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The Grand Deception:

Any diagnosis of 'non-specific' low back pain

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Narrative abstract: Studies from around the world on the back pain pandemic agree the medical model consists of 'outdated models of care' based on 'widespread misconceptions'. However, primary care physicians and spine surgeons have ignored the call for a paradigm shift to conservative (nondrug, nonsurgical) care popularised by Chiropractors that has gained support from spine specialists and researchers including the legendary Alf Nachemson, the god father of medical spine research and journalism.

Traditional medical practice led to the prescription opioid painkillers crisis and the tsunami of failed back surgeries. The current worldwide clinical disaster in spine care begins as this author contends with the initial misdiagnosis as 'nonspecific' primary pain, which is unsupported in research and is seen by this author as an admission of their educational and clinical ineptness in spine care that continues as a major scam upon the public. Undeniably 'bad disks' seen on x-rays and MRI scans have been used as effective selling points to gullible patients that have greatly increased the number of unnecessary surgeries at an enormous cost, waste, and chronic opioid abuse. Many studies confirm the medical model of spine care has been a '*20th century disaster*' causing widespread '*tragic human wreckage*' according to Gordon Waddell.

This paper explores the reasons and solutions for this unmitigated medical clinical disaster originating from a Spine Cartel hellbent on profiteering rather than a health profession seeking the 'best practices' in spine care as evidence-based guidelines recommend from around the world and long pursued by Chiropractors despite the ongoing medical war fighting in the most lucrative and wasteful market in American medicine at US$134.5 billion annually, more than cancer, heart disease, or diabetes.

Indexing terms: Chiropractic; LBP; Diagnosis; low back pain; back surgery.

Introduction

One of the biggest acts of deception and an example of clinical incompetence in spine care that lead to surgical failures is the continued use of the debunked notion of 'bad disks' as the cause of back pain requiring the need for spinal fusion. Indeed, the fallacy of 'bad disks' and the fallacy of fusion surgery have been debunked for over 30 years by leading spine authorities but the trickery continues because the public is convinced despite the high failure rates leading to repeat surgeries.

> *... If Scope of Competence is to protect patients, each practitioner of any type must be honest with patients and other practitioners to do the right thing, even when no one is looking. ...'*

Whenever I hear a lecturer speak or I read a scientific study mention the '*nonspecific*' diagnosis for a low back pain case, I cringe knowing that diagnosis was made by someone poorly schooled in spinal problems, certainly naïve to the current concept of spinal mechanics. Not only a sign of their ignorance or bias that misleads patients, but it also often leads to the

first step on the slippery slope of ineffective treatments like opioid painkillers and disk fusion surgery.

The Washington Post also shone a light on ineffective spine care in 2014, '*Going to the doctor for back pain can be a slippery slope*' that begins with an incorrect diagnosis due to the lack of education on spinal mechanisms.

These inept MDs are not trained to look for '*biomechanical*' or '*functional pathology*' problems of the spine as described in the paper, '*Biomechanics of Back Pain*', by Michael Adams, Department of Anatomy, University of Bristol, UK:

> 'Finally, the concept of "functional pathology" is introduced, according to which, back pain can arise because postural habits generate painful stress concentrations within innervated tissues, even though the stresses are not high enough to cause physical disruption'.

Indeed, the use of either term, '*nonspecific*' or '*uncomplicated*', is an admission to the ignorance of MDs who are trained only to see Red Flags such as a 'bad disk' or other gross pathoanatomical problems on imaging such as cancer, fractures, or severe scoliosis.

Most likely a '*nonspecific*' diagnosis is that of an inept MD poorly schooled in back problems who has a myopic, static vision of spinal problems who cannot examine for spinal motion, joint dysfunction, or biomechanical issues. This has been the bane in spine care leading to millions of failed back surgeries.

Most certainly, the medical bias also contributes to this myopia and will not diagnose conditions such as vertebral subluxations, joint dysfunction, manipulatable lesions, or any functional issue with the spinal joints that have proven to be the cause in most back pain cases as many notable authorities suggest, including Dr. Alf Nachemson who spoke of the etiology of low back pain and concluded joint motion as the primary problem:

> 'One of the main goals of my career has been to determine the cause of nonspecific back pain. And in this I have failed…
>
> 'Many people have focused on the disc as the potential cause of pain. But its role in back pain causation is no more proven than those of other structures. Our knowledge of back pain causation remains poor. We still do not have diagnostic techniques that can link structural abnormalities to symptoms with any accuracy…
>
> I continue to believe that the origin of nonspecific back pain lies in the motion segment'. (1)

Inept MDs

Today the consensus opinion agrees medical primary care physicians lack training in musculoskeletal disorders (MSDs), (2) are more prone to ignore recent guidelines, (3) more likely

1. A Tribute to Alf Nachemson: The Spine Interview, The BACKLetter, Volume 22, Number 2, 2007

2 Elizabeth A. Joy, MD; Sonja Van Hala, MD, MPH, "Musculoskeletal Curricula in Medical Education-- Filling In the Missing Pieces, The Physician And Sports Medicine," 32/ 11 (November 2004).

3 PB Bishop et al., "The C.H.I.R.O. (Chiropractic Hospital-Based Interventions Research Outcomes) part I: A Randomized Controlled Trial On The Effectiveness Of Clinical Practice Guidelines In The Medical And Chiropractic Management Of Patients With Acute Mechanical Low Back Pain," presented at the annual meeting of the International Society for the Study of the Lumbar Spine Hong Kong, 2007; presented at the annual meeting of the North American Spine Society, Austin, Texas, 2007; Spine, in press.

to suggest spine surgery than surgeons themselves, (4) and only 2% of primary care physicians (PCPs) refer to DCs as a nondrug treatment despite our superior training and clinical results. (5)

In fact, Mark Schoene, editor of an international spine journal makes the case primary care practitioners are dangerous to patients:

> 'One can make the argument that the most perilous setting for the treatment of low back pain in the United States is currently the offices of primary care medical practitioners, primary care MDs. This is simply because of the high rates of opioid prescription in these settings'. (6)

Richard Deyo, MD, MPH, author of *Watch Your Back!* also mentioned the problems with physician incompetence and medical treatments in diagnosis and treatment of low back treatments:

> 'Calling a [medical] physician a back pain expert, therefore, is perhaps faint praise; medicine has at best a limited understanding of the condition. In fact, medicine's reliance on outdated ideas may have actually contributed to the problem'. (7)

Perhaps the most compelling witness indicating the lack of knowledge by the medical position was Dr John C Wilson, chairman of the *American Medical Association's Section on Orthopedic Surgery*, testified to the poor training of medical students:

> 'MDs often displayed a disturbing ignorance of the cause and treatment of low back and sciatic pain, one of mankind's most common affliction'. '
>
> At the postgraduate level, symposia and courses concerning the cause and treatment of low back and sciatic pain are often ineffective because of prejudices and controversy.
>
> 'These inconsistencies spawn disastrous sequelae:
>
> 1) patients operated upon after inadequate evaluation
> 2) reliance by physicians on poor quality X-ray films
> 3) surgery done only because of an abnormality in a myelogram without reference to plain films of the lower spine
> 4) exploratory surgery upon the lower back done without sufficient clinical basis
> 5) extensive surgery done for solely subjective complaints repeated attempts at spinal fusion - sometimes six or eight - by surgeons of limited experience
> 6) surgery authorised by industrial accident commissions comprised exclusively of laymen, and
> 7) extensive removal of posterior vertebral elements by neurosurgeons, making stabilization of the lower portion of the spine technically difficult if not impossible'.

4 SS Bederman, NN Mahomed, HJ Kreder, et al. In the Eye of the Beholder: Preferences Of Patients, Family Physicians, and Surgeons for Lumbar Spinal Surgery," Spine 135/1 (2010):108-115.

5 Matzkin E, Smith MD, Freccero DC, Richardson AB, Adequacy of education in musculoskeletal medicine. J Bone Joint Surg Am 2005, 87-A:310-314

6. The BackLetter, volume 30, number 10, 2015

7. Deyo, RA. Low -back pain., Scientific American, pp. 49-53, August 1998.

Wilson added that '*even the abundant and significant advances resulting from the medical profession's emphasis upon research have failed dismally to relieve modern man of one of his most common and bothersome afflictions, low back pain*'. (8)

Another problem is patients mistakenly think their MDs are properly trained as *Primary Spine Care Providers*, which they are not. As a fraudulent portal of entry into the domain of MSDs, they created the present opioid crisis beginning with incorrect spinal diagnosis as many experts now contend and simply prescribing prescription painkillers and muscle relaxants, has proven to be ineffective, addictive, and dangerous in the long run.

