment and management interchangeably. For her, treatment only includes “stuff within the practice as opposed to management, which is outside of the practice” that affects their home and work environment. In her view, management could include interdisciplinary and psychosocial factors and is therefore a broader term (P 4: 4:25 (202:245). According to Dr Krause, in-office treatment might include modalities such as adjustments, soft tissue, application of IFC, either independently or in combination.

Like Dr Hussein, Dr Krause considered patient management to be a highly individualistic process, which depends on the circumstances of each patient. The aims and outcomes must be negotiated with each individual before treatment is started:

> There will be a difference in terms of what the practitioner would want to do immediately for that patient to reduce pain level or the severity of the condition . . . each management will be tailored to the patient (P 4: 4:26 (267:281)..

According to Dr Rays, to manage a patient means:

> . . . to commit yourself and the patient to a course of treatment that will end where the symptoms of the disease are completely gone and that might mean telling the patient that they will have to see you on an ongoing basis. That is according to your assessment of the diagnosis. You might be able to tell them that within a week their problem should be over. Management means communicating with the patient on what to expect. Management starts at the first visit and you tell them what your expectations, you experience might say that this is a problem which you have had difficulty with before and you might warn them that you might have to see me over an ongoing period over a month or two. That I call management, letting the patient know what is in your mind (P 9: 9:36 (139:151).



From this response, it is clear therefore that management entails a process, which is individualistic in nature and highly dependent on clear communication between doctor and patient – especially with respect to expected outcomes. He considered care to be the ability of the practitioner to communicate with the patient, to create the perception that the practitioner is "interested in their well-being" (P 9: 9:39 (281:290).

Dr Manning contended that the two concepts are so closely related that a "grey area" exists between where management stops and care starts. Dr James, on the other hand, drew a clear distinction between management and treatment:

> Management is more than just the treatment . . . the actual manual part or using the physiotherapy techniques. The management part of that would be to prescribe exercises and to check on the patient's well being after the first treatment and after the second treatment and after the third treatment (P 5: 5:33 (127:165).

Dr James also indicated that the term has acquired different meanings. For some, it entails maintenance treatment, i.e. the setting of regularly spaced appointments, whereas others would interpret it as he does. Consequently, treatment frequency and patient management are used interchangeably.

It is interesting to note that what Dr James considered patient care is equivalent to Dr Krause's view of what wellness care entails. Therefore, for Dr James patient care is an extension of management into areas like nutrition, the home situation and "personal or potential stresses, how to avoid them and how to deal with them when they come up" (P 5: 5:36 (317:323).

Dr Manning's definition is in keeping with the other respondents. He described it as "the entirety of how you're dealing with the problem that the patient is presenting to you" (P 8: 8:19 (165:175). However, he considered the term to be fairly logical and fairly well understood amongst practitioners.

Dr Manning considered patient care to mean "looking after your patient" from a holistic perspective. This implies following a compassionate approach reflecting concern for the patient beyond the individual practitioner's direct scope of practice (P 8: 8:26 (289:303).

According to Dr Krantz, management consists of:

> . . . treatment and the amount of times that you see the patient for return visits; it incorporates education, which to me is the big thing. Education based both on what the literature says and on your experience of what works . . . It's the totality of all the different things mixed in (P 2: 2:24 (172:204).

Dr Krantz suggested that education grounded in evidence, based either on literature or on experience, secures patient compliance during management. She considered this a key determinant of success. Specifically, education is emphasised where integrated management strategies rely on the successful interaction of factors like nutrition, exercise, posture (P 2: 2:31 (396:400).

Dr Grant also provided a fairly concise definition in line with the previous respondents:

> I think that includes knowing not only what is wrong with the patient, treating the patient, but also when and where to refer them to and knowing your

> avenues of referral and ultimate end goals, before your patient asks you to do it (P 7: 7:14 (180:185).

However, he added that patient care includes being accountable for managing the patient's health and ensuring that the patient is informed at each step of the process. He also considered patient care to involve wider areas, such as family life, and that there is an overlap between management and care (P 7: 7:17 (332:355).

For Dr Armstrong, patient management is more related to the business side of practice: "it is how you handle the patients when they come in, sit down, when they fill out the forms, how you collect payment" (P10: 10:22 (130:169).

In summary

It is again obvious that the notion of patient management suggests a spectrum of activities, which vary in nature and number depending on the practitioner's interpretation. On the one hand, if interpreted fairly narrowly, management implies keeping the patient to a regular appointment schedule, whilst applying the required interventions to remove symptomotology. However, it can also imply a journey, which the doctor and patient undertake in order to improve and maintain the patient's health. It is in the latter interpretation that I found the notion of the doctor taking responsibility for the patient's well-being to be a prominent theme. This responsibility seems to revolve around developing individually tailored management protocols and the provision of constant patient education. It is particularly in the management of the chronic patient that constant education maintains patient compliance, which in turn is a key factor for management success. It is my impression that this concept might not be clearly understood and that for many practitioners the term may simply imply the setting of patient visits.

The group seemed to struggle with the patient care concept. The data indicates that patient care is a rather nebulous term and consequently hard to define. However, it is my view that this group views care as a practitioner's attitude, which is aimed at optimising the patient's well-being and as such extends beyond the boundaries of the office visit.

6.3.2. Approaches to management

In defining chiropractic, the respondents provided an indication of how they might approach practice. However, this was mixed with beliefs and philosophical

perspective. In this section, I shall provide text that specifically relates to the approach this group tends to follow when managing patients.

Dr Levine utilises both anecdote as well as trial and error to inform what is best described as a rather prescriptive (practitioner-oriented) approach. Evidence for this can be found in the following response:

> Well, there is often wisdom in old wives' tales. The recipe approach is not necessarily a bad thing, provided that one is prepared to be broad minded and think. I work out with my patient what works for them. There is value in the recipe approach, but it is not a substitute for intelligence. For me there is a key for each patient – what gets them well quickly (P 1: 1:39 (252:256).

> I do a history, examine the patient; if you need some special tests, order them. Make a diagnosis and come up with a treatment plan in your own mind and then sit down with the patient and say, listen this is what is wrong – this is what I plan to do and this is what you have got to do and this is what you may not do, for the next month and so on (P 1: 1:40 (310:321).

Although Dr Levine did not state it explicitly, it is evident that his view is congruent with the manner in which management protocols are developed in allopathic medicine.

Whilst Dr Hussein also identified with the clinical, biomedical model, it is clear that he supports the practice of health maintenance through regular spinal manipulation:

> I treat them for their diagnosis and, depending on their diagnosis, I always advise them that chiropractic is something that you need to have regularly . . . Just as how we are advised to go to the dentist every six months (P 3: 3:39 (269:277).

Dr Krantz identified strongly with a clinical biomedical approach and specifically stated that hers is unlike the "straight chiropractic philosophical approach". She motivated her view by saying that "patients could present in any manner, both mentally and physically, with different sorts of ailments", and that the practitioner is consequently tasked with the responsibility of rationally resolving each case as best he/she can. Hence, to her, following a recipe management approach to the patient is unacceptable (P 2: 2:9 (51:56).

Dr Krantz seems to be more consultative or patient-centred than Dr Levine and tends to try and incorporate more wellness maintenance routinely as part of her approach:

> . . . I don't dictate to the patient, but I incorporate the patient in the amount of times I would see him or her for return visits, I don't just use straight chiropractic in the management approach and I tend to incorporate, to the best of my ability, postural advice, nutritional advice, ergonomic advice, exercise advice (P 2: 2:36 (206:214).

According to her, a recipe approach to practice stems from the practicalities of running a financially viable practice. She suggested that her view might be somewhat idealistic and that when “people want to make money” and are “strapped for time”, it is easy to fall into the rut of following a blanket approach treatment across cases (P 2: 2:37 (498:504).

Dr Krause too is strongly influenced by the biomedical model of practice, what she terms the “scientific method” rationale of reaching a clinical diagnosis. Which, according to her, must be based on the available evidence with which the patient presents (P 4: 4:33 (139:143). However, what is also evident is the explicitly consultative nature of her approach to patient management:

> I don’t see myself in a dictatorial role at all. There as an educator, facilitator and where I can help, I will intervene so it is more a partnership to get the patient back where they need to be (P 4: 4:32 (364:369).

Dr James did not differ greatly from the biomedical model already expressed by the previous respondents. However, he did provide a rationale for why this model is appropriate to him. He contended that “focusing on diagnostics” has helped him avoid “potential downfalls” in his management and consequently has turned him into a better practitioner. “I can explain what I am doing and why I am doing it, and I can rationalise it in common terminology; it makes me more successful in practice” (P 5: 5:38 (224:245).

Considering that Dr James’ philosophical views are oriented towards fostering relations with allopathic medicine, his approach to management seems consistent.

Although a prominent theme in Dr Black’s approach to practice is also oriented to healthcare maintenance, his approach seems different from Dr Hussein. He claimed that ”what I can do for you is half the battle; the other half – the rest is what you can

do for yourself" (P 6: 6:25 (54:65), implying that the patient must take up the role of active participant in their own health. His approach can also be described as consultative as he progressively introduces more of these factors as the patient is able to cope with them. For example, Dr Black may start off with simple stretches and home exercises and work up to larger issues, like smoking, as the patient adapts to the management strategy. Through this approach, Dr Black therefore implies that, although a patient may consult him with what might seem like a purely musculo-skeletal problem, what he may end up managing is the patient's high cholesterol or stress levels.

A key factor, however, is that management outcomes are negotiated with the patient, so that the practitioner and patient can work towards the same goals. Interestingly, the management strategy includes integration with other healthcare practitioners. This is evident from the following example of chronic low back pain management:

> . . . having got my patient to perhaps change their lifestyle in some way or another, I reassess and from there on I will either continue or refer them out. The parameters are the intensity of their pain, duration for which they have had the pain and the frequency with which they get it (P 6: 6:26 (140:161).

Like Dr James, Dr Black considered the biomedical approach to management to be a safety net, one that has helped him personally to avoid and detect gross misdiagnoses (P 6: 6:28 (306:325)).

Drs. Grant and Manning are both firm adherents to the biomedical model of patient management. However, Dr Grant provided another rationale for why this approach continues to be useful. Apparently, it caters to his cynicism and at the same time has helped him "not just to accept what I read or what I listen to" and that, accordingly, it has made him a better practitioner.

Interestingly, he initially did not consider himself to have any particular philosophical view with respect to practice. However, as part of this response he re-visited this issue, stating that perhaps his "philosophy" may need reviewing. He consequently said:

> Perhaps it is a play on words, but maybe it's a philosophy of using a lot of the scientific method; I agree, perhaps that needs reviewing; so yes, maybe that is part of the philosophy by which I approach practice generally (P 7: 7:21 (214:226).

My impression is that he is strongly influenced by the positivist approach found in allopathic medicine.

According to Dr Rays, his approach is the one laid down by the founding father of chiropractic, which is that:

> . . . nerve interference in the spine is achieved when vertebrae in the spine are not sitting in the correct position and when these mal-positions are there for a long time, I think they can cause chronic states of disease in the body (P 9: 9:41 (50:58).

Accordingly, his approach to practice simply entails mechanistically reducing this lesion through spinal manipulation. In an established (chronic) case, Dr Rays negotiates the terms of management with the patient through the following:

> I can advise you that this treatment won't make you better in a week or two and you have got to understand that this is a long term situation, and you must be prepared to come and see me over the next month or two. Are you ok with that? (P 9: 9:43 (153:166).

This then sets up the scenario where the patient will pre-book a number of appointments, during which the practitioner will adjust the perceived spinal lesion. Interestingly, the level of the subluxation may stay the same, but it could also change.

It was difficult for me to establish the exact nature of Dr Armstrong's approach to practice from his response. According to him, medical diagnosis is a screening tool to establish if patients should be seeing him. However, he considered the diagnosis as "just naming what is going on in the body" and he therefore tends not to adjust according to this diagnosis. He contended that in the case of an apparent cervical condition, the cause may be in the lumbar spine and that he therefore would adjust or manage the lower back also. This he considered to be a more holistic view of the individual and argued that he is considering areas other than "just where they are having pain" P10: 10:40 (46:60).

As previously indicated, Dr Armstrong does not use any other modalities in practice, and it seems that his approach can also be classified as mechanistic. Whilst being quite aware of the interventions available to him, he considers these to interfere with

the effect of manipulation and hence chooses not to use any. Considering his vitalist stance, this would appear to be a consistent interpretation of management.

In summary

Three factors appear important with respect to the approach to practice a practitioner may follow. These are the importance of the diagnosis, holistic healthcare issue, particularly maintenance practices, and the mechanistic aspect of the chiropractor's actions. The first two tend to be grouped together so that it could be labelled as a biomedico-wellness approach to practice, whereas the last factor stands alone and informs a simple mechanistic approach to practice.

Although the first two approaches may achieve much the same in the acute setting, due to the use of spinal manipulation in both, the indications are that the first approach alone can substantiate ongoing patient management. This is because of its multi-factor approach to chronic patient management. Furthermore, with the lack of concern for even a basic diagnosis, there may be unanswerable ethical questions levelled at this type of approach. This is due to the practice of not labelling and managing definable and identifiable clinical entities or only doing so to "appease" the system. Healthcare insurers require a clear name for any clinical syndrome so that they can substantiate its validity and track the costs associated with it. Without a diagnosis, no such action is possible, which makes justifying a fee for service claim near impossible to verify.

6.3.3. The acute and chronic setting

The literature review indicates that there is a meaningful difference between acute and chronic patients and that consequently their management is often aimed at achieving different goals. The respondents, in keeping with this view, highlighted some of the differences according to their experiences.

Dr Levine considered the main problem with chronic patients to be that they become dependent on their practitioner. This, for him, is due to the more biological nature of acute conditions, which can be linked to direct markers like pain and stiffness, and also due to the short period of interaction between doctor and patient. According Dr Levine, what sits in the "back of his mind" is the idea of treating the patient and then discharging him/her. However, Dr Levine acknowledged that there are cases where long-term management must be undertaken and that consequently the risk of patient dependence is increased. Dr Levine alluded to the importance of an internal locus of

control, where patients see themselves as instrumental in maintaining their health, as opposed to looking toward the doctor as the provider of health.

Furthermore, in the case of a chronic condition, a positive doctor-patient relationship is central to successful management because the outcomes are based on quality of life and therefore have to be negotiated. In this regard, Dr Levine states:

> Mr. Jones, I think I can help you. You have had this problem for a long time and, to be quite honest, I think you are going to go on having the occasional headache, if I can get your headaches 80 to 90% better, will you be happy?" They say, 'Yes, I would be delighted' (P 1: 1:43 (335:373).

For Dr Krause, the actual treatment process used to manage acute and chronic patients does not vary significantly. What is distinctive about the chronic setting, however, is the role of constant communication between doctor and patient. According to her, effective chronic patient management depends on "how that doctor-patient relationship is set out from the start". Therefore, congruence of care features is a key factor in managing chronic patients. If this aspect is not developed, frustration builds between the parties, because "you didn't have a combined goal" at baseline (P 4: 4:26 (246:281).

Dr Krause added that what might also be different in the two settings is that acute patients tend to have a "more defined resolution period" (P 4: 4:36 (296:315). The reason for this being that the acute patient tends to presents primarily with a musculo-skeletal cause, whereas the chronic patient presents with a mixture of "musculo-skeletal, organic or psychosocial" causes (P13: 13:4 (9:26).

Dr Rays further highlighted the role of communication when treating the chronic patient, but at the same time also reconfirmed that in-practice treatment protocols do not vary significantly:

> Chronic patients need more management with interaction, discussion, explaining to them why it is going to take a long time. Acute patients, all they really want to know is how soon can their pain go away. My approach is distinctly different with both (P 9: 9:45 (228:235).

Dr Armstrong added more insight to the difference in communication in the two settings:

> My communication skills differ with the chronic patient; I have to educate them differently than the acute patient. The acute patient, I cannot talk to

> about chiropractic or about how the body is going to heal, because they won't hear it – they are in pain; so my focus is to assist in getting the body to self heal so that the pain goes away (P10: 10:32 (239:275).

From his response, it seems that Dr Armstrong reinforces much of the previous debate around this topic. It seems that in the acute setting, focus lies solely with the physical presentation of the condition and reducing these. However, in the chronic setting, the focus seems to include positive lifestyle practices and at the same time creating an awareness of quality of life changes.

According to Dr Krantz, chronic patients are more difficult to manage because they have more factors associated with their ailment(s). Consequently, they have to be more pro-active in their own healthcare, which increases the risk of relapses due to undesirable lifestyle habits (avoidable and unavoidable):

> . . . if they are not willing to help themselves either, make lifestyle changes, which in this day and age is difficult. I mean, if it is the job situation that is adding to the problem, nobody can leave their work situation fully and rest (P 2: 2:38 (223:235).

Dr Hussein contended that chronic patients require a multi-treatment strategy to ameliorate their clinical signs and symptoms, due to complex physiological mechanisms. However, this is not only effective with respect to affecting physical symptoms, but to psychological mechanisms as well. Dr Hussein argued that, when more time is taken treating the patient, the perception of a caring attitude is conveyed, which is beneficial to patient response:

> The people who have had a long history of low back pain, and there is lots of fibrosis and lots of inflammation, I would try to use as many modalities to treat the problems as possible . . . I feel that by using those different modalities, they definitely do have an effect on the outcome and then also the patient feels that somebody is not just – it is not just a matter of in and out of your rooms. They come in a lot of pain, and the pain is a big part of their life, and by spending time on the patient, they feel that something is being done (P 3: 3:40 (296:346).

Dr Manning stated very simply that, in the acute setting, his focus is "to get rid of the pain", whereas in the chronic patient, the focus shifts toward "rehabilitation, body strengthening changing the possible causative factors" (P 8: 8:29 (238:271).

Therefore, the indications are that chronic patient management takes place on more than one level, i.e. dealing with the clinical symptoms as well as possible causal factors.

Dr James considered the difference between the two setting to lie more in the treatment frequencies applied:

> . . . in a chronic condition, we get them over the acute phase and then try and get on a type of ‘maintenance’, but then they actually set the rules as far as that goes. Whereas a patient who is in acute pain, I then try to see fairly close together to get them over the acute phase as quickly as possible, and then once they are over the acute phase and their symptoms have resolved, I then discharge them (P 5: 5:40 (247:261).

This is an interesting comment because it considers the possibility that chronic patients experience acute episodes. It provides a further indication that the chronic setting, due to its more complex causality, requires a more developed management strategy; one which will, according to Dr James, include healthcare maintenance.

Dr Black highlighted three differences between the acute and chronic setting. The indications are that the management period is shorter and that the causal mechanisms are simpler. Furthermore, the outcomes for success shift from clinical to those associated with quality of life:

> Generally speaking, my acute patients, I tell them, I should be able to get somewhere with one or two treatments, often with one treatment you fix them, because they did it the other day . . . and you can perform the so-called 'miracle' that they think we are capable of. But, with your chronic patient, where they have had the problem for months or years, you are not going to get very far in one or two treatments. Two, three treatments down the line, all I am looking for in an improvement. From there I'll take it further, maybe when I get to the sixth treatment, I might have improved the quality of their lives sufficiently. I will never use the term 'cure' in my profession, because I don't believe we can cure many things, but we come pretty close with the headache that is there just because of a fixated neck (P 6: 6:30 (163:175).

Interestingly, Dr Black referred to the one treatment “miracle cure”, which is when an appropriate adjustment is applied to a biomechanical disorder, presenting acutely. In this situation, the practitioner is so confident in the interventions used by

chiropractors that he considers this scenario to be very close to providing a cure to the patient.

In summary:

Practitioners recognise that the context of management, i.e. acute setting or chronic setting, affects their approach to practice. The acute patient is simpler to manage, because there is every reason to expect a complete resolution of symptoms within a relatively short period of time. Furthermore, during the course of management not much is expected from the patient, except to passively report the changes in his/her symptom picture. In the case of the chronic patient, however, the priorities of management change, because chances of complete cure become less certain. The accent in these patients shifts to that of improving quality of life. Due to this shift in emphasis, the role of the practitioner accordingly changes and includes a greater degree of negotiation, counselling and positive reinforcement of the patient.

In the chronic setting, management can extend over a prolonged period and consequently requires the management process to be successfully negotiated and carried out. If this is achieved, the patient's outlook on health shifts to include positive lifestyle habits, which affect management positively.

The differences in managing a chronic *versus* an acute patient are summarised in table 6.2 below.

Table 6.2. Managing the acute and chronic patient.

Factor	Acute setting	Chronic setting
Practitioner	Prescriptive style	Prescriptive-consultative style
Patient	Passive participant	Active participant
Interim management goal	None	Est. and maintain. congruence of care Develop internal locus of control
Management outcome	Resolution of symptoms	Improve quality of life

6.3.4. Modalities in practice

Considering the mixed interpretation of the adjustment, it is important to understand how the adjustment is viewed relative to other treatment interventions present in the chiropractic scope of practice.

Dr Hussein stated that the spinal adjustment is the hallmark of the profession. However, it stands as one of a number of other treatment alternatives available to the

practitioner. The choice of usage lies in the clinical scenario and what might be required of the particular case being managed: “Well, I do have access to an ultrasound machine, IFC, TENS infra-red. Those are the modalities and then pure chiropractic treatment would be manipulation or mobilisation of the spine” (P 3: 3:15 (395:404).

Dr Hussein also indicated that the modalities used by chiropractic are, barring the adjustment, shared amongst manual medicine practitioners.

Dr James added a number of other therapies or techniques to the ranks of what can be termed treatment modalities. To him, the contemporary “mixer” practitioner will use “acupuncture, myofascial trigger point therapy, ultrasound, interferential current or even sometimes massage” (P 5: 5:17 (98:103).

Dr Black agreed with Dr Hussein and Dr James, but added that he tends to use TENS and electro-acupuncture regularly. In the acute patient scenario, Dr Black also uses anti-inflammatory medication (6: 6:15 (257:263).

Dr Rays and Armstrong, on the other hand, only use manipulation and identify solely with this modality. Dr Armstrong uses manipulation only because, according to him, it suits his approach and is therefore a personal preference (P10: 10:14 (29:36). However, Dr Rays considered this to be the hallmark of the profession and hence feels compelled to use it as a first choice management tool for all patients. As was seen in section 6.1.3, he holds the fundamental belief that those practitioners who do not use it as a first choice in their management are not practicing according to their given scope of practice:

> It is not distinctly chiropractic thing; I consider it a different profession . . . my first choice treatment is always the adjustment or the manipulation, but when I hear of chiropractors who’s first choice of treatment is acupuncture or massage, I go cold, because that is not what we are licensed to do (P 9: 9:30 (336:344).

In summary

It seems that chiropractors appear to have a unified understanding that modalities and physiotherapy techniques essentially mean the same thing and that there are various kinds of interventions, which can be used to treat the patient. They are mainly used as adjuncts to the main treatment intervention, which is the adjustment.

The interesting issue here is the variation in the use of adjunctive interventions. The variation tends to have less to do with the diagnosis and with what is required for the patient, and more with the availability, personal preference and philosophical stance of the practitioner.

Therefore, with the variation that is present in the use of modalities or therapies, there may be substantial perceived variation between the treatment protocols followed by chiropractors, even when they have been similarly trained.

What has emerged from the patient-practitioner interface?

It seems that the confines of practitioner-patient interaction is fairly well demarcated amongst practitioners. However, it also seems that differences in the interpretation of the constituents, i.e. management view, the patient-practitioner relationship, the patient role and the application of available modalities, could result in a significant variation in the manner in which chiropractic is perceived by the patients. If enough variation exists, it may cause doubt in the mind of patients about the exact identity of and the service itself that chiropractors offer. This is illustrated in diagram 6.3 below. Even two fairly congruent views on management can result in a theoretical angle of variation, which translates to two significantly different identities for chiropractic.

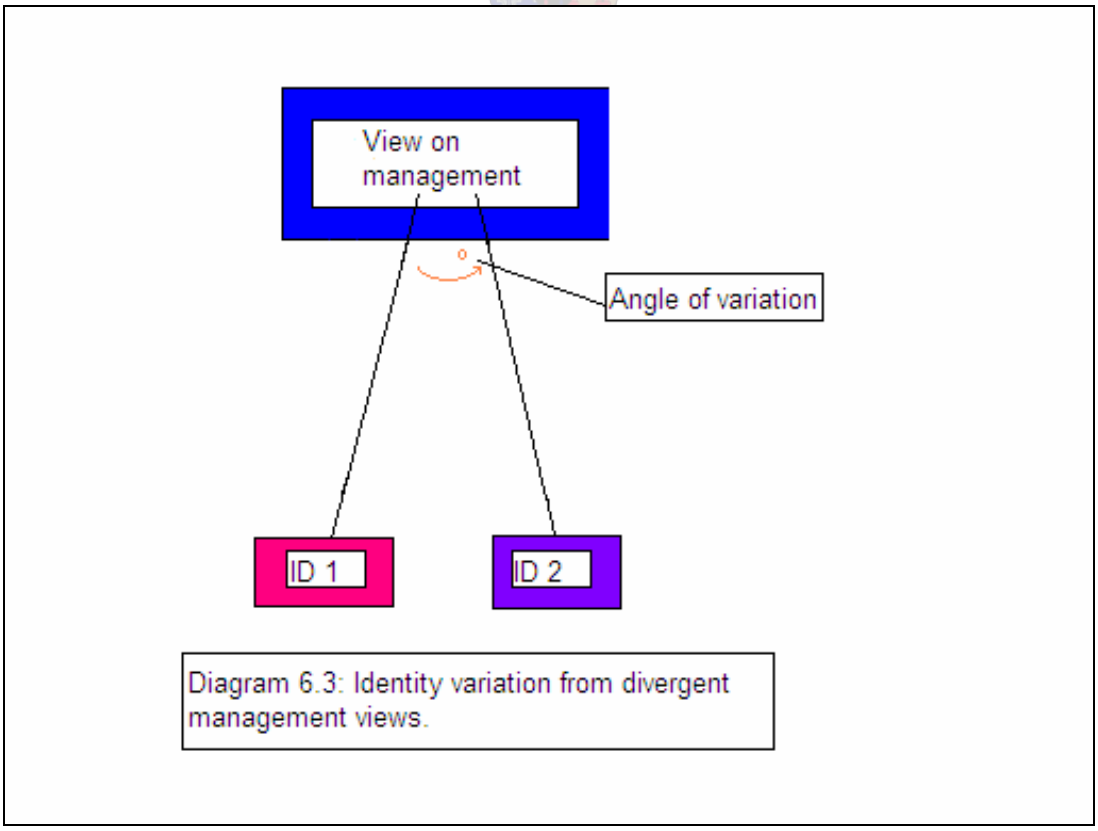


Diagram 6.3: Identity variation from divergent management views.

If we add the variation in philosophies to this theoretical view, the notion of a fuzzy chiropractic identity becomes an even stronger possibility.

6.4. Practitioner views on professional development in chiropractic

In the last section of this chapter, I will present data with respect to the development of chiropractic as perceived by the respondents. This data was gathered mainly from a questionnaire, during which I asked the respondents where they see the profession in ten years time and what changes they deem necessary to achieve this position.

Dr Levine considered chiropractic to be a distinct part of medicine that is not well understood by its healthcare counterparts. Therefore, creating a need for chiropractic services among these individuals is a required area of development. According to him, “Medicine is not really dependent on us – they should be more dependent on us” (P 1: 1:5 (26:36).

From Dr Levine’s response in the follow-up interview, the basis for this is that “medicine does not actually believe that manipulation is effective or safe; therefore they think they don’t need us at all” (P11: 11:16 (139:142). Greater awareness of chiropractic utility for medical practitioners should therefore be created.

According to Dr Levine, particularly public hospitals represent the access point with which to reach the general population. According to Dr Levine, “chiropractic is for the privileged in South Africa, it’s not open to the masses” (P 1: 1:45 (466:475). This causes two significant problems for the profession. Firstly, not enough black South-Africans identify with and choose chiropractic as a career and secondly, government cannot appreciate the relevance of the profession. This issue is pivotal to Dr Levine:

> “. . . in 10 years’ time, this program will not exist if we do not have black chiropractors. It is simply a matter of survival” (P 1: 1:46 (481:482).

Dr Krantz considered the integration of healthcare systems to be a priority for chiropractic’s future success. She argued that this process could have very beneficial implications for the profession with respect to inter-professional referral and access to hospitals. However, Dr Krantz also contended that the process will not be simple and will have to be considered carefully. Gains in integration and general acceptance

may be off-set by a reduction in status and professional autonomy, resulting in a dramatic shift in the profession's identity:

> . . . chiropractors would see that they no longer work for themselves, that they are at the beck and call of other specialists, but . . . there is an outside chance that that could work, because why should we be so proud as to try and hang on to any historical status that we've had if a chance is going to bring about positive growth and new dimensions, even if it does mean adopting the name manipulative therapist – it might expose us to other things that we haven't been exposed to in private practice. But, to try and work it all out would probably be very difficult and tricky, and there would probably be a heck of a lot of debate and argument and trouble (P 2: 2:39 (438:464).

Dr Krantz provided two further reasons why the profession may never be able to negotiate full integration with mainstream healthcare. She firstly argues that a number of chiropractors who want to "keep doing what they have been doing for years, because they are making good money out of it" will strongly resist strong moves towards medicine. Secondly, Dr Krantz suggested that the profession has a duty towards those loyal patients who have chosen chiropractic as an alternative to allopathic medical care to remain separate and distinct. However, Dr Krantz also states:

> . . . in this economic climate with the emphasis placed on primary healthcare, chiropractors aren't really in a true sense of the word primary healthcare practitioners, because we aren't dealing with the third world (P 2: 2:43 (403:424).

Therefore, Dr Krantz suggested that a professional shift would have to occur in chiropractic to assume its true professional role; that this will necessitate some integration, but that it is likely to be only partial.

For Dr Hussein, a pivotal issue for the future of chiropractic is to maintain its unique and distinct identity as the provider of manipulative therapy. In this, Dr Hussein considered integration with mainstream medicine to be a potential obstacle:

> You cannot be taken under the medical professions' wing – I personally wouldn't want that. I don't think it's necessary. But, I don't want that to happen and we get smothered into some stream and we just become some type of technician (P 3: 3:41 (479:488).

However, Dr Hussein also considered it important “to see chiropractors integrated with the medical profession, especially in state hospitals” (P 3: 3:42 (419:425), because there are many patients who would benefit from integrated management.

Dr Hussein furthermore stated that the profession should be seeking acceptance as a profession from the general public, rather than the medical establishment, and therefore should be creating awareness of its identity through distinctive brand marketing (P 3: 3:43 (183:188). For this to occur effectively, Dr Hussein stated that what has to occur firstly is that the profession rids itself of internal conflicts, like the “mixer-straight” debate.

For Dr Krause, the practice of chiropractic must become more evidence-based and more holistically oriented in the future, so that the intended scope of the profession can be utilised more effectively (P 4: 4:38 382:388). Furthermore, Dr Krause suggested that the profession currently does not have “a multi-disciplinary approach to teaching”, which allows the profession contact with the public sector (P 4: 4:39 (449:462).

For Dr James, the key developmental issue for the profession is that it develops a consolidated, evidence-base model of practice with which patients can clearly identify. This view is reflected in the following to statements:

> . . . patients often don’t have a clue what we are doing and that is a negative. So quite often you have to play the chiropractic missionary; what you are where you come from and how you are going to work on them. Not always a bad thing, but if chiropractic had a standardised approach, it would alleviate the problem to a large extent (P 5: 5:42 (50:60).
>
> They are going to have to substantiate their treatment of choice on a scientific basis – on a research basis (P 5: 5:41 (346:368).

Dr James furthermore suggested that, should chiropractic seek integration with allopathic medicine, the benefits may include increased financial reward from healthcare funders. However, like Dr Krantz, he fears that the profession would lose its identity in the process:

> . . . our reimbursements from the medical aids would be heightened and our benefits and patient benefits would be improved. The disadvantage would be that we then fall under their control, because we are a smaller profession and we'd lose our identity (P 5 5:43 (194:198).

Instead of seeking wholesale integration, Dr James suggested that the profession improve its approach to practice and bide its time until the number of chiropractors can provide a more powerful voice with respect to gaining "more political clout in dealing with medical aids and insurance companies, and with organisations like the road accident fund" (P 5: 5:44 (346:351).

Dr Black considered the greatest challenge to the future of the profession to be the threat of being "usurped" by the medical fraternity when they realise the usefulness of spinal manipulation (P 6: 6:13 (449:452). Consequently, he suggested that the profession proactively integrate with the rest of the medical fraternity, so that by the time spinal manipulation does become a standard feature of healthcare, it has positioned itself as the designated provider of the service. Dr Black suggested that the relatively small numbers in the profession is currently a stumbling block as it limits the finances available for "advertising and inter-professional development" (P 6: 6:32 (433:441). However, he did suggest that the profession could start building inter-professional relations from an academic discipline perspective by co-hosting scientific conferences with appropriate medical sub-specialties.

Dr Grant also supported partial integration with medicine on the basis of professional peers, much the same as dentistry, where chiropractic would be recognised as a mainstream medical practice, but retains its own identity:

> I am not suggesting that we integrate underneath or subordinate to medicine; I would like to see us integrated on a par with medicine so not necessarily loosing any identity (P 7: 7:25 (357:366).

However, he would also like to see:

> . . . chiropractors fully integrated into mainstream healthcare, including government and private hospitals. Working for the military and in the military, and being inculcated as being part of everyday patient perception, as what they might look for as a part of their healthcare management (P 7: 7:26 (349:355).

From this comment, it would seem that healthcare system integration is not as much about being accepted by medicine as about being recognised as a legitimate part of healthcare practice through its presence in public and private institutions.

Like Dr Levine and Dr Black, Dr Grant also suggested that the profession must broaden its appeal to allopathic medicine. Specifically, he suggested that chiropractic scholars have been preaching to the "wrong audience" and wider readership would go far to improve chiropractic's position amongst "the general practitioner and certain specialists" (P 7: 7:29 (418:424). He also concurred with Dr Krause that educational practices must become more integrated:

> I think separate education has a big role to play and if we can marry the education as they are now doing in Denmark, for example. That will go a long way to getting rid of these barriers (P 7: 7:30 (152:155).

The result of these two processes would essentially be to reduce the level of ignorance that exists amongst medical practitioners with respect to chiropractic patient management.

Dr Manning agreed with Dr James that chiropractic's identity is not clear and that through public, rather than intra-professional opinion, this should be clarified and then disseminated. He highlighted the problem well through the following discourse in which he also used dentistry for comparative purposes:

> . . . for me, it has caused confusion as to the identity of chiropractic, because you have a singular name of a profession, but you may be getting a totally different service from various individuals with the same title. You know we are paramedical like dentists and you go to dentists for dentistry. Can you imagine having your idea of what dentistry is, but there are some dentists out there who don't do anything with your teeth, they are mainly involved with measuring the tone in your Temporalis muscle and giving you bite plates? We know that exists in dentistry, so it is not a farcical suggestion I am giving, but

> should 20% of all dentists treat all dental disorders like that, I mean it is ridiculous. Certainly it is going to confuse the public and they want to know: 'if you are that kind of dentist that just does the biteplate thing, I want to know, because I have a rotten tooth' (P 8: 8:33 (391:404).

Furthermore, Dr Manning concurred with the notion of obtaining hospital rights for chiropractors, improving inter-professional relations and increasing the level of reimbursement from medical insurers.

Dr Rays also considered the range "in the principles that are applied" problematic, and would like to see the profession develop a more coherent identity with respect to the "product" that it delivers (P 9: 9:46 (33:39).. However, Dr Armstrong did not offer any clear suggestion about how this should occur:

> Our product description is not clear and it is difficult to describe our product – that is the point. This is my contention that we don't describe what we do clearly enough, because what we do is difficult to describe (P 9: 9:48 (207:210).

As a result, he would like to see the profession concentrate more on its role as manipulation specialist. He generally considered chiropractic to be developing well and suggested that other aspects like healthcare systems integration and "holding public office" will come naturally as the profession matures (P 9: 9:47 (326:334).

Dr Armstrong suggested that the chiropractic profession should embark on a campaign of changing medical thinking to a philosophy of chiropractors first, drugs second, surgery last (P10: 10:35 (354:373). He suggested that chiropractors become the gatekeepers of healthcare and that they, much as the general practitioner is now, would stand as the initial contact practitioner. The idea is that chiropractors would manage what they can and then refer appropriately those cases they are unable to manage.

In summary

Chiropractors do not seem to be recognised as important in healthcare by their mainstream medical counterparts, which has a detrimental effect on inter-professional referral. Hospitals are seen as a highly important access point for the profession in order to improve this relationship. However, an equally significant issue is the perception that entrance to the public healthcare sector will create an

increased awareness of chiropractic among the general populace. This is necessary to integrate the profession fully into the South African context. A general call for healthcare systems integration was also evident, which includes medical education. Integrated education is seen as an important tool with which to improve inter-professional activity. It was also widely commented that the profession's identity is not uniform, which poses a problem for the public seeking out chiropractic services. This view corroborates the argument I made at the end of 6.3 that the practitioner's interpretation of practice tends to determine the identity of the profession. This is because, although the treatment protocols might be similar, the approaches are not, which introduces the possibility of varied impressions, especially in patients.

The chiropractic profession is presented with three areas of improvement from the perspective of practitioners. These are a) its level of healthcare system integration, b) its level of institutionalisation and c) developing the coherence of its professional identity.

a) The inadequate levels of integration into the healthcare system are reflected in the poor inter-professional relationships with healthcare counterparts, as well as unclear pathways of referral to and from chiropractors.

b) The lack of institutionalisation is reflected in chiropractic's absence from hospitals, its educational "segregation", its relatively poor relations with medical insurers and the lack of governmental support.

c) A lack of professional maturity is reflected in the call for the profession to market its product more clearly in order to clarify the split image it seem to be portraying to patients, fellow medical practitioners, medical insurers and legislators.

From the literature review, I argued that a hybrid profession-discipline requires maturation and institutionalisation in order to become socially integrated. This integration affords the profession a power base, which in turn supports its ongoing existence and prosperity. The evidence presented suggests that the chiropractic profession has perhaps yet to attain an adequate power base, which will sustain it as an unquestionably legitimate entity in the mainstream healthcare sector.

Conclusion

This chapter initially set out to present evidence with respect to the state of the art of the profession from the perspective of the practitioner.

From the analysis of standard terms used in professional practice, it became evident that practitioners distinguish between two main views of the chiropractic identity – the “technician” or ”physician”. The technician has a limited diagnostic role, whereas the physician carries the full responsibility of a primary contact practitioner. The former has a narrow, pre-determined function of providing spinal manipulative therapy, whereas the latter is a patient manager, whose role varies depending on the presenting clinical complaint.

From a philosophical perspective, vitalist traditions tend to inform the technician’s view of chiropractic, whereas biomedical and holistic philosophy support the physician’s view. However, pluralist cognitive strategies are prevalent amongst the practitioners studied. Based on these interviews, a typology was constructed, which indicated that practitioners’ behaviours are over-determined by their beliefs and that these are used to maintain and justify behaviours, rather than change them.

When viewing the patient-practitioner interface, it seems evident that patient management differs between practitioners right from its conceptual understanding through to type and combinations of treatment interventions used. The effect being that chiropractors can function in a broad spectrum of practice approaches. This tends to vary from integrated, multi-modal and consultative to isolated, mechanistic and prescriptive, depending on the variety of interventions they employ or do not employ, and the associated wellness factors they consider or do not consider.

The overarching theme of this chapter is that the identity of a chiropractor is variable with respect to beliefs, philosophy and approaches to management. This is important considering that the developmental issues considered central, revolve around this very issue.

Professionally, chiropractic is not considered to have a coherent identity and is furthermore not adequately grafted into mainstream healthcare. This is reflected in its lack of institutional representation on at least three fronts, namely hospitals (public and private), governmental or political structures and healthcare insurers. This has meant that the need for chiropractic services, particularly from mainstream medicine,

is less than satisfactory. Therefore, the profession is currently a relative outsider in the healthcare context and the developmental strategies suggested are aimed at securing its scope of practice and consequently its position in healthcare. Based on this, chiropractic's suggested *modus operandi* are "integration on all fronts", even though it may at times be frustrating for practitioners.

On a disciplinary level, chiropractic is considered to be educationally segregated because its curriculum does not include contact with the public sector and other medical practitioners. Consequently, it is perceived to be relatively poorly integrated with respect to contemporary medical education.

It is my conclusion that views of field practitioners do not relay a coherent message with respect to chiropractic's identity, its approach to patient management and its role in South African healthcare. The profession is not fully accepted as a legitimate healthcare provider in the local context due to its relative lack of professionalisation and institutionalisation.

Chapter 7
Patients' experiences of chiropractic healthcare

7.0. Introduction

The chiropractic patient has traditionally been the profession's greatest ally in its struggle to be recognised as a legitimate healthcare provider. In Chapter 6, the evidence presented suggests that the chiropractic profession does not present a coherent image to the public. Nevertheless, as I will demonstrate in this chapter, the enthusiasm and belief on the part of the patients suggest a more positive view of the profession's contribution and role in healthcare. To this end, I will indicate why patients enjoy their experiences with their respective chiropractor(s), as well as the experiences they have in making the choice to receive "alternative" healthcare.

The results from the interviews with patients have been organised according to the following four broad themes:

a) The reasons why chiropractic patients experience frustration with the current allopathic system of healthcare (with general practice as an example of this);
b) Reasons why patients identify and shift towards chiropractic management for back pain;
c) The experience of patients with respect to healthcare by a chiropractor; and
d) Patients' views of professional development and healthcare integration pertinent to chiropractic.

These themes will be discussed under the following headings:

7.1 Patients' concerns with allopathic management;
7.2 The move to chiropractic management through key healthcare experiences;
7.3 The actions of chiropractors responsible for maintaining patient support; and
7.4 Patients' views on professional development and integration in chiropractic.

7.1. Patient's concerns with allopathic management

I will argue that the reasons why patients seek chiropractic management are motivated by a combination of push and pull factors. Push factors are those issues that benefit chiropractic, not due to any activity on the profession's part, but simply because it is perceived as an alternative to mainstream healthcare. Pull factors, on the other hand, tend to be activities that are attractive to patients, attributable to the

actions of the chiropractor. I shall elaborate on the push factors firstly because they tend to precede any activities attributable directly to chiropractors.

Perhaps the primary source of discontent with allopathic medicine is the wholesale prescription of pharmaceuticals by most general practitioners. This is reflected by the following frank and emotional statements by Alfie and Nazeem:

> I feel chiropractors make a big difference in our health, where . . . drugs really make you addicted to it (P 1: 1:3 (9:11).
>
> I hate medicine because, since 1997, I have had to take medicine for my continuous pain (P 1: 1:4 (24:26).
>
> . . . there are no drugs going down my throat. No injections and no drugs (P 2: 2:8 (54:55).

The prescription of medication is problematic for two reasons. Firstly, medication is considered to be addictive and secondly, its iatrogenic effects on organs like the liver are viewed very negatively. This is particularly relevant to the two respondents quoted above who were forced to take pain medication for protracted periods.

In this regard, it is not so much the strength of the chiropractic profession in terms of its healthcare provision, but rather the appeal its practice holds because of its drugless practice. Chiropractic's drugless nature is the first push factor I encountered.

Nazeem has accepted that a complete cure is not likely to be attained and therefore ongoing treatment will be required. In this, he considers the compartmentalised approach to management he has experienced in allopathy as inappropriate. His perception seems to be that the allopathic approach does not provide ongoing quality care and value for money:

> . . . definitely the GP cannot cure me. The hospital cannot cure me, so why must I sleep in the hospital or continuously go to the GP, when I come here to the chiro and I can get more done here then if I went to anyone of those two places? (P 2: 2:6 (42:45).

This appears to have created doubt in Nazeem's mind about whether the allopathic practitioners are motivated ethically:

> . . . my GP is there for the money. Anything that he does for me over and above what I go there for is money . . . and then he only treats you for the complaints you give him. If you tell him I have headache fine, here is twenty tablets, you will be ok. If you are not ok within three days, then you come back, I will change your tablet and give you more poison (P 2: 2:11 (78:86).

Value for money treatment might therefore be another push factor in favour of the profession.

A heavy reliance on medication, as well as lack of differentiation in the management of organic as opposed to mechanical complaints, seems to be the reason for Nazeem's shift of allegiance towards chiropractic. The classic, drug oriented allopathic approach patient management mechanical disorders does not make sense to patients on a pragmatic level. Therefore, chiropractic's image as a hands-on profession is beneficial in this regard.

This side-effect of allopathic management is viewed so negatively that it can be associated with a more general shift away from allopathy. This is noticeable, particularly in the case of Claire, who stated, "Well I only have a family homeopath. I only see the homeopath. I used to go to a doctor, but that has kind of fallen away (P 4: 4:8 (100:106).

Claire suggested that, besides the negative effect of medication on other areas of the body, the allopathic approach may not be appropriate for back pain management because it requires no active patient participation.

> You just go and buy the tablets and you have them, you don't have to make the effort to make the appointment, go, and perhaps go back again, to have it properly sorted. It is quicker to take the tablet . . . it is bad for your system, I mean your stomach lining (P 4: 4:12 (122:136).

Claire created the impression that she may have had a clash with a mainstream medical practitioner and because she experienced the individual as arrogant, the entire biomedical establishment was rejected:

> I think they like to think they have the answer to everything and I think it is also the way they are taught and they are taught to think. A lot of people just think like this, where you have to think laterally, if you really want to

> understand what is going on in the world. A lot of people have their one direction and you can stand on you head, you can do anything, but they are just blinkered (P 4: 4:20 (231:236).

In this instance, it is once again not the actions of the chiropractic profession that are instrumental in the systematic move, but rather the general shift toward alternative approaches to health, perhaps due to a dislike of the allopathic practitioner(s). A general shift in cognitive strategies could therefore be viewed as the fourth push factor that leads patients to chiropractic offices.

Liz considered general practitioners as too generalist in their training. She therefore consults area sub-specialists for management. In this instance, she considered chiropractors as the appropriate practitioners to manage occupational, biomechanical injuries.

> Oh, the GP is too general. You have got to go to a specialist. So as far as I am concerned, I would rather go and see someone who has studied that only (P 6: 6:6 (84:86).

This process, rather than an outright rejection of allopathy, constitutes a pragmatic rationale for self-referral: “I just think the GP is too general medically; whereas here we are talking posture, which is related to the way we work and the way we bend. I mean therapists generally end up with chiropractors or physios (P 6: 6:10 (131:133).

Liz, unlike Claire, seemed to have a good relationship with her general practitioner. Her move to chiropractic is thus less likely to be due to a general shift from mainstream medicine. I specifically asked her whether she had a more trusting relationship with her chiropractor than with her GP, to which she replied, “No, not necessarily, I think” (P 6: 6:25 (297:302).

The fifth push factor is thus pragmatism, where a discerning patient recognises the “right person for the job” and consults him/her directly, rather than paying the general practitioner a consultancy fee, only to be referred.

In summary

The patients indicated that mainstream medicine does not offer a consistent, value for money service in the management of mechanical disorders. It is also viewed as one-dimensional and heavily reliant on pharmaceuticals. Furthermore, a sub-group of

patients did not fundamentally adhere to the views of mainstream medicine anymore and therefore they have generally moved from allopathy toward complementary and alternative medicine. The modern patient has become a discerning “shopper” in the area of healthcare and wants to see the appropriate healthcare practitioner without the general practitioner levying fees as the intermediary. These then represent the push factors indicated by patient respondents. They tend to benefit chiropractic by attracting and maintaining patients without any action by the profession specifically aimed at building or maintaining patient loyalty.

7.2. The move to chiropractic management through “conversion” experiences

In the Kuhnian context, conversion experiences are required for a new paradigm to gain adherents. These conversions are considered to be acts of faith during which scientists accept the new paradigm by an act of will, rather than on the strength of prevailing evidence (Kuhn, 1996: 93). This is not what I had in mind when considering the more incisive patient experiences associated with shifts towards the chiropractic profession. Nevertheless, I decided to retain the term in order to reflect the emotional content that is often part of these changes.

From the respondents I was, however, also able to isolate a number of events that specifically led patients to “experiment” with alternative medicine for the management of their back pain. In one instance, it was the inability on the part of the respondent to accept the prognosis given by allopathic medicine, “big specialists at St. Augustine's hospital that had said go home and live with your problem or we are going to cut your leg off, and I got the biggest fright of my life and that is when I was introduced to chiropractic” (P 1: 1:13 (109:112). This was coupled with a final, desperate effort to find help:

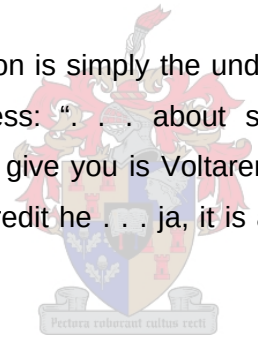
> I have tried all the other routes; I have tried medicine, I have tried the praying route, I have tried any other route. I have tried Panados, migraine tablets and an hour or two later, I feel that the condition has come back and that the tablets have not helped and that I still have to lie down and then I go and see my chiropractor and two hours later I seem to be rid of the problem (P 1: 1:5 (30:35).

For Nazeem and Claire, it was a gradual move toward alternative healthcare (chiropractic) due to their positive exposure to chiropractic coupled with a general shift from allopathy, with respect to back pain care:

> If I continue with my GP, he will love me because I was all the time feeding him. I have stopped my GP. My whole family, if they have a problem, they come to the chiro. Whether it is a stomach problem, or a hip problem, internal, external, they come to the chiro. Even a newborn two months old from Johannesburg comes here (P 2: 2:20 (160:165).

> I think perhaps it started off with my daughter when she was little; she was on a whole lot of anti-biotics and she just kept on getting sick, so I eventually started her on homeopathy and took her over to homeopathy completely and the chiropractic, I don't know, it just seemed more logical, if you have something wrong with your neck, you should go to person who can sort it out, you don't go to your GP all the time (P 4: 4:6 (90:95).

Perhaps the most obvious reason is simply the undeniably positive results achieved during the management process: “. . . about seven years ago, GPs couldn't really help me because all they give you is Voltarens and that didn't help until I got to xxx and I have to give him credit he . . . ja, it is alternative and it worked for me” (P 5: 5:4 (58:61).



”Conversion” experiences frequently motivate patients to use chiropractic services and they occur as a combination of passive and active processes. The profession has benefited passively by being a last resort or as being part of a general shift to CAM, for instance chiropractic and homeopathy. However, the profession has also benefited from the active process of providing effective management, which is perceived as beneficial by the patient. Therefore, I shall label this a push-pull factor due to its hybrid nature.

7.3. The pull factors in chiropractic responsible for patient support

Chiropractors must somehow secure patients as firm supporters of the profession because chiropractic does not form part of the established referral system, and it consequently has to rely on word of mouth to broaden its patient base (Langworthy & Birkelid, 2001). Therefore, it would be interesting to develop a view of how this process might occur.

In my view, the respondents' insights show how this reinforcement takes place in three interrelated areas:

a) They were made aware of and agreed with the conceptual merits of this approach to healthcare:
b) The agents of the paradigm were effective in "selling" its merits; and
c) The manner in which patients engaged with their management process indicate active involvement in this process.

Firstly, it became evident that respondents identify with a biomechanical approach to management, which they perceive as appropriate for the mechanically oriented illnesses from which they suffer.

Alfie and Jock both expressed the view that spinal alignment or the lack thereof is responsible for their dysfunction as their spines are "pulled out of shape". Chiropractic management apparently has the ability to rectify this (P 1: 1:2 (15:19) and (P 3: 3:2 (10:11).

Nazeem used a motor vehicle "alignment" metaphor to articulate his understanding of chiropractic management:

> . . . because I can walk out from here and two hours later I could cause . . . just like doing wheel alignment, you can drive out with the car and there is no guarantee, because you can climb over a little pebble and your alignment goes off. So I can go and walk haphazardly and fall off the pavement and I can hurt myself again (P 2: 2:9 (56:64).

This has a clear biomechanical connotation, but it also has implications for maintenance care, as I would find out in a later interview with Goldmann:

> If you want to go to full-scale maintenance treatments, I think it makes sense – and for no other reason than, surely, if we look at most people and even think of ourselves, you go through a month's worth of life, some of the small peccadilloes that happen, you know a slip here, a fall there, your body could use a little bit of mechanical work so often. I often use the example of a car, I won't go into all of it, but it reminds people that you have to take care of it, have it checked out every so often.(P 3: 3:50 (187:194).

The pertinent issue here is that the mechanical imagery assists patients to understand the nature of the disorders chiropractors generally manage. These are

often functional rather than pathological and, because they are strongly associated with lifestyle factors such as exercise, physical therapy is considered the appropriate route of management. This is confirmed by Nazeem and Claire's comments respectively:

> . . . chiropractor always explains to me the relationship between my pain and that part of the moving . . . that moving part. My lifestyle could affect my posture (P 2: 2:13(94:96).

> . . . it just seemed more logical, if you have something wrong with your neck you should go to person who can sort it out; you don't go to your GP all the time (P 4: 4:7 (93:95).

> She has given me all sorts of exercises to do for lower back and for my neck and given me advice on doing proper exercise and things like that (P 4: 4:13 (145:146).

With respect to "selling" the merits of the practice paradigm, one might argue that the practitioner acts as the agent whose responsibility it is to secure patient loyalty. In this context, securing patient confidence is central to reaching this goal. With respect to confidence, Alfie, Jock and Liz provided interesting responses. Alfie's adherence to chiropractic seems to stem from the strong element of trust built into his relationship with a number of chiropractors:

> Well, I have three chiropractors that oversee me and I think they are the most greatest people out . . . I think that any doctor (chiropractor) can be your friend, where medicine cannot be your friend (P 1: 1:10 (74:89).

This consequently translates into a general confidence, which allows him to unreservedly acknowledge his use of chiropractic services when consulting an allopathic practitioner: No, I like to come straight down the line. I will tell the guy, listen, I have seen my chiropractor, but I would like your opinion (P 1: 1:23 (200:205).

Jock generally considered the profession as being most able to assist him:

> I feel also that, personally, with my own body they have done things that physiotherapists could not do. Maybe over a longer period the physiotherapist could have done it, but for me they have done in a day what physiotherapists take maybe two or three weeks to do. So, therefore, they have relieved pain for me quickly (P 3 3:5 (11:16).

He also has confidence in his personal chiropractor, which stems from a successfully negotiated management situation, including specifically the negotiation of consultation fees:

> X and I have been very good friends for a long time and I have got a deal with him, which helps me financially, so it makes it easier for me to want to do what I have to do. I think the important thing for me is what I have to do (P 3: 3:9 (99:102).

> There are quite a few aspects to what makes me happy now, because I am going to a guy regularly and he knows my body and he is therefore adjusting me according to the progress, what ever he sees as important (P 3: 3:13(144:146).

However, he reiterates his belief in the ability of the profession to help him as generic to its practitioners, on the proviso that they exhibit an attitude of interest and readiness to negotiate the management process: ”I think that any chiropractor can do for me what xxx does, if they are interested” (P 3: 3:15 (173:176).

Whilst Jock’s response, as with Alfie’s, suggests that a close relationship is instrumental in developing confidence, Jock’s response is rooted more in pragmatism. He is firstly of the opinion that the chiropractic approach is most successful in managing his condition and secondly, that a certain type of chiropractor, one who is prepared to take time with his case, is able to best assist in his needs.

Liz expressed a low level of confidence in one specific chiropractor, due to an early referral, which she deemed unnecessarily conservative:

> Are you talking about one specific chiropractor or in general? Some are better than others and some are better with specific problems, definitely. I have been disappointed with my results before, where I was referred, where I did not think it was necessary to refer me. I think that they could be a little bit over cautious sometimes . . . Yes, and reduced my confidence (P 6: 6:17 (214:223).

However, she also stated that she has now found a chiropractor in whom she has total confidence as the manager of her particular complaint: “I wouldn't let anybody else touch my neck. I wouldn't even let anybody massage my neck (P 6: 6:5(73:94).

From these respondents, it appears that confidence can have both narrow and broader implications for chiropractic. All three respondents exhibited high levels of confidence in their practitioners. This in itself would be fairly unremarkable, because it could be argued that many patients have confidence in their allopathic practitioners. In fact, evidence for this was present for both Jock and Liz, who considered close doctor-patient relationships not to be specific only to chiropractic (P 3: 3:37 (244:255) and (P 6: 6:25 297:302).

However, what is of interest is that the confidence displayed by these two respondents is assigned to the profession and not the individual practitioner. The inference one could draw from this is that, in promoting themselves successfully, practitioners also establish or reinforce confidence in chiropractic by conveying the merits of the profession. As the established healthcare model, allopathy in its entirety is less likely to be doubted in terms of its utility, with a poor outcome rather placed at the door of a “bad” practitioner. However, in the case of chiropractic, this might not be the case. Hence patient confidence is perhaps of greater importance to chiropractors as an indication of professional acceptance in the eyes of patients.

The only text that expands on whether and why chiropractors might develop a closer relationship with their patients than general practitioners came from Marie, who said:

> Yes, I think so. It is not so formal, it is far more informal, more relaxed. It is longer intervention, whereas with your GP it is fifteen minutes and you are out . . . You are more comfortable (P 5: 5:5 (67:91).
>
> . . . I think you are a little bit more relaxed because there is a trust relationship and you know that the person is going to do something with your back for which he has to build a rapport in order for you to relax. I think if you go in and adjust immediately, I don't think I would have been that relaxed, I would probably be quite tense . . . because I don't trust easily; so therefore I would tense up whereas if you take time with me . . . (P 5: 5:5 (67:91).

It is evident from this response that the close relationship between patient and chiropractor tends to have a specific purpose, which is to create the necessary trust required to perform manipulative procedures. However, one could argue that this would be a requirement for all physical medicine practitioners, who at times require patient relaxation, for instance physiotherapy, massage and acupuncture.

It therefore seems likely that in the chiropractic context the agents of the profession have to establish confidence and trust in their patients for two reasons: a) to secure the role of chiropractic in the mind of the patient and b) to enable the chiropractor to perform manipulative procedures for which relaxation is required.

Compliance is a sought after commodity when managing chronic patients. It performs two important functions considered central in achieving success. Firstly, it assures that the instructions of the clinician will be carried out over time and secondly, it instils in the patient a sense of active participation (internal locus of control). A management protocol that will secure these components should therefore be not only agreeable to the patient, but must actually co-opt the patient as a partner in order to function optimally. Successful management protocols end in successful management, which is then attributed to the profession's competence. Gauging from the level of positive interaction participants exhibited in their management, it seems that chiropractors are able to develop such protocols in conjunction with their patients.

The responses of Alfie, Nazeem and Jock, all of whom are chronic back pain sufferers, indicate that the negotiated management process has given them the ability to take control of their own health, to establish their own healthcare goals and the belief that these are ultimately within their reach:

> Yes and that I have set my own goals. Well my goal is to have normal life, not to have a form of disability over my head and to have freedom of mobility (P 1: 1:26 (247:265).

> Very beneficial, it tells me what I must not do. If you do that then this is the result, negative result (P 2: 2:14 (99:100).

> Yes, X has always enlightened me as to what he is trying to do, what he is going to do, what he, what he hopes to achieve. This last period, over this last nine months, I have actually felt better, less pain in my leg, not because he has been telling what he is going to, it is because he has been doing it, and I have been going back for that regular maintenance thing and I think it is the most important thing (P 3: 3:20 (265:281).

Specifically, in Nazeem's case, the increased control seems to have led to a feeling of empowerment and pride: "Oh, I feel very proud that I am associated with the chiropractor. I feel very proud when I walk into this place" (P 2: 2:23 (194:201).

Claire's sense of control over her health seems to be accompanied by the view that control equate to responsibility. Her response, I think, highlights the fact that she is prepared to face the consequences of not performing her allocated component of the negotiated health management contract. However, the responsibility is a small price to pay it would seem, for being capable of controlling her own health status:

> I much prefer it, because it means I have more control of what is happening to me and I am quite happy for that. Because then it seems that they are actually looking for a long-term solution to your problem, they are not just making you come back all the time. You actually can do something to help your situation along. And if you don't do it, like I don't do it, then you . . . then you have to have your neck put back in again.
>
> (The issue of control, and you mentioned that you feel like you have control. What is the effect that that has on you?)
>
> It means that if you don't take the advice, what follows after that is your responsibility. It is not the chiropractor's responsibility. So if you do the exercise, it will improve, but if you don't, it is going to get stiff again and it is your own fault. So I think responsibility is probably a better word than control.
>
> (And do you think that it is a fair situation?)
>
> Yes, I think so, because then you are more involved in getting yourself better. It is not a matter of somebody waving a magic wand and making you better. You have got to see it more holistically, it is the whole system (P 4: 4:15 (153:180).

I found the response above particularly pertinent, not only because it provides further confirmation of patients identifying with the type of management offered by the chiropractor, but it also provides an indication of patient maturity in accepting the role of personal healthcare provider. This is similar to Dr Manning's view that not all patients grasp holistically oriented healthcare and consequently are incapable of accepting the responsibility (P 8: 8:36 (73:84).

