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EDITOR'S COMMENT: This is a special issue of The Monograph that was totally organized by Dr. M. Thomas and Dr. J. Scholten . It contains some of their perceptions on the present status of upper cervical chiropractic and research, and possibly more importantly, contains responses from doctors in the field of upper cervical chiropractic to their position paper. It is truly remarkable to have a position paper engender such a variety of comments from leaders of all of the major upper cervical techniques. Hopefully their paper and the responses to their paper constitute the beginning of a new renaissance in upper cervical chiropractic. Because this issue is 52 pages- 12 more than the previous Monograph- an Editorial has not been included, thus enabling The Monograph to be shipped in the usual envelope format.

# A Shift in the Prevailing Winds

An exploration of current issues in the practice of upper cervical chiropractic

Michael D. Thomas, D.C., Jeffrey N. Scholten, D.C.

## Prologue:

This paper is intended to act as a catalyst for an introspective examination of NUCCA (National Upper Cervical Chiropractic Association) and to a degree, upper cervical chiropractic as a whole. The authors believe it is critical to re-examine the assumptions and assertions that drive NUCCA both scientifically and socially. The percentage of chiropractors working from an upper cervical perspective continues to constitute less than 5% of the profession. The voice of upper cervical chiropractic is essentially silent outside of its own borders. The reasons are many and diverse: historical, technical, political, financial, and social. This isolation has however, resulted in a simplistic perspective that reinforces a sense that we are "right" and that the rest of the profession ought to "wake up" or is "wrong". This manner of communicating our work to the outside world has not worked for sixty years. We remain basically invisible.

The rest of the profession has not stood still in the intervening decades. Both the chiropractic field and healthcare itself have undergone tremendous changes in the past few decades. The rules are changing and what sufficed in the past is not going to be adequate to guarantee survival into the future. This paper is offered as the beginning of an analysis that can take us into the future. By clarifying our foundation we will improve our delivery of care while building the structure necessary to make our case to the world at large.

Most of you reading this paper owe your livelihoods to upper cervical chiropractic. The right to practice this work is precious and must be protected. You are on the front lines; there is no army in front of you. The need to validate the work we do is paramount and fortunately much work has already been done. Much of this work has however, been published only in upper cervical periodicals and/or passed down by word of mouth. Little has been published where we now need it, in peer reviewed, indexed literature. It is critical that we document what we know as well as what we know we don't know. Further research can then work to "fill in the gaps" and make our case more objective and complete.

Upper cervical doctors tend to be highly principled, intelligent, thoughtful individuals. In fact, without those qualities, it is unlikely an individual would choose to become an upper cervical doctor. For historical reasons, we have not tended to make much use of this incredible brain trust. We would like to change that and the reader is invited to make one of several choices:

1) You may read this far and decide to toss the paper in the trash.
2) You may read the whole paper and then toss it in the trash.
3) You may wish to respond to one or two items that mean something to you.
4) You may sit down and analyze the paper, making comments (agreeing, disagreeing, perhaps shifting perspective) and adding other meaningful topics that you believe to be of critical importance to the future of this work.

Our plea is that you express your thoughts and opinions. In so doing, you may help to change the face of chiropractic and perhaps even healthcare.

We plan to publish this paper along with the responses we receive in a special issue of the Monograph. The responses will then engender the next step. We believe that a focused group of doctors working together may be more effective than the heroic efforts of a handful of individuals who by sheer force of will have driven this entire segment of our profession. We will always owe them our livelihoods but now the torch is being passed and along with it the responsibility to further this work.

*Note: The paper is fairly long and contains a tremendous amount of material. It should probably be chewed slowly. Upper cervical chiropractic cannot be summed up in a "sound-bite". Just as the work itself is complex, so any meaningful discussion of it will also likely be somewhat complex.*

## The Real and the Ideal

The Upper Cervical Monograph was launched in 1973 as a vehicle for NUCCA and NUCCRA (National Upper Cervical Chiropractic Research Association) to disseminate the ongoing findings from current investigation and research into the ASC (Atlas Subluxation Complex). It has served NUCCA well for over thirty years. When it was initiated, there was virtually no place in any peer reviewed, indexed journal for investigators in chiropractic to publish their findings. Medicine had simply shut us out. This made The Monograph a critical link in communicating new ideas. As venues have opened up in chiropractic, upper cervical work has still found it difficult to gain access to publication, often because our protocols involve radiating patients and the safety and efficacy of taking pre and post films has not been established in the literature. This has in some ways created a "Catch-22" kind of situation. So the problem has been that the only people who are aware of upper cervical chiropractic research findings are those within our own community. Anyone outside upper cervical work and certainly, any researcher who does a literature search on Medline, will not find any of these papers. As far as the work published in The Monograph is concerned, we are still invisible outside of our subscription population.

Any new research conducted should now be published in a journal, which will be available to the scientific community at large. This leaves The Monograph at a crossroads. The ever-decreasing frequency of Monograph publication is one symptom of this change in professional climate. There are, and will continue to be, still more articles that are of specialized interest only to orthogonally based upper cervical chiropractors which still make sense to publish "in house". At the same time, it may be time to examine other uses for The Monograph.

The NUCCA landscape has changed in the fourteen years since Dr. Gregory's death. The major concepts are set and the basic protocols established. Changes are much more incremental now. This is a natural evolutionary consequence of the success of the Grostic and Gregory investigations. At the same time, there has been tremendous change over the past several decades in the scientific community at large in understanding of complex and nonlinear systems. New mathematical models exist that were unknown and unavailable in the past. Biomechanics itself is undergoing rapid change in understanding. The frontiers of biology are approaching models that may accommodate orthogonally based upper cervical chiropractic and may, ultimately, greatly improve its application.

*"New ideas in science are not always right because they are new. Nor are the old ideas always wrong just because they are old. A critical attitude is clearly required of every scientist. But what is required is to be equally critical to the old ideas as to the new. Whenever the established ideas are accepted uncritically, but conflicting evidence is brushed aside and not reported because it does not fit, then that particular science is in deep trouble-and it has happened quite often in the historical past."*

Thomas Gold

At this point, excellence has come to be defined by close and long term attention to detail and consistency in all of the various sub-protocols that comprise upper cervical chiropractic. This remains essential and probably always will, but it is no longer enough. As professionals, it is our duty to examine not only the new concepts that arise, but also to periodically re-examine the foundational concepts. When NUCCA was a handful of doctors meeting in Monroe, Michigan with Dr. Gregory, it was appropriate to defer to the decades of close examination of ideas that comprised the life of Dr. Gregory. No one else had the depth of experience, the methodical analytic abilities or frankly, the overriding brilliance that he demonstrated. He was able to explain in considerable detail his process and the rigor by which he arrived at the specifics of all the various components of the work.

We have grown beyond that handful of doctors. We are on the cusp of the next evolutionary step. Dr. Gregory was well aware of the requirements of a scientific endeavor. His work with Dr. Grostic and later individually, was the initial and perhaps most critical step. Individual investigation and experimentation are the genesis of any new scientific process. The issue today is that if we are to be taken seriously in the world at large, we can no longer validate our work by saying that Dr. Gregory (or Dr. Grostic) told us it is true. This is not meant as a refutation of their body of work. In fact, it is the reverse. The years since their deaths have only increased the clinical evidence as hundreds of practitioners have taken on this work and validated its results in the patients who have been adjusted by them. It is precisely for this reason that it is up to this next generation to take the next steps. We owe it to Dr. Gregory, Dr. Grostic and humanity.

## The Burden of Proof and Impediments to Truth

Science is often discussed in an idealized form. Returning to Gold for a moment, here is his admittedly "naïve" definition of "what a scientist is":

*"He is a person who will judge a matter purely by its scientific merits. His judgment will be unaffected by the evaluation that he makes of the judgment that others would make. He will be unaffected by the historical evaluation of the subject. His judgment will depend only on the evidence as it stands at the present time. The way in which this came about is irrelevant for the scientific judgment; it is what we know today that should determine his judgment. His judgment is unaffected by the perception of how it will be received by his peers and unaffected by how it will influence his standing, his financial position, his promotion – any of these personal matters. If the evidence appears to him to allow several different interpretations at that time, he will carry each one of those in his mind, and as new evidence comes along, he will submit each new item of evidence to each of the possible interpretations, until a definitive decision can be made." (p. 245)*

Gold asserts that there is probably no one who can actually fulfill this rigorous description. It is acknowledged that people have motivations beyond the abstract ideal of scientific methodology. He sees danger existing in those motivations that are more social in nature. He asks:

*"...what are the communal judgment-clouding motivations? What is the effect of the sociological setting? Is our present day organization of scientific work favorable or unfavorable in this respect? Are things getting worse or are they getting better? That is the kind of thing we would like to know." (p. 246)*

Gold then describes two motivations that are deleterious to scientific progress -the unwillingness to learn, and the "herd" instinct.