Dr Richard Deyo acknowledged in his article '*Low Back Pain*'that abnormal anatomy (pathoanatomy) like a 'bad disk' was not the cause of most back pain when he admitted:

> 'Perhaps 85 percent of patients with isolated low back pain cannot be given a precise pathoanatomical diagnosis'.

He mentioned most back pain is '*mechanical*' in nature, aka, pathophysiological disorders, not pathoanatomical problems:

- '*Mechanical Low Back or Leg Pain*' constituted 97 percent of these cases, of which '*lumbar strain, sprain*' accounted for 70 percent of these cases (9)
- Non-mechanical Spinal Conditions [disk, fractures, infections] accounted for about 1 percent
- Visceral Disease (referred pain) accounted for 2 percent.

Deyo also confirmed that '*many of these abnormalities are trivial, harmless, and irrelevant, so they were dubbed as "incidentalomas" because they may be incidental to back pain*' as he explains:

> 'And we know that bulging, degenerated, and even herniated discs in the spine are common among healthy people with no symptoms. When doctors find such discs in people with back pain, the discs may be irrelevant, but they are likely to lead to more tests, patient anxiety, and perhaps even unnecessary surgery'. (10)

Concurring with Deyo is Dr KS Dhillon in *Spinal Fusion for Chronic Low Back Pain: A 'Magic Bullet' or Wishful Thinking?*:

> The disc is implicated in about 40% of the patients with non-specific low back pain. (4) The facet joints is believed to be the source of low back pain in 15 to 40% of the patients (5) while the sacroiliac joint is implicated in about 15% of the patients. (6) Though we believe that these three are the main sources but not the only source of chronic low back pain, no conventional clinical test can discriminate the source of pain in patients with disc, facet joint or sacroiliac joint abnormalities. (4, 5, 6)

That may be true for medical physicians who are not trained in MSDs, but chiropractic practitioners are well trained in these subtle differences.

This deception for 80% to 95% of back pain cases begins with inept medical training in a domain of healthcare within which they have not only shown to be undertrained, but their treatments have led to the 2018 NIH health alert about *Opioid Addiction and Chronic Pain* due to medical mismanagement that begins with a misdiagnosis by inept MDs looking for '*incidentalomas*' but when none are found, they invoke the '*nonspecific*' excuse.

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8. JC Wilson, "Low Back Pain and Sciatica: A Plea for Better Care of the Patient, Chairman's Address," JAMA, 200/8, (May 22, 1967):705-712.
9. Deyo RA, Weinstein JN. Low back pain. N Engl J Med 2001 Feb 1;344(5):363-70.
10. Richard A. Deyo, MD, MPH and Donald L. Patrick, PhD, MSPH, Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises, AMACOM books, (2005): 36-37

Mayo debunks 'bad disks'

In 2015 the Mayo Clinic systematic review (11) that found 'bad disks' in pain-free people (see Table 2). As you can see from this chart, this Mayo study found that by age 50, 80% of people will have degenerative disks but are asymptomatic, which means they have no pain. Yet surgeons fail to inform patients of this important finding instead choosing to use this as a selling point that '*you got a bad disk*', the biggest lie in spine surgery to convince them of the *fraud of disk fusion surgery*.

Table 2: Age-specific prevalence estimates of degenerative spine imaging findings in asymptomatic patients[a]

	Age (yr)						
Imaging Finding	20	30	40	50	60	70	80
Disk degeneration	37%	52%	68%	80%	88%	93%	96%
Disk signal loss	17%	33%	54%	73%	86%	94%	97%
Disk height loss	24%	34%	45%	56%	67%	76%	84%
Disk bulge	30%	40%	50%	60%	69%	77%	84%
Disk protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

Many experts believe there is too much spine surgery done in the US and much is based on the 'bad disk' diagnosis, a concept that lingers because spine fusion surgery also makes a lot of money. A dated (1976) study of hospital charges for single-level anterior cervical discectomy and fusion found a range in total charges of US$26,653 to $129,220. (12)

Of course, patients rarely have just one; revision surgery is commonplace according to *Failed Back Surgery Syndrome: A Review Article*:

> Repeat spinal surgery is a treatment option with diminishing returns. Although more than 50% of primary spinal surgeries are successful, no more than 30%, 15%, and 5% of the patients experience a successful outcome after the second, third, and fourth surgeries, respectively.

Dr Zoher Ghogawala, a Yale neurosurgeon, agreed there is too much fusion surgery: '*I see too many patients who are recommended for fusion that absolutely did not need it*'. (13)

Spine researcher Chien-Jen Hsu, MD, admitted in the journal *Spine*:

> 'By far the number one reason back surgeries are not effective and some patients experience continued pain after surgery is because the disc lesion that was operated on is not, in fact, the cause of the patient's pain'. (14)

The difficulty diagnosis of joint segmental motion dysfunction is a skill only taught in Chiropractic colleges and this explains why medical operatives are untrained to detect

11. W. Brinjikji, et al, Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations, American Journal of Neuroradiology April 2015, 36 (4) 811-6.
12. Epstein NE, Schwall G, Reillly T, Insinna T, Bahnken A, Hood DC. Surgeon choices, and the choice of surgeons, affect total hospital charges for single-level anterior cervical surgery. Spine (Phila Pa 1976). 2011;36:905–9.
13. RA Deyo and DL Patrick, Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises (2002):191.
14. CJ Hsu, et al. "Clinical Follow Up After Instrumentation-Augmented Lumbar Spinal Surgery in Patients with Unsatisfactory Outcomes. In Journal of Neurosurgery," Spine 5/4 (October 2006):281-286.

subluxations and/or unwilling to refer to Chiropractors to detect joint dysfunction. They are not trained in the matter.

Mr RJ Craddock summarised the elements of the vertebral subluxation to the *New Zealand Commission on Inquiry*: (15)

> 'The concept of the subluxation which is central to chiropractic theory and practice is not inherently a complicated one, and the essential elements are clear:
>
> - Abnormal function in a spinal joint.
> - Neurological involvement.
> - Perhaps, but not necessarily displacement of a vertebrae.
>
> 'The problem is a functional not a structural one … the abnormal function of the spine may produce a vascular involvement as well as the neurological one… the medical profession simply fails to see the direction and subtlety of the chiropractic approach towards spinal dysfunction. Because the chiropractor uses x-ray extensively the medical practitioner thinks he is looking for a gross bony change, and when the medical practitioner cannot see this on the x-ray the chiropractor is using, he immediately becomes skeptical. He might as well expect to see a limp, or a headache or any other functional problem on x-ray'. (16)

When medical radiologists cannot detect on imaging the 80% to 95% of chronic low back pain cases that Dhillon suggests, they categorically considered them to be '*uncomplicated*' and '*nonspecific*' rather than admitting they simply had no idea why these people were in pain and have no realistic ideas how to help them other than prescribing dangerous opioid painkillers, which becomes a slippery slope to worse when it results in abuse, addiction, and spine surgery.

The Washington Post also shone a light on ineffective spine care in 2014 '*Going to the doctor for back pain can be a slippery slope*' by Jill Adams that revealed the '*discordant care'* in medical spine care:

> 'With unclear cause, treatment options are murky. Yet many doctors turn to surgery. Twenty years ago, *Cherkin documented that rates of back surgery* in the United States were double those of many countries and five times those of the United Kingdom. Eight years ago, *another group found* dramatic regional differences in back surgery rates within the United States'.

Dr Alf speaks: 'very sick people'

Since 80% of asymptomatic people over 50 years of age show signs of 'bad disks' according to a *Mayo Clinic study*, it was a catch-all diagnosis that wasn't completely wrong, but it was very simplistic and far from being right for most cases. In effect, it was a selling point for disk fusions to show degenerative disks on imaging pictures to convince gullible patients.

