Letter from . . . Dunedin

Chiropractic in from the cold?

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Sid Scales has an astute political wit, a social perception, and a comprehension of his fellow Kiwi which sets him high as a graphic commentator in the *Otago Daily Times*. Scales recently picked upon a quotation from the report of the Commission of Inquiry into Chiropractic in New Zealand, which said: "In the public interest there must be no impediment to full professional co-operation between chiropractors and medical practitioners." His drawing showed a commission benignly smirking behind the chairman's comment as the black-coated, striped-trousered figure strode from the bench carrying his black bag in his hand and his nose in the air, "You ought to see a chiropractor about that stiff neck of yours, doctor!"

Uneasy bedfellows

The New Zealand Medical Association approached the commission with expensive vehemence. The levy placed on its members was justified as necessary for "the fight against chiropractic." The Association was putting a lot of energy into their claim that chiropractors and their "nineteenth-century concept" of practice—pace Edward Jenner—were undesirable associates. They were certainly fellows with whom the conventional faculty wished to share neither bed nor patient.

Chiropractic in New Zealand is a full report of 377 pages, eminently readable, and not lacking in literary artistry. The commission consisted of Mr B D Inglis QC; Betty Fraser, who is a school teacher; and B R Penfold, a professor of chemistry teaching at the University of Canterbury. Their terms of reference included the barbed point "To consider whether health and accident compensation benefits [government welfare payments] should be made available for chiropractic services." The greater brief included exploration of the nature of chiropractic and its role in the health services. The commission took care to explore not only the practice of chiropractic, but the education and ambitions of its practitioners. From this publication we may learn what a chiropractor is—a piece of information a lot of us have not had before. We also learn just what it is that the medical profession has feared for so long—basically, it is our ignorance and misconceptions of their professed aims and ambitions.

Of the reactions aroused by the report, however, that of the General Practitioners' Society has hit one nail on the head. Their spokesman was reported as saying that the commission "was all about whether chiropractors should have access to health funds." That was specified in their brief. For lack of evidence, the commission repudiated, and therefore refused to consider further, the submitted suggestion that opposition to chiropractic was fear of loss of income on the part of medical men. The physiotherapists saw acceptance of the establishment of chiropractic as a separate profession as leading to "apartheid in medicine," but I doubt if it is as black and white as that.

Chiropractors have been licensed in New Zealand since 1960; they require an annual certificate of practice; and they bear the same relationship to their national professional body, the New Zealand Chiropractors' Association, as do conventional medical men to the Medical Association. The outstanding anomaly lies in the administration of the Chiropractors Act by the Department of Justice, which sets them apart from medical and paramedical practitioners in New Zealand, who are administered by the Department of Health. The commission found that professional discipline was not enforced among New Zealand's 94 certificated chiropractors. Individual chiropractors brought disrepute on their profession not only by making ill-advised claims to be able to cure visceral disorders, and by proselytising and even overtly advising against conventional medicine, but they were also said to adopt a distinctly commercial air for the furthering of their practice. The commission found that the great majority of New Zealand chiropractors obtained their training from one centre in the United States.

The commission was firm in its opinion that there was a definite role for manual treatment of the spine in axial musculoskeletal and possibly vascular disorders. The role for the chiropractor that it advocates is the one sought by the more conservative chiropractor—that of a paramedic in conditions in which manipulation of the spinal joints, physiologically diseased as much as anatomically displaced, will help. The commission was careful to emphasise that the patient would remain under the overall care of his medical practitioner, whose responsibility it would be to ensure that any chiropractor is competent—in the same way that he ensures that a non-medically qualified physiotherapist is competent. The commission had met no chiropractor who maintained that his profession offered an alternative system, but only a wish "to be treated as partners in our overall system of health care." The commission was strong in placating doctors by condemning the more undesirable elements among chiropractors. It indicated that the New Zealand Chiropractors' Association already disowned the attitudes of its more ambitious and avaricious members and also offered constructive advice on the policing of that body's policies.

At this stage the Government spokesman on health has refused to be drawn on the implications of the report, which the Department had not yet studied. Despite being equally unlightened at the time, the New Zealand Medical Association chairman was reported as finding it unacceptable, rejecting absolutely any suggestion that "rules of medical ethics be abolished by statute," a facet that the commission had explored thoroughly. Ironically, castigatory criticism of rhetorical vehemence was directed by the New Zealand Medical Association towards the New Zealand Chiropractors' Association's action in circulating its patients at the inception of this commission. Patients were asked to complete a questionnaire, write a letter, or both, which would be sent direct to the commission—which at that time was soliciting public opinion. The commission felt, therefore, that the charge of a "gigantic manipulation" by "11 000 letters" by the New Zealand Medical Association was "less than fair." It went on to point out that the 1978-9 New Zealand Medical Association *Annual Handbook* contained the first specific written statement: "It is unethical for a doctor to

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refer a patient to a chiropractor for treatment." The General Medical Council and British Medical Association told the commission that there was an "unwritten rule" which did not preclude referral to a heterodox practitioner—so long as the doctor assured himself of the former's competence, and retained overall responsibility. No one, the commission points out, has ever suggested that referral to a physiotherapist was unethical in these circumstances.