*"Too many people think that what they learned in college or in the few years thereafter is all that there is to be learned, in the subject, and after that they are practitioners not having to learn anymore."*

*"When people pursue the same avenue all together, they tend to shut out other avenues, and they are not always on the* ***right*** *one." (p. 246-7)*

He heralds diversity and recognizes the danger of limiting our avenues of investigation.
Gold continues his paper with a devastating critique of the peer review system in science, which seems to him, designed to maintain the status quo actually squelching innovative ideas and dissenting voices. (The reader is encouraged to read the whole paper at: www.suppressedscience.net/inertiaofscientificthought.pdf ) Although we are not looking to overturn the peer review system, we **are** looking for access to the mainstream scientific community. The flaws of the system are not our greatest concern but they are instructive. We find ourselves entrenched in a process that we are not really examining with a critical eye, hoping to gain access to the "greater herd" which has its own inertia. Keeping our heads down and concentrating on optimizing our x-ray techniques and maintaining parallel forces in our adjustments is critical but not enough to assure the sustainability of this work beyond our generation.

We believe that many of our problems are simply representative of our current level of maturity. We have a very small number of practitioners, many of whom are isolated by geography. We have no real university funding and we have no real corporate sponsorship. Almost all of our investigation and research has been the product of selfless service by individuals, very few of who have any training in research methodology. Each of us is very busy with family and business life. And yet, somehow, upper cervical chiropractic remains a viable career path in chiropractic. Also, considering our scant numbers, we

are well represented in the current chiropractic literature. None of this would or could, be true if it wasn't for the incredible power of the upper cervical adjustment.

It may have been necessary in the past to tightly control access to instruction and information in order to systematize it and create a series of protocols that could produce safe, effective and consistent care. This system is now well in place and has been comprehensively codified in the NUCCA seminars and in the NUCCA textbook. New students as well as long time doctors, all have clear guidelines regarding all of the sub-protocols. Restriction of conversation, ideas or innovations by doctors regarding aspects of the work only serves to disenfranchise the members of our community. Very often, behaviors that are appropriate at one point in time (to protect the work) become the very behaviors that restrict further evolution of it in the future. We believe this to be the case now. While class time at the seminar is not the proper time to delve into a diversity of viewpoints regarding the protocols, we believe there should be some venue for this process.

## The Proof is in the Post

In numerous talks to chiropractic colleges, Dr. Gregory often noted that the use of any specific technique was unimportant to him; it was the results that mattered. By "results", he meant post-films. He often said that he didn't care if someone adjusted the big toe if it could produce corrections on film. Our gold standard is the radiological measurement of maximal and proportional reduction (correction) of misalignment. Post film analysis ensures that the patient is not left with disproportionate, different or even greater misalignment factors than prior to intervention. Other techniques do not share this goal and therefore the offer to take a set of pre-films prior to some "other" intervention, have the patient "adjusted" in whatever technique is being evaluated, and then posted to analyze whether misalignment factors have been reduced is not necessarily appropriate. The explicit assumption here is that if the misalignment factors are unchanged, reduced disproportionately, or increased, then the intervention has failed to improve the health of the patient. Outcome measurements for most other techniques do not include x-ray analysis of upper cervical spinal alignment. Apples are not oranges and demanding that an apple taste like an orange is unreasonable. There are more than 300 techniques now being utilized in chiropractic and many people have derived health benefits from the whole diversity of procedures.

The growth of chiropractic in recent years can certainly not be credited to the work of a handful of upper cervical chiropractors. All chiropractic procedures exist within their own context and the best ones are internally consistent. Outcome standards vary because our collective understanding of health is at best incomplete. Part of the current challenge upper cervical chiropractic faces as a minority, is in becoming able to enlarge our perspective and not demand that other procedures fit our mold. Instead, we need to work to more completely define and properly document what sort of physiological changes can be consistently expected under our care. When these physiological changes coincide with changes reported by other procedures then the efficacy of different interventions can be compared. The commonality may point to new directions. The upper cervical chiropractor has the burden of proof because of our minority status. Demanding that other techniques conform to the outcome standard of orthogonal upper cervical is not reasonable. There is a plethora of wonderful healing stories that come out of the chiropractic profession in every technique.

Considering the immaturity of our current physiologic understanding, the loss of continued development would be tragic. It is a near certainty that any procedure that does not take the upper cervical misalignment factors into account is not going to produce proportional reduction on post film analysis. Only when the complete reduction of misalignment factors on post film analysis equals a total and completely sustainable return to health in all people all the time will this standard be appropriate as a universal outcome measure for all chiropractic techniques. Health is multi-factorial and each practitioner and procedure brings different pieces of the puzzle to each individual case. Not everyone sees life in the same way however, and honest people take data in different directions. Just as light is both particulate and wave depending on the methods used by the observer there are different truths to each incomplete puzzle depending on the observer's vantage point.

Integration of our ideas into healthcare will not come from making everyone else "wrong". We have empirically and repeatedly proved this point over the past sixty years. As mainstream chiropractic continues to move away from the specific structural subluxation concept all together, the very real possibility exists that we could become "righteously" extinct.

Upper cervical chiropractic is simple in initial concept but difficult to truly understand at the level of practical competence. It is also difficult to perform as a consistent and accurate physical act. After six decades of evolution, there are still very few doctors who can be called masters of the work. If the only benefit humanity can derive from upper cervical chiropractic is from this (literal) handful of masters, then the work is of minimal practical significance, perhaps, an asterisk in the history of chiropractic at best. But the truth is that right now many hundreds of upper cervical doctors do their very best everyday and

make incredible differences in hundreds of thousands of lives. A twenty percent decrease in misalignment factors can, at times, produce dramatic results. It may take several adjustments to obtain the best possible reduction. Some practitioners find they are unable to produce the results they know are possible with hand adjusting and begin to use an instrument. Any given individual or instrument (mechanical or manual) has greater and lesser qualities that need to be assessed and evaluated but not just discarded out of prejudice. It has been shown time and again that blinded division and unproven prejudice only serves to dilute our pool of talent, frustrate innovation and stall progress. To avoid this righteousness we must be willing to speak from and to share our own experience and allow others to speak from their own experience and observations. The "open forum" is certainly a step in this direction.

## The Map and the Terrain

The association between maximal, proportional correction on post film analysis and restoration of health in a multitude of people has astounded upper cervical practitioners and gratified untold numbers of patients for several decades. The correlation between correction on film and return to health is so profound that it has led to the use of post-film analysis as an equal synonym for return to health, among upper cervical doctors. As great as this correlation may be (and we certainly do not dispute this), the post film remains merely a reflection of this potential for the restoration of health in an individual. It is not the transformation itself and it is not inclusive of all the myriad factors that are responsible for optimum health. **The map must not be confused with the terrain itself.**

This error occurs in the deep-seated conviction among many upper cervical chiropractic practitioners that restoration of health cannot occur without reduction of the upper cervical misalignment factors as measured on film analysis. This may seem to be a trivial point since we are not debating that there is a high correlation. This error in logic has however, in our opinion, created nearly irreparable harm to our standing in the chiropractic community and in healthcare at large.

In the world at large, this has translated into a tiny group of practitioners with the firm conviction that they are "right" and everyone else is "wrong" if they don't conform to the outcome measure delivered by the post film analysis. This social impediment to widespread acceptance appears unassailable if we maintain our present course. We are not questioning the foundation of using the post film analysis as our main outcome measure; in fact we heartily endorse it. We are questioning the oversimplification that mistakes the map for the terrain and in so doing, dismisses the veracity of all other work.

A map can only take a person into areas that have been explored and charted by others. It is only as accurate as the knowledge and abilities of the maker of the map can allow. Of course, reading the map and orienting the map with the terrain is always a function of the knowledge and abilities of the map-reader, too. There is great comfort (and safety) in following a map that has long proven its worth. When Columbus looked at his map, it told him he could sail west across the Atlantic and find India. What he found, of course, was the Western Hemisphere -a little something that had been left off his map.