In 1993, *Alf Nachemson*, MD, PhD, also spoke of the emerging issues plaguing spine care in America. Keep in mind Nachemson was an '*exceptional pioneer in spine care*' as the primary thought-leader, researcher, and for 20 years he was co-editor of *Spine*, the bible of spine surgeons. (17)

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15. Inglis BD, (Chairman). (1979). Chiropractic in New Zealand. Report of the Commission of Inquiry presented to the House of Representatives by Command of His Excellency the Governor-General. Wellington: Hasselberg, Government Printer. Summary here: *CHIROPRACTIC IN NEW ZEALAND*
16. Inglis, BD, Fraser, B, Penfold, BR, Chiropractic in New Zealand, Report of the Commission of Inquiry into Chiropractic, PD Hasselberg, Government Printer, Wellington, New Zealand. 1979, p. 55.
17. *Nachemson – An exceptional pioneer in back pain research*

As the godfather of spine surgeons Nachemson, while speaking at a conference of spine surgeons, strongly criticised his spine colleagues of inventing '*disk degeneration*' as a disease that required surgery:

> 'You are violating all the rules of epidemiological science when you name this a disease. You are making people sick … If this is a disease, then this room is full of very sick people'. (18)

In an editorial, '*Low-back pain: Are Orthopedic Surgeons Missing The Boat?*', Nachemson debunked the 'bad disk' premise as well as argued for a moratorium on spine surgeries.

Remarkably as the godfather of the evidence-based spine care movement, he admitted a disdain for surgery:

> 'Fusion surgery is typically not a cure and should not be presented as such. Few patients experience complete relief of back pain following surgery. Only one in five patients in these studies became pain-free'. (19)
>
> 'During the last decade we have seen an enormous increase in imaging and surgical technology. CT, MRI, etc demonstrate anatomic changes which often have no importance at all for the patient's pain. New surgical methods are constantly being introduced and presented in uncontrolled case series. Orthopedists, trained for surgical solutions, are too quick to use the new screws, hooks, pins and needles, promoted by the inventors and the instrument companies despite mediocre results and many complications.
>
> 'After 60 years of surgical experimentation we seem to have reached an impasse. Given the potential risks of our interventions with various ingenious contraptions for the lumbar spine, and the lack of clinically proven success, there should be, perhaps with a few exceptions, a moratorium on unproven invasive methods for the treatment of chronic low-back pain'.

Despite his expertise and honesty, the Spine Cartel *note* had to have known but did not want to follow his advice to admit these back pain cases did not need medical intervention such as surgery and due to their anti-Chiropractic mindset they refused to acknowledge those pesky Chiropractors were right all along that spinal joint dysfunction was the primary problem, not bad disks.

Nachemson's opinion has been verified by other spine experts who also suggest the disk issue is minor in the grand theme of spine problems.

Why surgery fails

Gordon Waddell DSc, MD, FRCS, gave fair warning in 1989 that back surgery is '*leaving more tragic human wreckage in its wake than any other operation in history*' (20) and it continues to do so to this day.

Note: The US Spine Cartel consists of 25,000 spine surgeons with cohorts trafficking patients from primary care providers, physical therapists, anaesthesiologists, pain management clinics, osteopaths also in cahoots with hospitals, device manufacturers, insurers, imaging centres, Big Pharma, et al. [*Return to p. 19*]

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18. The BackLetter, 1994: 9:85-92
19. RA Deyo, A Nachemson, SK Mirza, "Spinal-Fusion Surgery—The Case for Restraint," New England Journal of Medicine 350/7 (February 12, 2004):643-644
20. G Waddell, The Back Pain Revolution, Philadelphia, Churchill Livingstone Inc, (1998)

Dhillon noted Waddell's classification of low back pain is '*widely accepted*' and divides low back pain into three categories:

- 'Specific spinal pathology which can be found in 1% to 2% of patients. This would include diagnoses such as tumours, infections, fractures, and cauda equina syndrome.
- 'Radiculopathy caused by disc prolapse and spinal stenosis which is seen in about 5% of the patients.
- 'Non-specific low back pain which occurs in about 85 to 95% of the patients'. (2)

In this diagnostic triad, the first two categories encompass (5% to 7%) a proper pathoanatomical diagnosis which fits into a classical disease model and this makes effective treatment possible.

On the other hand with the third category, the absence of a pathoanatomical diagnosis makes effective treatment fraught with difficulties. Waddell has eloquently described a diagnosis of non-specific backache as '*intellectually and scientifically inadequate and it fails to provide any biological basis for real understanding*' which results in treatment remaining '*empirical or based on unproven hypotheses*'. 2 The belief that diagnoses such lumbar strain or degenerative spine disease causes chronic low back pain remain unfounded and this leaves a lot of room for uncertainty about treatment, prognosis and clinical outcome. 2

Dhillon also shows his medical bias and lack of understanding of pathophysiologic issues that are segmental dysfunction that are a source of pain in '*non-specific low back pain which occurs in about 85 to 95% of the patients*'. This is a contentious issue for the medical society concerning their bias and inability to understand the scientific nature of the '*vertebral subluxation*', a termed coined by early chiropractors that is equivalent to what medical professionals such as Scott Haldeman DC, MD, PhD, call a '*manipulable lesion'*. (21) Haldeman testified at the *NZ Inquiry* that it would take 12 months' full-time training in spinal manipulative therapy following a medical degree for it to be appropriate for MDs to diagnose and treat them. (22)

Instead of admitting their medical education failed to teach this underlying problem that is now widely accepted by impartial researchers and practitioners, the AMA deemed subluxations as '*imaginary*' which speaks volumes of the political nature of medicine. Indeed, this '*wilful ignorance*' and refusal to refer to DCs has led to one of the worst pandemics that was clearly manmade, and not an unforeseen act of nature such as were COVID or the *Spanish Flu*, but due to the political dirty tricks and defamation.

Instead of seeing most back pain cases as a functional problem of the 24 vertebrae interconnected by 137 synovial joints sitting atop the 3 pelvic bones acting in concert as a weight-bearing column, the myopic medics focused on the 23 intervertebral disks as a static problem to diagnose and treat with drugs, shots, and surgery, deemed '*outdated models of care*' by *The Lancet* review.

Disks vs. Joints

I contend just because these '*nonspecific*' low back pain cases cannot be given a '*pathoanatomical*' diagnosis does not mean there is no other specific diagnosis that would be applied from the perspective of spinal function, such as the classical Chiropractic '*vertebral subluxation complex*', or John Mennell's '*joint dysfunction*', or as Alf Nachemson similarly called a '*motion segment*', or Scott Haldeman called a '*manipulable lesion*'. (23)

21 Inglis, BD, Fraser, B, Penfold, BR, Chiropractic in New Zealand, Report of the Commission of Inquiry into Chiropractic, PD Hasselberg, Government Printer, Wellington, New Zealand. 1979. p. 194.

22. Inglis. ibid, p. 244

23. Inglis, ibid, p. 194.

Donald Murphy and Eric Hurwitz, both DCs, found joint dysfunction was the cause of *low back pain* (lumbar and sacroiliac) in 50-75% percent of patients. (24) Murphy admits another problem in spine care is the prevailing medical bias against chiropractic adjustments might cause harm:

> 'Many patients are told not to go to a Chiropractor, told that their spine is degenerated and the last thing they want to do is to have someone move it. In my experience, having someone move the spine is the best thing'.

