Scientifically Speaking

Chiropractors and the AMA

BARBARA J CULLITON, WALLACE K WATERFALL

British Medical Journal, 1979, 1, 467-468

Washington, DC—Whatever its difficulties in adapting organisationally to such developments as rapid expansion of biomedical knowledge, increased expectations of medical care, and waves of Vietnam-reinforced wariness about all establishments, the American Medical Association until recently has spoken with authority on matters of ethics in medical practice. Its policy statements about ethical principles—which must be approved by the representative House of Delegates—and its interpretations of the ethical standing of individual instances of practice—which are issued as needed by the Judicial Council—have kept the organisation buoyant on some tricky and shifting currents of moral sensitivity over several decades.

A question of ethics

And so, while the growth of specialty societies eroded both AMA membership and its position as prime expositor of scientific advances in medicine, while social activists castigated the AMA for failing to put doctors into city slums and rural wastelands, and while the very phrase “organised medicine” came to connote in some minds a monolithic impediment to health care, the AMA’s powers of policing and pronouncement about medical ethics were apparently undiminished.

Among its longstanding ethical proscriptions are those against doctors advertising and doctors consorting professionally with such “unscientific cultists” as chiropractors. But now the AMA position on both issues is under attack, and it is the matter of chiropractic that seems most threatening to the organisation’s residue of leadership of the profession. The ban on advertising by doctors to attract patients is being challenged by the Federal Trade Commission, the Government agency that is supposed to assure a truly competitive marketplace in all commercial endeavours that fall under “anti-trust” laws. On another medical issue not bearing directly on ethics, the FTC also believes the AMA should have no control over the accreditation of medical schools.

Trouble with chiropractors

The AMA has vowed to combat these and some other Governmental incursions on the medical profession, by taking

certain cases to the US Supreme Court if necessary. It has not made statements of similarly clearcut pugnacity about the troubles with chiropractors.

Those troubles began in the autumn of 1976, when five chiropractors from different states filed a lawsuit in a Chicago federal court, alleging that the pursuit of their business activities was being restrained by the concerted actions of the AMA, the American Hospital Association, five medical specialty societies, including the American College of Radiology, the national organisation of osteopaths, the city, county, and state medical societies that cover Chicago, a hospital accrediting body, and an assortment of individual executives of medical organisations. Three months later, chiropractors in New Jersey filed a similar suit in their state court, presenting it as a “class action” on behalf of all the state’s chiropractors and their patients against the AMA, American College of Radiology, New Jersey Chapter of Radiologists, seven hospitals, and four practice groups of radiologists. Five months after that, a Pennsylvania chiropractor and his state society filed a class action anti-trust suit in a Philadelphia federal court against the AMA and a panoply of defendants similar to those named in the Chicago lawsuit, but adding the state association of pathologists.

Allegations in all three lawsuits are essentially the same: the defendants conspired to restrain the trade of chiropractors, grouped together to boycott chiropractors, and attempted to monopolise health services by medical doctors. No two suits are exactly alike but, in the aggregate, they seek money damages (including, in the Chicago action, establishment by the defendants of a \$10m fund to promote research and education between chiropractors and doctors), a court ruling that medical ethical principles that prevent professional association between doctors and chiropractors are unlawful, a court order against a refusal by radiologists to provide x-ray services to chiropractors, and a change of hospital accreditation standards to permit chiropractors to have hospital privileges and access to hospital services. Radiology and pathology are traditionally regarded as hospital services.

In exercising the responsibilities it assumed for setting standards and maintaining vigilance about medical ethics, the AMA has long inveighed against chiropractic. When it decided in 1957 to rewrite and pull together a decades-long accumulation of ethical pronouncements into 10 terse “principles of medical ethics,” they included: “A physician should practise a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.”

In case the meaning of that should be misconstrued, the AMA house of delegates in 1966 made an explicit policy statement: “Chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. The delay of proper medical care caused by chiropractors and their opposition to the scientific advances of modern medicine often ends with tragic results.” In 1970 the delegates reaffirmed that statement at the request of doctors in Louisiana—one of the few states that did not license

5026 Eskridge Terrace NW, Washington, DC, 20016, USA

BARBARA J CULLITON, AB, news editor of *Science*, the weekly journal of the American Association for the Advancement of Science

WALLACE K WATERFALL, AB, senior professional associate and director, Office of Communications, Institute of Medicine, National Academy of Sciences

chiropractors. And in 1968, the delegates urged all the AMA's constituent state and local medical societies to adopt some similar castigation of chiropractic and to publicise "the health hazard posed by the cult..." A little later, the delegates adopted a policy statement urging the US Congress not to allow payment of chiropractors by any federally-assisted health care programmes.

Incursion into exclusive preserve

Much if not all of this activity on the part of organised medicine has been the result of reaction to an increasing movement by chiropractors into the precincts of health care which have long been regarded by doctors as their exclusive preserve. It began with state licensure of chiropractors—first in Kansas in 1913, and then steadily throughout the 1920s and '30s in other states, until all 50 of them had adopted the legislation so persuasively presented by chiropractors and their sympathisers.