Preconceptions necessarily guide even the questions we ask. We can't know what we don't know. Samuel Clemons once noted that it wasn't what people didn't know that scared him; it was what they "knew" that wasn't true. What we "know" can also be our current knowledge of what is "possible". The routine resolution of dis-ease after correction of the upper cervical subluxation complex remains outside the realm of "possibility" for both the medical community and for the general population at large. How often have your patients shook their head as they talked with you about their friends who "know" that it isn't possible to deal with an issue (sciatica for instance) by touching the afflicted behind the ear?

## Paralysis by Analysis

Historically, NUCCA seems to have arisen out of the reaction of Dr. Gregory to the complex biomechanical problems requiring additional understanding and training that had not been available. For Dr. Gregory, the complexity of the issues involved required not just the memorizing of formulas, but a complete biomechanical understanding of the ASC. He believed that a more comprehensive understanding of the various components of upper cervical work would allow a doctor to circumvent or at least correct the problems that arose on post films.

NUCCA's certification process continues as a successful attempt to develop this biomechanical, kinesthetic and intellectual understanding of our work and is essential to produce a more competent practitioner. This solution has however, created another problem, which is social in context. Our methods of awarding competence to the certified doctors have created a presumptive incompetence among uncertified doctors. The result has been a very small number of doctors charged with

tremendous responsibility and a general sense of disconnectedness, even disenfranchisement, among the rest of the membership. The burnout among (and loss of) these few seems to occur faster than the creation of new certified doctors.

The disenfranchisement of the internal membership has a parallel in NUCCA's relations to chiropractic in general. Essentially in isolation, upper cervical work has, over several decades, consistently and methodically evolved into a sophisticated set of effective protocols. Even so, it continues to remain hidden from public and professional view.

The reasons for this continuing anonymity have long been debated. Perhaps the major reason for this lack of entry into the public domain is that upper cervical chiropractic has demanded a shift in understanding that has no context within the (earlier, as well as) current healthcare paradigm. Only now are some in biology beginning to take on a holistic viewpoint that can accommodate the upper cervical perspective.

There have been no large granting institutions funding upper cervical chiropractic research at the university level across the globe, as there is in medicine. There is no army of PhD's who have been educated in research methodology critically examining the various aspects of the field. Primarily, any progress that has been made has come from individuals working within their own practices over decades of time. The diversity of protocols in upper cervical work may simply illustrate the level of current maturity of the field. Tremendous gratitude should be rendered to those who have toiled in relative obscurity and who have laboriously developed the current protocols. We simply would not be here without them. This work of decades has been handed over to the current generation. We have much work to do if this work is to be passed on to subsequent generations.

Though the literature now contains ample information to validate the importance of the upper cervical spine to health, communicating this news to a general audience has largely failed. Publication has been difficult until the last decade or so. Aside from JMPT (The Journal of Physiological and Manipulative Therapeutics), we still have no peer reviewed, Medline indexed journal in chiropractic. Any publishing we do in our own journals is seen primarily by upper cervical doctors, and interested students.

This cloistered existence has led to the (decades long) evolution of a shared perspective among a fairly small community that cannot be easily transmitted to others outside of this shared body of knowledge. It has also led to a "self evident" sense of proof that also cannot be shared with others outside of the upper cervical community that have not shared the same experiences. Upper cervical chiropractic has essentially lost its voice in the chiropractic profession, which itself has a very small voice in the overall scheme of healthcare. It took several decades to develop the current protocols, which now provide a method to safely and consistently correct the upper cervical spine. We roughly estimate that upper cervical doctors constitute between 1 and 4 percent of the chiropractic profession and the number of organizations representing this voice presents a challenge to cohesive progress.

The aspirations of the upper cervical chiropractic profession remain essentially the same as they were in the 1940's. A quote from the Council Bulletin-Official Organ of the Palmer Standardized Chiropractic Council in December of 1944 revealed much of the same frustration still felt today in the field. Dr. Roy Labachotte, in a personal letter to a colleague (and then republished in the Bulletin) wrote:

*"We have been going along for years hoping against hope that something would happen which would bring Chiropractic to the front as it deserves. We have during this period watched, only to see that the enemies of Chiropractic have from within been tearing the very foundation out from under our science. We have worried ourselves sick about it but we have been unable to do ANYTHING about it."*

We remain the best-kept secret in healthcare. There are aspects of the work that cannot be changed without loss of the integrity of the work itself. These must be kept clear and inviolate. In our desire to hold onto our legacy, we may lose the flexibility required to move us forward.

The upper cervical approaches are truly a distinct form of chiropractic. As with any specialty, it is neither critical nor appropriate that the entire profession practice the same way we do, but it *is* critical that they understand how what we are doing is different. As a group, it is essential that we realize that to gain respect, we must give respect. Some of our historical positions have turned out to be self-defeating the most damaging of which has been that we are "right" and until proven to us differently, everyone else is "wrong".

We have become truly a minority component of the chiropractic profession, and as such the burden of proof is ours. We need more than the post radiograph to convince the rest of the world. It is also critical to our survival that awareness of scientific methodology be propagated amongst the average upper cervical clinician. It is time to create an environment that encourages inquiry and evaluation.

## Parallel Systems

A strictly hierarchical model of organization is the traditional form of coordinating a group of people engaged in a process. It is certainly present in the Darwinian natural selection process, and most business and political models. Biology itself has historically been modeled this way assigning ultimate "control" of the organism to some discrete area within the brain. At one point in history the pineal gland was assigned this ultimate role but newer models, unable to find any physical location, began to talk about the "ghost in the machine". The supposition is that without some ultimate authority (and controller), only chaos can result. Deeper study of biological and other complex systems has clearly shown that stability arises out of "chaos" although it is not the same kind of stability that arises out of equilibrium. Two children on opposite ends of a teeter-totter may "balance" out in a stable equilibrium that leaves the teeter-totter level and unmoving. The balance that occurs at equilibrium is static. The kind of stability that occurs in living systems is however, of a very different kind.

Ilya Prigogine, a Nobel laureate (Chemistry, 1977) for his work with complex systems, wrote in **Modern Thermodynamics: from heat engines to dissipative structures** (Wiley, 1998, p. 409):

*"In nature, far from equilibrium, systems are ubiquitous. The earth as a whole is an open system subject to the constant flow of energy from the sun. This influx of energy provides the driving force for the maintenance of life and is ultimately responsible for maintaining an atmosphere out of thermodynamic equilibrium...every living cell lives through the flow of matter and energy.*

*"...far-from-equilibrium states can lose their stability and evolve to one of the many states available to the system...these new states can be highly organized states. In this realm of instability and evolution to new organized structures, very small factors, often beyond laboratory control, begin to decide the fate of a system. As for the certainty of Newtonian and Laplacian planetary motion and the uniqueness of equilibrium states, both begin to fade; we see instead a probabilistic Nature that generates new organized structures, a Nature that can create life itself."*

The parallel here with the subluxated state is cogent, but is a subject for another paper. For living systems, stasis (or equilibrium) is death. Life is dynamic and always moving. In a social organization, stasis, or the attempt to concretize process into some "final" rigid form causes a loss of vitality. It results in a lack of innovation and evolution. Socially, a great deal of energy must be expended to "hold" the form in place. The underlying assumption is that the work is in a "final" form and must be formalized in order to prevent loss of the foundation. While it is obviously true that one should not "throw the baby out with the bath water", it is also true that this "baby" is not yet mature. If it were possible, stopping the growth of our "baby" might ensure preservation of its life, but it also prevents the untold possibilities that maturation into adult form holds. Indeed, the locking up of one area of the spine is defined by chiropractors as a deleterious circumstance that is at least a fixation if not a subluxation.

It is fear of chaos and loss of meaning that is at the heart of the urge to control and limit change. A hierarchical system that maintains control in an elite and centralized way ultimately alienates the majority who find themselves without a voice and unable to be a part of the process. Some form of organization is however, necessary to coordinate activities and assist in the evolution of a process. An interesting possibility for innovative organization leading to enhancement of the goals of the group has surfaced in the design of computer software. We would like to discuss the solution as a possibility for future innovation in our work.