Instead, the medical profession contends vertebral subluxation were '*imaginary*' because they were unable to detect them, but the *NZ Inquiry* refuted that notion as hearsay. Terry Yochum DC, was also able to explain clearly what the technique of Chiropractic adjustment involved in terms of movement (Transcript, p. 3191):

> 'The movements of vertebra in my opinion are millimetric in nature, very small degree of actual movement of a segment. I do not know if I can document that. It is a matter of my expertise, training, and experience as a chiropractor and as specialist in x-ray. I believe even though the movement is millimetric in nature it is of centimetres in significance in that it does not take more than a few millimetres of derangement to affect the whole neurological complex of a motor unit in the spine. That is what creates the clinical phenomena that we treat'. (25)

With this functional approach in mind rather than the medical static 'bad disk' model, the *New Zealand Commission* applied common sense to conclude the medical opposition is '*an unreasonable and unscientific stance*' and that '*the chiropractors' hypothesis is so far unproven. It does not mean it is invalid*' (26)

> 'Having weighed all the evidence we accept that Chiropractors are not unreasonable in believing that through their specialised training and skill they are capable of identifying and treating functional defects in the vertebral column which others without that training or skill would not regard as significant.
>
> 'We consider that to deny that such functional defects can exist and can impinge on the nervous and/or vascular systems, is, in the present state of knowledge, an unreasonable and unscientific stance. The exact nature of such defects has not yet been demonstrated; nor has the mechanism by which its apparent effects are produced'. (25)

The NZ Report found that undoubtedly chiropractors believe that there is such a condition as a Chiropractic Subluxation. They do so because when they apply manual therapy, supposedly to correct the subluxation, the patient's condition in many cases improves. The fact that there is not yet any conclusive explanation of exactly what happens means nothing more than that the Chiropractors' hypothesis is so far unproven. It does not mean it is invalid. We accept, for the purposes of this inquiry, that a chiropractor is equipped by his training and skill to locate and

24. Donald R Murphy and Eric L Hurwitz, "Application of a diagnosis-based clinical decision guide in patients with low back pain," Chiropractic & Manual Therapies 2011, 19:26
25. Inglis, BD, Fraser, B, Penfold, BR, Chiropractic in New Zealand, Report of the Commission of Inquiry into Chiropractic, PD Hasselberg, Government Printer, Wellington, New Zealand. 1979, p. 51.
26. Recall this comment was made in 1979 and was accurate for its time. To learn of advances, logon to *Modern Revelations*.

relieve a condition which for want of a better term he calls a subluxation, and that the result of his therapy can provide relief from, at least, back pain. (27)

In 1992 Paul Shekelle, MD, director of RAND Corporation's *Southern California Evidence-Based Practice Center*, also begged to disagree with the medical status quo:

> 'To say that there is no scientific proof of spinal manipulation, I would say that there's considerably more randomised controlled trials which show benefit for this than there is for many other things which physicians and neurosurgeons do all the time'.(28)

Scope of competence

This issue of educational training, clinical skill level, and overall competence became an issue in a federal courtroom when the A*merican Chiropractic Association* sued *Trigon*, a BCBS affiliate in Virginia, when it substituted MDs, Osteopaths, and PTs in lieu of Chiropractors to render the 'Chiropractic benefit' of spinal manipulation to treat subluxations in Medicare patients which the original Medicare law called for exclusively to be done by chiropractors. Correcting subluxations was the only foot in the Medicare door allowing Chiropractors to participate after years of political wrangling (see *DECEPTION IN MEDICARE*).

Ironically after decades denigrating Chiropractic as an '*unscientific cult*', labelling subluxations as '*imaginary*' and spinal manipulation as '*quackery*', once the Medicare law began paying for this service the medical guys were ready to cash-in despite being untrained.

Of course, the chiropractic profession sued to stop this outrage. After setbacks in lower district courts, the *Court of Appeals* in *Washington DC* finally ruled in favour of the ACA when it focused on '*scope of competence*' and '*qualifications*' rather than the outmoded medical model of a plenary license being all that is needed to deliver any skilled service. (29)

Attorney George McAndrews spoke bluntly about the impact of the competency issue during the Trigon case:

> 'When patients are forced to take their health problems from a chiropractor to a medical physician [or PT] who isn't skilled in that area … that is a funnelling of business from the most-skilled to the least-skilled providers'. (30)

Then-ACA President Richard Brassard DC announced:

> 'We are happy that the issue is now whether or not a practitioner is "qualified", not whether or not a practitioner is simply licensed. The ACA's position has been and remains that only Chiropractors are qualified by education and training to correct subluxations. Because of the *Appeals Court's* decision, Chiropractors can continue to fight to safeguard their right to be the sole providers of this service, and to ensure Medicare patients' rights to access doctors of chiropractic'. (31)

The scope of competence issue remains both a political and legal topic, and a personal health care issue that every patient should be aware. Don't assume any MD is competent on every health issue only because he/she has an MD degree, which is how the Double Crisis blossomed when patients were deceived by the MDs who prescribed opioid painkillers like Halloween candy and refused to refer to chiropractors due to bias and animus.

27. Inglis, BD, pp. 49-55.
28.. Shekelle, P. et al. RAND Corp Report, "The appropriateness of spinal manipulation for low-back pain," Santa Monica, Calif. 1992.
29. Louis Sportelli, DC, "A New Revelation - A Renewed Hope for Resolution," Dynamic Chiropractic 24/02 (January 15, 2006)
30. Judge Rules on Trigon's Motion to Dismiss ACA Lawsuit, Dynamic Chiropractic, August 6, 2001
31. Michael Devitt, Landmark Decision in ACA Lawsuit Against HHS, Dynamic Chiropractic – January 15, 2006, Vol. 24, Issue 02

Red Flags

When 'bad disks' or other Red Flags such as cancer, fractures, infections, severe scoliosis, spinal deformities, cauda equina, or those neurological cases unresponsive to conservative care, were not seen, these myopic medical practitioners diagnosed back pain as '*nonspecific*' and/or '*uncomplicated*'. When in fact, most of these problems were much more complicated and multifaceted than medical schools taught with the fallacy of 'bad disks' that has led to *the fraud of fusion* and millions of unnecessary surgeries.

One of the most striking papers debunking surgery for 'bad disks' was *Spinal Fusion for Chronic Low Back Pain: A 'Magic Bullet' or Wishful Thinking?* by KS Dhillon FRCS, MD, orthopedist, who suggests the number of necessary spine surgeries may be as little as *5% to 7% of all low back pain (LBP) cases*:

> 'The treatment of chronic low back is difficult and is often ineffective. For treatment to be effective the cause of the pain has to be established but unfortunately in 80% to 95% of patients the cause cannot be determined despite the existence of modern imaging techniques. A pathoanatomical diagnosis which fits into a classical disease model where successful treatment can be carried out can only be made in 5% to 7% of the patients.
>
> 'The back pain in the rest of the patients where no pathoanatomical diagnosis can be made is often labelled, unscientifically, as chronic low back pain. Despite the existence of sophisticated imaging techniques and a plethora of diagnostic tests, the source of pain in patients with nonspecific back pain cannot be established. There exists no causal relationship between imaging findings of degenerated disc, lumbar facet arthritis, spondylosis, spondylolysis and spondylolisthesis, to the pain in these patients. Surgical treatment of non-specific back pain where no pathoanatomical diagnosis has been established is bound to fail. Therefore, the outcome of spinal fusion in these patients can be no better than nonsurgical treatment'.

As Dhillon admits '*Surgical treatment of non-specific back pain where no pathoanatomical diagnosis has been established is bound to fail*'. Indeed, when fusion surgery fails, people don't walk away without side effects from rods and pedicle screws implanted in their spines and prescription opioid painkillers in hand as therapy for chronic pain control.

Green and Yellow Flags in spine care

Considering the Mayo study found 'bad disks' in many pain-free people, it appears that some standard Red Flags are also questionable as the source of pain in many patients and the need for surgery. Obviously, something else aside from disks is at play.

Although less than 10% of cases are deemed Red Flags as Dhillon noted, he made no distinction for other possible reasons. When this happens in the field among non-responsive patients, too often PCPs believe its psychosocial issues some label as 'Yellow Flags'. (32) According to a New Zealand guideline on acute low back pain:

> 'Yellow flags are psychosocial indicators suggesting an increased risk of progression to long-term distress, disability, and potential drug misuse. They include the patient's attitudes and beliefs, emotions, behaviours, and family and workplace factors'. (33)

32. Yellow flags are psychosocial indicators suggesting an increased risk of progression to long-term distress, disability and potential drug misuse. They include the patient's attitudes and beliefs, emotions, behaviours, and family and work place factors.
33. New Zealand acute low back pain guide: Incorporating the guide to assessing psychological yellow flags in acute low back pain. Accident Compensation Corporation (ACC)' Wellington 411, 2004. (Sourced 24/2/14) http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/internet/wcm002131.pdf

I suggest many of the '*nonspecific*' or '*uncomplicated*' cases misdiagnosed as 'Yellow Flag' cases should be dubbed 'Green Flags' to include the majority of cases stemming from structural or dysfunctional movement cases of the spinal joints that chiropractors treat.

These Green Flag patients don't need psychologists as Yellow Flag cases may nor do they need drugs or surgery as Red Flag cases may, as much as they need Chiropractors and complementary and alternative (CAM) providers as many guidelines recommend. Nor is the pain in these cases '*all in your head*'.

