The Unlikely Defender of the Subluxation

Interview with Gary Jacob, DC, LAc, MPH, DipMDT

By TAC

Gary Alan Jacob, DC, LAc, MPH, DipMDT completed his baccalaureate studies in Philosophy of Science. He graduated from Los Angeles College of Chiropractic in 1978 and the California Acupuncture College in 1981. He was the first DC and the 12th individual to receive a Diploma in Mechanical Diagnosis and Therapy in 1991 from the McKenzie Institute International. In 2003, he received a Master's in Public Health in Community Health Education and Promotion from UCLA. He is an Elected Enrollee of the Johns Hopkins Delta Omega Honorary Public Health Society. Gary remains in private practice in Pacific Palisades, California. He teaches locally (at SCUHS and acupuncture colleges) and internationally about clinical reasoning, philosophy of chiropractic, biopsychosocial approaches, and the McKenzie method (MDT) model. Dr. Jacob has authored several textbook chapters about the McKenzie approach.

The American Chiroptactor (TAC): What are some of the services and products you provide to chiropractors?

Dr. Gary Alan Jacob (GJ): As an educator, I have attempted to serve the chiropractic profession by promoting the logic and ethics regarding rehab issues. It is my responsibility to make students aware of resources for products geared toward promoting self-efficacy.

Most of the products I employ are produced and distributed by OPTP, a company that was chiropractic-friendly before it was fashionable, and one that has promoted important interdisciplinary links between chiropractic and other disciplines.

As an educator, I have attempted to promote critical clinical reasoning regarding chiropractic's most unique attributes, including the following:

1. That movement of the spine to end-range can have positive health outcomes.

2. That movement of the spine to end-range in one direction may have a better response than movement to end-range in another direction.

3. That movement of the spine to end-range in one direction may be deleterious and should be avoided until health is restored to the point of that direction being safe.

Of these three principles, most chiropractors employ the first two in practice, and although most might agree with the third, most do not employ it in practice, which results in adjustments that do not "hold."

TAC: What are your goals in treating patients?

GJ: My goal in treating patients is to promote self-efficacy from the perspective that spinal complaints are of multifactorial origins. In addition to mechanical therapies, the promotion of positive health behaviors is important regarding diet, supplementation, exercise (aerobics, strengthening, relaxation exercises), etc.

TAC: How did you develop your treatment protocols?

GJ: After graduating from chiropractic college, I had manipulation skills but no clear way of knowing how to use them except for palpating for sticky joints.

After seven years in practice, I stumbled on the McKenzie method (MDT), an approach developed by a New Zealand physiotherapist that, for me, illuminated my understanding of the subluxation (McKenzie calls it a "derangement"). What the McKenzie method provided for me was the symptom profile of the subluxation listing; it is my belief that chiropractic has been handicapped historically by ignoring the symptom pattern of the

subluxation, i.e. how symptoms behave, in tandem, with mechanical findings. The McKenzie method identifies patterns of those behaviors permitting a better understanding of which spinal movements should be pursued and which should be avoided in relation to positioning, exercise, or manual therapies. In addition to McKenzie, I have been influenced by others, such as Mulligan, Butler, and Laslett.

My approach for the lower back pain of a 44-year-old would be as follows. After ruling out red flags, I make the assumption that complaints are derangement (subluxations) until proven otherwise. Should evidence for that be lacking, the next consideration would be the sacroiliac, tested via Laslett protocols (specific and sensitive) requiring three out of five reliable SI tests (iliac distraction, Gaenslen's, thigh thrust, iliac compression, sacral thrust). Should that fail, the next consideration would be facetogenic pain, keeping in mind that Laslett demonstrated extension rotation pain to be 100% sensitive for facetogenic pain (i.e., if there is no pain with the test, you don't have it!). My next consideration would be whether short tissue explained complaints, which would require a ROM loss consistent with the muscle believed to be short. Other explanations to be considered, if presenting phenomena remains unaccounted for as joint or short-muscle based would be inflammation, clinical instability, nutritional, sensitized nervous

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system, psychological, etc. The approach I follow is shared by many rehab-oriented chiropractors and has best been formalized by Donald Murphy, DC, DACN, initially known as the Diagnosis-Based Clinical Decision Rule and currently called CRISP (clinical reasoning spine pain).

TAC: What is the most common problem you see new or struggling chiropractors have in treating patients?

GJ: Aside from the economics of practice, the most common problems I see concern both conceptual and physical skills. When confronted with a clinical problem, there is no clear understanding of what to do or when to do it. The erroneous medical assumptions of spasm and inflammation have infected chiropractic thought precluding the willingness or ability to determine and correct subluxations. Curiously, the lack of ability of new graduates to adjust the spine by hand is commensurate with chiropractic institutions being less willing to use the word subluxation. Many new chiropractors lack the confidence or ability to adjust the spine, resulting in a fear of moving the spine and the pursuit of non-movement passive therapies. New graduates can tell me more about contraindications for adjusting versus indication for adjusting.

TAC: What types of chiropractic techniques do you prefer?