Eric Raymond wrote about this development in a seminal paper entitled "The Cathedral and the Bazaar", which can be found at http://www.catb.org/~esr/writings/cathedral-bazaar/cathedral-bazaar/. This paper compares two different methods of organizing the development of software. Raymond describes the hierarchical model as a "cathedral", in which complex undertakings needed to be *"built like cathedrals, carefully crafted by individual wizards or small bands of mages working in splendid isolation, with no beta to be released before its time"*. (p. 2.) He notes that his prior assumption had been that *"there was a certain critical complexity above which a more centralized, a priori approach was required"*. (p.2)

Raymond then introduces another model based on a parallel systems approach. He terms it "the bazaar model". In a bazaar, there are many people interacting together with many different "agendas and approaches". It would seem that such uncontrolled diversity would lead to little more than chaos. On the contrary, open source software development has now led to several successful outcomes. One of Raymond's main examples is the Linux kernel (an open source software operating system)

Linus Torvald was the originator of the Linux kernel. Instead of trying to build a proprietary system in the usual "cathedral" style, Torvald put all of his source code on the Internet for everyone to see. By approaching development in this way, *"the Linux community seemed to resemble a great babbling bazaar of differing agendas and approaches". "The fact that this bazaar style seemed to work, and work well, came as a distinct shock".* The development process *"seemed to go from strength to strength at a speed barely imaginable to cathedral builders." (p.3)*

We are a community of upper cervical chiropractors. The protocols we use and the science and philosophy behind them are the glue that binds us together. It is in our common interest to develop greater understanding of all phases of our work to make it easier to learn and perform as well as becoming more effective in optimizing our patients' health. To this end, a closer examination of a parallel systems approach may be helpful. Raymond made a number of points in his paper, many of which seem important to our theme.

Raymond took the lessons he learned with Linux and applied them to a project of his own. He also put his source code onto the Internet so it could be examined by anyone with an interest. He notes: *"Given a bit of encouragement, your users will diagnose problems, suggest fixes, and help improve the code far more quickly than you could unaided.*

The reason it is so important to have many people involved is Raymond's next major point: *"Given enough eyeballs, all bugs are shallow." I dub this "Linus's Law".*

*In Linus's Law, I think lies the core difference underlying the cathedral-builder and bazaar styles. In the cathedral-builder view of programming, bugs and development problems are tricky, insidious, deep phenomena. It takes months of scrutiny by a dedicated few to develop confidence that you've winkled them all out. Thus the long release intervals, and the inevitable disappointment when long-awaited releases are not perfect.*

*In the bazaar view, on the other hand, you assume that bugs are generally shallow phenomena -or, at least, that they turn shallow pretty quickly when exposed to a thousand eager co-developers pounding on every single new release. Accordingly you release often in order to get more corrections, and as a beneficial side effect you have less to lose it an occasional botch gets out the door.*

Raymond introduces a phenomenon identified in sociology as the "Delphi Effect" to explain the idea that *"Given enough eyeballs, all bugs are shallow"*. The concept is that given a population of observers, the averaged opinion of these observers is much more reliable than that of any single (randomly chosen) observer within the population. Raymond's article contains much more cogent information much of which may relate to our topic but this is enough to make the main point.

So how does this relate to upper cervical chiropractic? We acknowledge that since the 1930's, several different concepts regarding upper cervical work have come forward. Maintaining the metaphoric parallels, the operating system kernel, (the orthogonal Grostic based approach) was developed in the traditional Cathedral style of inquiry. In the intervening decades, many eyes have looked at it and there are now several variations of practice based on divergent perspectives. The science has always been empirical. Different investigators have taken their empirical data in different directions. But within the orthogonal approaches, the protocols are more similar than different.

This generation of upper cervical doctors finds itself in a dilemma. The clinical results of the work point to possibilities that could profoundly improve delivery of healthcare in the world. At the same time, the publication of the specific components of the work in peer reviewed, indexed journals have not been done so that the scientific community at large continues to be unaware of our existence. In addition, the work is full of unexamined assumptions and unproven assertions. Having made this distressing statement, it seems only reasonable to acknowledge that orthogonally based upper cervical chiropractic has done as much or more to validate itself through investigation as any other work in chiropractic. Dr. Eriksen's new text (Upper Cervical Subluxation Complex: a review of the chiropractic and medical literature. Lippincott Williams & Wilkins, 2004) makes this point in an extremely thorough fashion.

As valid and important as it is for individuals to improve their accuracy in the various protocols, it is even more important to begin to examine our assumptions and prove our assertions. Even extreme accuracy in the application of (at best) incomplete protocols still results in real limitations for the potential improvement of patient care delivery.

The current NUCCA assertion seems to be that extremely consistent accuracy is required to deliver adequate patient care. Today we find a NUCCA culture that essentially assigns a verdict of incompetence at every level to those who have not become part three certified. The fear is that the incompetence of the uncertified doctors leads to potential changes that are the result of incomplete understanding, wrong thinking, or attempts to make a process easier. All of this is thought to arise because the disciplined rigor necessary to master the particular aspect in question has not been undertaken, leading to poor or incomplete results. This is undoubtedly true at times.

Those doctors who have been in practice for a while have all received films and adjustments from multiple other doctors. Questionable films and poor adjustments are not the territory of the uncertified alone. No one has ever said that certified doctors are perfect but only that the whole certification process is an attempt to minimize this possibility. As noted above, we applaud this process and encourage everyone to participate. At the same time, it should be noted that, "The Emperor wears no clothes". We are all doing the best we can with what we have, but no one is perfect.

We posit that the winnowing process that results in the actual formation of an upper cervical doctor is rigorous enough to guarantee a caliber of practitioner that is unusual in the general population. A parallel systems structure for ongoing inquiry into the diverse aspects of the work can offer hundreds of sets of eyes to the process; -eyes that are connected to years of study and practice. If one hundred people with ten years experience look at a topic, they form a collective pool of a thousand years of expertise. Within those thousand years of experience, someone among those one hundred is very likely to be able to make a cogent suggestion, ferret out an error, or come up with a possible solution. We are not suggesting some chaotic version of anarchy. Torvalds had a core group (perhaps analogous to the NUCCRA Board) that analyzed the plethora of comments and suggestions and using their own expertise, were able to find the solutions to problems that had been untenable in the past.

## The Road Ahead

**How did we come to our protocols? Where are our assumptions? What are we ignoring? What do we still need to know? What have we forgotten?** This paper is offered as a beginning step toward opening up this conversation to our whole community. We can together, create an open forum for individual effort to be supported, critiqued, argued over, celebrated, modified and enhanced.

In order to successfully do this, we all have some learning and some "unlearning" to do. There is nothing quite so polar as "right" and "wrong". This judgment leaves no room for maneuverability. It leaves no room for modification of your position. Real science does not make polarized stands without massive and long term overwhelming data in favor of a proposition. Even so, concepts like Newtonian physics that remained "bedrock" for hundreds of years have been greatly modified by new findings. Areas like relativity, quantum mechanics, and string theory have greatly enlarged our basic conception of the universe and changed our sense of what is possible.

In any scientific endeavor, the goal is to move toward progressive clarification of understanding regarding our observations. This is accomplished by observation, development of a hypothesis, implementation of an experiment designed to test the hypothesis, and evaluation of results. Proof and what constitutes "proof" is harder to come by. In fact, scientific methodology can ultimately falsify a proposition but it cannot ultimately make the case for the absolute truth of the hypothesis. Evaluation leads to three possibilities: equivocal results requiring further (and possible modification of) the experiment, falsification of the hypothesis by experimentally disproving it, or statement of apparent support of the hypothesis, possibly within certain constraints. The conclusion may also ask more questions which arise out of the experimental results. It is also important for others to duplicate the experiment to validate the results. Within our own work, each practitioner should be able to revalidate the results for themselves in their own experience.

The premature attempt to concretize the upper cervical protocols actually has an ultimately anti-scientific effect. This formalization of the protocols has not taken place for strictly scientific reasons, but also for important social ones. The teaching of the protocols requires some uniformity of action so that a core of shared knowledge can be created and so that the teachers have a depth of common experience to help the student master the task at hand. At the same time, the rote repetition of the task begins with the assumption that this answer is the "best fit" for the accumulated data. Any inquiry is directed only

at doing the task as defined in an optimum manner. Again, this is very appropriate for those beginners who are engaged in learning the common body of knowledge. From the wider perspective, it is always necessary to examine our assumptions.