Medical gaslighting

I have seen many patients still in pain whose MDs could not properly diagnose or treat their back pain. Instead of admitting their misdiagnosis or refer to a Chiropractor, they diagnosed a Yellow Flag situation and told the patient that '*It's all in your head*'.

This deception is a phrase by physicians to patients presenting with symptoms unexplained by the PCP's diagnostic training. (34) Instead of admitting their mistake as a lack of training and refer to a chiropractor, these inept MDs resort to trickery to blame the patient.

This is especially true for women misdiagnosed when they have non-specific symptoms not evident on an x-ray or MRI as we Chiropractors see too often when primary care physicians are untrained to detect vertebral subluxations according to *'It's All in Your Head': The Dangers of Medical Gaslighting*: (35)

> Medical gaslighting is a phrase used to describe physicians or other medical providers who wrongly blame a patient's symptoms on psychological factors. Of course, some patients present with non-specific symptoms and it can be difficult to pin down a diagnosis. But in the case of medical gaslighting, the doctor is too ready to downplay or dismiss the concerns of their patient as insignificant. Symptoms may be brushed off as psychosomatic. Signs of medical gaslighting can include victim-blaming or denying a patient's illness entirely, for example, wrongly telling them they are not sick. It can refer to a doctor who doesn't listen or appear to care. Commonly, medical gaslighting involves attributing the patient's symptoms to age, race, sexuality, gender, or other factors.

The author noted '*There can be serious repercussions for biases in health care, including delayed diagnosis and treatment*'. Or, I might add, it may lead to guesswork and incorrect treatment for so-called nonspecific primary back pain down the slippery slope to opioids, MRIs, and eventually spine surgery.

Deyo also confirmed this 'medical gaslighting' may lead down the slippery slope:

> 'And we know that bulging, degenerated, and even herniated discs in the spine are common among healthy people with no symptoms. When doctors find such discs in people with back pain, the discs may be irrelevant, but they are likely to lead to more tests, patient anxiety, and perhaps even unnecessary surgery'. (36)

Women's experiences of medical miss-diagnosis: How does gender matter in healthcare settings? by Jessica Thompson and Denise Blake also investigated the issue of misdiagnosis of women's conditions:

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34. *"It's All in Your Head"—Medicine's Silent Epidemic*, JAMA Network, 2019.

35. Psychology Today, Karen Stollznow Ph.D., May 25, 2022

36 Richard A. Deyo, MD, MPH and Donald L. Patrick, PhD, MSPH, *Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises,* AMACOM books, (2005): 36-37

> 'Medical misdiagnosis for women continues to be a significant problem, leading to disparate health outcomes … This work was guided by feminist principles and used narrative analysis to develop the following three themes:
>
> i. Contradictory dialogues: doctor as expert or not?
>
> ii. Self-advocacy in the misdiagnosis experience; and
>
> iii. Not taken seriously in healthcare settings: it's all in your head.
>
> Supported by previous work, our findings assert that women are treated poorly in healthcare settings with detrimental outcomes for them and their wider community.
>
> Other researchers found that women who have experienced misdiagnosis report being dissatisfied with medical explanations about their symptoms. Some of the women in these studies were told they were 'over exaggerating' or that their symptoms were 'all in your head'. These forms of condescension imply women are malingerers who create psychosomatic symptoms and work towards fuelling discourses of women as attention seekers or hysterical hypochondriacs'.

Compounding the misdiagnosis and mistreatment of acute or chronic low back pain by inept MDs who routinely prescribe opioids or any painkiller only adds to the patient's psychological anxiety fuelling many other side effects such as addiction, depression, hopelessness, loss of work, disability, and worse as researchers found in patients suffering from this Quiet Epidemic of chronic low back pain.

According to the *Institute of Medicine*:

> The widespread use of CAM is of major importance to today's health care consumers, practitioners, researchers, and policy makers. For example, statistics on CAM found 42 percent of people in the United States report that they have used at least one CAM therapy: however, less than 40 percent of those using CAM disclosed such use to a physician. (37)

They need conservative (non-drug, non-surgical) multimodal care such as Chiropractic with extensive self-care home care such as yoga, body-mind techniques, and spinal muscle core strengthening to achieve better vertebral alignment, core strength, spinal flexibility, and axial decompression to stabilise the spine as a weight-bearing pillar of 24 vertebrae and 3 pelvic bones.

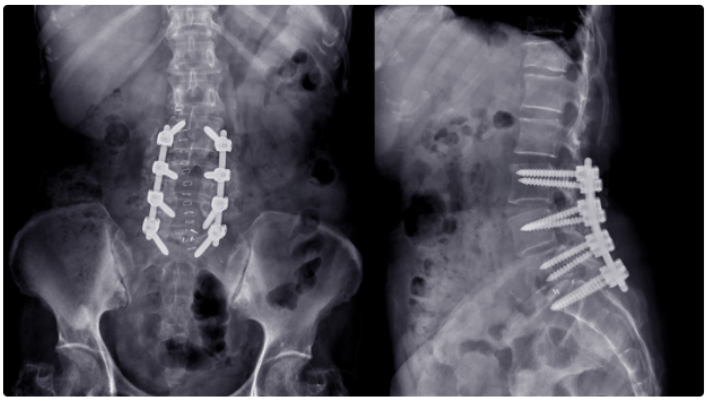
In this light, acute or chronic LBP is neither '*nonspecific*' or '*uncomplicated*'. Indeed, it is much more complicated than MDs or surgeons understand.

In my 40+ career, I have seen thousands of patients with severe chronic LBP and failed back surgery who were initially misdiagnosed. While the MD focused only on the 'bad disks' with opioid painkillers, epidural injections, and surgery, they ignored the joint dysfunction and structural alignment of the spine. They turned a blind eye to joint motion, they ignored subluxations, and they were untrained to see a tilted pelvis indicating a short leg syndrome and/or a possible sacroiliac subluxation.

I wrote about one such incident with an Army veteran who I met years after a FBSS that left him addicted to chronic opioid therapy, disabled from work, and still in a lot of chronic pain. In effect, he was misdiagnosed, mistreated, subjected to wrong-site surgery, and misinformed about his options to care. He is now suffering from PTSD from his original injury while on active duty

37 Institute of Medicine (US) Committee on the Use of Complementary and Alternative Medicine by the American Public. Washington (DC): National Academies Press (US); 2005.

deployed in Afghanistan. He also suffers today from *Double PTSD* from 1) post-traumatic stress disorder from the initial *IED attack* that destroyed the emergency vehicle he was driving. After spinal fusion surgery that failed to help him, he also suffered from 2) another type of PTSD: *post-traumatic surgical disorder*.



Only Chiropractic care put this military Humpty Dumpty back together again after failed back surgery left him with 8 pedicle screws in his spine with chronic pain and addicted to *chronic opioid therapy*. As you can see from his x-rays, his spine and disks are relatively healthy. However, after the surgeon did his handiwork, the solider was fused in a misaligned position resulting in lumbar lateral scoliosis to the right side with a 'kink' at L2-L3. If you look closely, he also has a right short leg syndrome putting a lot of pressure on his right sacroiliac joint, which was the source of his pain upon my palpation examination.

I never adjusted any of the Red Flag lumbar fusion, but when I adjusted his RSIJ with a side-posture classic adjustment, he let out a huge sigh of relief that was so loud he probably woke up patients in my waiting room. I was startled too, not expecting such a loud reaction not because he was in pain, but from his immediate sense of relief. Then he said '*That's the first time in 8 years it's stopped hurting*'.

As someone myself who also has a chronic SIJ problem from an old football injury, I know these Green Flags can buckle on occasion and exactly how he felt. As comedian Bob Hope once said, '*You know you're getting old when your back goes out more often than you do*'. The Key is daily maintenance care of spinal exercises, periodic adjustments, and proper sitting posture and awareness.

The military physicians never checked this soldier's SIJ, they were fixated on finding a 'bad disk' to practice their surgery honing their skills for private practice later in their careers.

Mayo also mentioned a study showing the sacroiliac joint is a common source of low back pain. (38) This is a common problem when patients are misdiagnosed with a bad lumbar disk when in fact they suffer from a sacroiliac joint problem as Dr. William Cross, an orthopedic surgeon at Mayo, mentioned in a study, *Back pain after back surgery: The SI joint and adjacent segment disease*:

> In our clinic we routinely see patients who have had one, two or even three spinal fusions but develop or continue to have SI joint pain … The SI joint is often glossed over as a pain generator, especially in people who have had spinal fusion and experience continued pain.