A further indicator of active participation was evident in Alfie and Nazeem's ability to temper the need for an outright cure with realistic perceptions of successful

management. The best examples of this were evident in the following responses from them:

> Yes, I do expect a cure for my condition . . . with the research on RSD it has shown that it has affected my back, because of the uneven walking; the discomfort of the walking, and then it does affect my back, especially my lower lumbar area, where I then struggle to bend forward and then I have to come for treatment, because the uneven walking causes the back pain . . Well, we know that RSD takes a long time to heal, they have not found an exact cure, but the research on the RSD has shown that if the rest of the body is lined up comfortably and properly it makes the RSD easier, because the sympathetic nerves do affect the back's nerves as well (P 1: 1:7 (44:69).

> I have been told that it is never going to be correct. I have been told lots of things. I have been told that I have six lower lumbar vertebrae, I have heard that that is a big problem seemingly, an extra vertebra. I feel that the fact that I keep getting it is that I am never going to be a hundred percent cured . . . They certainly improve my quality of life. I have gone to him in chronic pain and I have a golf match the next day and I am thinking that I am never going to be able to play and I go in there and he treats me and I can play golf and I don't have after effects (P 3: 3:17 (216:239).

Alfie and Nazeem were both aware that they suffer from intractable conditions (Reflex Sympathetic Dystrophy and a congenital sixth lumbar vertebra). However, they are also aware that these diagnoses do not preclude them from living a relatively pain-free life, experiencing a high quality of life and remaining functional. Therefore, their outcomes for successful management are accordingly aimed at recognising improvements in these areas, rather than a reversal of their initial diagnosis.

The diminished importance of the “cure” concept is perhaps most apparent in Liz’s response. She clearly articulated the notion that the arthritic process, from which the diagnosis stems, cannot be reversed but “looking after it” is the manner in which to prevent pain. I thought Liz’s response was particularly sophisticated, because she recognised that her “cure” lies not in attempting to reverse what is essentially an

irreversible pathological process, but to successfully maintain a pain-free status through appropriate measures.

> If we are talking about degeneration, you can't have a permanent cure, but you can look after it in a way that you will help or prevent the pain. So pain, yes, cure probably not . . . realistically (P 6: 6:4 (59:72).

> It is not so much that I don't expect a cure, it is that you have to maintain your back. It is just that once you have had back pain, you always have to look after it. So you need to go for regular maintenance, because the inflammation comes and goes. Whatever, the nerve entrapment, etc (P 6: 6:18 (229:233).

Jock and Claire also suggested that healthcare maintenance practices are essential to coping with back pain. Exercises and stretching, in particularly, are seen as that part of management that falls under the ambit of patient responsibilities and, if not kept up with, are instrumental in reducing their level of health (P 3: 3:31 (417:427) ; (P 4: 4:9 (111:115).

The table below provides a summary of the maintenance practices highlighted by patients.

Table 7.1. Health maintenance factors identified by patients.

Factor	Sources
Exercise	1:27(147:147),3:32(232:232),4:25(66:66),4:26(146:146), 4:27(171:171),4:28(267:267),6:33(279:279),6:34(280:280).
General lifestyle	2:24(95:95),6:26(22:22),6:27(25:25),6:28(25:25), 6:30(115:115),6:32(279:279).
Posture	2:25(95:95),6:29(106:106),6:31(132:132).
Maintenance visits	3:33(89:89),3:34(92:92),3:35(111:111),3:36(270:270), 4:29(268:268),6:35(231:231),6:36(291:291).

From the responses, it would seem that respondents engage actively with the management process in the following ways:

a) Respondents tended to develop a sense of responsibility (internal locus of control) for their own health though the management process;

b) Respondents are quite sophisticated in their ability to appreciate successful management and distinguish this from their need to be cured; and

c) Respondents accentuate health maintenance practices, such as exercise, which they consider important to overall management success, but not a factor that is the responsibility of the chiropractor.

Although they do not provide grounds for generalisation, one could argue that these factors may contribute to a positive view of the management provided for this group of patients.

In summary

From this group of respondents, it would appear that three broad factors generally influenced their experiences under chiropractic care. These can be classified as the pull factors of the profession. Firstly, they seem to identify with the rationale from which their practitioner(s) approaches clinical practice. In this instance, respondents seemed to identify positively with a biomechanical view. Secondly, this group deemed it important to develop a sense of confidence in their practitioner, which is associated with confidence in the profession. Thirdly, they tended to develop an independent understanding of cures *versus* healthcare practices, and believed that healthcare maintenance plays an important role in assuring ongoing quality of life.

If we include the hybrid factor mentioned in 7.2, four factors emerge that may keep a patient loyal to the chiropractic paradigm due to the direct actions of its agents. This is illustrated in Figure 7.1 below.

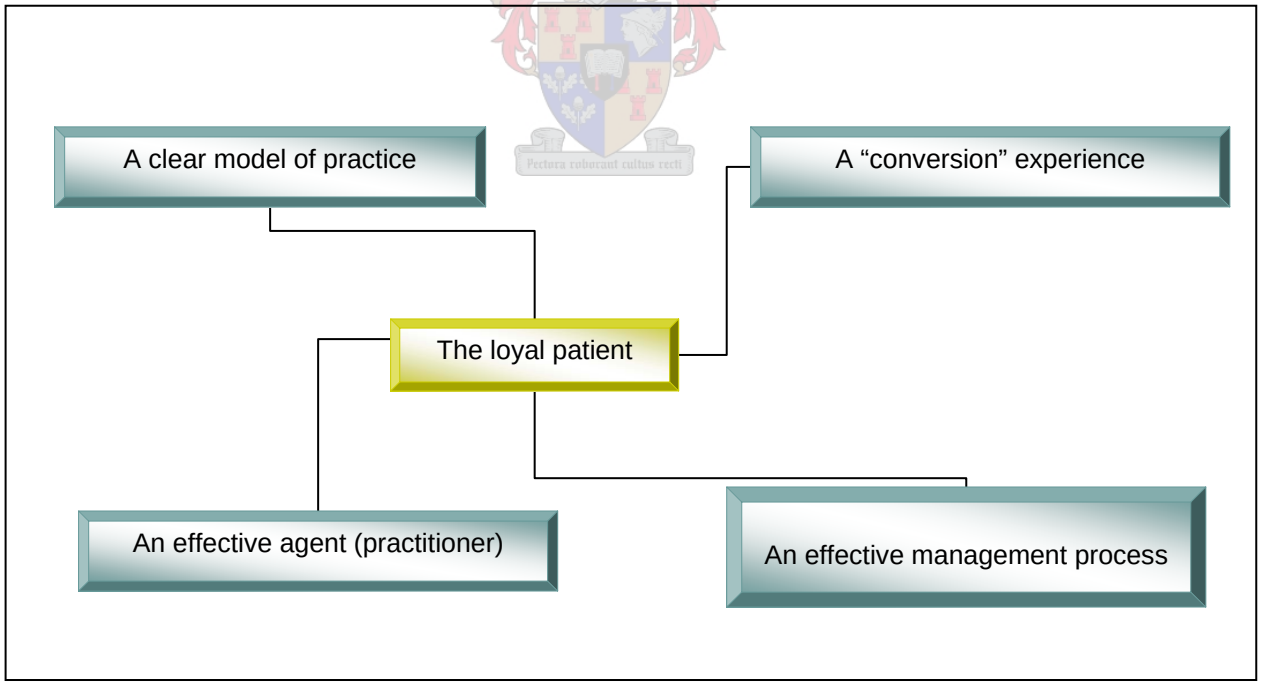


Diagram 7.1: Factors that tend to maintain the loyalty of the chiropractic patient.

This diagram illustrates that patients keep consulting chiropractic practitioners for at least four different reasons and, in most cases, probably because of a combination of two or more. Therefore, the profession should, in its strategy to secure a growing

patient base, take cognisance of these in order to optimise them. Strategies that might aid in this endeavour would include educating chiropractors in developing these qualities, ensuring via the professional association that the public can clearly identify chiropractic practice and constantly updating management protocols in order to keep demonstrating the required utility.

7.4. Patients' views on issues of chiropractic professional development and healthcare integration

Having developed a view of how patients come to consult chiropractors and why they tend to remain loyal to the profession, what remains to be discussed is their views on chiropractic in the local context.

The respondents, in particular Alfie and Marie, classified chiropractors as musculo-skeletal specialists, who effectively manage their patients through physical therapy, with spinal manipulation being the dominant intervention: "Well, chiropractors manipulate us and we feel better afterwards" (P 1: 1:1(9:11).

> I think they adjust people's backs, especially pain, in terms of lower back, that is my knowledge . . . That is their specialisation field (P 5: 5:1(9:25).

According to Alfie and Jock, they reduce pain and discomfort by improving spinal biomechanics. This process is perceived to reduce symptoms rapidly when viewed in relation to the management procedures of physiotherapists for similar conditions:

> A manipulation is where you get massaged and you find out that your bones are not lined up properly, and that is where your discomfort comes from; and your discomfort is where your chiropractor can then line up your spine and you can feel much more comfortable, and that discomfort causes you sometimes to walk uneven and this can cause a skewed back (P 1: 1:2(15:19).

> Well, they have relieved me from pain many times. I feel that they put my body back to the shape that it is supposed to be. I feel also that personally with my own body they have done things that physiotherapists could not do quicker. Maybe over a longer period the physiotherapist could have done it, but for me they have done in a day what physiotherapists take maybe two or three weeks to do. So therefore they have relieved pain for me quickly (P 3: 3:1(10:16).

It is interesting to note that Alfie considered soft tissue massage to be part of the experience of receiving spinal manipulation. This is perhaps an indication that the two are often used together by practitioners.

The scope of practice of chiropractic, on the other hand, does not seem clear cut. For instance, Nazeem consulted his chiropractic on just about any health matter: “a physiotherapist and a GP put together still does less than what the chiropractor does . . . If I have stomach pain, I phone my chiropractor and ask, what do I do?” (P 2: 2:2 (8:31).

Claire, on the other hand, considered the profession to specialise mainly in the musculo-skeletal system, although it has broadened its use of modalities in its specialisation field:

> Well, I would agree that that has actually changed over the years; they put the body back into alignment, but there is more muscle work involved now. Whereas before you used to go and they used to just click you back into place, now there seems to be they relax the muscles first and do various other things before they actually get to putting the actual vertebrae back into place (P 4: 4:1(9:14).

Liz too considered the scope of practice to be broader than just the musculo-skeletal system. She considered the profession to be involved more with wellness practice, which she interpreted mainly as considering lifestyle factors as possible causative factors: “I think it is not just adjustments and massage; I think it is more of a wellness, more general health, not just treating specific problems to the whole skeletal system”.

> (Would you say from your experience that chiropractors focus mainly on the skeletal system?)
>
> No, not really, not in my experience . . . for me personally it helped me with a lot of things. Just my lifestyle, the reasons it was happening. It wasn't just going to have it sorted out; it was also to prevent it happening and that sort of thing. It makes you more aware of what you are doing wrong; more of a lifestyle . . . change your lifestyle (P 6: 6:1(9:25).

The role of the chiropractor in the healthcare system, according to these respondents, varies from a fairly narrow musculo-skeletal function to a primary contact general physician.

Another interesting view of chiropractic pertains to the education of its practitioners. For Alfie, chiropractors receive a more desirable type of training because “GPs want to stick a tablet down your throat as quick as possible”. Chiropractors, on the other hand, are perceived as having a more direct, causal approach to managing back pain, due to the hands-on nature of their interventions (P 1: 1:17(150:160).

Nazeem considered the training of chiropractors and general practitioners to be very similar, with a minor variation being that chiropractors are further trained in manual therapy: “From what I have read in the clinic here, the chiropractors go through the same mill as the GPs and they have to also do chiro work. The GPs just do GP” (P 2: 2:16(111:113).

Jock’s view of chiropractic training is very different:

> I would think that we have been led to believe that GPs have a more structured and longer period and more intense training, more in-depth training than you guys. I think that is the perception that the public has got.
>
> (And in your view?)
>
> Well, I would go along that route. It is my personal feeling that the GP probably has, I am battling for the words here, that he has got a more in-depth training with regards to what they can do for the human being and I would never want to be a GP (P 3: 3:22(285:295).
>
> Yes, the public have a misconception about people who go and train as chiropractors, what is the degree of education they have had prior to going to university to become a doctor or to become a . . . Is that what you are talking about?
>
> (Yes that is something that I would be interested to know about.)
>
> Well, I feel that anybody, I don't know why I have this feeling, but I think that anybody can become a chiropractor, whereas I know that to become a doctor, you have to have a certain prior education. That is my feeling. Not to knock the present people who are doing the job, but I have just seen from . . . I have never been involved with people at universities, doctors, but I have been involved with the technikon and the guys who go around there and I think to

> myself. I don't know what degree of education they have, besides my conception (P 3: 3:24(317:331).

Jock initially suggested that the general public view is that general practitioners receive a more in-depth training than chiropractors do, which he then politely endorses. However, on deeper questioning, he firmly stated that chiropractors not only receive less in-depth training, but that the requirements, with respect to prior education, are lower for chiropractic students.

Marie suggested that, if there is an overlap in education, it lies in the basis sciences as well as clinical training (P 5: 5:10(143:147). Liz reiterated Alfie's view that chiropractors tend not to receive instruction with respect to medication, which extends into pharmaceutical research: "I would say GPs research medicines more, much more, whereas chiropractic has got nothing to do with medication really (P 6: 6:11(139:148).

She considered chiropractors clinically competent and believed that chiropractors focus on manual interventions, which she considered appropriate. Interestingly, Liz was also aware of the duration of the training of chiropractors in South Africa (P 6: 6:13(159:173). She also considered chiropractic training to have evolved and improved considerably:

> . . . but I think the more modern, or the training today, is much better than what it was years ago. So I prefer going to the more up to date chiropractors from my point of view and so I recommended to go to someone who had just qualified and that is what I did (P 6: 6:2 (34:40).

However, what is further interesting to note in Liz's response with respect to training is that chiropractors rank alongside, or slightly higher, than physiotherapists (P 6: 6:16(192:209). This is interesting because, as I will demonstrate later, this rating tends to correlate with Liz's ranking of the profession's status in the healthcare hierarchy.

Because the literature suggests that chiropractors mainly rely on word of mouth, it seemed pertinent to ascertain whether this was also the case for these respondents. However, as it turned out, this group suggested at least two different ways in which they sought out their respective chiropractor. Jock did make use of word of mouth in seeking out his chiropractor: "I hurt my back and someone told me about a

chiropractor they knew at the golf club, and I went to this guy and I got great relief. So I have been a regular for thirty odd years" (P 3: 3:7(79:82).

Claire sought out her chiropractor initially for neck pain, after which she received care for her low back also. She does not specify, however, how she came to see the chiropractor initially: "I have always had a stiff neck. My tension goes to my neck and I tend to get headaches, so that is why I initially went and my lower back also goes out quite a lot" (P 4: 4:2(23:30). However, the indications from the text are that she was not referred by another practitioner and instead went on her own volition (P 4: 4:10(38:46).

In Liz's case, the indications are that her chiropractor was recommended to her. However, whether this was a referral by another medical practitioner or a member of the public is unclear: ". . . he was recommended to me, because I had been seeing physiotherapists and I wasn't getting enough results, but I had also seen a chiropractor years ago and I wasn't fully convinced . . . (P 6: 6:2 (34:40). My interpretation of her response is, however, that she most probably received an informal referral and not one via the physiotherapist treating her at the time.

Considering these responses, it would not be possible to conclude that chiropractors still rely solely on informal referral roots. It is therefore my view that the evidence at my disposal is inconclusive on this matter.

When I asked patients where they would rank the profession in the hierarchy of healthcare professionals, the following views were expressed. Alfie and Nazeem indicated earlier that, on the grounds of training and the type of management they had received, chiropractors rank higher than GPs (P 1: 1:20(173:179); (P 2: 2:17(122:124).

Jock considered chiropractic "not to be a big deal" and considered chiropractors to rank lower than physiotherapists, suggesting that chiropractors are not pro-active enough in developing their public image (P 3: 3:4(38:42). He also said that, "If I am going to look for pain relief for my back, I am going to go to x (chiropractor's name), that is where I would go first" (P 3: 3:23(299:308).

This suggests that Jock distinguished between the status of a profession and its ability to manage health disorders effectively. In Jock's case, status is not determined

by usefulness. This was not the case with Alfie and Nazeem, who both assigned status based on their personal healthcare experiences.

Liz considered chiropractors to have a lower status than general practitioners have, based on her views on the training of the chiropractor. However, she considered chiropractic's relative "new-comer" status to be changing. She expected that, as its recognition improves, so too will its professional status as a legitimate healthcare provider:

> That is an interesting one. Not really, because it is only in recent years that chiropractic has sort of started climbing the ladder in recognition. So, I would say 'no' it hasn't been, but it will get there. It could be getting there; there is a definite place for it (P 6: 6:14(182:185).

There is no indication of what the markers of recognition might be other than not being new. The data does not provide a clear indication whether status and utility are linearly correlated.

Marie views the chiropractic profession as having an equivalent standing to any of the other healthcare professions. In her mind, this equivalence is grounded in chiropractic being an independent healthcare profession:

> No, I see them at the same level, because they are professionals in their own field. Maybe because I have been involved with alternative medicine for so many years and myself in so-called alternative medicine . . .
>
> (You are referring to your own profession?)
>
> Yes, as a psychologist. To be honest with you, if you say to me, if you say to me chiropractor as compared to, example, a specialist in medicine. So you, if you say to me, a specialist compared to chiropractic, then I will see a difference there. I don't know . . . that is just my perception. People like your GP that studies further, your anaesthetists, that sort of thing, but that is specialisation (P 5: 5:13(171:185).

Marie's view of chiropractic's relative status stems from her experiences as a psychologist in which she seems to have been considered as an alternative healthcare provider at some time. She therefore seemed eager for chiropractic not to be seen in a similar light because it represents an alternative view to allopathy.

Whilst the respondents unquestionably supported the chiropractic profession, there did seem to be uncertainty about the position of chiropractors in the healthcare hierarchy. This could be interpreted as an indication that chiropractic has not yet found an accepted niche amongst the healthcare providers of the country. The uncertainty over chiropractic's position is highlighted by the responses to the levels of antagonism between it and mainstream medicine.

Alfie is not sure whether antagonism exists or why it does. However, he has never been persuaded to consult chiropractors: ". . . the GPs and the specialists that I have seen have said, stay away from chiropractors, so I don't think they like chiropractors" (P 1: 1:22 (190:198).

Nazeem firmly believes that GPs and chiropractors are antagonistic towards one another. According to Nazeem, patients find the drugless approach to management more appealing and therefore GPs dissuade patients from seeing chiropractors for fear of losing their patronage to a preferable management approach (P 2: 2:19(140:153).

Jock believes that the antagonism between chiropractors and general practitioners is beginning to change. He considers this to be because of reports reaching general practitioners about the positive results achieved through chiropractic management.

> I believe lately, I believe there has been a change. This is just something I have picked up among chiropractors and doctors, that there seems to be more respect for one another. I think that chiropractors are now looked on differently from the medical profession . . . I think possibly among peers and so on that word of mouth has gotten back to the GP, that they are getting good treatment (P 3: 3:26(344:360).

Claire perceived the level of antagonism between the two camps as still high and that it is due to the fear of competition on the part of the general practitioner. She considered this to be a result of ignorance with respect to the functions of chiropractic and medicine.

> I think there is still a bit of antagonism, whether it is fear of competition, but I get the impression that general practitioners are hesitant to refer to chiropractors. The competition that may or may not be there, it could actually just be a perception and GP's and chiropractors . . . I think competition

> probably comes into it, but also they think they know better then anybody else (P 4: 4:21(241:242).

It is interesting to note that she suggested that the competition between the two groups may just be a perception, and that in reality they might not be competing over a common patient pool to the extent perceived. Furthermore, Claire contended that some of the antagonism between the two groups could be ascribed to allopathic practitioner arrogance in their belief that their approach to healthcare is superior to that of the alternative group of healthcare providers.

Chiropractic patients recognise that chiropractors and allopathic practitioners have been at odds for a number of years. However, they also perceive a change in the relationship between these two groups and that integration of healthcare is necessary.

In summary

Three broad themes were “extracted” from patient responses with respect to the chiropractic profession. Based on the classification of chiropractic and the perceived scope of practice, one can argue that the role of the chiropractor in healthcare is still unclear. Similarly, the debate over education and professional status indicates an uncertain and changing position for chiropractors amongst the fraternity of healthcare providers. It also seems that the level of healthcare integration for chiropractic is still relatively poor when viewed in the light of inter-professional communication and perceived antagonism. Although patients seem unanimous in their support of chiropractic utility, the above-mentioned issues cast doubts on whether chiropractic is accepted as an unquestionably legitimate profession.

Conclusion

In the minds of the patients interviewed in this study, the strengths of the chiropractic profession lie in a) its social desirability and b) its healthcare utility. Socially, chiropractic has benefited from fairly rapid patient healthcare shifts away from mainstream healthcare, caused by frustration and powerfully negative experiences. However, slower shifts in patient healthcare philosophy toward holism in particular have benefited the profession due to its association with this philosophical tradition. Furthermore, the nature of the relationship between practitioner and patient is perceived as distinctly positive because it reinforces healthcare maintenance practices.

In the area of healthcare utility, the biomechanically oriented management protocols are desirable to patients, not only due to their effect, but because they reduce the level of iatrogenesis brought on by long-term drug use. This was particularly noted in the case of chronic patients for whom management is ongoing.

However, the social desirability and the utility of the profession are counter balanced by a perceived lack of academic institutionalisation and professional integration. The uncertainty over academic standing is reflected in the debate over professional training and the levels of education of chiropractors. Some respondents voiced doubts about whether the calibre of students who embark on a career as a chiropractor, as well as the level of education imparted in chiropractic programmes, is equivalent to allopathic healthcare. With respect to professional integration, patient perception is that chiropractic still stands outside the conventional referral pathway. Patients find this perplexing as incomplete integration perhaps implies less legitimacy.

I therefore conclude that, for this group of patient respondents, chiropractic in South Africa enjoys both social desirability as well as healthcare utility. However, chiropractic cannot claim unconditionally confirmed professional status because of the uncertainty about its quality, its training and the unconfirmed niche area amongst mainstream healthcare providers in the local context.

Chapter 8
Researcher perspectives on the chiropractic philosophy, research and practice

8.0. Introduction

This chapter concerns itself with the views of researchers on state of the art and development issues related to philosophy, research and practice in chiropractic.

As the researchers I interviewed are both scientists and clinical practitioners, I anticipated the interviews to cover not only material related to chiropractic's investigative paradigm, but also its paradigm of practice (Coulter, 1993). This was indeed the case and therefore data related to both research and management will be presented and discussed.

8.1. Cognitive strategies and philosophical stances among researchers with respect to chiropractic healthcare and research

Like the practitioners, researchers not only observed the development and current status of philosophy, patient management and research in chiropractic, but they had an opportunity to internalise it as part of their personal beliefs and views.

In this section, will present quotations related to personal beliefs, cognitive strategies and philosophical stances as a means of introducing the reader to each individual.

These initial views are not a comprehensive summation of the respondents' personal views on philosophy in science, but rather their responses to the ones highlighted by the literature review, which I used as a basis for developing interview questions. These included the six metaphysical tenets discussed in the literature review, concepts like science, biomedicine, positivism and the notion of paradigms in chiropractic.

Hayes was aware of and even receptive to meta-physical theories in chiropractic. He considered it imperative that as a scientist or scholar he should focus on operational aspects so that empirical facts inherent in these theories might become apparent

> I don't think I ever rejected, some people I know rejected the entire chiropractic premise . . . I don't think I ever did that, but I tended to focus on narrow, I am a neuro-physiologist, so I focused on narrow neuro-physiological

> theories and believed that I could explain everything in neuro-physiological concepts (P 1: 1:24 (173:178).

Hayes specifically stated that the approach he chose was neuro-physiology and that he has become an adherent of this discipline through which he explained aspects of the ”chiropractic premise” related to nerve function and energy flow. It is interesting to note that Hayes considered it necessary to step out of the chiropractic domain in order to access a scientific discipline he considers best able to investigate questions pertinent to chiropractic. He consequently chose neurophysiology as the (possibly legitimate) vehicle through which to answer questions relating to the chiropractic paradigm traditionally viewed as part of vitalistic philosophy.

Hayes was fundamentally loyal to chiropractic: “I have always been a chiropractic patient, so I never lost faith in the treatment as a method of treatment” (P 1: 1:25 (178:180). The faith he exhibited was grounded in his experience as a patient and hence the effects of management rather than the scientific discipline of chiropractic. Hays’ faith in the profession seemed furthermore to be grounded in role modelling because his father was a chiropractor (P 1: 1:45 (301:311).

However, his cognitive strategy seemed also to be influenced by a self-critical and anti-dogmatic view of healthcare. According to Hayes, this attitude has led him into situations of conflict with those who have chosen not to question chiropractic in the way he has:

> I think where I got into conflict with large numbers of the profession was where … people, who rejected science as part of their rejection of medicine, somehow bought into a philosophy, which I consider non-chiropractic, that the subluxation was god and they ignored issues of classic innate intelligence and healthy lifestyle and so on . . . Chiropractic is basically the promotion of a healthy life and an adjustment when you need it and they got into ‘everybody needs an adjustment every day or every week’ and ignored the health, and I think my greatest conflict occurred in that separation . . . I felt that that movement was non-scientific and non-chiropractic and I think that what we are seeing now is that the research is backing the original chiropractic theory of healthy environment, healthy individuals, promotion of health with some manipulation when you need it, as opposed to the using of the ‘subluxation’ as a god issue (P 1: 1:28 (182:197).

Hayes viewed dogma and the central importance placed on the “subluxation” as contrary to the ethos of health promotion. To Hayes, manipulation is one intervention that might lead to attaining this goal. Therefore, it should never be raised to a pseudo-scientific (meta-physical) level and used as a rationale to indiscriminately manipulate every patient.

In this discourse, Hayes hints at the idea that vitalistic principles (innate intelligence) are alive, well and progressing beyond the domain of meta-physics. The next section of text provided a further useful insight into the reason why Hayes developed the type of cognitive strategy he exhibited:

> Oh ya, I think that vitalism, if interpreted correctly, as a force within the body that has the capacity to heal, given the right environment . . . We still don’t know . . . we have no adequate scientific explanation of what makes a living thing versus a dead thing. I mean we talk in terms of genetics and DNA . . . but when it comes down to everything is still there in a dead person. It is not doing very well, but all the pieces are still there and so you have to still philosophise over what it is, what makes a person or plant living *versus* dead. So this is vitalism and chiropractors have called it innate intelligence, others have called it chi, any of a number of different words, and what I think is happening is that public is starting to intrinsically believe and the medical model that ignored that has basically led to some isolation of the medical world from their patients and has encouraged the growth of complementary healthcare. I think that it gets too systematised, like in acupuncture, looking for all the various points; I think it is not going to work if it gets systematised and focuses on something called subluxation. I think that is going to be unrealistic. But, I think that vitalism in its broader context is going to come back, not go away (P 1: 1:31 (202:219).

It seems that Hayes still utilises metaphysical concepts, such as holism and vitalism. He does this specifically because science has not yet been able to explain key processes like human animation. This pluralistic cognitive dynamic, i.e. not entirely based in science or meta-physics, seemingly allows him to entertain “loftier” ontological views, whilst at the same time realising what is operationally achievable.

It seems that at some point Tusker held certain philosophico-theoretical views about chiropractic and the nature of the relationship between the nervous system and spinal manipulation congruent with classical philosophical thinking within chiropractic.

However, these have shifted considerably, to the point where he even tended to dissociate from its inaccurate, confusing and value-laden language:

> . . . I have changed on the notion that the nervous system is the centre point of chiropractic. I don't think it is. I think it is one venue of expression of problems that happen when this subluxation lesion occurs and personally, I don't even like the term subluxation; it has too many definitions. Too many people use it in different ways, and two chiropractors can use it and you still don't know what they mean. I have come to the conclusion that the primary problem is a mechanical disorder, that it has mechanical side effects. That those mechanical side effects are either local or remote – I probably said that wrong – the mechanical effects give side effects that are either local or remote. Local being inflammatory tissue changes, etc and remote being reflexic or neuro-physiologic changes that may occur (P 2: 2:21 (128:145).

Consequently, Tusker adopted an operationally grounded philosophical stance aligned with a classical view of biomedicine and biomechanics. I could find no indication from his responses that indicated a link with metaphysics. In fact, Tusker seemed intent on avoiding issues of philosophy related to chiropractic and instead focused on the more tangible aspects of the profession. Consider the following discourse:

> For me, the alternative approach is to step back from the preconceived notions of manipulation and to begin to recognise that manipulation apparently has some kind of role; we may not know what it is. So, perhaps the best thing to do is to become more integrative in incorporating more medical, chiropractic and other CAM procedures into the availability. Even to the extent that chiropractors who are so interested or so inclined, there ought to be a venue for those who are interested for using pharmacy to be adequately and appropriately trained to incorporate pharmacy, because it is of value and benefit to the patient. When you have one stop shopping, when you have appropriate utilisation of services being it manipulation or medication, the patient gets what they need in one location. Not to have two visits, two costs, delayed time, etc. So, my view of the alternative for the future is integration and integration on the individual doctor training basis, as well as integration between doctors of disparate training (P 2: 2:19 (86:1000).

Tusker's position was that the welfare of the patient is the most important. He used this as a platform from which to argue that, should it be necessary for chiropractic

to alter its identity to achieve this goal, then such steps should be taken. In redefining the chiropractic's role, Tusker placed little importance on chiropractic's image of being drug-free (therapeutically conservative), or that it has philosophical views divergent from allopathy (holism and vitalism). These seem to be stumbling blocks in achieving intra- and inter-professional healthcare practice assimilation. If we follow this type of thinking to its logical extremes, the implications are that a new "breed" of healthcare practitioner may arise and that the chiropractic profession may cease to exist.

Goldmann was very frank about the influence of beliefs and philosophical tenets in chiropractic: "Well, maybe the best way for me to answer that is to say that I am a strong holist and a complete anti-vitalist" (P 3: 3:31 (385:390).

He defended his position by arguing that, in scientific investigation, a certain amount of systematic thinking (reductionism) is required as part of hypothesis testing. This is difficult for holistic and vitalistic thinkers to reconcile because in essence this means doing exactly the opposite of what the tenets espouse, i.e. compartmentalising. However, to Goldmann, holistic or vitalistic principles must be exposed to this type of activity because the metaphysical tenet in themselves do not constitute adequate bases from which to motivate clinical interventions.

> I think that those who have used the word holism or vitalism on the one end of the so-called polarity have, in a sense, hidden from their dark side – what they would consider their dark side, let's say, then they would need to operationalise things in reality. What does that actually mean? And when you speak it out and operationalise it in a language that could be the language of science, the language of mathematics, the language of just . . . verbal language, and when you specify it in the real world, unless you are like a Kantian who says that we can never. Then, if you specify it in the real world then you can approach it from a scientific point of view and science automatically is 'reductionistic' because it does that very thing. It says, I am going to look at this little chunk right now of the world and I have to be able to control it otherwise I get chaos, etc. etc. And even if you do it in a very different paradigm, as they do come along in science, you know the quantum paradigm, or the chaos paradigm or whatever it is you are still doing in science. You are still applying reason and observation to the effort and trying to do it in a somewhat systematic way (P 3: 3:58 (204:223).

To him personally, there existed no conflict in applying the scientific method to hypotheses generated from holistic/or vitalistic principles. In this regard, he considered vitalistically motivated practitioners to have avoided this and consequently considered them to have dodged their societal responsibility of substantiating clinical practice through empirically defendable investigative traditions. He contended that the basis for this, rather than being rooted in philosophical purity, is simply the fear that their theoretical claims might be disproved.

> I see no contradiction between taking any hypothesis that might come from a so-called philosophical domain, let's say, and applying scientific methods to them so that they end up being either useful or not useful in a clinical setting. We don't have . . . we can't claim it is a right of ours to be able to do whatever we want in society. It is basically a privilege . . . to take your great wisdom and ideas and ply them out there. You need to be reasonably thought out and reasonably successful. You can't have people wandering the streets claiming all sort of things, like quack doctors we used to have many years ago; that is just not on anymore. Now if you say that the real pole is between the metaphysical and anything called physical-materialistic, then I think that is a polarity simply by definition. So, if you have a belief system that the things that are important to you are operating in this supernatural, metaphysical world, my simple response to that is: 'Send me a postcard' (P 3: 3:20 (220:233).

Therefore, Goldmann's criticism of vitalism was not so much levelled at the metaphysical *per se*, but rather at the perceived actions of its adherents. Perhaps if there were more evidence of a systematic endeavour, regardless of the results, to operationalise vitalistic theories in the chiropractic context, Goldmann might not hold the position he currently holds.

Goldmann inadvertently provided evidence that this might be the case in the next segment of text, which actually concerns itself mainly with holism. Goldmann's disapproval of vitalism is due to his disassociation from those who claim it as one of their philosophical principles. He contended that practitioners with a limited understanding of holism tend also to be influenced by the flawed vitalist view that patients should receive spinal manipulation on a regular basis in order to maintain the flow of energy through the body and hence maintain good health.

> Yes, there can be oddly enough a narrow holism, which is obviously oxymoron in a way . . . narrow holism means to suggest that the only thing

> one has to do to keep well is to just keep coming in for maintenance adjustments. I mean, the chiropractors who maintain that and then insist that there is holism coming out of that have, I think failed to realise just what I have said, which is that it seems odd to pin all of one's holism onto a single approach. But, of course, that approach also reflects that that brand of chiropractic can never distance itself from the vitalistic idea as well, so that there is a constant conjunction of vitalism and holism in that model; but if you say to a patient your condition, having been chronic, may require some supportive benefits, maybe help prevent you from some recurrences, which are very common anyway. And that is just the limited manipulation side of it, but that you begin to use that as an entrée into that person's life, which is reflecting what I said before. Your wellness carries on after your acute symptomatic picture has disappeared (P 3: 3:44 (683:700).

Therefore, although Goldmann accepted holistic thinking, this acceptance was not wholesale and was based on an interpretation other than that of "vitalist" practitioners. He accepted holism as a belief on the basis that, if interpreted appropriately, it has the potential to support a greater level of integrated practice than the current, widely accepted biomedical model. However, it must evolve beyond the point of being supported solely based on belief systems in order to lead to significant development in healthcare.

> Even in the medical model, the role of the nervous seems to be very important, but they just don't seem to recognise it as such. They are so used to, and so committed to, the development of pharmacological means to deal with things that they in a sense don't quite seem to see the forest for the trees, and we are on the other end having very much a nebulous, holistic approach, that has the forest, but we don't seem to be able to log a single tree out of it. We need to have some mapping out of our ideas onto basic physiologic and patho-physiological research. The longer we don't have that, the longer these ideas just seem airy-fairy. The just don't map out onto reality and the more you need a belief system to sustain them (P 3: 3:46 (373:383).

It was my impression from Goldmann's responses that what he held most sacred is the endeavour to provide evidence, not so much the evidence it may or may not produce. In this, vitalism has fallen short of his expectations.

Glover is both a chiropractor and a medical practitioner, which in a sense makes him somewhat of a “hybrid” practitioner. It would seem that receiving a dual education did much to develop the belief in chiropractic. This was because biomedicine at the time was no better off with respect to evidence-based management of low back pain than chiropractic.

> What was also an eye opener was that, at least at that time, medical education and medical practice, really wasn’t a hell of a lot better off in terms of science base than chiropractic was at the time, and that really a lot of it was hogwash. I think it broadened my horizons very much. It allowed me to put the strengths and weaknesses of chiropractic and the chiropractic profession into perspective. Whereas before that perhaps . . . If I hadn’t have done medicine, I would imagine that I today would be a very self-critical, discontented chiropractor who would put down most of what the chiropractors did, because I would think that medicine was sort of very, very good and it is not (P 4: 4:7 (117:135).

For Glover, the role of metaphysical constructs in contemporary chiropractic had become defunct. Although these were important in the days pre-dating contemporary scientific investigation as a basis for motivating clinical practice, his view was that they no longer informed the ontological views of practitioners. He considered a “natural science philosophical base” to be the uniformly accepted frame of reference in the Danish chiropractic context.

> The philosophical base for chiropractic as I see it, as it is in Denmark today, is pragmatic, natural science philosophical base. There is no world-encompassing superstructure. Adding on to that, I think that the whole superstructure and the whole chiropractic philosophy essentially was created by people who in the early days, around the 1900s, were trying to explain some phenomena where they really didn’t have the tools to explain them and then they made this philosophical universe, which could explain them. Which is perfectly ok, and without it, the profession would not have survived, but I mean now we have gotten the building stones from science, which allows us to explain those things rationally. So, we don’t need the superstructure anymore and therefore we also have to be willing to say, well it was a good thing, we’re glad we had it, thank you for coming, we put you on the shelf (P 4: 4:11 (166:178).

It is interesting to note that Glover considered the use of supernatural entities (the universal intelligence concept in chiropractic context) as a “philosophical universe”, whereas in contemporary chiropractic practice, it is seen as a “pragmatic philosophical base”. This imagery perhaps illustrates the downgrading of the role of metaphysical traditions as secondary to scientific investigation.

Besides Glover’s lack of use for metaphysics in general, he considered the term to be a vessel for unethical practices. Glover argued that vitalism, or what he terms “fundamentalism”, is unethically used as a marketing tool in private practice and as a quasi-religious motivator to attract students to sub-standard chiropractic programmes (P 4: 4:5 (94:103).

In summary

From the limited “snapshot” of the four respondents, and using only their respective views on metaphysics, it appears that:

a) Hayes is eager to see some sort of justification for previously held metaphysical theories by contemporary research;
b) Tusker envisions a re-defining of a profession based on healthcare needs, even if it means a reinvention of its identity;
c) Goldmann would like to see holism developed through an appropriate investigative paradigm and an assumption of responsible roles for those touting holistic and vitalistic thinking as part of clinical practice; and
d) Glover sees no further need for considering classical “chiropractic philosophy” and advocates assimilation with a positivist-empiricist view of biomedicine.

Individual ontological stances vary considerably. However, operationally they seem to share a common cognitive strategy. Whilst each individual has a distinct vision for chiropractic, they share the common practice of not allowing beliefs and philosophies to exist on the same level as science. Although they may consider philosophical views to be at the root of many scientific theories, they require empirical evidence to motivate their pragmatic cognitive strategies.

8.2. The reactionary chiropractic research paradigm: Comments on its nature, importance and structure

According to Chalmers (1982), the common sense view of science contends that scientific knowledge is proven knowledge. It functions on the premise that scientific theories are derived in some rigorous manner and are based on the facts of

experience derived from observation and experimentation. This view was derived from the scientific revolution of the seventeenth century and essentially stands as a rebuttal to the deductive teachings of Aristotle. Chalmers dubbed this view “naïve inductivism” and argues that its appeal lies in “the fact that it gives a formalised account of some of the popularly held impressions concerning the character of science, its explanatory and predictive power, its objectivity and its superior reliability compared with other forms of knowledge” .

Tusker seemed to consider this as the appropriate structure for science. In the context of clinical, experimental designs in chiropractic, he argued:

> Science is supposed to start with a simple observation and hypothesis building, and development of preliminary studies and preliminary work before you ever get to a randomised trial. Because of political pressures, or whatever reasons, we have often jumped from hypotheses, and sometimes not even formal hypotheses, just philosophical tenet to randomised trial (P 2: 2:32 (18:23).

Tusker’s view suggests that the profession conducts research in a reactionary manner due to political pressure, rather than in a manner that reflects the orthodox view of scientific progression. Specifically, Tusker considered the lack of conceptual thinking and consequent hypothesis formation to be the missing ingredients.

Goldmann too would like to see chiropractic research take on a structure more like the standard view of science, what he terms “proper” science. However, he added an interesting anecdote about why pragmatism, in the chiropractic context, must be of primary importance:

> I mean the phrase we used to use about the guy who stole from banks. The judge asked why he did that and he said, ’That’s where the money is’. So, you have to go with your strength, and it was with low back pain, and once you embark on proper scientific investigation, you adopt the biomedical standards as you have alluded. So, you have to do that in what appears to be somewhat of a reductionistic, hypothetically minded, quantitative approach for the most part, in order to get the results that people were looking for (P 3: 3:25 (322:329).

Goldmann argued that the profession must target areas where key empirical substantiations potentially lie and that this is to be done in a manner that will provide

the most compelling type of evidence. In chiropractic, this area has traditionally been spinal manipulation and the approach, reductionist and quantitative.

Goldmann also stated that “the notion that research always precedes treatments in the biomedical world is probably a bit of a myth”. In chiropractic, researchers are going to have to accept that clinical practice will most probably precede research endeavours. In this, he considered chiropractic to be in the opposite position to allopathic medicine in general, where a degree of scientific testing tends to precede clinical practice:

> There is a lot going on that is somewhat empiric. Having worked with general practitioners for example, you tend to take on that approach because you know that any drug you are going to prescribe, for example, has been through complete, scientific testing, I don’t mean to validate the testing, but at least you know the testing has been done . . . chiropractic again, looking at the big picture, it is very much the opposite. It is the cart leading the horse sort of thing, and the researchers have always felt that we are playing catch up ball, as we say here in North America, with the practice community, and it is like the tortoise and the hare. I don’t think we are ever going to catch up because practice is a well-establish situation out there now. It has had its history, its time to set roots and I don’t think you are going to see the science lead practice in that way. It will more or less fill out and broaden, and provide more of a support and certain (P 3: 3:43 (661:679).

Because chiropractic developed through clinical practice and not in relation to the application of basic science research, the profession finds itself in the position of “retrofitting” its activities with scientific substantiation. This can be a difficult position to be in, because no assumptions can or should be made with respect to the nature of phenomena being investigated, even though they may have been in use for some time.

Goldmann therefore implied that the manner in which chiropractic research evolves challenges the assumption of the standard view of science that it informs practice. In his view for the development of the chiropractic investigative paradigm, Goldmann did not consider developing a research paradigm like that of biomedicine to imply adopting the philosophies and practices of biomedicine. Consequently, Goldmann argued that avoiding science, whilst preserving a distinction between paradigms, i.e.

scientific *versus* non-scientific, does little to reduce the level of ignorance of practitioners.

> Solving some of these problems and getting on with business. We have made so much needless importance out of all the stuff we have talked about here, in the sense of each of us trying to stake out some kind of distinctiveness and uniqueness and, to get back to the comment I made before about what I think is the insecurity or inferiority complex that I see and the compensation for that, which is apparently the opposite, is really a level of ignorance about many of the things that go on in the bio-scientific world (P 3: 3:49 (237:243).

Thus, scholars in chiropractic research must feel free to apply all relevant information or practices developed through basic sciences in order to develop chiropractic's research paradigm. Furthermore, their thinking must shift from the notion that, in doing so, they will somehow lose the chiropractic identity.

The following passage, although lengthy, provides an important link with some of the previous comments relating to the nature of the chiropractic investigative paradigm. This brief historical account from Goldmann's perspective indicates that research in the biomedical tradition played a key role in establishing the credibility of clinical practice in chiropractic. Specifically, the vast number of the clinical trials conducted on spinal manipulation between the mid-1970s to the early 1990s produced such clear evidence for the utility of this intervention that chiropractic was able to substantiate its inclusion in medical legislatures and insurers. Contrary to losing its identity, clinical trials actually seem to have done the opposite, which is to identify chiropractic as a legitimate healthcare provider in the area of back and neck pain management.

> One of the ways I have tried to answer this for the students, because they tend to see, seem to want to create, some kind of distinction or dichotomy between what they think is the biomedical, particularly the medical research paradigm and the chiropractic one. And, I use the framework of biomedical research, the one you use to try to capture everything scientific in the healthcare world and I feel we belong to that one. We may not belong directly to the medical one in many particular senses, but . . . and of course, the word 'belong' is a funny word in any way. But I use this anecdote to try and focus them a bit, because sometimes these exhortations that people make reflect the same kind of frenetic appeal to philosophy that you see in the other dimension as well, and it not being a very critical one as well. The

> anecdote is that the early effort in clinical trials, both outside of chiropractic and with respect to manipulation alone, and within chiropractic on low back pain – and you might think, well that is just buying into the medical model of just looking at a symptom bla, bla, bla. Well, from the first clinical trials in 1975 to the very early 1990s, there were enough clinical trials that a group formed by the agency for healthcare policy in the US could compile all that research and produce a stunning result, which is that spinal manipulation was one of the only two scientifically validated procedures. And had that not happened, given that from the early 1990s on in the US, the development in the major national group of chiropractors in the world, the US, was transformed by the managed care system, which clearly imposed the requirement of some sort of evidence basis for what we do, otherwise we wouldn't be included. Now had that research in low back pain, which would have appeared to be symptomatic and not following some kind of nebulous holistic approach, I don't know what you want to call it. Had that work not been done . . . I very much doubt whether the chiropractic profession would have survived. So, on the strength of what appears to be a somewhat limited focus in research, we really saved the profession, frankly, and there is no question that you have to lead your research efforts with what is very obviously the priority of utilisation (P 3: 3:57 (284:315).

For Goldmann, the holistic ideal must be developed in conjunction and not at the cost of pragmatism, i.e. chiropractic's area of clinical expertise. He did not perceive holism to be juxtaposed with positivistic traditions as prevalent in biomedicine, but rather that positivistic thinking is a part of the fabric of holism. This translates into the notion that reductionist methodologies contribute to the spectrum of approaches associated with holistic traditions.

Goldmann also suggested that an element of pre-scientific thinking is still present in the chiropractic investigatory paradigm. From a Kuhnian perspective, this would imply that a state of normal science has not yet been reached. In the context of the other comments, it does seem that the research framework of the profession is still maturing.

> I think that these more fundamental questions that we sort of have hanging around us for a long time, in fact need to be addressed by very much the opposite, which is very hard-nosed, good, basic science research, because these so-called philosophical issues generally translate into hypotheses about

> the physiology of the body, whether it is the role of the nervous system. And even that is a translation from a very metaphysical idea into something obviously more physiological, and the connections there need to be addressed and those are more . . . the kind of thing that people need to muse on. But, once you have a reasonable representation of the metaphysical into the physiologic, then I think studies can really address that validity of that whole idea (P 3: 3:62 (359:369).

Hayes believed that the chiropractic research paradigm has matured to the point where it will now start to support some of the traditional, anecdotally based clinical practices. He suggested that the historical lack of continuity between the science and practice of chiropractic is simply a feature of a developing research paradigm. Hayes argued that the initial absence of mature researchers forced scholars to look outside the profession in order to develop as scientists (himself included). These young researchers consequently had neither the benefit of a theoretical grounding with empirical potential, nor appropriate role models within the profession from which to develop chiropractic's discipline. However, as the research paradigm has matured, a critical mass of older scientists, who practice within the discipline of chiropractic, now guide younger scientists from a theoretical framework grounded in sound scientific practice. This has had a knock-on effect into clinical practice, as the traditional practices are now being reconciled with research practices.

> Chiropractic was unique in that it was separated from the scientific community by legal statutes in most places, or ethical statutes by medicine. When those barriers broke down, chiropractic researchers started to become active. The first thing a researcher does when they are young is to be sceptical. So this huge period of scepticism, and so we had no senior researchers . . . So there was alienation between the researchers and the practitioners. They were talking different languages and some of the initial research did not back some of the widely held beliefs. So, you had the perception by the practitioners that this research was threatening and the perception by the researchers that the practitioners were a bunch of idiots. What has happened as our research community has matured, we still have young guys and they have to be sceptical. If the young researchers are not sceptical, then we get no new ideas, so that is crucial, but we are now getting a group of senior researchers, some of which are able to mentor, putting it into perspective. Starting to communicate with the practitioners and showing that this is not destroying your ideas, we can just modify the way we practice and the way we think, and

> actually advance thought processes and I think we are going to see a greater acceptance by practitioners of the scientific model with that evolution; and I think it is a natural evolution of the profession (P 1: 1:22 (135:162).

Hayes argued that, as the investigatory paradigm matures, there are at least three areas where research approaches will change in the near future to address specific chiropractic priorities. These are clinical-experimental designs, doctor-patient interaction and biomechanical effects (P 1: 1:11 (44:54). These “fields of research”, according to Hayes, will bring with them appropriate new methodologies from both natural science and the humanities.

Goldmann suggested that the chiropractic research paradigm has reached a level of maturity where it can be considered self-sustaining. This has been largely due to the establishment of chiropractic programmes around the world.

> As more colleges have come on stream and research efforts have been developed, we are seeing an international research capacity developed in the profession and I think it is big enough now. It has got enough wheels to create an internal pressure or drive, which is wonderful to see. We will have to work hard to keep that up. I don’t know that we have reached the point where we now don’t have to consider broader issues at the level of the profession’s place in the larger scheme of things, and even the efforts to continue to advance the profession at the professional level, for example interactions with the World Health Organisation at the highest level globally, still require a research base by which we can, well quite, simply prove our case there (P 3: 3:63 (117:127).

In this respect, he agreed with Hayes because academic institutions foster the development of the science (discipline) associated with the profession and hence sustain the academics who become the role models for subsequent generations.

However, Goldmann’s optimism was qualified by the proviso that the profession reconciles its own position and priorities with that of healthcare as a whole.

> We will never be in a position where we are accepted as fully part of the biomedical research world, such that researchers just naturally move from within chiropractic to medicine to whatever. We are always going to have to be cultivating connections with the hope that, in some places, particularly the chiropractic schools that are affiliated with universities, will begin to see more,

> well established and secure research efforts at these particular locations. (P 3: 3:13 (133:161).

Goldmann questioned whether chiropractic will ever be able to claim unconditional legitimacy in the area of disciplines. He argued that chiropractic scholars will never be able to assume congruence with biomedicine and that they will always, consequently, have to cultivate inter-disciplinary relations. According to him, chiropractic's preference for quantitative designs reflects the general historical dominance of positivist research methods and designs. Therefore, the use of quantitative designs in chiropractic once again returns to the issue of acceptance (perceived legitimacy). The notable exception is the nursing profession, which (as my review and this respondent indicated) contributes significantly to qualitative designs. Glover suggested that this situation is changing, however, as scholars recognise the limitations of highly controlled, experimental research.

> I think it is changing and it should change, so that we get a better mix between quantitative and qualitative; and the problem with it is that if you do only one of these basic types of research, you can only answer one type of question. So, if you do only one type at some point, you are going to grow dry. You are going to run into some problems that you are not going to be able to get out of again (P 4: 4:12 (187:202).

Interestingly, Glover closely associated quantitative methodology's dominance with a male dominance of research and that the change in views may be associated with the emergence of more female researchers who support naturalistic approaches.

In summary

Tusker and Goldmann recognised the standard view of science in which empirical research is a consequence of theoretico-conceptual thinking and hypothesis formation. Their view was that this process did not occur in chiropractic, mainly due to external pressures related to professional legitimacy. Consequently, the profession's investigatory paradigm, whilst providing the necessary disciplinary backing for professional clinical practice, is perhaps lacking with respect to the manner in which philosophy should influence research practice. In this regard, reconciling holistic philosophical traditions with methodologies used in biomedicine was cited as an area where maturation is required. This is an important process to ensure that the view within chiropractic, which sees the clinical trial belonging solely in the research traditions of allopathic medicine, might be changed.

The naïve inductivist view is considered by Chalmers to be both inaccurate and misleading (Chalmers, 1982). He argues that the claim made by inductivists with respect to the justification of scientific theories on an inductively derived "secure base of experience", is flawed. Therefore, conforming to a view that is perceived to be correct due to its mainstream appeal may not be beneficial to chiropractic, especially as its merits have been questioned for more than two decades. The profession would arguably be better off developing along trends beneficial to its own needs, which might conceptually include a more anarchistic view of the development of science.

The indications furthermore are that the position of the investigatory paradigm is in a state of positive flux. Evidence for this seems to lie in the steady reconciliation of clinical practice and science in chiropractic through the proliferation of university-linked chiropractic programmes. In addition, a uniquely chiropractic reference framework is developing in which mature scientists provide guidance to younger ones. Thirdly, chiropractic seems to be prioritising its own research questions *a propos* the use of naturalistic research designs.

8.3. Comments on designs and methodologies in chiropractic research

Besides the "historico-philosophical" perspective of chiropractic's investigatory paradigm, the respondents also provided valuable input with respect to research focus areas. Five areas were highlighted, namely neuro-physiology, biomechanics, epidemiology, clinical management and sociology, in chiropractic with the latter two providing the richest data. The bulk of the discussion will therefore focus on these.

Hayes and Tusker stated that significant developments had already taken place in the areas of biomechanics, epidemiology and neuro-physiology, and that these would continue to develop along established trends. These are indicated in Table 8.1 below.

Table 8.1. Some established focus areas in chiropractic research.

Area	Quote from primary document	Reference
Neuro-Physiology	. . . you have about a dozen chiropractic neuro-physiologists that are looking at receptors, transmission from various spinal structures.	P 1: 1:3 (15:17)
Biomechanics	The biomechanics, we have about five or six biomechanics labs that are looking at what happens when you give an adjustment. What are the forces, how are the forces distributed. In the clinical sciences, they fall into two categories.	P 1: 1:2 (17:21)
Biomechanics	I think what you are seeing . . . is we are beginning to see true mechanistic studies start or we are beginning to isolate specific aspects. So for example what, not just does manipulation help a low back? What is the property of manipulation that helps? Is it the speed? Is it the force? Is it the frequency? What is it? You are beginning to see mechanistically designed studies to answer these questions.	P 2: 2:4 (30:36)
Epidemiology	You are also beginning to see studies that are trying to get at detail of triage in patients, who are the right candidates to get into these studies? So, for example, we heard that perhaps the fact that perhaps tension headaches there is not the right candidacy group for manipulation and so these are the kinds of studies that are the next step.	P 2: 2:10 (36:41)

It seems that these areas will continue as core areas of basic and applied research, which stem from the established research cultures within the profession. The respondents were predictably hopeful that chiropractic's research might develop the profession into the leaders of conservative manual medicine (P 1: 1:42 (316:325), (P 2: 2:14 (87:94); (P 3: 3:12 (126:131). Their views on the placebo effect and the continued use of clinical trials in chiropractic research provide evidence that traditionally held positions may be shifting.

Hayes and Glover were of the opinion that, to give a true placebo implies that you give research subjects nothing whatsoever, and that they therefore represent regression to the mean. Therefore, a true placebo will not heal the patient. However, Hayes elaborated further that to achieve a true placebo is very difficult because, even if all physical variables can be controlled, psychological factors may impart "therapeutic" effects. These are termed non-specific effects.

> . . . the old concept that a placebo heals is starting to be discredited a little bit, but the concept that psychological expectations lead to reduced symptomotology is actually gaining some influence . . . the transference of belief systems has at least the capacity to reduce symptoms. . . . the closer you get to an absolute placebo, doing nothing at all, the closer you get to regression to the mean . . . if you get counselling, massages, if you get laying on of hands, you really haven't got a placebo, you really aren't a placebo now,

> you are just an alternate approach, and you are comparing two treatment approaches. So I think the true placebo is going to disappear or at least not be as prominent . . . we can't ignore the patient's psychosocial environment when they approach a treatment, because that appears to be quite strong (1:32(226:244).
>
> . . . the effect of giving the patient a placebo . . . does not differ significantly from nil (4:16(261:272).

Whilst Glover seemed content with the traditional view of placebo, Hayes suggested that researchers alter their view with respect to the nature of the placebo effect. His view was that this phenomenon should be considered a legitimate contributor to management effect as opposed to an extraneous variable to be eliminated.

Tusker and Goldmann tended to agree with this view. Both indicated that, whilst manipulative techniques carry a specific effect beyond that of placebo, chiropractic interventions also include a high non-specific effect due to the laying on of hands. Consequently, this must be considered during the research process. They respectively stated:

> Clearly it happens, but it happens for anybody who pays attention to patients, not just chiropractors . . . the placebo effect exists, but the results of manipulation is additive to the placebo effect (2:17(107:116).
>
> The danger is that anything new that you do with a truly chronic patient, they will respond to the non-specific effects for a period of two weeks or four weeks and appear to improve initially. That is a "discount"; that is a grace period (2:24(155:158).
>
> It is probably very large . . . the clinical rituals that we perform, they carry a high placebo valence. The flip side of, and it isn't the bad flip side, but it is just another important facet of we chiropractors taking our hands and our minds deep into someone's tissues, is the notion that the patient permits that and so immediately the idea, if not necessarily relaxation *per se*, but a compliance, a willingness to participate in that effort, taking that all the way to the level of when we apply our forces to the body, the patient has to permit them, they have to engage actively. I don't call chiropractic manipulation passive therapy, someone has to very actively allow that to happen . . . as a researcher in the

> biomedical model, I am very aware of the standard definitions of how the placebo element is thought of as a non-specific or, even more negatively; but I think those of us in the complementary and alternative therapy worlds have begun to really rebuff that and show through both our philosophic writings and in our studies that this is a positive effect . . . The shift in paradigm is to think of the patient's placebo ability, which is to really get very close to the ideas in chiropractic about a person's internal or natural healing abilities (3:39(516:543).

It seems that this phenomenon should be looked upon positively because, if non-specific effects are used appropriately, they develop patient compliance as well as active participation. This in turn facilitates the therapeutic process and leads to improved outcomes. It is therefore postulated that the "placebo potential" of any patient can be developed to foster therapeutic intervention.

There is a caution here, however, to develop this aspect of management appropriately and responsibly, especially in the case of the chronic patient. Non-specific effects may blur true outcomes for a period and it may seem as if the patient is improving. However, if no gains attributable to specific therapeutic effects are also made during this window period (two to four weeks), the patient's status may rapidly deteriorate.

As indicated in the literature review, the randomised clinical trial (RCT) has been a prominent design in chiropractic research. The reason for this prominence is perhaps most aptly summarised by Hayes: "randomised control trials have had the impact of putting chiropractic and manipulation on the map. Without them we would be out floating free and probably discredited" (P 1: 1:13 (59:89)). Interestingly, Hayes implied that chiropractic, rather than being validated in its own right, is accepted by proxy in the healthcare system due to the evidence indicating the usefulness of manipulation.

Tusker reiterated the importance of the clinical trial, but also suggested that it is used to appease legislative decision makers. He suggested that more legitimate and basic types of research are at times sidelined in favour of clinical trials. He considered the dearth of basic research to lead to avoidable methodological errors, which in turn lead to poor perceptions regarding potentially valuable treatment interventions.

Tusker consequently suggested that more basic science research is required to optimally utilise this design type.

> We will ultimately continue to see randomised controlled trials because we have to; but I don't think we are going to see huge advances in the state of the art because of randomised clinical trials until we have gone back and done the preliminary work, and we select the patients more clearly, and we understand the elements of the treatment we are testing, rather than just lumping into treatment and lumping all candidates, who just happen to have back pain into the group that we are going to treat (P 2: 2:5 (41:48).

Goldmann was strongly of the opinion that the RCT was and still remains a highly influential tool for the chiropractic profession, especially with respect to "decisions about what treatments are effective" (P 3: 3:3 (20:31).

For Goldmann, the issue relating to RCTs in the future will not be its limitations, but rather the manner in which results are applied. He argued that the responsible interpretation and consequent transfer to clinical management is indicative of the level of maturity of the investigative paradigm. In this regard, he argued that chiropractic still has to demonstrate its ability to balance the need to deliver the levels of substantiation deemed necessary for its practice, with claims to evidence deliverable through this design.

> I don't think the research community as a whole has done as good a job in the issue of translating research, both what is going in research as a methodology and the results of it to the field, as well as we could have and we have been caught with a couple of valises, which is to jump on any positive results and make the biggest run we can possible make with it and overdo that, and then not understand if negative results come out of specific studies. We have tended to, because we have come into this research time in our profession so late and so recently, we tend to want to speed up the process a bit. Researchers have the responsibility to modulate that interaction between field and researchers, and we didn't realise this (P 3: 3:60 (614:635).

This phenomenon might be attributed to an immature research tradition, which was placed under significant pressure to sink or swim. The indications are that, perhaps as the paradigm matures, this might become less of a feature among its scholars.

In the areas more related to the social sciences, it was suggested that more work be done in the area of the social context and identity of chiropractic, the doctor-patient relationship and the psychosocial context effect on patient response to management. This is evidently Hayes' view as he stated: "In the social research, we are seeing a number of studies on what chiropractors are, what they do, what they think, how they impact society (P 1: 1:7 (25:27).

His view is that the profession will be re-visiting its identity in the social sciences context as opposed to one determined through clinical interventions, such as manipulation. Of greater significance is to identify the factors that, besides direct practitioner intervention, have the capacity to influence the management process.

> Questions are being asked now as to what impacts results apart from treatment; is it patient selection, is it patient behaviour, is it doctor behaviour? And this is why the qualitative research is becoming more important (P 1: 1:20 (121:124).

It is in this regard that he considered naturalistic research designs as important: ". . . we can't ignore the patient's psychosocial environment when they approach a treatment, because that appears to be quite strong" (P 1: 1:33 (240:244).

In summary

Five focus areas of research were mentioned by practitioners. Clinical management and sociology in chiropractic seem to be the areas where most development is anticipated.

The view presented by this group of respondents with respect to the placebo effect is that it deserves serious consideration in research designs because if forms an integral part of manual therapy. Research methodologies should therefore give due attention to this phenomena, particularly in designs where intervention effects are being measured.

As antagonism between allopathy and chiropractic has turned from a legislative to a scientific tussle, the RCT arguably became chiropractic's single most powerful tool with which it secured its existence over the past thirty years. However, the RCT, or any research design ormethodology, will never "prove" the legitimacy of chiropractic and therefore, whilst appreciating its usefulness, it must be employed with ever-increasing rigour to the right context in order to maintain its valuable contribution.