Chiropractic has a scientific aspect, but like all healthcare systems, it also has aspects, which fall under the categories of art and philosophy. Our own interactions as a group of practitioners are not a strictly scientific endeavor as our relations with patients in our practices hinge as much on art and philosophy as they do the scientific. To reiterate our position, we believe that these protocols so far appear to constitute the best way yet found to help our population of adjustors deliver safe and effective care to their patients. The danger lies in our unexamined assumptions and assertions.

The scientific method constitutes a way to logically and systematically understand the material world. The upper cervical procedures are a systematic method for adjusting people. The two concepts are related but not identical. It is certainly logical that the extent of our scientific inquiry would extend past the current protocols used in adjusting people. The official protocols will always lag behind the cutting edge. It is important to realize that the beauty of the current protocols is that they are an unbroken chain of procedures that together, allow effective care while minimizing any potential harm. Creating a way to move forward while maintaining the integrity of the work and ensuring patient safety is imperative. We are still struggling, fourteen years after Dr. Gregory's death, to find a systematic way to do this.

## So What Does it Look Like?

Upper cervical chiropractic has not yet made an incontrovertible case in the accepted scientific literature for its proposition that correction of the upper cervical subluxation complex is a major factor in restoration of health. We cannot expect others to uncritically accept the presently (meager) published data (in the indexed journals) as adequate proof necessary to sweep aside the current segmentally based chiropractic paradigm.
There are many in upper cervical work that much prefer to focus solely on improving accuracy and consistency in their own practice of the upper cervical protocols. This is laudable and even necessary in every upper cervical practice, but it is not enough to sustain the profession. The shifting healthcare environment can no longer be ignored if upper cervical work is to be kept alive in coming generations. We would like our children and their children to be able to receive an orthogonally based upper cervical adjustment.

NUCCA and upper cervical chiropractic in general faces challenges on many fronts. We do not pretend to understand all of the challenges we face nor do we have the definitive answers to them. This paper was designed for a different task. Instead, we make an offer to the reader. Upper cervical doctors are usually of definite opinions. We are asking you to look at your experience and relate your understanding of our current standing. **We believe that the solutions are within our grasp, especially if we grasp loosely to what we think we know while stretching our sense of what is possible.**

This paper will be disseminated as widely as possible so we can test the idea of developing a parallel system of upper cervical doctors. The paper is meant to serve as an open door not as an exhaustive list of current issues and/or problems. Our request of you as a committed member of our community is to seize this opportunity to respond to these topics and/or whatever you believe to be of critical importance to upper cervical chiropractic. We have written this paper as two NUCCA doctors. Some of these issues apply only to the NUCCA organization. Others are of wider practicality. We intend to distribute this paper beyond the NUCCA membership because we believe Linus Torvald was correct: "Given enough eyeballs, all bugs are shallow."

Our intent is to gather all of your responses and publish them along with this paper in a special edition of The Monograph. These various responses will hopefully engender an ongoing cumulative process of organized but dynamic dialogue within our community providing an additional use for The Monograph. By its nature, we will likely find several different issues that are of interest to different segments of our population. Like minds can find each other and dialogue can greatly accelerate the learning process. The form this takes will depend on the issues that are developed by your responses.

# Voices From The Field

*The following responses were elicited from our paper. They are reproduced here without editing (except for minor spelling and spacing issues, unless noted) and in the order they were received.*

*Drs. Thomas and Scholten*

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Hi, This is Dr_____, I wish not for this opinion to be published in my name. Thank you. I skimmed over the extensive article, and I seem to agree with many things. Most importantly I am dissatisfied with the process to be certified and the many levels. If there were not only 2 NUCCA doctors in my state I would not belong to NUCCA to be displayed as not certified. As well as, what happened to the skyrocketing fee's to buy equipment and become a member yearly. The bad are beginning to out-weigh the good to remain a member of the organization. I do hope for change to remain a member. I do not need the organization to touch the many lives, you get that from school...

In Health...

(Anonymous)

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Hi Michael,

I just read your letter. I feel a strong pull to "concretize" the NUCCA work and "just stay with what we know that works". At the same time, I also feel a strong pull to say that there is more to be learned. "Staying with what we know" is static and saying that there isn't anything else to learn. If something is true, then investigation will not tear it down, but instead will only confirm and strengthen it.

I believe that I have talked with you about having tried some of Tom Elliot's (sp?) work? I tried it for a while and gave it up. It seemed too volatile, very touchy, small margin of error with very large repercussions with that error. BUT it did work at times! Dramatically at times. And most importantly, I gained much understanding of biomechanics through trying to understand and work through problems with another "system". That experience, even though I don't use that "system" any more, has helped me understand and work my system more effectively. I have a better understanding of what headpiece placement and Height Vector (and their interplay) do in the correction process. There was value to trying something that didn't work for me.

Years ago, I asked Dr. Gregory to write down a history of all the procedures that he went through in developing this work. Those that worked and especially the ones that did not work, because I thought that we could learn from the ones that did not work and would not have to go through the process of trying those which had already been proven not effective. I'll let you decide the significance of what he said. I'm not sure where it fits. Maybe it's not even significant. Here goes, "I wouldn't want to tell you the ones that didn't work because they might work for you." Somehow, I thought he was saying that there was value in going through the process of figuring out the problems yourself. It seems that issue has many facets that could be discussed. I still think that at least "seeing" the process of the rationale he used with the ones that worked and the ones that didn't would be of value. The "many eyeballs" might have seen a way for the ones that didn't work to have worked after all!

I am in favor of discussion and investigation with the understanding of it being in the right venue. (I guess I'm still slow to change with strong pulls going both directions.)

If you feel that you want to print any of my response, please don't use my name. This was just more of a personal response to you, Michael, than a statement to the profession or organization. Just my "first gut feelings" with a bit of rambling. Ha.

Thank you, Michael, for including me in your list. It is always good to hear from you.

You guys did a great job in presenting a touchy issue that does need to be addressed.

Best regards,

(Anonymous)

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THE PARADIGM OF THE GURU.

I hope that this discussion group will be read and everyone will share their ideas. Everyone has good ideas and here are some of my thoughts.

NUCCA was founded on the work of B.J. Palmer, Wernsing, Grostic and Gregory. They were gurus. I believe that Gregory founded NUCCA in an attempt to get away from the guru paradigm so that the work would continue.

This paradigm continued under Berti and Dickholtz. Those of us who studied under these people accepted their teaching because we could conceptualize what they were trying to do but were unable to do ourselves.

These men, like the great athlete of golf, Tiger Woods or hockey's Wayne Gretzky, had a natural advantage and fine tuned this advantage so that they became masters in the method.

Unfortunately, with this type of paradigm of guru and disciple there are many negative problems.

The guru's words become "written is stone". He becomes arrogant and overbearing to a point that anyone who disagrees becomes a heretic.

A similar paradigm is the Roman Catholic church.( I am an R.C.) Catholics believe that the Pope has the ultimate authority to teach on matters of faith or morals. While most Catholics will agree with this in principle, nearly every one has their own ideas. This is not the subject of this paper but I am offering this as a similar paradigm. Those who disagree, who wish to contribute their insights are many times labeled heretics. The paradigm of "we are right and you are wrong". As a result Christianity has split into hundreds of belief systems.

The sad thing about this is that probably 99% of Christians believe in the same thing. The same thing is true of all religions - they all believe in the same thing, 95% of the time.

To get back to the guru/disciple paradigm - the problems are many and among them are arrogance, inflexibility, dismissal of new ideas and eventual splitting of the groups into different factions. From the original Palmer group we have how many different upper cervical approaches and from Grostic/Gregory even more.

This paradigm does not work. Why? Because of human nature. In an attempt to solve this age old problem, science and the scientific method was born. Someone with an idea publishes a paper with an idea which other people can duplicate. If everyone agrees that things work this way then it is accepted as truth.

The claim is made that the academic world is closed to our researchers - that the refereed indexed journals do not accept our truth. If this was true then why has Don Harrison published numerous articles in these journals? Perhaps he knows something which we do not and he should be approached as to how he did this.

I do not believe that these refereed indexed journals are permanently closed. I believe that a way must be found to open them to our truth and our primary objective should be to find this way.

The actions of the present NUCCA board is to raise our fees and make us an even more exclusive group than we have been. We should be opening our arms and including all chiropractors of good will into the group.