38. *Back pain after back surgery: The SI joint and adjacent segment disease*

I can't begin to count the number of patients throughout my career suffering from *Failed Back Surgery Syndrome* who come to my office seeking relief. The image above shows another person with 4 pedicle screws in his 2 sacroiliac joints as well as the presence of a left short leg syndrome and rotated pelvis.

These patients could have avoided surgery if they were informed about Chiropractic care as a frontline treatment as every evidence-based guideline now recommends. As well, Cross said the '*First line treatment for SI joint dysfunction consists of nonoperative management …*' Of course, the best non-invasive care are manual adjustments of the SIJ, a 'knack' developed by Chiropractors using traditional spinal joint adjustments. (39)

These two examples show the gist of this controversy. When patients have LBP without evidence of pathoanatomical problems, the obvious Red Flags, that are outside the purview of medical care, poorly trained MDs call these cases '*nonspecific LBP*' as if they are untreatable, so they may prescribe opioid painkillers and wash their hands of them thinking the opioid high will help Yellow Flag psychological cases too.

These inept MDs are not trained to look for the Green Flags of '*biomechanical*' or '*functional pathology*' problems of the spine as described in the paper, '*Biomechanics of Back Pain*,' by Michael Adams, Department of Anatomy, University of Bristol, UK:

> 'Age-related biochemical changes and loading history can also affect tissue vulnerability. Finally, the concept of "functional pathology" is introduced, according to which, back pain can arise because postural habits generate painful stress concentrations within innervated tissues, even though the stresses are not high enough to cause physical disruption'.

Indeed, the use of either term, '*nonspecific*' or '*uncomplicated*', is an admission to the ignorance of MDs who are trained only to see Red Flags such as a 'bad disk' or other gross pathoanatomical problems on imaging such as cancer, fractures, or severe scoliosis. They could not detect Green Flags such as a vertebral subluxation or axial compression problems if shown to them by Yochum, who explained these to the *New Zealand Inquiry on Chiropractic*:

> The movements of vertebra in my opinion are millimetric in nature, very small degree of actual movement of a segment… It is a matter of my expertise, and training, and experience as a chiropractor and as specialist in x-ray. I believe even though the movement is millimetric in nature it is of centimetres in significance in that it does not

39. Let me add not all chiropractors have the knack, skill, or kinesthetic sense to adjust the SIJ, so they use other methods that may work but not as well or as quickly. But any type of spinal manipulation is better than anything the medical world has to offer.

> take more than a few millimetres of derangement to affect the whole neurological complex of a motor unit in the spine. That is what creates the clinical phenomena that we treat. (40)

Nor would MDs know how to care for these complicated cases that require spinal care to restore joint motion by classical Chiropractic adjustments, nonsurgical spinal decompression, spinal distraction, or intersegmental traction; nor do these inept MDs know anything about lengthy spinal rehab to restore tone, flexibility, and stabilisation just as a football player with a damaged knee would need. Indeed, proper spinal care is much more than masking pain with opioids or the *fool's errand* of chasing 'bad disks' commonplace in many asymptomatic people.

Creepy joints

John 'Jay' Triano, DC, PhD, former Professor and Dean of Graduate Education at the *Canadian Memorial Chiropractic College*, explained in his paper the sequence of events in biomechanical problems, '*Biomechanics of Subluxation: Modern Evidence of Buckling Mechanism*.' (41)

As Triano explained, most low back pain cases stem mainly from biomechanical '*buckling*', problems due to axial overloading caused by a '*creep effect*' on the vertebral motor unit consisting of synovial facet joints and lumbar disks, which in turn leads to discopathy, nerve inflammation, and muscular pain problems:

> 'Several characteristics of buckling behaviour are known. An obvious causative factor is a single overload event that exceeds critical load for the conditions. For less severe tasks, the process is more complex. Normal creep deformity occurs with prolonged static posture [from sitting, as example]. Creep alters the constitutive properties of the tissue and the relative critical load. Under the right conditions, even a small additional load will cause the joint to buckle. Rapidly applied loads also are associated with buckling and vibration reduces the threshold necessary to achieve it. Finally, tissues that are damaged, as in discopathy, may buckle sooner and reach maximum displacement (deformation) under lower peak loads than do healthy tissues'.

As you can see, these are not '*uncomplicated*' problems, but serious multifaceted biomechanical problems that require sophisticated imaging/interpretation to pinpoint areas of mal-alignment in the spine, spinal biomechanical diagnosis for areas of fixation/hypermobility, and multifaceted corrective treatment.

Triano, in another paper *Biomechanics Of Spinal Manipulative Therapy*, refutes the literature review of spinal manipulation that tends to think all chiropractors practice the same:

> 'The field of spinal manipulation has often been treated by the literature, incorrectly, as being homogeneous. Much of the confusion regarding this form of treatment can be traced to the ambiguity surrounding the procedures themselves. This report summarises the clinical biomechanics of SMT and evidence for its associated manipulable lesion is reviewed'.

Researchers such as Triano and Adams now suggest so-called nonspecific LBP is due to pathophysiological problems with the spine, that is, how the spine functions, aka, '*functional pathology*', not merely how it looks on imaging, pathoanatomical problems. Namely, the medical terms of '*functional pathology*' as Adams suggests or the synonymous term '*joint dysfunction*' as

40. Inglis, BD, Fraser, B, Penfold, BR, Chiropractic in New Zealand, Report of the Commission of Inquiry into Chiropractic, PD Hasselberg, Government Printer, Wellington, New Zealand. 1979. p. 51.

41. John "Jay" Triano, DC, PhD, gave a precise explanation in his paper, "Biomechanics of Subluxation: Modern Evidence of Buckling Mechanism."278 He explained there are a set of joints between two adjacent vertebrae comprising the "motor unit" where motion and weight-bearing occur. These gliding zygapophyseal joints,

John McMillan Mennell speaks are the same entity classic chiropractors referred to as the '*vertebral subluxation complex*'.

Mennell referred to the functioning of the spinal motor unit as '*joint play*' as a primary concern when he testified at the Wilk antitrust trial:

> 'Eight out of ten patients that come out of any doctor's office complain of a musculoskeletal system problem, regardless of what system the pain is coming from … I will say 100 percent of those complaints … are due to joint dysfunction in the musculoskeletal (system)'.
>
> 'If you don't manipulate to relieve the symptoms from this condition of joint dysfunction, then you are depriving the patient of the one thing that is likely to relieve them of their suffering'. (42)

In this light the vast majority of spinal issues are misdiagnosed and mislabeled by the medical radiologists untrained to detect pathophysiologic/biomechanical issues or to detect spinal joint dysfunction, aka vertebral subluxations, since they do not study these chiropractic principles in their medical training.

Different emphasis

As the NZ Commission noted about this difference '*… the chiropractor on the one hand and the medical practitioner on the other have different emphasis*':

> 'When the chiropractor uses the term subluxation, however, he is referring principally to a functional defect in a joint. The joint may look normal on an x-ray plate. There may be no perceptible misalignment of structural abnormality. But when the joint is examined as it is put through its ranges of motion, it may be found that there is either an abnormal limitation of movement ('fixation'), or an abnormal excess of movement ('hypermobility'), or some other functional abnormality. These abnormalities in joint action may be apparent when the joint is put through one particular arc of movement, but not when it is put through another. The possibilities are wide.
>
> So, the chiropractor on the one hand and the medical practitioner on the other have different emphasis. In examining a suspect joint, by palpation, radiography, or other means the chiropractor is looking primarily for some abnormality in function. He will not necessarily expect to find a structural component, because a functional abnormality need not involve structural abnormality. By the same token a structurally abnormal joint may function perfectly well, although it is common sense to suppose that a structural fault will in most cases be accompanied by some functional deficiency. The point is that structural and functional deficiencies need not necessarily run in harness'. (43)

Clearly this '*different emphasis*' combined with a bit of medical bias has led clinically to the medical radiologists and clinic practitioners misdiagnosing the majority of LBP cases when they apply the pathoanatomical Red Flag explanation that only covers 5% to 7% of patients but misdiagnoses as nonspecific the remaining 85% of pathophysiological or functional cases.