From a social perspective, Hayes in particular considered chiropractic to be embarking on a period of self-identification and role dynamic discovery through the use of qualitative research designs.

8.4. The evolution of chiropractic clinical practice

As I indicated, the researchers commented on issues of clinical management as well as research practice. I shall therefore present the views on management issues in the second section of this chapter.

It would appear that chiropractic started its early days of practice around the world with a clinical apprentice model. Hayes stated that, as the profession gained status and position, it developed greater contact with the scientific community, which in turn had an impact on the approach to practice taken by its clinicians.

> Basically, chiropractors started off and for the first seventy-five years of the history, as with most of medicine, was based on clinical procedure. You had it, you taught your next generation, they got offered the service and you felt is was beneficial and your patients felt it was beneficial, and so you continued going without any basis, and chiropractic was unique in that it was separated from the scientific community by legal statutes in most places, or ethical statutes by medicine. When those barriers broke down, chiropractic researchers started to become active (1:21(130:138).

Tusker argued that, because the clinical focus in chiropractic primarily lay in the mechanistic (biomechanical) aspect of manual interventions, the consequent research efforts rallied around this aspect. The effect was a move toward a biomechanically oriented view of clinical practice, with the result that the scope of practice was relatively narrow.

> I think that a core group of sufficient size, a critical mass who was really and truly interested in teasing out the truth with respect to manipulation and the mainstay effect of chiropractic and its mechanistic effect, recognising that some of those are going to influence the non-specific or placebo effect, but it would not be a primary focus of how I would organise resources for the profession (2:20(116:122).

Goldmann agreed, but added that this was followed by the realisation that the profession would start to become clinically hampered by this narrow focus. Although

spinal manipulation might be considered the hallmark of the profession, it cannot be allowed to overshadow what is diagnostic rationale in clinical practice.

> . . . the assumption that only adjusting is chiropractic is something that I would not agree with . . . the primary focus is manual therapy and I think that the way in which chiropractors can assess ultimately, not exclusively of course, with their hands, but apply a very rational diagnostic paradigm (3:36(473:486).

(This process seems to mirror the technician-physician concept observed in Chapter 6.)

Most recently, according to Hayes, some scholars started to consider the notion of wellness practice as part of the chiropractic management model. In order to incorporate aspects of holism into clinical management, one would have to develop a clear understanding of what the concept operationally implies. Hayes argued that this requires, in particular, clearly articulating that wellness practice implies more than manipulation and setting regular appointments. This is corroborated by Goldmann, who argued that this is the paradox of "narrow holism" (see Goldmann in 8.1). Hayes suggested that this model, which accentuates the management role of the practitioner and quality of care.

> It is an unfortunate reality that most chiropractic wellness clinics do not promote wellness, they promote more office visits. It is used as a sales pitch rather than a wellness environment. It is actually very easy and it does not take a tremendous amount of time to counsel patients on good health. It takes some time, more time than giving them adjustment and getting them out the door, but it does not take a lot of time. You can have a whole series of ways to do it. You can do it one on one; you have to at a certain point. You can do it with pamphlets, group sessions, and educational material. So, there are a number of ways. My father ran this type of clinic and he used to have whole sessions with groups of people, who would then discuss their problem and what they could do to improve it and we are seeing a lot of the rehabilitation centres getting into group discussion, which is part of the wellness process (1:39(298:311).

For the first time, the notion of inter-disciplinary care is also introduced. Goldmann argued that no single practitioner can feasibly manage every aspect of the patient's healthcare needs. He consequently suggested focusing on a few wellness care areas

as well as creating an appropriate inter-professional referral structure to assure that all appropriate wellness factors are dealt with effectively.

> I am looking at relaxation, stress management; that is another area. When you say wellness, you have to accept that you can only be good at probably a couple of things, you don't want to be everybody's nutritionist, psychoanalyst, mechanicalist, bla, bla, bla. So, you are good at a few things and you try to carry that on (3:18(181:193).

The combined view of these researchers therefore seems to trace a developmental path, which seems to be heading toward a "wellness oriented, evidence-based biomechanical" model. Under this model, the chiropractor would focus primarily on manual medicine, but at the same time would form part of a healthcare team that manages the patient's welfare in an integrated fashion. Diagram 8.2 below visually represents the evolutionary steps that may have resulted in the development of this model.

Figure 8.1. The evolution of the chiropractic practice model can therefore be summarised with the following flow diagram:

		Evolution factor
	Clinical apprenticeship model	
		contact with science
Result	Mechanics emphasised, Nervous system de-emphasised	
	↓	evidence base grows
	↓	diagnostic skills
Result	**Evidence-based biomechanical model**	
	↓	wellness practice recognised
Result	**Wellness-oriented, evidence-based biomechanical model**	

In summary

One could argue that the development of the chiropractic practice model(s) has "mirrored", to some extent, the path of its philosophical development. Initially, management was based on the experience of previous generations grounded in metaphysical explanations. This was followed by a period during which "chiropractic philosophy" was shunned and the focus lay solely with the profession's tangible

components. As we enter a more moderate, contemporary position, it seems that broader contributors to care are being considered in management alongside practitioner-oriented practices as scholars start to take a fresh, scientific look at philosophical tenets like holism.

8.5. Healthcare systems integration through clinical management

Based on my analysis of the qualitative responses, I identified two main areas regarding specific practice activities during the management process. According to researcher, these were factors that increase or reduce the efficiency of wellness practice and the differences between managing the acute and chronic patient. Therefore, I will elaborate on these solely for the purpose of triangulating their remarks with the more comprehensive views of the field practitioners from Chapter 6.

(Excerpts from the respondent interviews are presented as evidence from the primary texts in Table 8.2 below.)

8.5.1. Wellness practice

What constitutes effective wellness practice? It is acknowledged to be more time consuming than a mechanistic practice, but it is not considered unmanageable. The researchers viewed setting frequent office visits and providing a purely mechanistic intervention, as stated in 8.4 above, as a poor representation of the “wellness oriented, evidence-based biomechanical”. On the other hand, holistic thinking can be overpowering for the patient if too many avenues are explored simultaneously. Patient specific wellness issues should be progressively explored as the relationship between the practitioner and patient develops, and the primary symptomatic factors with which the patient presented are resolved.

8.5.2. Acute and chronic care

Respondents warned that chronic back pain sufferers will initially respond to the non-specific as well as the specific components of care. After this initial period of between two to four weeks, non-specific effects start to wear off and, if inappropriate management has taken place, the patient’s condition will rapidly deteriorate. This then has the effect of entrenching illness behaviour, making the case harder to manage. Therefore, the initial period is very important in the management of chronic patients with respect to educating the patient about what may occur and then to adopt an evidence-based management strategy.

With respect to successful management outcomes, it is accepted that chronic patients are satisfied with small improvements in symptoms and function, which improve their quality of life. However, in the acute setting, resolution of clinical syndromes must be rapid. Quality of life is therefore an appropriate management outcome in the chronic setting only.

8.2. Management issues in chiropractic practice.

Factor	Excerpt	Source
Counters wellness practice	. . . clinics do not promote wellness, they promote more office visits…	1:44(298:301)
Promotes wellness practice	It is actually very easy and it does not take a tremendous amount of time to counsel patients on good health. It takes some time, more time than giving them adjustment and getting them out the door…	1:45(301:311)
Counters wellness practice	. . . bombard the patient with wanting to come at them from all sorts of angles…	3:52(460:470)
Counters wellness practice	. . . is to just keep coming in for maintenance adjustments.	3:53(686:689)
Chronic care success	. . . they will respond to the non-specific effects for a period of two weeks or four weeks and appear to improve initially. That is a discount, that is a grace period. The reality is, when you are four, six, twelve weeks down the road and they are still benefiting from what you did, that is important.	2:25(151:169)
Acute vs. chronic care management outcomes	. . . recognise that a small amount of change or status has a much larger benefit for their quality of life than for someone who has got first time onset acute back pain	2:26(160:165)

In summary

Although not a comprehensive discussion on issues of management, the researchers did provide insight into two areas, which relate closely to the application of models of clinical practice. The acute patients seemed to be the simpler case to manage, as they require a much lower level of sophistication to achieve the more biological management goals. However, in the case of the chronic patient, it would seem that the more elaborate wellness-oriented, evidence-based biomechanical model is the one with the greater chance of achieving ongoing success.

8.6. Academic institutionalisation as part of professional development in chiropractic

I previously argued (see 8.2) that some maturation of the chiropractic investigative paradigm has taken place. Broadly speaking, this pertains more to the disciplinary component of chiropractic. However, having a higher level of integration between practitioners and scientists could quite possibly have a crossover effect to affect the professional maturation too. Therefore, it would seem that developing the process of

disciplinary maturation will have a positive effect, not only with respect to institutionalisation, in which milieu it inevitably occurs, but also professionalisation. This seems to be Hayes' suggestion for chiropractic's future development:

> Starting to communicate with the practitioners and showing that this is not destroying your ideas, we can just modify the way we practice and the way we think, and actually advance thought processes, and I think we are going to see a greater acceptance by practitioners of the scientific model with that evolution; and I think it is a natural evolution of the profession (P 1: 1:46 (152:162).

It would seem that Hayes considered co-operative professional and disciplinary development as crucial for the coherent development of chiropractic's identity.

Tusker was more radical in his suggestions for future development:

> . . . perhaps the best thing to do is to become more integrative in incorporating more medical, chiropractic and other CAM procedures into the availability. Even to the extent that chiropractors, who are so interested or so inclined . . . there ought to be a venue for those who are interested for using pharmacy to be adequately and appropriately trained to incorporate pharmacy, because it is of value and benefit to the patient (P 2: 2:15 (88:97).

One might strongly question whether such a practitioner would remain a chiropractor, should chiropractic develop into a profession that is composed of an infusion of influences from various healthcare fields like allopathy, acupuncture and herbalism. As it turns out, however, if one considers the scope of local practice, which caters for the use of some anti-inflammatory medication, it seems that elements of acupuncture and physiotherapy are a feature of chiropractic education in South Africa (DIT-Chiropractic Handbook, 2003). Therefore, the type of chiropractor active in this country may not at times be too dissimilar from the one described by the respondent.

Considering Tusker's view of scope of practice, his view of full integration between healthcare practitioners is predictable and consistent:

> So, my view of the alternative for the future is integration and integration on the individual doctor training basis, as well as integration between doctors of disparate training (P 2: 2:16 (88:100).

It is interesting to note here that he advocates teaching integration, which could have a significant effect in developing the level of chiropractic institutionalisation in tertiary education. He clearly does not believe that chiropractic's identity will be altered in a negative manner.

> Once we are trusted members of the team, we will make observations that will lead to further studies that clarify non-musculoskeletal use, and to me that is a strategy and I have had patients and doctors say to me, but if you do that you will lose something in chiropractic. Well baloney; dysmenorrhoea is not going to go away just because I choose to focus on musculoskeletal, and if I am successful at becoming a trusted member of the team and becoming professionally and economically secure in musculoskeletal, and then observe that there is this group of patients that get dysmenorrhoea that seems to get better, I am now likely to get access to those patients to truly test the hypothesis. The big problem in chiropractic is we make all these claims. We don't even see enough of these patients to determine if there really is a question to test (P 2: 2:27 (180:196).

It would therefore seem that this respondent not only believed that the chiropractic identity will be maintained, but that it will actually change to resemble the view envisaged by its founders. This would occur because practitioners would have the opportunity to investigate conditions to which they never previously had open access.

Goldmann also considered institutionalisation in the tertiary education context to be a key developmental issue for the profession.

> We are always going to have to be cultivating connections with the hope that in some places, particularly the chiropractic schools that are affiliated with universities, will begin to see more well established and secure research efforts at these particular locations (P 3: 3:61 (136:139).

Glover agreed with Tusker about the healthcare systems integration; the consensus opinion being that chiropractors should play a key role in the future management of musculo-skeletal conditions. However, what makes his response interesting is his view that chiropractors ought to be the gatekeepers in this area.

> Yes, both gatekeepers and the ones to whom a GP would automatically refer those musculo-skeletal patients where he felt uncertain. Who after sort of a week of analgesics had not cleared up and he wanted somebody else to look

at. He would automatically refer to a chiropractor and nowhere else (P 4: 4:18 (303:315).

The gatekeeper is a key figure in healthcare, particularly for healthcare funders, because these individuals have first access to the patient and often determine the course of management (Teitelbaum, 2000). Therefore, the level of integration suggested by this respondent is high.

With respect to the chiropractic scope of practice, Tusker and Glover once again shared a common view. They both emphasised limited prescription rights in particular, although Glover considered the use of these to be limited (P 4: 4:19 (326:335).

Glover's comment here was interesting more for what he omits from the response. Even though it is clear that a certain element in chiropractic wants to employ medication as part of their scope of practice, the rationale for why they want access to it is not. With all the research and development going into these pharmaceuticals, they would be widely marketed and would reduce the need for the chiropractic profession if they had been effective for the management of back pain. This has clearly not been the case. Therefore, it would seem that the motivation for wanting rights to prescribe might not lie so much in the utility of these interventions, but rather simply in the status of being able to do so.

In summary

Respondents identified four areas of professional development. These were a) the continued evolution of the research community, b) further Institutionalisation of chiropractic profession, c) healthcare system integration and d) developing the chiropractic scope of practice.

Their views suggested that chiropractic's identity, rather than being lost through greater institutionalisation and integration, will be enhanced even to the point where the profession might take up the role of gatekeeper in its field of expertise.

Conclusion

This chapter sought to develop a view of the chiropractic profession from the perspective of a group of individuals who function in the domain of applied clinical science research. In this context, the respondents provided useful data with respect

to the history and current status of beliefs, research methodologies and clinical management. They also provided a future view of factors that might feature in the development of a chiropractic specific investigative paradigm.

Each respondent's cognitive strategy is informed in a unique manner by the beliefs and philosophical traditions associated with chiropractic. The consequent vision for the application or non-application of traditional philosophy in scientific endeavours ranged from a call to apply metaphysics like vitalism appropriately at the level of science, to the exclusion of traditional philosophy from the domain of research.

The standard view of science (naïve inductivism) was identified as the "ideal" model for the development of science by some, but is not seen to be in tune with the development of the chiropractic investigative paradigm. In the light of the work of Chalmers, a move toward this view might not be advisable for chiropractic, especially considering that the positive development is unclear. Evidence for this resides in the following:

a) Science and clinical practice in chiropractic seem to be finding more common ground;
b) A more mature internal framework seems to be developing as more institutions support the activities of an increasing number of career academics; and
c) Research questions in tune with paradigm specific problems are being asked, utilising appropriate methods.

At the level of methodologies, it would seem that chiropractic researchers attempted to "prove" the worth of an entire profession by proxy by demonstrating the utility of spinal manipulation. The RCT, as the perceived pinnacle of accepted evidence, became the vehicle for this endeavour and consequently changed in nature. Rather than simply a methodology used to observe a very specific type of research question, it became the golden goose laying "eggs of legitimacy". However, as the profession has become more secure, it seems that scientists recognise this misapplication and are re-visiting their application of research methodologies in order to rectify their context of application. For instance, the placebo effect, traditionally viewed as an undesirable by-product of the controlled RCT environment, is being redefined in the chiropractic context as the non-specific effect. The indications are that such effects are so inherent to hands-on professions that, rather than attempting to exclude them, their effect is now being factored in as part of a move toward the so-called pragmatic

clinical trial. This is a variation on the clinical trial theme, considered more appropriate to the chiropractic context. A further broad suggestion was that chiropractic should look toward the social sciences for methodologies, which more aptly reflect naturalistic phenomena central to patient management. Examples of these relate to the social identity of chiropractic, the doctor-patient relationship and the psychosocial context of the patient during management.

In the area of clinical management, it seems that the profession has evolved through three stages. These included an apprenticeship-based model, a science-oriented (biomechanical) model and the most contemporary model, which I termed a "wellness oriented, evidence-based biomechanical" model of practice. The latter is the most sensitive to chiropractic clinical traditions, but at the same time provides the most room for integrated management strategies.

The respondents identified four areas they consider important in chiropractic's future development. They made a general appeal for the continued evolution of the research community. In this regard, their view was that the profession should improve its level of academic institutionalisation so that more disciplinary integration between applied chiropractic and basic science research with healthcare application can occur. Furthermore, they appealed for an evidence-based development of chiropractic's scope of practice and integration in the mainstream healthcare system. Their view was that chiropractic's identity, rather than being lost through greater healthcare institutionalisation and integration, will be enhanced even to the point where the profession might take up the role of gatekeeper in its field of expertise.

In closing, it is my view that this group of respondents portrayed chiropractic research and clinical practice as two key endeavours, which have and will continue to determine the prosperity of the profession. The indications are that, in both areas, the profession is showing signs of positive growth and self-determined development. However, as a minority healthcare provider, the investigatory and practice paradigms will most probably always encounter pressure to conform and assimilate to mainstream views and practices. It is therefore important that chiropractic develops and maintains a clearly defined, confident and critical view of both these domains. This will allow the uniqueness of the profession to be admired and its practice ethos to be integrated with the general priorities of healthcare in the South African context.

Chapter 9
Conclusions

Introduction

In a time of educational and healthcare change, a profession with a clear vision for its future might use the opportunity to stake new claims. Chiropractic, both as a discipline and profession, has full responsibility for the role it will play in the healthcare system of the future South Africa. With a favourable legislation governing its broad scope of practice, the profession has the potential to become a fully-fledged member of the mainstream healthcare team. However, the opportunity will not last forever, particularly with respect to primary healthcare management, where the profession's potential contribution is unknown. If chiropractic does not achieve integration both as a discipline and a profession, it is possible that its status may revert back to that of a group practicing on the fringes of healthcare. Chiropractic research has succeeded in forcing acceptance of its activities in a narrow area of practice. However, this one-dimensional effort has proven inadequate to change the perceived status of the profession as complementary and alternative to being unconditionally accepted as part of the mainstream. With a privileged status relative to chiropractic in other parts of the world, this may be achievable in South Africa if a well-conceived, strategic plan is carried out to alter this view at the level of practice and science. Against this background, the purpose of the study was formulated as follows:

a) To review the main beliefs, philosophical paradigms and modes of inquiry underpinning chiropractic practice;
b) To describe chiropractic's process of professionalisation and institutionalisation; and
c) To undertake an empirical study aimed at establishing how the profession is currently viewed and understood by scholars, practitioners and patients.

I will draw together the strands of the individual stories told by the three groups of respondents in order to indicate how these contributed toward addressing the stated objectives. Specifically, this chapter will provide a brief summary of the main findings of the different individual interviews, a thematic triangulation of the conclusions and an integration of these against the existing scholarship.

A look at the results on two levels

Exploratory studies are by their nature open-ended, therefore the researcher must always be prepared for unexpected results. This study was no different in this regard, largely due to the distinct groups and the hybrid character of chiropractic as a profession and a discipline. Therefore, I would like to present the main contributions of the study from two different perspectives in order to reflect the broad range of the results.

I shall present the results simply as themes either unique to one group or shared amongst two or more respondent groups. The results will be presented as a function of chiropractic's professional or disciplinary component. Lastly, I will present the themes of the study in relation to "the three worlds" framework.

The contribution of the three responding groups

The study has shown how practitioner behaviour and practice is "over-determined" by their beliefs and philosophical views. Practitioners often tend to rationalise and even "justify" their practices in terms of multiple (sometimes even seemingly contradictory) beliefs.

With respect to patients, it would seem that the shift toward a holistic outlook on health has benefited CAM providers, including chiropractic, and it is thus an important push factor for the profession. This suggests that philosophy plays an active role in the cognitive strategies patients follow when choosing their healthcare practitioner, and that the profession should perhaps aim to maintain this perception.

Furthermore, with regard to beliefs and philosophy, this study indicated that the researcher respondents, whilst expressing many different individual perspectives, tended to converge around a standard view of the progression of science in chiropractic. Their view was that research must progress in a fairly predictable manner from theory to hypothesis testing and then clinical practice. In this regard, they objected to the use of metaphysics, when not part of a theory that holds empirical potential, being used as a tool to motivate clinical practice.

The study has shown how practitioners, patients and researchers are influenced by beliefs and philosophies. Beliefs and philosophical traditions, albeit indirect, play an active role in the practice and science of chiropractic.

The researchers believed that the chiropractic investigative paradigm has started to mature. Evidence for this resides in the growth of its internal framework, i.e. academic programmes and research units, as well as the number of career scientists who work within it. These scholars, who themselves had to step outside the boundaries of the chiropractic discipline to study it, have become positive role models as they have matured. It would seem that they have started providing a theoretical grounding of applied science within the chiropractic discipline for younger scholars to build upon. This is perceived to be closely associated with the development of research questions unique to chiropractic. Furthermore, because practitioners see these individuals as loyal to chiropractic, the level of communication has improved, which in turn narrows the gap between applied science and clinical practice.

Researchers also hold the view that, whilst a very valuable tool for demonstrating chiropractic utility in the area of spinal manipulation, the view that the aggressive use of RCTs would somehow translate into full professional legitimacy, may have been naïve. ”Proving” the scientific legitimacy of chiropractic is beyond the scope of any one research methodology, no matter how widely accepted. The perception is that, although the RCT will continue to play an important role in chiropractic, its limitations are now being understood. For instance, the non-specific treatment effects due to the hands-on nature of interventions can no longer simply be ignored as an extraneous variable. Therefore, research designs must cater for this characteristic by moving toward pragmatic clinical trials, which more faithfully represent the natural setting. Furthermore, naturalistic designs are considered to be approaches that more successfully reflect the relationship and clinical rituals. It is hoped that the introduction of qualitative research designs will allow the discipline to design a unique chiropractic model of practice, which has the ability to incorporate evidence gained from the classical biomedical, as well as phenomenological, quarters.

Whilst these responses indicate how the investigative paradigm is maturing, they also provide a sense that the contextual role of research methods is starting to be understood. In themselves, designs or methodologies are merely blueprints through which knowledge can be attained. How this knowledge is applied in order to increase the legitimacy of the profession is an entirely different process.

Patients and practitioners presented a mixed view with respect to chiropractic clinical practice. The manner in which these occur is perhaps not as evidence-based as it should or could be. In particular, too many interventions are motivated through

metaphysical beliefs rather than on the strength of prevailing evidence. Therefore, the study questioned the evidence-based nature of contemporary practice and suggested that it is perhaps not at the level where it provides a coherent image of the profession's activities.

When patients have powerful negative experiences with allopathic management for back pain, they seem to seek out chiropractic care almost as a last resort. What they encounter is a model of practice that engages in their problem on a very personal level. Chiropratic both recognises their individuality and enters into a shared clinical reality in which their health is dependent on their active involvement. When coupled with a common sense, non-drug approach to interventions and a consideration for broad lifestyle issues, it creates a recipe for great support and loyalty. A unique set of push and pull factors associated with chiropractic practice has created a model of practice that is significantly different from the perceived standard medical model, which is pathology driven and heavily dependant on medication.

This favourable model, however, seems somewhat counter-balanced by what I have termed the "fuzzy" identity of chiropractors. Practitioners, through their own responses, have indicated that they tend to act as a technician or a physician, depending on their particular cognitive strategy. This role allocation seems mostly dependent on the importance the practitioner places on spinal manipulation. Consequently, some will use all the interventions available to them under the chiropractic scope of practice, depending on the requirement of the case, whilst others will limit their interventions to manipulation only or simply to whatever modality to which they happen to have access. The consequence is a number of typologies (see Table 6.2), which present a spectrum of potential models of practice. For this reason, practitioners are under the impression that patients are confused over the identity of chiropractic professional practice, because it is possible that patients are not exposed to consistently uniform clinical management. It is my view that the favourable factors that develop and maintain the positive view of patients toward chiropractic practice are somewhat blunted by the relative confusion over the exact nature of the service provided by the doctor of chiropractic.

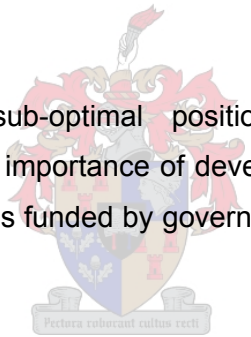
As opposed to identity, professional status refers to the position the profession holds in the healthcare system relative to others who function within it. In this regard, practitioners consider their position to be unclear, because their activities are poorly integrated with mainstream healthcare. Evidence for this was found in practitioner

perceptions that inter-professional referral is not at the levels it should be. Patients too were not able to identify where exactly chiropractors are situated. For some, the profession has a status similar to physiotherapy and for others it rates similarly or even higher than that of a general practitioner.

Practitioners consider the chiropractic profession as absent from a number of key institutions that are involved in determining healthcare policy. Furthermore, chiropractic is perceived as educationally "segregated" as its students do not have contact with mainstream healthcare during their under-graduate and graduate years. This places the profession in jeopardy in the local context as inter-professional links are not well established.

Patients also questioned chiropractic's institutional presence, specifically with respect to tertiary education. They questioned the merits of chiropractic education because it does not seem to be part of general medical education, which has the image of being of a high standard.

Researchers confirmed the sub-optimal position chiropractic finds itself in institutionally. They stressed the importance of developing a research community by integrating with tertiary institutions funded by governments, rather than creating more privately run programmes.



The study has shown that chiropractic cannot claim full legitimacy within mainstream healthcare. Simply providing a worthwhile service to patients does not give chiropractic enough momentum to access the corridors of power. A network of professional integration and academic institutionalisation is required for this to occur.

In summary then, the themes developed in this study are:

1. Beliefs and philosophical traditions play an active role in the practice and science of chiropractic.
2. The chiropractic investigative paradigm has started to mature.
3. The contextual role of research methods is being clarified.
4. Is contemporary chiropractic practice as evidence-based as it should be?
5. The chiropractic model of practice is significantly different to the perceived standard medical model.
6. Chiropractic clinical practice has a fuzzy identity.
7. Chiropractic's professional status is unclear.

8. The professional and disciplinary components of chiropractic are still institutionally immature.
9. The legitimacy of chiropractic.

Themes one to three are closely related to the first objective of the study. Far from being theoretical and inconsequential, beliefs and philosophical traditions affect the way in which chiropractors conduct themselves clinically, the way their patients view the world of healthcare and the manner in which researchers study clinical phenomena.

Themes four to six suggest that the state of the art of chiropractic clinical practice (objective 3) is perceived as markedly different from that of medicine and for the most part this seems advantageous to chiropractic. However, the exact nature of its model of practice seems quite fluid and, whilst this unknown quantity does not necessarily detract from the profession, the notion that it may not always be based on prevailing evidence does raise concerns about patient welfare.

Themes seven, eight and nine in turn inform objective two. It seems that the degree of professional and institutional maturity chiropractic can claim amount to it being at most partially legitimised as a mainstream healthcare profession. Therefore, chiropractic, both as a discipline and profession, has to address this in order to remain relevant in South African healthcare.

In the remainder of the discussion, I provide a further refinement of these themes in terms of whether they relate to the professional or disciplinary component of chiropractic.

Issues related to the discipline

Beliefs and philosophies do influence chiropractic practice as was seen with the practitioner respondents (theme 1). However, in the context of practice, they refer to cognitive strategies and not scientific theories. Therefore, it is my view that the critique of Phillips and Mootz (in Haldeman, 1992: 31) of vitalism and holism should be limited to the level of discipline. At this level, there appears to be no possibility of falsifying vitalist and holistic theories within chiropractic. The results tend to support Coulter's (1990c) view that metaphysics is not always amenable to operationalisation. However, when it is, the scientist functioning within the discipline of the profession should address it. The practitioner should not be expected to apply

a set of principles imparted to him/her during his/her education in practice in the same manner that a scientist would in academia. This suggests that science and education have an important buffering role to play between the patient and the practitioner, even if only to avoid practices based on ”folk lore”. Perhaps as the investigative paradigm matures further (theme 2), better channels of communication will develop to better inform clinical practice (theme 4).

The literature makes the point that chiropractic is not a classic example of the Kuhnian paradigm because of its hybrid nature. However, it is comparable to other professions that have been viewed in this manner (Coulter, 1990; Louw, 1990). Therefore, the results of this study, which confirm that the investigative paradigm did indeed develop in a unique and reactionary manner, should come as little surprise. However, what is perhaps somewhat unexpected is the view held by two of the researchers that chiropractic should progress according to the naïve inductivist view of science (Chalmers, 1982). According to their own responses, we know that chiropractic is not progressing in this fashion. Why should it therefore conform to a standard view of science when the appropriateness of this view has been questioned? It is my view that, as a higher level of institutional integration develops (theme 8) and further paradigmatic maturation occurs (theme 2), these developmental issues will be clarified.

New methodologies are required to reflect the true nature of the complex phenomena in practice (Jamison, 1996a; 1997a). However, more specifically, as my meta-discussion revealed, the role of the clinical trial must change so that it can be applied in the correct context. The results confirmed that phenomena, such as non-specific treatment effects and clinical rituals, are better observed by naturalistic research methods. These designs can then in turn be used to increase the level of evidence for a broader array of chiropractic practices (Gatterman, 1995; Jamison, 1997b). In my view, this reflects a dynamic relationship between themes three, four and eight. As the contextual roles of methodologies are clarified, appropriate inferences will be conveyed to practitioners, a process that will be fast tracked through appropriate institutionalisation.

Issues related to the profession

The literature demonstrates that a number of systematic chiropractic techniques were developed around spinal manipulation (Keating, 2003). This study showed that this practice still exists today, i.e., the “technician” or “physician” modes of practice.

Therefore, there are different views of chiropractic modes of practice that conform to different “philosophical” beliefs. This seems to relate to themes six and seven, which indicate, along with the literature, that the profession will move in the direction of therapy or primary contact practice, depending on the manner in which its identity is further ”constructed” (Nelson, 2000; Langworthy & Birkelid, 2001).

The literature does not comment specifically on the beliefs and views of the patient with respect to chiropractic. It indicates that chiropractic patients consider wellness practices to be important in their healthcare (Jamison, 1996a; 1999). This provides only an indirect link with our finding that chiropractic patients have moved toward a holistic outlook on health, which has been of benefit to its clinical practice (themes 1and 5).

This study has introduced the notion of push and pull factors in clinical practice (theme 5). Patients are often pushed toward chiropractic as a consequence of negative experiences with allopathic healthcare and the side-effects of drug treatments. On the other hand, they are drawn (pulled) to the profession by its biomechanical approach to treating mechanical back pain and the wellness factors managed by practitioners. I was unable to find literature in chiropractic that links specifically with this phenomenon.

Chiropractic’s lack of professional integration was highlighted by the literature review (Freburger, *et al.,* 2003; (Caplan, 1991; O′Malley, 1995; Coulter, 1996: 443; Mootz *et al.*, 1997). This was not only confirmed by our study, but the results are consistent with Menke (2003), who postulates that the profession’s lack of integration with mainstream healthcare counterbalances its utilisation. The result being that chiropractic’s professional legitimacy is still questioned. The same essentially applies to the level of chiropractic institutionalisation. Its general absence from accepted tertiary institutions like medical schools and ivy-league colleges create the perception that the profession only attracts poor quality students. Consequently, it is imperative that increased interdisciplinary integration and academic institutionalisation are sought to counteract this situation.

Crossover issues

Two issues have a bearing on the relationship between discipline and practice.

This study indicated that, as the investigative paradigm in chiropractic has matured, it has started to narrow the gap between applied science and clinical practice (theme 2 and 3). The review of the literature confirms this trend. A gradual shift to more non-experimental research designs, which focus more on the clinical rituals in clinical practice, is apparent (Cherkin & MacCornack, 1989; Cedrashi *et al.*, 1996; Jamison, 1997a; Jamison, 2001a).

Legitimacy (credibility) is a recurring theme in chiropractic. Its history is full of examples of how one group strived to attain it, whilst another tried to deny it (Haldeman, 1992; Chapman-Smith, 2000). However, one of the most interesting examples is the process chiropractic went through to "prove" its professional worth by "proving" the effectiveness of spinal manipulation. Both the literature (Nelson, 2000) and my meta-discussion indicate that this was to some degree a misguided exercise (themes 2 and 3). Chiropractic's legitimacy cannot lie in the opinion of medicine, which is by nature a competitor and as such not in a position to "legitimize" its status. The profession must seek it legitimacy through a combination of entities, e.g. the public, universities and legislative bodies, who collectively will contribute to chiropractic being accepted as a legitimate healthcare profession (theme 9). Whether at the level of clinical practice, education or research, chiropractic in the local context can most probably only claim conditional legitimacy. Both the empirical investigation and the literature confirm that professional maturity and institutionalisation lead a profession to become integrated with the body of applied knowledge, which it then uses to gain legitimacy (full acceptance) in the public eye and which consequently leads to the acquisition of power (status). Chiropractic is still struggling with this process.

On the three worlds of chiropractic: A final interpretation of the results

Mouton (1996:8-10) argues that we can distinguish between three "worlds" of knowledge production and utilisation, each of which requires knowledge for different purposes. In world one, knowledge is produced and utilised mainly for pragmatic reasons; in world two, for epistemic (the search for truthful knowledge) reasons and in world three it is required for critical or reflective reasons. World one is referred to as the world of "everyday life", world two is the world of science and research practice, and world three the world of meta-science. The relationship between the

three worlds is as follows: In world two, scientists identify phenomena in world one and “make” them into “objects” of inquiry and investigation. World three, in turn, critically reflects on the research practices of scientists in world two in order to improve its ability to search for “the truth”. This flow is indicated visually in diagram 9.1 below.

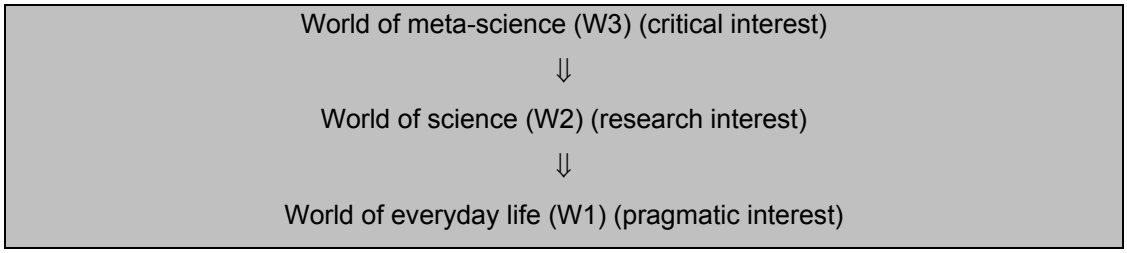


Figure 9.1. Flow diagram illustrating the relationship between the three worlds of knowledge. Adapted from Mouton (1996: 10).

Applied to chiropractic, a strong argument can be made for the existence of these three levels or “worlds” within it. Chiropractic clearly contains a domain of clinical practice (W1), a domain of research (W2) and a domain of meta-scientific reflection on its research practice and philosophy (W3). In this study, it seems that many of the contributions, whilst useful in understanding the characteristics of chiropractic healthcare, also reflect on the relationships between these three worlds.

The importance of applying this framework to chiropratic is that the profession becomes more reflexive of the different domains of its existence and has an analytically more complete frame of reference. This frame of reference can be employed to consider chiropractic in the broader context of social phenomena and in so doing, the profession stands a better chance of prospering.

The first three themes are forms of meta-scientific reflections (W3 – W2). Theme one comments on the influences of metaphysical concepts (beliefs) and philosophy on all three the groups of respondents. In it, practitioners are seen to apply certain beliefs to motivate their different approaches to practice; patients use them to inform their different views of healthcare and researchers to inform their view of science in chiropractic.

If we look at this in relationship to the worlds, an interesting situation becomes evident. Not surprisingly, the researchers are the only group that commented on the

discipline specifically. It is only in their responses that a reflection on the relationship between W3 and W2 can be seen. In their beliefs, they expressed a view of the philosophy of science in chiropractic, which is that the profession should distinguish between metaphysical debate and scientific practice and not allow the two to mix. This is typical of the flow of knowledge between the worlds. In the case of practitioners and patients, their reflections informed their clinical practice (practitioners) or their choice of a healthcare provider (patients). Therefore, both groups, whilst having a practical interest, actually reflected on the relationship between W3 and W1, which is not a typical application of this framework. I would argue that this might be due to the "remnants" of an academic frame of reference embedded in the practitioner after years in practice. They "inform" themselves and their patients with respect to appropriate philosophies for chiropractic. However, this occurs without the benefit of contemporary debates in academia. This then results in an "unfiltered" influence directly onto W1.

Theme two is a reflection by researchers on the development of the chiropractic paradigm (philosophy of science) and its effects on methods of scientific inquiry. This is a typical example of how W3 relates to W2. In a similar manner, researchers reflect on the use of the RCT in chiropractic research.

In theme four, both practitioners and researchers presented the view that chiropractic practice (a W1 activity) is not sufficiently influenced by research (a W2 activity). Therefore, their reflection on the current relationship of W2 and W1 (research and practice) indicated that a breakdown in the flow of applied knowledge occurs somewhere between the two. The consequence is a lack of synthesis of the evidence gleaned at the level of science into the world of practice.

The remaining five themes focus on W1 activities. Briefly, theme five is a reflection on how the chiropractic model of practice is unique, theme six reflects on the identity of the practitioner in practice, themes seven suggests that the professional status seems unclear, theme eight concerns the immature status of chiropractic in important institutions, and theme nine is a reflection on the legitimacy of chiropractic's activities. The commonality between the themes is that they address issues related to the real world and the resolution of each will lead to answers with "existential interest"; this being the improvement of chiropractic clinical practice.

Therefore, the analytical contribution of the results can be summarised in Figure 9.2 below.

	Practitioners	Patients	Researchers
W3→W2			1,2,3
W2→W1	4		4
W1	1,6,7,8,9	1,5,7,8,9	8,9

Figure 9.2. The contribution of practitioners, patients and researchers to W1, W2 and W3 in chiropractic (Numbers 1 to 9 are the themes gleaned from the results).

As one would expect, the matrix indicates that the different groups are not equally well-equipped to comment on the three worlds. As practitioners and academics, the researchers were able to comment on three levels, practitioners tended to reflect on W2 and patients commented only on W1. This could be seen as one of the strengths of using different groups to comment on a complex unit of analysis, such as chiropractic.

The study's contribution lies on three levels. Firstly, by reflecting on the chiropractic *status quo*, the ideas can be used to develop it constructively in the local context by considering the themes that relate to W1 in particular. Secondly, the study also indicates which aspects might be addressed through disciplinary and which through professional activities. W2 and W3 activities should be addressed through the disciplinary component, whereas W1 issues fall under the ambit of professional issues. Lastly, it also illustrates how different interested groups (researchers, practitioners and patients) can together contribute to obtaining analytical clarity when observing a complex unit of analysis. This broadened view can be applied to the profession in order to facilitate focused development in the different analytical realities of chiropractic.

In closing, chiropractic has exploited its status as the brave David to medicine's Goliath. However, the time has now come for it to shed this image in order to accept the responsibilities as well as the status that come with being part of mainstream healthcare. The profession certainly has the potential, and the discipline is demonstrating its ability to inform such a shift. However, the respite that RCTs have bought chiropractic is coming to an end, as chiropractic is no longer the exclusive provider of manipulative therapy. The competition is already a part of allopathy and chiropractic must therefore take the next big leap, which is to establish itself entirely along the spectrum of legitimate healthcare providers.

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Appendix A: Interview themes for practitioner interviews.

1. The participant's experience of being a chiropractor-
Why did you decide to become a chiropractor?
Was it a deliberate decision or more of an accident?
How would you define chiropractic?
What type of chiropractor would you describe yourself as?
What type of values do you prescribe to as a chiropractor?
Do you have a philosophy of practice?
What is the single most important virtue of a good chiropractor?
What type of person do you think makes for a successful chiropractor?
What do you find most negative/unacceptable when viewing other chiropractors?

2. The paradigm of practice the chiropractor seems oriented to-
What do you understand by the term patient management?
Is the term 'management' in your opinion a generally accepted notion?
What is your approach to patient management?
How strongly do you emphasize medical diagnosis?

3. Management of chronic patients-
Is there a difference in the manner in which you treat chronic and acute patients?
Should there be a difference in management approach?
Is there anything that you find frustrating about managing chronic patients?
Why do think chronic patients come to see you?
To what extent do you consult with your patients during the 'management' process?
What do you understand "consultation" to mean?

4. Future practice paradigm-
What would you like to see chiropractors doing in 10 years time?
What do you think chiropractors have to change to get there?
What do you regard as the main deficit in your own training?
What would you like to see included in the current and future curricula?
What are the greatest challenges facing the profession currently and in the near future?

Appendix B- Practitioner interview primary documents.

Interview 1

I: You read the letter of information. It is really at this stage for us to find out more about your experiences as a chiropractor and the interview is going to be very exploratory and I really have very little in terms of criteria. So I have a couple of things that I think might be relevant but it is kind of up to you. Shall I start by giving a very general question? Why did you decide to become a chiropractor?

R: I come from a chiropractor family basically. But I did not want to become a chiropractor just because they were chiropractors. I wasn`t sure what I wanted to do with my life and so I did what many people did and that is get a teaching diploma and I taught maths and science in high-school for 7 years. By the time 4 years had gone by, I realised that I wasn`t a teacher and it was about that stage that I became a Christian and became interested in healing and initially from a religious perspective and then realized that the best way to get involved was to become a professional healer of some sort and I became a chiropractor.

I: So basically you got bored with other things, realized what you wanted to do. So the decision was something that evolved over time.

R: Ja, I took time before I made the decision because I had to leave a good teaching position, a good future, security and that kind of stuff.

I: Can I ask you then, how would you define a chiropractor?

R: Well, I think a chiropractor – I don`t go very strongly on the subluxation model, but I do believe in subluxation. I do believe in them although it is not a term that I use a lot. But it does underlie my understanding of what is going on. I think it is to broad a condition or a term. So I think more in terms of medical pathology when I am looking at a human condition. So I look at them as sprains and strains and set syndromes and poor muscles and so on. So what I understand by chiropractic probably doesn`t fit in that way of some models of chiropractic. It is a fairly medical model. It is just that I see chiropractic as a very specific part of medicine in that we were particularly trained in – better than anyone in medicine does. But I don`t see it as being exclusive to a part of the whole being. We really are dependant on medicine. Medicine is not really dependent on us – they should be more dependent on us.

I: Can I just interrupt you for one minute and take you back to the definition. You seem to have a bit of a dichotomy there – with subluxation on the one hand and the political/pathological on the other.

R: Well, the typical subluxation model says that you should have nerve pressure in order to define something as a subluxation. I do not go along with that at all. I think many of the chiropractic conditions that we treat that I do think have subluxations –they certainly have abberations in terms of movement – either increased or decreased fixations or hypermobility problems, but without true signs of nerve pressure at all. There is no referral pattern and is specific local joint or muscle pain and some people would deny that that is a subluxation. In my understanding it is bio-mechanically abnormal. And it is a treatable lesion. I don`t particularly call it subluxation, its just like I said not a word that I use, but I do believe that it is subluxated, not out of place.

I: Am I correct in saying that subluxation, the use of the term, defines a certain entity?

R: Well, I think that the people who use the subluxation model would certainly define it as an entity. For me it is a more nebulous term. In particular if I take most of the conditions we treat, do not have direct signs of nerve pressure, some do some don't.

I: So then just back to the definition of chiropractic. Could you maybe just sum it up for us again?

R: I see chiropractic as that healing profession which treats muscular conditions, which primarily involve a joint lesion of some sort, but more than likely there is an associated muscular component which maybe in some way is nerve related but is in fact probably not directly nerve related. For me it is a technique. My model treating the lesion is to adjust joint and restore the biomechanics to it. To treat and strengthen the supporting muscular tissue and I believe very strongly in a rehabilitative program to strengthen the muscles surrounding the joints and giving the joint a chance to heal itself and I look upon all of that as being chiropractic. It's more than just adjusting the subluxated segment. I see that rehabilitating phase, that strengthening phase, that restorative phase, that prevention of problems next week, next month, next year is a likely part of true chiropractic. It is not a sort of attachment. I like to put quite a lot of emphasis on helping patients to help themselves to stay well. If we can get them to prevent subluxations forming, through better biomechanics, through better understanding of their lesions through stretching, through exercises, through sport, then I think that is part of the whole medical model – the whole chiropractic model.

I: Ok, fair enough. You mentioned just now a concept you called a healing paradigm or something of that nature. What do you understand by that? What is your perception regarding the term?

R: If a patient walks into my office, I don`t just see a subluxated spine or ankle or whatever. I try to see a whole person - a person who is under stress for one reason or another. Having

experienced quite early in my practice where I treated a man with an acute low back, he got better and a month later had a heart attack and died. And it had quite a profound influence on the way I practiced, because it reinforced to me that anybody that calls himself a healer has to look at the whole patient – not just see a subluxated spine. I made some passing reference to his blood pressure and weight and passed the responsibility to somebody else to deal with. Of course patients don`t want us to speak about their exercising or their weight or their smoking or their blood pressure – they don't want their medical doctors to speak to them about it either. So what tends to happen is that they fall in between everybody and die prematurely. For me the healing paradigm is to see the whole patient and I don't just see them as a sore back. I see them as people who need holidays, who need more exercise, people who eat badly, people who have bad habits.

I: Keeping that in mind then, what type of chiropractor would you describe yourself as?

R: The word holistic is a somewhat - rather a cheap word today- overused and I suppose there are degrees of holism, but I certainly try to treat the whole patient in so far as I am able. I don`t really think I do it as adequately as I would like to. I would like to know more about minerals, vitamins and dietary things and better rehabilitative programmes, better integration of medicine. I don`t think any of us knows how well we do it and its only in relation to some norm that is not defined anyway. Ja, so I try for better or for worse to be a holistic chiropractor, I try to see the whole patient.

I: Would it be fair to say that it an ideal. Something that you think you can attain?

R: It is an illusive ideal. But I think it is still one that we should struggle to try to find.

I: I would love to hear more about the 'cheapness' of the use of the 'holistic' term. Would you like to elaborate on that?

R: Ag it is just a buzz word that people use but when you actually see what they do, they give lip service to the term. Because to be that type of holistic doctor takes time, it takes a lot of energy, it takes a lot of guts because patients don`t like you to delve into these other more holistic areas. They don`t want you to talk to them about their diets and their relationships and their smoking habits. They came to see you about a sore back. It is none of your business all this other stuff that goes on. So neither the patients wants it –really- many of them, most of them. I don`t find it easy to be a holistic chiropractor. I wouldn`t say that I am all the time, but I do try for better or for worse, I do try. Others may try harder – I am sure some try harder. I think some like to use the term, but nothing actually happens. It is also time consuming.

I: Would you like to say anything more on that topic?

R: The time consuming part is important. If one is going to get involved in those deeper – I mean as chiropractors we see the subluxation as the sort of deep foundation of the human being. I am not convinced about that. I think what people eat, how much they exercise, whether they take holidays, whether they are fighting with their wives or their boss or with God, the amount of medication they take, their habits – these are all foundation things. It is very difficult to rate them in terms of importance. I suspect that a bad diet would kill a person far quicker than subluxations would.

I: These all contribute to the holistic view?

R: Ja.

I: What values would you describe as being important for a chiropractor? Or which value do you ascribe to as a chiropractor?

R: Top of the list probably conscientiousness. I think to be that kind of doctor is hard work. You have to be committed to it. You have to discipline yourself. That last patient of the day at quarter to 5 when you're tired and you have worked hard all day, home is beckoning. The whole question of being conscientious is making myself think to give my patients time, be thorough. I think it is probably one of the most important things. I don't that without being consciencious any of us can be good at our job.

I: Other values?

R: To like people. To be concerned about people. I suppose one can be a good technician only, I suppose that is one form of chiropractic and I'm sure that it has its place. But for me liking people and enjoying working with people is important. You must be strong – not physically, but mentally and emotionally strong. Patients get sick, patients die, patients go in for operations that fail. People criticize you. You have to be able to take that kind of knock, because they come and they hurt and I think every doctor – I'm sure medicine has it exactly the same, you have to be a mentally strong person to be a good chiropractor. It is something you grow into. I don' t think I was that mentally strong when I started, but I think it is something that if you can see the problem you can grow into being a stronger person, more forceful. More forceful more blunt, but at the same time more compassionate. I struggle with this balance of bullying a patient into doing what you want them to do – what they need to do as you perceive it, but at the same time recognizing that it is their body and you have to treat them by their consent. It is a priviledge and it is quite a difficult balance to find. One has to be prepared to be flexible. Sorry what was the other question?? What are the qualities necessary to be a good chiropractor?

I: Ja, what values would you prescribe to a chiropractor, you have mentioned-I think- three.

R: Integrity, it goes along with conscientiousness. Patients can see through you very quickly if you lack integrity, if you're just after their money – people can see if you are simply in this game for the money. You have to have integrity in the financial sense as well as in other areas. It is important. I think the whole question of sexual morality is an important and difficult area. We are treating patients, some of them who are very beautiful, many of whom are scantily clothed. Some of them are actively hunting. Women with a 'divorced and looking' sticker on the back of their car. That is something that every chiropractor is going to be faced with on a daily basis and a strong sexual morality I think is important. I think it is more difficult to define and perhaps more difficult to grow into. It is one of the things as a Christian I find strength there and chastisement. It helps stimulate one to rise to a higher ideal- chiropractic marriages are notoriously bad. I think it is important that one is treating patients of the opposite sex and even of the same sex – it is a priviledge and a responsibility to both the patient and their spouses to treat them as – we have an enormous amount of sexual abuse of children in SA and it probably happens doctors rooms in many different ways. I think the whole issue of sexual morality is very important.

I: Anything else with regards to values?

R: It is probably quite important to accept that as a chiroprator you are never going to be a very rich person and so everyone has this high flying bottom line driven goal of chiropractic. By the time you have paid your rates and your rent and taxes and you've paid your secretary a living wage – I think it is quite interesting – I don`t think we know how much chiropractors earn. I don`t know many of them who are wealthy. I had a fine colleague who was an excellent chiropractor – a good man, a good person, a busy chiropractor and he died with ziltch.

I: The philosophy of the practice – of yours – do you have something that you want to define for us, does philosophy come into your conscious mind?

R: Are you talking about chiropractic philosophy or just philosophy of life? I have really talked a lot about my philosophy in my practice – about patient relationships and exercise – that is all part of my health philosophy. My health paradigm. Are you referring to something other than that?

I: I am referring to the philosophy of your practice specifically, so am I being correct in saying that this kind of holistic ideals that you spoke of earlier, they form your philosophy?

R: Yes

I: You also mentioned a form of chiropractic called technical chiropractic.

R: Well what makes for a good chiropractor, to me, involves a lot of different aspects. The technical part is not unimportant, in fact its very important. One needs to be able to treat sacro-iliac syndromes and Torticollises, quickly and efficiently. So the technical side of the practice is an important part of the practice. I don`t know how good a chiropractor I am and part of the problem is that we have very poor measuring skills in which to rate ourselves against the guy next door. That is one of the things that we as a profession should look at. How good am I as an adjustor? How would my colleagues rate me?
Would I be prepared to let the peer-review committee come and watch me treat patients?

I: It seems like a quality control sort of concept that you are referring to. How does that link with your practice philosophy and the technical side?

R: I try to be as good as I can. I think the most important thing is to be prepared to think and not just get lazy- adjust the left S-I, adjust the right S-I 'good bye'- I think and try and work quite hard at – I think there are two parts here. The first is simply the adjusting ability. The ability to get the bone to move, the joint to move as quickly as possible with the least trauma to the patient. Probably even more importantly though is should I be adjusting L4 or L5 or should I be adjusting into flexion or extension or the left or the right – those are for me important parts of the technical part of chiropractic and it is an area where we have done, as I understand it, very little research. We are beginning to get stuff coming out – nice research that is being done here but not which we're not publish enough of. So the technical side of the technique and what procedures, these are all important questions as far as the technical side of chiropractic is concerned. I do think about them and I do struggle with them. I do not have all the answers because basically the profession hasn`t subjected all those questions to investigation.

I: What do you find the most negative/unacceptable of being a chiropractor? You have given me a good idea of what you despise. What you dislike in a chiropractor?

R: It is a hard question to answer. I dislike arrogance. I am very conscious of the fact that there is no one right way to do things. I think I get irritated with narrow-minded chiropractors who say "this is the way". A fair number of those people are overseas.

I: So the recipe of performing techniques or approaches to practice is a problem for you?

R: Well, there is often wisdom in old wives tales. The recipe approach is not necessarily a bad thing, provided that one is prepared to be broad minded and think. Its not a substitute for thinking. I work out with my patient what works for them. There is value in the recipe

approach, but it is not a substitute for intelligence. For me there is a key for each patient-what gets them well quickly.

I: What do you understand by the term patient management?

R: It is a difficult area. It starts for me with a plan of action. It starts with a diagnosis and plan of how you are going to go about treating that patient and it involves the various phases that treatment would involve. Firstly getting the patient out of acute pain.
Putting the patient onto a stretching regimen, putting the patient onto a strengthening. Looking at the patients habits and posture and setting up of type of protocol. So it involves a plan. That's the first part of patient management. The second part, which is probably more difficult, except that I suspect many of us don't have that much of a plan, we just kind of muddle along, where all you can see is the sacro-iliac joint, you adjust the sacro-iliac joint and when its no longer fixated you discharge the patient, because you don't have a proper plan of where you are going. Equally important is you have to sell the plan to the patient and patient management to me means getting the patient to comply with your plan for their restoration and their health and mostly they don`t like it too much. They couldn't be bothered to do exercises, the certainly don't want to come and pay you money while you are trying to get them rehabilitated and strengthened. They are looking at short-term relief of pain and they cannot see that next year or the year thereafter as equally important.

I: So the patient management for you means having a plan and the second is managing the patient in the direction you want it to go.

R: Yes, and some patients I give up with completely. They will not comply. And you reach the stage when you say ' Ok, we'll do it your way, I'll adjust the sacro-iliac and you on your way good bye.' Because that's the only model they can see for themselves.

I: Is the term management a generally accepted notion among chiropractors?

R: I'm not sure how much it is used. I'm not sure just what it means. You know one hears things for example that patients have been to practice building seminars, these seminars which thank God we don't have much of in S-A, would start by saying:" Mr. Jones a survey of a large number of chiropractic practices would show that this condition that you have is going to require twenty-seven treatments in the first phase and another twenty-seven treatments in the rehabilitative phase. Over the next six months I have to see you three times a week. I am not sure if that what is meant by management?

I: You have mentioned treatment just now as what you actually do for the patient. Does treatment fall within management?

R: Ja, I think so. I mean treatment means this is how you strengthen your triceps muscle that would be part of the management of the patient. You can look at in a narrower sense – this is actually a plan of what we are going to do, not actually me doing it. I would see it as part of the whole plan. I don`t know to what an extent chiropractic management is an acceptable term. It is a very acceptable term to me.

I: Would I be correct in my understanding then that management seems to be a broader term than what treatment is?

R: Oh Ja. Yes much more.

I: Do you have a specific approach to patient management? I think you kind of answered me in a way.

R: Yes it does. I follow a process of - the usual process. Nothing unusual about it. It is the way I was taught, it's a good way – do a history, examine the patient, if you need some special tests, order them. Make a diagnosis and come up with a treatment plan in your own mind and then sit down with the patient and say listen this is what is wrong – this is what I plan to do and this is what you have got to do and this is what you may not do, for the next month and so on. If it doesn`t go according to plan, part of my philosophy is in three or four or five weeks, depending on the seriousness of the condition, if they are not at least 50% better, I think of another plan. What was actually your question?

I: My question was do you have a specific approach to management that you ascribe to? Do you have a name for it?

R: No. This is my management. Does that answer your question?

I: Yes. You mentioned diagnosis as part of the plan. Is that a diagnosis as in the medical/bio-medical approach to diagnosis or trying to get to a very specific cause of what is going on there?

R: Ja, very much so. If I am treating a patient with Ankylosing Spondylitis with a painful sacro-iliac syndrome, management is going to be quite different to a guy who played golf and hit the big ball and now has a sacro-iliac syndrome.

I: Very much along the lines – is there a difference in the way you treat your chronic vs your acute patients?

R: Yes there is and it is perhaps a bit controversial in chiropractic terms. Part of my philosophy of health is that no patient wants to be dependent on his/her doctor. In the back of my mind the idea is to treat this patient and get them well and discharge them – good bye, go away to your home, thank you. I don`t think it is a healthy thing to be dependent on doctors and I don`t think it is a healthy thing for patients to be dependent on chiropractors. I have a suspicion that for financial gain we try to make them dependent, which I think is immoral. Having said all there are some patients that you know are utterly going to be dependant on you. A patient with diabetes is going to be dependant on his doctor forever. A patient who has a scolisis and has had a serious injury, he comes to you and says:' I have had a pain in my back for twenty years, you're never going to be able to discharge him. I always try to say to myself is this is a patient we should treat, rehab and say goodbye to. If the answer is yes, I actively go for that. I try to get my patients independent of me.

I: If the answer is no?

R: Then I say to them:" I'm afraid I can't cure you." And we are going to have to come up with a program where we have to be involved to a lesser or greater extent – maybe forever.

I: How do the patients react to that?

R: Not well they want to be cured. Health is an important part of the doctor-patient relationship and when you say to a patient boldly that you cannot cure them, they loose their hope, so I try not to use the term, because it robs them of their hope and hope is an important part of healing. I will try to find some way of saying to the patient that:" Mr. Jones, I think I can help you, you have had this problem for a long time and to be quite honest I think you are going to go on having the occasional headache, if I can get your headaches 80-90% better will you be happy?" they say: "Yes, I would be delighted."

I: When does the patient flip from being acute to chronic?

R: It is hard. I don`t think it is well defined, because the acute patient may or may not get better.

I: Do you find that frustrating?

R: Yes. I like patients to get better and go away – goodbye. Those are also patients who send you their referrals.

I: Chronic patients?

R: No, the guy you fix and discharge, he sends you his niece and the guy next door. The patient who you end up seeing once a month, and you have sweat, blood and tears and you try a lot harder with him, he doesn`t send any referrals. He doesn`t think you are a great doctor.

I: Because you cannot install a cure.

R: Ja

I: Why is it that you think that the chronic patient who has to see you once a month, comes back to see you?

R: Sometimes it is just because those patients are very receptive, compliant and I manage to bully them into doing it. I like to moralize and convince myself that it is for their benefit rather than mine and I think that's true, because these patients are probably 10% of my practice. If I were the other sort it would be 90% of my practice, which is not good. The other reason is that they just experience the benefits of it. I can say to a patient at the end of a course of treatment, I want to see you once a month for three months and then we see how we go from there and I will frequently examine them. If they have no pain and I find nothing and I do nothing to them, I don`t charge them. Then I send them away and say see you in a months time. And the whole consultation might not take more than 5 minutes. And then they know that you are after their health and not their money. And then they come back in a months time. In a months time, you might give them an adjustment or change their exercises and you spend the full consultation time with them, upgrading their exercises and you charge them. Then I sometimes keep contact with them by saying please phone me regularly. Phone me in a months time to tell me how it is going. Sorry, what is your question again??

I: My question was why do they come back to see you. Can I just make a comment on that? You say that they come to see you when you have their health at heart.

R: Patients are not stupid. They can see greed a mile away.

I: So they come and see you in pursuit of health.

R: Ja. If people have had heachache for the last 20 years, they don`t expect a cure. If you can keep them 80%/90% better, they are absolutely fine – it is Christmas!

I: To what extent do you consult with your patients during the management process?

R: Quite a lot. I like to listen to patients. I don't always go along with what they say, but I always listen and hear them. If they have something specific to say, I always weigh it and think about it and say yes I agree or disagree. I think it is an important part of the relationship. If you start to say I am the doctor and you are the patient and you shut up, then that is the kind of arrogance that I don`t like at all. Doctors are not people on pedestals. They are ordinary human beings.

I: Can you maybe give an example of when you say that you consulted – of how that has happened?

R: It comes in two forms. It depends on the nature of the patient. Some patients have a very low pain threshold and you might perceive that they are a bit whimpish in the back of your mind. Then you say I don`t think it is such a bad problem and I don`t need to see you for a month but come say I would rather return in ten days time. The other side is that money is tight in SA. There is not a huge amount floating around. People are looking at both sides of that R100 before they spend it. So there are a lot of patients who ask do I really need to come back in a months time. And then you have to sell health to them and I am not business of empoverishing patients and I will sometimes charge only 50% of a consultation but then they have to be here in a months time. So I listen to patients – if they don`t have the money or they don`t have the time. For those who just cannot be bothered, I do not have much time for that.

I: So the consultation is basically then a negotiation process?

R: Very much so. I don`t see it as doctors up there and patients down here.

I: So the negotiation takes place on an equal ground.

R: Yes. We are equal in a sense that we are both human beings. We are unequal in a sense that we have certain skills and certain knowledge that they don`t have. So we are able to advise direct. Chiropractors are not Gods or politicians. We are human beings.

I: What would you like to see chiropractors doing in 10 years time?

R: I would like to see them in hospitals. I would like to see them a lot better at MRI's and CT's. I would like to see more chiropractors in hospitals.

I: What would you like to see chiropractors doing in 10 years time?

R: Im

I: Can I ask you why hospitals?