It was D.D. Palmers who first envisioned giving the gift of chiropractic to the world. Somehow we have "missed the mark". The arrow instead of striking the target has gone off into the bush and wasted its energy.

We must abandon the guru/disciple paradigm and make a new one.

GROUP BEHAVIOR and BELIEF SYSTEMS

If a group of people meet, whether very smart and gifted, or the opposite, a common thing happens. They pick a leader. Once the leader is chosen, then his word is accepted by the majority of the people present. They will usually agree with his opinions even though privately they may disagree. In other words, when people meet as a group they do not necessarily behave in a rational manner. The decisions of a group reelect the opinion of the dominant leader and are not necessarily the correct decisions.

The leader, when he is chosen, attempts to maintain his position by using all of the tactics of the guru.

There are different levels at which a topic can be discussed.

1. Discussion level.

2. Belief level.

On the discussion level, one can share ideas in a rational manner.

As soon as beliefs are entered into, people react with emotion. Once emotions take over all further rational thought is impossible. Emotional responses range from fear to all of the seven deadly sins, among which are pride, covetousness, anger, envy etc.

We know this is how people act as a group - so how do we overcome this - by sitting down as I am now and share our ideas. Write them down and form a basis for common beliefs.

If these beliefs are shared and agreed upon, then there is not an irrational emotional response.

Then we can agree and perhaps have a meeting of minds and accomplish our goals.

Dwain Ingram, D.C.

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Michael and Jeff,

First of all thank you for writing this timely and important paper. My points and opinions are just and you can take them or leave them as this is your paper. However, I do feel quite strong about a couple of points. I have only had time to read over the paper once. Anyway, there is just not much that I disagree with in paper, but I do have a few comments.

One thing that I do disagree with is this statement:

Aside from JMPT, we still have no peer reviewed, indexed journal in chiropractic.

If you want to make this statement: (which I do not think you should) then you need to specify that you are talking about index medicus. Here is a recent a message from Dr. McCoy: [*Editor's note: Dr. McCoy is the editor of JSVR*]

*Kirk/Bo,*

*The real question is whether or not you want anyone to read your article. While JMPT is indexed in Index Medicus it is my understanding that they have only about 2500 subscriptions. Since all the journal editors and publishers agree at this point that being indexed in IM is a moot point with the advent of the internet - the issue is how many people are reading the work, what is the access and how aggressively is it being promoted?*

*JVSR is indexed by MANTIS, the Index to Chiropractic Literature and CINAHL. Type "subluxation" into Google and see what comes up - JVSR will come up first or second depending on the day of the week. Like every chiropractic journal we go through the 4 year cycle of applying to IM and we'll eventually get in. But if we don't, it won't matter much except to those who like their name to show up when they search in Medline.*

*In addition, JVSR has an active public relations and press release program. The results of this is best illustrated by the recent response to our Infertility Special Issue. JVSR has been featured in at least ten city's news programs resulting in millions of viewer exposures. Dr. Behrendt, who edited the special issue, has referred over 100 patients to chiropractors so far as a result of these. The story was recently picked up by Reuters and she is now getting requests from local parenting magazines for stories and interviews.*

*JVSR gets millions of unique hits yearly - in internet jargon this means individual people who access JVSR as opposed to just the number of hits – and these people access JVSR from nearly every country in the world.*

*All this and we are not indexed by IM. The reality is that JMPT is dying along with the other chiropractic journals. Just look at how many have gone out of business in the past 2 years. The ACA and the ACC are trying to figure out how to prop up JMPT so that Mosby will not drop them as their publisher. Meanwhile JVSR is growing in subscriptions and submissions on a daily basis.*

*Hope this helps,*
*Matthew*

We do not need to only "preach to the choir" with this paper because the issues that you cover are so important. Chiropractors as a whole (and subluxation-based docs specifically) need to hear our plight and our internal struggles). I think that this will help to endear them to understand that we are trying to address these issues, not to mention that we could obtain valuable feedback and help to open dialogue. I would love to get your permission to send this paper to Dr. Matthew McCoy (editor of JVSR) for his opinion and what he thinks for eventual publication.

Under The Map and the Terrain I think you need to add references such as my post X-rays study from 1998 and Gregory and Seaman's paper (see my book for such info). My paper did find statistical significance; however, it is far from a conclusive study.

We in Orthospinology, are also very concerned about issues of measurement and precision. That is why we have been so revolutionary in developing instruments to help improve upon the accuracy of the adjustment and improving the analysis (i.e. computerized digitization). We lead all upper cervical groups in putting out more peer reviewed research papers and case studies as well.

Yes, this paper needs to be circulated to those way outside of NUCCA. I argue that it does not need to go only to other UC chiros but needs to go into JVSR and be seen by thousands of others. Michael, I cannot not believe or fathom anyone in NUCCA who could possibly have a major problem with your paper. Maybe some minor disagreements but this paper is wonderful. It has and will be well worth yours and Dr. Jeff's time in putting it together. I applaud you and Jeff for your courage, but really what you say is not very bad at all.

Kirk Eriksen, D.C.

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I want to thank Drs Thomas and Scholten for their effort at starting a dialogue, "A shift in the prevailing winds", and would like to make some observations. In my travels amongst those who consider themselves to be science/academic/evidence based chiropractors, there are several objections to specific upper cervical work. These most often include the necessity of x-ray (both pre and post), the validity of specificity, the reality of upper cervical anatomic symmetry, and the validity of specific upper cervical work for lower back pain. The first two objections go to the heart of specific upper cervical work.

When Drs Thomas and Scholten wrote, "The upper cervical chiropractor has the burden of proof because of our minority status", in my mind, it is proof of these premises of specific upper cervical work they referring to.

There is much in the biomedical literature that concludes x-ray, for the most part, does not find any recognized pathology and does not improve outcome. As such, given the invasive nature of radiation and the cost involved, rules have been promoted that restricts when x-ray is considered necessary, even ethical.

As with x-ray, specificity of adjusting has also taken a beating. Studies have shown that most often a particular vertebral segment cannot be found, even if it is, it cannot be manipulated without moving other associated segments. As such, generalized long-lever mobilization is gaining acceptance over specific short-lever segmental adjustments.

Our challenge, as specific upper cervical practitioners, lies in demonstrating that the x-ray examination and vectored upper cervical adjusting provides a better clinical result than what I call a well-thrown rotary break. To accomplish this, I believe an outcome comparison between general diversified and specific upper cervical is necessary.

As a concrete suggestion, there are a several published studies in which a diversified or Gonstead lower cervical manipulation was used on subjects with restricted/asymmetric lateral flexion ROM. Such manipulation did increase ROM, but only temporarily. From an upper cervical perspective, proper cervical biomechanics proceeds from proper balance of the skull on the lower cervical spine through the atlas/axis. The hypothesis would be that specific upper cervical procedures, applied to a population similar to the studies already done, would also result in increased and symmetric cervical ROM, and the results would be longer lasting than was found with lower cervical spine manipulation. Two groups could be tested: one whose treatment was the full, standard upper cervical protocol - leg check, pre x-ray, vectored adjustment, post x-ray; and one who had their upper cervical spine adjusted in a vectored manner without the benefit of x-ray analysis (and perhaps a third, given a well-thrown rotary break to the upper cervical spine). Comparing the outcomes would help to establish how vectored upper cervical work and x-ray based vectored upper cervical work compare to each other and to standard lower cervical manipulation for this particular population. The protocol and outcome measurement for these studies has already been worked out. What is necessary is to plug in specific upper cervical analysis and adjustment, gather data, and compare the results. On the down side, I'm not sure the protocol for the measurements of cervical ROM are considered valid today. Such a study would take a stream of patients and at least two or three people to treat, collect, and analyze the data. The problem, as noted by Drs Thomas and Scholten, is the lack of a college or other specific location centralized to some volunteers to do such a study. I have no solution for this problem.

