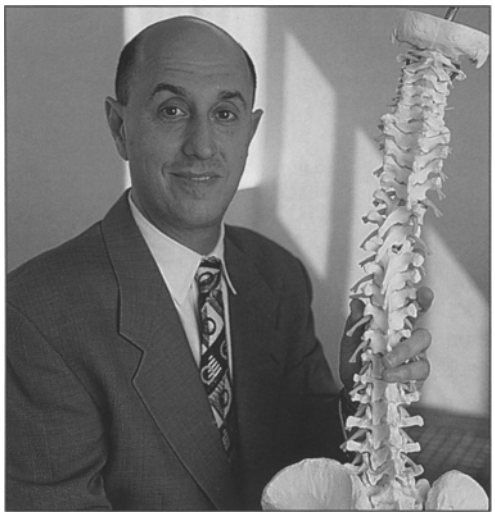

# Rehabilitating Chiropractic

*Activity therapy benefits chiropractic and the patients it serves.*

BY GARY JACOB, DC, LAc

**T**he rehab movement for common spinal disorders is about 20 years old. It has been slowly, but surely, transforming the chiropractic profession for the benefit of both patients and the profession itself. The rehab movement within chiropractic has moved the profession toward evidence-(literature) based behaviors that can serve an essential role within an integrated health care system.

### WHAT IS CHIROPRACTIC?

To better appreciate chiropractic's potential within the rehab community, it is important to understand the role of chiropractic care. Clearly, some chiropractors predicate therapy on specious criteria and spurious reasoning. In fact, some things chiropractors do may represent shamanistic behaviors. Often, the conceptual context of chiropractic treatment pro-motes chronic passive co-dependency.

Some chiropractors claim to treat internal ailments, although most restrict practices to musculoskeletal complaints. At one extreme of the chiropractic continuum are those who demonstrate religious fervor about correcting subluxations (vertebral disrelationships) to solve all human ailments, while at the other end are critical, science-based practitioners. Reed Phillips, president of Los Angeles College of Chiropractic believes this continuum involves "true believers" at one end of the spectrum and "questioners" at the other. Curiously, both ends of the spectrum have an interest in rehabilitation. The true believers have an interest because rehabilitation is the logical progression from the surgery-less, drug-free movement therapy of manipulation; while the questioners find rehabilitation attractive based upon the evidence of peer-reviewed literature.

Setting aside the questionable techniques, chiropractic is, first and foremost, a profession skilled at spinal manipulation. (Our proprietary term is "adjustment.") Curiously, during the 100 years chiropractic has existed, there have probably been just as many different techniques developed to determine how, why, when, and where to apply manipulation to the spine. In spite of this, the current literature-based wisdom is that manipulation is an appropriate form of care for the management of common spinal complaints, which affect 80% of the adult population.

Although it is of no surprise to the rehab community, it is news to most health care practitioners that the only conservative approaches that benefit the spine are movement therapies (manipulation and exercise). To many chiropractors, this "revelation" made them interested in therapeutic exercise—an area they were not pursuing. Intrinsic to the belief system of clinicians who manipulate is the notion that dynamic movement of even the acute spine can be quite beneficial. It is, therefore, a natural progression for chiropractors to appreciate approaches employing self-generated movements.

### MANIPULATION'S RELATION TO REHABILITATION

Manipulation involves dynamic movement of joint structures beyond voluntary range of motion to what is known as the "paraphysiological joint space" just short of anatomical end-range. Typically, a "cavitation" or "cracking" sound is experienced or heard. The rehab perspective is that if manipulation to end-range affords relief, then self-generated movements to end-range may be of equal if not greater benefit. For this reason, many within the chiropractic rehab movement are attracted to the works of Robin McKenzie, RPT, from New Zealand who developed a system of evaluating and treating spinal complaints utilizing self-generated end-range movements.

Chiropractors skilled in manipulation and rehabilitation methods employ movement therapies with the goal of independence in self-care. Manipulation appropriately employed within this context makes the chiropractor a valuable member of the health care community, as one of the few professionals skilled in what works.

### HISTORY OF THE CHIROPRACTIC REHAB MOVEMENT

Turning points for practitioners dealing with common spinal complaints were the Quebec Task Force's 1987 Assessment and Management of Activity Related Spinal Disorders, which reviewed the acceptable literature on low back treatment, and the 1995 Agency for Health Care Policy Research Guidelines, which updated the Quebec study. These literature reviews found no evidence to support the success of passive non-movement therapies (electrical stimulation, heat, ultrasound, etc) for low back and sciatic complaints.

There was, however, evidence of the efficacy of manipulation and exercise. The 1997 Quebec Task Force Whiplash Associated Disorders Study had similar conclusions regarding the cervical spine and curiously classified both manipulation and exercise under the category of "activation," indicative of the philosophical and practical continuum the passive movement therapy of manipu-lation and self-generated activity therapy.

