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Increasing Market Share, Part I

Avoiding Competitive and Market Identification Limitations

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My first experience with discrimination against practitioners of "alternative medicine" came in the early 1980s as a result of being the attorney for medical doctor criminally prosecuted for involvement in a natural/nutritional and functional medicine cancer treatment program at Murrieta Hot Springs, California. Very little was known about the concept of "functional medicine" in the United States at that time. Indeed, it is still not well known today. (Please see my article on "Biofunctional Medicine" in *Dyn. Chir*. 9-21-98.)

The district attorney's office (where I had formerly been a prosecutor), together with the California Attorney General's Office, had obtained a search warrant for five items which could have been housed in a shoe box. Nonetheless, the police seized enough documents and things to fill 17 large boxes. Unfortunately, this was and still is a typical scenario when it comes to practitioners of alternative medicine.

During my involvement with this Murrieta case I met several interesting persons, including one of the country's leading biomedical researchers. This researcher was very interested in all kinds of natural healing processes and had previously been an expert witness in several alternative care cases. I intended to use him in this case. I also met a chiropractor who knew a great deal about all forms of natural healing. (If that doctor reads this, I would like to hear from him.) Against my strongest advice, my client and the promoter of the cancer program went on "60 Minutes." As expected, Mike Wallace slaughtered them. (I understand this segment has been one of the most frequently re-aired programs on "60 minutes.") Suffice it to say, the promoter of the program jumped bail and disappeared into South America (or somewhere) and the case was finally dropped against my client.

In preparation for the defense of my Murrieta client, I did a significant amount of research into natural healing, the history of the "quackbusters" and the dominance of the AMA. This made me realize there has,

throughout most of this century been an ongoing suppression of alternative biological and medical models; especially any model which asserts that life is the product of intelligent design. Society is much richer when all opinions relative to such matters are invited to the discussion table, the funding stream and are afforded constitutional protection. Of course, that cannot happen when the materialist, Darwinian "viewpoint" corners the market place of ideas and becomes the "established" arbiter of all issues relating to life and death.

It is equally impossible to avoid "viewpoint discrimination" whenever one group of chiropractors asserts the right to define "chiropractic" for everybody else. Under such circumstances, it becomes advisable to create a larger umbrella under which different types of drugless practitioners can define their own market identity. I intend to show in this series of articles that the concept and title of drugless physician is the most suitable umbrella. I will address the legal, educational, and political aspects of the process needed to create the license category of drugless physician. The additional articles will be "Part II: Prince Charles: Scopes Trial and the Concept of a Core Curriculum," and Part III: Maximizing Practice Options and Market Image in a Changing World."

Practice Options

Real or Illusion?

Practice options, whatever they may be, may be either totally or substantially illusory for any one or more of several reasons:

1. The proposed activity does not fall within your legal scope of practice.
2. Some other practice group has a significant competitive advantage in that arena for legal (e.g., access to managed care) or market identification reasons.
3. Somebody, or group, is creating a market identity for "chiropractic" which does not include the type of practice in which you may wish to engage.

The "scope of practice" category is the most obvious, but it may not be the most important. Suffice it to say with respect to the "scope" issue that in California, (at least, under the terms of the Rule 302 which resulted from the litigation in the 1980s) as I have discussed at length in prior articles, a chiropractor is not entitled to do anything other than adjust the spine and perform other services as a direct adjunct thereto. This is also true in many other states. There is at least one notable exception -- Illinois. (I will return to these points

more directly in Part III.) For now, I will make some brief connections between the competitive advantage and market categories relative to the musculoskeletal specialist and the "straight (philosophical) chiropractic" perspectives.

Musculoskeletal specialists: Personally, I like this model, as far as it goes. I have handled personal injury cases (as a lawyer) for over 25 years and I, and all other P.I. lawyers, want to hear only this perspective in injury cases. There is a huge amount of competition for this limited market. Let’s look at a few examples.

Chiropractors obviously have significant competition for the osteopathic spinal lesion is essentially the same as our current model of the "subluxation complex" which was, in significant part, derived from the work of Dr. Korr, an osteopath. I realize that some of you will disagree with my conclusion about the osteopathic lesion so I will quote the judicial explanation of osteopathy from two court cases:

Collins v. Texas (1912) 223 U.S. 295-297
"An osteopath professes ... to help certain ailments by scientific manipulation affecting the nerve centers."

Osteopathic Physicians v. CMA (1964) 36 Cal. Rptr. 641, 643
"Osteopathy is a separate school of the healing art and profession, embracing ... emphasis on functions of musculoskeletal structure, and on natural curative resources, and manipulative therapy."

I am well aware of the argument about "adjustment" v. "manipulation." To use an expression often used by lawyers, it seems to be "a distinction without a difference." That really is not my point anyway. The question is competition and the possible need for an expanded market identification.