R: In the SA situation there are 9 out of 10 patients treated in government hospitals and they do not have access –chiropractic is for the priveledged in SA, its not open to the masses. I would like to see a lot of black chiropractors. I am disturbed by the fact that we are not even near in producing enough black chiropractors. I would like to see us having a new strategy with a distinct goal of having at least 5 highly competetent, well skilled, intelligent black chiropractors graduating every year. So for me, I think it is vital for a lot of reasons but the least of which is if chiropractic remains a white elitist program, we will very soon seize to get government support- we will die. We have to think of a strategy whereby we would make it possible for black students to graduate as chiropractors.

I: So chiropractors in hospitals in 10 years time are a vehicle for us to gain access to the masses. A plan is required to get them there and something in the education system is where we should be looking at.

R: It is a highest priority yes. I would like to say that in 10 years time this program will not exist if we do not have black chiropractors. It is simply a matter of survival.

I: Something a little bit more related to our practice?

R: I don`t think I need to change anything. I am excited about chiropractic getting into the sports world. But it is actually not for me. But I am delighted that other people are doing it. I think it is fantastic.

I: Are there areas that you would like to know more about that you see as a deficit?

R: Ja, there are quite a lot of areas. I personally would like to see myself doing more research. I have a lot of ideas. I would like to see myself and other chiropractors getting more actively involved in research programs and to see if there are other chiropractic techniques which are valid by which my patients could benefit if I have access to it.

I: So research as an entity is something to look at and then newer and different techniques.

R: Yes, its no good having these things at congresses – congresses to my mind are a waste of time. You don't learn anything new at congresses – you sit and listen to somebody chalk and talk. They are interesting at the time and stimulating at the time, but that is it. Six months down the line, you might remember 5% of what was said. I would like to see courses set up. Where we get somebody to give a 6 week presentation.

I: Are you speaking of the postgraduate setting?

R: I think both formal and informal.

I: You mentioned the inclusion of black South Africans as one of the areas you would like to see developed.

R: More than like to. We either do it or we will not survive as a profession.

I: Would I be correct in saying that that would be one of our biggest challenges?

R: Probably, probably the biggest.

I: Anything else that strikes you as a challenge for us for the future? Maybe more practice related.

R: To be recognized in the chiropractic world – that has got to be one of our goals.

I: How do you mean recognized?

R: We gain recognition, so that South-African chiropractors can practice in Britain or America.

I: Are you referring to international reciprocity?

R: Yes

R: Lets just call it the international standards of training. We don`t even vaguely come near.

I: Do you see that as a challenge?

R: To the future?

I: How is it a challenge, rather than a progression?

R: I don`t understand what you are saying? I just think it is something important. If you decided now – lets say a Swedish family comes and you marry the daughter and she convinces that you have to go back with her to Sweden, I think it would be good if you could practice there, but the chances of that are probably fairly slim. The opportunities for chiropractors from this institution to practice overseas are quite limited. I don`t understand

these things, but there are these different evaluations where people come and look at your courses and if we could get that to international standards, I think it would be good.

I: And that is a challenge

R: It is a challenge. It is an important challenge and a difficult challenge.

I: Thank you very much. We are done.

Interview 2

I: Thanks very much for agreeing to take the interview with me again. I think it would be great if you could start off by relaying to us what you based your decision to become a chiropractor on.

R: I wanted to work physically with people in some sort of service profession not actually then knowing that I was destined to become a chiropractor. There were one or two options and I was introduced to chiropractic by default.

I: What was the default?

R: It was a friend of my dad who worked at the Technikon who said that this course was starting up. He was a student counselor here and offered to do an assessment on me and he thought that I might fit the profile for chiropractic. He encouraged me to go and visit chiropractors as well as the other two professions that I was considering and it certainly interested me.

I: What were the other two professions?

R: Physiotherapy and nursing.

I: Dr. Kretzmann, how would you define chiropractic?

R: It is a hands-on healing profession.

I: Would you like to elaborate on that?

R: well you're trying to apply some sort of healing to the patient whether it be physical or encouraging their mental health and well-being. Physical literally by what you have been taught in your years of study and I think that that also has an effect on the patient, not just physically, but mentally as well.

I: How would you use the term healing profession? What does that mean to you in the context of chiropractic?

R: I suppose one can never hope to achieve full health in any one patient, but one can hope to steer them in the right direction. Healing I think just without considering the definition too much is what you are attempting to do when working on the patient.

I: and that is what chiropractic is about?

R: I would say partly yes.

I: What type of chiropractor would you describe yourself as?

R: Diversified…

I: What is a diversified chiropractor?
R: Not just using one straight philosophical approach and sticking to that, but keeping an open mind that patients could present in any manner both mentally and physically with different sorts of ailments and you have to understand what the problem is and try and work with what you've got both with your own skills and what the patient is willing to allow you to do.

I: What is a straight philosophical approach?

R: Well I would think, this is just my opinion, that you adapt one philosophy and it applies to everybody.

I: and yours is obviously the counter to that?

R: Well I suppose, that then in turn becomes my philosophy. But, one tries to keep an open mind about things, especially when you hear about other philosophies and techniques that other people say are 'the thing' and are the bible. One could consider those, but I tend to think that if there is no scientific grounding to or no relatively scientific grounding to the technique or the philosophy then it's actually, what is the point of using it?

I: What do you consider as a scientific grounding?

R: Based on something that's rational and reasonable.

I: What type of person do you think makes for a successful chiropractor?

R: I think its definitely the approach that you use and you might have to develop that approach through the years to realise that what patients respond to. Sensitivity, sincerity, giving people time if they require the time, but also being sensitive if they are in a hurry. So I think it's a sensitivity to people's needs. And also the attitude you approach them with, perhaps the attitude of positiveness and of encouragement as well as knowing your thing and feeling confident in what you doing is going to help. Based on your experiences as well, sometimes your experiences are not far reaching enough, but you try your best.

I: …and all these things are mixed into an approach towards the patient.

R: Ja, I don't think you can adopt exactly the same approach to each patient you have to adapt your approach to the patient, but I think that on the whole you try to be as positive and as encouraging as you can and as helpful as you can both in your advice and in your treatment.

I: what do you find most negative or unacceptable in viewing other chiropractors?

R: Closed mindedness, especially closed mindedness to other professions-medical professions and feeling that they, that there are certain chiropractors that think that by using a limited technique can cure everything, that just irritates me.

I: and does this closed-mindedness, as you put it, is it linked to a certain approach or philosophy?

R: Ja, I think it must be linked to a certain philosophy, because they so soundly believe what they say and it just, based on one's training just doesn't make sense at all. It just astounds me that patients can believe them, which means that they must be very, they must come across as very charismatic in what they say and do and believe.

I: …and this is not your approach?

R: Well sometimes we have to adopt that approach, but I suppose that my technique could be classified as a type of philosophy, but I would say that the difference is that one tries to incorporate rational, scientific thinking and to the whole thing and keeping in mind what other people have to offer.

I: The closed-mindedness, that you do not enjoy, does that imply not utilizing scientific methodologies?

R: Well maybe they thought they were being scientifically trained, but nowadays, well there wouldn't seem to be any literature to support what they base their approach or their technique on and certainly I have come across very little literature myself that supports some of what goes on- or almost nothing. The flip side of it is the experience, if you have experience in a certain technique and you have developed that then a slight modification of that might help the patient and certainly these guys are helping patients, so I can't totally lambaste them, because some of the patients that have not been helped by me have been helped by them.

People that seem to be using not such sound scientifically based approaches. So then one question is what they are doing is valuable and reliable and sometimes there has to be that to consider. So, experience I would say also comes into developing your approach and both with patients during interaction and with your technique and learning what works and what doesn't work.

I: Do you have a philosophy of practice?

R: Well I think again the attitude of helpfulness and positiveness are the two mainstays of practice, even if you are not going to be treating yourself but being positive about their condition and making the appropriate referral and being there even as a support if necessary.

I: Does the term subluxation mean anything to you?

R: Can we go back to one of the questions you asked about my philosophy or approach, I also think that if you have an approach of wanting to learn all the time and being open-minded if someone has done something better than you have if you haven't been able to make a diagnosis correctly one also has to admit to that and learn from that and adopt an attitude of "learningness" if I can say it that way and not just being proud and carrying on, saying well I didn't make that mistake or whatever.

I: so a perpetual learning cycle in practice, would that make up part of your philosophy of practice?

R: yes, definitely a part of it.

I: The subluxation question?
R: Well it's a joint restriction somewhere within the joint's normal range of motion.

I: Do you see yourself as a mixer or a straight chiropractor?

R: Mixer, without a doubt who uses a diversified approach.

I: Patient management, what do you understand by that term?

R: Again, I try to encompass a holistic approach when trying to get the patient better. Trying to manage their condition so that they get as optimally and as quickly as possible.

I: What are the types of things that management can entail?

R: Both your treatment and the amount of times that you see the patient for return visits, it incorporates education, which to me is the big thing. Education based both on what the literature says and on your experience of what works.

I: Is management a generally accepted term in the chiropractic profession?

R: I think that from what I have heard and seen that management equates to the amount of return visits that you would like to get the patient in for again and I certainly don't see that as the mainstay of my management approach.

I: Elaborate on that…

R: Well that's not what drives me in practice. That's not what keeps me financially viable. For me management. It's the totality of all the different things mixed in. its not just the amount of return visits you get out of the patient.

I: where do you think the notion comes from then that management means booking your patient in for a certain number of treatments.

R: Ah, articles and congresses where they use that term for the amount of return visits you getting from each patient.

I: so there is a misconception that management is the frequency of treatment.

R: Yes, for instance they would advocate that for a facet syndrome you must have eight to twelve visits from the patient, that's an example of a management approach.

I: what is your approach to patient management then?

R: Look depending on the condition and how acute or chronic the patient is, the management approach would differ. So there is no one set management approach, but I tens to adopt the approach where I don't dictate to the patient, but I incorporate the patient in the amount of times I would see him or her for return visits, I don't just use straight chiropractic in the management approach and I tend to incorporate, to the best of my ability, postural advice, nutritional advice, ergonomic advice, exercise advice.

I: What do you mean by straight chiropractic?

R: We've chatted about that already, it means that the adjustment is the be-all and end-all of the treatment and getting them in for x amount of adjustments, where as I even refer to anti-inflammatories if I think the patient needs them.

I: Why do you distinguish between chronic and acute patients in the management?

R: Well that would dictate as to how quickly the patient is going to get better and you need to inform the patient as to what to expect.

I: So is it possible that the chronic patient may never return to 100%?

R: That's always a possibility, especially if they are not willing to help themselves either, make lifestyle changes, which in this day and age is difficult. I mean if it is the job situation that is adding to the problem. Nobody can leave their work situation fully and rest. Anyway that wouldn't be the right thing to do physically.

I: How would you explain to a chronic patient that they would always have their condition?

R: Well, understanding the causes, trying to extrapolate from the patient as much as possible to try and understand what is causing the problem and then working within those parameters and if its something that the patient can't change, well then you need to say that this is something that is adding to it and its going to keep recurring as long as you engage in this activity or this disease process goes hand in hand with the physical symptoms that bring you here. So really educating the patient on the cause and the effects and any predisposing factors that they might have as well.

I: What do you think brings the chronic patient back to you once you actually inform them that they are not going to be a 100% better?

R: Thrust, and also hopefully if patients are in a chronic pain cycle, your attitude towards their pain.

I: So your attitude as an effect on the trust that's built up?

R: It has to. Its also being honest with them as to trying to identify what the cause of their problem is. Trying to help them as much as possible. Honesty has a lot to do with it and the end result to me.

I: So a strong personal relationship….

R: Well I would say that people with chronic pains start to perhaps display a degree of mental fatigue/disability- that's perhaps going down another avenue- but a lot of other practitioners perhaps shrug off people like that, but you need to be as honest and open and down the line, whilst adopting a helpful attitude with people like that. Not all chronic patients have psychological overlays though, but I think its ones honesty about their condition.

I: How strongly do you emphasise the medical diagnosis?

R: Well, one tries to emphasise it as much as possible?

I: Why?

R: Well that's again only being honest to yourself and the patient in terms of what you know.

I: Does the medical diagnosis assist you in the relationship do you think?

R: Yes, again it's bringing in your honesty and it's educating the patient about the condition. Sometimes you need to leave that diagnosis for a specialist, but then at least you have been able to diagnosis something and make the correct referral. So that the patient is helped optimally and patients appreciate that when you have made a timeous and correct referral.

I: So, let me understand this then, giving a name to a bunch of symptoms….

R: Its not always easy to give a name to a bunch of symptoms, but sometimes you are unsure, but at least then you have got some facts to work on, which would steer you in a, steer you towards making a decision on the patient.

I: How do think mainstream/allopathic medicine has influenced you?

R: Well our training has incorporated a lot of mainstream principles, like for instance anatomy, physiology, chemistry, pharmacology, pathology, diagnostics. And then always when we have learned about what chiropractors can help, there has always been:" But the differentials are."

I: So the chiropractic oriented diagnosis have always been contrasted with the medical ones?

R: Yes

I: How have they been contrasted?

R: By emphasizing that a differential diagnosis is important, to understand what else could give a similar cause.

I: What influence do you think the scientific method has had on you in practice?

R: Well, again it's in the attitude of not just saying that the adjustment cures all. How can one believe that when you know that there could be other causes for a fixation and other causes of pain?

I: To what extent do you think you consult with patients during the management process?

R: To a large extent. Case history is the important one and that is where you need to gather as much information as you can and to take a relatively decent case history you have to ask quite a few different questions and sometimes the patient's response is lengthy and sometimes its very short, but based in the case history you get a sense of what makes the patient tick and you work within those parameters.

I: What else makes up the process of the consultation, besides the history?

R: I think for me, it might be slightly different, because working from home there is perhaps a more relaxed environment, its more conducive to patients wanting to hang around and talk

and my personality is not to just shut them off, which perhaps has positive and negative sides to it, so one has to try and develop a balance of not interacting too much, but I think the professionalism needs to be maintained and other aspect are your examination, your treatment and then education.

I: Some would say that to consult would be to collaborate or come to a point where you agree on a diagnosis, would you also agree that that can be a meaning of consultation?

R: what with the patient?

I: Yes

R: I'd say that a lot of people are uneducated about the possible things so they rely fully on you and your expertise to make the diagnosis, but if you can try and use them to try and understand why the condition is there, they more readily will accept the diagnosis that you make.

R: What do you understand by the term patient care?

I: That's not a simple one, because that to me incorporates everything. Care and help of the patient, which starts with your attitude and approach, your intervention and your education. To me it incorporates everything, once again.

I: So that would be an umbrella term even above management?

R: Well I think they go hand in hand, to me the two should be a similar thing.

I: How many psychosocial factors do you consider generally when you treat patients?

R: Psychosocial…. I think most us tend to want to avoid delving into psychological problems if we can, because we are not psychologists, although sometimes you end up having to do a bit of that, but in terms of psychosocial problems in terms of money…is that what you are getting at? Or lack of money or lack of support systems.

I: Do patients speak to you about their money issues a lot?

R: The retired people tend to emphasise that, perhaps we don't have full conversations about it, I actually don't encourage that, because I am delivering a service, but when it comes to money they usually ask directly if that's the cash price or if there is any pensioners discount. If people do have money problems they rather tend to come to the Technikon as opposed to private practice, because it is stipulated that I am cash, cheque or credit card. But psychosocial, in terms of family problems, is that your definition of…?

I: Yes

R: Abuse…

I: Do you pick that up at times?

R: Oh yes, but there I am afraid I'm not particularly good with that one, I tend to refer out. So I just try and handle it as professionally as possible and make a referral.

I: The notion of holism and wellness practice, how do you incorporate that into your practice if at all?

R: Well, you want to get the patient well as soon as possible, so that once again encompasses everything- education regarding nutrition, exercise, posture. To me that's all holism and wellness, as well as your treatment. That's again care, management, holism, wellness… to me its all integrated or fairly closely related.

I: Where would you like to see chiropractors in ten years time?

R: It's a difficult question, because in this economic climate with the emphasis placed on primary health care, chiropractors aren't really in a true sense of the word primary health care practitioners, because we aren't dealing with the third world. The other thing is we aren't just physiotherapists, so how does one bridge the gap in terms of trying to fit us into the whole medical paradigm? A lot of chiropractors don't want to fit into the medical paradigm, they want to keep doing what they have been doing for years, because they are making good money out of it. I haven't given this question too much thought as to where we should head, but it is a tricky one. I think what we need to do, from my own opinion and I think other people graduating form the same college would probably agree, is that we should try and cross bridges where bridges have been broken in terms of trying to fit into a, again a paradigm of happy inter-referrals and happy communication with other medics, so that we ca do the best we can for the patient.

I: So, some sort of integration.

R: Some sort of integration, but I doubt very much whether full integration would be, firstly acceptable and secondly would still keep the name chiropractor going, because a lot of people feel that the word chiropractor has great power, somehow.

I: And you feel that integration would somehow diminish that…?

R: Well it has to if you consider the politics.

I: So chiropractic, lets keep to word power, has a definite political feel?

R: Well within the medical profession it does. The medical people don't like chiropractors and they would have to come under incredible scrutiny and perhaps change their status and become more to what is called manipulative therapists, which equates very much to what physios can offer nowadays as well and the word chiropractor has great historical value I think.

I: So full integration into a medical paradigm as you say will almost be a drop in status for chiropractors?

R: It would and a lot chiropractors would see it like that as well, that they no longer work for themselves that they are at the beck and call of other specialists, but I from a personal point of view, there is an outside chance that that could work, because why should we be so proud as to try and hang on to any historical status that we've had if a chance is going to bring about positive growth and new dimensions even if it does mean adopting the name manipulative therapist, but it might expose us to other things that we haven't been exposed to in private practice. But to try and work it all out would probably be very difficult and tricky and it there would probably be a heck of a lot of debate and argument and trouble.

I: What added exposure do you think chiropractors would get if they were termed manipulative therapists?

R: It depends on who made the decision to call chiropractors manipulative therapists. If it were the medical profession at large together with the chiropractors you'd get a lot more referrals and interaction and happy interaction as opposed to guarded interaction and again it would probably make a difference in making us more visible in institutions like hospitals. But whether there would be a full need for us to work in hospitals, should we fall under the medical umbrella I don't know. We might loose our primary contact practitioner status as some chiropractors believe that we have through doing diagnostics and being able to make referrals in the right direction. That might be taken away from us.

I: So a primary contact practitioner is what?

R: Where the patient comes to see you first before having to consult anybody else, where they believe that they need to make you the first stop and also that …

I: Why is important that they make you the first stop?

R: There are lot of people of who have developed a mistrust of the medical model and they just have faith in chiropractors and they tend to come to chiropractors first for any and everything. Out there in a third world country it would be ideal if they could make you their first stop, but that is not what happens. Why would it be ideal? Because or training perhaps wouldn't go amiss and we'd probably develop more of our techniques than what we probably do. Utilize them in practice. We've been trained to think that we could be a primary contact practitioner and that I suppose comes into the six years of training. In reality I actually don't think it works like that.

I: So who do we see and when?

R: We see anybody who feels like coming to see us, but its mainly a first world type of person and I think the chiropractic profession has become fairly elitist feeling that they no I won't go down that line.

I: Let me ask you this, what is a first world type of person?

R: People that can afford to pay for a service, people that are educated and have access to health, sanitation and medication and the care that they would need.

I: What do understand by the medical paradigm or the medical model?

R: Well I think that people get into a rut very quickly, my approach to practice might be a unique or idealistic one. People want to make money, they are strapped for time for various reasons and the thing is that one does get into a rut, but chiropractors can also get into a rut. I suppose it's an individualistic thing. But on the whole the medical paradigm, probably is based more on listening to what the patient has to say, making a quick diagnosis and handing out drugs.

I: And that's not what you're about?

R: I think I personally try not to e like that, but I think the medical model is more of the allopathic drug approach to see what medicines can do to help people as opposed to what other forms of care, but then I contradict myself, because physiotherapists and occupational therapists all form under the medical model, I think that each one has their speciality and works within those constraints. I think that basically is the medical model, but then don't we do the same? That to me is a tricky question.

I: What do you think the greatest challenges are for us in the near future. You mentioned a lot about the integration and a couple of other things.

R: To try and stay viable in a third world country, to try and continue to try and better ourselves without becoming egotistical about it, to try and build relationships with other professions so that we can be more integratory with other professions. I think that what going to ultimately help us more in a third world country.

I: Should be remain separate and distinct, in order to integrate more effectively?

R: I think that we can get away with it ultimately, but we need to remain as professional as we can as open-minded in terms of learning and in terms of how we can build bridges more effectively with other doctors and specialists and other health care providers. To me, that would be something to work on.

INTERVIEW 3

I: Welcome Dr Docrat. Thank you for taking the time to have this interview with me. I am going to start with a simple question. Why did you decide to become a chiropractor?

R: It has got to do with my dad. He works in the computer field and he was having a battle with neck pains and headaches and so on and nobody could find the problem. He used to spend a lot of time working in front of the computer and then somebody at work said to him – after he had been to physician to physician, somebody went to him and said go and see Dr Ben George. And that is where he found his relief and then he came home and he explained to us that he went to see this doctor and he put him on a table and he felt lots of relief afterwards and then he came home with a leaflet that Dr Ben George gave to him on what chiropractic was all about and that is where it all started.

I: And from there it just developed?

R: Ja, I just did more and more reading and it was at that time that I was in std9/matric and that is when I decided that it is what I want to do.

I: So it was very much a deliberate decision.

R: Ja.

I: Was there anything else that you wanted to study?

R: Well, something in the health field. I even applied for physio I remember, but chiropractic was my first choice.

I: So it was always going to be a manual medical type of career for you.

R: Ja

I: Ok. How would you define chiropractic?

R: Well, chiropractic – you can give it the definition that you like in text books. Like maybe in Haldeman's textbook that it is the science or art of locating subluxations and so on. I feel that it is a field that has developed over the years and it is constantly evolving. It involves mainly the spine. It inolves mainly treatment of the spine using manipulation. That is what I would say is chiropractic. But if you look at it today, it has lots of grey areas with some of the other musculo-skeletal fields or fields that treat musculo-skeletal conditions. A lot of people are

using modalities, all types of modalities. That is basically it. I would say chiropractic could be defined as something that- a form of therapy that involves manipulation of the spine as its hallmark to treat musculo- skeletal conditions.

I: The modality that you refer to – they are various tools and machines that you can utilize.

R: Yes, those are just like adjuncts. I wouldn`t say that somebody has been treated chiropractically if they just got ultrasound or IFC on their back. If they are receive an adjustment only, then it was chiropractic treatment.

I: Ok. What kind of chiropractor would you then describe yourself as?

R: I would describe myself as maybe a mixer. I adjust and use modalities – I don`t mind doing that. I feel that if there is anything that will help the patient in getting better, then it should be carried out. However, I wouldn`t subscribe to the view for example if somebody had low back pain, chronic low back pain and you know that this patient will improve by manipulation and this patient will only take medication, I wouldn`t subscribe it if I feel the patient has to be manipulated.

I: Is there ever a time that you wouldn`t manipulate?

R: Ja. There are lots of times where I wouldn`t manipulate. Basically following the contra-indications, you know people that are old, osteo-porotic or have hard neurological signs etc. But then also in certain types of patients who just don`t want to be manipulated although there is no contra-indication. I do always make a point of explaining to the patient that this is the hallmark of my profession. If I am not going to manipulate you I feel that you are not going to get better and then you are going to think that my treatment is not helping. So you might as well move to somebody else where you feel that you are going to get more relief.

I: Ok. What type of values do you ascribe to as a chiropractor?

R: I think considering – are you talking about the profession itself or just generally as a person?

I: Your value system and how you apply it to being a chiropractor.

R: I always feel - I have had many patients tell me that when they see a chiropractor its is just one visit after the next. I always strive to make my patients feel that I am not calling them back for nothing. They need to come back – it is necessary and this is how the treatment works. So if you ask me from an ethical point of view, I always maintain that I only treat my

patients for what is necessary. I wouldn`t call them back unnecessarily. Number two – I am a chiropractor who work with medical aid. I get lots and lots of queries from patients who would like to use chiropractic, but also they have alternative motives with their medical aids. I don`t subscribe to any of that at all. I don`t know if that is a values you are talking about?

I: Sure, sure.

R: When it comes to the treatment of – like for example in my religion some ladies are very reserved to be treated by a male and I refer them out. If a man comes and he wants his wife to come for a treatment but she is uncomfortable with a male, I refer her to the clinic here where we have lots of ladies or maybe another chiropractor in the field who is close by. But a lady chiropractor. That is basically it.

I: Do you have a philosophy of practice that you subscribe to?

R: I wouldn`t call my philosophy of practice the traditional chiropractic hardcore philosophy, you know innate and all that, I just don`t subscribe to that. My philosophy is that chiropractic is a scientific way of treating musculo-skeletal conditions. We are very limited in what we treat. We cannot treat everything, but we do have a very big scope of practice, because of the number of people who suffer from musculo-skeletal conditions. My philosophy is - I have a very open philosophy where I like to include allopathic and complementary therapies in my practice. But only those complementary therapies that have stood the test of time and that have some scientific background and when it comes to allopathic treatments, I try as much as possible not to go with anything that is risky or that is not acceptable by the wider percentage of the practitioners in that particular field.

I: Can you give me an example of a complementary therapy and then maybe an allopathic one as well?

R: Ok, complementary – I would for example, I would refer my patient if I feel that this patient is really stressed out, I would refer them to somebody who does aromatherapy. Thats on the complementary side. On the allopathic side, I always recommend my patients to go to GP`s and neurologists and so on. But I tend to always be conservative. I wouldn’t refer to anybody who is knife happy, I would always refer them to someone who will try the conservative way first.

I: Would it then be fair to say that you tend not to adhere to some of the metaphysical aspects of chiropractic?

R: Ja. I think that would be correct?

I: Ok, and your particular philosophy is grounded more in its scientific and sort of biomedical side of things.

R: Ja, that is how I would describe my philosophy.

I: What type of person do you think makes a successful chiropractor? We spoke about values. This is more characteristics.

R: Somebody who has got to have people skills. You have to be able to interact with people well. Somebody that has success on a level that is acceptable to your patients. Somebody who is determined to built a practice, if you look at the South African context. Not just wait for the practice to build by itself. You have to be a pro-active person in order to build your practice and you have to have people skills. You have to be able to accept criticism, because chiropractic is going through a growing curve in South Africa. Many people don`t know what chiropractic is and because of ignorance they are very quick to criticize. Even GP's or other professions. You have to be able to deal with that in a constructive way. If you are going to fight fire with fire, those people that are questioning your profession or your particular area, they are not going to refer to you – even if you convince them that you have a role to play. So I feel you have to be somebody that is understanding also that people don`t understand your profession and you have to do your own brand of marketing and patient education.

I: What would you find unacceptable about other chiropractors when you observe them?

R: First of all, I wouldn`t say there are lots of chiropractors like this but there are a fair amount. I don`t know whether to say the majority or just a minority, but one thing I do not like is when we have this attitude that medicine is wrong. Chiropractors would have a conference and they have an hour and a half talk about why immunization is wrong. We don`t have any scientific background to make that kind of criticism. If they had immunologists speaking about the topic well and good, but here we have a bunch of chiropractors who have no qualification in immunology speaking about the reasons why vaccination is wrong. That is the stuff that brings our own profession into a whole ,because you get somebody from the allopathic health profession or the media who takes that out and it just wipes out the whole profession. If we question those things that are also being questioned by the allopathic people themselves within normal medicine or allopathic medicine, then well and good. But principles and methods of treatment that have been acceptable everywhere all around the world, you find a few chiropractors who try and question that. If they have genuine scientific reason to do so, then well and good, but most of the time you find that they have absolutely no ground for their critisism.

I: Can I just ask you a question? What do you think is the motivation for arguing those things?

R: I think is it is because – basically they are trying to get back at the medical profession because medicine hasn`t fully accepted us. I think it is a matter of throwing mud from one camp to the other.

I: Can I ask you why do you think this acceptance by medicine is such a moot point?

R: I think it can only be because of commercial reasons. If we get accepted by medicine, people are going to flock to us. That's why I think there is so much mud slinging going on. Personally I feel that it shouldn`t be important that we get accepted by the medical profession. Patients themselves see that this is a profession that works and that is who we should go to to seek acceptance. Or we should do your own brand of marketing – not being dependent on medicine.

I: Your second point that you were going to raise?

R: Ja, secondly, I would say, I have a problem with people who practice with the whole innate philosophy where they believe they can cure ulcers by manipulating the spine. I have had many patients who tell me that a chiropractor said that he can cure cancer. I have had a patient about three months ago who said that this chiropractor said that I would cure cancer by manipulating someone`s back. And apparently he also says he can cure diabetes and he tells patients to stop taking their diabetic medication and so on. I don`t like that. I don`t think there are a lot of chiropractors who do that in Durban. That is one thing I do not like – when chiropractors come from an old school of thought and they just haven`t kept up with the latest developments in the field and they are still practicing the old way of chiropractic and because they have such large practices it damages the profession.

I: The first point which was the mud slinging and the immunization thing and practicing in the old way – are those two linked?

R: Ja, I think they would be linked.

I: Can you just expand on that?

R: I think those chiropractors who come from the old school of thought, they believe in all this innate philosophy – they body being able to cure itself etc. And the immunisation thing was just an example. They use lots of other things about the medical profession. I think that chiropractors that have graduated more recently, would tend to think of things a little more differently compared to the guys that are in the field for a while. The guys who have been in the field for a while have that old type of philosophy that is so much under debate – they run that type of practices. So ja, I think it is how it is linked linked. They are not prepared to be

mixers or they are not prepared to use other modalities in their practice – just manipulation and that is it.

I: How do the younger or more recently graduated chiropractors think differently?

R: I think they would realise that when it comes to the treatment of organic conditions just purely by manipulation of the spine - that is not what we do. I would really be surprised that somebody would think that coming from the chiropractic school now at this point in time. I think it is unacceptable that we can treat things like cancer or – There may be some of the conditions that have grey areas in allopathic medicine or even in the scientific literature like maybe colic etc. manipulation of the spine could be shown to help. But when it comes to established things like treatment of ulcers or asthma or cancer or so, there is no way we are going to be able to treat that by manipulating the spine. If anyone come out of the schools I this century thinking like that, then I think it's a serious problem.

I: What do you understand by the term patient management?

R: To me that would be managing a patient with respect to his condition in such a way that the patient either learns to cope with his condition if no further progress can be made or leading the patient onto the road to recovery. If you know that a patient has a facet syndrome then you know he can be treated and "cured", then your patient management would be how you lead that patient to the outcome of being free of the syndrome. If somebody has got a more serious condition, then your patient management would be how you lead that patient to the outcome of feeling a lot better with the condition – being able to cope with the condition.

I: Patient management can last for some time then?

R: Ja, depending on what you are treating, it can last for some time. I have younger patients who I treat once or twice and they are off and you never see them again, because they feel a lot better and then you see older patients who have been battling with back pain for a long time, he's got anatomical changes in his back already and you treat them and then they normally come in every month or every few weeks just to get adjusted – to keep their spine or back or neck bio-mechanically sound. So that would be a long-term management of the patient for his condition.

I: Is the term management in your opinion an accepted notion amongst chiropractors?

R: I don`t think so. Ja, it could be accepted because you do get chiropractors – I myself do it, where you advise your patient to come in at least once a month or every two weeks first to get their spine adjusted. I think on that point of view, they might not call it management but that is

basically what I think is patient management. Maybe that is how the other guys would feel as well.

I: What do you think they would call it if not management?

R: Maybe maintenance. Patient maintenance.

I: Do you have a particular approach to patient management?

R: Not really. I treat them for their diagnosis and depending on their diagnosis, I always advise them that chiropractic is something that you need to have regularly. You need to have your spine assessed regularly. So I normally advise them that at least once a month or every two weeks, that they should come in whether they are in pain or not just to get the spine motioned out or adjusted if its necessary. Just as how we are advised to go to the dentist every six months.

I: So if they are not in pain and they come in to you, would that be maintenance?

R: Ja, if they are not in pain and they still come in for their regular checkup, that is in my opinion maintenance.

I: So it is possible that maintenance would fall under the broader umbrella of management?

R: Ja

I: You mentioned diagnosis. Is that diagnoses in the sort of medical diagnoses framework?

R: Ja, from the way we are trained, I feel diagnosis would mean diagnoses as in the medical way which would include also the aspects of chiropractic like the level of fixation, which ever levels of the spine are affected. But then also the aspects of the medical way of diagnosing like joint dysfunction, stenosis disc hernation and so on.

I: Is there a difference in the manner in which you would treat your young acute patient vs. the older episodic person?

R: Ja, the younger patients, I try not to use many modalities. Just massage manipulation and maybe stretching. Older people I would tend to use ultrasound and IFC a lot in my treatment-infra-red as well.

I: Reason for that?

R: I think because of the response to the treatment. People who have had a long history of the condition – older people might have a back pain for the first time and they would be treated just by massage manipulation. The people who have had a long history of low back pain and there is lots of fibrosis and lots of inflammation, I would try to use as many modalities to treat the problems as possible. In a younger patient who has had a terrible injury to the spine or maybe a badly injured knee or ankle, then I would use modalities, but as a rule generally, I use more modalities for older people.

I: The chronic patient that you treat with a lot of different modalities, what is the reason for that?

R: I feel that by using those different modalities, they definitely do have an effect on the outcome and then also the patient feels that somebody is not just – it is not just a matter of in and out of your rooms. They come in a lot of pain and the pain is a big part of their life and by spending time on the patient, they feel that something is being done.

I: So in a chronic patient, time is linked to…

R: Ja, the amount of time you spend with a patient is linked to the outcome.

I: You mentioned with chronic patients there is something that you like to achieve and the modalities help you to do it. What are you trying to achieve with a chronic patient?

R: Well, first of all to try and give them relief from their condition – relief according to them – subjective and objective. If they feel that something makes a very big difference to them, and they are feeling a lot better, then I am happy with that. Objectively, I try to achieve as much objective improvement from the patient as possible. That is what my goal is.

I: So with the chronic patient there is the possibility of not achieving ultimately a cure?

R: Maybe with not all types of diagnosis. It depends on the diagnosis. You may get a patient who has been suffering from a condition for a very long time and just hasn`t been managed properly and by reassessing the situation and managing it properly, he may feel a lot better not having the condition anymore. And then you get the guy who has got something and we all know that and you know that you are not going to be able to cure him.

I: So when the chronic patients have the perception that you are spending time and that you are using these different modalities, that it might very well influence why they come and see you even thought they are not going to get cured?

R: First of all, proper management would include informing the patient about his condition. They shouldn`t be advised in the way in which you send them on a wild goose chase where they feel that they are going to get cured. They must be informed that you will achieve a certain level of relief for this condition but that this condition is not going to be reversed. They should be informed that we try as much as we can to get the best outcome and the most amount of relief as we can.

I: To what extent do you consult with your patient during the management process?

R: I would say I ask my patients fairly often what they think is going to help them and then using my own clinical judgement I think about whether it is something to consider or not. Sometimes patients come in and say I feel a lot better and I don`t think I need the treatment today and I would just follow. I wouldn`t force them to do something they don`t want to do. But in certain conditions you have to make the decision for the patient.

I: When would that be?

R: When the patient is not aware of what is going to happen and you know that manipulation of the neck would make a really big difference to this patient and that is when you have to make the decision even if they feel they don`t want to be manipulated. Obviously you cannot force them, but you have to advise them.

I: What do you understand under the term consultation?

R: I think consultation would mean that the patient and myself are together in trying to get him towards optimum health. My treatment is not just dishing out a lot of things whether the patient likes it or not. In consultation you have to find out from the patient what is going to be comfortable for them, advising them on what will help them and getting the response from the patient. Whatever response you get from the patient, you make a decision accordingly.

I: The term modalities and treatment – how do they relate to each other. Treatment is a word that is generally used to describe interventions of some sort.

R: Modalities would fall under treatment. I don`t think it is separate.

I: Some examples of what modalities are in chiropractic?

R: Purely chiropractic modalities or what is being used?

I: What is used in your day to day practice?

R: Well, I do have access to an ultrasound machine, IFC, TENS infra-red. Those are the modalities and then pure chiropractic treatment would be manipulation or mobilisation of the spine.

I: So you draw a distinction between a modality and a treatment?

R: No, I wouldn`t call it a distinction. Modality is a way of treating a patient. But if they receive IFC or ultrasound or infra red, they haven`t been treated chiropractically. If they receive all that with an adjustment, then they have been treated chiropractically. And the adjustment is the hallmark of the profession. If somebody has just had a manipulation of the spine, they have been treated chiropractically.

I: And then if you can just relating it back to the broader management? If you say that the adjustment is the main treatment, how does that treatment fall under the broader umbrella of management?

R: Like I said, we are very limited in what we are able to treat. There are certain types of chronic conditions where manipulation is not advised. The chiropractic adjustment forms a very integral part of patient management, but it is not always necessary to use that adjustment in the treatment of a particular condition.

I: What would you like to see chiropractors doing in 10 years time?

R: I would like to see chiropractors integrated with the medical profession especially in state hospitals. If we could have access to patients that are coming to state hospitals and working a lot more closely with medical doctors because I feel that there are many patients who are being treated allopathically and they are getting relieved but I feel that their management would be a lot more effective if they had chiropractic treatment.

I: So hospitals and working more closely with the medical fraternity. What part?

R: Particularly orthopedic surgeons and physiotherapists.

I: What do you think chiropractors have to do to get there?

R: I think we have to first of all get our act together, meaning that we cannot have a 101 different camps all fighting for the same think. We have to be one unified profession – everyone under one umbrella and everybody trying to achieve the same goal. That is when we will make some progress. I am not talking about fighting to be accepted by the medical profession but trying to get ourselves established in society as an acceptable profession.

I: Ok, what do you regard as the main deficit in your own training?

R: That is a difficult question to answer. I think one answer to it would be the state of the profession in SA – when I was in fifth year, we generally understood what the state of the profession was in SA and also practice management skills etc. These are things that one has to pick up by yourself. Unless you have the opportunity to practice with somebody, you have to learn this on your own. I think that is one aspect.

I: State of the profession in SA – just briefly elaborate on that?

R: I am speaking about the different camps we have. It wasn`t until very late in our training when we realised that some people think that chiropractic is this or that and we assumed that what we were studying is what chiropractic is. It was only when we got to 5th year level when we realised that there are a lot of people who will disagree with you about what you think chiropractic is. That was one defect.

I: How do you think we can remedy that in future curricula – the management and the state of the profession?

R: I think the changes that have been made recently in our curriculum will address some of the issues. We should also educate from 1st year level about the different schools of thought in chiropractic and where we come from exactly – what our philosophy is.

I: Once again briefly, what do you think that philosophy is?

R: I think we are very different from chiropractic elsewhere because we are very scientific in our course structure. You will see lots of shades of the medical profession and also you will see we are very research orientated. Basically critical thinking – that is what our course is based on.

I: And you think that the research basis is a positive influence?

R: I think it is a very positive influence

I: What are the greatest challenges facing the profession currently and in the future?

R: I think the greatest challenge would be to keep ourselves distinct from others. Everybody is turning to manipulation and that is the hallmark of our profession. If people ask what is the difference between a chiropractor and a physiotherapist – all the modalities that I use come from my sister`s office and she is a physiotherapist. But when it comes to adjustment, that is

what I do. She treats her patients using all those modalities, but she cannot adjust. The hallmark of our profession is manipulation. We have to remain distinct from others. That is our greatest challenge. You cannot be taken under the medical profession`s wing – I personally wouldn`t want that. I don't think its necessary. But I don't want that to happen and we get smothered into some stream and we just become som type of technician. That's with regard to the adjustment and then also, I think our philosophy or the way in which we manage our patients. Chiropractic has its background in complementary medicine and just the way we manage our conditions should be distinct from others. I don`t want to end up in 10 years just adjusting people but also trying to use as many of the advances that are made on the allopathic side incorporated in our treatment for the benefit of our patients.

I: I thank you for your time sir.

INTERVIEW 4

I: Thank you for agreeing to the interview. First of all if you wouldn`t mind telling us why you became a chiropractor?

R: Well, that was a rational approach to what I wanted to do. I developed almost a list of do`s and don`ts so there was certain things that I wanted to do in my career and there was certain things that I didn`t want to do and I developed that over time – three to four years and I went to a school counselor and I said please can you dig up some profession that look at these different do`s and don't's and so she gave me a whole lot of technikon and varsity booklets after she had been through my list and so I started to go through it and the one that stood out the most was probably chiropractic or homeopathy. I always wanted to go into the health care field. After that process of research as to what I wanted – chiropractic or homeopathy and then being more of physical interactive type of person and chiropractic was just the best choice of the two at that time.

I: Why chiropractic and homeopathy?

R: I have never seen much scope for medicine in general. I have never been overly impressed with the medical fraternity. Based on passed history with my mother and my father in the medical fraternity and then myself not reacting very well to drugs. So it had to be something that was alternative, which was one of the dont's on my list, it couldn't be medical or that way inclined so I was looking for something in health care – probably something more alternative and then from there which one was available to me.

I: So your decision to become a chiropractor was very much a sort of step by step process.

R: Ja, a process of elimination

I: And then at that point you made a very strong connection between medicine and drugs.

R: Ja

I: How would you define chiropractic now?

R: I think chiropractic as a primary contact physician to someone who is able to diagnose any sort of pathology walking in the door – much like a GP would. Almost a gatekeeper in many senses and then referral of those cases which you cannot treat. Mostly those cases would be outside the parameter of neuro-muscular-skeletal, which is our forte of what we are able to do. In terms of the treatment approaches – they can vary depending on what type of

practitioner you want to be. Obviously I stick to more to the scientific as suppose to some kind of fringe developments, but definitely adjusting being the primary focus of what chiropractic is but it does not only have to be adjusting – it can be tissue work, muscle work, the complex between the muscle and joint interaction as well as the supplementation, the wellness, the nutrition of the patient – psyco-social factors that would influence the way the patient responds to your treatment.

I: This all falls under the definition?

R: Ja

I: You mention that you are a more scientific oriented chiropractor?

R: Ja

I: Would you like to expand on that?

R: Essentially in terms of scientific, probably a better word would be evidence-based. So you use what has been proven to work as suppose to use what we know little about. Either research what it is that we know little about to find out if it does work or alternatively experiment in terms of practice with different patients with a new therapy to evaluate if it works in the clinical practice – if research was not an option for you say in the clinical field. But I wouldn`t advocate using fringe line treatment as a main stay treatment, if you don't know what the patient benefits are.

I: Can you give us an example of what fringe is?

R: Fringe would be something like the use of the concept of networking. We don`t know much about it. We assume that is it is somehow linked to vibrational medicine or concepts of vibrational medicine, but there is no information as to how it works, if there is a protocol that has to be followed, what reactions the patient have to it, whether its positive or negative. What is it? How would one define it? How would one rationally explain it to someone who doesn`t know how it works?

I: What do you describe as mainstream chiropractic?

R: Mainstream chiropractic would be adjustment, the physical manipulation of the patient as indicated. The use of soft tissue therapies auxillaries or massage techniques and then as well as the advise and nutrition and all that sort of things.

I: You said that you would adjust as indicated or manage as indicated. How do you get to that indicated stage? What gives you the indication?

R: That would be your assessment as a primary contact physician. That would incorporate things like your case history, your physical relevant region examination based on orthopedic testing and diagnostic evaluation like your vitals, blood pressure, chest exam. Those type of basic medical assessment tools.

I: That is how you relate it to the GP concept?

R: Yes

I: What values do you ascribe to being a chiropractor?

R: In terms of being a practitioner or?

I: Your value system applied to chiropractic.

R: Well, in my personal field in terms of dealing with patients, you obviously have to be honest and open with what is going on. You have to have a communication with the patient at all times to ensure that they are always in the know as to what is going on and they are always in a position of being informed of what is going on. So that they are able to say I don`t want this, I rather want that so that they have a choice of what is happening to them. Also you need to be ethical, don`t withhold information from the patient purely because the patient then does not have informed consent. Be open to the options available to the patient and treat them to the best of your ability within the given scope that you have and not make assumptions that you can treat conditions that are not within the scope of what chiropractic is. So in that respect – open, honest, ethical, truthful. That is your baseline.

I: Do you think you have a philosophy of practice?

R: It depends on how you define philosophy, but I would say that the biggest philosophy I have is more in terms of bringing relief to the patient, whatever their condition is by a set rules or criteria that you have in terms of the patient approach, your ethics – all that stuff and then next to that more a case of guided by your evidence base. So it is a mixture of being a person who is empathetic and sympathetic to the patient but basing what you do on evidence based rules and guidelines.

I: Where do you think the evidence stem from mainly?

R: Evidence I would go back to as I said earlier more the research based idea. Not necessarily randomized controlled clinical trials, but some sorts of investigation as to broaden the horizon of what is available for you to be in an interactive doctor-patient relationship. Things like a survey of some sorts like what you are doing right now.
Some sort of an investigation to find out more about what that relationship actually entails and how that relationship can be improved for patient care. Obviously your research clinical trials are aimed at the intervention of a particular clinical condition as opposed to the general patient interaction.

I: So is it fair to say that your philosophy of practice definitely include research in the scientific method kind of way?

R: Yes, I mean you would have to use your scientific method as part of your rationale in diagnosing the patient anyway. Your law of probability and then all your differential diagnoses that you would have to consider and then include or exclude based on available evidence is pretty much a scientific method approach that you would have to use.

I: What do you think makes for a successful chiropractor?

R: It depends on what field you go in to. Obviously if you are a sports chiropractor vs a family practice, you would have to have different qualities and different ways of ensuring the doctor-patient relationship is maintained. It takes on the side of a pediatric for example a person who is very comfortable with children, is able to play with them and have all the toys and so. So you have to be very flexible to the situation. You have to be flexible for each patient. You have to give them what they want to as an individual as suppose to what you think they should have. Each field has their own individual demands so it would depend entirely on how you approach each situation and that flexibility you have to build into your system. A sports chiropractor have to be aware of the fact that the person wants to be on the field again tomorrow or the next day and apply their protocols and procedures in that context. So you have different parameters in which to work. So in terms of being successful you have to be flexible and sticking to your principles and be consistent in what you do and don`t always change your treatment protocols. Don't start with the low back if the ankle is the obvious complaint.

I: What do you find most negative or unacceptable when looking at other chiropractors?

R: One thing is flamboyant statements that are unproven and promoting the profession in a manner that is not always consistent with the norm or the general consensus on what chiropractic is. Purely because that not only adds pressure to the profession to define itself but it also adds pressure to the individual chiropractor where a patient comes to you from Dr

X and says well he did this and you then have to try and explain to them that is not necessarily a proven scientific track record or type of treatment, that it is not the general norm/consensus. That would be the one thing. Second thing maybe just in-house – not necessarily to do with patient interaction – is the level of communication between chiropractors.

I: Can I take you back just for one second to your first point – how does the flamboyancy of statements made ill-define the profession?

R: Well, say for example that someone says that chiropractor can cure all disease, which has been proven to not be the case. But, if the patient comes in to you with cancer or something that you are unable treat, maybe even hypertension. You will then have to try and explain to the patient that that principle is totally incorrect and that often presents its own problems – especially if the patient is adamant or has had previous successes or perceived successes by another chiropractor or physical therapist, that aligns themselves very closely to chiropractic. That in itself presents problems with patient interaction. Also on a global scale – how do you logistically motivate for health care funding based on a principle that is not necessarily proven or does not show any sort of moral or rational judgement when it is made.

I: Your second point?

R: The second point was more a case of communication. A lot of communication both within the profession and the outside medical fraternity has always been lacking. In terms of the communication I mean patient information communication. So on a referral basis if a patient is received from a doctor there should be more communication with that medical doctor to say this is what I have found, this is what I am doing – is it consistent or inconsistent? Are we working with one another or against one another? So looking more at promoting communication between different health care professionals to the benefit of the patient and not necessarily only to the benefit of the chiropractic fraternity.

I: What do you understand under the term patient management?

R: Patient management for me is where there is one principle person whether it is a chiropractor or a medical doctor in charge or a particular patient`s well being. For example if a patient has high blood pressure, diabetes and a chiropractic pathology, one person would be in charge of managing that case or keeping tabs on whatever that patient is progressing through, but it doesn`t mean that that person does not refer that person out when it is necessary to other professionals. But there is at least one person who knows that at any given time what that patient is going through. So you don`t deal with that patient exclusively. You don`t just treat the chiropractic aspect – you would need to have an idea of what is going

on in terms of their blood pressure – is it medicated, do they need to be referred back for a dose adjustment. So there is a communication between professionals and some sort of an idea that that patient as a whole is being treated as opposed to I do this and you do that and we don`t know what the other person is doing. So in that respect patient management includes that entire spectrum as well as within your own discipline ensuring that you assess and treat according to your range and scope of practice. So you look at supplementation in each and every patient. You look at the ergonomics of each and every patient to ensure that you are doing the best that you can in your little section and co-ordinating that with the other people that are treating the particular patient.

I: You mentioned treatment – how does treatment relate to management?

R: Treatment is a portion of management. It is not the be all and end all of patient management. Treatment to me refers to what you physically will do to the patient in your consultation but your management include what you will do that will effect not only the patient there and then but maybe their home environment or their work environment – things that you can advise them on to do outside of the actual practice constraint. In that respect you are making a life long change as opposed to a once off intervention.

I: So treatment examples would be?

R: Adjustment, soft tissue, application of IFC or a combination of these modalities.

I: The term management – is that a generally accepted term among chiropractors?

R: Not really. A lot of people would use treatment and management interchangeably whereas I see a greater differentiation between the two terms. A lot of people will assume that treatment would mean that you will be assessing the all those other factors, but that doesn't necessarily always happen, so I don`t know if it is a lack of awareness that treatment only includes stuff within the practice as opposed to management which is outside of the practice and maybe interdisciplinary, psychosocial factors of the patient – a more broader term.

I: Is there anything that you find frustrating in managing chronic patients?

R: Not particularly. It depends on what your outset and your goals are at the end in terms of where you and your patient need to be in a year or 2/3 years time. And also what understanding you have with that patient. Say for example it is a patient that once to come back for maintenance treatment or they feel that they have to come back every two weeks just to make sure nothing is wrong, it would be based on an understanding between the practitioner and that particular patient. If I would say to my patient there is no need for you to

come in but if you so wish, you must understand that I may not adjust you or may not do x,y or z modalities on based on the fact that so many manipulations over a given time are not beneficial to you . So it would depend on how that doctor-patient relationship is set out from the start. And I could see that there would be frustrations if you didn't have a combined goal and understanding of what would happen – again going back to when you assess your patient; treat your patient, you need to inform them of all the options – where you stand as a practitioner and what they have available to them. If that baseline is drawn properly, very few frustrations arise later.

I: Should there be a difference between how a chronic and an acute patient is treated?

R: There will be a difference in terms of what the practitioner would want to do immediately for that patient to reduce pain level or the severity of the condition. But there should not be in terms of the whole management procedure much of a difference. Again each management will be tailored to the patient and you would have to even in an acute situation treat that patient as is necessary in that context and then with your rehabilitation and continued care after that point your principles as layed down by your interaction with the patient and your contract that you draw up either formally or informally, would then be that basis of what you carry through. That doesn't necessarily mean that you can't alter that contract as time goes on or change it, change your goals. If your patient is getting better quicker then there is no need to prevent the patient form going on to the sports filed for another week, we can then re-negotiate. So, I don`t think in principle there is a whole lot of difference between acute and chronic because your basic principles that you have to go through in terms of your assessment, your treatment, and how you plan your rehab state after that, would be very similar – just modified for the patient situation and condition.

I: You mentioned that patients may require continued care – what kind of patient usually gets the continued care?

R: Again it is condition dependent. Using my RSD patient as an example. Say for example where a neurological pathology takes up to 4.5 years to decrease or become improved over time. That patient would need some kind of continued care or some kind of surveillance. They can be taught to do home therapy which is often the case as well as you have to check on them at least every second week or third week purely because of fluctuations that can occur. So continued care does not necessarily mean that you would be treating them, but you have a constant tab on where they are as a patient and you have to be able to alert them to problems. So it is more a management role in your continued care as opposed to a treatment role.

I: Your acute and chronic patients – which of the two would you say have a greater likelihood of a definite end in terms of management?

R: I would probably go with your acute patients – however acute can become chronic depending on the condition. But acute would have more defined resolution period. Chronic patients have a slightly longer period of intervention and their management is more long term. Based on the fact that they are more likely to go back to bad habits.

I: Is it possible that the chronic patients will actually never have an end point?

R: It is possible in both, but I would say it depends on what your philosophy is with your chronic patients. You can get them to a point where they become self sufficient with their particular problem. For example you cannot solve the condition that they have but you train them to become more able to cope with the situation they are in. So you become more of a mentor as opposed to a physician that treats them. So the relationship is such that you guide them in terms of what they should and should not be doing, intervene and treat if necessary, but they are then responsible for taking over their condition and maintaining at their optimum. You cannot be there as a physician for them all day- every day, especially if it is a long term pathology or chronic pathology.

I: So, if the patient is not going to be resolve would you say that you are being a mentor in guiding them to their potential and that is the main reason why they would come and see you considering that they ultimately may not respond to the treatment?

R: Ja, that relates to how you set up your contract with your patient. If you say to them this is what I am able to do and this is what you need to be able to do, the balance shifts between the doctor and the patient depending on what phase the patient is in. If they have a condition where it will never go away irrespective of what I do it may ameliorate and get less, but my intervention won`t keep that condition at bay, that patient has to learn and understand that they have to help themselves. You will find that there is a shift from a very high doctor dependency initially, because they don`t understand what the problem is and they don`t know how to help themselves to a point where that patient starts to take over their own treatment. In as much as they are able to within the constraints of being a patient. So they become more in charge of their case and you almost empower them to help themselves.

I: So this contract and negotiation process – would this be your understanding of the consultative approach?

R: It is more a partnership where the doctor is in the know and is able to explain and define things to the patient. Where once the patient understands what the problem is, they are more

able to help themselves and you are able to facilitate the process much more easier. It is more a case of teaching them or showing them what the problem is and then using that education for them to make a decision. 90% of the time you will find that a patient is much more happy if they find that they can do something for themselves.

I: What you understand with consultation?

R: Consultation is when a person comes to you for information. Whether it includes a treatment or not be the case. If you are able to treat, you can offer that intervention and they can accept or reject it.

I: To what extent do you consult with your patients?

R: If we are for example initiating the process of management, explaining to them the baseline of where we are at – ideally where I would like them to be. In terms of where I would like them to be, would then be modified in terms of patient constraints. Are they able to see me for the given time? So I start by proposing what I see for them and modifying that process accordingly. Secondly, if there is a change in the patient presentation, a new problem comes up and also when you change phases in a condition. As soon as there is a change that needs to be addressed within the relationship, that contract or understanding becomes renewed.

I: Does the relationship/contract occur within the consultation process?

R: Ja

I: Overall, how would you describe your approach to management?

R: Consultative is probably one word you could use, but I don`t see myself in a dictorial role at all. There as a educator, facilitator and where I can help, I will intervene so it is more a partnership to get the patient back where they need to be.

I: Where does the emphasis lie for you in terms of direction of management – you mentioned earlier the diagnosis – is that really important for you?

R: That is the starting point from which all your contracts or agreements come from.

I: So then management your management approach is diagnose the patient, make a contract with the patient and use other practitioners?

R: Ja

I: What would you like to see chiropractors doing in 10 years time?

R: Definitely a shift to being more evidence based, being more in tune with holistic patient care or management and taking time out and spending time with the patient as opposed to just adjusting. Adjusting, yes that is the mainstay of what chiropractors do, but that is not the only thing chiropractors are entitled to do. Using the scope of practice more fully as oppose to limiting ourselves to one aspect of that whole scope of practice that we have.

I: You mentioned holistic care – can you elaborate on that?

R: Holistic care is something that I would use with patient management where you are looking at more aspects than just what a chiropractor can do. You have your interaction with other medical doctors, you look at your patient situation like social factors, so you look at the entire complexity of factors that could be influencing the patient at the time.

I: So holistic practice and management. What else?

R: Communication is very important – more people interacting on a more open level – referring patients to the relevant people. In terms of things like the profession status – that will come naturally if communication and proper management were in place. Research is very important to develop evidence based care.

I: What do you think chiropractors would have to do to get there – to change?

R: The biggest change would be to be more open and be more open to the fact that patients come to you because you are an alternative health care practitioner, but there are instances where you have to refer them back to the medical fraternity for a number of reasons because you maybe cannot treat the particular pathology. You have to be aware of what you can and cannot do. Communication wise – just to instill in future practitioners that you need to be able to communicate effectively within the profession but also outside of the profession and develop a ethos and culture of communication and understanding of it. That would build towards a more holistic patient care.

I: What do you regard as main deficits in your training?

R: Coming back to the evidence based care and communications problems. I would think that the holistic patient care or the management of a particular patient does not necessarily come through at student level because you are not exposed to or encouraged to develop that area. Then also perhaps in classroom situation where you are discussing cases it would maybe be

beneficial if different practitioners can come in and discuss the case or panel discussion or forum.

I: So the evidence based issue that you have is getting to the diagnosis in an interdisciplinary sense?

R: Ja

I: So holistic teaching fosters holistic thinking and the spin-off from that is better communication.

R: Ja

I: What would you like to see included in the current and future curricula?

R: Probably the model of a holistic approach whether it is through a panel discussion where you have a number of people coming from external sources and not by definition only chiropractors. Maybe a GP, a neurologist or an orthopeadic surgeon.

I: And in your opinion this does not exist in the curricula at all?

R: It does to an extent but it is very limited.

I: What are the greatest challenges facing the profession currently and then in the near future?

R: In SA I think the biggest challenge is to try and consolidate what we have and trying to build on that consolidation. So taking what has been good in the past and developing that potential and adding to that what we don`t really have – one of that would be the more multi-disciplinary approach to teaching and from there develop a greater understanding of what chiropractic is so that it becomes more accepted. So that chiropractic becomes more the rule than the exception. Also trying to access markets that have previously been unavailable to us, say for instance in KwaZulu-Natal only few educated people have access to what chiropractic is and what they can actually benefit from it. So education in terms of the patient as well as access in those communities by having more chiropractors out in those particular areas. Also the greater need for younger chiropractors to gain a lot more experience purely because the chiropractors that are in the field currently would probably be in practice for another 10 to 15 years on average – at that point the younger chiropractors would have to have consolidated enough to take over the reign in the SA context.

I: When you say the older guys – are those the chaps who have been in the practice for 10 years or more?

R: I would even go as far to say 20 years.

I: And when you talk about them gaining experience, is this experience other than that they would pick up in their practice?

R: Experience in terms of the holistic patient care scenario – some of the older practitioners are that way inclined based on their experience that they have actually generated, but the younger chiropractor is still in a groove where they will be wanting more of a turnover of patient than bothering about patient care – spending an extra 5 minutes on each patient in that regard.

I: You mentioned holistic care in the same context of time. Is there a link between the two?

R: There can potentially be a link between the two because if it goes in to holistic patient management and communication it will take more time for a practitioner – if they write their own referrals – to do that, whether it is after consultation time or after hours. So it is a little bit more time intensive. Alternatively you could use your receptionist to dictate whatever you need dictated and then to type it. The 5 minute extra in the consultation would be for me personally to negotiate the individual contract. You have to sit with them and say this is what I am able to do and this is what I see you will need and have some sort of an agreement between the two of you. That will take a little bit more time. It is not just be default that you are walking in to come and have an adjustment or some soft-tissue and walk out again. So it is a change in the paradigm of thinking that needs to be addressed.

I: Do you think that the financial structures allow the young chiropractor to be holistically orientated?

R: Initially, if I look at the way I set up my patients now, spending the extra time initially when you have very few patients starting out, it becomes a routine to do it. Once that you are in that routine, it stays with you. If you start off without doing it, and then getting more patients, it becomes more lucrative for you, so it is less likely.

I: And can you put a sort of a value in minutes or hours on what you think is acceptable.

R: Not really – for me it is not necessarily what I stand gain financially from the patient – it is what I can do to make that patient better in their circumstances and that is almost invaluable –

if the patient receives the care they need. It is not for me to say I will charge you R5 more because I am giving you that which you should rightly have or what you are entitled to.

I: What do you think puts you in a position to be that charitable or that humanly orientated?

R: Purely because going back to the experiences my parents had with the medical fraternity – they were never given certain options that they should of maybe be given. Maybe I am being too charitable about it but I still feel very strongly that a patient should be given baseline options and those options should be explored when you are looking at the agreement or contract. If they choose not to take them, then it is up to the patient but they should at least be given the alternative. In my opinion in the scope of chiropractic, that is part of what you should be doing.

I: How long do you think do you spend on average on a new patient and how long on a follow up?

R: On a follow up I would probably spend about – depending on whether a patient is acute or chronic, between say 30/40 minutes for the follow up. New patients – if it is very complicated or intense, I would spend up to a hour.

I: You spoke about paradigms – what does that mean to you in the context of challenges for the future?

R: Paradigms for me are areas of thinking or in terms of a dominant paradigm – if you look at a paradigm as an area or section in which you have particular processes that occur within a group of people. If you look at research, a research philosophy or paradigm would have in it the scientific methods related to it, the processes or infrastructure related to it. A paradigm for me would be in terms of chiropractic the holistic paradigm and then that determines patient management and how you equate that to patient treatment as opposed to a straight forward “I am the doctor and you are the patient” philosophy – more dictatorial philosophy. Those would be two paradigms that I would contrast. Again I would contrast the medical and the chiropractic models as they should be in terms of their scope of practice – what should be happening as opposed to what is happening. So in terms of chiropractic what is happening at the moment is the paradigm of thought is very much on interventional treatment whereas it should be more on the holistic patient management where you are looking at the entire patient – you are not just treating from the perspective that you are the chiropractor and that is what you have to do. You are looking at the patient as opposed to a doctor-centered paradigm.