The fallacy of 'bad disks' also fools MDs into believing an '*incidentaloma*' seen on imaging may be the cause of the pain, such as a degenerative disk that research found in most asymptomatic patients as the *Mayo study revealed*. On the other hand, many patients absent of pathoanatomy may have back pain due to the joint dysfunction.

42. Transcript of testimony of John McMillan Mennell, M.D., Wilk v AMA transcript pp. 2090-2093.
43. Ibid. p. 50.

Dhillon mentioned most surgery cases based on patho-anatomy alone explain the high failure rates of spinal fusion:

> 'Despite the existence of sophisticated imaging techniques and a plethora of diagnostic tests, the source of pain in patients with nonspecific back pain cannot be established. There exists no causal relationship between imaging findings of degenerated disc, lumbar facet arthritis, spondylosis, spondylolysis and spondylolisthesis, to the pain in these patients. Surgical treatment of non-specific back pain where no pathoanatomical diagnosis has been established is bound to fail. Therefore, the outcome of spinal fusion in these patients can be no better than nonsurgical treatment'.

Even Dhillon showed his myopia about back pain when he stated '*the source of pain in patients with nonspecific back pain cannot be established*'. Like many MDs, Dhillon still overlooked a major source of nonspecific back pain in many patients was 'joint dysfunction' aka, vertebral subluxations. His omission is more evidence of the blind spot in formal medical education regarding the spine among radiologists, researchers, and practitioners.

He was willing to admit medical methods were ineffective but, to the contrary, the outcomes for nonsurgical spinal treatments such as chiropractic care that have proven to be *more efficacious* in many studies than anything the medical world has to offer. All guidelines now call for conservative, nondrug, nonsurgical care like manipulation, yoga, and exercise before any medical treatments.

John McMillan Mennell MD, orthopedist, who taught at eight American medical schools from 1950 to 1980, explained at the *Chiropractic v. AMA federal antitrust trial* (*Wilk v. AMA*) the nature of joint play, joint dysfunction, and the manipulative therapy as the best solution to this pathophysiological problem:

> 'To understand it, you would have to accept that the science of mechanics demands that anything that moves has joint play built between the moving parts…This joint play movement is prerequisite to normal pain-free functioning of movement… in the spine there are about 137 synovial joints between the lamina facets, the occipital condyles, the bottom of the skull as it rests on the atlas, the sacroiliac joints, the sacrococcygeal joints, the z-joints, even the joints of the *fundusca* in the neck.
>
> 'Eight out of ten patients that come out of any doctor's office complain of a musculoskeletal system problem, regardless of what system the pain is coming from …
>
> 'I will say 100 percent of those complaints … are due to joint dysfunction in the musculoskeletal system.
>
> 'If you don't manipulate to relieve the symptoms from this condition of joint dysfunction, then you are depriving the patient of the one thing that is likely to relieve them of their suffering'. (44)

The anatomy, physiology, and mechanics of the spine tell the fascinating story of spinal biomechanics and axial compression that far supplants the simplistic 'bad disk' theory as the main cause of back pain. The spinal column is a precarious weight-bearing pillar of 364 joints interlocking 24 vertebrae interconnected by 23 cartilaginous disks that act as shock absorbers. This joint total includes all synovial, symphysis and syndesmosis joints according to Gregory D Cramer DC, PhD, Dean of Research at *National University of Health Sciences*. (45)

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44. Transcript of testimony of John McMillan Mennell, M.D., Wilk v AMA transcript pp. 2090-2093.
45. Cramer, G.; Darby, S. 2014 Clinical anatomy of the spine, spinal cord, and ANS. 3rd Edition, Elsevier/Mosby, St. Louis, 559 illustrations, 672pp. Appendix I, pp. 638-642.

Fool's errand

Undeniably 'bad disks' seen on x-rays and MRI scans have been used as effective selling points to gullible patients that have greatly increased the number of unnecessary surgeries at an enormous cost and waste according to a Stanford study, *MRI abundance may lead to excess in back surgeries, study shows*. This study also found increased surgery rates do not improve patient outcomes. (46)

In fact, back surgery rates are highest where MRIs are the highest. In a randomised trial, researchers found that doing an MRI instead of a plain x-ray led to more back surgery but did not improve the overall results of treatment. (47) The reason for these poor results rests with the widespread misconception of the 'bad disk' diagnosis as the cause of LBP and the need for disk fusion surgery.

The presence of a herniated disk also does not warrant the need for surgery until conservative care has been tried. In 2010 the *North American Spine Society* journal published an article *NASS Contemporary Concepts in Spine Care: Spinal Manipulation Therapy For Acute Low Back Pain*, suggesting spine fusion should be a last resort and recommended that spinal manipulation, 5 to 10 sessions over 2 to 4 weeks, should be considered before surgery. (48)

The issue of unnecessary spine surgery is not a new revelation considering in 1994 the *Agency for Health Care Policy & Research* (AHCPR) mentioned no need to rush into fusions:

> 'Even having a lot of back pain does not by itself mean you need surgery. Surgery has been found to be helpful in only 1 in 100 cases of low back problems. In some people, surgery can even cause more problems. This is especially true if your only symptom is back pain'. (49)

Researchers now recognise a lesser-known fact that disk bulges and herniations often undergo some degree of regression without surgery. In the past decade, research has shown that discs do, in fact, move back, and do so to a significant degree (70 percent or more). (50, 51, 52)

Another surprising discovery has shown that clinical improvement does not generally correlate with regression, indicating that the '*ruptured disc pinching nerves*' concept may also be wrong. Just as Boden and Jensen found, patients with obvious bulging discs often had no back or leg pain. In fact, the ubiquitous nature of 'bad disks' in pain-free people was seen a study at the *Sydney 2000 Olympic Games* which found these elite athletes had a greater prevalence and greater degree of lumbar disk degeneration than the normal population, yet they were the best athletes in the world. (53)

To focus a spinal pain solely on the disk is a fool's errand where too many in the *Spine Cartel* [*see Note, p. 7*] have taken millions of unsuspecting patients in pain to convince them of the need

46. MRI abundance may lead to excess in back surgeries, study shows, Stanford School of Medicine, 2009.
47. Richard A. Deyo, MD, MPH and Donald L. Patrick, PhD, MSPH, Hope or Hype: The Obsession with Medical Advances and the High Cost of False Promises, AMACOM books, (2005): 36-7.
48. MD Freeman and JM Mayer "NASS Contemporary Concepts in Spine Care: Spinal Manipulation Therapy For Acute Low Back Pain," The Spine Journal 10/10 (October 2010):918-40.
49. Acute low back problems in adults: assessment and treatment. Agency for Health Care Policy and Research
50. E Ilkko, S Lahde, ER Heikkinen, Late CT Findings In Nonsurgically Treated Lumbar Disc Herniations. Eur J Radiol. 16/3 (1993):186-9.
51. MR Ellenberg, ML Ross, JC Honet, et al. Prospective Evaluation Of The Course Of Disc Herniations In Patients With Proven Radiculopathy. Arch Phys Med Rehab 74/1 (1993):3-10.
52. K Bush, N Cowan, DE Katz, et al. "The Natural History Of Sciatica Associated With Disc Pathology," Spine 17/10 (1992):1205-12.
53. A Ong, J Anderson, J Roche, A pilot study of the prevalence of lumbar disc degeneration in elite athletes with lower back pain at the Sydney 2000 Olympic Games, Br J Sports Med 2003;37:263-266 DOI 10.1136/bjsm.37.3.263

for spinal fusion or laminectomy which explains the high failure rates of 50% or more with diminishing returns.

The spine surgeons also see the tsunami of the 50% of failed back surgeries but don't bat an eye to do more since there is no Lemon Law to provide a no-cost remedy for patients in order to compensate for services that repeatedly fail. This fool's errand can be seen not only as misdiagnosis, but also as trafficking of gullible patients not knowing most spine surgeries are only at best 50% effective for only 5 to 8 years before the patient will undergo additional fusions with the diminishing returns. (54)

Not all Chiropractors are the same

Triano in another paper, *Biomechanics Of Spinal Manipulative Therapy*, refutes the fallacy that spinal manipulation is all the same:

> 'The field of spinal manipulation has often been treated by the literature, incorrectly, as being homogeneous. Much of the confusion regarding this form of treatment can be traced to the ambiguity surrounding the procedures themselves'.

