The Common Sense Chiropractor

By Marc Heller, DC

Once a year, my editor permits me to stray from my niche of soft-tissue and low-force technique, and wax philosophic.

Dear reader, you can read on or move on.

Chiropractic assessment is full of “soft findings.” These findings have become even softer as we have learned we cannot necessarily isolate a single segment with either palpation or adjustment, and cannot agree on what joints are fixated, etc.

In our profession (along with other professions that deal with pain), solid evidence of “what to do for what condition” is still in its infancy. There are very few gold standards in our line of work.

I appreciate those who attempt to move us toward being evidence based. I would highly recommend all of you take a look at, or better yet, join an online discussion group for chiropractors and students, such as Spinedocs (**www.spinedocsonline.com**).

I don’t believe I can really practice evidence-based chiropractic; I prefer the term *evidence-informed.* There are few studies that show that (BLANK) is consistently associated with effective treatment of back pain. What is the BLANK? Fill it in yourself. For me, it would include the 30 to 50 things I check when someone has back pain. I would include foot-joint dysfunction, tight and/or weak muscles in the back or lower extremity, ligamentous laxity, poor timing of core-muscle firing, along with many others. There is evidence for some of what we do, but by no means all of what we do.

Evidence-based medicine, at its worst, is a one-size-fits-all approach. For this condition, use that therapy. Or worse yet, the insurance company doesn’t pay for that treatment, since there is insufficient evidence to support it. Don’t get me wrong. I appreciate what the evidence has given us, and my practice has changed in a positive way from incorporating what the evidence has shown us.

In my opinion, if you want to be most effective at musculoskeletal care, you have to be willing to live in the uncertainty, the not knowing and the constant feedback from your patients. You have to be willing to run mini-clinical trials. I think the patient has condition X, with variation Y. My experience and the literature say that using treatment Z has been effective. So, give it a try for a few treatments and see how the patient responds. If they are moving in the right direction, continue on that path. If not, change and try something else. You have to be willing to give up; to know you can’t help everyone.

Also, the patients who say, “I’m a little better” or “I got two hours of relief,” and whose VAS score stays the same, are not getting better. They may be trying to make you, the

doctor, feel better. Don't count it as improvement. You have to be intellectually honest. You have to know when you are failing in order to move forward and figure out something else that may help this patient get better.

Common sense also means listening to the patient, not just to your own belief systems. I suspect that at least 30 percent of the benefits I give patients come from my "common sense" advice after taking the time to listen to what they're saying. I believe we all need to learn to "listen to our muse" and empower our patients to pay attention to their lives and intuitions. Their feedback from their life is powerful healing medicine.

They tell you they're in pain after every weekend? What are they doing on the weekend that could make them worse? They're splitting wood, playing basketball, whatever. Tell them to change the activities, stop entirely or figure out a way to get in shape to continue. Did they sit on the floor addressing invitations? That leaves them stuck in a severely bent-forward position with bulging discs. No wonder they're hurt.

I also believe we shape our practices and our patient base by what we believe and what we do. If you think the adjustment is the whole answer, you likely are to attract patients who are more passive, or even worse, convince patients to be more passive and that all they need for better health is more adjustments. If you, the doctor, eat well, exercise and focus on positive beliefs, you will be much more effective at getting your patients to do the same. I recently met with a medical colleague, an interventional spine care anesthesiologist; I came away feeling sorry for him. His practice pays no attention to what the patient is doing or not doing for themselves. He has to "fix" everyone. I much prefer being a facilitator of change, being part of a process if healing with my active, involved patients.

In my practice, I go beyond what my more evidence-based colleagues would be comfortable with. I use my intuition, right-brain findings and muscle testing as feedback tools. I'll quote Malcolm Gladwell from his book *Blink: The Power of Thinking Without Thinking:* "I think those instant conclusions that we reach are really powerful and really important and, occasionally, really good." I agree. For all of these less objective tools, here's my caveat. My intuition, my muscle testing and my right brain are not perfect. You have to go outside your technique system to get accurate feedback or you'll get stuck in a loop. The patient's response is as perfect a feedback as I am going to get. I love working with pain; it gives us such quick and accurate feedback. I will combine functional testing, palpation for tenderness, and the patient's subjective perception of pain to give me an immediate outcomes assessment.

In my most puzzling cases, I will find a couple of functional tests and tender spots, and use these as my guide. For example, the patient can't bend backward and the L sacral base is severely tender. I'll then search, using muscle testing, "listening" and any clues I can get by looking for whatever is in the body that may be affecting this pattern. Treat that and then retest. This approach is fairly simple. It makes sense and it enhances my results as well.

I'll quote here from Stephen Perle, DC, in a comment he made on Spinedocs, relative to the comfort or lack thereof without "knowing." Dr. Perle's main point was that we have to become comfortable with the fact that we just don't know: "Clinical uncertainty is the norm of clinical encounters. However, TV has affected our thinking to make us all – doctors and patients – expect that if we do our job correctly, we will have a definitive answer. We expect that all diagnosis is based upon pathognomonic signs, symptoms and diagnostic tests … it's all a game of probabilities. All we're looking to do is get a high probability (over 65% – although the higher the better) that our diagnosis is correct. If so, we treat the patient. If they don't respond, that lowers the probability and we go at it again. If they respond, that raises the probability and we continue the treatment. I think Tony Delitto[1] articulated this best initially that diagnosis should be based upon not the lesion, but the response. For a chiropractic version of this, please see Murphy's paper."[2]

To be an efficient and effective chiropractor, you have to be willing to live in the mystery, in the not knowing. If you insist that you know, you are at risk of becoming a "true believer" – having all of your experiences fit your limited view of the world. This is the easy way out. It makes for less cognitive dissonance and less difficulty with selling your services. As a chiropractic friend of mine said after we listened to a sales presentation on corrective care, "But I want to believe that it's true." During my chiropractic career, I have had stretches where I was overly focused on one technique or another. I always come back to attempting to integrate all that I have learned, take a broad approach and continue to use "real-world" checks and balances, including outcomes assessment.

I've been in practice for 28 years, still love it, still continue to learn every day, and can't imagine retiring. I hope your practice feeds you as well.

References

1. Delitto A, Erhard RE, Bowling RW. A treatment-based classification approach to low back syndrome: Identifying and staging patients for conservative treatment. *Phys Ther*, June 1995;75(6):470-85;discussion 85-9.
2. Murphy DR, Hurwitz EL. A theoretical model for the development of a diagnosis-based clinical decision rule for the management of patients with spinal pain. *BMC Musculoskelet Disord*, 2007;8:75. **www.biomedcentral.com/content/pdf/1471-2474-8-75.pdf** .