I: So our challenge in your opinion is to acquire that holistic paradigm and make it part of our day to day practice.

R: Yes

I: Dr Korporaal – thank you very much.

Interview 5

I: Why did you decide to become a chiropractor?

R: I decided to become a chiropractor mainly through family influence, my dad had a history of back pain that was only relieved through going to a chiropractor and then as luck would have it I met Dr. Engelbrecht from Bethlehem and was guided along the root from there onwards. I looked at physiotherapy, but chiropractic was my first choice.

I: Were you always going to get into a manual medicine healthcare field?

R: Initially not, from the age of fifteen I was looking more at engineering, law or medicine and I wasn't decided in either way. From 1986 onwards, and that is mainly when my dad went to Dr. Engelbrecht.

I: How would you define chiropractic?

R: For it me it would be nerve, muscle, bone and a combination of any ailment between the three.

I: So any conditions related to the areas that you have just mentioned are fair game for chiropractors?

R: Yes, anything biomechanical and specifically related to the S-I joints, facet joints, anything myofascial, yes that what would go along with.

I: What type of chiropractor would you describe yourself as?

R: A conservative chiropractor working on a diversified technique as a primary treatment of choice.

I: Would you like to elaborate on diversified?

R: Diversified as in chiropractic manipulation, not using applied kinesiology, SOT or AK or BEST or any of those other techniques.

I: What are those other techniques that you have mentioned?

R: From the way that I understand them, its using the body's natural energy fields to 1- do diagnosis and 2- do the treatment and I am not familiar with them to the extent where I could use it as a treatment.

I: what type of person makes for a successful chiropractor?

R: Somebody who is outgoing, who has good social skills. Somebody who will make the time to listen to his/her patients, with enough leadership skills to guide the patient along their particular healing course.

I: What do you find most negative or unacceptable when viewing other chiropractors?
R: Probably the techniques I know less about. Sometimes the diversity in the chiropractic field does not allow for a standardized approach to chiropractic. So, if you went to a physiotherapist you would know what to expect, if you went to a GP you would know what to expect, but if you go to a chiropractor, patients often don't have a clue what we are doing and that is a negative. So quite often you have to play the chiropractic missionary, what you are where you come from and how you are going to work on them. Not always a bad thing, but if chiropractic had a standardized approach it would alleviate the problem to a large extent.

I: Well don't you think then that the word then, then that the word "diversified chiropractor' in the light of what you have just told me is a little paradoxical?

R: Yes.

I: What is about the other techniques, besides not knowing what they are about that bothers you?

R: That there is no or seems to be no scientific background to them, that they haven't been researched fully. Their diagnostic methodology is not accepted in the scientific world.

I: Do you have a particular philosophy of practice?

R: Yes, to first of all try and do the best I can for each patients, within my capabilities, without doing any damage and without risking the patient's health in any way. So referring when necessary and to stay within my boundaries as a chiropractor.

I: What do you think those boundaries are?

R: Not to prescribe medication, not to get involved with too in-depth psychotherapy, not to try and do any sorts of small surgical techniques, those are all out of bounds.

I: What do you understand by the term subluxation?

R: Subluxation in old chiropractic terminology would mean something as a fixation or as a restriction in movement, in medical terminology that would mean a partial dislocation, now partial dislocation would be one of the boundaries that I wouldn't treat. A restriction in movement or a fixation is something that I would be treating as a chiropractor.

I: You said that you consider yourself as a diversified chiropractor, do the term mixer and straight chiropractor mean anything to you?

R: Yes, a straight chiropractor would be someone wouldn't do any acupuncture, myofascial trigger point therapy, ultrasound, interferential current or even sometimes massage. A mixer would be someone who takes different techniques, like a Gonstead-type adjustment, a short lever type adjustment, and then use that in conjunction with any of the physiotherapy techniques, that would be a mixer.

I: What are the physiotherapy techniques?

R: Like ultrasound, interferential current, massage and to a certain extent trigger point therapy.

I: So then you would be a mixer?

R: Yes, I would be a mixer.

I: So how do the terms mixer and diversified chiropractor link?

R: Diversified in my interpretation of it relates just to the chiropractic technique of choice where as a mixer would employ other chiropractic techniques in conjunction to his/her chiropractic technique of choice.

I: Would a mixer therefore incorporate diversified techniques?

R: Yes.

I: Would that always be the case?

R: I think so yes.

I: What do you understand by the term patient management?

R: In my interpretation it would be to explain to the patient look whatever their case history involves that they would have a series of treatments if necessary and that you would guide them along those treatments. So it wouldn't necessarily be to make a set follow-up every month, that would be patient maintenance rather than management. So for example if a patient came in with an acute lumbar facet syndrome, I would do three treatments in the first week, two treatments in the second week, one treatment in the third week or something similar to that.

I: How do the terms treatment and management relate to one another?

R: they definitely relate to one another. Management is more than just the treatment, the treatment I see as being the hands-on portion of the treatment, the actual manual part or using the physiotherapy techniques. The management part of that would be to prescribe exercises and to check on the patient's well being after the first treatment and after the second treatment and after the third treatment.

I: Is the term management a generally accepted notion in the profession?

R: Yes and no. I think it means different things to different people. Some people would do a set treatment everyday for a month and then every second day for two months and every third day for three months, where others would stay according to what the condition would prescribe.

I: How does management and treatment frequency relate to one another?

R: Yes, the treatment frequency would be dictated according to what phase of healing the patient would be in, the management would prescribe that treatment frequency.
I: So is it possible that for some chiropractors the establishment of a treatment frequency may be their interpretation of management?

R: Yes. Some practitioners could perceive management and treatment frequency as being the same thing. The way that I perceive it management entails more than just the frequency.

I: How strongly do you emphasize a medical diagnosis?

R: Very strongly.

I: Why do you feel so strongly about that?

R: I try to explain everything according to a biomechanical model. This model has been researched and is fully understood. It gives me what I feel a sound foundation to prescribe the different exercises that I do and to administer the treatment that I do and without that scientific background I don't think I could manage my patients as effectively.

I: Does that 'edge' that it gives you, what do you think it means to the patient?

R: Well, I think it gives that patient more security, so that they know where you are coming from. That they understand that chiropractic is a branch of medicine and not a philosophy and I think it gives them confidence in the treatment that you administer.

I: Do you see chiropractic as a branch of medicine in the mainstream medicine sense or do you see it as a branch of health care?

R: No I see it as a branch of mainstream medicine, but slightly separate to it.

I: And that distinction that exists do you think it is important to maintain?

R: Again yes and no. There are advantages to being part of the SAMDC, because that would mean, or could mean, that our reimbursements from the medical aids would be heightened

and our benefits and patient benefits would be improved. The disadvantage would be that we then fall under their control, because we are a smaller profession and we'd loose our identity.

I: Why is important that we maintain our identity?

R: The benefits that we retain our separateness are that we are not seen as punting anti-inflammatories. We tend to be viewed as being slightly more natural and allowing the body to heal naturally.

I: And that orientation toward the body's homeotostatic processes, why is that important?

R: That is important, because the body has a natural healing process. You go through the different stages of inflammation. If you tend to drown out the inflammatory stage then the healing does not occur properly. Also by taking medication, besides the side-effects, the patient does normally more harm, because they don't realize the extent of the pain they are in and then they over extend themselves. So by using natural methods without the use of anti-inflammatories, I think the patient could benefit.

I: Would you say that is a philosophical difference you would have with biomedicine?

R: Yes, I think so that would be a difference.

I: How has mainstream or allopathic medicine influenced you, if at all?

R: It has influenced me, because what we end up trying to do is fit into a scientific medical model and quite often meeting with resistance on the other side in that mainstream medicine is quite resistant to chiropractic as a whole. They tend to understand very little about what we do and to justify my existence in the area, I have to be solely scientific in my approach to patient and patient management.

I: so by that sort of process happening, would you say that you become a better practitioner for it?

R: I think so, I think by focusing on diagnostics and trying to eliminate any potential downfalls from the treatment, I think it does make me a better practitioner.

I: What influence do you think the scientific method has had on your approach to practice?

R: If I was thought only the philosophical and patient management side of it, I don't think that the practice that I got would not be as strong as it is. I think the scientific method and the fact that I can explain what I am doing and why I am doing it and I can rationalize it in common terminology makes it more me more successful in practice.

I: is there a difference in the manner in which you treat chronic and acute patients?

R: Yes, definitely. Chronic patients would receive a treatment on a basis where the patient would actually come in and ask for a treatment. Not that I would prescribe a treatment every single month its not a rigid program. What we try and do with the chronic patient is try and get them over, if its an acute phase in a chronic condition, we get them over the acute phase and then try and get on a type of 'maintenance', but then they actually set the rules as far as that goes. They would say to me we find that a treatment every six months tends to keep us mobile and helps us in that quality of life. Where as a patient who is in acute pain, I then try to see fairly close together to get them over the acute phase as quickly as possible and then once they are over the acute phase and their symptoms have resolved, I then discharge them.

I: So, by that rational is it possible that a chronic patient may consult you ad infinitum?

R: Yes, although I am not altogether happy with that, because even though you look at a condition like osteoarthritis of the spine and chiropractors could help mobilize and maintain

movement by and by prescribing stretching exercises etc. you can improve the person's quality of life, but you cannot change the osteoarthritis that is there. Somebody like that would probably come and see me in theory ad infinitum, but that is not something that actually promote.

I: Why not?

R: I am not altogether comfortable with doing that partly, because there is often a view that chiropractors tend to milk their patients for everything they can and that is something that I try and stay clear of, maybe to excess.

I: So, assuming that it is possible that your chronic patients will not resolve completely, why do think they come and see you?

R: They do get relief, even if it is just for a shorter period. So if they get relief in terms of increased mobility, maybe slightly decreased pain. Maybe a better functionality in their lives, that would then last anywhere between three weeks and six weeks, depending on the patient. And then once the feel that the effect has started to wear off, they would then come in for a fill up dose.

I: To what extent do you consult with your patients in the management process?

R: To a large extent, I have to keep their financial needs in mind, but I also have to keep the set guidelines of each condition, depending on which phase they are into, in mind. I also try to consult them on the other side of it, which would be more the nutritional and ergonomic side of it.

I: Speaking of those nutritional and ergonomic factors, what are some of the other things you tend to consider on a regular basis?

R: Postural would fit with ergonomic side of things, nutritional that leads to increase weight, but also using the nutritional side as an anti-inflammatory base.

I: Do you think that those factors that you have mentioned are considered by mixer or diversified chiropractors in general?

R: I think that a mixer chiropractor would consider it and the diversified chiropractor would probably consider it as well, I am not sure that a straight chiropractor would.

I: What would a straight chiropractor do?

R: In my opinion a straight chiropractor would perform a manipulation only without any consideration for the others.

I: What do you understand by the term patient care?

R: There is an overlap between patient care and patient management. Patient care would involve more than just the hands on, it would involve looking at the nutritional side, looking at a little bit of the home situation, personal or potential stresses, how to avoid them, how to deal with them when they come up.

I: The factors that you have just mentioned, home stresses that kinds of things, would you consider them psychosocial factors?

R: Yes

I: What other psychosocial factors do you commonly deal with?

R: Economic ones, stresses related to lack of finances. Particularly down in this area, because this area tends to be more blue-collar worker. As a result, take for example a

company like Toyota lays off three hundred people, then at least some of those are going to be patients of mine. So that will affect how many times they could come on or would want to come in and see me. But also the direct impact and the effect that it has on stress levels and a result myofascial trigger points etc.

I: So a psychological cause of physical symptoms?

R: Yes

I: Where would you like to see chiropractors in tend years time.

R: I would like to see more chiropractors, because I think having a stronger body here would help strengthen our position as being mainstream medical. I would like to see chiropractic avoiding, what I would like to call far left or far right and the unscientific approach to health care. I would like to see them gain more political clout in dealing with medical aids and insurance companies and with organizations like the road accident fund.

I: The undesirable lefts and rights that you have mentioned can you maybe give an example of that?

R: A good example would be chiropractors selling tachions and claiming that as a chiropractic expense to a medical aid. Or a chiropractor using a techniques which has not been substantiated scientifically and then actually doing the patient harm as a result of that and then being unaccountable for that.

I: What do you think chiropractors have to change to get there?

R: They have to narrow their…What I see is chiropractic colleges training in methods that might not be as scientific as others. They are going to have to substantiate their treatment of choice on a scientific basis- on a research basis. They might have to, chiropractic in South-Africa anyway, would have to try and limit the people who gain access to the profession.

I: The unscientific practices, are you insinuating that they come more from abroad?

R: Yes, definitely, but we know that certain of our South-African graduates are influenced by those places as well.

I: Why do you think that happens?

R: In my opinion it's a financial basis, its easier to sell, its easier to market, its also an easier way to practice- you don't have to work as hard.

I: what do you regard as the main deficit in your training?

R: To look at x-rays in more depth, to link it more with, instead of looking at it form a straight pathology point of view, to link it more with chiropractic paradigm or like Gonstead listings. We were never taught that and I think it could be an advantage to us. Practice management was another field that I think we can improve on. The lack of emphasis on chiropractic philosophy, I don't think is a weak point.

I: What do you mean by the term chiropractic philosophy?

R: The chiropractic philosophy that I have seen in the members our profession, their philosophy involves trying to get the most out of the patient in terms of follow up visits.

I: Would that be a philosophy of practice?

R: Yes

I: Thank you very much for your time.

Interview 6

I: Welcome Dr White

R: Thank you Dr Myburgh

I: I think I'll start you off with an easy one:" Why chiropractic?"

R: Why did I do chiropractic, my interest was stimulated as a school teacher getting involved with sports injuries, where I ran a first aid system in our school to look after the rugby injuries and kept careful notes whether the injuries went to Dr. Ashton Weiss or Dr. Mike van den Bos, both chiropractors or acupuncturists or physios or orthopods and I soon noticed that these guys got them back on the field more permanently than the others and I then used them myself and was impressed. Then I decided to leave teaching and go and study something in the medical field, I got in to medicine as well as chiropractic school and I arrived at chiropractic school quite happily…So it was the experience of what it could do.

I: How would you define chiropractic?

R: I look at it as a holistic approach compared to what I unfortunately see in straight medicine without being derogatory to our colleagues there and my definition to my patients is that it is a neuro-musculoskeletal approach. It is a type of physical medicine where very basically I am satisfied that if I can free fixations I find in the spine or any joint for that matter, I can add to the quality of their life and hopefully reduce pain and in some rare instances change the physiology of the problems for them as well.

I: You mentioned the word straight medicine is that the same as allopathic or mainstream medicine?

R: Yes that is what I mean, when you use the word the allopathic to a patient they look at you aghast.

I: what type of a chiropractor would you describe yourself as?

R: Short…(laughter) I am very clinically based and I also use western medicine quite a bit. I run tests, I don't use x-rays an awful lot, but I do do other pathological testing and that sort of thing. Being an acupuncturist as well, I often take that sort of approach, but I am very holistically orientated in my approach, I like to know what is happening in my patients lives. If a patient comes in with a lot of shoulder pain, I want to know if they have been through a stressful period. They don't have to tell me what, but I do need to know if they are under strain. Because I believe that the whole thing needs to be looked at, not just the particular little pain points.

I: So being a holistic chiropractor it sounds like you are very inclusive, or integrated if I can call it that. What are some of the other things you place under the banner of holistic practice?

R: With respect to my patients?

I: Yes

R: Most of my patients are given stretch exercises or exercise programs, something that they can do for themselves, very simplistic, because giving them too much- they just through up their hands in horror. But I try to and show them- a statement that I often use is:" what I can do for you is half the battle, the other half the rest is what you can do for yourself." I do discuss diet with my patients, particularly if they look to me that they are not on a good diet and I often discuss the other problems with them like if they have blood pressure problems or of they have cholesterol or they are smokers I go into detail and I am often quite annoyed to find out how little they have been informed by some other practitioner who is supposed to be

treating that condition. And when you take that approach I find that patients are far more prepared and ready to listen to you, because they realize that you are someone who is prepared to explain, but I suppose it's the teacher in me, I like to talk.

R: What type of person do you think makes for a successful chiropractor?

I: I think that a successful chiropractor, from my limited experience so far, needs to be someone who is a fairly open and charismatic sort of person. You don't need to 'bulldust' your patient in any way, that is very important, but if you are too shy and introverted, you are not going to exude the confidence that someone needs in their chiropractor. You can't 'um and arr' too much, I have got no qualms with saying I don't know the answer and looking it up, but I try and give them as a much information as what I can to try and reassure them, because they often come in very with these big words like osteoporosis and osteoarthritis and when you tell them:" Yes, but you are fifty-eight years old, its pretty par for the course, now lets look at it this way." It's very different to them suddenly getting some big word thrown at them. A lot of them I find the psychological impact of pain has had a massive effect on them, so I always try and inject a little laughter no matter what. I try and tease my patient, because it puts people at ease. But then tats the way I teach as well…

I: Besides openness and confidence what else is would you think a chiropractor requires?

R: Confidence, openness, you need a high degree of integrity, you need to be a caring, empathic person and I think you need a fairly wide knowledge of things like psychology, sociology. They're of use, we tend to think they are wishy-washy subjects when we are young students, but in the long run you realize, particularly if you have a holistic approach, there is a lot of things bearing on why a patient is getting aches and pains in their approach to life. If a patient is depressed you have to help them get over that or help them in some way, show them how to help themselves, otherwise you are hitting your head against a brick wall. It's no use releasing the fixation when it's coming from pressure elsewhere.

I: Why do you think confidence helps you as a practitioner.

R: I think that at any initial appointment, the patient is watching you very closely. If you look like someone that is not too certain of themselves, they immediately loose confidence in you, they become reticent, they don't think they are going to get better. The same is if you don't give them too much attention. All too often they come in, they have been to one or two people and they have been in and out in eight minutes. Now I am only four and a bit years into practice, but I don't see myself being able to pull anything off in that amount of time, even when I know them well. So, the patient needs to feel that you have some idea of what their problem is. I often say to the patient:"Its this or that, this is the approach we are going to take. I am going to do two or three treatment, if I have had no change after that I'll reassess." You have to be that way, because sometimes you can't be certain, but others you say:" No, this what is wrong with you, if I press here, you get pain there," The guy feels happy, you are half way there. You don't even have to treat after that sometimes…

I: What do you find most unacceptable when viewing other chiropractors?

R: Brutal treating and hurting patients so that they scared, that is my biggest annoyance amongst my own profession. I often have patients come in and ask me if I am going to hurt them, some of them have been hurt by chiropractors in the past. The other very annoying thing is chiropractors that tell their patients' straight that they are going to need an excessive number of treatments to get anywhere. I think that is over servicing and I am afraid that is big in our profession. That bugs me a lot. Other than that I think we have a great profession with reasonable good people to be honest in what I have seen so far.

I: What is a brutal treatment, how do they brutalize their patients?

R: They don't explain enough what they are going to do and very often a lot more force are used. One of the things that I was taught and I believe in is myself is that its about knack and not knock and without being facetious your lady chiropractors and the smaller people like

myself, your technique has got to be that much better than someone that is big and heavy. Any fool can get a crack out of a person, but to get the crack at the right point, takes techniques and knowledge and often I think that people are adjusted where they 'go' easy and not at the right point or as I often hear:' When so and so adjusts me, I hear a lot go.', now that is not chiropractic to me that's a physio trying to manipulate. But, you know, part of our code is to be specific in our adjustments, so I don't expect to hear six cracks in the neck at a time. But then I suppose it is difficult to if you are a big fellow, you have got to realize that little old ladies don't need as much force, but I am generalizing…

I: You mentioned that you try to be a holistic chiropractor, do you have a philosophy of practice that you have thought about in line with that?

R: I battle with the term philosophy of practice. Let me give you a reply and see if I cover you. My basic approach is if I can't get someone within three to four treatments, having got my patient to perhaps change their lifestyle in some way or another that I might have deemed necessary, then I reassess and from there on I will either continue or refer them out. But I often say to the patient, I am going to do two-three treatments, if any one of 3 parameters has started to change, I am happy, because then we are in the right ballpark. The parameters are the intensity of their pain, duration for which they have had the pain and the frequency with which they get it. If any of those start to improve, particularly if they are chronic... I believe that all patients deserve the best that you can give. There are patients that irritate and patients who you enjoy treating, I try not to let them realize that sort of thing, but I am also very much aware that I am a physical doctor and not a physiological doctor to any great extent, although we try and change those sort of things with diet and all that, to be aware of my own limitations I can do so much. If I think that the problem is coming from something other than a fixation or a spasmed muscle, it's not really my field. Have I answered you there…?

I: That's 100%, just to clarify your philosophy of practice then, you view very much as an approach to practice.

R: Yes, I am part of a picture as far as I am concerned, I need orthopods and neuros out there and gaenocologists, I can't fix them all.

I: You mentioned the chronic patient, is there a difference in which you treat chronic and acute patients?

R: Yes, generally speaking, my acute patients I tell them, I should be able to get somewhere with one or two treatments, often with one treatment you fix them, because they did it the other day and they come in, you find the fixation and you can perform the so-called 'miracle' that they think we are capable of. But with your chronic patient, where they have had the problem for months or years, you are not going to get very far in one or two treatments. Two, three treatments down the line all I am looking for in an improvement, from there I'll take it further, maybe when I get to the sixth treatment, I might have improve the quality of their lives sufficiently. I will never use the term 'cure' in my profession, because I don't believe we can cure many things, but we come pretty close with the headache that is there just because of a fixated neck.

I: You mention the term 'fixation' quite a lot, what is a fixation?

R: Ja, a fixation to me is simply when I find either in the vertebra or in an elbow, or any joint that is giving irritation to the patient, a blocking or a lack of joint play, compared to the other side or elsewhere in the body. It often presents as the point of pain, which is easy or that hard nodule that the patient puts his finger on and says:" I can feel this hard nodule, what is it?" If its not a very serious triggerpoint, which it can be at times, then its usually a point in the vertebral column where one or other facet is not moving the way I deem it should, so the joint play is lost and then you get muscle spasm in that area. Ja, I am very much fixation based, in Horace's definition of fixation when I can feel there is something not moving as I would like to move. I trust my fingers more than what my patient tells me.

I: So a fixation very much very much represents a physiological entity of some sort?

R: Yes, a mechanical more than physiological

I: You mentioned that you improve your chronic patient's quality of life, but that they will quite possibly never achieve a cure. Why do you think they come and see you if they know that?

R: Well lets put it this way, a lot of chronic patients are getting on in life and they realize that the body doesn't function quite as perfectly as it did in their twenties and thirties and they come to you in the end through the exacerbation of other systems or that they really are in a hell of a lot of pain, so of you can reduce the pain and maintain it by seeing them once a month or once every two months they are happy with that. People don't expect at the age of sixty or seventy to be totally pain free, but when they have got a really bad pain they get tired of the practitioner who just says well you are eighty years old now, you should expect that, that I think is harsh. But I am also firmly believe that my approach, my way of talking to them, my joking with them in the chronic patient is very important. What I often say to my students is when you get a come in and you ask them how they are feeling, they will often reply:" Not much better doc", but when you look at their eyes or their facial expressions you will see that they are not in as much pain as they were, but they are exhausted so they haven't realized that they have improved a little bit yet. Or they will tell you a joke and they wouldn't have joked the first couple of times, because they were too damn sore, which means immediately that their whole psyche has changed and they are slowly improving, and that was important to me. I used to find that when I worked with Prof. Liggins, I used to see these very sore people come in and then two weeks later, they reported that they were just as sore, but yet they had a joke or something, then he knew that they were improving overall. You have to look for those little signs. I always tell my students that you have to read the eyes, because the eyes tell a lot more than what the patient's mouth often tells. Not that they are lying, its just human nature.

I: What is a subluxation?

R: A subluxation, well the definition of subluxation as I learnt, not a term I use an awful lot, is when a joint, particularly a facet joint, that is meant to be able to move a certain number of degrees has lots it's ability to move through one or other reason. A medical subluxation, is actually a medical emergency as far as I am concerned, that is when a joint is completely out of place? Now a always tell my students that as a chiropractor I don't put bones back in place, because when they go out of place it's a medical emergency, all I do is to try and restore the correct range of motion to a joint that is not moving properly. My favourite personal trick is to show them my fist and say that is a smooth neat fist and then I project one knuckle and say that when they come in like that and that one should be down there, but it won't go down, that is when you get a facet subluxated. Now all that I am going to do is to push it in its direction of motion and they should hear a 'crack' and then I explain to them what the noise is and that its actually gas escaping and not bone rubbing against bone.

R: Would it be a true statement to make then, that to you fixation and subluxation mean essentially the same thing?

I: Yes, the way I use it in my practice, on an exam pad I would probably see my behind now, but yes that is what I use them as.

I: Do you see yourself as a mixer or a straight chiropractor?

R: Oh very much a mixer, I am quite happy to use a bit of acupuncture and a bit of electrotherapy to work on muscles before I move things sometimes and vitamins, diet, minerals. I actually use quite a bit of Scussler salts in my practice.

I: What does a straight chiropractor do?

R: A straight chiropractor as far as I can appreciate are simply those who are opposed to any physiotherapeutic modalities in which I have been trained and they just believe in adjusting only without doing much muscular work. But to be honest, I don't think there are too many die

hard, straight chiropractors around. There are some, but I think a lot re in between and don't want to admit it sometimes.

I: What are some of the physiotherapy modalities that you use in your practice?

R: That I use personally in my practice? Actually very few, I use TENS quite a lot and electro-acupuncture mainly. I use a lot of ice, relatively little heat. I use stretching a lot, which is not really a physiotherapeutic modality, and I use an APS machine and its head, but then I cheat, I use anti-inflammatory gel instead of ordinary gel if I am dealing with an acute patient.

I: Why would that be a cheat?

R: Well I use the term euphemistically I that we are supposed to use just electrode gel, apparently most of the inflammatory gels, if used with an ultrasound head or APS head for instance, damages the head, but my philosophy is that if I am going to help my patient more that way then I will buy a new head when I need one, because it definitely works on myself, so it works on them (chuckle).

I: What do you understand under the term patient management?

R: Patient management, to my mind incorporates what the patient can do for themselves at home, in the way of stretch or exercise, strengthening, their diet, being compliant with my instructions. Basically that. What I talk about is posture or back hygiene, although they don't like the term patients seem to understand the term, because it is in the media. To avoid how to hurt themselves again, how to lift correctly, how to lift their baby up and not fall asleep with it suckling on the breast, which mothers do and it causes hassles. Things like that and warming up before they do things. I suppose I could also incorporate business plans, but I am not a businessman so that's where I come short in my practice perhaps, because I don't bring them back enough from a financial point of view. Once I have got them right I tell the patient to listen to their body and call me when you need me. I don't subscribe to:" I want to see you every three months or six months."

I: Is patient management a generally accepted notion in the profession?

R: I don't know if I am really in the position to answer you there Corrie, I have a feeling that among our colleagues that trained overseas, they have a lot more of an idea of what they mean by patient management, and it probably incorporates a lot more common sense as well. But patient management to me is simple; it's just my protocol and how I am going to set about fixing my patient in the first place and my immediate dealing with that occurrence.

I: So does patient management in your view also include your treatments?

R: Yes, how I am going to manage this problem. I might have two patients with a very similar problem, but I might take a slightly different tack. For instance in some patients I know that if I tell them to stretch themselves this way and that way all I have to do is to adjust them and they will comply, but in another patient I might realize is not going to do exactly what I say, then I am going to take a more aggressive approach from my point of view, which I don't like to do if I can get away with it.

I: How strongly do you emphasize a medical diagnosis?

R: For my own purposes, or outside my practice?

I: when you treat patients…

R: Pretty strongly in that its very important to me that when they come in with a back pain its very important to me to establish that its not coming from something else, but my medical comes from the taking of a thorough history and I establish that the patient has no other symptoms that the patient may not be aware of for instance, it will give me the clue and maybe I start treating a right tip of the shoulder pain, when in fact its coming from the

gallbladder and I forgot to ask. That sort of thing. The medical approach is there for those very few cases when you don't want to come short and have egg on your face two months later and I would rather take a little with ninety percent of them to catch those ten percent that could slip through my fingers. But again I have had a few bad experiences where I have picked up nasty things, which should have been picked up by someone beyond me and the weren't, so I don't let that happen. I did not come short, but I was annoyed, because if the doctor had actually stepped out from behind his desk and touched the patient he wold have realized that this was actually a gallbladder or an ovarian cyst.

I: How has mainstream medicine influenced you?

I think I am fairly strongly influenced through my training and then once I started practicing, I realized that the two chiropractors that I had modeled myself on originally were very medically orientated. But I only realized that once I got into the training myself and realized that not everybody is like that. In fact I will be perfectly blunt, when I got into Durban and started looking around at other chiropractors, I seriously doubted whether I had come into the right profession, because I was quite horrified at what was going on and what I did not see going on and I was really quite annoyed.

I: What didn't you see which you should have seen.

R: I saw patients being taken in off the street with absolutely no reference to other possibilities other than a fixation in the head causing the headache. I have seen patients taken off the street with headaches by someone who does not even know how to use a stethoscope. No one gets through my practice without getting their blood pressure taken, whether they say it is normal or not, but I do it while I am talking to them, that is how I get my own baseline. I don't rely on someone else's readings. I also don't let any female come into my practice with a lower back pain without a traumatic cause, if they can say to me I did this or that, then I am happy to go and look for a mechanical fixation. But it has been on and off for ages I will do a brief physical exam in the area, just in case it is coming from within. If I can't elicit it then I go and look for a mechanical cause. My original first chiropractors I ever went to were very much that way and of course that is what I am based on.

I: What influence do you think the scientific method has had on your practice?

R: A lot, because I was a science teacher and as I am fond of saying when people ask me how I have changed from being a science teacher to a chiropractor my short answer is very honest and simple. In the old days I used to consider myself just a coldhearted little scientist, if a fact or something could not be proven through a scientific experiment, I chucked it out. Today as a chiropractor and particularly as an acupuncturist, I realized one thing and that is that just because I can't explain something through the scientific method it is now no longer good enough for Horace to chuck it out. That has taken me about six years of chiropractic training to realize, because there are lots of things I do that I can't always explain, but I am satisfied that I am doing no harm.

I: To what extent do you consult with your patients during the management process?

R: If by consult, you mean do I sit them down before I work on them, then every single time. My patients without fail they sit down for a minute or two, maybe ten if necessary. I never walk in and have a patient lying on the bed waiting for me. I sometimes gowned and ready, because I can operate two rooms at a time, but they always sit down and talk to me. I feel it is important for the patient not to be treated like… shortchanged. I don't walk in say right lie down and crack them. I often ask them if they are feeling better:" How do you know you are feeling better?" Then they look at me wondering what the hell I mean. Eventually I'll get it through to them what I mean like is the pain less, is it gone completely and then they'll tell me well I can move better, its still sore but its better. So I can establish for myself how much better they really are.

I: Do you consider psychosocial factor in your practice and if so what are they?

R: Yes, can I be quite open on this thing?

I: Yes…

R: I deal with different population groups. I am very much aware, for instance in our Indian community. When I have an Indian lady coming in with triggerpoints and that sort of thing and she tells me she's not stressed, she doesn't work, she's just a housewife I need to know what sort of things she is up to. Then I find she has got a family of six she is cooking and cleaning for, then I have got a far better idea of why she's got these sort of problems. When you have one coming in and the husband wants to come in and answer all the questions for you, then you also know why they have these triggerpoint problems, its depression and you know they have got no freedom and that sort of thing. Where as with the white community, it can happen, but its usually slightly different. They've got their own business and they are picking up kids. I had a guy come in today and when I found out what sort of business he was in, I realized why he was stressed out, he is a stockbroker and of course the bottom has gone through that market and everything has gone haywire throughout the world. And as much as he originally said to me that he was not stressed, I always like to ask what sort of sport they play, so I can know what types of stress the body is subjected to by that individual. I want to know if they are married or divorced and they often say that this is the case. That to my mind has a big influence on 1: how I am going to approach this patient and 2: what I am going to tell them to do for themselves. As opposed to the guy who come in, who is making oodles of money and his problem stems from playing too much golf. Then I simply tell him to swing his club in the opposite direction as well, because golf is a very one-sided sport. He doesn't need a lot of looking at form a psychosocial point of view. Yes, I am a firm believer in looking at all the possibilities that could have the patient in the condition I find him.

I: What would you like to see chiropractors doing in ten years time?

R: I would really like to see us working more hand in hand with other medical professions. So we can have an inter-referral base. What I get really hassled about is the inability of some of our own profession to refer out, because they don't want to loose the patient and then the total lack of referral from other professions to use, because they are scared they are going to loose it our way. I am fortunate, I have three physios' that refer to me regularly, then I do what I can do and then I send them back and vice versa. But then there are other phyisios that I would not dare send to, because I know the y will try and influence the patients against me. But generally there is far too much jealousy. I am hoping, and I think it will happen, that your younger generation of medical doctors are more open and aware of what chiropractors can do. Some of them are still very arrogant, but the older generation I understand, because they probably had some bad experiences thirty years ago, it does not excuse it, but ja I would like to see more of an holistic approach. More healthcare clinics, which have a doctor and a gynecologist, a psychologist and a chiropractor around, but unfortunately we have not evolved there yet.

I: So holistic in this context would mean inter-disciplinary?

R: Yes, very definitely I would like an inter-disciplinary approach, if we can get there one day, I reckon we will get there.

I: What do you think needs to happen for us to get there?

R: well I think our main thing at the moment is our lack of number, because once we are bigger in our own association so that we can afford to pay in what is needed for advertising and inter-professional development we'll get off the ground. At this stage I think we are still limited within ourselves, and I think that is a very significant thing, its not the lack of keenness on the part of young chiropractors, it's the lack of finances as a body, because it takes big bucks to make the noise we need to make to let the world know about us in this country and other professions. We need to be able to host conferences and get togethers and that will not cost the medics a fortune and get them involved. A little bit of pie in the sky, but that is what we have to do.

I: What do you regard as one of the main deficits in your training?

R: Well my main deficit would be my radiology, which was not up to scratch.

I: What are the greatest challenges facing the profession in the near future?

R: The greatest challenge I see is being usurped by medics, that will eventually realize what we can do and will want to take it over and keep it for themselves. Physios trying to limit us and make us into ‘straights’, which we don’t want to be and physios trying to adjust and making a muck of it for us.

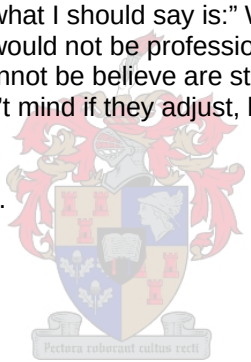
I: Straights meaning…?

R: They would want to limit us to adjusting and nothing else. As far I am concerned then we cannot do a full job, from a physical medicine point of view. That’s about it. I really battle with the fact that physios and chiros can’t work together, because between us I think we have a lot to offer.

I: Why is it in your opinion that if physiotherapists adjust they will make a ‘muck of it’?

R: Because I see it in rooms regularly, I have had them come down from one particular patient in Hillcrest, they follow me down and in my area and that and they look at me and I say well what have you done? No I went to a physio and they did this and they did that to me. Did it help? No it actually made them feel worse. Well have you been back and told them? No, think I’ll come to you now. And what I should say is:” Well why the hell didn’t you come to see me in the first place?”, but that would not be professional, but that is how I feel. And I could name three right now that I cannot be believe are still doing what they are doing, because I think its very wrong. I don’t mind if they adjust, but not if they use long-levers and they get the wrong thing to crack.

I: Dr. White I thank you for your time.



Interview 7

I: I think the easiest think for us to do would be to kick off by you telling us why chiropractic?

R: Why is studied it?

I: Yes

R: I always wanted to do something in healthcare, I knew that and my family chiropractor told me about the course opening here in Durban. It was one of the things I knew I would have wanted to look into at least, so I knew something in healthcare..

I: Was it always going to be manual types of health care…?

R: Not necessarily, but certainly just by virtue of the fact that I had been exposed to chiropractic that gave me more of a bent toward it.

I: How would you define chiropractic?

R: Generally, dealing specifically with neuro-musculoskeletal conditions and chiropractors being neuromusculoskeletal specialists. Whether that includes art and philosophy is controversial, but I think it may to some extent. Certainly art and science it does, in my opinion and philosophy, perhaps of less importance.

I: What is the science that it associated with chiropractic?

R: In terms if the research that has been done to show that it is effective, that is my perception of some of the science, but also in terms of the anatomical studies that have been done by Lynton Giles for one and others.

I: And the art side?

R: Like in any health discipline, the actual interpretation sometimes of certain things, that not always science and also in terms of the implementation, in other words in terms of treatment and so on, that will vary.

I: What type of chiropractor would you describe yourself as?

R: In the light if what if have just said, I would like to think if myself as a neuromusculoskeletal specialist with very definite links to other healthcare specialists or other healthcare providers and with a constant thirst to improve my knowledge.

I: What type of person makes for a successfulr chiropractor?

R: I think somebody who is prepared to admit that they don't know everything and that is always willing to continue to learn, whether that be formal learning or otherwise and also one who is humble enough to keep wanting to improve him or herself.

I: What do you find most negative or unacceptable when viewing other chiropractors?

R: The very esoteric or alternative stance that some of the practitioners adobt and feel very comfortable slotting in with. I think is a very …it casts a very negative light in the profession, but not in all quarters and I think it is important that ones perspective on that be viewed. In other words depending on who is asking the question. Alternative may be a very good and positive thing for some people, depending on their background.

I: What are some of the esoteric approaches or stances that you are aware of?

R: Can we mention names of techniques?

I: Ja sure that is no problem.

R: Without knowing enough about them I don't think it is fair that I necessarily criticize them, because of my bias some of the things that come to mind are BEST. Those techniques that perhaps have not been studied enough to quantify/qualify what they are actually doing, and certainly those that that don't involve chiropractic at all. Another one that comes to mind is this soft touch chiropractic. I don't understand it, but perhaps that is my problem.

I: Well then I think we need to identify and refine your view of what chiropractic entails.

R: As I said earlier, chiropractic involves neuromusculoskeletal assessment and treatment and within that, one would then look at the scope of practice and the legal requirements. Those legal requirements include manipulation, soft tissue work etc. we all know what those are. But anything over and above that until it has been shown to be at least significantly beneficial so that we can't ignore it or it is shown be research to be effective I think should not be touted as chiropractic or should not be used by chiropractors. If they want to use those things they should not be calling themselves chiropractors and that by all means they can use them, but then not to trade as chiropractors.

I: Do you have a philosophy of practice?

R: No

I: Ok then what does the term subluxation mean to you?

R: I think I have tried to distinguish it medically, in other words what medical doctors would understand by it and that is something just short of a dislocation. I think it is important that one make the distinction that subluxation not be called subluxation alone, but a subluxation complex or nothing at all. And if it is a subluxation complex then let it involve dysfunction of or restriction in movement of spinal or extremity joints with or without soft tissue involvement.

I: Is it a term that you use?

R: No not commonly at all.
I: Do you have an equivalent to it?

R: I prefer to use the terms fixation, dysfunction or restriction in movement.

I: We'll get back to the philosophy question a bit later, but in the meantime do you see yourself as a mixer or a straight chiropractor?

R: A mixer

I: Why?

R: Because my understanding of a straight chiropractor is simply manipulation with very little diagnostic involvement and or soft tissue involvement as opposed to a mixer who is trained in diagnosis and soft tissue modalities over and above manipulation as well orthotic use and prescription, lifestyle, ergonomic advice etc.

I: Where do you think the thinking process or the stance for the use of straight chiropractic comes from, why does it exist still?

R: If I have my history correct I think from B.J. Palmer, or D.D. for that matter, and I think it is still in use because a lot of people who have lived and died by that approach and it has helped to make them separatist and distinct from medicine and other professions, but I don't necessarily see it being used indefinitely unless of course the schools that teach it continue to thrive and prosper as well.

I: Separate and distinctness, I assume you mean form medicine.

R: Yes

I: Does it exist today and should it exist today?

R: I think it does, again based on ones baggage or background and I don't think that it should exist today. I think gone are the times for separate and distinct professions. I think that the consumer is far more streetwise these days, so they all invariably choose anyway and that should encourage us to be seeing eye to eye as professionals.

I: What do you think the barriers are, if any, today for distinctions that exist as rudiments of history? What do you think has to happen for them to fall away?

R: I think ignorance is a big part of that. I also think separate educations has a big role to play and as if we can marry the educations as they are now doing in Denmark for example. That will go a long way to getting rid of these barriers.

I: Do you think chiropractic will loose its identity if that happens?

R: No, simply because, optometry, denistry practice is separate and distinct practices as such, but very much work together with medicine.
I: There is another term that gets used in chiropractic often, its 'diversified practitioner' do you have a comment on that?

R: No, I would like to know what you mean comment on.

I: Ok, is the term 'diversified practitioner' something that you are familiar with?

R: My understanding of that is that it entails using a type of manipulative technique, which is one of many. So as opposed to being Sacro-occipital technique or Pierce Stillwagon or maybe like one of those others like BEST, diversified is just a type of, or Gonstead for that matter, diversified is a type of approach used. That is my understanding.

I: You mentioned that you don't use BEST or Gonstead or any of those, would diversified be a technique that you use?

R: Yes

I: What do you understand by the term patient management?

R: I think that includes knowing not only not only what is wrong with the patient, treating the patient, but also when and where to refer them to and knowing your avenues of referral and ultimate end goals, before your patient asks you to do it.

I: Is management a generally accepted notion within the chiropractic profession?

R: I thin within the realm of South-African trained chiropractors certainly, I am not entirely sure whether means the same thing to the overseas trained chiropractors.

I: Are you aware of what it could mean other than what you have just explained to me?

R: I think it might mean slightly different avenues, for example the so called more alternative avenues, including nutritional advice, which is shared by the South-African trained chiropractors, but perhaps solely nutritional advice, radiographic assessment etc.

I: How strongly do you emphasize medical diagnosis?

R: I think I am forced to emphasize it in practice largely due to the referrals I receive from medical doctors and other specialists, so I emphasize it a lot.

I: How has mainstream/allopathic medicine influenced you?

R: I think it has influenced me to a point of first of correctly or at least needing more correctly diagnosed, to diagnose patients and being far more specific about how we do things. Also it has helped me to realize that in all different professions we all have our own problems and that chiropractic doesn't have problems unique to itself.

I: What influence dot you think the scientific method has had on your approach to practice?
R: I think it has a significant influence, in that I am fairly cynical at the best of times. It's also helped me to question things more and not just to accept what I read or what I listen to and I think to some extent has made me a better practitioner for that.

I: In retrospect do you still think you don't have a philosophy of practice?

R: Perhaps it is a play on words, but maybe it's a philosophy of using a lot of the scientific method, I agree perhaps that needs reviewing, so yes maybe that is part of the philosophy by which I approach practice generally.

I: Is there a difference in the manner with which you treat acute and chronic patients?

R: Yes.

I: Would you like to elaborate on that?

R: Yes, generally in terms of, you don't mean in terms of treatment as such?

I: You can include that, yes.

R: Generally I don't think the treatments differ that much as long as they are similar conditions, but I think the number of times and the timing of the treatment is significantly altered by the severity of the condition or the acuteness or chronicity.

I: Would it be appropriate for me to assume that you are referring to treatment frequencies?

R: Yes.

I: Should there be a difference in the approach to treatment of the two?

R: I think certainly in the case of the acute patient, a short course of treatment administered over a short period of time is generally what I use, as opposed to a chronic patient who has a niggle and is seen once off and generally responds favorably to one or two treatments. I think there should be a difference based on that.

I: Is it possible that your chronic patients never resolve?

R: I think chronicity generally there is perhaps a different understanding as why things become chronic as opposed to what we use to understand some time ago and that involves I think how some people may become acute as well, in other words there is a brewing of the problem over a period of time and that may or may not develop as the patient presenting with a chronic niggle or presenting in acute severe pain, but ultimately the pain in many respects has been brewing over a period. For example an acute pain just doesn't develop immediately over a short period, due to a particular injury and this is I think a very different concept to what we used to think and used to believe.

I: So you are saying that even if somebody seems to present with a very specific complaint after a very specific incident, in fact a number of preceding events may have contributed to the presentation?

R: Not necessarily causing pain at different times, perhaps just little niggles as they go and at some times, depending on the patient, it will vary when the patient presents to the chiropractor or the GP for that matter. But it is a continuum of a problem in my opinion.

I: What factors play a role in the development of the two ultimately?

R: I think occupational things generally, daily lifestyle and leisure activities, sleep postures and I think something not paid a lot of attention to by some, are the ergonomic factors. That I think may be more problematic than we realize.

I: These are all factors that you pay attention to?

R: In practice here?

I: Would it be fair to call them psychosocial factors?

R: I am not sure if that is what they are called, but ja for want of a better term ja.

I: I am going to just take you back for a second, I originally asked you whether you thought that chronic patients have the ability of never resolving and we moved on to a parallel topic, would like to respond to that question now?

R: I think in certain circumstances, there may be certain chronic patients that will at some point resolve and never have a problem again, depending on what treatment they had been getting in the past. I think it is fair to say that they had been getting a type of treatment that was not addressing their actual problem and if I may use examples when they are getting manipulated a) in the wrong areas or b) not having a myofascial component addressed for example where they persisted in manipulating joints, where in fact muscles are causing a large proportion of the pain. So I think in some cases there may be cause for saying that those so-called chronic patients may well resolve and in others as their spines change over time, we know that some back pains will resolve by themselves. So some chronic problems may resolve by themselves eventually.

I: Making the assumption then that there is a small percentage of patients who do not resolve, why do think they come and see you if you make them aware of that factor?

R: I don't think it has anything to do with dependency, to a large degree I think the get relief from what one does for them. There are some arguments that state it is purely dependency and I don't know if that is all the cases, perhaps there may be some of that, I am not sure, because they believe it works for them and they have seen the results.

I: To what extent do you consult with your patient during the management process?

R: Fairly extensively, I try to avoid the white coat syndrome in prescribing what they need done or will get done and I try to for example see a patient initially I will try to lay all the cards on the table as far as possible and for them to have an opinion on what they would like based on their needs and their wants.

I: What do you understand by the term patient care?

R: I think patient care involves partly being accountable to your patient in terms of being responsible for the decisions you may make with them in terms of what you decide they need to have done. I also think to means listening to them and again what their needs and wants might be. That involves caring for your patient. I think it also involves that within certain boundaries that you take an interest in their other activities, family life or otherwise within reason.

R: Is there a difference in your opinion between patient management and patient care?

I: I think they may be linked based on the fact that if you are accountable and responsible for some of the decisions you take that is involved and interlinked with management so I think there is some overlap.

I: What would you like to see chiropractors doing I ten years time?

R: I'd like to see chiropractors be fully integrated into mainstream healthcare including government and private hospitals. Working for the military and in the military and being inculcated as being part of everyday patient perception as what they might look for as a part of their healthcare management.

I: There are some that would feel or say that if chiropractic would integrate that it would loose two things, the first would be the name and the second would be the autonomy of practice. How would you answer that?

R: I would say that it has happened in other professions as I eluded to earlier. Dentistry for example has become integrated to a certain extent, but has become completely separate profession with its own identity. I am not suggesting that we integrate underneath or subordinate to medicine, I would like to see us integrated on a par with medicine so not necessarily loosing any identity.

I: What are some of the advantages to integrating?

R: I think the advantage would be most certainly to the patient, those would be the people who stand to gain the most. That would be a huge advantage in terms of patients being given the correct care for the correct condition at the correct time as opposed to what happens still unfortunately that despite a lot of medical doctors and chiropractors working together there are a lot of people who eventually find their way to the chiropractor and eventually get themselves sorted out, when it could have been done a lot sooner. Having said that I think it is important that one see things in context as well and it is very easy to point fingers when that has happened and the patient has for example been through the mill, it makes it very easy for the chiropractor to say they were the treatment of choice, but that is once all other nasty things have been excluded anybody on the end of that one would look very clever. So I think one has to see things context and therefore if all those things could work together it would make things a lot more fluid and efficient.

I: What would you regard as the main deficit in your chiropractic education and training.

R: The first possibly is that we are not adequately equipped to run a practice. Within this school particularly I would perhaps say the radiology and perhaps the rehabilitation aspect.

I: what are the greatest challenges facing the profession currently and in the near future?

R: I think the greatest challenge is going to be for us to identify ourselves as not the sole caretakers of manipulation, because there are many other professions using it, but that we are seen to be best people doing it and that the challenges lies in continuing to show that is what we are: the best providers of manual therapy, because it is not exclusive to chiropractic.

I: Could you elaborate on manual therapy for a moment.

R: Manipulation specifically, adjustment, I think specifically that.

I: Are there any other manual therapies that are integral to the chiropractic profession, which you believe we have to hold on to.

R: I think so, because if we rely solely on manipulation we are going to fall short, because we are not the only ones using it and certainly as more and more evidence shows that it is effective for certain conditions, there are going to be more and more people jumping onto the band wagon. So, yes I think it is important that we improve our knowledge of rehabilitation for one thing. Possibly even drugs and how they might augment that practice.

I: Do you think the profession is vocal enough at the moment regarding its claims about manipulation?

R: I think its vocal to, generally speaking, to the wrong audience, and I think that the studies that have been published are now starting to be more so published in the more reputable

journals such as spine, the New England Journal of Medicine. The JMPT's are important and I think they have been a very good voice for chiropractic specifically, but they need to be, that information needs to be disseminated to the general practitioner and certain specialists.

I: If we are to assume that there are medical sub-specialities that exist like dentistry and optometry, but there are a number of groups at least two, physiotherapy and chiropractic being the main groups, how do you reconcile, but at the same time holding on to the hallmark of chiropractic, the manipulative procedure?

R: I don't think that is easy, but I think for physiotherapists to be using manipulation and to be doing it correctly they need to be studying to becoming chiropractors, if that is what they are wanting to use in practice. I think the same should be true for ourselves, if we want to be using other forms of manual therapy, we need to be studying further in those sub-fields, so not to take on rehabilitation based purely on weekend courses. Which I think could be said for physiotherapists not manipulating based on weekend coursed.

I: Dr. Gomes I thank you for your time.

Interview 8

I: Just to kick off, why chiropractic?

R: Why did I become a chiropractor?

I: Yes…

R: I wanted to something along the medical line, whether it was a vet, a dentist, doctor, physio, chiropractor, I wasn't too sure, but somewhere along that line. So health related science, I wanted to do something in that line and I applied to various options there, mainly being medicine, physiotherapy and chiropractic. The chiropractic thing was based on, I had never been to a chiropractor at that stage, friends applying and friends in the course that said it was interesting and from that I started finding out about it. There was a careers day at our school as well and I applied. I was not accepted for medicine anywhere, I was accepted for physio at UCT and I had to make a choice between the two and the decision was partly based on how well I was received at my initial interview at Technikon Natal and on financial reasons and proximity to home and decided to do first year chiro and from there either stick it out or throw in the towel and start with the UCT.

I: How would you define chiropractic currently?

R: It is a big question to just put out like that, because to define a profession superficially can be done quite easily by what the profession's representative association or board will put out publicly, so we all know that story about its part of the healing arts that its based mainly on the spine using mainly manual methods to treat ailments of the spine, but also other areas of the body and they may use orthotic appliances, dietary advice, exercise etc. so we all know that. The most important definition is the definition that the public that uses the services of chiropractors has and it is not as clean cut and neat as out by the profession itself, but I have the idea that the public would define a chiropractor generally as someone you got to for back pain for headaches and common ailments around your back and neck area and in that sense they are really seen as the treater of pain and discomfort for those areas of the body. Particularly if you have an interest in dealing with something at a causative level and are, as many people are now days, more involved with the health movement than just resorting to medication.

I: Do you agree with this public definition, would you go along with it?

R: Yes a hundred percent, I do, I think it is incomplete, there is a lot more scope to it, but if we look at where most chiropractors are earning their money from every day are those cases.

I: Where do you think the public gets the perception from that chiropractors are causatively oriented when treating ailments?

R: It is obviously from understanding from the chiropractor or from common sense, from their own logic in terms of understanding that certain ailments in the body can be treated purely from a chemical level. When I say treat I mean address the problem and not just avoid the symptoms or sedate the symptoms. That distinction of trying to treat a structural problem requires a structural intervention, I think is the understanding that they develop either themselves, but largely from the education from the chiropractor and then I think that is what that whole thing means to try and address the cause of the problem.

I: Ok, what type of chiropractor would you describe yourself as?

R: A generalist practitioner, I don't feel I specialize in anything particularly and I treat a bit of everything and my main focus is to establish at what level the patient require your service and try and provide that. So I don't specialize in anything, I don't try and attract a specific condition; I am a general practitioner type chiropractor, very much orientated toward family

practice and that is the best way to describe myself. Using very much mainstream, logical explained, generally accepted techniques.

I: When you say that the patient requires you at a certain level, would that be a certain level of health care?

R: Ja, healthcare being one of the issues, you know some people will rely on you to take responsibility for their back pain, others won't. They will be very much responsible and I think it is important as a practitioner to establish at what level the patient wants you to be involved with the problem. The patient in control and responsible with their body can take you suggesting maintenance treatment or follow-up treatments on a monthly basis as purely trying to make money out of them. Where as the other case, which doesn't have the time or inclination to be that involved in their own spine, need that and appreciates that and the lack of trying to get them onto some kind of maintenance programme is seen as you don't care about their spine. So you have to be able to read a patient on that level and be flexible on how you are going to offer control of that problem.

I: What type of person do you think makes for a successful chiropractor?

R: Well your people skills need to be well developed, there are lots of things you do not, should be. You should not be condescending or patronizing. You should not be too glib about it either. So I think what makes for a good chiropractor is firstly professionalism and secondly also being able to sit down with the common man. A good blend of those two, so it's a compassionate teacher, that type of attitude is what I think leads to the most successful chiropractor.

I: Could you expand briefly on the negatives or do nots when viewing other chiropractors?

R: Well I am not really a viewer of chiropractors, I don't have much to do with many of my colleagues, so I can't really say that, but I will have certain limitations for myself and my practice where… and I don't know, because I haven't necessarily tried to do them, but I don't think it would be wise for me to take certain approaches with my patient pool that I have. For instance like saying things such as you need to pay in advance long-term, those types of recipe pay treatment plans. Where inter-professional accusations and jealousy are used at every moment to run down the patient's GP or physiotherapist etc. Those things I feel are generally unacceptable and other things like constantly using a marketing approach on patients to try and generate new business is also not a wise move in my opinion. For instance guys might push the:" I am seeing you, how can you allow the rest of your family to continue with these problems and not bring them along." So none of that emotional salesman stuff, I don't think that is fair.

I: Do you have a particular philosophy to practice that you have thought of?

R: Ja I do, it's basically do what works for the conditions that are presenting. Most of the time if there is a scientific basis to it, try and use that as an explanation for what you are doing. There isn't always and then at least be open and honest by saying:" Look there isn't a scientific explanation." For instance, why vertigo will respond well to adjustment, but if it seems to work on an initial trial basis then there is no reason why it should not be carried on.

I: What does the term subluxation mean to you?

R: It means… Well all know what the literary definition is, and I am not too distant from the literal definition, which is a partial dislocation of an articulation of a joint.

I: Would you describe yourself as either a mixer or a straight chiropractor?

R: I am a mixer.

I: What does that mean to you today?

R: a straight chiropractor is generally the Palmer or Sherman type graduate who will be entirely focused on establishing subluxation, misalignment, fixation in the spine and treat only that.

I: Would a straight chiropractor have a different interpretation of a subluxation to what you do?

R: Yes, very possibly, they might extend the possible results or effects of a subluxation. Where I would say:" hey you have got this it is going to give you discomfort/back pain", I am not always going to trace glandular or organ involvement from a certain spinal level, where as I think they will very much use that system.

I: When you explain lesions or sights of lesions to your patients, do you use the term subluxation?

R: Very rarely.

I: Which terminology do you prefer then?

R: Well, neither of the common ones, I say:" Your joints have become jammed or stuck." I think generally it is better to use common layman terminology for a patient when I use the academic terminology. But in my mind when I when I am saying stuck or jammed, I am thinking along the fixation line.

I: Jammed joints or fixated joints are they the same as subluxated joints?

R: Yes.

I: What do you understand by the term patient management?

R: Patient management encompasses the entirety of how you are dealing with the problem that the patient is presenting to you with. So not just their back pain, but also the ergonomics, their exercise general lifestyle factors as an entirety.

I: Is the term generally accepted within the profession?

R: I think so, yes, a pretty logical term.

I: Do you have a specific approach to patient management lets call it a recipe for lack of a better word?

R: No I don't, my first level of treatment for a patient is to focus on the physical disorder and try and treat that as best as possible. If the case is not straight forward and isn't responding within two or three treatments, we will go to the next level where we investigate causative factors especially if they are more obscure for instance postural factors and ergonomics and so on. So that will go to the next level and should it be even further than that, then it may require other investigations and second opinions and it goes deeper. So my level of management on a case will grow proportionately to the speed at which a case is resolving.

I: How strongly do you emphasize a medical diagnosis?

R: No I don't, but it depends on the definition of a medical diagnosis, because in my opinion if we are talking allopathic medical diagnosis, many of the lesions we see, its not a diagnosis at all its naming a symptom for instance sciatica and I don't see that as relevant. I prefer, if a diagnosis can be taken to either be the best briefing or summary of the disorder or the naming of the causative factor, then I will rather use that diagnosis and the medical diagnosis is not always the most accurate.

I: How do think mainstream allopathic medicine has influenced you?

R: It's influenced me a lot, I certainly am very pro mainstream medicine. For instance my journal subscriptions are medical journals, I read no chiropractic journals. So I see it as very important, I see it as very positive factor and the clinical thinking processes I use are very much general practitioner based, so it has a major influence on my practice.

I: Well then linked to that you mentioned a scientific rationale, which you like to use, explain things to your patients. Does the scientific method as such feature in the way you go about your practice?

R: Yes, a patient presents with a problem, I explain to them based on the history and examination what my most logical idea or understanding of their problem is, so a hypothesis is formed and then I explain that I don't necessarily know whether they will respond to my treatment, so I initially suggest that it depends on the case duration, but generally I suggest a three treatment trial in which we must make significant progress. Should there be no difference by then or very little difference then I will rather send them for a second opinion or further investigation. However, should they be significantly by three we may continue with treatment, hopefully they will have responded all together by three and we won't have to go through more. So that will be testing the hypothesis theory. So to me that is generally scientific method.
I: Where do you think this approach comes from?

R: It doesn't come back from my training entirely, but the idea of that, you see the most important thing in practice is that you don't want to be wrong, you want to be right and it is impossible to always be right with patients, even if they present the same, they don't always end up the same, because they different bodies and lives etc. The application of a trial and error process based on logic, which is what the scientific method is, is a way to keep yourself on track, but clear of commitment to fundamentalist or idealist principles, which may make you wrong in the end. That is the approach I take, it is not the most courageous approach, but it is the most practical approach to reaching a solution in a reasonable amount of time and that is a principle I don't necessarily only apply in practice, I apply it in everything else. So part of it is related to my training yes, but I think most of it is just a principle that I adhere to personally.

I: Is there a different manner in which you treat your chronic and acute patients?

R: Yup, in the acute patient the main focus is to get rid of the pain so in those cases often the treatment will need to be in some ways down scaled, because you need to be aware that there is a lot of inflammation, sometimes spasm, there are restrictions so your treatment has got to be geared to that and the additional use of secondary factors like anti-inflammatory drugs from the doctor or the pharmacist, orthotic appliances like braces or corsets they all play a large role. The focus is to get the patient as comfortable as possible as soon as possible. The chronic patient the focus is different, you might not be using as many secondary features, but rehabilitation, body strengthening changing the possible causative factors are far more focused upon and treatment can be more aggressive in the chronic patient.

I: To what extent do you consult with your patients during the management process?

R: What do you mean?

I: Consult in the sense of planning what is going to be done during the course of treatment, how often they are going to see you, that sort of thing…

R: Ja not very much, in any case chronic or acute is managed on the treatment trial that I have spoke about, lets try three on your case and see how you go. Depending how they go depends on how much further it goes. But lets take a case of…If it is a case that is responding very quickly, lets deal with that one first, then there is not too much focus, there is too much consultation, they are just too happy to be out of the pain. It's a nice easy case, it's a low stress case we get it over and done with and that is it, and should this happen again, watch out for these features and this is what you do. A little action plan for future events, in

the chronic more difficult cases and that again is proportionately scaled up to suit that condition.

I: you don't subscribe to consultation much as a rule by the sounds of it, what does the term consultation mean to you?

R: Sit down and talk about things. Spend quite a bit of time talking and planning ahead.

I: Why is it not something that you adhere to too much?
R: It's not always necessary.

I: The term patient care, do you have a specific definition that you can give us for that?

R: No I don't, I can make one up.

I: Would you like to comment or not?

R: No I don't mind either way. Patient care is looking after your patient, trying to do it from a holistic point of view and that is basically it.

I: All right let me give a bit of context here. Patient care comparative to patient management or treatment. Where does care fit in or how does it relate to those two terms?

