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EDITORIAL

# PACBACK study and its relationship to Chiropractic: Is Chiropractic spinal manipulative therapy?

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When I read the review of Bronfort et al.'s *'Spinal Manipulation and Clinician-Supported Biopsychosocial Self-Management for Acute Back Pain: The PACBACK Randomized Clinical Trial,'* published in the February 2026 issue of *The Journal of the American Medical Association*, (1) I found myself asking a fundamental question:

> *… we risk confusing what is measurable with what is meaningful … '*

'What exactly was studied - and was it Chiropractic?'

The trial aimed to compare spinal manipulation and clinician-supported biopsychosocial self-management with guideline-based medical care for adults with acute or subacute low back pain (LBP) at increased risk of chronicity. The principal finding …

> that clinician-supported self-management produced a small reduction in disability, while spinal manipulation showed no difference in pain or disability compared with medical care, has clear implications.

But those implications depend entirely on whether the intervention labeled ‘spinal manipulation’ meaningfully represents the Chiropractic clinical encounter.

## That question deserves careful scrutiny

Randomised controlled trials (RCTs) are designed to isolate variables, reduce bias, and eliminate confounders such as placebo effects and regression to the mean. Their strength lies in reduction. Yet Chiropractic, as historically practiced and taught, is not a reductionist intervention. It is a clinical process, comprehensive, iterative, and individualised. (2)

When an RCT studies ‘spinal manipulative therapy’ (SMT), it necessarily operationalises the intervention into a standardised, reproducible procedure. This is methodologically appropriate. However, in doing so, the intervention becomes a distilled technical act rather than a systems-based clinical encounter. The more tightly controlled the procedure, the further it may drift from the complexity of actual chiropractic practice.

This is not a rejection of RCT methodology. It is a question of construct validity.

If Chiropractic is defined within a study as a generic spinal manipulation that can be delivered interchangeably by multiple professions, then the profession itself has effectively been removed from the equation. What remains is a mechanical input, stripped of the analytical frameworks, technique systems, pre- and post-assessment strategies, and philosophical underpinnings that guide clinical decision-making in Chiropractic practice.

In that case, negative or neutral findings may tell us something meaningful about generic SMT, but not necessarily about Chiropractic.

Over recent decades there has been a discernible shift within segments of Chiropractic academia toward redefining the profession in increasingly biomedical terms. This shift includes de-emphasising traditional terminology such as *subluxation*, minimising technique systems in educational curricula, reframing clinical expertise as anecdotal rather than practice-based evidence, and replacing profession-specific language with the broader term ‘spinal manipulative therapy’. (3 - 7)

These moves are often justified as necessary for scientific legitimacy and integration within mainstream healthcare systems. Yet integration achieved through erasure of professional distinctiveness carries consequences. If Chiropractic becomes indistinguishable from physical therapy or other providers of manipulation, then large-scale trials comparing ‘SMT’ across disciplines will inevitably flatten professional identity into procedural equivalence.

> The PACBACK trial may reflect precisely this flattening

When I entered Chiropractic education in the 1970s, I encountered a discipline that viewed the adjustment not as a mechanical manoeuvre alone, but as part of a broader clinical philosophy emphasising structure-function relationships, nervous system integrity, patient agency, and wellness-oriented care. Over decades of practice, I came to understand Chiropractic as a dynamic interaction between assessment, intervention, reassessment, and patient engagement.

Technique systems were not arbitrary traditions; they were structured methods of clinical reasoning. Each provided a coherent internal logic; guiding where to adjust, how to adjust, and how to evaluate

response. Removing these systems from education and research in favour of standardised technique 'packages' risks dismantling the analytical architecture that differentiates Chiropractic from generic manipulation.

## A profession cannot study itself accurately if it first reduces itself to something else

RCTs are inherently reductionistic. (2, 8) They excel at studying tightly bounded interventions. But Chiropractic, as practiced by many clinicians, may not be reducible to a single procedural input without altering its essential character. When SMT in a clinical trial approximates a generalised diversified adjustment or mobilisation, the intervention studied may represent only the outer shell of Chiropractic practice.

The implications are significant. If trials define Chiropractic narrowly as SMT and find minimal differences compared with medical care, then policymakers, educators, and patients may reasonably conclude that Chiropractic offers little distinct value. Yet such conclusions may reflect the limits of operationalisation rather than the limits of the profession.

This raises a broader epistemological question: What forms of evidence are most appropriate for evaluating complex, systems-based healthcare encounters?

Practice-based research networks, pragmatic trials preserving clinical individuality, mixed-methods studies capturing patient-reported meaning and functional transformation, and longitudinal observational data may better approximate the lived reality of chiropractic care. Elevating only highly reductionist RCTs as definitive evidence risks privileging methodological purity over ecological validity.

A mature profession should not fear scrutiny. Nor should it fear refining traditional concepts in light of emerging evidence. The term *subluxation*, for example, can and should be examined critically, clarified operationally, and updated scientifically. Vitalistic language can be interrogated thoughtfully. Clinical expertise should be studied rather than dismissed.

## But refinement is not the same as elimination

The future of Chiropractic may depend on whether it chooses assimilation through simplification or collaboration through distinctiveness. A profession that abandons its analytical frameworks, technique systems, and philosophical foundations in order to fit neatly into biomedical research templates may gain temporary legitimacy at the cost of long-term identity.

The PACBACK trial invites not only interpretation of its data, but reflection on how Chiropractic is being defined within contemporary research. If we study Chiropractic as generic SMT, we should not be surprised when the results describe generic SMT.

The deeper challenge is this: Can Chiropractic research design methodologies be robust enough to withstand scientific scrutiny while still honouring the complexity of the chiropractic clinical encounter?

Until that question is addressed directly, we risk confusing what is measurable with what is meaningful, and mistaking the reduction of Chiropractic for its representation.

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