Political attitudes

One might have thought that the apparently petulant response of the New Zealand Medical Association to the nasty medicine of the commission would have been sweetened by earlier Government comment that it was sympathetic to their view. Nevertheless, in their 1978 manifesto, the National Party, presently in power, was the only party who made no mention of their attitude to alternative means of health care. By contrast, both Labour and Social Credit published loosely favourable consideration of such matters. Furthermore, before we become starry eyed over the altruistic virtue behind any rejection of the findings which the National Government *may* make, remember "the commission was all about whether chiropractors should have access to health funds." In a nation whose gross health costs rose from \$492m in 1974-5 to \$689m in 1976-7, and whose present administration is accused of perfidy for failing to implement the provision of two body scanners to neurosurgical centres in Dunedin and Wellington, might fiscal matters be a colourer of attitudes? If chiropractors did gain access to health funds—whether the decision was to enlarge this vote or to cut it finer to spread further—the Government is going to have a prickly bush to hurdle in order to pay the \$1.25m which the commission suggests their recommendations may cost. Clearly, one of the most surprising experiences to which the commission was subjected was the Department of Health's ill-concealed attitude of sympathy for "organised medicine." In paraphrase, the Director General of Health declared that should

the commission recommend the use of Government funds for health benefits to pay chiropractors, the Minister would be advised to resist strongly. The commission clearly bridled at this pre-emptive attitude.

The commission saw the attitude of the New Zealand Medical Association and its friends in little better light and reflected that 80 years of argument had, in fact, produced little enlightenment but a lot of heat. They saw that the opposition was "largely misconceived." Indeed, the commission's opinion may be summed up by an extract from a passage describing what it saw as one of the great virtues of this public hearing: "By listening to each other's points of view . . . subjected to very intensive cross examination, the medical and chiropractic organisations, have at last had the opportunity to acquire some understanding of each other's positions. That seemed to have been conspicuously lacking in the past." It went on in the same conclusion, "... good deal of mistrust . . . demonstrated by organised medicine risen from ignorance of chiropractic. . . ."

The Chiropractors' Association, of course, gleefully accept this invitation in from the cold. One can be sure that its reported views are right, that such findings will reassure the public of the virtues of chiropractic. Conversely, I wonder just what the public view will be of the New Zealand Medical Association's spokesman's abreactive rejection of chiropractors and the report. I can see Scales's appellation of stiff-necked being applied to one who doth protest too much.

In summary, the commission found that orthodox medicine should curb and cure the bigotry arising from its own ignorance of chiropractic and that the latter needs firm and organised discipline within its ranks. In these circumstances, chiropractic has a part (as a paramedical discipline) to play in the treatment of axial musculoskeletal and possibly vascular problems, irrespective of the present ignorance of all parties as to the basis of its success. To achieve these things they went on to make constructive suggestions for legislation, funding, and education of all parties by research in the universities and with the help of the Medical Research Council in New Zealand.

In communities where tuberculosis is endemic, all normal children are given BCG vaccination within the first month of life. Are there any contraindications to this? Can it be given to newborn babies who are preterm or of low-birth weight? If not, when are such babies fit to receive this vaccine?

The only contraindication to BCG in the first month of life is an immunological deficiency, such as hypogammaglobulinaemia or immunosuppressant therapy. It can be given to preterm or other low-birth-weight babies, but in that case antibody production may not be very good, and it would be wise to repeat the BCG six months later.

What is the best treatment for epistaxis? Is a medicated snuff useful?

If the epistaxis referred to is the common and troublesome epistaxis seen in older people, it is usually associated with hypertension and atheroma. Epistaxis in children and adolescents is nearly always the result of bleeding from a vessel on the anterior part of the nasal septum, or Little's area, and it is cured by cautery. In every case of epistaxis it is essential to exclude a lesion or infection in the nose, nasopharynx, or nasal accessory sinuses. A blood dyscrasia must also be excluded. In older people with hypertension management should be under the combined care of the physician and ENT specialist, as the treatment of the hypertension is an important factor. The diet should always be investigated, as even today an unsuspected deficiency of vitamin C may be a factor in old people eating a poor diet. Ascorbic acid quickly corrects this. An abnormal intake of aspirin can also lead to epistaxis. If the site of bleeding can be established, electrocautery is performed, but this is not always possible and treatment with a nasal pack may be necessary. The inflatable rubber balloon is a valuable non-traumatic form of control and is always preferable to gauze packing. The use of any form of "snuff" is not recommended as it can lead to a chronic rhinitis.

What is the aetiology of leg cramps in pregnancy, and how do you treat these patients?

Cramp is muscular spasm, presumably in skeletal muscle, but theoretically possible in venous or arterial muscle. Local vascular change might precipitate the contractions, and this is currently the favoured theory. There is a time-honoured belief that calcium metabolism has something to do with the symptom, and indeed calcium lactate or gluconate, vitamin D, and a glass of milk on retiring often seem to work. A passing thought should be given to the idea that cramp is a variant of sciatica. And further consideration has been given to salt deficiency as the cause; taking salt cures many.¹

¹ Robinson M. *Journal of Obstetrics and Gynaecology of the British Empire* 1947; 54:826.

Is there an increased risk of malaria after splenectomy?

All the evidence points to splenectomy leading to an increased risk of malaria among those who harbour a latent infection and among those who enter malarial endemic areas. There is much evidence that splenectomy in primates leads to increased susceptibility to the infection. As is to be expected, examples in man are much more difficult to obtain, however, but there are several on record.¹ Garnham also records that the only West African patient who, within his experience, developed cerebral malaria did so after splenectomy. This patient had hitherto had good immunity to the infection. Babesia infection is also, in many respects, similar to malaria, and one of the very few fatal babesia infections is known to have occurred after splenectomy. Malaria has become reactivated after splenectomy in people who had a latent infection. Therefore there is an increased risk of malaria after splenectomy.

¹ Garnham PC. *Acta Trop* 1970;27:1-14.