R: Ok well, my opinion then would be that patient care as to management or treatment would be a compassionate approach in terms of having a concern about the patient. It might involve a telephonic checking-up on a really painful case that you saw that day, which I do. It might be phoning a patient who you found had an irregular pulse and sent to the cardiologist and phoned them even before you got the referral letter back just to find whether things were all right in that respect. So its care for and beyond just the scope that you are consulted on.

I: Are the any psychosocial factors that you consider on a regular basis in practice beyond the physical causes of management and treatment?

R: The obvious and most common one is stress. People always say:" Could this be stress?" it's always a question. A lot of people don't understand, in my opinion, that stress does have very real, physical results be they secondary or not and they just… To just deal with stress is no simple matter and that I will certainly make suggestions in terms of that. From short-term use of muscle relaxants and sleeping pills, to anxiolytics, anti-depressants and psychologists. So it does span a whole field, but my role in it is to explain that emotional stress very definitely results in physical changes in a person's body and some are those physical changes are causing the conditions for which they are presenting to me and I can treat those and the treatment will always only be palliative as long as the emotional stress cause is occurring and that they must understand in that respect that it is going to be a symptomatic treatment for the secondary factors and try and focus on primary cause even be it not in my primary field and to try and get them to take some steps in addressing that.

I: Do you feel that in the area of stress that you were prepared adequately during you training or was this something you have had to develop through experience?

R: Ja, the training was inadequate, it is something I have developed personally.

I: What would you like to see chiropractors doing in ten years time?

R: I would like to see them doing what they are doing now, but also to have hospital rights. I'd like to see them using some drugs that are applicable. I'd like to see better inter-professional respect and I would like to see better financial reward.
I: I know it's a big question ask, but what are some of the things we can do to bring these changes about as a profession?

R: What can the practitioners do…? Well I think these are issues that are felt by most practitioners and they are raised at AGM's and at branch meetings. The people that have the ability to bring about the changes in those respects are active at those functions and try to absorb what of support they have for those movements at the meetings and in terms of getting membership votes and from there mandates are brought forward and so I don't think we are off track, I think we are on track for changes within those of kinds of avenues and ten years is a relatively long time. I think there will certainly be some changes of what I have spoken about that would have occurred or will be well on their way in ten years time.

I: Many of the things that you have mentioned are very much related to integration with mainstream medicine both from a management as well as a payment perspective, dot you think that chiropractic will loose any of its identity in the process?

R: I don't know, it depends on what chiropractic's identity is now. There we have to establish which identity, the mixer or the straight, is the strongest one in public opinion and I think if it goes my way in ten years time then the mixer identity will be dominant and certainly the straight will have lots some of its identity, should it go the other way then the mixer identity will suffer. In the end there is no way it will ever loose a clear identity as a chiropractor. Patients will still, the public will still have the idea, that for back and neck pain I go to the chiropractor it works quicker than the physio, its better than taking pills. I know I feel better, I don't need words to tell me that. I know I feel better when I do this… and that is the identity that will never be lost.

I: We touched on it briefly just now, what are some of the main deficits in your own training?

R: I don't really know, but I think it may be better to have some grounding in all these 'techniques' that are spoken about. I don't think that my skills are inadequate at the moment, because the vast majority of my patients respond very well to the skills I have been taught, but I would have like to at least have a grounding in the various techniques, so that I could at least have an objective judgement whether they are worthwhile yes or no. So I think the general techniques available would have been very worthwhile, especially when you are trying to deal with patients who have had other techniques that you don't know anything about and this layman knows more about a certain technique than you do.

I: Could you give us an example of one or two of those?

R: Thompson drop, SOT, Activator, Applied Kinesiology, I don't even know what they all are, Gonstead etc.

I: Do you think it is possible that those techniques have caused confusion in the minds of patients with regards to the identity of chiropractic?

R: Ja.

I: Why is that?
R: Well, I can't really answer why that is for other people, but for me it has caused confusion as to the identity of chiropractic, because you have a singular name of a profession, but you may be getting a totally different service from various individuals with the same title. You know we are paramedical like dentists and you go to dentists for dentistry. Can you imagine having your idea of what dentistry is, but there are some dentists out there who don't do anything with your teeth, they are mainly involved with measuring the tone in your Temporalis muscle and giving you bite plates? We know that exists in dentistry, so it is not a farcical suggestion I am giving, but should 20% of all dentists treat all dental disorders like that, I mean it is ridiculous. Certainly it is going to confuse the public and they want to know:" If you are that kind of dentist that just does the biteplate thing, I want to know, because I have a rotten tooth."

I: Dr. Mathews I thank you for your time.

Interview 9

I: Let me start off with a simple question, why chiropractic for you?

R: It happened on a personal basis where I was having very bad back pain and I went to a chiropractor and he corrected the pain, which I had had for fifteen years, and that was a light bulb moment in my life and I decided right there and then to become a chiropractor.

I: How would you currently define chiropractic?

R: Defining chiropractic is not a black and white thing, it's not and easy thing to describe. Particularly I found this with two patients, once we had a nice talk. The definition of chiropractic is not clearly understood by my patients that is what I would like to say from the start, but I define it as and art of healing whereby, through our adjustive techniques we can restore the function of the body particularly because of the nervous system malfunction. We can re-establish the proper functioning of the body through manipulation mainly of the spine.

I: What type of person makes for a successful chiropractor?

R: A person who has a real understanding, firstly of what health is and secondly a need or a willingness to help people who they can see are in that kind of situation where chiropractic would be beneficial. The one thing that I do appreciate in chiropractors is firstly enthusiasm and secondly they have got to have that passion for the job, because it is not an easy job. So I would say somebody who shows an above interest in helping other people.

I: When you view other chiropractors, what do you find most negative on unacceptable as characteristics.

R: Just the large variation in the principles that are applied. From one extreme to the other the public must get very confused about what chiropractic really is and really is to me isn't really what chiropractic is to somebody else. So we have a different idea of the philosophy and practices of chiropractic. So that does disturb me, particularly when I hear that people are not adjusting spines and calling themselves, because by definition we have to adjust the spine.

I: would you say that is above all else the hallmark of the profession?

R: No I don't think it is a hallmark, I think a hallmark is a very much more positive thing. The world will see chiropractic very much more positively than that statement I have just made. I think the hallmark of chiropractic is that generally that I experienced a very high regard for chiropractors. I think that will be a thing. The different, varying attitudes to chiropractic. I think is a negative, but it doesn't disturb the positive side.

I: Well making the assumption that there are different approaches followed when practicing within the profession, what is your particular approach that you like to follow in practice?

R: I like to follow an approach first written down by the doctor Palmer father and son where I believe that nerve interference in the spine is achieved when vertebrae in the spine are not sitting in the correct position and when these mal-positions are there for a long time I think they can cause chronic states of disease in the body.

I: What does a subluxation mean to you?

R: Subluxation to me means that a vertebra is not firstly, not in its correct position anatomically, secondly it has no proper movement in respect to adjacent vertebra and thirdly it had an effect or is interfering with the nerve root at that level.

I: There is a mainstream medical definition for a subluxation, which is a partial dislocation. Do you first of all agree with that definition and then secondly what is the difference between your definition and the mainstream one?

R: Firstly we differ with the medical profession in that they claim they can see a subluxation on an x-ray, we would never claim that. Secondly, their subluxation is just short of dislocation, and our subluxation may be very far from dislocation, but our subluxation has a neural element to it, which the medical profession does not talk about.

I: Are there other similar words that you might use to describe this subluxation…

R: Complex. Ja I use the misalignment sentence. For example if you have misalignment or this vertebra is misaligned with its neighbour, with its adjacent bone and then I go on to explain causes interference with the neural transmission in the spine and then go on to say that alteration of the neural transmission may lead to alteration of the function of the body. So I use misalignment and subluxation, but I only use subluxation with patients who I see are understanding what I am talking about. If I do mention subluxation, then the next day they don't remember, but misalignment they remember.

I: There has always been a use of the two terms mixer and straight chiropractor, what do they mean to you?

R: In the negative way they mean to me what has happened in America, there is two different parties of chiropractors in America and I think its terrible. But basically what they are arguing about is not a lot. One assumes that any chiropractor undergoing training will be told about the Palmer theory, they must bare that in mind when they are dealing with the scientific side of what is happening in the body, the physiological, they anatomical etc. etc. that everybody in taught at school. Yes we have evidence now of tissues becoming inflamed with nerve irritation. The difference is that people are, they become absolutely focused in that one statement of subluxation causing disease. They seem to disregard all the other evidence that not only subluxation causes disease. So they are a little limiting, they limit themselves in their vision. Where as the modern chiropractor that is aware of all the scientific implication of physiology and anatomy can deliver his treatment appropriately, but also bearing in mind that there may be the basic principles in results they may find. For example if someone has a Torticollis, a cervical Torticollis, they may clear they may clear the Torticollis up and the patient may report that their sinuses have improved which they have had a problem with over the years. Whenever I treat a Torticollis I am always aware that there might be effect on the sinuses or the headache compartment of the person's problem. I don't just focus on the cervical Torticollis as a blockage of the joints.
So if the two camps, the straights and the mixers would just relax a little and accept that both philosophies are working at the same time, then we wouldn't have the problem. People do get stuck and dogmatic and that causes the problem. So I am in actually both camps.

I: So in your mind then is there a practical difference between the two or is the classification purely theoretical?

R: The treatment is no different, but the approach to the treatment is different. The language they use is different.

I: Would I be correct in saying that you follow a mixer approach?

R: Not strictly, I sometimes am a very straight chiropractor and believe that the adjustment will get rid of the symptom.

I: So the basic classification for you is unnecessary and impractical?

R: Which classification…

I: The mixer and the straight…

R: Yes absolutely

I: What do you understand by the term patient management?

R: To a manage a patient means that you have to commit yourself and the patient to a course of treatment that will end where the symptoms of the disease are completely gone and that might mean telling the patient that they will have to see you on an ongoing basis. That is according to your assessment of the diagnosis. You might be able to tell them that within a week their problem should be over. Management means communicating with the patient on what to expect. Management starts at the first visit and you tell them what your expectations, you experience might say that this is a problem which you have had difficulty with before and you might warn them that you might have to see me over an ongoing period over a month or two. That I call management, letting the patient know what is in your mind.

I: Do you have a particular approach to you patient management, which you seem to use often. A kind of a routine or a recipe or does it vary.

R: I think it varies, I can't say that I have a set routine. So I could go on about that one a little bit. There are cases where patients have been to numerous practitioners before they come to see me, I know I have got to talk to them a bit more about the problem, because by this stage they are pretty confused. I spend more time explaining what the subluxation might cause, if they are comfortable with the term, or what the misalignment can cause. And sometimes it will take a longer time to rectify the problem than with someone else. So we would say I can advise you that this treatment won't make you better in a week or two and you have got to understand that this is a long term situation and you must be prepared to come and see me over the next month or two are you ok with that?
I: There seems to be two main issues which you have highlighted under management, the first is the setting of treatment frequencies and the second being the communication aspect. Are there any other categories that fall under the management umbrella that comes to mind at the moment?

R: Well of course advise on lifestyle is always part of the management thing, you have got to tell them the things that they are doing that are not helping their health and things that they have to do to help. Very much so.

I: How do you think mainstream or allopathic medicine has influenced you?

R: The only thing that I can say about that is that I have a high respect for medicine and what they can do, but as far as our profession is concerned, they have very little influence on how I do my job. I have good communication with the medical guys. So, they don't worry me at all. I refer a lot of patients to medical practitioners. May I say that they never refer back to me?

I: Are there times that you will discuss medical diagnoses as alternates to what is going on with them?

R: Very much so. I point out that all medical diagnosis is aimed at the symptom. They very seldom give them the cause of the problem and I say if we don't treat the cause, the problem won't go away. So, I just make that clarification in their mind. I don't know if this is the right time to say this, but I might get a patient who has been to see me after seeing all the doctors and physio's, neuro's, radiologists. They have seen seven or eight thousand rand and they finally end up in my office and within three or four treatment their headache disappears and they are happy and they phone me a week later to tell me the headache is gone. A year or two later they will come in and see me and again they have gone through the process of being to the physio, the radiologist, they have had more x-rays taken etc. and again they come to me after that route has been taken. So what happened to them in my office wasn't powerful enough to forego all that next time and come straight to me and it hasn't happened once, it has happened on a number of occasions and that is quite an interesting observation.

I: I am sure you have thought to yourself what the possible roots of that might be?

R: I don't think we have made our product clear. Our product description is not clear and it is difficult to describe our product that it the point. This is my contention that we don't describe what we do clearly enough, because what we do is difficult to describe.

I: How do you think the scientific method or science has influenced the way you practice?

R: I can't say that it has a lot. I remember reading up on studies that were done on neurotransmission. They were measuring the difference in transmission down a nerve root with pressure on in and without pressure on it and with severe pressure on it and I was very interested in that, because that to me was the practical side of what I assume was happening with this nerve interference. I think more work should be done on what types of different impulses flow down the nerve once pressure is put on it, because it certainly does alter the function of the tissues that it reaches when it is interfered with. Apart from that, science hasn't affected the way I work at all. I think medical books allows me to use the language the medical guys use so that we can more freely communicate, because they don't understand for instance our meaning for subluxation. So it doesn't really affect the way I treat.

I: Is there a difference in which you approach chronic and acute patients?

R: Absolutely. There are techniques that you use for acute patients and then there are techniques that you use for chronic patients. Chronic patients need more management with interaction, discussion, explaining to them why it is going to take a long time. Acute patients, all they really want to know is how soon can their pain go away. My approach is distinctly different with both.

I: Is it possible that your chronic patients may never resolve completely?

R: I have to unfortunately say "yes" there is a possibility.

I: Would it be correct for me to say you make this clear to them in consultation?

R: Absolutely.

I: Why is it then that you think the come and see you in any case?

R: Mostly as a last resort, they have heard stories about chiropractors. For instance a case I that I have just seen just before you. This patient has a history going back twenty-five or thirty years of visiting chiropractors and physios and medical doctors and her problem is obviously with an emphasis on the psycho. Now I have told her that I can never help her get over her problems, she has to go for therapy. She doesn't like that, so she comes back to see me even though I have told her. Yes, I explain these things very clearly to people and this example is classic. I say to her:" Please, do not come and see me again, I cannot help you." But she likes to talk to me. There are chronic cases where I feel that the body has lost its ability to rebound from the situation it is in. For example chronic smokers have emphysema and I say to them:" There is nothing I know of that can help your problem." And they have got to face up to it themselves.

I: To what degree do you consult with your patients, you have given me some idea already.

R: To what degree…Pretty broad spectrum I would say. I ask them questions that nobody else has ever asked. How is your family life, where did you got to school, what sports did you play at school. I try and get some information about their background to understand what their relationship was like with their parents, their siblings. See what kind of a psycho input there might be and then go through the physical traumas that might have happened throughout their lives. Once you start asking them those sorts of questions they open up and they give you more information. So ja, for some patients we go into a lot of detail. So in fact the consultation takes much longer than the treatment.

I: So the consultation process in your mind revolves communication aspect with the patient?

R: Ja…Ja.

I: Some folk would draw a distinction between the term management, treatment and care. Could I ask you your views on patient care?

R: Again, I think that is on a psychological level. Patient care is a communication between you and the patient that you really are interested in their well-being and that you do care and that is very important to most people, but not to all. Management is more of an instruction, doctor-patient type thing where you instruct them on what they have to so to improve themselves and their health situation. Its blended there is no black and white area there; it's a gray area.

I: You mentioned that you like to get a feel for family life and things like that. What are the other psychosocial factors that you routinely encounter and look at when managing patients?

R: Basically relationships, how their relationships are with their husband or wife, their colleagues at work. Whoever is in their social environment. That is very important. Stress levels… I mean stress covers so many things. I think stress is caused a lot by the personal relationships that that patient has with the people in their world. And of course the relationship with themselves and if you find the type the type of person, who gets stressed under normal circumstances, one has to try and advise them on how to handle that and not to become stressed. A lot of them appreciate that. I mean I might suggest a weekend up at the Buddhist retreat and some of them have taken me seriously and they have really benefited. It is just themselves and the relationship with themselves, but that goes back to their childhood and how their parents treated them. So it is a hugely psychosomatic thing that I am conscious with every patient that comes in.

I: Is there a time when you make a decision that there is a psycho-social issue that you do not feel easy with dealing with anymore and it is time for the patient to maybe consult somebody else. Is there a rule of thumb a practical point…

R: Well that one that I mentioned earlier that was in today, I have in fact to go to someone else, but she doesn't want to. She obviously feels that I care, and I do. There is a typical example. I cannot manage her, because I cannot tell her what to do, because she refuse to, but I do care for her and I think that is what keeps her coming back. I think that is quite a good definition, the answer to the previous question, but ja there are certainly times when I have said to people I am afraid that this treatment is not having any effect. Can I suggest that you and see a homeopath or whoever?

I: What wold you like to see chiropractors doing in ten years time?

R: I would like to see them not doing any acupuncture. I would like to see them concentrate more on the manipulative field that we have been trained to do. I would like to see them more in the public I, holding public office, getting into the local governments, that would certainly help us. But generally I am happy with the chiropractic profession is doing, they are doing fine. The public has got a respect for chiropractic that has been built up over the years. I think the medical guys are changing their ideas. I think in ten years time, chiropractors will be very much more accepted into medical congresses and things as we are now. I think it is a good, positive, future.

I: You seem to have a strong feeling towards the acupuncture side that is involved in chiropractic, why is that?

R: It is not distinctly chiropractic thing, I consider it a different profession. I mean the guys can do it, like I do a little bit of radiology here, not every chiropractor does that. But my first choice treatment is always the adjustment or the manipulation, but when I hear of chiropractors who's first choice of treatment is acupuncture or massage, I go cold, because that is not what we are licensed to do.

I: Do you feel the public is done a disservice and this primary treatment that you feel so strongly about is not administered?

R: Ja, very much so.

I: Why is that?

R: I just think it is from history. You know we have battled over the last eighty or ninety years to get the chiropractors out of jail and then into the law books so that we can earn a living and there are practitioners that are doing treatments, and I am not saying that the treatment doesn't work, but they are not doing what chiropractors have fought to do. They are not doing what was taught to us and I think that they might be taking advantage of they situation where chiropractors are now benefiting from medical funds and all that and meanwhile they are doing something else, which is acupuncture, massage all that stuff. Which we can do yes, but it should not be the first choice of treatment. That should be in our armamentarium, but not our first choice of treatment. I think there are a lot of chiropractors, particularly in this country, that are riding on the situation, but yet not doing what a chiropractor should do. Like this network chiropractic. If I can select one of the things, I don't believe that it is chiropractic and I feel pretty sold on that.

I: Could I ask you to just briefly ask you to elaborate on you avarice toward network chiropractic?

R: Briefly…they are trained chiropractors I believe, I don't know a lot about it, but what I have been told is that the treatment does not include an adjustment. I therefore ask myself, according to the definition of chiropractic in this country, as the law stands, that is not a chiropractic treatment they have received. So when the medical aids come and say:" What it is that you actually do?" we have had to tell them that we adjust spines and now they hear that patients are being treated with something else. So they get confused, the government gets confused and basically it's not a chiropractic technique as far as I am concerned.

I: All right, my final question to you. There is a view that is held where a the public feels that when they go and see a physiotherapist or when they go and see a GP or any of the other sister professions that there is a broad understanding of what it that that person does. What do you think chiropractic's biggest challenge is to get that view of the profession?

R: That is the crux of the whole thing. The misunderstanding gores through from patients to politicians in that they don't really understand what the treatment of chiropractic is and what it does. That is the crux. Now to define exactly what the chiropractor does, you fly into all these other things like - straights, mixers and everything. I thin that personally, if we could all standardize the term subluxation and make that completely a chiropractic word. In that the nerve is being interfered with when the vertebra is out of place, that is what we deal with. If we could make that our product that's what we deal with, I think that will make it a lot clearer. I think that will clear up a lot of misunderstanding and a lot of confusion. Now unfortunately the word subluxation has been grabbed by the straight chiropractors and they disagree that the mixers should be able to use it, so you come into all that sort of crap. But, I firmly believe that if the world knew what a subluxation was, that what chiropractors treat, I think we will be in a much better position. Hopefully in ten years time that will be the situation.

I: Dr. Rethman I thank you for your time.

R: A great pleasure Corrie.

Interview 10

I: Why did you decide to become a chiropractor?

R: Because I found out that they do sports chiropractic. My dad was a chiropractor, but I was going into medicine, checking out med. School, because my uncle is a medical doctor and I found out that…My uncle spoke to me and told me that he is not having fun as a medical doctor. He got sued, a huge law suit, for giving someone an aspirin and at the time he was going through a lot of stress with that. And I always loved helping people. I didn't want to do exactly what my father did, I didn't want to copy cat, until I realized there was a new field called sports chiropractic and so that really interested me and I decided I would take the plunge.

I: Ok, your definition of what chiropractic is. Do you have a ready made one?

R: Umm… chiropractic is a science, it's a philosophy, it's a way of life basically of trying to help people self-heal by removing any interference in the nervous system. You know primarily in the spine. I also look at the cranials and extremities you know as interference, basically to assist a normal balance in the nervous system. To help the body and the brain to communicate efficiently.

I: There has always been a debate that has raged traditionally in the profession, and it has been between the concept of mixers and straight chiropractic. Could you classify yourself as either one of those or do you not subscribe to the concept of mixers and straights?

R: Ya, I don't use physical therapy. I don't use physical therapy for specific reasons, but I don't like using the term straights or…

I: The physical therapy, would that be in the context of South-African physiotherapy. The physical therapy modalities and that sort of thing?

R: Ya, that would be ultra-sound, hot packs, ice packs, massage. Ya, there is a specific reason why I choose not to do that.

I: If we can't classify yourself as either one of the two what type of chiropractor would you classify yourself as?

R: I would probably say more in terms of a wellness-style, where I don't focus on treating symptomotology, I focus on restoring health.

I: So the focus on the medical diagnosis is not necessarily your primary aim?

R: My primary aim is to first… I use the medical diagnosis to kind of give a name to what presents itself and also to find out are they in the right place, because they may have meningitis and then they are out of the office as soon as possible to the medical doctor. So, to me the medical diagnosis is just naming what is going on in the body. So, I don't stop there, I give the name, but then the next step is…I don't…my adjustment isn't…the diagnosis does not influence my adjustments. So, if I have a cervical diagnosis, I don't just work on the cervical spine and sometimes that can be the case, where you go and you focus, you give like a cervical brachial syndrome with myofascial tendonitis and fibrous tissue disorder and things like that and so you tend to work off the diagnosis. The diagnosis says this is what it is and what I do, they may have a cervical syndrome, but they may have something out of balance in the lumbar spine that is keeping the neck out of place, so I kind of take a more holistic viewpoint of the individual where I take a look at the whole person, rather than just where they are having the pain.

I: So, would it be fair to say that your philosophy of practice is a holistically driven one…

R: Ya, holistically driven…

I: … and that you are into wellness practice?

R: I am into wellness practice after about two to three months of care. The first two months is more where you are actually dealing with the symptoms. If patients choose to continue, then I go into wellness care. Wellness care starts when the symptomotology is going away and you want to improve on chronic injuries and start to heal chronic injuries.

I: We'll get back to chronic injuries in a moment. What type of person makes for a successful chiropractor?

R: One who loves helping people with… who loves helping people naturally, with no drugs or surgery and who also receives chiropractic care themselves.

I: Why is that important?

R: You have to walk your talk.

I: What do you most negative or unacceptable when viewing other chiropractors?

R: I actually don't… the thing about chiropractic is that everyone has their own way of adjusting, so I accept however anyone chooses to adjust. I guess what I don't like is when chiropractors use scare tactics. I don't see it in this country, but in America there is a lot of the push-push for practice management and scare tactic things where people abuse health insurance. There are chiropractors who call themselves NOPI doctors, no out of pocket expense, I don't know if you know anything a bout that.

I: This all falls under scare tactics…?

R: No that is more business skills, how you run your business, how you run your practice. I believe in just pure honesty with the patient and just shooting from the hip instead of saying you have to have x-rays and tell them that they may die if they don't get adjusted…you know, scare tactics.

I: what does the term subluxation mean to you?

R: Basically where a joint is out of alignment, but not out of alignment enough to be called a dislocation. So it is partly out of place and it affect the physiological function of the joint, so the joint cannot do its range of motion.

I: You mentioned the term patient management earlier on in the context of chiropractors using scare tactics. What do you understand by patient management?

R: It is so important to educate their patients, because they don't understand about chiropractic, it can be quite scary to them, especially if you do structural adjustments and cavitations and things like that. It is important to explain what you do and then also it is important to do what you say. So, people getting tired of taking drugs are turning toward a natural form of healing and chiropractic has been around over a hundred years and it is around, because it works.

I: So education is the one of the main aspects…

R: It is one of the main aspects…

I: What else would you classify under that umbrella term, besides the education…

R: In terms of main aspects…?

I: Ya, so you've got education under management, what else would fall under management?

R: I think a doctors morals… Trying to be on time with the patients, being honest, because that leads to a good referral based practice. People will tell other people:" Wow I went to doctor Smith and he referred me to a medical doctor and I really appreciate that or he was late and he called me and apologized or he gave me the visit for free, because he was so late and things like that. And also in terms of office flow, management means how your practice runs. So the more honest you are and the more you believe in what you do it makes a smoother flow to the practice.

I: Is there a difference in your mind to the concepts of management and care?

R: Ya, because management is how you handle the patients when they come in, sit down, when they fill out the forms, how you collect payment and also it's... 'cos it is a business this is the business side, the management to me is more the business side where you are managing the patient, because there are human beings and you want to have good business skills. So how the receptionist answers the phone, how they book patients, it's all about time management. It's all about, this step that took you ten minutes, can you do it in two minutes in a more efficient, easier way.

I: Do you think the profession, particularly in South Africa, has a common view on what management is and also what care is? Do think there is a common definition or do you think there is a lot of variability there?

R: Well, there's I don't think many people here, unless the doctors overseas understand about managing a chiropractic practice, because there is no…Well that is my personal definition of managing the patient, which is like the business and there is no courses that teach that at this point, other than maybe at the university when they teach the students. There is no continuing education on practice management, because what fall under there is ethics. To me it is a high form of the practice, in terms of how you deal with your patients. There's a lot of doctors, that I have heard, not just in this country, but in other countries, where there is like unethical practices that hey do. In this countries I haven't seen teaching programmes teaching people how to do it effectively.

I: So what it your particular approach to patient management then?

R: That they find they smooth when they come into the office. That they find it happy, that they find it pleasant. They find it very efficient, that they get their receipts. That they are able to go into the office and the receptionist can book them quickly. We do multiple bookings, in terms of… In stead of a patient coming in every time they have to schedule the next visit need a booking, we maybe give them a month in advance where they might have to see me twice a week and then I will go and do that so that it is in their schedule and then they make time to come in. You use management also in terms of education to show them the importance of their body.

I: How strongly do you emphasize the medical diagnosis during the management process?

R: Ok, I use the medical diagnosis basically to give a name to what they are feeling and if they have health insurance to put in on the health insurance thing. I don't have a specific treatment plan for the diagnosis. Let say cervical-brachial syndrome. I don't in mind think ok cervical-brachial syndrome means ten visits or lumbo-sacral disorder means twenty visits. I don't have a specific… you know in my mind…

I: There is no recipe?

R: No…no.

I: How has mainstream or allopathic medicine influenced you?

R: Well in two ways. One thing I feel the allopaths are absolutely necessary and they are absolutely amazing what they can do. My daughter would not be alive today, because she was born three months premature. Their ability to help her just was amazing, so I have a

good belief system with the medical profession with my own life and with my own kids, but o don't over use it and I feel and I feel that a lot of people over prescribe medication, they over prescribe anti-biotics. I believe that medical doctors save lives, but chiropractors restore health and I believe that medical doctors have nothing to do health, they are more the emergency care guys. You can't give someone thyroid medication and say keep it for the rest of your life or take it for the rest of your life and not expect them to have side effects. There are studies that say that when a person hits seventy, when they finally die after the age of seventy, it is usually due to drug complications that they are taking. That's in America. You know I have forgotten the word that they use if you die of drug complications…

I: Iatrogenic…?

R: Ya.

I: So, would it be fair for me to equate biomedicine or allopathic medicine with sick care as opposed to health care?

R: Well healthcare is such a broad term, because you also get re-constructive care, plastic surgery, you also get cosmetic surgery, which is for looks, you also get rehabilitation, you know to help someone walk and that can also help someone's health. Not directly, but indirectly. What I am talking about is getting the life force back, getting the energy back into the body.

I: The life force or force principle is very much a vitalistic view of life. Does that inform your belief system, your philosophy a lot?

R: Ya, rather than a reductionistic view. The reductionistic view in my opinion is more the mechanical view where I believe in the system belief that our bodies are made up of systems rather than just one thing, like in a car if something is out it can influence other parts of the car, the same thing with the body. If you have a problem in your neck with time it is going to effect the entire body, because we are one, and the system view meaning every system influences the other system and that is more the vitalistic or the holographic viewpoint.

I: When I comes to looking at acute and chronic patients, do you treat them differently?

R: No…yes. My communication is different with them. I may do things quicker when someone's in acute pain, I may adjust them very quickly. I may use pillows I may make them more comfortable on the table. My communication skills differ with the chronic patient; I have to educate them differently than the acute patient. The acute patient I cannot talk to about chiropractic or about the body is going to heal, because the won't hear it they are in pain, so my focus is to assist in getting the body to self heal so that the pain goes away.

I: When you say you adjust quicker what…?

R: I have them lying on the table for less time.

I: Ok

R: Rather than a longer time, because I realize that they are in pain lying face down I don't want them you know… so I will put special attention on them compared to the chronic patient, because they can lie there for a longer time without excruciating pain.

I: What the difference in the communication aspect between the chronic and the acute patient?

R: That one thing the chronic will listen, whilst the acute patient they are in pain, they just want to know one thing:" Doctor can you help me." So chronic is educating about:" Hey you know what this going to take time, you have had this problem for twenty years it's not going to be…"So its telling them stories about the philosophy of how the human process works and how… and assist them at noting change in their body, because sometimes the patient may be

walking better and they don't know it. Say:" Hey I have noticed that you got on the table much quicker then you did last time." They'll often say:" Oh ya, your'e right."
I: Is it possible that your chronic patients will never heal?

R: I have a pretty good…If they don't heal, then I refer them out, but I have a pretty good…They may not heal their exact symptom, but most often they will heal other stuff, because on thing I tell a chronic patient is that we don't know what is permanent, we don't know what can heal and what can't heal, so lets just try it.

I: And they are satisfied with that?

R: Ya, that I am trying, absolutely. I am honest with them I say if you are not healing I am not going to continue to adjust you. I'll only adjust you if your body is changing, if there is increased range of motion, if there is increased respiration, if your body is moving much easier, if there is less muscle facilitation, muscle guarding. So all those diagnostic tools that used in the first visit I look to see if there is a reduction in it.

I: There is a notion that acute patients, when managed, the outcomes for success are more related to physical symptoms and signs-pain, movement ability all that sort of thing. Where as chronic patients outcomes for success are more related to quality of life. Would you go along with that?

R: Yes and no, I mean you do get a lot of patients that are in a lot of pain. You do get acute patients that are emotionally upset, because they can't play rugby anymore. They had a severe injury and now they can't play their favourite sport in the world and that affects quality of life. When a chronic patient heals, there is a change in the quality of life, because they get restoration of function and that is the benefit of chiropractic in that you get the energy back, the joint moves better, you get better range of motion and there is an emotional component that they are still doing research on in how emotional stress can affect the spinal region.

I: what is your definition of an adjustment?

R: Restoring nerve flow. Doing a procedure involving the spine that will restore nerve flow to an area to allow it to start to self generate and to self heal.

I: To what extent do you consult with your patients during the management process?

R: I do a first visit, I spend time with them, then I do a report of findings on the second visit where I sit down and give them my diagnosis, I tell them what is going on. I may not… I don't give them a medical…I don't tell them you have cervical-cranial misl…, I don't do any of that, it will just confuse them in my opinion. I specifically tell them where the misalignments are and I let them know how much its going to cost, I let them know how long its going to take I tell them about re-examination, because I re-examine every patient and I tell them about the talks I have, because I do talks in the evenings to educate them about the healing process and about chiropractic.

I: So it sounds to me that consultation forms an integral part of what you do there is continual consultation…

R: I speak to them all the time, I may not speak specifically every visit about is going, but I give them progress reports on:" Wow this vertebra is moving better", or:" I see your breath is opening up", or:" There is less muscle tension in this area, have you noticed that" and it changes with acute and chronic.
I: Are there any psychosocial factors that you would focus on specifically in your practice?

R: Psychosocial?

I: Yes, the sort of non-physical factors that people suffer from, you know stress and that sort of stuff. So issues that a broader than just the patient.

R: Ya, that is where I come in with the holistic view. When I treat someone I look at not just where they have the pain, but I look at other areas like the lumbar spine when they have neck pain, but I also look at not only the physical stress like if the lift heavy boxes, but I also look at the life stuff. Are they going through a divorce, are they buying a house, did a kid just die, did they brake up with their girlfriend from over ten years. I kind of use common sense. Part of my role as a chiropractor is to assist in… it's hard to describe.

I: You have given me some issues that you consider, that's good enough.

R: Ok.

I: What would you like to see chiropractors doing in ten years time?

R: To be working more closely with medical doctors. To have medical doctors doing a lot less prescribing. To be using the philosophy chiropractors first, drugs second, surgery last. So the chiropractor has… because we have the training to know if the person should be in here, that is my first step when someone walks in:" Are they in the wrong place?", and so most chiropractors, I feel, have that philosophy to, well I hope they do that they are not treating someone that should not be in there. So with that said, it is safe to say that a chiropractor can be the first entry for people. That is one thing in the states that they have been talking about. Now they see a chiropractor first and if the chiropractor can't help them, then they see a medical doctor. So I would like to see medicine and the chiropractors make up and be friends and to start to work more cohesively together and that everybody knows their place.

I: What you are referring to sounds very much like the 'gatekeeper' concept, where the chiropractors are…

R: Ya absolutely ya.

I: What do you think we have to change to get there?

R: Public belief. Stop medicine from slamming chiropractors at every chance they get. To stop the propaganda mill. There is a huge propaganda that is toward allopathic medicine. Chiropractic has changed dramatically and it is very healthy in this country, compared to other countries. In France its illegal, I have friends who have been arrested for practicing chiropractic. It actually does not make sense, because it works. I had a child that since one week old, had eczema all over his body and had been on cortisone, I mean that is hectic stuff Cortisone for a little kid. Within two adjustments the eczema was gone by about 80% and that is a common thing in a chiropractic practice, but if we ever say anything about we get told that:" No you are pulling it out of proportion, you just focus on this. You are just back doctors, you are just neck doctors." I wasn't treating the eczema, I was just treating the misalignments in the baby's spine, because when I examine the child, I first want to see if I can help them or not and I didn't know if I could him or not. If it was then I could correct the misalignments I didn't know what the eczema would do, but guess what it got better and that happens quite often. So…

I: Dr. Armbruster I thank you for your time.

Interview 1b

I welcome the participant back stating that I have some secondary questions I would like to ask in order to cover some of the issues which were left unresolved in the first interview.

I: You mentioned that holism was a buzz word that many people use in their practice, but don't really develop and you mentioned that it takes a lot of guts to be a holistic practitioner, because patients don't like you to delve into the more holistic areas. What do you mean by that?

R: for me the holistic concept means going beyond the confines of whatever your profession is. For example a cardiologist or cardiac surgeon who works only with the heart or questions around the heart, unless he asks questions about exercise, for example I would not think of him as a holistic person. Patients don't like, in my experience, for you to delve into the areas around your particular profession. They come to you lets say in our case, because the have a pain in the back. If you start to ask them questions like how much exercise do you do, questions about their diet, questions about their weight, questions about their prostrate, when did they last have a prostrate test, what influence could smoking have on their health, they resent those kinds of questions. They came to you specifically to treat their pain in their back and they don't want you to talk about their constipation and all these other areas and for me a holistic practitioner has to at least make a serious attempt to look at the whole patient rather than just the specialty of what he came and consulted you for.

I: So, would it be fair to say that the moment you move away from your role as a mechanist or a manual medicine practitioner, your role becomes more intricate, because you deal with softer issues.

R: I am not sure what you mean by softer issues, but I mean what is critically important for me…In my experience if people have episodes of severe back pain, they can have two or three, or sometimes even more, without neuralgic signs. However, once they start to have four, five, six episodes the chances of them developing signs of nerve root entrapment with all the attendant complications the incidence becomes much higher. So in my mind the holistic practitioner must make a serious attempt to limit the number of acute episodes the patient has in their lifetime to one, two or three otherwise all that happens is that the neurosurgeon scores a try in injury time. We are simply putting off the day, he doesn't have the back operation this week, he has it next week, but patients don't necessary like you to…they just say fix my back, because of their limited understanding of what is happening in their health and they don't want to change their ways.

I: You mentioned that as chiropractors we see the subluxation as the deep foundation of the human being. Is that necessarily your particular view?

R: I am not what I would call a subluxation based chiropractor, but that does not mean that I do not believe in the subluxation. I do believe in subluxations, but I believe they are a very complex condition and our various attempts to define it may be better or worse. I must say that I don't particularly think really in terms of subluxations. I don't for instance think that a subluxation is a diagnosis perse. I am more inclined to think of the tissue involved in the subluxation process. I prefer to think in terms of is there an injury to the disc, is there a frank nerve root entrapment, and are there signs of nerve root entrapment? So I am more neurologically and orthopeadically based than subluxation based. But that is not to say that I do not believe in the subluxation, I do believe in it. We might use other terms, but lets just say that it is quite clear derangement of one sort or another within spinal joints do affect people's health directly in the sense that they cause pain, probably predominantly and pain will affect people's well-being. It will affect their health, their state of mind, their thinking, their activity, and their ability to function. The subluxations cause headaches, people with headaches do not function well, however I do not think in terms of and occipito-atlas subluxation as causing the patient'' headache. Does that answer your question?

I: Yes it does to a certain degree. Can we agree then that you see the subluxation as a subtle physiological or pathophysiological entity, which can have an affect on the patient? However, do think the subluxation interferes somehow with energies of the body and nerve flow. What is the implication of the subluxation?

R: whether directly or indirectly, I would say yes. The person, who is suffering from the headache, his energy flow, if you want to use that term, is disturbed. There is no question in my mind about that.

I: Would you use the term?

R: Energy flow?

I: Yes.

R: Probably not. One last thing about that, the term subluxation, when it is frankly present I have no difficulties with at all. It is when it is subtle subluxation that I have difficulty with. It causes no signs and no symptoms and there is a question of whether it is really there and it comes back to does every person need to have a chiropractic adjustment on a regular basis, even though there are no signs and no symptoms? And there is a group of chiropractors, rightly or wrongly, from the way they talk imply that every person needs to have a regular chiropractic adjustment, because of a disturbance of energy flow. For me, I have difficulty with that concept of subluxation and I am not convinced that every patient must have a chiropractic adjustment. I wonder if it is not a financial thing that they are talking about? Is this not another way to make money? You have this condition that nobody can identify, it is causing no signs, no symptoms, but we think you should pay us a fee and have it adjusted.

I: Well that may lead us into the next clarification then. You mentioned that you struggle with bullying they patient into doing what you want them to do, what they need to do as you perceive it, recognizing it is their body and that you have to treat them by their consent. Are you able to elaborate on that? Bullying has a negative connotation to it and I would like you to clarify that notion.

R: Let me give you an example of something that walked through my life this week. I had a patient see me, who has been a patient of mine for the past 15 to 20 years and a year ago he had quite a severe angina attack and he went into hospital and they put a little device, I can't remember what it is called, into the artery and it expands the artery like a spring.

I: A stent?
R: A stent, and I said to him Billy you have to change your lifestyle. He was not very overweight, but overweight, he wasn't a smoker, blood pressure did get high on occasions and I said to him you have to change your lifestyle, because research shows that 50% of people who have an angina attack, will have a heart attack within one year and we went through it in a fair amount of detail yes, yes, yes. He made some attempt to loose weight, he lost a kilogram or so, but two weeks ago his wife cam into my office and told me that he had just had a triple bypass. Now for me the difficulty is what is my responsibility towards Billy. He comes to me, because he had a fracture of the atlas in a car accident forty years ago. He comes to me with terrible headaches that only respond to chiropractic adjustment. And it comes back to the question of holism. What is my responsibility toward the patient? And I perceive it that I actually failed in this regard to him. I should have been more proactive. Billy I want to see you in this weigh-less programme. You shall loose five kilograms or ten kilograms. I want to see a record that you are walking for at least thirty minutes and because we had a good relationship he didn't say no I won't do it this is none of your business I come to you for my headaches. We had a good relationship, but I hadn't seen him for six months and the next thing I know he has had this major heart attack and triple bypass. Does that answer your question?

I: Yes it does. Dr. Lewis you mentioned that medicine is not really dependent on us; however, in your opinion they should be more dependent on us. Can you elaborate on that statement?

R: I think it is probably true to say that medicine does not think that they need us. They do not depend on us. A large part of medicine does not actually believe that manipulation is effective or safe, therefore they don't think they don't need us at all.

I: Dr. Lewis what in your opinion is the main difference between a chiropractic model and a medical model?

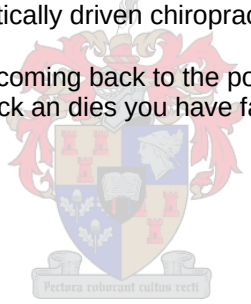
R: Perhaps rather than talking about there about medical model, what I mean in a more general sense simply a healthcare model and I think there is an enormous breadth of opinion of what the chiropractic model is and medical people would no doubt have the same difficulty that that there is the same breadth of opinion within medicine. But let's say that ideally the medical model and the chiropractic model in their intention of improving health, preventing disease are probably similar.

I: Dr. Lewis when you mentioned the notion of a healing paradigm does that refer to what you would actually, physically do to your patient or do those refer to the underlying driving force from which you work?

R: I see a human being as a very complex organism, physical, intellectual, emotional, spiritual. The driving force, which determines the way I treat people is both a reflection of those principles within me and my full acceptance that this person that I am treating also has all of these other parts of their total being. It is this complex human that I am that drives me to look after far more than just subluxations that ail people.

I: So would it be correct to say that the philosophical framework within which you function is that the human being is very complex and that it is not good enough to look at just a subluxation to be considered a holistically driven chiropractor?

R: Without a doubt, because I keep coming back to the point that if you treat the subluxation only and the patient has a heart attack an dies you have failed the patient.



Interview 3b

I: Dr. Docrat you said that at times what you would do is consider what's going on with the patient and you may go through a consultation where you don't treat or manipulate. Could you elaborate on that?

R: I think that initially it depends on what the patient presents with. I would first of all immediately begin thinking:" Is this a chiropractic case no 1.?" You could have the scenario that the patient could be a chiropractic case where the patient needs to be treated somewhere else first. Let me give you an example, about a week ago a patient was referred to me via another patient and the referred patient had very serious spinal pathology and when I was told this patient would present to my rooms by the original patient I assumed this was a normal chiropractic case-the guy had back pain, leg pain etc. But when he presented he came in a wheelchair, he came with his reports etc. and I saw this guy had major instability in his spine and congenital stenosis of the spine and he was slowly becoming paralysed. They were assuming that, because I had helped his friend I was going to be able to help him out and I could see that the guy was desperate for help. I sat him down and I didn't touch him at all, I looked at his reports and said to him:" Look at this…" its not a chiropractic case and I spoke to him about what chiropractic is about and why was not able to treat him etc. As a summary to answer your question, my mind would be thinking about what is it that I can do for this patient and what is the patient expecting from me and if there is a discrepancy, we have to immediately speak about it at the outset, because if the patient is expecting something from me and I am unable to deliver that, because its out of the scope of my profession, then both parties are not going to be happy at the end of the treatment. So I would first try and determine am I going to be able to treat this if I am not able to do so I tell the patient.

I: One of the things that concerned you is that chiropractic would get incorporated into the medical system. You felt that chiropractors needed to remain distinct. Now there seemed to be a little bit of tension, because you wanted integration so that we could be in hospitals, but you also wanted to be distinct. How do feel about that now?

R: Well I still feel the same. What I think should actually happen or what would be the ideal situation would be that chiropractors are left or are allowed to practice their profession and it should be decided by chiropractors themselves what the scope of practice is what I am concerned about is, if we become integrated into the medical profession, in other words they give us access to hospitals, they refer a lot more patients, we work together in a clinical setting, what I am really concerned about is that we mustn't become too dependent on the rules of the medical profession, in other words they mustn't be the ones who determine what we are able to do and what we aren't able to do. For example, an orthopedic surgeon will say this patient must not be manipulation or chiropractors are not allowed to do this manipulation then they will be allowed to practice among the medical doctors. Or if they say no cervical spine manipulations then you will be allowed into the hospitals, only mobilizations or you can only treat according to how physiotherapists treat, that's what I am worried about. Integration is good, but we should be distinct as a profession.

I: So what you term distinct, would autonomous be another word for it?

R: Ja, I think we have to be autonomous and we have to practice chiropractic as determined by chiropractors, not what is the medical definition of chiropractic or what we are able to do, our scope of practice.

I: You mentioned that there are a number of different camps in chiropractic, and that it is one of the impediments for the profession going ahead in the future. What are the main, different camps that you perceive?

R: Ok, I feel that I won't be able to give you the exact names, I can tell you generally we have the mixers and you have the "straights". Those are the two general camps. In other those people that practice pure chiropractic, no modalities what so ever, and then you get the other group who do use modalities like ultra-sound, IFC, acupuncture to help that patient towards being manipulated or towards being treated chiropractically. Those are your two broad

groups, but then you get the other people that are for example, all sorts of new therapies that haven't been researched and I would say that the would fall under one camp. And then you these people that would practice the old school of chiropractic which believes that for example if you adjust the lumbar spine you can treat diabetes or you can treat asthma by adjusting the thoracic spine. Or if someone has cancer of the brain that adjusting the neck is going to get rid of the cancer. All those sub-groups fall under one camp of chiropractic that have the old school of thought that believes that treating the spine releases the innate etc. and that allows the body to heal itself completely of all types of serious organic conditions. I think that is what I am speaking about. That camp, are the type of people that the medical doctors or the scientific community look at and say this is hocus pocus.

I: So the camp that you have just mentioned are linked to this innate philosophy that you havr just mentioned?

R: I would feel that they their innate philosophy is just stretched too much

I: Would you say that the term diversified chiropractor and mixer are used interchangeably?

R: Yes I would think that that would be the case

I: Any difference in meaning to you?

R: Personally I don't think there is a difference in meaning

I: You used a very interesting phrase, you termed it knife happy versus conservative physician. What is a knife happy medical person?

R: Somebody who just thinks that surgery is the solution to their problem. If an individual has symptoms of rotator cuff problems, they immediately want to put them under an arthroscope and repair, they wouldn't consider rehab as a first option. If somebody has chronic low back pain, immediately go in for surgery- do a fusion, without even considering rehab. That's what I would consider a knife happy person. They are surgeons and feel it is their job, so the moment the patient presents to their office, they end up going for surgery. But you do get lots of surgeons who do not perform surgery on a patient unless they have had extensive conservative therapy and everything has failed and then they'll do the surgery. So a first time person, presenting with back pain who hasn't had any rehab., or proper rehab., they don't actually operate.

I: You mentioned that your philosophy of chiropractic is that it is a scientific way of treating musculo-skeletal conditions, could you clarify the phrase?

R: It means that whatever the modalities of treatment are that they have been accepted, that they have been tested to work for whatever the aim to treat. In other words it has been tested scientifically and has been found to help and that's what we use to treat our patients. I think the hallmark of our profession is manipulation. Manipulation has been proved effective in the treatment of musculo-skeletal conditions of a mechanical nature and obviously we have a list of what we are and aren't able to do with manipulation and following that list keeps us within the realms of scientific reason. So you wouldn't say that by manipulating a guy's lumbar spine, its going to get rid of his spondylolisthesis, that is not scientific reason, but manipulating somebody's lumbar spine who has spondylolisthesis at the levels above and below the lesion, will alleviate the symptoms not the actual lesion. Alternatively, somebody who has facet syndrome a manipulation won't give him relief of the pain, muscle spasm and inflammation of the joint etc. it will just restore normal biomechanics. That is where I would say we are scientific, but where an individual claims that by manipulating the thoracic spine he can get rid of asthma or ulcers or diabetes, that absolutely ludicrous- no scientific basis what so ever at the moment. May be that will change in twenty years time.

I: what does the term pure chiropractic mean?

R: it means practicing manipulation of the spine, that would be pure chiropractic. The question arises whether a patient has been treated chiropratically if they haven't been manipulated in your rooms and I would say that he hasn't been treated chiropractically, in other words if somebody presents with low back pain and all you did was ultrasound and massage and for whatever reason you did not deliver an adjustment, then the patient was not treated chiropractically.

I: However, you consider yourself as a diversified or a mixer-type chiropractor, how do you reconcile that tension, which exists?

R: Well I don't think there is a tension, I think that our aim is to treat musculo-skeletal conditions and there are many such conditions that are treated using manipulation, you will get the occasional patient where manipulation is completely contra-indicated and some other modality has to be used and ultimately being a practitioner who treats musculo-skeletal problems using manipulation as my main tool, if I cannot manipulate an individual then obviously I to use some other modality which I use as a mixer to improve the patient's condition. I don't think its correct to say that if someone goes to the GP's office and he hasn't given them medication or he hasn't given them an injection, all his done for them has given them advice. I don't think it is correct to say that he hasn't practiced medicine. The advice may help to cure some type of organic condition.

Interview 4b

I: In our previous discussion, under the topic of philosophy that your biggest philosophy is more in terms of bringing relief to the patient whatever their condition by a set of rules of criteria. I would appreciate it if you could elaborate on that. The question was around whether or not you had a philosophy of practice.

R: Well philosophy more or less is a guide for what you do for the patient, so if you are looking at relief of pain you have a normal set of criteria that you follow in terms of bringing the best treatment to that patient, if you are looking at the steps you are looking at things like what is the patient coming in to you for? Is the pain primarily as a cause primarily musculo-skeletal, organic or psycho-social, where is the pain actually coming from- is it a combination of all those factors? Once you have ascertained more or less what the problem is, whether it's a working diagnosis or whatever you are looking at, then to go from there to go to something in a stepwise sequence to either eliminate through your treatment what the problem is or and try and address the problem. So it's a multi-factorial stepwise system that you need to follow. If you are looking at an acute patient, you will do an acute remedy for that patient, where as if you are looking at someone who is more chronic the pain that is presenting at that point in time may not be your direct target that you will target the very first treatment. You may need to got through other biomechanical, nutritional of psychosocial factors before you actually get to treat the patient's pain. So as to take away obstacles or hindrances to be able to help them.

I: Would you say that your philosophy is patient oriented or diagnosis oriented?

R: Diagnosis is a working tool, so I wouldn't say that it's the be-all and end-all of what I do its just a mechanism or a starting point to be able to describe to the patient what we theorize is going at that point, what I need to do to help them, what they need to do to help me to come to a functional resolution. Its almost a point at which you can either have a contract drawn up between the two of you where you can have something to work with otherwise you are working in limbo you've got no goal setting abilities.

I: so your understanding is in essence an evidence based protocol to..

R: Yes, to a greater or lesser extent.

I: You indicated that besides the pathological/ physical causes, you also considered biopsychosocial factors, in the context that these factors can and do influence the way patients respond to treatment. Could you elaborate on that?

R: If you are looking at a patient, like an RSD patient, if you treat them you will only get maybe 40% of functional ability back if you don't have the patient convinced its not the right way. If you don't explain to the patient what is wrong with them and what they can potentially do for themselves, they become very negative and depressed so it becomes a negative cycle, which is a hindrance to you getting them better. Where as if they understand their condition and what they can do to help themselves then they are more positive, they almost feel empowered, to help themselves get better and feel that they can functionally contribute to a better way of living.

I: So the psychosocial factor in that example is that patient education…

R: Patient education, but if you are looking again at your RSD patient and you are looking at psychosocial aspects, they are always perceived as being negative, down trodden type of person- everything goes wrong with them. Society almost isolates them or shuns them, because it does not understand what's wrong with the patient, so they become isolated within society and that contributes to their negative cycle. If you are looking at the patient, they are constantly in pain so they withdraw from and avoid human contact, which is not something they should have, it should be exactly the opposite- motivation and stimulation to get better. So you have to try and broach those concepts with the patient to help them live a fulfilling life or to get them to a stage where they can get others to help them and they can help themselves.

I: You spoke about the scientific method, which you utilize to diagnose, could you elaborate on that?

R: Looking at the scientific method goes back to the concept of evidence based approach, where you have a logical sequential pathway that you follow in arriving at a diagnosis, or plausible explanation about what is wrong with your patient. If you are looking at a stepwise approach you can't just dive into the physical exam if you have no idea about what the history can potentially give you.

I: So your scientific method is essentially the evidence based approach to management? Would you use those two terms interchangeably?

R: You could I would say evidence based is more soundly scientific, where as more logic and the common sense approach does not necessarily mean that it is based in evidence. It may be your common, logical process- the patient can't do "x,y,z" therefore you can't assess them this way, but you can do it another, which may not necessarily be scientific, but it can be evidence based.

I : So the scientific method applied to the healthcare context, would that be termed evidence-based?

R: Yes, I would be happy with that.

Appendix C: Researcher interview schedule

1. The participant's experience of the chiropractic profession-

How did you become interested in chiropractic?
How would you define chiropractic?
What type of person do you think makes for a successful chiropractor?
What do you find most negative/unacceptable when viewing chiropractors?

2. The paradigm of practice the participant seems oriented to-

What paradigm(s) of practice do you identify with in terms of healthcare?
Can both straight and mixer chiropractors fit into your paradigm of practice?
What do you understand by the term patient management?
Is the term 'management' in your opinion a generally accepted notion?
How has mainstream/allopathic medicine influenced chiropractic?

3. Management of chronic patients-

Should there be a difference in management approach toward chronic and acute patients?
What psychosocial factors do you think should routinely be considered by chiropractors in daily practice?

4. Research paradigm-

What types of research methodologies are most prevalent in chiropractic?
Are there research methodologies unique to chiropractic?
Should there be unique chiropractic research methodologies?
How has the RCT contributed to the development of the chiropractic research paradigm?
Are there areas that it has been inappropriately applied?
What other methodologies do you think should be considered in the investigation of the chiropractic research paradigm?
How significant is the placebo effect in chiropractic?
What do you think determines its effect size in the chiropractic context?

5. Future practice paradigm-

What would you like to see chiropractors doing in 10 years time?

Appendix D- Researcher interview primary documents.

Interview 1

I: Dr. Vernon how would you define chiropractic?

R: My definition would be phrased as:"What do chiropractors do?" Chiropractors are doctors of manual therapy with an emphasis on holistic and a natural approach to healthcare.

I: Specialization in the musculo-skeletal system or not necessarily?

R: Ya, I would say specialization, but to the extent that manual therapy of the body what assists people with non-neuromusculoskeletal disorders, I feel there is a role to play there.

I: We covered some ground regarding the methodologies that are utilized in the profession. Do you have a comment regarding the most prevalent types research studies that have been found in the chiropractic literature specifically. What those were and what they are today.

R: There has been a tremendous increase in the number of randomized controlled trials, clinical trials, in the literature and there is no question that everyone regards those as having the most significant impact on research with respect to decisions about what treatments are effective. Perhaps to a certain degree under what circumstances they are effective. So, I think we have to pay attention to that and the fact that such large number of clinical trials for back pain, slightly less for neck pain and then more for headaches have come along… have helped us out tremendously. I eluded to that talking about the story of the agency for healthcare policy and research and how the clinical trials were so important and yet, then that seems to reflect a certain bias in that regard in that the thing to do is to develop a clinical trial somewhere. And I think that both as a profession as whole and particularly with regard to our developing researchers there is a gap there between the more fundamental layers of research where we learn more about our patients with these problems, do outcomes research that looks at groups of people without the necessity for an experimental approach, prognostic studies, studies of the efficiency of diagnostic tests etc. We seem to have skipped passed these a bit in the zeal to develop some of these clinical trials and particularly in the emerging areas. Maybe neck pain headaches and some of the other musculoskeletal complaints. As I say that I should say that there are important areas that there are important areas that have not been touched much by this type of research in general and that would include Scoliosis, virtually anything with respect with the extremities has been unfortunately largely ignored by the profession and certainly the sports chiropractic group ought to fill that gap and begin to look at the impact of chiropractic care in various ways at the common sports injury complaints. Knees and shoulders, ankles, repetitive work injuries for the workers, upper extremity and such. So we seem to have set back and neck pain and maybe headache and then... The notion is somehow or another is that we must now move on to this very small area of non-musculoskeletal complaints, but I think there is a big area that we haven't touched yet. And then as well we haven't looked at a variety of populations within those major categories. We have virtually nothing good in peadiatric work where back pain in adolescents is very common, neck pain as well. We have nothing on peadiatric headaches. So people could move into those areas, but in doing so they should first conduct studies that are more descriptive to establish their credentials in that area.

I: In basic research, in your area of interest in particular, what types of methodologies are going to start making themselves known?

R: There is an interesting history of chiropractors attempting to use animal models to study what I call both sides of the primary issue in the spine. The two sides being what is the problem and the nature of the problem and how might we get it and what implications does it have and then what happens when we remove it or correct it. Most of the work in the animal model studies has been on the first aspect of trying to understand subluxation to put it simply or spinal dysfunction and the history of that work up and till about ten years ago was rather primitive in the sense that animal models were used to try and replicate subluxations by misaligning bones of the animal preparations and studying various things after that, but in the

last ten or twelve years several groups have begun to become much more sophisticated and this is where the greatest emphasis ought to be now and what all of these groups have shared is a common sense of a model whereby it is accepted that the important clinical manifestations of some dysfunction in the spine is local pain those structures. So local pain can be induced in animal models without a bother of trying to create the mechanical conditions which we think have created the pain as I said misalignment or some kind of fixation or something like that. So we are trying to replicate the immediate important consequence of spinal dysfunction where we talk about the most segmental, local, deep, whatever word you want to call it pain and inflammation so the effects of that can then be studied. There are some groups that are looking also at the effect of spinal dysfunction on nerve structure itself and these are also studies that involve the structures that are very deep to the spine. So if you can create models that produce injury and pain in those structures then you can monitor and study the effects of those on more superficial muscular structures for example and certainly on visceral malfunction, which I think is critical for us right now.

I: Just for clarity purposes the subluxation, misalignment, fixation concept is used in the context of the normal capabilities of a joint…

R: Yes…

I: This is not the partial…

R: No…Right that is why I use the word dysfunction, unless your concept is that either the most important or perhaps the only thing that matters, if there is any kind of dysfunction, is that some nerve is being compressed somewhere, which has been…which has not been shown to be the case in most instances. Then it seems to me that you have to create a linkage between the dysfunction and the local pain created in those structures and from there we can begin to examine the more wide-scale, dispersed sort of effects on those and also if we encounter those sort of effects we can begin to ask questions which are even more deeply mechanistic as to what is the mechanism within the nervous system that is maybe contributing to that on an acute basis and then in some studies even on a chronic basis.

I: do you think that the profession will now be in a time of relative peace in a sense in terms of being able to look at research questions through internally driven mechanisms as opposed to external pressures?

R: Well it is always a balancing act between those two very things. I think you are seeing now that in 2003 the situation with the development of the research capacity of the profession, you might say without too much argument that that started off in a North-American context, with a few notable exceptions. Certainly the Swiss involvement in earlier years and then the Anglo-European college and then as more colleges have come on stream and research efforts have been developed we are seeing an international research capacity developed in the profession and I think it is big enough now. It has got enough wheels to create an internal pressure or drive, which is wonderful to see. We will have to work hard to keep that up. I don't know that we have reached the point where we now don't have to consider broader issues at the level of the profession's place in the larger scheme of things and even the efforts to continue to advance the profession at the professional level, for example interactions with the world health organization at the highest level globally still require a research base by which we can, well quite, simply prove our case there. I think the sports injury is an important one. Identifying and doing research on other areas of clinical opportunities like as I mentioned earlier peadiatrics, geriatrics, ethnic indigenous populations and how health delivery can be modified across the globe. All these areas are important an are being considered from the point of view of their implication and benefit to the external face of the profession. So I don't think we are ever going to loose that. We will never be in a position where we are accepted as fully part of the biomedical research world, such that researchers just naturally move from within chiropractic, to medicine to whatever. We are always going to have to be cultivating connections with the hope that in some places, particularly the chiropractic schools that are affiliated with universities will begin to see more well established and secure research efforts at these particular locations.

I: Lets just assume for a moment that a number of these areas get explored to great lengths and a slow but very definite integration takes place on a practice level with a greater interaction with medical sciences and things like that. Do you think that the chiropractic profession will loose its identity through that? Is it important that it keeps its identity?

R: Well you might say that that is sort of the coming revolution in chiropractic. We've had a decade more of integration of chiropractors in the US into the mainstream healthcare delivery system. I don't think you have necessarily seen them necessarily feel a great loss of identity perse, but I think in each of these areas as I say particularly, because these are now emerging developments, the possibilities are fraught with opportunity and some risk. You could point to some locals, some jurisdictions where there is concern about the compromises made in order to create the integration that looks good with the issue of what is our scope of practice for example, what identity chiropractors maintain for themselves, what their identity is within the communities that they serve. There are some risks there for sure. But I think all told it is probably optimistic that we will not have some catastrophic change where we simply become submerged as some kind of therapist group and loose our capacities. I think the political structures are also too strong for that too.