Another point of agreement I have with Drs Thomas and Scholten is that it is unreasonable to demand other techniques conform to standards of specific upper cervical care - especially without any evidence that specific upper cervical care is superior! In my interactions with other chiropractors interested in specific upper cervical care, I try to take them step-by-step from where they are comfortable towards where we think they should be. They are not ready to toss all they've done, take classes, buy a specialized x-ray machine and adjusting tables just to try specific upper cervical work. I reason with these interested DC's by noting that the atlas can move in lateral flexion as well as axial rotation, a fact that is verifiable in any biomechanical text. When asked how they adjust the atlas, most will admit to applying a p-a rotary break through the posterior arch. I then make two points: 1) research done by specific upper cervical analysis has demonstrated that the subluxated atlas is far more likely to be anterior on the side of laterality, thus, a p-a thrust may be causing further misalignment if done on the side of laterality, and 2) while axial rotary thrust may have an effect on the axial rotation aspect of the misalignment, it is also likely that any lateral flexion rotation (atlas laterality) will still remain. Most often, these points are conceded, and interest in a more vectored approach to atlas adjusting is expressed. This is the first step. Since most DC's seem to have an Activator™ instrument, I recommend they approach (what they consider) an atlas problem using a transverse contact on the side of laterality with a correction vector that is high and from the anterior. This is step two towards seeing the value of specific upper cervical work. If, by changing their approach to atlas adjusting in these simple ways, they have better results - and odds are they will - then an interest in furthering their knowledge if specific upper cervical work will have been created. Some may denounce these small steps as being grossly incomplete and not at all representative of specific upper cervical work - and they are right. However, I would point out that these patients are better off if a more vectored attempt at reducing an atlas subluxation is attempted. I believe that practicing chiropractors can be led to specific upper cervical work by logic and results - a strategy superior to demanding immediate conversion and conformity.

While I am in agreement with Drs. Thomas and Scholten as to some of the problems in the specific upper cervical world, I must also take issue with one of their (and from their article, Dr. Gregory's) basic premises. That is: "By 'results' he [Dr. Gregory] meant post-films", and, "Our gold standard is the radiological measurement of maximal and proportional reduction

(correction) of misalignment". My opinion is that "results" means the elimination of pathologic changes in the function of the nervous system, not whether the atlas is "zeroed out" on a post. While I believe opinions on this issue should be openly debated and not debased, this is an "in-house" disagreement and is not currently relevant to the problem of validation of the pre- x-ray and vectored adjusting of the atlas. Still, this question of results - neurologic vs biomechanic and what mix - does need to be examined.

Specific upper cervical work has face validity, which means it makes logical sense and a compelling argument. In addition, there are several pieces of the evidence puzzle that have been published in mainstream literature. However, this is not enough. It's time to take the next, most crucial step in the documentation of specific upper cervical work. That, in my opinion, involves some sort of comparison between diversified manipulation and specific upper cervical work. If taking the x-ray's are worth it, we have to prove it.

Lastly, and I apologize for the length of this commentary, make no mistake regarding the airing of these criticisms of specific upper cervical work. Criticism is a good, not bad thing. As B.J. Palmer is quoted, "Hail the storm, it is your antagonist come to develop you".

Gary A. Knutson, DC
Bloomington, IN
Palmer '80
Grostic trained

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To me, A Shift in the Prevailing Winds" is a poetic reference to the intrinsic value and advantages of inclusive thinking. One of the many paradox's of practicing upper cervical chiropractic lies in the "exclusiveness" of its therapeutic parameters. If one possesses the mental fortitude, physical aptitude or unswerving conviction, then the practice of upper cervical chiropractic, can become a wonder to behold. As Dr. Gregory was fond of saying" Adjusting the Atlas is a full spine technique." Truly speaking, the practice of upper cervical chiropractic is more akin to classical homeopathy and acupuncture, than to the "manipulative techniques" which should be aligned (no pun intended) to physical therapy. So, as upper cervical chiropractors, we are in somewhat of a philosophical quagmire. We are alienated from our own profession and at the same time, practicing the absolute best that chiropractic has to offer.

It is imperative that the Grostic based practitioners join hands and "include" each other in speaking as one strong voice, not just on paper, but in action. We need to put aside methods of correction and focus on the corrections, period. Although DR. Gregory was a phenomenal hand adjuster, he was in principle, not opposed to instruments. The Post X-ray is the gold standard for Grostic based practitioners. As long as we agree on the fundamentals, there should be ample room for discussion and consensus. We should be inclusive in our exclusiveness. I don't think the practice of upper cervical should ever be "included" as one of the "modalities" of Chiropractic. It is not a therapy-as is manipulation-but a unique and powerful healing principle for all time. As we become more proficient in correcting in the C1 subluxation complex, the value and sublime uniqueness of this great healing art will emerge. Our collective proficiency will improve, only if our "eyes" are focused, not on each other's inadequacies, but the unique qualities and insights that each of us possess. Let us unite in head and heart, and forgo the "shallowness" of self aggrandizement, elusiveness and narcissism. Let us be exclusive in our commitment, dedication and service to humanity, and inclusive to anyone who joins us in that commitment.

Many of us who honor and love what we do, feel a shift in the winds. Only God knows what will prevail, but we must do our part not to become part of the underlying problem, (greed and power) and work together in the spirit of harmony and compassion.

Steven Goodman, D.C.

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I must say that the introductory picture was most appropriate for the NUCCA organization and upper cervical chiropractic in general. I have said many times that we are but a small drop of water in a vast ocean of mainstream chiropractic, and more so the overall healthcare arena. Upper cervical chiropractic has lost its voice in the chiropractic profession, and never had one in the overall scheme of healthcare.

I do not know where the impression came from that what we know now is all there is to be learned. However, I must add that what we know up to now was not pulled out of thin air, but has been investigated by principles of physics and mathematics, and logic, as well as by research established by the founders of this work.
I do believe the burden of proof is ours, as it is anyone's that needs to establish a protocol.
It is always good to examine our assumptions, and should be an ongoing process, until they have become proven fact.
It is in our common interest to develop greater understanding of all phases of our work to make it easier to learn and perform, as well as becoming more effective in optimizing our patient's health.
I think it is here where it would be appropriate to address the definition of health, which is multifactoral; true health has many faces.

In my opinion, there are three main components that make up a person's health.

1. Genetics- if you are born with a genetic defect (e.g. Down's Syndrome, cleft palate, heart defect) or a genetic tendency (mental deficiency), there is not much control we have over the initial condition, but we can work with the person to achieve better outcome (e.g. surgical repair, educating patient to help themselves).

2. Environment- this includes presence of clean air, clean water, good nutrition, and exercise, stress (emotional and physical), trauma (e.g. punctured lung in car accident which would affect breathing) and toxins, (poisoning your body with drugs, working with asbestos) etc.

3. Subluxation- compromise of body function due to loss of neurological integrity, which keeps the body working at its optimum capacity to function.

Food for thought, if a person is overall clear of 1, 2, 3, and gets their arm cut off, are they healthy or not? What do you think? (Hint-don't confuse impaired and healthy).

If a person eats something that is spoiled, and ends up vomiting for 2 hours, did they get sick, or was their body eliminating toxins in the body the fastest way is knows how?

Is a lack of symptoms or a change in symptoms as a sign of health? If you have a cavity in your tooth, and apply anbesol, the toothache disappears. Why need dentists to take care of teeth with cavities? Maybe people are aware of the **long-term** outcome of not taking care of the cavity (CAUSE of the toothache-**condition of the tooth.**)

I suggest that we not look at symptoms, but at the **condition** of the body (or the tooth) and establish **CRITERIA** to determine or evaluate what is a good condition and what is not. In our examination we need to know what to look for. We should all be looking for the same thing (our objective findings) to decide what state the patient is in. Like all other professions, we need a standard system to go by. Better yet, our patients should also know why they are in our offices and what we are looking for.

Do you think there is any question in the mind of a patient of a dentist why they are there, or of an optometrist? It should not be that difficult to convey to the public the necessity of brain-body communication to maintain optimum body/system functions as a necessary requirement for a healthy body.

If the body is subluxated, what condition is it in, if it is not subluxation what condition is it in, and what criteria do we use to evaluate each state? We must define subluxation, what distinguishes the difference between adjustment and manipulation, **and how we determine which was done to the patient.** We need to know, as a profession, not just as a technic, who we are, what we do, what a subluxation is and what compromises an adjustment, that we do it by design with an intent in mind, not by any hit and miss approach.

I do not care if a person takes a hot shower, gets a massage to feel better or gets a rotary break, if it can meet all the criteria necessary to put the condition of the body into a non-subluxated state, fine by me. There stands the burden of proof.
Dr. Gregory always said you could hit someone in the behind with a broom and change symptoms. Drugs and surgery can change symptoms or create results. Intrusion into the nervous system by other techniques can create symptomatic change. The changes in **the condition** of the body, that were created, are to determine whether this was beneficial or not.