At about the same time literature reviews were making it clear that passive non-movement therapies were of little use, Kim Christensen, DC, of Vancouver, Wash, established the Chiropractic Rehab Association post-graduate program, stressing aerobic, flexibility, and strength conditioning principles; the philosophies of Leonard Matheson, PhD; and clinical reasoning regarding self-care and manipulation developed by McKenzie.

Christensen's program sparked a quiet revolution within chiropractic. His course instructors seeded chiropractic college post-graduate programs: 300-hour post-graduate programs regulated by the American Chiropractic Association's Council on Chiropractic Physiological Therapeutics and Rehabilitation.

Permeating the chiropractic rehabilitation movement is cognizance regarding issues related to locus of control, symptom magnification, and the avoidance of chronic co-dependency, as well as the need to employ reliable measurements of patient objective and subjective status over time. A chiropractor who chooses the rehab approach chooses the goal of independence in self-care for the patient, something that has all too often been lacking among all practitioners attending to common spinal complaints.

### THE YOKE OF PASSIVE THERAPY

Until recently, rehab methods were not applied for common spinal disorders, regardless of the caregiver's license. Passive modalities were the rule of the day. While rehabilitation has always been the centerpiece of care for exceptional athletes on one end of the spectrum and the brain injured on the other, those in the middle were not instructed regarding self-generated movement therapies. This was due, in part, to medicine's long tradition of conceiving of spinal complaints as inflammatory conditions requiring rest.

In 1876, Hugh Owen Thomas, the father of British Orthopedic Surgery proclaimed, "It would, indeed, be as reasonable to attempt to cure a fever patient by kicking him out of bed as to benefit a joint disease by a wriggling at the articulation." Unfortunately, much of medical care for common spinal complaints was predicated on this notion as opposed to the much wiser advice of Lucas-Championiere, who wrote in 1910 that "every movement which is not injurious by reason of its amplitude promotes repair."

Over time, both continuous passive motion manipulation, as well as self-generated motions has proven beneficial for joint conditions previously considered untreatable by mechanical therapies.

### CHIROPRACTIC GUIDELINES

In 1993 the chiropractic profession published the Guidelines for Chiropractic Quality Assurance and Practice Parameters Proceedings of the Mercy Center Consensus Conference. Those unfamiliar with chiropractic may find it interesting to note the following guidelines:

1) Reach the rehab phase as rapidly as possible and minimize dependence upon passive forms to obtain the optimal result.

2) Prolonged limited activity risks failure in return to pre-injury status.

3) Often, complete resolution of pain is not possible until the patient begins to focus on increasing the number and kinds of activities in which they participate.

4) Elements that should be addressed include persuasion from pain behavior, body mechanics education, supervised training for flexibility, stability, strength, coordination, and endurance.

5) When signs for deconditioning or chronicity are present, simply handing out a list of exercises will not do.

6) Early return to activity is associated with reduced disability and symptoms.

7) Chronicity should be prevented wherever possible.

8) Repeated use of acute care measures alone generally fosters chronicity, physician dependence, and overutilization.

9) Pain behavior and illness conviction are best managed with focus on what the patient is able to do. Understanding movement is safe and healthful, even if not comfortable, needs to be emphasized.

10) Focus upon rehabilitation as a means to improve the quality of life, and to reduce suffering can result in a significant reduction of secondary somatization.

### CHIROPRACTIC'S PLACE

The above may, unfortunately, not sound like the belief system of the chiropractic you may love to hate. Sometimes it appears as if other members of the health care community actually cherish and wish to preserve an adversarial relationship with chiropractic as opposed to perceiving the advantages of cooperating with its responsible members.

Within California, there are those among the physical therapy community who have attempted to restrict chiropractors to providing manipulation only—or to *require* a chiropractor to manipulate, if the chiropractor wants to employ ultrasound, for example.

Nobody owns physical medicine. Turf battles between health care professions do not benefit the patient. Chiropractors do not own manipulation and PTs do not own "shake and bake" or exercise. There is no reason for any health care professional to indulge in adversarial or proprietary behaviors, because, in fact, we have much to learn from each other.

Chiropractic has remained somewhat of the royal opposition due to its exclusion from the university setting. Chiropractic institutions have been run historically on a private basis. This is beginning to change. Texas College of Chiropractic, Pasadena, Tex, may soon be part of the Texas State University system. Chiropractic colleges outside of North America are already university-affiliated. The association with the community of scholars is changing chiropractic towards a more accountable and self-critical entity, as well as exposing the virtues of chiropractic to these institutions.

In addition, in increasing numbers, chiropractors are becoming members of multi-disciplinary teams, which also places accountability pressures on chiropractic. In return, chiropractors continue to remind the team that many patients benefit from early movement or "activation." Chiropractic has, for over a century, realized movement is beneficial much sooner than traditional medical thought allowed.

Within the chiropractic rehabilitation movement, chiropractors are adopting treatment behaviors consistent with literature-based evidence and are monitoring patient response with reliable measurements, all geared towards exploring activity as a means to control, eliminate, and prevent symptoms from returning.

Like it or not, as chiropractic drifts into the rehab model, chiropractic itself is being rehabilitated. ❑