I: We were talking about the wellness practice and whether or not it was the operationalization of holism…

R: Yes, so like I said if you look at the person holistically to start with so as to identify a number of different areas to intervene. The dysfunctions of their spine needing adjustment. The functions of the local region with respect to muscles, meaning strengths and weaknesses, leading to posture and exercise. Discussion with the patient about the major things they do like work or certain key avocation, like if your were looking at an athlete or someone who is an artist or who's favorite hobby is archery or whatever. Taking people as they are, you find all these different elements that you can begin to guide them at the very least, give advice for, prescription for exercise for example. Someone mayt say well I am going golfing and you ask: "Well how did the game go?", it shows you interested in them number one, but you are interested in them number one, but you are using that as a tool find out what is going and then you can take it further a field if you wish and here you may say:" Ok all of that is musculoskeletal, but now I would like to look at it from a nutritional point of view." I tend to be interested in issues related to psychological status in the sense that I am looking at relaxation, stress management; that is another area. When you say wellness you have to accept that you can only be good at probably a couple of things, you don't want to be everybody's nutritionist, psychoanalyst, mechanicalist bla bla bla. So you are good at a few things and you try to carry that on and as one of the anchors for that you say as well that the chiropractic analysis and adjustment of the spine when necessary in a schedule that makes. If you want to go to full-scale maintenance treatments I think it makes sense and for no other reason that surely if we look at most people and even think of ourselves you go through a months worth of life, some of the small picadillos that happen, you know a slip here a fall there, your body could use a little bit of mechanical work so often. I often use the example of a car, I wont go into all of it, but it reminds people that you have to take care of it, have it checked out every so often.

I: Ok well if I can just reflect back briefly, when we started off you agreed with me in terms of research that we looked at things very much in a biomedical fashion, in terms of a research paradigm, but you also practice wellness practice, but philosophically some would say that holism and the biomedical, reductionistic approach represent polar opposites. However, you seem to have a bit of a mix, do you think it represents a bit of tension in your belief system or approach. How do you feel about that?

R: I guess I don't buy the premise fundamentally, you can… I think that on the one hand those of have used the word holism or vitalism on the one end of the so called polarity have in a sense hidden from their dark side what they would consider their dark side lets say, then they would need to operationalize things in reality, what does that actually mean and when you speak it out and operationalize it in a language that could be the language of science, the language of mathematics, the language of just…verbal language and when you specify it in the real world, unless you are like a Kantian who says that we can never. Then if you specify

it in the real world then you can approach it from a scientific point of view and science automatically is “reductionistic”, because it does that very thing it says I am going to look at this little chunk right now of the world and I have to be able to control it otherwise I get chaos etc etc etc. and even if you do it in a very different paradigm as they do come along in science you know the quantum paradigm, or the chaos paradigm or whatever it is you are still doing science. You are still applying reason and observation to the effort and trying to do it in a somewhat systematic way. I see no contradiction between taking any hypothesis that might come from a so called philosophical domain lets say and applying scientific methods to them so that they end up being either useful or not useful in a clinical setting. We don’t have…we can’t claim it is a right of ours to be able to do whatever we want in society. It is basically a privilege society to take your great wisdom and ideas and ply them out there. You need to be reasonably thought out and reasonably successful. You can’t have people wandering the streets claiming all sort of things like quack doctors we used to have many years ago, that is just not on anymore. Now if you say that the real pole is between the metaphysical and anything called physical-materialistic, then I think that is a polarity simply by definition. So if you have a belief system that the things that are important to you are operating in this supernatural, metaphysical world, my simple response to that is: ”Send me a postcard.”

I: What would you like to see chiropractors doing in ten years?

R: Solving some of these problems and getting on with business. We have made so much needless importance out of all the stuff we have talked about here, in the sense of each of us trying to stake out some kind of distinctiveness and uniqueness, and to get back to the comment I made before about what I think is the insecurity or inferiority complex that I see and the compensation for that which is apparently the opposite is really a level of ignorance about many of the things that go on in the bio-scientific world. Some have what appears to be some kind of fear of that and if they were just to understand what we now know about this area then they wouldn’t feel the need to behave or stake out ways that are so counter productive. We could all get along a little bit better.

R: What I consider to be the beginning of this whole effort. I am certainly not claiming to have primary status perse, but I participated with the only two active chiropractic participants to the NINS conference in 1975, I wrote a good deal of the paper that dr. Ron Gilltleman presented there. We worked together on both the more factual evidence as well as some of the more philosophical aspects of trying to portray to that audience back in 1975 what chiropractic was all about and I have seen 25 years worth of the growth of our profession and in fact in some of my lectures I essentially say that the era of chiropractic research started in 1975, its 28 years old and I pretty much participated in and seen everything that has happened. So it will be tough for me to highlight…there have been some major advancements of course in the way of conferences. One of the things I tell my students is that when I was educated from 1973-1977there wasn’t a single textbook in chiropractic that had been published by a biomedical publishing firm. There were a small number of texts that had been self published by groups from within the profession and now it’s a… there is a plethora of textbooks, you have to make decisions about what not to buy and you can fairly trip over the ones that have become available since then. So just the codifying of our profession in that form, the advancement of our scientific organization in the form of conferences, the development of our journals, seeing the JMPT start up in ’78 and receive indexing a couple of years later. Being an associate editor of that journal as well as many of the others that have come since and been successful. The research conferences that we stage have just continued to grow. There are a number of important organizations that are North-American and some international that have grown in prominence and have had a tremendous impact. The consortium for chiropractic research. I have been involved with FCER since the beginning of the time I have mentioned. Canadian efforts have advanced greatly, we now have a consortium of Canadian Chiropractic research centres that the CCA has also promoting that involve chiropractic research chairs, which would have been unthought of just ten years ago, never mind 25 years ago.

I: What effect has the biomedical paradigm had on the chiropractic research paradigm?

R: One of the way I have tried to answer this for the students, because they tend to see, seem to want to create some kind of distinction or dichotomy between what the think is the biomedical, particularly the medical research paradigm and the chiropractic one and I use the framework of biomedical research, the one you use to try to capture everything scientific in the healthcare world and I feel we belong to that one. We may not belong directly to the medical one in many particular senses, but… and of course the word 'belong' is a funny word in any way that way. But I use this anecdote to try and focus them in a bit, because sometimes these exortations that people make, reflect the same kind of frenetic appeal to philosophy that you see in the other dimension as well and it not being a very critical one as well. The anecdote is that the early effort in clinical trials, both outside of chiropractic and with respect to manipulation alone and within chiropractic on low back pain and you might think well that is just buying into the medical model of just looking at a symptom bla bla bla. Well from the first clinical trial in 1975 to the very early '90's there were enough clinical trials that a group formed by the agency for healthcare policy in the US could compile all that research and produce a stunning result, which is that spinal manipulation was one of the only two scientifically validated procedures. And had that not happened, given that from the early '90's on in the US the development in the major national group of chiropractors in the world, the US, was transformed by the managed care system, which clearly imposed the requirement of some sort of evidence basis for what we do otherwise we wouldn't be included. Now had that research in low back pain, which would have appeared to be symptomatic and not following some kind of nebulous holistic approach, I don't know what you want to call it. Had that work not been done, had the HCPR not have enough of it to do what it did with it, had the HCPR guideline not come about, I very much doubt whether the chiropractic profession would have survived. So on the strength on what appears to be a somewhat limited focus in research we really saved the profession frankly and there is no question that you have to lead I your research efforts with what is very obviously the priority of utilization. The statistics continue to show that about two thirds of patients come to us for neck pain, about a quarter for neck pain and very small numbers for anything else. So when students say to me how come we are not doing research in any one of those small areas, I say well what kind of a strategy would that be? So of course we had to embark on, in our research efforts and if you want to call it the development of our research paradigm, but that is the key word being development, we had to start where the money is. I mean the phrase we used to use about the guy who stole from banks. The judge asked why he did that and he said: "That's where the money is." So you have to go with your strength and it was with low back pain and once you embark on proper scientific investigation, you adopt the biomedical standards as you have eluded. So you have to do that in what appears to be somewhat of a reductionistic, hypothetically minded, quantitative approach for the most part, in order to get the results that people were looking. To misinterpret that as well that is all these people are all about or care about was a big mistake on the part of the profession, but it was also something our researcher did not help by having a perspective on to present themselves as something being bigger than that. And the research landscape in the profession has expanded of course since that time, but I think it very much adopts the model that we got started with in low back pain, to look at the important clinical areas, develop expertise on t he part of our researchers so the didn't show up doing a study and then dissapear into the landscape again like a weed. You know embedding these people in science so that they can expand their efforts. So it isn't just, say a clinical trial that gets done, it's the creation of a team of individuals that is knowledgable about all the areas involved, lets say if it the back or the neck or headaches or whatever and they can do far more studies and have a much greater impact.

I: You mentioned that the landscape had sort of changed. Do you think that the recent development in qualitative research specifically is heralding a time when the profession now can start asking the types of questions, which are important to it as opposed to trying to survive in a sense?

R: Well I don't think that this so-called dichotomy lets say between qualitative and quantitative work is necessarily the devide or congruent with the devide between, lets call it mechanistic or biomedical research and something that you would call the chiropractic if you are looking for some different attributes there and without being cute about it if people are looking for research that somehow reflects the ideas of holims and possible even vitalism if that is what you are interested in and if that is what is designated as the so-called chiropractic paradigm,

and by the way I don't buy into that, but if that is what people want to do, I don't think that the quantitative-qualitative polarity is necessarily the place to go. I think that these more fundamental questions that we sort of had hanging around us for a long time in fact need to be addressed by very much the opposite, which is very hard nosed, good, basic science research, because these so-called philosophical issues generally translate into hypotheses about the physiology of the body. Whether it is the role of the nervous system, and even that is a translation from very meta-physical idea into something obviously more physiologic, and the connections there need to be addressed and those are more…the kind of thing that people need to muse on. But once you have a reasonable representation of the meta-physical into the physiologic then I think studies that can really address that validity of that whole idea. I think that there are some tantalizing issues out there with respect to the role of the nervous system in health in general that have been ignored or not been given anywhere near as much importance in the limited medical model lets say, and even that is paradoxical, because it turns out that even in the medical model the role of the nervous seems to be very important, but they just don't seem to recognize it as such. They are so used to and so committed to the development of pharmacological means to deal with things that they in a sense don't quite seem to see the forest for the trees and we are on the other end having very much a nebulous, holistic approach, that has the forest, but we don't seem to be able to log a single tree out of it. We need to have some mapping out of our ideas onto basic basic physiologic and patho-physiological research. The longer we don't have that, the longer these ideas just seem hairy-fairy. The just don't map out onto reality and the more you need a belief system to sustain them.

I: You mentioned two of the philosophical tenets, holism and vitalism. If I can just focus on those briefly. Have any of these managed to find their way into your make-up or approach to the profession today.

R: Well maybe the best way for me to answer that is to say that I am a strong holist and a complete anti-vitalist.

I: The issue of management of patients. There seems to be a perception that management equates to frequency of visits. How would you define management and how to you feel about the statement I have made?

R: I would like see chiropractors adopt the approach that the moment they see a patient for the first time what they are all about is developing a relationship with that person. A relationship that is initially premised on helping that patient, working to help that patient with their health-related issues, but I guess that is a bit jargonisitic. To help them improve their health,…well to do those sort of things. I think if you start off with that paradigm or approach then I think that everything related to management falls into a very different framework then simply seeing somebody as a specific diagnosed complaint and imposing some sort of template on them of x- number of visits which in many chiropractic ways of looking at things can be small, medium or huge and you are always looking for somebody to explain that to you. But if you take the approach to establish a relationship with that patient and one of the things that people do with relationships is they have empathy for people and the empathy for a patient ought to be:" what would be like of I were that person and this person were me, what would I like to see happen?" I don't think you would like to see and exploitative type of relationship, you would like to see a relationship or the result of the relationship be that some positive benefit comes to you that you feel you can leave that environment so you can go out and be independent and be yourself. That you feel welcome to come back to it if you need it. That you share with the doctor whatever is necessary about yourself and open your personality up as necessary to explain yourself and what is going on in your life and I think chiropractors pride themselves on a level of communication that they with patients. You will often hear people describe their chiropractor as their friend, or somewhat like that and their doctor a lot less so like that, but of course there are always boundaries that need to be bided by. I think if you go into the matter that way and I have always tried to do that, so that I don't look at the patient as x-number of visits. I also approach the actual clinical management of problems very much from the perspective of always thinking I am involved in a single clinical trial, in other words everything is being done to see what works. I don't impose some kind of system of approach chiropractically, as far as diagnosis or treatment is concerned, where as I

would be taking into that something that someone taught me last week in class or something like that. I feel I have sufficient diagnostic and treatment related skills, to be able to determine for myself what I think is wrong and how I am going to be able to provide what is best for the patient, which could of course include deciding not to do anything and sending them somewhere else. But if we are treating people then I am always approaching them from the perspective of testing out what would work and letting the person, which would mean themselves as a personality as well as… I strongly believe in the interaction of our treatment with the nervous system so that it allows the nervous system to adapt to what we are doing. So with those basic principles I can generally carve out a management programme that is deliberate, that I have a sense of what I am doing with it, I don't feel lost. I am not imposing something just because some, say guideline even said see them three times per whatever… and you feel like you are somewhat in control and conveying that sense of confidence in what you are doing is important to patients, they don't feel like they are out to sea with them. When I say trial and error I don't mean just throwing everything at them and seeing what works. So I was trained in a model of applying chiropractic that you can probably describe as doing less is more. I tend to be the kind of person who would only do one adjustment at any one point just to see what happens to that. Just to see how that area responds, maybe how the person responds and take it form them and go from there and when it is necessary to add on a bunch of elements to get some kind of an effect you are prepared to do that, particularly in the beginning. And then recognizing that most people have some reservations about chiropractic, it is not well understood in the public's mind and if it is, it is in very narrow ways and you are dealing with someone who there on somewhat of a tentative base anyways and if you come on too strong or if you overburden them with all sorts of information or say that in order to see me you have got to go to those classes and read this and all that. As I say if you listened to what I just said about if this was you, let them come along, you can many gains by starting off slowly and letting that patient gain confidence with you. The other thing too is often is the issue of maybe treating different things or treating 'holistically' like we talk about. Well again if you bombard the patient with wanting to come at them from all sorts of angles or deal with everything and if they come in with one problem and you start dealing with some other area of the body and they don't understand what your 'paradigm' is about, then they are frustrated and they don't know what you are doing, but if you start off with attention to what they came in with and then slowly begin to explain to them the connections between the body parts, the system of loco-motor system and how different interact, you can bring them along and they can understand that looking at the legs will help for the back. Looking at my neck might help for my headaches might have an effect bla bla bla…and you can move on from there.

I: If we make the assumption for the moment that the high velocity, low amplitude thrust is still the hallmark of the profession, that sets us apart of others. If you decided not to adjust a patient-manipulate, would you still consider yourself as treating that patient chiropractically?

R: Oh yes and I guess as you have presented it to me the assumption is that only adjusting is chiropractic is something that I would not agree with and if there was chiropractor who said that is all I do, then they could very easily of course answer your question differently and that might be one way to characterize the differences between myself and anybody else, but I don't think I am the only one around. But I did say at the outset that the primary focus is manual therapy and I think that the way in which chiropractors can assess ultimately, not exclusively of course with their hands, but apply a very rational diagnostic paradigm, which starts with your eyes and your ears, but eventually ends up with your hands to find those critical areas in the body system that really needs some attention. Whether that be specific adjustive thrust or some other manual technique which then leads you to consider:" Well what will help me with my manual techniques?", and you develop an armamentarium of other techniques. I guess I have no problems considering myself a chiropractor in that way and treating somebody chiropractically if all the things that I had around me are aimed at assisting with what I can do with my hands. If on the other hand I don't think that way and I am just applying some treatment modalities or whatever, then I would feel very much less a chiropractor and maybe not even one and I wouldn't do that. If I were offered for example the opportunity to do something like that, but not be able to apply all of my skills then I wouldn't do it. I think it isn't just the treatment, I think that people get caught up in the idea that you can define chiropractors as the people who adjust people's spines, but I think what is even more important than that is the people who figure out where they needs to adjust people's spines.

So whole assessment, diagnosis effort that ends up with these subtle, refined, intimate explorations that you make with the person's body:" Where are things not working right and how can I affect that?", with the knowledge that that is going to have some pretty profound effects that we may not know everything about right now, but you have pretty good confidence that it is going to help locally, it is going to help regionally and it may even have some more systemic effects. I think you can establish a core of tremendous worth for yourself in doing that and really make that your distinctiveness and you don't see that elsewhere. You see on the one hand some manual therapy like massage that is very generalized, very superficial. There are physiotherapists who might not use their hands much at all or they simply move body parts around they are not concerned with some of these more local, subtler effects. That is where I think we have a real distinction.

I: How significant do you think the placebo effect is in chiropractic?

R: It is probably very large. Just intuitively and on the basis of some evidence we have to admit that if you translate all I have just said into a set of actions you might even call them clinical rituals that we perform they carry a high placebo valence. The flip side of, and it isn't the bad flip side, but it is just another important facet of we chiropractors taking our hands and our minds deep into someone's tissues, is the notion that the patient permits that and so immediately the idea, if not necessarily relaxation perse, but a compliance, a willingness to participate in that effort, taking that all the way to the level of when we apply our forces to the body, the patient has to permit them, they have to engage actively. I don't call chiropractic manipulation passive therapy, someone has to very actively allow that to happen. They may not look like they are doing a lot, but I think they are doing a lot and you can actually engage that even more. But as a researcher in the biomedical model, I am very aware of the standard definitions of how the placebo element is thought of as a non-specific or even more negatively, but I think those of us in the complementary and alternative therapy worlds have begun to really rebuff that and show through both our philosophic writings and in our studies that this is a positive effect and positive issue. I wrote once about how we needed to chance our thinking about that very thing once, about how we have to change our thinking about the placebo effect, because in the medical model it is seen as just that; an effect in engendered by the doctor and in the older model with having a sugar pill that you can engender some healing effect by the giving of that pill. The shift in paradigm is to think of the patient's placebo ability, which is to really get very close to the ideas in chiropractic about a person's internal or natural healing abilities and how you can turn those on or make use of them or enable them. I don't think that that is a passive, in it's worst incarnations or deceptive thing at all. At the same time when you compare studies and I think that there is a good number of them looking at either a single adjustment or a course of treatments in research. Just doing those rituals is not enough and I think that is a specific effect of the manual treatment procedures and the most powerful of those effects, when you look at the literature, is the adjustment. So I think although you deliver an adjustment…and another thing to is that people talk in terms of so called objective or subjective things like signs or whatever and people say I did objective tests like I tested their range of motion or I tested this or that. Anybody who does not understand that those are just as much performances by the patient that you just happen to be guiding, is really misguided, they are not objective at all. When someone demonstrates ninety degrees of straight leg raising in the sitting position and ten degrees in the supine position, they are very active in that test. They very much influence the test, so to call it objective is quite foolish, it's misguided. So that also helps us look at the passive-active dynamic as well and what impact you can have. When you guide people around the table, when you put your hands on them, when there is warmth and interaction all those things are not menial, they are not small issues, but on the other hand they are just the way you guide the patient even just to the very things you want to do, all those have a very powerful impact.

I: So, if the chiropractor is able to develop the relationship you eluded to earlier on, would it equate to a powerful non-specific effect?

R: Yes, I guess it would and I know from my own experience that I felt that whenever I was in a situation of reinforcement of the chiropractic care that I valued. It can work the other way, whether you are unsure when you are seeing some chiropractor for the first time or you are not sure what is going on. Maybe you don't get the same cues with respect to the way the

office looks or the staff works or all those things as well, but they happen with everybody. In other words the atmosphere that you are creating, that includes your behaviour as well as the behaviour of your staff and such and so a highly professional atmosphere that is supportive and enabling of a patient's relaxation and confidence. Who wouldn't do those things? Admittedly they are not available in every part of the globe, when you are out in the countryside you might not be able to do all those things, but you know the general urban expectation is that those elements are there to a certain degree. Why not have a fish tank and a nice impressionist painting as opposed to God knows what else if it reflects a certain sophistication etc? So, yes I think that you can have an atmosphere that is strongly supportive of the patient's relaxation and the patient's positive reinforcement so that perhaps a fair amount of healing has started even before you see them. But we know as well of course about the true placebo by looking at research in it that they are relatively short-lived effects. By just giving placebo's to patients you may get an effect, but it tends to taper off quickly. So we know that the placebo effect even when it is looked at rather limitedly is not all-powerful and it is not equivalent to an effective treatment even in the absence of supportive elements as well. So it may not be everything it's blown up to be on the one hand, but it may be far more than it is made out to be and you just have to try to capture the positive elements and not overdo it. I think that there can be a kind of delivery of chiropractic treatment that some have called charismatic healing, where it is so evident by the way in which the chiropractor comports themselves that there is so much going on 'razzle-dazzle'. You can… some people prefer to treat a number of people together in what they call an open concept, where it is like group therapy. I would never do that. That could produce some positive effects, others negative. A lot of this very individualized. I knew one chiropractor who congenitally just had very cold and clammy hands and had to quit after three years. He simply could not take how he's patients responded to him and he was a very good adjuster and probably knew everything he had to know, but he just could not pull it off.

I: If we have this element of pragmatism that kind of pervades practice and has an influence on the day to day practice. Is it possible that that effect has been misinterpreted in the running of clinical trials where the statement is made that this is a pragmatic clinical trial, however a large amount of control still exists within the trial in terms of taking the patient out of the practical situation. Could it be a bit of a conflict?

R: Well that is what clinical trials are all about. Clinical trials are essentially assembling a gigantic steam shovel to move a couple of rocks in a way. It is incredibly powerful machinery to look at something that is relatively tenuous perhaps and little vulnerable to this and what I am speaking about are the methodologies that you employ and one of those is that you square off the circle a little bit, you limit what you are doing, you limit what who can get in, you limit how much of it you are doing and so what you are speaking to is the generalizability of the results of any study to anything else. I don't think the research community as a whole has done as good a job in the issue of translating research, both what is going in research as a methodology and the results of it to the field as well as we could have and we have been caught with a couple of valises, which is to jump on any positive results and make the biggest run we can possible make with it and overdo that and then not understand if negative results come out of specific studies. We have tended to, because we have come into this research time in our profession so late and so recently, we tend to be wanted to speed up the process a bit. Researchers have the responsibility to modulate that interaction between field and researchers and we didn't realize this. Part of the reason why there have been some misgivings or some misinterpretations is, because we didn't quite realize what we were doing either when we stood up and said, this was our result here or there or we are going to save the day, which I never believed etc etc. It may be that… To go back to what I said before about the clinical trials on low back pain, if low back pain was the major area to get involved in, then surely very standard, low amplitude, high velocity thrusting manipulation was the treatment to study. If you want to call the diversified technique or something, because that was what was being done by most chiropractors and conversely the majority of those treatments were being delivered by chiropractors as opposed to physiotherapists or anyone else so it was natural for researchers to turn to that treatment. So, if we have a body of work that looks at those very basic type of adjustments and if someone says you don't have research on these techniques or those techniques, that is a natural outcome of the way this thing would have gone. Remembering to at the colleges, where most of this work is being

done, that interest in this core diversified approach reflects the environment at the colleges where we are trying to teach chiropractors to do that well, students I mean and the fact that most of the colleges, but not all haven't really made their environments open to many of these other types of techniques that might not have a strong scientific basis that have been proprietary that have been pushed by field practitioners sort of on their own and some of us I will admit might have taken the attitude along the way :"Well if you think you have got fancy technique 'A' well you go and research it, we are going to something here that benefits the majority of the profession and we are not going to do it to show that your technique is better than somebody else's." The researchers in North-America and to a certain extent England, we went through quite a long phase of trying to work that out. Hoping that we could bring in some of these technique developers to educate them as to how to go about doing that and then conduct their own work if the wish to do that. So you are not going to find full generalizability, full applicability from many of the things we do in research to the things we do in practice and the bottom line in all of this is that if you accept…The notion that research always proceeds treatments in the biomedical world, is probably a bit of a myth. There is a lot going on that is somewhat empiric. Having worked with general practitioners for example, you tend to take on that approach, because you know that any drug you are going to prescribe for example has been through complete, scientific testing, I don't mean to validate the testing, but at least you know the testing has been done. It may end up the worst drug in history or it kills all sorts of people, but at least you walk into it with a certain faith that research has preceded practice. While in chiropractic again, looking at the big picture, it is very much the opposite. It is the cart leading the horse sort of thing and the researchers have always felt that we are playing catch up ball as we say here in Nort-America with the practice community and it is like the tortoise and the hare, I don't think we are ever going to catch up, because practice is a well establish situation out there now. It has had its history, its time to set roots and I don't think you are going to see the science lead practice in that way. It will more or less fill out and broaden and provide more of a support and certainly in certain arenas it will provide the lead shot that you might make. But to have it directly inform practice is probably a difficult task to ask of it.

I: Would you agree with the notion that the philosophical/metaphysical tenet of holism is operationalized in wellness practice?

R: Yes, there can be oddly enough a narrow holism, which is obviously oxy-moron in a way, but the narrow holism means to suggest that the only thing one has to do to keep well is to just keep coming in for maintenance adjustments. I mean the chiropractors who maintain that and then insist that there is holism coming out of that have, I think failed to realize just what I have said, which is that it seems odd to pin all of ones holism onto a single approach. But of course that approach also reflects that that brand of chiropractic can never distance itself from the vitalistic idea as well, so that there is a constant conjunction of vitalism and holism in that model, but if you say to a patient your condition, having been chronic may require some supportive benefits, maybe help prevent you from some recurrences, which are very common anyway and that is just the limited manipulation side of it, but that you begin to use that as an entrée into that person's life, which is reflecting what I said before. Your wellness carries on after your acute symptomatic picture has dissapeared.

Interview 2

You welcome the respondent to the interview and give the general context within which it is to be conducted.

I: Dr. Nilsin thank you for taking the time out to do this interview with me, I think ill start you off with an easy one, how did you become interested in chiropractic?

R: Well that was actually because of my mother. When I was about fifteen or sixteen, my mother got low back pain and sciatica. Pretty acute and in the mid sixties, she had the usual treatment which was first you were told to go to bed and stay and then in those days you could even get opioids. Your family doctor ran the show and then after about two weeks with no improvement, actually getting worse he got worried and had her hospitalized. In hospital they gave her the standard treatment at the time, which was three weeks of strict bed rest also with pretty serious painkillers in the opioid group. That did not help either and in any case she was not very good at lying still, but she withstood it for three weeks. After that she said she did not want anymore of it, she might as well go home and in any case they gave up and said they could do surgery and all that, but she did not want that so she went back home. She was in a bad state; this was a serious sciatica. So then one of her employees who was a chiropractic patient and my mother was a very stubborn woman, she had already mentioned to my mother that she should go and see this man, because I mean not licensed and not heard of it and all of that, but this employee was an even stronger woman, so she called the chiropractor, made an appointment and then she grabbed my mother by the collar and said we are going now, I have already made an appointment and within a week she was almost pain free and back to normal and that sparked the interest and then my father who was a business… I read about it and said to him this is what I want to be and my fatter looked at me and said where are you going to get the money for this? I said I don't know and in any case there were two levels of a-levels left. Then my father, looking back he must have pretended to get back pain, he figured out that I was pretty stubborn too, so this thing of becoming a chiropractor, he would have to finance, so he would have to deal with it and find out what this stuff…not chiropractic, he just wanted to find out how much money the make so he said he had back pain, called and got an appointment and had a series of treatments and whenever he had a treatment he always arrived an hour early and then he would sit and count the number of patients that went in, calculate the average number of patients per hour, the number of patients per week and fees per patient and he went home and did a complete accounting for the clinic. He saw that it was pretty good business and when he had done this he asked me if I still wanted to become a chiropractor, I said yes and he said 'ok' I will pay for you go.

I: So you pretty much had both sides of it, the belief experience and the practical side of it, that is pretty strong motivation…

R: Oh yes.

I: How would you define chiropractic today if that were possible?

R: Well it depends where in the world and it is actually very different. At the moment and I think it is because we are in the profession worldwide is in an important transition process, where it is moving from philosophy-based to evidence-based and I think that Europe and from what I have seen from South-Africa are ahead in that move. I think that it will end up with the entire profession becoming evidence-based and not philosophically based and if that is right then I think Europe and South-Africa is in the very forefront of that move. Where as the US and strangely enough, the Australians in particular, are in the rear.

I: So, in a European sense then, what would the definition be?

R: Of chiropractic…It is a profession, which deals with functional disorders of the musculo-skeletal system.

I: As simple as that?

I: Yup.

R: What type of person makes for a successful chiropractor?

I: The same kind of person who makes for a successful private practitioner in medicine and it is… We actually know something about this, because it has been studied. You need the science background, but all graduates at least in Europe and I am sure in South Africa have this and that is not enough. There are a couple of Australian studies that show that to be a good clinician, you have to have a science background, but on top of that you have to have an interest in liberal arts, music, theatre, film, books. If you have those, then at least you have the main ingredients. Then of course also, if you have what is needed to be a good clinician and then if you are saying a successful chiropractor in private practice, you also have to have a practical, economical side, because you are a business man, because you are in there to make money, but if you are unable to balance your own bank account every month, then the chances are that the accounts in your practice are going to be a terrible mess and you are going to spend most of your time fighting with the tax man or something like that.

I: This might be a difficult question, but are there things that you find unacceptable when you view other chiropractors?

R: Yes…yes I find the practice building aspect and the painless extraction of money from patients, if that is your driving goal, I find that disgusting. The other thing I find disgusting is the fundamentalism that you see particularly in the US. I have been a part of the international circle now for the past 16, 17 years and I have been in chiropractic research and education for 16, 17 years and I do believe I can look through it, because when it comes down to the fundamentalist chiropractic schools and colleges what they really is a cover up for making money on students and it is. So I mean it is like my father said, don't ever do business with very religious people, you can't trust them…he was not dumb.

I: It is a very interesting point that you raise, I am going to make the assumption that the fundamentalism is linked to the philosophical dogma…

R: Oh yes…

I: And that is in fact a rouse for a marking strategy?

R: Yes it is a cover, an easy, convenient, comfortable cover for running a college where the quality of teaching and the quality of the course is bad, but therefore also cheap, so that somebody can skim off a lot of money at the top and they do. I won't name names they might sue me.

I: How has the medical discipline or the biomedical model influenced you?

R: I think it has influenced me a lot, that has to be qualified, because I graduated form Palmer in1975 and at that time, I wasn't much different from any Palmer graduate and then after that I studied medicine. In a way it has influenced me both positively and negatively. No, it has only influenced me positively, but that is not necessarily positive from the medical profession's point of view. One positive influence was that at that time what was a modern medical course, I had for the first time courses in research methodology and statistics and that was an eye opener. What was also an eye opener was that at least at that time, medical education and medical practice, really wasn't a hell of a lot better off in terms of science base then chiropractic was at the time and that really a lot of it was hog wash. I think it broadened my horizons very much. It allowed me to put the strengths and weaknesses of chiropractic and the chiropractic profession into perspective. Where as before that perhaps I… If I hadn't have done medicine I would imagine that I today would be a very self-critical, discontent chiropractor who would put down most of what the chiropractors did, because I would think that medicine was sort of very, very good and it is not.

I: Would you say that your education in both has made you less skeptical about the chiropractic profession?

R: Yes, I wasn't sceptical about it when I did medicine. That is not why went into it, but I think I would have become sceptical. I actually went into medicine, because we have and did in back in 1975, a mandatory 1 year internship in Denmark and I was well read even at that time and doing that when I called general practitioners about a patient when I thought we ought to check something here, they were very high brow and condescending and after a year of that I got so mad that I decided that either those guys don't know about back or they are bluffing, so I'll do medicine University is free and you don't pay tuition, so I did that. So I went to medical school in the morning, practiced as a chiropractor and did my homework in the evening, but it cost my first marriage.

I: And were they bluffing?

R: They were bluffing, completely. I mean I had in six years of medical study, 2 hours on spinal problems, two one hour lectures on spinal problems, a one hour lecture on Rheumatoid Arthritis and a one-hour lecture on lumbar disc prolapses and that was the basis that these GP's had. A complete bluff…

I: In hindsight, with the regards to the philosophical basis or tenets that chiropractic sort of stemmed from the vitalism, the holism, that sort of thing and then the biomedical education that you had how do you think…where does your philosophical base stand at the moment?

R: We are very concrete. Chiropractic philosophy is an important part of chiropractic history, but it is not an important part of chiropractic today in my book. That is one thing. The philosophical base for chiropractic as I see it as it is in Denmark today is, pragmatic, natural science philosophical base. There is no world-encompassing superstructure. Adding on to that, I think that whole superstructure and the whole chiropractic philosophy essentially was created by people who in the early days, around the 1900's, were trying to explain some phenomena where they really didn't have the tools to explain them and then they made this philosophical universe, which could explain them. Which is perfectly ok, and without it the profession would not have survived, but I mean now we have gotten the building stones from science, which allows us to explain those things rationally. So, we don't need the superstructure anymore and therefore we also have to be willing to say, well it was a good thing, we glad we had it, thank you for coming, we put you on the shelf.

I: Moving onto methodologies for a moment if I might. Briefly which types of methodologies have been the most prevalent in chiropractic research.

R: What do you mean by methodologies, you mean types of research?

I: Yes

R: I think we have had all types of research in there and if we are looking at a higher level in terms of qualitative versus quantitative, it has been quantitative. It is like in medicine, not in all health sciences, because the nurses have done a lot of qualitative stuff and other female dominated professions, which I think is probably the reason and I think it is ok. In many issues it has been a question of chiropractic research getting accepted as research and there, quantitative research is easier accepted in say Spine journal or JAMA. But I think it is changing and it should change, so that we get a better mix between quantitative and qualitative and the problem with it is that if you do only one of these basic types of research you can only answer one type of question. So if you do only one type at some point you are going to grow dry. You are going to run into some problems that you are not going to be able to get out of again. So, you need both and up to now it has been mainly quantitative and that goes not only for the chiropractic profession it is the same thing for the medical profession, for the dentists for that sake. The qualitative stuff has to start coming in much more.

I: Are there any specific designs on the qualitative side of things that you either have an interest in or that you would like to see come in more of for instance ethnographic studies?

R: I come from a mono culture, in terms of race and genes and what have you, but I think there is one question that needs addressing, both quantitative, but also very much qualitative

and that is the issue of outcome variables. How do we measure patient states? How the patient feels, are they better are they not and the tradition of course had been that you use the Oswestry questionnaire and I mean why? Practicing clinicians, they don't use the Oswestry questionnaire, they ask the patient. So they are using the patient's global, actually the patient's retrospective global assessment. How have you been Mr. Smith? But if you did this in research you would be skinned alive. It is a …and that is both quantitative and qualitative. We need to know some more about how to measure this. Which tools can measure this and which ones are the most sensitive and I have a feeling that:"How have you been doing Mr. Smith?" is the most sensitive. That is at least what the figures suggest when you look at studies with patient satisfaction in low back pain, which 94% of chiropractic patients will say that the treatment was effective and did help and if you do the Oswestry questionnaire, you get 14 percentage points improvement. They don't add up, it is two different worlds and we have to find out what is going on there.

I: I am going to paraphrase you from one of your presentations and forgive me if I get it wrong, but you said that:" The placebo effect does not exist, it is just regression to the mean." Can I maybe introduce the term non-specific effect for a moment instead of placebo…?

R: The problem is that there is this Icelandic guy, Aspion, who I know in Denmark. He ahs a funny background. He first has a Master's in philosophy from Oxford and then after that for some strange reason, and he was very good at that, he decided to become a medical doctor and then he did that. Once he had done that he did a Ph.D. with the Nordic-Cochrane centre in Copenhagen and what Aspion asked, he asked a very awkward and very intelligent question. His Ph.D. was going to ask the question: "How big is the placebo effect?" and he did a big meta-analysis, I mean it was one of the most brilliant studies I have ever seen. Perhaps there really wasn't that much work in it, but getting the idea…

I: The conceptual…

R: Yes, but that was his philosophical background I am sure, which allowed him to that. So he actually and I won't go into this, he did a meta-analysis in a very shrewd, so that he could measure the size of the placebo effect. Three hundred and twenty trials he did, or something like that. High quality randomized controlled trials, which all had, I don't know do you know the study?

I: No I am not aware of it.

R: well all the trials operated with three groups, a non-treatment group, a placebo treatment group and an active treatment group and we are always interested in the difference between the active treatment group and the other two. Nobody, but in effect the difference between the no treatment group and the placebo treatment group that is the placebo effect. So he did a meta-analysis of three hundred and twenty high quality trials, banged them all together and did some high-class statistics and said now I know what the size of the placebo effect is. What is the effect of giving the patient a placebo and the statistics came up with the size of that effect does not differ significantly form nil. In other words, it is not there. If it is there, it is nil. But nobody, I mean I know the guy. It was published in New England Journal of Medicine. Do you know how long the review took? Three and a half years. They had to find and the co-author was the director of the Nordic-Cochrane centre who was his supervisor. They had to fight like mad. They had a brilliant study with an outstanding methodology; you couldn't put a finger on anything, but the whole… The mere thought was so unacceptable. They took it in the end. It took three and a half years of writing back and forth. Now it has been published, now everybody tries to pretend that it is not there.

I: Some studies from Australia have looked at different behavioral characteristics amongst chiropractors and those may affect the response from patients in terms of satisfaction and those sorts of things. Do you think that it is a phenomenon that is present and can it affect the healing encounter?

R: I don't know anything about it. But my gut feeling would be 'probably', but it is a line of research that I have not…I don't even read the papers. It is not that that it's not important, but you can't do it all.

I: Fair enough. The issue of management of patients has been a slightly misinterpreted by some, but it has many different meanings. What does patient management mean to you?

R: Patient management means, how do you explain to them what is wrong to them, how do you explain to them what to expect. How do you expect this therapeutic course to run? How do explain that to the patient. That sort of thing. The other interpretation, if you go the US is how do squeeze most money out of the patient. That is how a lot of people interpret it.

I: So patient management in your opinion is definitely means more than setting the treatment frequency?

R: Oh yes, oh yes. What it means to me is the whole encounter between the clinician and the patient.

I: A little bit of a cast into the future. What would you like to see chiropractors doing in ten years time?

R: Well I can answer that question for chiropractors in Denmark. I would like to see chiropractors being the clinicians who are in charge of and who are carrying out treatment and management of musculo-skeletal patient, certainly spinal patient. I think that in Denmark is in within reach, but the answer depends a lot on the society you are talking about.

I: Would that be in the sense, if I can use the term 'gatekeepers' of musculo-skeletal medicine?

R: Yes, both gatekeepers and the ones to whom a GP would automatically refer those musculo-skeletal patients where he felt uncertain. Who after sort of a week of analgesics had not cleared up and he wanted somebody else to look at. He would automatically refer to a chiropractor and nowhere else.

I: If it is possible, what do think has to happen in Denmark from the profession's side?

R: We only have to keep going as we are and have been for twenty years. It is not that fear away in Denmark.

I: The role of medication and in particularly Non steroidal anti-inflammatories, do you see that becoming part of the scope of chiropractic in the future?

R: I think it will and actually the Danish chiropractic association have made sort of a mission paper and in that paper is limited prescription rights. Personally they are over estimating it, but that may be because I have has a prescription pad for twenty years and at least for five of those years or so, I practiced as a chiropractor. That is after I had my MD and I have never prescribed anything for a patient. If I have it does not work. If you want anything, use aspirin, there is nothing that works any better. Of the pharmaceuticals what works even better is two glasses of red wine. Honestly even pharmacologically it is a much more effective muscle relaxant than anything you can get on a prescription.

I: So the net effect is you have been saving on stationary?

R: Yes, I don't quite have the same pad I had thirty years ago, but that is only because I had to get to get a new one for family and personal use.

I: Finally, I would like to address the issue of chronic and acute patients. Why is it that chronic patients come and see you even they know that possible they will never attain a cure?

R: I think all patients come for the same reason, that they want to get better. They don't necessarily want to be cured. I mean of course we all want to be cured, but we also lots of times know that it is not always a realistic thing to wish and even if we can't be cured, if it can be improved then that will be great. I have always been honest with my patients in that respect and that is lets take the improvements we can get and once we can't get anymore, fine then we stop it.

I: So it is an improvement in the sense of…

R: An improvement in the sense of whatever the right outcome variable, but it is in the sense of the patient's perception. I mean that is the outcome variable all practicing clinicians use. They may admit it, but the researcher certainly won't admit it.

I: Dr. Nilsin, I thank you for your time.

R: You are welcome.

Interview 3

You welcome the respondent and explain the context of the interview.

I: Dr. Haldeman thanks very much for taking the time pout to do this interview with me. I wonder if I might start off the interview by asking you which types of methodologies are the most prevalent in the chiropractic research in chiropractic today?

R: most prevalent…are we talking clinical or experimental?

I: I think both.

R: in the experimental research field I think we are starting to see neuro-physiological and biomechanical research. The neuro-physiology, you have about a dozen chiropractic neuro-physiologists that are looking at receptors, transmission from various spinal structures. The biomechanics, we have about five or six biomechanics labs that are looking at what happens when you give an adjustment. What are the forces, how are the forces distributed. In the clinical sciences, they fall into two categories. Almost everyone is trying to do a randomized controlled clinical trial with varying degrees of success. There are some comparative cohort studies coming up and I think there is even distribution there. We are not seeing a lot of case series anymore, which used to be a problem. In the social research we are seeing a number studies on what chiropractors are, what they do, what they think, how they impact society. I think we are spreading through clinical, social and experimental research very well.

I: Are there any methodologies that are unique to chiropractic in your opinion?

R: There is no methodology that is unique. Most chiropractic researchers have gotten their research training in standard universities and so they have studied standard methodologies. There is an emphasis difference an emphasis on spine and spinal mechanics and that you don't see in other professional groups, but it is not a methodological problem.

I: so if there is a sort of sub-area that chiropractic researchers tend to give preference to, should this develop into a unique methodology or should it just remain as a sub-section of generic methodology if we can call it that?

R: Hard to say, it will develop the way it develops. I think we will find that there will be fields of research, rather than methodological research research, so we an adaptation of research models to a problem which is very difficult, there are unique problems in chiropractic in that we are dealing with a hands-on profession, therefore [placebo treatments are very difficult, so we move into comparative research rather than placebo research in our randomized trials and in the social field there is a greater interest in doctor-patient relationships as opposed to general, social, observational research and in the basic sciences we are seeing a focus of attention to on segmental changes, which not many other people are doing.

I: How do think the RCT as you have mentioned contributed to the development to the chiropractic research paradigm?

R: Well it has done a few things. Firstly it is the gold standard of the Cochrane collaboration and most reviews on the topic and the fact that we have done a number of randomized control trials has had the impact of putting chiropractic and manipulation on the map. Without them we would be out floating free and probably discredited, because the studies have tended to be positive or semi-positive or at least no worse than alternative treatments and virtually every review of the literature has come up with some kind of positive statement about manipulation and that is all based on the RCT. So that has impacted the profession greatly.

I: Is there an area or areas that the RCT has been applied inappropriately?

R: I don't know if it can be apply it inappropriately, but you can ask a research question where the RCT does not give you any answers. A couple of classic examples an RCT on mobilization versus manipulation, well one could anticipate that the differences would be

negligible. You need a far… when you are using two types of manual therapy you need a much greater population of patients in order to detect a difference and so we are seeing a few studies coming out as neutral or equivicable, equivicable meaning no difference between procedures. That still, however has value; because the value is that it is no worse than-equally effective treatment option. The other thing is that a number of RCT's where the baseline pain scores are so small that regression to the mean has eliminated any potential differences and the classic is the Deyo study in the New England Journal of Medicine. They said there no difference between three treatment approaches, but the average pain scores were like three and four to start with and in that case you would have expected them not to have much impact. So we have to be careful how we interpret them.

I: what methodologies with the type of research questions that we are dealing with today, are perhaps under utilized or should be looked at more carefully?

R: I think we are going to see a move in qualitative research. Things like decision analysis. What makes a patient choose a certain treatment? We have got a study here on expectations. How do expectations drive patient care? We are doing a study as part of the task force on utilities. This is all new stuff that I think is going to grow and have a tremendous impact on what happens in the future and how we look a people with spinal problems.

I: so you see a certain resurgence or upsurgence of qualitative research, why now?

R: twenty-five years ago with the NINCDS conference it basically became evident that at that time there was no RCT as a basis to accept or reject manipulation. No studies were done. It was a blank sheet. There was one comparative study that was unblended and uncontrolled, but there was nothing else out there and it became very evident to those of us in research that we had to create some justification for the use of chiropractic or manipulation, forget about chiropractic and that is why the focus was on RCT's. It was the gold standard, widely accepted gold standard and it became very evident that if these did not occur you are never going to put manipulation on the map and so fifteen, twenty years the focus was on RCT's and still is for the most part. It is moving more into comparative studies now, but what the RCT's have shown is that there is some benefit, but there is no magic cure. Some treatments are a little bit better than others, but none of them are curing people from back and neck pain and most of the other conditions there are just minor differences in effectiveness. Questions are being asked now as to what impacts results apart from treatment, is it patient selection, is it patient behaviour, is it doctor behaviour and this is why the qualitative research is becoming more important.

I: There are some that say that the particularly approach that has held sway particularly in the last twenty years or so has had an effect on the philosophical basis upon which chiropractors and in particular, chiropractic researchers function. Would you like to comment on that?
R: Yes. You know conflict is one thing. Basically chiropractors started off and for the first seventy-five years of the history, as with most of medicine, was based on clinical procedure. You had it, you taught your next generation, they got offered the service and you felt is was beneficial and your patients felt is was beneficial and so you continued going without any basis and chiropractic was unique in that it was separated from the scientific community by legal statutes in most places or ethical statutes by medicine. When those barriers broke down, chiropractic researchers started to become active. The first thing a researcher does when they are young is to be skeptical. So this huge period of skepticism, it will happen in your life, it happened in mine, it will happen in every researchers life. You don't believe what the old guys are telling. They are full of it they don't know what they are talking about and so we had no senior researchers, we had only young, gung-ho, smart researchers who were extra-ordinarily skeptical and whenever they stood up and talked, now I can remember doing it myself, your first statement is well you guys don't know what you are talking about, I am the only one that knows what is going on. So there was alienation between the researchers and the practitioners. They were talking different languages and some of the initial research did not back some of the widely held beliefs. So you had the perception by the practitioners that this research was threatening and the perception by the researchers that the practitioners were a bunch of idiots. What has happened as our research community has matured, we still have young guys and they have to be skeptical. If the young researchers are not skeptical

then we get no new ideas, so that is crucial, but we are now getting a group of senior researchers, some of which are able to mentor, putting it into perspective. Starting to communicate with the practitioners and showing that this is not destroying your ideas we can just modify the way we practice and the way we think and actually advance thought processes and I think we are going to see a greater acceptance by practitioners of the scientific model with that evolution and I think it is a natural evolution of the profession.

I: if I might, the beliefs that you held as when you were a researcher in your day and have come full circle in certain aspects, which of the belief systems still hold sway in the way you go about things and which have changed?

R: Hard to say. I was the smartest I ever was in my life when I got my master's degree, that was when I knew everything and they didn't know anything and I told them that they didn't know anything and it has been going gradually down hill since then. I know less and less than I did before. The changes that occurred initially…I don't think I ever rejected, some the people I know rejected the entire chiropractic premise even some of the speakers here for a block of their life. I don't think I ever did that, but I tended to focus on narrow, I am a neuro-physiologist, so I focused on narrow neuro-physiological theories and believed that I could explain everything in neuro-physiological concepts. I have always been a chiropractic patient, so I never lost faith in the treatment as a method of treatment, but I also realized and I was brought up, my father being a chiropractor, in the belief that exercise, a healthy life style, no smoking is crucial. I think where I got into conflict with large numbers of the profession was where a large number of the peo0ple who rejected science as part of their rejection, somehow bought into a philosophy which I consider non-chiropractic, that the subluxation was god and they ignored issues of classic innate intelligence and healthy lifestyle and so on. We found more and more chiropractors who ignored their elders and rejected the concept of healthy life. Chiropractic is basically the promotion of a healthy life and an adjustment when you need it and they got into everybody needs an adjustment every day or every week and ignored the health and I think my greatest conflict occurred in that separation, because I never saw that movement and I felt that that movement was non-scientific and non-chiropractic and I think that what we are seeing now is that the research is backing the original chiropractic theory of healthy environment, healthy individuals, promotion of health with some manipulation when you need it, as opposed to the using of the subluxation as a god issue.

I: Would it be correct of me to say that the notion of vitalism as a meta-physical term has still remained and has become…

R: Oh ya, I think that vitalism, if interpreted correctly, as a force within the body that has the capacity to heal, given the right environment is whatever the life force is. We still don't know… we have no adequate scientific explanation of what makes a living thing versus a dead thing. I mean we talk in terms of genetics and DNA and, but when it comes down to everything is still there in a dead person. It is not doing very well, but all the pieces are still there and so you have to still philosophize over what it is what makes a person or plant living versus dead. So this is vitalism and chiropractors have called it innate intelligence, others have called it chi, any of a number of different words and what I think is happening is that public is starting to intrinsically believe and the medical model that ignored that has basically led to some isolation of the medical world from their patients and has encouraged the growth of complementary health care. I think that it gets too systematized, like in acupuncture, looking for all the various points; I think it is not going to work if it gets systematized and focuses on something called subluxation. I think that is going to be unrealistic. But I think that vitalism in its broader context is going to come back, not go away.

I: Earlier on Dr. Nilsin made the statement and I am paraphrasing here, that he did not believe in the placebo effect and that in fact all it was regression to the mean. I would really like to hear your comments on the role of the placebo effect in chiropractic.

R: The placebo effect depends in how you define it. There are some studies that say that the old concept that a placebo heals is starting to be discredited a little bit, but the concept that psychological expectations lead to reduced symptomotology is actually gaining some influence. Now if you want to call that placebo that is fine. Again Nils has talked about how a

lot of pain phenomena is central and we have issues like depression and there is growing suggestion or evidence that doctor-patient interaction, the transference of belief systems has at least the capacity to reduce symptoms. But if you try and get…the closer you get to an absolute placebo, doing nothing at all the closer you get to regression to the mean. The further you get from that. In other words if you get counseling, massages, if you get laying on of hands you really haven't got a placebo, you really aren't a placebo now, you are just an alternate approach and you are comparing two treatment approaches. So I think the true placebo is going to disappear or at least not be as prominent. The interaction between and this is where the qualitative research is starting to point that the…we can't ignore the patient's psychosocial environment when they approach a treatment, because that appears to be quite strong.

I: In the clinical encounter between the chiropractor and his or her patient, fro the clinician's side are there certain factors in your opinion that could increase the non-specific effect of treatments or interventions?

R: I think the chiropractor has to be confident that their treatment approach is of use; they have to convey a confidence. If the confidence is based on fact rather than belief I think the confidence carries more conviction. The patient has to be confident, have a positive expectation they can't be too skeptical or at least a strong desire and then I think things like time with the patient, education is gaining some importance and I think we are going to see a growing focus on what is it that interacts between the doctor and the patient. There is a recent study for example that shows that, a randomized trial of massage versus acupuncture and it showed no long term outcome differences, but when they looked at the patients expectations to be better, if the patients thought that acupuncture would be better and you did a subset analysis on that, they were much more likely to improve and the patients who thought that massage was much better were improve, were more likely to improve with massage. If you took a randomized status, in other words the expectations were randomized, you came up with nothing. The issue is does the patient know better, in other words does the patient intrinsically know which one is going to fox them or did they just believe or have a greater faith in one or the other.

I: some research has shown that patient satisfaction in terms of chiropractic care is high even if there is an understanding from the patient that an ultimate cure is not apparent. Why do you think chronic patients see their chiropractor even though they know they are never going to get better?

R: A couple of thing. First of all the inevitably get some sort term relief. I think there is enough data to say that you get short-term relief from chiropractic and they haven't got many other places to go to get short-term relief. Some of them will take aspirin and get some short-term relief or an anti-inflammatory, but a large number of people get side effects or they don't want to go that route, so they go to their chiropractor for short-term relief, get them over the bumps. The second thing is they are in a bit of misery in this pain and they want a councilor and chiropractors have traditionally been very sympathetic and empathic to their patients. So one of the most sympathetic counselors has been the chiropractor. Medical doctors routinely spend two minutes or five minutes with someone with back pain and basically say go and live with it and here is an aspirin. Chiropractors will talk about philosophy, the better ones will talk about exercise and lifestyles and will council a little bit and will be a little empathic and will help with other social problems and I think patients feel this. They don't want to go to a psychiatrist. Religious leaders are less available to us now as councilors, so you go to somebody who is willing to listen.

I: my second to last question. What amount of wellness management is feasible in day-to-day practice?

R: it depends on how you define wellness care. It is an unfortunate reality that most chiropractic wellness clinics do not promote wellness, they promote more office visits. It is used as a sales pitch rather than a wellness environment. It is actually very easy and it does not take a tremendous amount of time to counsel patients on good health. It takes some time, more time then giving them adjustment and getting them out the door, but it does not take a

lot of time. You can have a whole series of ways to do it. You can do it one on one; you have to a certain point. You can do it with pamphlets, group sessions, and educational material. So there are a number of ways. My father ran this type of clinic and he used to have whole sessions with groups of people, who would then discuss their problem and what they could do to improve it and we are seeing a lot of the rehabilitation centers getting into group discussion, which is part of the wellness process.

I: Finally doctor Haldeman, where would you like to see chiropractors in ten years time?

R: I would like to see chiropractors being the lead group for non-surgical management for spinal disorders. I would like to see them take the lead group in symptomatic care and the lead groups in screening for serious pathology and the lead group in educating the public in proper health, wellness, spinal care, so that they promote and some of this is happening. The WFC for example has this international no-smoking initiative. I think that is very valuable. Then we need exercise and anti-obesity initiatives that the average chiropractor can get into. If we do that we can establish ourselves as caring more about the patient tan our own wealth, I think the rewards will be without bounds.

I: Dr. Haldeman, I thank you for your time

R: Not at all.

Interview 4

You welcome the respondent and set the context for the interview.

I: I think I am going to jump straight into things, because of our time restrictions. A quick question about methodologies; which in your opinion are the most prevalent in chiropractic research?

R: Well we are in a situation of transition. There used to be a huge emphasis in the past on reliability studies and those kinds of things a rehash of the same issues, because they did not get the answers they were looking for. Palpation was not reliable, so we'll do another study to prove palpation is reliable, but it doesn't become reliable on that one, so they do another one. We have also gone through a rash of randomized clinical trials, some of which were very useful, some of which are less useful and the reason in my view that they have become less useful is because they have become template trials. Instead of looking truly at the issue of…Science is supposed to start with a simple observation and hypothesis building and development of preliminary studies and preliminary work before you ever get to a randomized trial. Because of political pressures or whatever reasons, we have often jumped form hypothesis and sometimes not even formal hypothesis, just philosophical tenet to randomized trial. So we don't have any information on what is the proper group to be studied, what are the proper indicators for inclusion, what are the proper outcome measures to be using and so forth and so on. When you do that repeatedly you ultimately regress to the mean. All of your studies begin to say there is not a whole lot of difference, you get less and less difference, because you are studying less and less explicitly what you want to know, rather than more and more explicitly and that is sort of our state of the art right now and I think what you are seeing begin is we are beginning to see true mechanistic studies start or we are beginning to isolate specific aspects. So for example what, not just does manipulation help a low back? What is the property of manipulation that helps? Is it the speed? Is it the force? Is it the frequency? What is it? You are beginning to see mechanistically designed studies to answer these questions. You are also beginning to see studies that are trying to get at detail of triage in patients, who are the right candidates to get into these studies? So, for example we heard this morning that perhaps the fact that perhaps tension headaches there is not the right candidacy group for manipulation and so these are the kinds of studies that are the next step and we will ultimately continue to see randomized controlled trials, because we have to, but I don't think we are going to see huge advances in the state of the art because of randomized clinical trials until we have gone back and done the preliminary work and we select the patients more clearly and we understand the elements of the treatment we are testing, rather than just lumping into treatment and lumping all candidates who just happen to have back pain into the group that we are going to treat.

I: Are there any methodologies that are unique to chiropractic in your opinion?

R: It is getting less and less easy to identify uniqueness. There are those that will tell you that the uniqueness of chiropractic is the intention to treat. We intend to accomplish something, relieve a nerve irritation or what have you. Well that is bogus, because the patient's body does not know what your intention is and if someone else happens to use a mechanism of action to treat a patient that is similar to how you would mechanically treat the patient, irrespective of your intent, his body is likely to respond the same way. So, because we have been successful politically and socially and now somewhat scientifically, more and more people are trying to do what we do with more or less success, based upon skill level and their ability to triage and so forth. But what we are beginning to observe, with the exception of verbiage, there is not a lot unique. The one thing that might still be unique is the fact that we hold the preponderance of emphasis in a certain area, but we do not own the sole emphasis in those areas.

I: in what areas do you think the randomized controlled trial has let the chiropractic research community down in our strive for validity, truth whatever the case may be?

R; well for example in low back pain we have a few studies that look at acute low back, a few at chronic low back. We had people look at just all low back. The more studies we do, the

smaller the size of the effect seems to be getting. Part of that seems to be rigor in the studies, because we know that any time you have a more rigorous study, the less the effect is going to be, it is just the nature of the beast. But in relatively comparable rigor, we are still seeing regression to the mean and I think it is, because we are dealing with the heterogeneity of the problem, rather than honing on the aspects of the problem.

I: Alternative methodologies that could or should be considered more regularly in your opinion?

R: for me the alternative approach is to step back from the preconceived notions of manipulation and to begin to recognize that manipulation apparently has some kind of role; we may not know what it is. So, perhaps the best thing to do is to become more integrative in incorporating more medical, chiropractic and other CAM procedures into the availability. Even to the extent that chiropractors who are so interested or so inclined, there aught to be a venue for those who are interested for using pharmacy to be adequately and appropriately trained to incorporate pharmacy, because it is of value and benefit to the patient. When you have one stop shopping, when you have appropriate utilization of services being it manipulation or medication, the patient gets what they need in one location. Not to have two visits two costs, delayed time etc. so my view of the alternative for the future in integration and integration on the individual doctor training basis as well as integration between doctors of disparate training.

I: the non-specific effect or the placebo effect, as some would call it, that chiropractors have the ability to impart during the clinical process to their patients. Would you like to comment on what may strengthen that non-specific effect and if so should we be looking at doing that?

R: Well there is a whole world that looks at strengthening placebo effects. Clearly it happens, but it happens for anybody who pays attention to patients, not just chiropractors. Two randomized controlled clinical trials have been conducted explicitly addressing those issues and in both cases it was clear that the placebo effect exists, but the results of manipulation is additive to the placebo effect. There is more effect when you have manipulation. I think that scientists who are interested I placebo effects should study placebo effects. If they happen to also be interested in manipulation that is fine or vice versa, but we have a whole world out there that is paying attention to that and dealing with it. I think that a core group of sufficient size, a critical mass who really and truly interested in teasing out the truth with respect to manipulation and what is the mainstay effect of chiropractic and its mechanistic effect, recognizing that some of those are going to influence the non-specific or placebo effect, but it would not be a primary focus of how I would organize resources for the profession.

I: Having come down the line in your research career to a certain degree, when you look back on the past, what of your philosophical belief system have you kept in tact and where have you changed your opinions?

R: Well have changed on the notion that the nervous system is the center point of chiropractic. I don't think it is. I think it is one venue of expression of problems that happen when this subluxation lesion occurs and personally I don't even like the term subluxation it has too many definitions. Too many people use it in different ways and two chiropractors can use it and you still don't know what they mean. I have come to the conclusion that the primary problem is a mechanical disorder, that it has mechanical side effects. That those mechanical side effects are either local or remote. I probably said that wrong; the mechanical effects give side effects that are either local or remote. Local being inflammatory tissue changes etc. and remote being reflexic or neuro-physiologic changes that may occur or vascular and if you look at the total cascade of possibilities, perhaps neuro-physiologic or vascular leading to hormonal or what have you. But the fundamental thing that we deal with and the manner in which we treat it is mechanical and so that has been my change. I don't discount the neuro-physiological aspects, but I do not consider them as part of the lesion, I consider them a consequence.

I: There is a possibility that chronic patients who consult you will never make a full recovery to full, functional health or have a cure. Why is it that they seek your consult in practice?

R: Well chronic patients seek anybody's consult, because they are frustrated and trying another venue. So if they have never seen you before or a chiropractor before when they come in. that is why they are coming in. If once they get there, they observe a positive change that is why they try to stay. The danger is that anything new that you do with a truly chronic patient, they will respond to the non-specific effects for a period of two weeks or four weeks and appear to improve initially. That is a discount, that is a grace period. The reality is, when you are four, six, twelve weeks down the road and they are still benefiting from what you did, that is important. It is also that these patients, often better than others recognize that a small amount of change or status has a much larger benefit for their quality of life than for someone who has got first time onset acute back pain. So if they get a 10 or 20 percent benefit and it lasts a while, they are thrilled and they are very happy with that. The acute patient is not going to be happy with that. So it really is two separate motivations and you really have to be careful with the ones that are, who have a tendency to become physician dependent and promoting that is of no value to them and it is of no benefit to you expect for some short term, your pocket book.

