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Throwing Stones -- on My Patients' Behalf

By John Lowe, MA, DC

In my September column, I urged DCs to educate their myofascial patients about the dangers of prescription drugs.¹ Then came a letter of rebuttal from Scot G. Fechtel, D.C.² He wrote, "It seems apparent that Dr. Lowe has not read the research on myofascial pain to which he refers." This comment suggests to me that Dr. Fechtel might be a careless thinker. The rest of his letter supports that conclusion.

Dr. Fechtel (who announced he's a second year medical student) interpreted my column as just a lot of trouble-making MD bashing. He reprimanded me for lambasting medical iatrogenesis. His reason? Because there is also chiropractic iatrogenesis. He wrote that as an Independent Medical Examiner (IME), he's seen a great deal of damage done by DCs, and he knows of hundreds of myofascial patients who've been detained from proper care, with a long series of adjustments. Iatrogenesis is unfortunate in any discipline. But, chiropractic's backyard can't realistically be compared with that of medicine. Ours is a somewhat littered lawn, but theirs is a leaking, spewing, toxic waste dump. It's one thing to detain patients with adjustments; it's quite another to make them sicker or even kill them with poisonous chemicals. The fact is, medicine's dismal record dwarfs chiropractic iatrogenesis.

It's precisely the perils of medical care that repel me from cooperating with the average medic. In the years I've worked with myofascial patients, I've occasionally sought the cooperation of an MD when I felt my patient might benefit from it. This, however, has been very select cooperation. As often as DCs like Dr. Fechtel try to box my ears for not doing so, I resolutely refuse to use my patients as tobacco to smoke in a peace pipe with the average medic.

I consider cooperation a noble ideal -- in general. But when a patient's welfare is on the line, this ideal should move us only where critical thinking points. When our patients are likely to benefit from cooperating with MDs, then it's the only ethical thing to do. Too often, though, a DC's desire to cooperate is based on something other than potential benefit to his patients. His motivation, for example, may be to hobnob with

MDs and feed on the crumbs of their "prestige."

In any case, the cooperation-bent DC may forsake his patient's welfare unless he's choosy. To protect his patient, he must pick an MD as carefully as an explosives expert selects the wire he snips to defuse a terrorist's bomb. Choose the wrong one, and the patient may fare as poorly as the careless explosives expert. Illich, for example, documented that on the average, medics are monstrously pernicious. In 1976, he wrote of doctor-inflicted injuries: "The pain, dysfunction, disability, and anguish resulting from technical medical intervention now rival the morbidity due to traffic and industrial accidents, and even war-related activities, and make the impact of medicine one of the most rapidly spreading epidemics of our time. Among murderous institutional torts, only modern malnutrition injures more people than iatrogenic disease in its various manifestations."³

Early in my career, I was appalled to witness in many of my patients the medically-induced harm Illich had written about. Out of my mouth-gaping astonishment, I wrote in 1983, "Let's face it -- at this time, dogs rank head-and-shoulders above the MD as man's best friend. We can teach most dogs to help make life a happier affair for us, but trying to teach the same to the average MD is like trying to grow water lilies in a desert. The MDs extreme business, impatience, inflated sense of self-importance, his know-it-allness and arrogance make it impossible to teach him what he should know -- that he could best help patients by laying aside his prescription pad, rolling up his shirt sleeves, and physically treating them."⁴ Today, I would add that he should also diligently search for underlying factors that sabotage patients' recovery.⁵ In his quest, he'll find that for many patients, pharmaceuticals are the very root of their resistance to treatment.

The future for such myofascial patients is dim, as long as they remain under their medic's care. He dishes out drugs like he's throwing candy off a Mardi Gras float. This same view has been expressed (albeit more softly) by the man who's made more money for drug companies than any other human, Nobel prize-winning pharmacologist, Sir James Black. An interviewer asked him, "Why are therapeutic drugs so widely abused today?" He answered, "People consume prescribed drugs because someone prescribes them. The medical practitioner is the narrow wicket gate through which all the stuff flows. Are people with this privilege and responsibility making wise decisions?" His implicit answer to his own question was, of course, a resounding no.⁶

MDs make unwise and deadly decisions on a gargantuan scale. Scot Fechtel, as a DC, should stand beside me shouting for reform. Instead, he goes to medical school, raps me over the knuckles for criticizing

medical mayhem, and implies that I should be tickled silly that MDs will cooperate with me.

"If we are truly concerned about our patients," he wrote in conclusion, "we will seek out the best methods to treat our patients, not continue to throw stones." I've studied with obsession, the scientific papers Fechtel accuses me of not reading. It's the content of hundreds of such papers (integrated with my professional experiences) that has taught me what's best for my myofascial patients -- that I not cooperate with the average MD. Instead, I work vigorously to liberate my patients from them. As well as being a DC, I'm an educator. I talk and write about what I've learned, including the harm many MDs continue to do to myofascial patients. If that's to throw stones, then so be it. I'll continue to throw them -- on my patients' behalf.

References

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Editor's Note:

Dr. Lowe will be conducting his next Myofascial Pain seminar in Dallas, Texas, on February 2-3, 1991. You may register by dialing 1-800-327-2289.

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