GJ: Prior to attending LACC, I had a chiropractor in Manhattan who was a toggle-recoil HIO instructor for B.J. Palmer. When he heard I was to attend LACC, he went into mourning and then taught me toggle-recoil HIO to his satisfaction prior to my departing for Los Angeles. To that end, I have a MT-125 (MT Tables) toggle-recoil multidirectional headpiece stationary table with thoracic and lumbar drop pieces as well.

Of all areas of the spine, it is my opinion that the upper cervical spine perhaps needs more manual assistance than other areas and I find upper cervical drop-piece adjusting to be well suited for that purpose.

As a McKenzie chiropractor (McChiropractor?), I also employ the REPEX II table from Hill Laboratories, which permits continuous passive lumbar extension or flexion motions.

I do not prescribe to any particular chiropractic "technique." I am a hands-on, diversified adjustor guided by mechanical and symptomatic responses to loading as revealed by patient-generated positioning, movements, and exercises, as well as pre-manipulation mobilization testing. My approach is adjustment, not subluxation-based. The belief of having to determine exactly where the subluxation is so the force can be applied to exactly that spot may not be prudent (research indicates that the cavitation does not always occur where the hand is applied). One can conceive, for whatever reason,of situations where in that a subluxation may be best corrected with the force/fulcrum applied above or below the subluxation level. The mechanical and symptomatic responses to the force applied are more relevant than determining where to apply force based on criteria that ignores those responses.

TAC: What patients improve the most significantly with care?

GJ: The patient that improves most significantly with care is the patient for whom the appropriate education is provided. Education/exercise should be preferred to passive coping strategies that prolong the cost of care and reduce outcomes. The manner in which care is framed is very important. If benefit from exercise is explored before manual therapies, the sufferer realizes its efficacy, believes the DC feels it is important, and, therefore, is more likely to comply. If the DC rushes to rescue the patient with passive procedures and teaches exercise later, the outcome/compliance will not be as good.

The manner in which interventions are framed is also important. Benefit from an adjustment may be interpreted as meaning that the DC is the way, the truth, and the life, or a different interpretation may be forwarded for a better cognitive-behavioral effect. Benefit from an adjustment can also be diagnostic/educational by the following communication:

- There was benefit from movement
- There was benefit from aggressive movement to the end of range.

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- Your spine is, therefore, strong.
- Your spine is not damaged; it is deconditioned.
- It has a movement deficiency, especially concerning movements to end-range.
- Exercises to end-range (similar to adjustments) can be developed to give you similar relief.
- The avoidance of certain end-ranges will also benefit you.
- You do not need to fear exercises at home, as the forces involved are less than the adjustment.

The role of chiropractic versus rehab

Chiropractic is the name of a profession, not a technique. It is impossible to discern what "chiropractic" technique is for any individual chiropractor. Some distinguish what DCs do as "chiropractic" and "physio," the former meaning adjustments and the latter meaning modalities and, less often, rehab exercise.

It is my hope, (and I believe it is crucial for the survival of the chiropractic profession), that chiropractic would someday be indistinguishable from rehab, thus snuffing out critics of chiropractic that accuse us of promoting passive palliative procedures resulting in dependency.

I have referred to the "adjustment" as a diagnostic and educational tool for rehab. Of all the passive therapies, the

adjustment has the best evidence-based support and is related to rehab, inasmuch as it is a movement therapy.

Hopefully, chiropractic will have a future if it embraces the principles of rehab. Currently, the chiropractic profession is made of different tribes (techniques) having separate languages and approaches. The failure of the chiropractic profession to account for the symptom profile of the subluxation makes "magical" techniques attractive. It is a Tower of Babel that challenges the argument that the DC profession should be primary care.

The role of chiropractic should be indistinguishable from the role of rehab. For me, it has been the marriage of the McKenzie method with chiropractic that has permitted that to happen.

The McKenzie method takes a history regarding the effects of end range loadings and performs end-range loading exam procedures; based on that, an exercise program is developed involving the pursuit of certain end ranges and the avoidance of others. If complaints and mechanics recover, the sufferer was taught how to saddle up and ride innate themselves. If there is a partial response, greater forces in the same direction (i.e., an adjustment) is pursued.

Particular patients

The type of patient that sticks out in my mind the most is the patient that gets significant, albeit short-term relief from chiropractic adjustments, but has never been progressed to an adequate exercise program. The patient presents with a history of medications, injections, and modalities failing with the only significant (temporary) relief being realized with adjustments.

The history of relief with adjustment is a history of relief with movement of end range . It is rare for me to encounter a patient who reports significant short-term relief from adjustments who cannot be liberated from dependence on adjustments if instructed how to perform end-range loading exercises in certain directions (like an adjustment), and if instructed about which movement directions to avoid (so the correction "holds").

After that the patient would further benefit from being progressed to an adequate aerobic, strengthening, and relaxation exercise program. All too often, the only exercise given is "stretching" without any evidence of the ROM loss predicted by the muscle purported to be short.

▶ Please visit http://www.garyjacob.com to access educational materials written by Dr. Jacob or to contact him.