Most health-care services in the US are covered by some kind of insurance or government-supported programme. During the 1970s, chiropractors have managed to gain coverage of their services by a number of private health insurance companies. In 1973, they scored a particular triumph when payment for their services was approved under the Medicare programme (the Government-run system of health insurance benefits for those over 65).

The notable gain, however, carried with it a demand for proof that the patient needed chiropractic services: "... a subluxation that can be demonstrated by x-rays." Chiropractors do not routinely have their own x-ray machines, and in some states are precluded by the terms of their licensure from exposing patients to x-rays. Hence the importance to chiropractic of the medical specialty of radiology.

Although there is puzzlement in some quarters about what constitutes a "subluxation" (chiropractors generally agree that it is a misalignment of spinal vertebrae whose pressures on spinal nerves cause or predispose to disease in the bodily regions affected by those nerves), in 1977 Medicare paid more than \$26m for manual manipulative services to correct it.

Through all this medically disconcerting growth of chiropractic influence, the AMA *Principles of Medical Ethics, Section Three* has remained the same. But the "Opinions and Reports of the Judicial Council," which interpret the principles according to the perceived need for exegesis at any particular time, have changed noticeably since the first chiropractor lawsuit was filed. In 1971, for instance, the Judicial Council's expansion on Section Three stated flatly that "consultation with a cultist . . .

lowers the honor and dignity of the profession [of medicine] in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice." In 1977, the Judicial Council reworked the interpretation to emphasise that a doctor was not associating "professionally" with another person if he merely accepted a patient sent to him by that person. Additional phrases alerted the doctor that if he performed diagnostic services on a patient referred to him by a "licensed limited practitioner" and found a disease condition beyond the capability of that limited practitioner to handle, then the physician must tell the patient what he has found.

Unnerving interpretation

This interpretation is unnerving to some of the medical specialty societies. For one thing, it laid the groundwork for the submission by the AMA in May 1978 of a proposal to settle the Pennsylvania chiropractic suit, by withdrawing, in effect, any objection by organised medicine to doctors performing diagnostic services for chiropractors. The settlement, as yet not acted on by the court, is seen by the American College of Radiology as an "AMA surrender to chiropractic." It is not viewed any more charitably by the American College of Surgeons, the American College of Physicians, or the American Academy of Orthopaedic Surgeons, all of whom banded together at the December semiannual meeting of the AMA in a futile effort to reinstate the AMA's four-square position against chiropractic.

The AMA stand is somewhat clarified in an editorial in a November issue of its *American Medical News*: "The AMA believes that its position is the only position that can be successfully defended in today's legal climate: that a physician is free to accept persons as his or her patients who are referred by other physicians, chiropractors, or laymen, for that matter."

The horrified view of the specialty societies may be close to that expressed in an editorial by the director of the American College of Surgeons: "The AMA removal of its proscription leads through an inescapable chain of actions by others to an enforced professional association with cultists."

The workaday worry of the radiologist, for instance, is what to do with the information he might get from a film of a chiropractor's patient. "If he sees a lung lesion that looks for all the world like carcinoma," a Washington representative of the radiologists asked rhetorically, "who is he going to tell about it? There's no referring physician. You wouldn't hope to accomplish anything by telling the chiropractor. And what's going to be the result of telling the patient?"

No reprints will be available from the authors.

What is the significance of raised antibody titres to herpes simplex virus (about 1:32-1:128) in cases of epilepsy of undetermined origin in the absence of any recorded overt herpetic infections in the past three years? (Could one take these titres as presumptive evidence of herpes simplex infection in prenatal, perinatal, or early infantile period—that is, before adult patterns of immunity are established? Is one high titre enough in the absence of recent infection? If it needs repeating what is the minimum time interval?)

Over a wide range of cases studied this single reading would have no significance. It clearly must be taken as evidence of previous infection, and I would have thought it unlikely to be prenatal or perinatal because herpes infections at this time are peculiarly lethal. It is more likely to be during infancy. One high titre is not enough in the absence of recent infection. A reading is usually repeated at about two-week intervals. Any reading that shows a fourfold rise of antibody compared with the initial reading in association with a likely herpes infection, however, would be acceptable as cause and effect. Therefore should one take another blood specimen five days later and it showed a fourfold rise, this would be perfectly acceptable.

In rare instances there may be an anamnestic rise to another infection, but this infection may well be clinically apparent. Some people feel that specific IgM antibody to herpes simplex is evidence of a recent infection as this type of antibody tends to disappear after a recent infection and is replaced by IgG. The slight difficulty with herpes is that it is a latent virus and may continuously be giving small rises of IgM without causing any obvious gross lesion.

What is the action of ginseng and has it any therapeutic value?

The Chinese have used the dried root of *Panax ginseng* for over 4000 years to treat fatigue, hypotonia, anaemia, neurasthenia, and other diseases. It is said to have a stimulant effect on the vital centres while acting as a cerebral sedative; it is also popular as an aphrodisiac. It is given in doses of 1-2 g, and its toxicity is said to be very low. The root contains many saponin glycosides, and scientific investigations of how they work have not yet been carried out on a large scale.¹

¹ Court, W E, *Pharmaceutical Journal*, 1975, 1, 180.