Naturopaths have been adjusting the spine and dealing with muskuloskeletal problems since at least 1907 when Benedict Lust, the founder of naturopathy in this country, founded the American School of Naturopathy and Chiropractic in New York. Practitioners of Chinese medicine have been using manipulation of the spine for at least two thousand years. Perhaps the most troubling fact is that massage therapists (some with only 100 hours training) are being taught extensive soft tissue practices, including spinal manipulation, by the osteopath John Upledger and others.

From a perspective of chiropractic history, the most interesting group is the naprapaths. They are followers of the theories of Oakley Smith who, along with Solon Langworthy and Minora Paxson, founded the American School of Chiropractic and Nature Cure in Cedar Rapids, Iowa in 1903. Langworthy, Paxson and Smith wrote the first chiropractic textbook. This text became the core of the legal defense of a Japanese

chiropractor who was charged with practicing osteopathy without a license in Wisconsin in 1907. The attorney who represented this chiropractor argued that chiropractic philosophy, science and art has no resemblance to any other science. This "unique philosophy, science and art" thesis became BJ’s mantra three months after the trial when he first claimed to be the "developer" of chiropractic. (Please see my prior article: "Legal ’Image’ strategies for Chiropractic -- Past, Present and Future" (*Dyn. Chir.* Aug., 1998).

Naprapaths, among other things, emphasize the importance of defects in the connective tissue which interfere with neural function. The state of Illinois recently granted naprapaths the right to be licensed separately from chiropractors. Theï chiropractic license. The naprapathic license is recognized as a limited license and specifically precludes making a differential diagnosis. (More about this in Part III.)

The list of our competitors for the musculoskeletal market obviously includes orthopedic surgeons and physiotherapists; especially when one considers the fact that most of this type of work is going to come through managed care in the future. Psychologists are also getting into this area of practice through the use of surface EMG.

We can respond by intensive marketing, suing to attempt to limit the practice rights of these other practitioners as was recently done relative to Medicare Part C and/or we can: 1) seek to expand our practice rights and our market image or 2) limit our market identification to "straight" chiropractic. (See below.) Each of us needs flexibility to prioritize our own course of action and I suggest that some of us should seek a a new market identity and practice reights as drugless physicians. I will outline a specific program for achieving this objective in Parts II and III. Education will be seen as a critical component of this process.

Straight (philosophical) chiropractic: I must confess, I am not quite sure what this expression means. When I ask most of those chiropractors who speak about "philosophy" I cannot get much other than its the "big idea;" "the power that made the body, heals the body;" "one cause/one cure." Hardly a detailed philosophical or scientific dissertation.

Each of the stated propositions is grounded in D.D. Palmer’s ideas of "universal and innate intelligence." It is not entirely clear what he meant by these terms, but that does not really matter. The point is not what (or who) this "Intelligence" might be, but that it is. Ask a Chinese scholar what chi is and he will tell you it is energy, it is mind, it is compassion -- "It is." It also recognizes that "life" is more than the sum of its parts.

D.D. recognized that there was something more than mere matter involved with the processes of life and that disease could not be simply reduced to only a problem in one of the body's component parts. He also reasoned that the "vital force" is relevant to clinical practice through some material mechanism which can be interfered with. (And, perhaps through what Dr. Benson of Harvard would call the biology of belief.) D.D. thought that the material mechanism which brings coherent unity to the various parts is manifested through the nerves. It appears to be, at least in part.

Once one accepts the ontological (What is Reality?) proposition that there is more to reality than matter and separate, discrete events, the door is opened to focusing increased attention upon the scientific exploration and/or therapeutic utilization of at least the following:

1. A "wholistic" medical model which includes recognition of factors outside the individual cell/gene as critical to health and incorporates energetic, informational, vibrational thinking, etc., into its basic paradigm.
2. Techniques to improve host resistance by, in part, removing interference in, and maximizing the function of, the "life force" (chemistry, energy, information, etc.) as it manifests, in part, through the innate regulatory system(s).
3. Early therapeutic intervention at the level of electromagnetic (light) energy, information, chi, vibration (or as D.D. would say, "innate intelligence."
4. The greater use of natural (biologically synergistic) remedies: nutrition, herbs, homeopathics.
5. The concept that this "life force" is so irreducibly complex that clinical science must, at least in part, be based upon ascertaining what works. (Samuel Hahnemann, the founder of Homeopathy, espoused such an empiricist position.) Of course, we must recognize that this observation process must be quantified as was argued by Nick Black in an important 1996 article in the *British Medical Journal.* ("Why we need observational studies to evaluate the effectiveness of health care." BMJ, 1996; Vol. 312: 1215-8).

There is room for the musculoskeletal, "straight," biofunctional and other forms of drugless medical practice under one tent, but only so long as no one group is empowered to "brand" everybody else with their particular perspective. Indeed, we live in a transitional era in which all doctrinal assumptions, including those within our own heritage, must be open to thoughtful reconsideration and challenge.

We need to create a broader umbrella under which we may all be able to co-exist and work towards the mutual benefit of all concerned. I suggest the "larger umbrella" (drugless physician/limited specialist)

approach is the one to take and will spell out some of the details of this proposal in Parts II and III of this series.

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