I: Where would you like to see chiropractors in ten years time?

R: I would like to see chiropractors attitudes taken off their sleeves. I would like to see them take themselves much less seriously than they tend to do now. I would like to see them step back and recognize that they are only one group out there claiming to be treating the cause. I can now go into any CAM directory and find someone promoting something. It has no bearing in chiropractic like treat the cause not the symptom. Well, ok maybe we first, but obviously we did not get them all otherwise there wouldn't be this opportunity. I would like to see chiropractors be recognized and valued members of the healthcare team to contribute in every quality, every aspect for which they can demonstrate they have utility. I think the first of that is going to be musculo-skeletal and I think that ultimately observations. Once we are trusted members of the team, we will make observations that will lead to further studies that clarify non-musculoskeletal use and to me that is a strategy and I have had patients and doctors say to me but if you do that you will loose something in chiropractic. Well baloney, dysmennorhea is not going to go away, just because I choose to focus on musculoskeletal ad if I am successful; at becoming a trusted member of the team and becoming professionally and economically secure in musculoskeletal and then observe that there is this group patients that get dysmenorrhea that seem to get better, I am now likely to get access to those patients to truly test the hypothesis. The big problem in chiropractic is we make all these claims. We don't even see enough of these patients to determine if there really is a question to test.

I: Dr. Triano thanks very much for your time.

R: Sure.

Appendix E: Patient interview schedule:

1. What do chiropractors do?
2. Why did you come and see your chiropractor?
3. Why did you go and see him/her rather than your GP or any other Health Care Practitioner?
4. Do you/ did you expect a cure for your condition?
5. Is your relationship with your chiropractor different to any of the other Health Care Practitioners you have consulted?
6. Has your chiropractor explained to you what he/she is going to try and achieve through their management protocol?
7. Do you think that what your chiropractor does is based on scientific evidence?
8. Has your chiropractor dealt with other issues related more to your general lifestyle during your time with him/her?
9. Do you have confidence/ feel satisfied with your chiropractor's ability to deal with your problem?
10. Why do you think mainstream medicine and chiropractors don't see eye to eye?
11. Has your chiropractor ever discussed his/her own view of healthcare with you?
12. Has your chiropractor ever discussed maintenance care with you?

Appendix F- Patient interview primary documents

Patient interview 1:

You welcome the respondent and explain the process and do a sound check.

I: I am going to start you off with an easy question. What do you think chiropractors do?

R: Well chiropractors manipulate us and we feel better afterwards and I feel chiropractors make a big difference in our health, where tablets, drugs really makes you addicted to it.

I: what is a manipulation according to you?

R: A manipulation is where you get massaged and you find out that your bones are not lined up properly and that is where your discomfort comes from and your discomfort is where your chiropractor can then line up your spine and you can feel much more comfortable and that discomfort causes you sometimes to walk uneven and this can cause a skew back.

I: Ok and when you say that chiropractors tend to not use medication is that an advantage in your opinion?

R: Yes, I hate medicine because since 1997 I have had to take medicine for my continuous pain and I hate medicine and I rather, easy route, because that way you cannot get addicted to the medicine.

I: why did you come and see your chiropractor?

R: Because I have tried all the other routes. I have tried medicine, I have tried the praying route, I have tried any other route. I have tried Panados, migraine tablets and an hour or two later, I feel that the condition has come back and that the tablets have not helped and that I still have to lie down and then I go and see my chiropractor and two hours later I seem to be rid of the problem.

I: So you definitely saw another healthcare practitioner before you went to the chiropractor?

R: Yes.

I: Do you expect a cure for your condition.

R: Yes, I do expect a cure for my condition.

I: I think what we must most probably do is elaborate for the context of this research that although you have consulted chiropractors for your low back you also suffer from reflex sympathetic dystrophy, which tends to increase the severity of any other condition. Would that be a correct statement?

R: Yes, with the research on RSD it has shown that it has affected my back, because of the uneven walking; the discomfort of the walking and then it does affect my back, especially my lower lumbar area, where I then struggle to bend forward and then I have to come for treatment, because the uneven walking causes the back pain.

I: The reason why I mention whether you are expecting a cure has to be set in the context of the greater healthcare problems that you suffer from. So are you expecting a cure for your back pain as well as your RSD?

R: well we know that RSD takes a long time to heal, they have not found an exact cure, but the research on the RSD has shown that if the rest of the body is lined up comfortably and properly it makes the RSD easier, because the sympathetic nerves do affect the back's nerves as well.

I: So would that be a yes?

R: Definitely yes.

I: In general, how would you describe your relationship with your chiropractor?

R: Well I have three chiropractors that oversee me and I think they are the most greatest people out.

I: Would you like to elaborate on that a little?

Well Dr. Andrew Jones supervised Dr. Charmaine Korporaal before she qualified and now I am also under Dr. David Dyson for a neck injury and because I have been to the Medi-Cross clinic where they gave me medicine for my migraine and it didn't help, I then went to Dr. Dyson and Dr. Korporaal for my back and my neck which makes me feel better, better than the medicine do.

I: How do you think that this has affected your relationship with them?

R: Well I think that any doctor can be your friend, where medicine cannot be your friend.

I: Why is that?

R: Because with your chiropractor you communicate, but with medicine you can't communicate.

I: Once again, why do you say that is?

R: Because at least you then know that you are getting the results from your doctor, they play open cards and explain to you what your problem is, that I have known every time I have visited my doctors they have played open cards with me and I like a doctor who comes straight down the line and I know what my problem is. And then I know what the next step would be towards that problem.

I: Do you think that the particular view that you hold is because of your experience with healthcare practitioners before you saw the chiropractor or would you want to generalize that to mainstream medicine?

R: well I have been through three GP's big specialists at St. Augustine's hospital that had said go home and live with your problem or we are going to cut your leg off and I got the biggest fright of my life and that is when I was introduced to chiropractic, where I got treatment also for the neck and back, because the RSD did affect the sympathetic nervous system.

I: Would it be fair of me to say that the reason why your relationship has grown strong over time is because there is a willingness to help, to communicate, to as you say play open cards and not give you a fright in terms of your health conditions?

R: Yes, definitely.

I: With regards to your back pain specifically and think you have answered to question to a degree, but I will ask the question again. Do you think that your chiropractors have explained to you what they are trying to achieve through the treatment you receive?

R: Yes, definitely.

I: Why do say that, what information do you now have access to that you did not have before hand?

R: I find difficulty of really answering the question.

I: Ok, you say your chiropractors have explained to you what are they trying to achieve with respect to your lower back?

R: Well they say that uneven walking can cause severe lower back pain and that you have got to walk straight up and so you have to do your walking therapy properly and the exercises they give you to mange your lower back pain.

I: and that makes sense to you?

R: Yes, definitely, because if I don't do the exercises and stay on the programme that they have given me what is the visit going to help? Because you have been given an exercise programme that you are supposed to stick to.

I: Do you think that your chiropractor and other healthcare professionals get similar types of training and lets use GP's as an example?

R: No I don't think so. I think the GP wants to stick a tablet down your throat as quick as possible, but when you walk into the chiropractor, they have taken x-rays of you and they tell you that you can take as many drugs as you want to, but you are not going to get this back straight.

I: So in your opinion the actual training has a different focus?

R: There is definitely a different focus.

I: Do you regard the, and once again going to use the GP as an example, mainstream medicine and the chiropractic professions as equal professions?

R: No not really, I would not regard them as equal professions, because a chiropractor would not write out a prescription for you to go and take that specific drug.

I: I think what I am referring to mare and I absolutely appreciate your interpretation of the question is the relative status of chiropractors and GP's.
R: Well in my opinion I would probably see a chiropractor at a higher level.

I: What puts them at a higher level?

R: The type of approach to their treatment and to their examination of the patient.

I: How are confident are you in your chiropractor's ability to deal with your problem? I think you have probably given me an answer on this question already.

R: I feel very confident that they are able to deal with my problem.

I: Do you think that mainstream medicine and chiropractors see eye to eye in South-Africa?

R: I don't know what I have experienced when visiting doctors- the GP's and the specialists that I have seen have said stay away from chiropractors, so I don't think they like chiropractors.

I: why do you think that is?

R: I never asked and with my experience that I have received from the chiropractic profession I don't know why people don't like them, because I still think they made a big difference in my life regarding my treatment.

I: lets have a hypothetical situation. If you went to a specialist for the first time and you had seen a chiropractor for treatment, would you be reluctant to tell that medical person that you had been to a chiropractor?

R: No I like to come straight down the line, I will tell the guy listen I have seen my chiropractor, but I would like your opinion.

I: Have your chiropractors ever discussed their peculiar or specific view on healthcare with you? Now that is not just related to the treatment, but this is in terms of their view of healthcare in general? So have they ever discussed a little philosophy with you?

R: No I can't really remember the chiropractors discussing anything like that with me.

I: Have any of your chiropractors ever discussed the issue of maintenance care with you?

R: No not really no.

I: I mean you are a chronic sufferer, so has anybody ever discussed with you how your ongoing care should be structured?

R: That I basically just have to take it easy, that you cannot rush this sort of treatment and that you have to take it step by step.

I: Was there ever a number of visitations given?

R: Ja, originally when I was diagnosed I was told not to expect a cure within a year or two and they had to do it step by step and then they have to teach you the correct walking methods to avoid back and neck problems.
I: So, although there were no specifics discussed you knew there would be stages I your recovery and that the process would take upward of a year or two.

I: There is a view within the profession that the type of healthcare that chiropractors get involved with forces patients to become active in their own health and to take responsibility for their own health, but that it has the effect that patients become empowered. Would you agree wit that view?

R: Yes definitely.

I: What makes you feel more I control now than what you did a year or two ago?

R: I feel that because the treatment has been so successful. If I look back when the specialist said go home and live with your problem or we are going to cut your leg off, I got the biggest fright of my life. At one point in time in six weeks I had five lumbar punctures, because we could not establish what my back problem was from and with the x-rays that have been taken by these respective chiropractors, the skewness in the back and the uneven walking were the cause, so the lumbar punctures were basically a waste of time and money.

I: what I am getting from this is that the process that you are going through has been explained to you well during the time that you have spent with the chiropractors and it is positive.

R: Yes, and that I have set my own goals.

I: What are those goals if I might ask?

R: well my goal is to have normal life, not to have a form of disability over my head and to have freedom of mobility.

I: I thank you for your time

R: Thank you Corrie.

Patient interview 2:

You introduce the study to the patient and then start the interview…
I: The question was what do you think chiropractors do?

R: As I say a physiotherapist and a GP put together still does less than what the chiropractor does and during my experince at St. Augustine's when u had a back injury or I'll say back problem, I was talking to the physiotherapist and she says:" Did the chiropractor also use needles and other things that they others have used? You know they are not supposed to". I said you can speak to them if you want to.

I: Tell me your statement about the chiropractors taking on the roles of GP's and physios, that statement os obviously made in the context of back pain.

R: Yes, yes…

I: Ok, so wouldn't have the same criteria for example a flu, or a chest complaint or something like that, is it more related to muscles and that sort of thing?

R: Not necessarily. For example, my nieces colic, I did not know that chirorpactors were in a position to help out, but…

I: So it extends to more than just muscles and joints…?

R: Much much more. If I have stomach pain I phone my chiropractor and ask what do I do? But I know my remedy at home if I can't bare the pain, it's cold water.

I: Why did you come and see the chiropractor?

R: I can't remember exactly the first time, but I think I read chiropractor clinic somewhere in the papers or maybe in a flyer and I said to myself lets go for it.

I: Do you expect a cure for the condition that you are suffering from at the moment?

R: Well definitely the GP cannot cure me. The hospital cannot cure me, so why must I sleep in the hospital or continuously go to the GP, when I come here to the chiro and I can get more done here then if I went to anyone of those two places. For example, I came in here with a problem for my wrist and elbow and I got a massage to sort out my back as well as an adjustment on the spine. The doctor would never have done that. The doctor would have given me one injection and said:" Ah I am feeling all well, right go."

I: So the question about the cure then is much less oriented toward whether or not you will get cured, it is about what goes into the management and treatment quality, is that right?

R: Yes and there is no drugs going down my throat. No injections and no drugs.
I: Would it be fair then to say that you don't necessarily expect to be cured once and for all from your back pain, but that you are happy with the quality of life…

R: Yes, because I can walk out from here and two hours later I could cause…just like doing wheel alignment, you can drive out with the car and there is no guarantee, because you can climb over a little pebble and your alignment goes off. So I can go and walk haphazardly and fall off the pavement and I can hurt myself again.

I: Ok, fair enough. In general how would you describe you relationship with your chiropractor?

R: Very good.

I: Can you elaborate on that a little bit?

R: Very good. Very friendly, you have to…

I: All right lets have a look at it this way. Is your relationship different to the one you have with your GP for argument sake?

R: Ya, my GP is there for the money. Anything that he does for me over and above what I go there for is money.

I: and you don't get that view when you come to see your chiropractor?

R: I don't have any views like that when I come here. And then he only treats you for the complaints you give him. If you tell him I have headache fine, here is twenty tables you will be ok. If you are not ok within three days then you come back, I will change your tablet and give you more poison. But here there is no such thing as coming back for more medication, more injections.

I: I think you have already answered my next question to a certain extent, but I will ask it again. Does your chiropractor explained to you what they are trying to achieve whilst they are treating you? So what is the plan that they have in mind? Do you understand that?

R: My chiro always exlpins to me the relationship between myh pain and that part of the moving… that moving part. My lifestyle could affect my posture…

I: Do you find that type of discussion beneficial?

R: Very beneficial it tells me what I must not do. If you do that then this is the result, negative reasult.

I: And is that necessarily different to what you have experienced with and I am just going to take the example of the GP again?

R: Ya, he doesn't really tell you, because he wants you to come back again tomorrow.

I: Do you think that chiropractors and other medical practitioners, and I am going to stick with the GP's, do they get a similar type of training?

R: From what I have read in the clinic here, the chiropractors go through the same mill as the GP's and they have to also got to do chiro work. The GP's just do GP.

I: Do you regard the two profesions as being equal?

R: No it is not equal. You mean a chiro and a GP?

I: Let me rephrase. Do you consider them equivalent in terms of their status in the healthcare system?

R: No, the chiro is one above the GP, because the chiropractor has been through a GP's mill and now gone up through chiro's mill. So the chiro goes through two mills and the GP only does one mill.

I: How confident are you in your chiropractor's ability to deal with your complaints?

R: I think that she is exceptionally good. But I will not talk about her only. Whoever I have seen…

I: So you have seen a number of chiropractors and you have been happy and confident with the care you have received?

R: Oh yes, all of them.

I: Do you think that mainstream medicine, so the GP's, physio's and specialists, and chiropractors see eye to eye in South-Africa?

R: No, the GP does not like to hear the name chiropractor.

I: Why do you think that is?

R: Because if you go to a chiropractor, there is no medication, there is no drugs, but if you go to a GP, he has got 10000 things you have to take. Tablets, injections, ointments and everything like that.

I: And why would that make the GP's feel negative toward chiropractor?

R: Right, if I go to the chiro I would not go back to the GP, whether internal or external. Whether it is bone or muscle, I would still go to the chiro and once a person starts to understand what a chiropractor is doing to you, that person will never ever go back to the GP.

I: It is an interesting point that you raise there and I would like to get some clarity. In your opinion, it is not that GP's don't think that chiropractors aren't good, it is that they perceive them as competition and don't want to refer to them?

R: No, I think I should have told you a bit more. It is not only the competition. If I continue with my GP, he will love me, because I was all the time feeding him. I have stopped my GP. My whole family, if they have a problem, they come to the chiro. Whether iot is a stomach problem, or a hip problem, internal, external, they come to the chiro. Even a new-born two months old from Johanesburg comes here.

I: Have you ever discussed with your chiropractor(s) their particular view on healthcare, so a little bit of philosophy. Have you ever had a debate with them like that?

R: We could have spoken about it some time ago, but I did not keep that converstion particularly in my mind. It's like small talk and we don't really bother about that.

I: So the thing that has stuck with you is the approach to care, the quality of the care and any particular view of health hasn't made much of an impact, because of the results that you have gotten. Would that be a fair statement to make?

R: Yes, very fair.

I: Have you ever discussed the issue of health maintenance with any of your chiropractors? What I mean by that is once you have gotten rid of the symptoms, how to keep well. In other words how to stay out of this office?

R: We take about this often, on every visit we are talking about that.

I: Can you explain to me how that is done?

R: They encourage you to do walking for example. Not running, walking and I think that is very very good. Not jogging or running just brisk walking for an hour a day keeps the chiropractor and the doctor far away.

I: Tell me, how does this make you feel?

R: Oh number one.

I: Not the walking, I mean the interaction with the chiro.

R: Oh I feel very proud that I am associated with the chiropractor. I feel very proud when I walk into this place.

I: Thank you very much for your time.

Patient interview 3:

You explain the purpose and procedure of the interview to the respondent.

I: Mr. Clarke than you for taking the time out to do this interview with me. I think I'll start you off with a fairly general question. What in your opinion do chiropractors do?

R: well they have relieved me from pain many times. I feel that they put my body back to the shape that it is supposed to be. I feel also that personally with my own body they have done things that physiotherapists could not do quicker. Maybe over a longer period the physiotherapist could have done it, but for me they have done in a day what physiotherapists take maybe two or three weeks to do. So therefore they have relieved pain for me quickly.

I: So the very strong theme that comes from you is pain relief and you also mentioned that they put your body back to the shape that it should be. Can you elaborate on that a little bit?

R: Well, I have got family, my daughter, she has got back problems and she has never been to a chiropractor. She has never been to a physiotherapist either, but I know that if we went to a chiropractor on a regular basis, because half the time people don't know that their backs or their bodies are not in the proper shape. Lets talk backs that is my problem, and people could be walking around. I have seen many people at the golf club, they don't even know that chiropractors exist, they have heard of something, but they have never been to one. My own daughter is an example. My eldest son, he was a professional soccer player, he has been to chiropractors through me. My youngest son Justine, he is deceased, he was a professional golfer. He had been to chiropractors through my experiences. So I have seen people, family, I have seen friends, even to this day. I have seen people at the church. They say oh my back is and I will give them advice that there is someone out there who can help you. There are so many people who are ignorant to the fact that they could get help. I have said this to Rob, I feel that if people had known better years and years ago, I mean chiropractic is no big deal today even, it kind of takes a back seat to physiotherapy- not in my mind it doesn't, but in most people, I think, that is my own opinion. I think that somehow chiropractors have got to get out there and let the world know what is happening.

I: I get a sense form what you are saying that people are ignorant of what chiropractors do to a certain degree, maybe it is due to a lack of a marketing campaign or whatever, but also that people are ignorant of their own bodies and only recognize when something is going on when they are in extreme pain.

R: That is quite true, I mean how many people have you seen walk around like this and I say my back, it is terrible back pain, but they don't know that they can get it fixed. They think it is a time thing. Take anti-inflammatories, deep heat or whatever and they think they are going to get cured quickly.

I: Why did you originally go and see your particular chiropractor?

R: What you must know now that I have been dealing with chiropractors for, I have been in South-Africa for thirty eight years. H.S. Liebenberg, who was one of the first chiropractors up here in Natal, was my chiropractor in East-London. I had a whole host, you can't get an appointment with one, you go to another one. Some guys who went to school with my son, became chiropractors and I went to them to America to go and study. I actually was very keen to go to America and study myself, through a chap called Arthur Middleton. He was prepared to send me. Now my background is that I was a gymnast in Scotland. I was an athlete and a gymnast. I also played soccer. I had back pain and nobody could help me. Nobody even bothered, if you had back pain you could not play. I remember playing soccer and saying to the guy to get a replacement, but in my time you played eleven and if one had to come off, you played ten men. I said to the coach you have to take me off, I cannot take it anymore and there I am trying to play through this thing being ignorant. Then I came to South-Africa, nobody knew about chiropractors, yet my one cousin John, who had had bad knees, had gone to a chiropractor many years ago. I mean I am sixty years old and John is probably fifteen years older than me and this chiropractor word only came back into my memory when I

came back to South-Africa and then I suppose playing sports in South-Africa, I was the border squash champion, I played professional soccer, everything, maybe too much. I hurt my back and someone told me about a chiropractor they knew at the golf club and I went to this guy and I got great relief. So I have been a regular for thirty odd years.

I: When you say you have been a regular, does that imply that you would go for maintenance visits, or would you wait until things got sore.

R: Ja, I realized it now when I go to Rob, I go every month. When I worked for Dorbyl, I had medical aid and that is really when I should have kept going for the maintenance and I didn't, because it is like anything, you are slack, I am ok, I don't need and when something does happen you are back there and you get fixed. I had periods when I did have maintenance, particularly in East-London. I kept myself ok.

I: And you found that to be beneficial?

R: Yup and it was stupidity on my part that I did not continue. Here now with Rob after all these years, there is more to that then what I am telling you of course. Financially, I was going to the Tech., because I could not afford going to people like Hayden Pooke and Rob and stuff. Rob and I have been very good friends for a long time and I have got a deal with him, which helps me financially, so it makes it easier for me to want to do what I have to do. I think the important thing for me is what I have to do.

I: This is a very interesting point that you mention here. So there is an awareness of the benefits of maintenance, but possibly that maintenance care and when you develop clinical signs and symptoms should be scaled at a different rate in terms of repayment. Is that what you would like to see happen?

R: No, I wouldn't know how you would do that. If you go for neck things, is it a different price from a back thing, I don't know on a maintenance thing…you know in China they have a thing that the doctors treat you before you get sick, you know that sort of thing and this is now basically what I am getting with Rob. I have been to chiropractors in this town. Some good ones. The best guys I have been to over the years have been Rob and Hayden Pooke, because they are bigger guys and they can handle me easier. I have been to one woman who was very good as well. But I have been to guys, I mention names, I will tell you after, he could spread a treatment over five days and every time I went to him, it was another bill. Of course the medical aid were paying for that, but they are not going to pay forever. When I go to a chiropractor where I am going to pay after that experience and it is not the one guy, it was maybe two or three others I had that experience with. They prolong the treatment. They stretch the treatment out. They can fix you in one day. I thoroughly believe that, they can get me in a better state than I was in one day, but they stretch the treatment out over five that used to 'p'me off. So when I went to chiropractors after these experiences, I used to say look if you are one these guys that are going to put me in a room, rub some Deep Heat on my back, walk out the room to treat somebody else I another room and then come back ten minutes alter to adjust me and do all this crap, then I don't want to know, I don't want to come to you. That is my…I know the business, I know a lot more about the chiropractic then the average bear. Therefore I am saying to these guys don't stuff me around, get me the treatment I need. That is what I am getting today. I am getting honest treatment. Gus that don't bulldust me and I will go a back an I will recommend them to a lot of people.

I: On those lines then. What does the general consultation consist of?

R: What should it consist of?

I: Yes…

R: There are quite a few aspects to what make me happy now, because I am going to a guy regularly and he knows my body and he is therefore adjusting me according to the progress, what ever he sees as important. So two aspect basically, but then If I went to someone new, they would want to go through my records, which is fair enough, he wants to see where I am

coming from. Have I got x-rays, have I got this have I got that. Yup that is a necessity, I think, but after the first treatment, that kind of falls away. So that the moment I go to Hayden or Rob, they know me. I am there and I am regular with them and I feel comfortable with the fact that they are doing something for me.

I: I suppose I would be referring to your time on Scotland, but did you consult other health care practitioners for your back?

R: Doctors only and one time I went back to Scotland to live for a year, my daughter is backward, so we went to try and get treatment for her. My son was I throws of becoming a professional soccer player and we tried to get him some experience over there and I had a back problem and I went to hospital and I got treatment, but it was physiotherapy.

I: And what was the difference in the experience between the physiotherapist and the chiropractor.

R: At the hospital, they seemed to not care a lot, but they gave me treatment. They gave me ultrasound, but I mean I have had that from a chiropractor, they put me…What else did they do for me? Basically massage and stuff like that, which is lovely it is fantastic to get a massage, I think it is great. When I played professional soccer in Scotland, we used to get a massage once a week, a body massage, legs in particular, thighs and whatever and that was good. I just felt that the treatment was too slow. That is the best way to describe it. I go to Rob, I go any chiropractor. I think that any chiropractor can do for me what Rob does, if they are interested.

I: The manipulation being integral to the process…? Do you think that is what speeds up the process?

R: When I went to Rob recently I was in a bad way and I was going to leave it and leave and then I phoned up Hayden Pooke and I said to him what are you going to charge me for treatment and then I phoned Rob up and I got a completely different response altogether and so I went to Rob and he could, and I can understand it, he not adjust me perfectly the first time so he did his best and he said to me what percentage and I know the percentage have I fixed you had I could give him an idea only, a guestimate as to how much better I felt. As to what I said earlier, there were times when I could go to a chiropractor and I know that what he could do could get me right in one treatment. I understand also that Rob couldn't get me right this time with one treatment. I don't know if it answers that question.

I: So although adjustments or manipulations are used often by chiropractors, there is a situation when the manipulation may not be…

R: Successful, oh yes I could say that Rob battled to get my movement as good as he wanted to and he is a big guy too. Yes, Hayden as well also at times battled, but I would say one thing if someone could come up with some kind of brace or some kind of corsette that you could wear. I mean I have seen my torso come down straight, then kinking to left and kinking to the right and go straight again. Now these guys have gotten me right, but now imagine you are as bad as that. I had a situation where I worked for a particular company, I was in a chair like this and I could not stand up. People had to take that chair away from me, push my bum up and push me shoulders back to straighten me up. Now I just think as somebody who doesn't know your job. I think I know a bit about it, but once they have adjusted you isn't there some kind of thing they can put on you to keep you in the correct position, because aren't we wearing out all the little things by all the pushing back in and I don't' know. I don't know enough about it, I just have a theory in my head.

I: Would it be fair for me to say that with regards to your low back you do not expect a cure?

R: I have been told that it is never going to be correct. I have been told lots of things. I have been told that I have six lower lumbar vertebrae, I have heard that that is a big problem seemingly and extra vertebrae. I feel that the fact that I keep getting it is that I am never going to be a hundred percent cured.

I: so the fact that you go back to your chiropractor, because you get reduction of your symptoms also that the treatment works fairly quickly. Would it be fair to say that if you are not getting a cure then what it is doing for you is improving your quality of life very quickly.

R: They certainly improve my quality of life. I have gone to him in chronic pain and I have a golf match the next day and I am thinking that I am never going to be able to play and I go in there and he treats me and I can play golf and I don't have after effects. I had a situation some years ago where I was doing gym. Opened the gym at five o'clock in the morning with my son and you would do an exercise and you would get smart, you know, and I rolled of this machine and put my back out and hurt my shoulder that the same time and ended up with H.S. Liebenberg. H.S. gave me chiropractic treatment, he stretched me, he had a masseuse that worked for him full time and I played golf the next day it was a big competition and he was a golfing friend by the way and so he knew how important it was. Well not only did I play golf, but I won the competition. So I mean I always have good things to say.

I: It may be a slightly unfair question. First of all do you see a GP on a regular basis? Or do you see a GP from time to time.

R: No I see a GP, he is a very good friend of mine, whenever I need to see a GP. If I didn't need to see him I would never go.
I: Well then I can ask the question. How is your relationship different with your chiropractor as opposed to your GP as the example of mainstream medicine that you come into contact with fairly frequently?

R: Are you saying to me if the GP gave me anti-inflammatories.

I: I am interested in you report with your GP and the fact that he is a friend of yours kind of complicates matters slightly.

R: He is like Rob, he is a friend like Rob.

I: What is the difference between the relationship you have with your chiropractor as opposed to the GP. In your instance it may be nothing.

R: No nothing, none at all.

I: During the treatment/management process, does your chiropractor explain to you what he is trying to achieve with the management protocol.

R: Yes, Rob has always enlightened me as to what he is trying to do, what he is going to do, what he, what he hopes to achieve. This last period, over this last nine months, I have actually felt better, less pain in my leg, not because he has been telling what he is going to, it is because he has been doing it and I have been going back for that regular maintenance thing and I think it is the most important thing.

I: How does that make you feel in terms of your condition, in terms of the back pain?

R: I am feeling better more regularly, I don't have. I you have had the kind of pain like I have, it is like a tooth ache, it is really not a nice thing and sometimes you can't move properly, you have got to be careful when you do certain things. Yes, I am still careful when I get into the care I sit down nicely and I swing my legs in and do all of that stuff. It makes me more aware of the things I can do wring with my body, and when I am right I like to stay right, so i am more cognizant of what he has done for me.

I: Do you think that chiropractors and GP's get similar types of training?

R: I would think that we have been led to believe that GP's have a more structured and longer period and more intense training, more in-depth training than you guys. I think that is the perception that the public has got.

I: and in your view?

R: Well, I would go along that route. It is my personal feeling that the GP probably has, I am battling for the words here, that he has got a more in-depth training with regards to what they can do for the human being and I would never want to be a GP.

I: Yes, I suppose it is a difficult question to ask and answer, because it requires some sort of knowledge on your behalf with regards to education and the education system in the country and so on…Lets talk then specifically about the back pain. When it comes to the management of back pain, how would you view the professions relative ability to cope with…
R: To treat it? Look, Rob treats me and I also could get anti-inflammatories, I don't know if I could get a prescription from Rob, but if I could I would get it, if I want it from him. But I would go to Dave, my GP, and get the anti-inflammatories. I think that…yes if I am going to look for pain relief for my back, I am going to go to Rob, that is where I would go first.

I: and I am not trying to force an answer out of you in terms of the direction, it is just interesting that there is a view with regards to education, but somehow it does not quite tally up with what people end up doing when they go to the chiropractor, because the back pain is what the chiropractors tend top deal with and one would assume that therefore they get trained…

R: Yes, the public have a misconception about people who go and train as chiropractors, what is the degree of education they have had prior to going to university to become a doctor or to become a…Is that what you are talking about?

I: Yes that is something that I would be interested to know about.

R: Well I feel that anybody, I don't know why I have this feeling, but I think that anybody can become a chiropractor, where as I know that to become a doctor, you have to have a certain prior education. That is my feeling, Not to knock the present people who are doing the job, but I have just seen from… I have never been involved with people at universities, doctors, but I have been involved with the Technikon and the guys who go around there and I think to myself. I don't know what degree of education they have, besides my conception.

I: Do you feel confident with your chiropractor's ability to deal with your problem?

R: Do I feel confident? No matter what chiropractor I went to, I think to a certain degree I felt confident with most of them, but I certainly feel 100% confident with the guy I am going to now.

I: Do you think mainstream medicine and chiropractic see eye to eye in South-Africa?

R: I believe lately, I believe there has been a change. This is just something I have picked up among chiropractors and doctors that there seems to be more respect for one another. I think that chiropractors are now looked on differently from the medical profession, the medical profession as GP's ok. I see that among my friends at the golf club. There are a lot of chiropractors, Ray Rethman, Basil Duke.

I: Why do you think that is?

R: I think possibly among peers and so on that what the mouth thinks has gotten back to the GP that they are getting good treatment. I mean if I am getting bad treatment form Rob, I would tell everybody that the bloody chiropractors are a waste of time, but if I am getting good treatment, which I am getting, no matter which chiropractor I have gone to, I could say don't go to this guy, because I have had a bad experience with him, but not because he couldn't fix me, but because he prolonged the treatment and he is ripping me off.

I: So it is the ethics of the matter.

R: The bottom line is he is going to fix me. I could go to GP's and I had tonsillitis for years and years and eventually I went to this friend who, an African doctor, who said to me you are wasting your time, you have a pocket of mucous in you tonsils and it is closed up and you are never going to fix it and we are going to try one anti-biotic and if it doesn't work I am going to take your tonsils out. He took my tonsils out and I have hardly had a sore throat since. All these others guys, my own GP he was a Scotsman to, he just kept on giving me different medication you know.

I: What I am getting from you is that no matter what the profession, there are good and bad practitioners within them…

R: Oh yes very much so.

I: But that the chiropractic profession on the whole has stabilized I its role in South-Africa?

R: Yes, I think so, from the people in my circle that now go to chiropractors, I think the opinions have changed. Now my wife's opinion is not the same. She just does not believe that people can manipulate a body like that and you will be ok, but she has seen me and she has known how bad I have been, but she has got this blinker thing. Until one day I can talk her into going to get some treatment.

I: we mentioned it briefly earlier on and that was the issue of maintenance care. How did your chiropractor approach that aspect of the management with you? How did it come about?

R: Now or generally?

I: Whatever you prefer.

R: I would walk out the door fixed, but prior to that I would already have the appointments fixed and I kept saying to myself why? I then became dubious as to what his motives were and then I had this opinion that it was a scam with regards to the amount of times I had to go there. That was a particular chiropractor, then you go to decent guys and they give you the treatment and they explain things nicely to you, like the other guy to a certain degree has done as well, but there is no bulldust. It is, you know Ray this is the story and you have got to believe in this guy and you back and today that is the story. I am back now to the stage that I am looking forward to going back for him to tell me that my back is fine and that I may not need an adjustment and the last time I was back at Rob he felt it was much easier to adjust me and much less to adjust. Now that helps me, mentally I now feeling that something good is happening and that I am going to be better and therefore at the end of the tunnel I think maybe one day I am going to go in there and he is going to tell me you know Ray there is not much to do to you today.

I: Would it therefore be fair of me to say that you are becoming more aware now of how well you are and that you have to stay in the wellness band as opposed to dropping through the floor into being ill.

R: Like I said earlier, the pain in my buttocks and down my leg and across the bottom of my back is not there as often and that is nice. It is nice to get up from my bed in the morning, do a couple of exercises and not feel it. Ok I am stiff, but at my age I think I am going to be stiff, but I am feeling an awful lot better. I must say that I go to golf and I warm up a bit and I am not as stiff as I used to be. You now I also have my own theories and things. I feel better, therefore if I keep going back I am hopefully going to stay better. As I said earlier though, I don't think I am going to be a 100%, maybe it is because it has been left too long and I am thinking though that just maybe with the right kind of treatment it van be 100%.

I: I thank you very much for your time.

Patient interview 4:

You thank the patient for taking the time out to do the interview and do a sound check at the same time.

I: I think what I will do is start you off with the general and easy question. What do you think chiropractors do?

R: Well I would agree that that has actually changed over the years, they put the body back into alignment, but there is more muscle work involved now. Where as before you used to go and they used to just click you back into place, now there seems to be they relax the muscles first and do various other things before they actually get to putting the actual vertebra back into place.

I: But the main scope of what they do is still very much related to joints and muscles and that sort of thing, so the musculo-skeletal system.

R: Yes.

I: Why did you go and see a chiropractor initially?

R: I have always had a stiff neck. My tension goes to my neck and I tend to get headaches, so that is why I initially went and my lower back also goes out quite a lot.

I: When you say it goes out what do you mean by that term?

R: Ok. That the vertebrae actually get out of alignment, actually crushing the nerve and that is why it is giving me some pain.

I: When you get back pain, is it accompanied by leg pain as well or is it just sort of in the area?

R: No not leg pain no, just like lower back. I don't think it is anything major.

I: Did you before you consulted your chiropractor see another healthcare practitioner for your back pain?

R: No.

I: So you went straight to the chiropractor for your back pain? Now that is interesting.

R: Yes, mainly for my neck though.

I: So, you went straight to the chiropractor and then it kind of developed…

R: Yes, I said:" My back, oh my back is also sore'' kind of thing.

I: Ok. That is very interesting, because it has been my perception that a lot of people end up at the chiropractor as a last resort, not as their first, so it is very interesting to hear that you started off there. Do you think that there was a particular reason for that, do you have family or friends that you…
R: I am trying to think back now…

I: so a referral by a friend most probably, it definitely wasn't pick up the yellow pages…

R: No no.

I: Do you think that your back pain will ever get cured?

R: If I did the exercises yes (laughter). If I did enough exercise it would probably solve the problem, because what I am tending to do now before I go to Heidi is have a massage once a month and then the neck is not so bad, because when my neck gets stiff it really gets stiff. What happens with me is I don't have a lot of pain, but it gets very very stuck, so by the time I go to her when it is hurting me a little bit then it is really severe.

I: it is very interesting for me to hear that you are integrating the massage therapy and using it in conjunction with chiropractic, you are quite an advanced patient actually…

R: I also go to a Homeopath.

I: well once again. You are…

R: I think about it.

I: So you are very comfortable with complementary and alternative medicine?

R: Yes very much so.

I: why do you think that is?

R: I think perhaps it started off with my daughter when she was little, she was on a whole lot of anti-biotics and she just kept on getting sick, so I eventually started her on Homeopathy and took her over to Homeopathy completely and the chiropractic I don't know, it just seemed more logical, if you have something wrong with you neck you should go to person who can sort it out, you don't go to your GP all the time.

I: The question that I am going to ask you now makes the assumption that you do have a GP or a family doctor.

R: Well I only have a family homeopath. I only see the homeopath.

I: Right well then how your relationship differs with your chiropractor as opposed to the GP as an example of mainstream medicine kind of falls away.

R: Ya, I used to go to a doctor, but that has kind of fallen away.

I: All right then describe for me your relationship with your chiropractor. What makes you go back time after time for treatment?

R: Because it actually brings relief to the problem and I know that my tension goes to my neck and after a while that tension is going to build up again, so it needs to be released and the spine needs to get back in line again. So, it is not that the treatment isn't working, it is that I am doing is stiffening it up again.

I: So the perception then from your side is that life stress will happen…

R: Oh yes and you have got to find a way to deal with it and this is one of the ways of dealing with it.

I: I am asking you to speak for other people to a certain degree, but do you think that the use of things like anti-inflammatories and other medication are a root that some people choose…

R: Yes, it is quicker and easier.

I: Why is it easier?

R: You just go and buy the tablets and you have them, you don't have to make the effort to make the appointment, go and perhaps go back again to have it properly sorted. It is quicker to take the tablet.

I: effects in the long run?

R: No it is bad for your system, I mean your stomach lining…

I: Has your chiropractor explained to you what he/she is trying to achieve with you management?

R: Yes.

I: What do you understand by that?

R: She has given me all sorts of exercises to do for lower back and for my neck and given me advice on doing proper exercise and things like that.

I: So those are all things that are adjunct to the types of things that she would do herself?

R: Yes.

I: How does that make you feel to have that responsibility of having to do the exercises?

R: I much prefer it, because it means I have more control of what is happening to me and I am quite happy for that. Because then it seems that they are actually looking for a long-term solution to your problem, they are not just making you come back all the time. You actually can do something to help your situation along. And if you don't do it, like I don't do it, then you…

I: Then what you revert back to having symptoms?

R: Ja, then you have to have your neck put back in again.

I: The issue of control, and you mentioned that you feel like you have control. What is the effect that that has on you?
R: It means that if you don't take the advice, what follows after that is your responsibility, it is not the chiropractor's responsibility. So if you do the exercise, it will improve, but if you don't, it is going to get stiff again and it is your own fault. So I think responsibility is probably a better word than control.

I: And do you think that it is a fair situation?

R: Yes, I think so, because then you are more involved in getting yourself better. It is not a matter of somebody waving a magic wand and making you better. You have got to see it more holistically, it is the whole system and…

I: Ok. Well being involved or being an active patient is something that has been bantered around in the literature that it is a good thing and at the end of the day what does it mean to you in terms of medical aids for example. Do you think medical aids cater for active patients as opposed to ones that just take the tablet?

R: Shoe, I don't actually know. I don't know too much about the medical aids.

I: Ok no problem. Do you feel confident and satisfied with your chiropractor's ability to deal with your problems?

R: Yes.

I: Where do you think that confidence stems from?

R: well I think she knows what she is talking about, and I know a littler bit myself and whatever she tells me fits into my frame of reference. So it seems to make sense what she is telling me.

I: Your frame of reference, I suspect is broader than the average persons, having your family chiropractor and family Homeopath, I don't think is the situation in every South-African home.

R: (Laughter) No I don't think so either.

I: That frame of reference is of interest to me, because I would like to know how it came about that you developed such a progressive, I am going to call it progressive, because it is just so out of the ordinary, view. Has it got to do with getting exasperated with the system as it was?

R: No, all I can see is that it is a progression of my whole growth as a person. We are actually getting into more am more alternative stuff as I am going along. I mean I am actually doing a course as a natural healer myself at the moment. It is just like laying on of hands and transferring energy to heal people. You know I am going off into that direction, so I think it is all just part of the growth process that I am going through and that everyone in the family sort of just has to go along with (laughter).

I: I see, I see.

I: Do you think that mainstream medicine and lets just once again use GP's as our example see eye to eye in South-Africa today?

R: No. I don't think so, I think some doctors are good, some are open-minded, but I think a lot of them are still closed-minded.

I: Where does that come from? The closed-mindedness?

R: I think they like to think they have the answer to everything and I think it is also the way they are taught and they are taught to think. A lot of people just think like this, where you have to think laterally, if you really want to understand what is going on in the world. A lot of people have their one direction and you can stand on you head, you can do anything, but they are just blinkered.

I: you don't think it has anything to do with competition or anything like that, it is just the system they have grown up in?

R: I think competition probably comes into it, but also they think they know better then anybody else.

I: So it is an ego thing more than anything else?

R: I don't know.

I: Ok, I don't want to put words into your m mouth, so we will just stay wit they think they know better.

R: You know I am not really into ego, so I don't know.

I: Ok. Has your chiropractor ever discussed their particular view of health with you? So a little bit of philosophy or something like that?

R: No (laugher), we usually chat about the family.

I: It is an interesting thing that you mention that you most often have chats about the family, so the assumption that one has to make is that you have a relatively close relationship with your chiropractor?

R: Yes, actually started going to Heidi before she became the nextdoor neighbour.

I: Have you ever discussed the issue of maintenance care?

R: I don't think so, but I thought that the exercise and stuff was like maintenance?

I: Ok, so that is your interpretation of what maintenance is all about, is the homework part of it?

R: Yes.

I: Never had a discussion along the lines that it is a good idea to come and see me every six weeks or so we can make sure that everything is still in tact that sort of thing?

R: Yes, if there is like a specific problem with the neck, then I will go like the last time when I went three or four times and then by the fourth time I was well enough so that I could carry on on my own.

I: And then the homework sets in or it does not set on depending what is going on?

R Yes (laughter).

I: Is there a pre-arranged time for when you should go back, or is it just go back when the symptoms start again?

R: Now that my neck is getting better, I actually go when it is getting very stuck or when I am getting a migraine.

I: Do you think that you are better now at identifying when it is time to go back?

R: Yes and I am going back less often now, because initially with my neck ten to fifteen years ago I was sometimes going one or twice a week.

I: If I may ask what do you use as an indicator that it is time to go back?

R: Usually when I am getting a migraine or if my neck is starting to get a bit stiff.

I: What does stiffness mean to you?

R: It is just a niggly feeling, because by the time I get to Heidi she can't believe it.

I: The reason why I ask is that there is a perception that, because of the healthcare system, and you seem to be an outlier with regards to that, is that people are only aware that things are going wrong when they dip below the health line and the are now ill. Then they recognize that oops I had better do something about this.

R: Oh yes, I used to be like that, but I have become better.

I: So you have become more refined?

R: Yes I would say so.

I: I thank you for your time.

Patient interview 5:

You welcome the patient and explain the context of the interview again.

I: Karin thanks very much for agreeing to do this interview with me. I think I'll start you off with a general question. What in your experience as a patient do chiropractors do?

R: I think they adjust people's backs, especially pain, in terms of lower back, that s my knowledge.

I: And the particular area that they tend to concentrate on, you have mentioned lower back?

R: Ja, lower back, neck, spine, the whole spine, ankles, knees, specifically joints and those kinds of things.

I: And you mentioned adjustment and manipulation…

R: Especially there of.

I: So that would be the hallmark or trademark tool that they use, would that be correct?

R: Yup, their specialization field.

I: Why did you se a chiropractor initially?

R: Basically I had severe lower back pain, but mostly on the one side where I couldn't sit and I went to the chiropractor and he reckoned that it could be a lumbar sic bulge maybe from coughing I remember that I had bronchial asthma during that time and a lot of coughing during the night and that could have caused that aggravation there and it was aggravating pain and I had to go and see, ja.

I: And in the context of this lower back pain then, did you go straight to a chiropractor or did you go to other health care practitioners before you got to the chiropractor.

R: Look Roy Mitchell always used to treat my back prior to when I, he used to do acupuncture on my back, so I have got quite a good idea when something goes wring with my back, he taught me quite well where there are spasms and I think it is now the past two or three or four years that I have been fine, but no I went straight to a chiropractor. I think maybe it is because of the position I am in and gained more knowledge about what chiropractors do and therefore went there.

I: So what you are basically saying is that because you have insider knowledge of the chiropractic profession through the Technikon and that sort of thing…

R: I think so yes, that might have played an important role, the fact that I have gained more knowledge.

I: So a GP or mainstream medicine didn't even come into the equation for you?

R: No, because I remember about four, five… no about seven years ago GP's couldn't really, because all the give you is Voltarens and that didn't help until I got to Roy Mitchell and I have to give him credit he…ja it is alternative and it worked for me.

I: In general how would you describe your relationship with your chiropractor, in the context of is it very different from the one with lets say your GP as an example of mainstream medicine?

R: Yes, I think so it is not so formal, it is far more informal, more relaxed. It is longer intervention, where as with your GP it is fifteen minutes and you are out. Where I think the diagnosis I think takes a little bit of time with your chiropractor, which is not necessarily wrong. You are more comfortable.

I: what do you think the effect is of the less formal relationship?

R: It puts you at ease and maybe, you are more comfortable.

I: Does the comfort factor somehow have an effect on how you respond to treatment or is it just…

R: I think so ja, I think you are a little bit more relaxed, because there is a trust relationship and you know that the person is going to do something with your back for which he ahs to build a report in order for you to relax. I think if you go in and adjust immediately, I don't think I would have been that relaxed, I would probably be quite tense.

I: are you saying that because the manipulation involves clicking of the back you need to have that relationship in order for you to…?

R: Yes, because I don't trust easily, so therefore I would tense up whereas if you take time with me, I remember with Roy Mitchell he took time until you relax.

I: well it is an interesting thing, because Roy Mitchell isn't a chiropractor…

R: No, but he didn't do chiropractic, he did more acupuncture and Bowden therapy. So his approach is slightly different and magnetism, but it is still alternative.

I: Yes, so therefore it is a very thing you mention in that there may be a common thread within complementary and alternative medicine in that the trust relationship is necessary.

R: No definitely, if you go to Roy Mitchell you are there for probably for an hour and a half and sometimes longer until such time ad he knows that you are relaxed.

I: And the fact that the intervention is longer, you mentioned that you were in and out with the GP in fifteen minutes, do you think that it has an effect on you first of all in how you respond and then secondly your response to what happens. Is there a view that a longer intervention equates to a better intervention?

R: I think the diagnosis is thorough, because I remember my initial session with the chiropractor was quite a long session in the sense that there was a lot of questions, diagnosis, it took longer.

I: And that makes you feel comfortable?

R: Yes, especially with the type of questions, you could see that the patient knew what he was talking about.

I: Has your chiropractor explained to you what he or she is trying to achieve through the management process?

R: Yes very much so. I think quite well throughout the process he would explain to me what he is going to do next, possibly what is wrong with me and whatever and I appreciated that.

I: Why did you appreciate it or what was the effect of it?

R: Because at least I knew what was going on and it was not a surprise when he started adjusting without introducing me to… I don't think I would have been comfortable if he did not do that.

I: So the knowledge of what is happening in the process does have a positive effect on you?

R: Yes, very much so, that is what I also appreciated about Roy Mitchell, his approach is very similar.

I: Do you think that chiropractors and GP's get similar training?

R: I think there is some overlapping, but not totally, because they specialize in different fields, I think chiropractors go more the alternative route, but there is some overlapping. There should be, because it is about people working with the human body, you know anatomy, those kinds of things.

I: Do you regard the two professions as equivalent?

R: I think they could be complementary.

I: In what sense?

R: I think that chiropractors could be involved with chronic pain, where as a GP, especially in chronic pain, cannot see results and then could refer to a chiropractor. Especially in terms of lower back pain or specific to chiropractic.

I: It is an interesting interpretation that you have. There is another way of looking at the question that I have just asked and that is in terms of status, do you think the professions are equivalent?

R: Hmmm, that is a difficult one. Status as to how I perceive status or status as people in general perceive it?

I: Well as a chiropractic patient, if you look at your chiropractor and you look at your GP and they are both professionals or do you see them one higher than the other?

R: No I see them at the same level.
I: Can you give me a reason for that?

R: Because they are professionals in their own field. Maybe because I have been involved with alternative medicine for so many years and myself in so-called alternative medicine…

I: You are referring to your own profession?

R: Yes as a psychologist. To be honest with you, if you say to me if you say to me chiropractor as compared to example a specialist in medicine. So you if you say to me a specialist compared to chiropractic, then I will see a difference there. I don't know… that is just my perception. People like your GP that studies further, your anethetists, that sort of thing, but that is specialization.

I: How confident are you in your chiropractors ability to deal with your problem?

R: I am pretty confident. It has worked so far.

I: So your confidence is very much related to the fact that in previous episodes you have had good results?

R: Yes, but I have to…maybe because of what I have gone through over the past seven years with different people, I personally think that chiropractors could have a bit more of an holistic approach. Not that I want to compare, but I must be honest with you that Roy Mitchell has got a very holistic approach. When I look at the way he diagnoses in comparison to how chiropractors diagnose. I think they should be a little bit more holistic.

I: What do you think the reasons are for, if they are not holistic, for being reductionistic in the way they go about things?

R: I don't know maybe it could be related to their training?

I: Do you think it is possible that in the South-African context the reason could be, because they have had to fit into the medical fraternity and therefore their training has been influenced by that?

R: I don't think so; it is something that I have been thinking about for some time. It can, if I look at the homeopaths, their approach is quite holistic, but their angle is different, where as I think you are right, it is more about fitting in with the medical. It could be, but I never thought about it.

I: As the chiropractic paradigm has developed it has had to take into account the way medicine does research and the way that medicine looks at the world and all that sort of stuff and has kind of had to fit in.

R: Or that they see themselves more in a closed circle, that is the impression I am getting.

I: When you say closed circle do you mean they see themselves as a sort of GP that deals with muscles and joints and that sort of thing?

R: Yes that is it.

I: That worries you?

R: Yes definitely, because in my own practice I believe in a holistic approach, because I have been trained like that, so when I approach a particular problem I would look at it very differently to a pure fundamentalist who would just diagnose one thing, I have been trained to look a little bit broader than that and if it is out of my scope, I would refer or have a multi-disciplinary approach.

I: So the way that chiropractors can become more holistic, in your interpretation is to act other professionals?

R: Yes, very much so.

I: That is the main thing/

R: For me yes, in other words if I…Look I a am not a chiropractor, but I just feel that when the diagnosis takes place that if you feel that there might be other issues that other multi-disciplinary fields should be pulled in or consulted. Let me give you an example. If I look at an ADD child, I know that I have certain limitations in my field, so I will refer that child to a pediatrician, but we will consult multi-disciplinary, because he will ask for my assessment, because he respects my field and I respect his field and in terms of that we will consult and he will phone me as much as I will phone him. So it is very much multi-disciplinary approach to diagnosing the problem, but that is just my practice.

I: Is it possible though that the reason for that lack of integration is because of the history of chiropractors in that they have only recently, say in the last fifteen or so years, become more and more part of the health care system and that they didn't traditionally form part of the tea, so to speak.

R: Yes I think so, because it is a young profession and therefore it could be.

I: do you think that mainstream medicine and chiropractors see eye to eye in South Africa today?

R: I don't think so. I think there is still a bit of antagonism, whether it is fear for competition, but I get the impression that general practitioners are hesitant to refer to chiropractors.

I: What do you think that is based on?

R: I think it is a fear of competition or lack of knowledge of what chiropractic really is, so ignorance.

I: The competition that may or may not be there, it could actually just be a perception and GP's and chiropractors…

R: I really think that it is just a perception.

I: Has your chiropractor ever discussed his or her own views on health care with you, so a little bit of philosophy and that sort of stuff?

R: Not much.

I: Maybe that would be one of the reasons for the previous issues, is because the lack of discussion?

R: Yes, there was no…he focused more on the problem and didn't really talk around the philosophical issues in the filed of chiropractic.

I: The issue of maintenance care did that ever come up. That you maintain your state of wellness and that it is a good thing to have adjustments on a regular basis. Did that ever come up?

R: He didn't say adjustments on a regular basis, but he did talk about stretching, he did give me exercises to do on the Palates ball. To stretch and maintain and he did say that if it recurred that I should come back, but he did not insists that I come back on a regular basis.

I: So the recommendation was that if the symptoms reappear then come and see me, but do x, y and z to keep yourself in good nick?

R: Yes and what I liked was that he said it was going to be sore at such and such a stage and that he predicted what would happen during the state of healing.

I: How did that prediction make you feel?

R: More comfortable, because I would not panic then if I do feel that something is sore, because he did say that it would be sore and then it would ease. One thing that I can remember with Roy Mitchell was that yes for three days it is going to be tender, because of the acupuncture and that made me feel comfortable.

I: And this was something that you experienced with the chiropractors as well?

R: Yes.

I: Karin I thank you for your time.

Patient interview 6:

You thank the respondent for agreeing to conduct the interview with you and once again explain the context discussion.

I: Carol I think I will start you off with a general question to get you I the groove so to speak. What do you think chiropractors do?

R: I think it is not just do adjustments and massage, I think it is more of a wellness, more general health not just treating specific problems to the whole skeletal system.

I: Would you say form your experience that chiropractors focus mainly on the skeletal system/

R: No, not really, not in my experience.

I: Well your experience is exactly what I am after, so why do you say that?

R: Because for me personally it helped me with a lot of things. Just my lifestyle, the reasons it was happening. It wasn't just going to have it sorted out it was also to prevent it happening and that sort of thing. It makes you more aware of what you are doing wrong; more of a lifestyle…change your lifestyle.

I: So you connect chiropractors strongly with the ideals of holism and wellness practice?

R: Yes health industry generally.

I: Why did you end up seeing your chiropractor initially?

R: Now he was recommended to me, because I had been seeing physiotherapists and I wasn't getting enough results, but I had also seen a chiropractor years ago and I wasn't fully convinced, but I think the more modern or the training today is much better than what it was years ago. So I prefer going to the more up to date chiropractors from my point of view and so I recommended to go to someone who had just qualified ands that is what I did.

I: But you had gone through the traditional medical route first, to your GP or someone like that?

R: Yes, GP, physio…

I: So the chiropractor wasn't your first port of call?

R: No.

I: Do you recall where they fitted in? 1,2,3,12…?

R: No out of what out 10, what do you mean?

I: No I mean in terms of the practitioners that you saw, you didn't see the chiropractor first…

R: Say three.

I: The discussion is taking place in the context of back pain. For that particular area, do you expect to get a cure for your back ache?

R: For the pain or for the problem?

I: we can talk about both.

R: If we are talking about degeneration you can't have a permanent cure, but you can look after it in a way that you will help or prevent the pain.

I: So pain yes, cure probably not.

R: Yes, realistically.

I: How would you in general describe the relationship that you have with your chiropractor?

R: Very good. Very trusting, in that I wouldn't let anybody else, if you are talking necks, I wouldn't let anybody else touch my neck. I wouldn't even let anybody massage my neck.

I: Now how is that different to the relationship with your GP, for argument sake?

R: Oh the GP is too general. You have got to go to a specialist. So as far as I am concerned I would rather go and see someone who has studied that only.

I: In your opinion of trust comes in…

R: Hugely...

I: with somebody who has worked and specialized in that particular area.

R: Ja, absolutely.

I: Your chiropractor, have they tried to explain with your management throughout the last while, what they are doing or what they are trying to achieve?

R: Maybe chiropractors in the early days no, but in recent years yes.

I: Very briefly, what was the plan, or what is the plan with the management of the back and you can include your neck as well, if you want to.

R: Posture, the way I work and maintain it, strengthen it.

I: You are in a fairly high stress occupation for that sort of thing, because of the somatology.

R: Yes.

I: So a lot of management was geared towards…?

R: Towards my profession and my lifestyle.

I: What do you think qualifies the chiropractor to be able to sort those things out with you? To be able to discuss posture, to look at ergonomics etc.?

R: I think he can relate to our industry very well and from his own way of working he can advise us.

I: Why do chiropractors link up with somatology closely do you think?

R: I don't know they seem to go hand in hand.

I: Why do think a somatologist and a chiropractor would gel better than a GP and a somatologist?

R: I just think the GP is too general medical, where as here we are talking posture, which is related to the way we work and the way we bend. I mean therapists generally end up with chiropractors or physios.

I: Do you think that chiropractors and GP's and I am sorry I am harping on about the GP's; I am just using them as an example of mainstream medicine. Do they get similar types of training?

R: Not at all.

I: How do they differ?

R: I would say GP's research medicines more, much more, where as chiropractic has got nothing to do with medication really.

I: So medicine as in pharmacology and that sort of thing?

R: Yes the drugs.

I: So besides the drugs and it would be relatively easy to see why chiropractors don't use it, because they use manual therapy, so besides the tools that they apply are there any other differences?

R: I think GP's should refer patients to chiropractors and I don't know if they do.

I: In terms of training specifically not inter…

R: You mean does the chiropractor have enough medical background? I would say that when they qualify they know what they need to know clinically.

I: How much do you know about chiropractic education in South Africa?

R: Not that much.

I: Any idea how long they study for?

R: Six years? Am I right?

I: Yes.

R: They get a lot of hands on, which is good.

I: It is good that you know how long they study for that is a very good patient.

R: Hmmm (laughter).

I: Do you regard chiropractors and GP's as equal professionals?

R: That is an interesting one. Not really, because it is only in recent years that chiropractic has sort of started climbing the ladder in recognition. So I would say 'no' it hasn't been, but it will get there. It could be getting there; there is a definite place for it.

I: I just want to get this straight then; you are saying that chiropractors could get there in the sense of the standing of the profession?

R: Yes.

I: Ok and where do you think they will peak or fit in terms of the hierarchy of the medical system?

R: You mean next to what?

I: Yes.

R: Well physios. I think that the chiropractors and the physios are working much closer than they did before and I think that it has become a completely different profession from when I knew it before. You either saw a chiropractor or you saw a physiotherapist, you didn't do both

and that has changed a lot since then. So I think physios are very well recognized and I think chiropractors lie just below physios in terms of their recognition as it stands today.

I: And in terms of training?

R: In terms of training, I would say equal absolutely, if not better.

I: All right it is interesting to see where about the fit in. How confident are you in your chiropractor's ability to deal with your conditions?

R: Are you talking about one specific chiropractor or in general? Some are better than others and some are better with specific problems definitely. I have been disappointed with my results before where I was referred where I did not think it was necessary to refer me. I think that they could be a little bit over cautious sometimes.

I: Oh that is very interesting, so the fact that the chiropractor referred you before you were ready disappointed you?

R: Yes and reduced my confidence.

I: That is fair comment. Let's talk about you low back for a moment. You said that you don't expect a cure, why do you go back to the chiropractor?

R: It is not so much that I don't expect a cure it is that you have to maintain your back. It is just that once you have had back pain, you always have to look after it. So you need to go for regular maintenance, because the inflammation comes and goes. Whatever, the nerve entrapment etc.

I: To what degree do you think chiropractors and mainstream medicine see eye to eye in South Africa today, if at all?

R: I don't know that is a hard one. I think in the last three to four years, the gap has closed a lot. I think chiropractors have got a lot more respect in the whole health industry and I think you'll find a lot more doctors referring, I think they were scared to previously. Definitely, that I would say.

I: This 'scared to' what do think that was all about?

R: As if the chiropractors were not qualified enough or didn't know enough or maybe doing the wrong things and now the doctors are actually being educated enough to know that chiropractic education is actually superb, especially in this country.

I: Ok, how do you think the GP's were to act if they were educated with regards to the levels of education in this country and they found out that in fact chiropractors were more highly qualified than they were?

R: It would shock them, because I reckon half of them don't realize that.

I: Do you think that it may have a negative effect, a sort of a rebound?

R: No I think it is very positive, because today GP's are almost old fashioned, because people go to specialists. GP's are referral doctors that is the way I see it.

I: So pretty much gatekeepers and they pretty much send people along.

R: Yes.

I: You spoke about maintenance earlier on. Have you ever specifically spoken to your chiropractor about his or her view on healthcare, so like a little bit of philosophy.

R: Yes lots.

I: And do you recall what sort of a view they have

R: Yes.

I: Can you elaborate on that?

R: Lifestyle management all that type of thing. General health, exercise, strengthening. Very much exercise in my case.
I: So essentially then it goes back to looking at things from a holistic point of view and wellness practice and that sort of thing?

R: Definitely it goes hand in hand.

I: Have you ever discussed maintenance care with your chiropractor form the point of view that you need to have x number of consultations over certain period of time?

R: yes I have done that before, specifically in the early days it was so many treatments per week, per month whatever and then maintenance.

I: And you were happy with that?

R: Yes, because it helped.

I: The issue of trust in the relationship with the chiropractor, I have come across the notion from previous interviews that people feel that their relationship with their chiropractor is less formal than with the GP. Have you ever felt that?

R: No not necessarily I think it depends on the person.

I: Carol, I thank you for your time.