Indeed, not all chiropractors practice with the same techniques, skill level, or clinical experience, but to the public, all DCs seem alike. According to the *Canadian Chiropractic Association*, there are about 200 chiropractic techniques, most of which are variations of spinal manipulation, but there is a significant amount of overlap between them, and many techniques involve slight changes of other techniques that include many non-force techniques.

Gatterman study

Certainly not all techniques are equally as effective for low back cases. In 2001, JMPT published an article, '*Rating specific chiropractic technique procedures for common low back conditions*' by Meridel I. Gatterman DC, Robert Cooperstein DC, MA, Charles 'Skip' Lantz DC, PhD, Stephen M Perle DC, MS, and Michael J Schneider DC, PhD.

In the rating scale of 1-10, the effectiveness of procedure ratings for acute low back pain for 10 procedures were quite revealing. Ranking them in descending order for low back pain found the following:

1. HVLA, no drop table (side posture) = 9.5
2. HVLA, prone, with drop table assist = 8.7
3. Distraction technique = 8.7
4. Mobilisation = 8.0
5. HVLA, prone, without drop table assist = 6.4
6. Pelvic blocking procedures = 6.3
7. Lower extremity adjusting = 3.7
8. Instrument adjusting = 3.7
9. Non-thrust/reflex/low force = 3.5
10. Upper cervical = 3.3

They concluded that the ratings for the effectiveness of chiropractic technique procedures for the treatment of common low back conditions are not equal. Those procedures rated highest are supported by the highest quality of literature. Much more evidence is necessary for chiropractors to understand which procedures maximally benefit patients for which conditions.

54. Nachemson AL. Evaluation of results in lumbar spine surgery. Acta Orthop Scand Suppl. 1993;251:130-3.

If a chiropractor was treating a patient with severe LBP and had a variety of techniques at hand, the best method may not be the most appropriate. For example, she may want an Activator gun to begin with, or may do a blocking technique to calm down the swelling. An UpC practitioner may choose to toggle the Atlas, or an experienced full-spine Gonstead practitioner may prefer to perform a gentle HVLA side-posture with a distraction table. Considering the patient's pain tolerance, level of inflammation, and doctor-patient trust, the preferred technique may depend on many non-physical or psychological factors, and this may change as the patient improves or not.

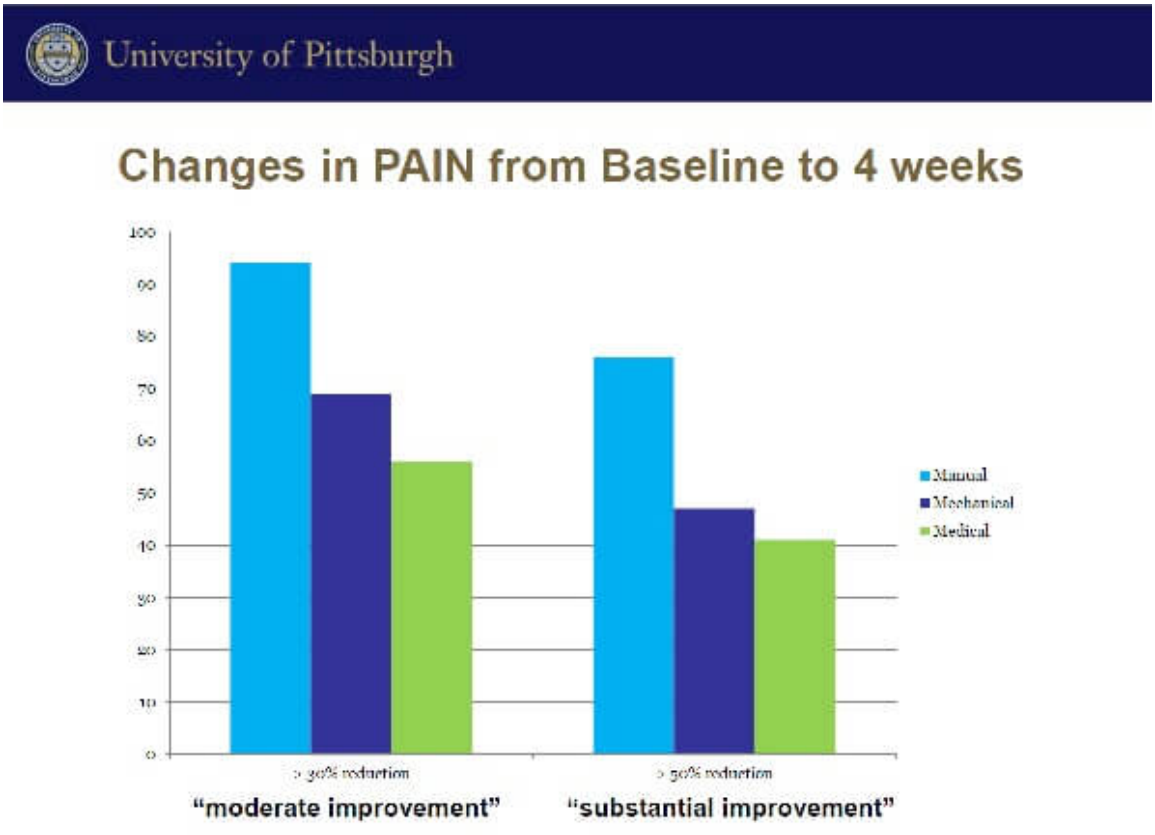
Indeed, in this era of 'best practices' and evidence-based methods, perhaps we should adapt our methods to the patient's need rather than adapting every patient to our technique!

Schneider study

Another comparative study was revealed at the 2014 ACC-RAC conference in Orlando by Mike Schneider DC, PhD, when he presented a new paper '*A Comparison of Spinal Manipulation Methods and Usual Medical Care for Acute Low Back Pain*.' (Michael Schneider DC, PhD; Mitchell Haas DC; Joel Stevans DC; Ronald Glick, MD; and Doug Landsittel PhD."

This study compared three methods for LBP care: classic HVLA chiropractic care vs. Activator vs. usual medical care (OTC meds).

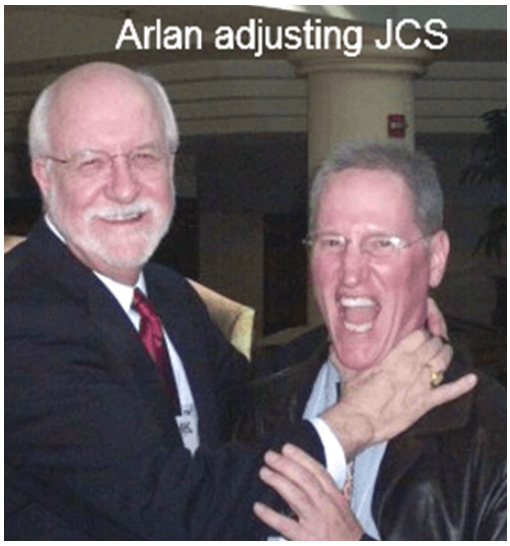
The graphs for Oswestry and Pain were revealing:



Conclusion

As shown above classic 'hands-on' Chiropractic care (Manual, Blue) out-performed both Activator™ and standard medical care in terms of Changes in Pain and OSW results. Schneider concluded that '*manual manipulation provides significantly more reduction in disability and pain at 4 weeks as compared to mechanical manipulation or medical care*'.

According Schneider, at best Activator™ is slightly better than NSAIDs; worse, it is rated low on the scale of effective chiropractic treatments by Gatterman et al and, at worst, it is sold to the public as '*safer, more gentle and modern*' compared to classic chiropractic care when this study showed it is not equivalent.



Chiropractors must be honest with patients who don't know there is a difference among Chiropractic treatments. At least the patient must understand the style of Chiropractic care care offered by that DC and that if that method fails to produce significant results in 2 to 4 weeks as the guidelines state, then the patient will be referred to another Chiropractor using a different technique before being sent to the surgeon, which should be the goal of every DC, that is, to avoid drugs, shots, and surgery.

Not included in this list is *nonsurgical spinal decompression* that poses a real threat to both Chiropractors and spine surgeons when fully accessible to all patients and may replace surgical decompression in 80% of cases as research now shows.

If Scope of Competence is to protect patients, each practitioner of any type must be honest with patients and other practitioners to do the right thing, even when no one is looking.

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