There was research done in B.J.'s clinic that a study group was intentionally adjusted on the **WRONG** side, and their "symptoms" improved, yet if you checked that patient on the Anatometer, leg check, instrumentation, what would you find about their **condition?** I doubt that they held their adjustment, unless the x-ray analysis was wrong. I really doubt that the symptomatic relief lasted, or that these people truly got well, since one needs to hold over a long period of time (healing is on a long-term basis) to restore total health. This is where NUCCA comes in.

Objective findings must be established to determine the condition of the body. It is either in a subluxated condition, or a non-subluxated condition, and what do you look for.
If a patient comes into your office complaining of a headache and says he needs to be adjusted, yet you find no objective findings to do so, what will happen if you try and adjust that patient (what happens if you adjust on symptoms without looking for objective findings)? If you delve into the situation a little further, and ask the patient what he was doing the night before, and found out he was drinking, that would be good cause for a hangover headache the next day. That doesn't mean he needs an adjustment. It does not mean we determine anyone's health status completely based on symptoms.

Again, we need to establish objectives findings to look for, and criteria to use. We must answer to a higher standard than joint manipulation or treating symptoms as other health professionals do. Our image as chiropractors needs to go beyond that of being a "back doctor". How many people know (or remember) that the first chiropractic adjustment restored someone's hearing? The whole chiropractic profession, if would examine this common ground, would then gear themselves into the correct path of who we are and how we are defined.

I would like to say we are right and mainstream is wrong, if you would establish the above-mentioned standards in the profession. But, even though I am beginning to get very tired of being politically correct with regard to this issue, I would be willing to say that what we have is maybe more of a precise and effective procedure than mainstream chiropractic.

Knowing what we know, would you let someone do a rotary break on you, even if they can produce symptomatic change? What do you think may have been **created** as a result? What would the **condition** in the body after such a procedure be, regardless of what happened to symptoms?
Unless we are willing to submit ourselves to this kind of care, are we allowed to state that the rest of the mainstream profession is not wrong, regarding standards of chiropractic care? I do not believe that we have been communicating this to the outside world for the last 60 years; I do not believe we have been communicating anything at all. If we communicate, it should be to show that what we have to offer is above and beyond what mainstream has to offer.

How many patients have we had that have been through every avenue, seeking help, including mainstream chiropractic, to no avail until discovering upper cervical care.

This should make a statement of its own. I highly question whether the statistics or clinical findings would show the same conversely.

This is not to say that other fields, like a nutritionist offering better nutrition, or an expert in a gym giving advice on good exercise techniques will affect health. This I would not hesitate to subject myself to. Starting to get the picture?

With regard to post films, I believe orthopedics take post films, for example, to determine that there is a fracture, then put it in a cast, and post later to see that it was cast properly, or later, if it is healing properly. How about post x-rays to see if the cancer drugs are working and the tumors are shrinking? Where is this not acceptable? Why should we be held to a double standard?

Yes, critique of peer-reviewed systems is necessary for us to be accepted in the scientific community. I think this is important, yet attempts have been made and we are dealing with prejudice and discrimination in this area. Maybe our only way to overcome this is to link ourselves up with university research departments, in chiropractic colleges, preferably, not necessarily. We need university funding and their skill and training in research methodology. We missed the boat when we did not approach Dr. Suh when he was doing so much good chiropractic research at the University of Colorado. The time is now to make these attempts. I do not feel we have the funds and resources to do this alone.

Another avenue would be through the insurance companies. If they would only realize **how much money** they can save by what we have to offer, they would help provide us with necessary resources. All they care about is their bottom line, yet I

just don't think they are open minded enough to hear us out. All we need to do is get through to one, and once the others see the outcome, they will follow.

Tight access to instruction is very important, since there is so much complexity in this work; we need proper information conveyed by those that are most familiar with the work. "Behind the doors" instruction in hotel rooms has only produced misinformation and skewed concepts of what should be properly taught at the conferences. (I know, I have been there). Properly taught, known information should not be confused with freedom of conversation and ideas regarding aspects of this work, but these need to be defined as such. The work needs to be protected, until research proves otherwise. If you can prove there is something better, this is where evolution comes in, if you can't, you need to stick with the best you have so far.

Techniques that do not share the goal of post- film analysis, is not necessarily appropriate for those that do a master rotary break, but not for us. If we want respect, we must EARN it. Why is it not appropriate to show the correction?

It is true that apples are not oranges, and if I were the apple, I surely would not want to be the orange. That is why we are different. Yet we need to stand behind what we do.
Again, of those 300 techniques, how many of those would you allow to be used on you, knowing what you should know about NUCCA work?

Again, I do not deny that others have derived some health from a whole diversity of procedure. Intrusion into the nervous system can do that, but they need to be defined as **symptomatic** change, unless a change in the condition of the body per established criteria can be proven.

In a nutritional aspect, a better diet can make someone have health benefits. Yet again, apply criteria established to these patients, put them on an Anatometer, run some instrumentation on them, check the state of the paravertebral musculature. What will it tell you about the **condition** (or state) that their body is in? Here in, again, lie our definitions, standards, and criteria. A person cannot be considered healthy, if they are neurologically compromised, I do not think even the allopaths would disagree with this one.

Criteria need to be established to determine or evaluate the condition of the body is in, otherwise, how do you know what you have done. Does change in symptoms determine a change in the condition of the body? Did putting anbesol on the cavity change the condition of the tooth?

Standards and criteria need to be applied to the whole profession so that we have a common ground to define subluxation. This should define who we are. (note: this is a losing battle in itself, since there is a platform in mainstream chiropractic at present to drop the **outdated** term of subluxation out of our definition of chiropractic).

Correction should be related to improved neurological and structural integrity, improved function, and thus improved health. You can change symptoms many ways. We need to establish the relationship between structure and function.

Decide whether you are eating apples or oranges, and they should taste appropriately as such. True, our collective understanding of health is at best incomplete, but this does not just apply to the chiropractic profession. I feel we are at least closer than many others.

Our commonality should point towards issues of criteria used, function, the state the body is in, and understanding of health as per Stephenson's textbook.

What state of health do you think a person who has had cervical rotaries or lumbar rolls three times a week for the last ten years would be in? Is this patient balanced, are they neurologically clear? More is not always better. Are they any healthier than someone with only one NUCCA "adjustment" that held a year? How effective is this procedure in meeting criteria to determine this? Would you subject yourself to these procedures knowing what you know about upper cervical care?

We do have the burden of proof because of our minority status, but not because we are wrong, but because, unfortunately, POPULARITY always RULES over TRUTH.
We cannot demand anything of others, even though I would like to, but I do not believe any reasonable health provider can argue with outcome standards of restoring and maintaining balance, structural, neurological and functional integrity, therefore homeostasis in the body.

If you check your percentages in clinical outcomes, you will see that correlation of reduction on x-rays and restoration of structure (improvement of short legs, correction of pelvic torqueing, better readings on instrumentation, improved paravertebral muscle tone, etc.) can well correlate close to 100% of cases. If it doesn't, I would consider it safe to say it is the chiropractOR, not chiropracTIC, that was the problem. Can drugs or surgery do the same, not to mention good nutrition, exercise, you name it.
Practical competence, when accomplished (and no one says it's easy), does not mean it is not possible or that it doesn't work.

If researched appropriately, efficacy of different interventions can be compared on not only physiological changes, but on physical changes as well.

It is taught that 20% of a decrease on x-ray misalignment still clears the nervous system, thus initializing symptomatic response, and it can be profound. If again, we go to our criteria or objective findings, you can find a great clinical correlation, on a very **consistent** basis, which then affects symptoms and health outcomes of our patients. My experience has been very true to this.

In my experience, greater reductions on x-ray affect holding and stability, not as much symptomatic response. The better you hold, the healthier you will become.
This correlates with a good post (food for thought-define health, how do you know you made a correction, maybe you just changed symptoms by cutting off some nerves, make a 0/0 to a 5/5 and live with it, see how healthy you get). You cannot be healthy (don't confuse with asymptomatic) if you are not neurologically clear.

To achieve practical competence, the skill level to achieve it must be worked on, it is not beyond reason, and even though it is somewhat difficult, there is nothing better at present, when you need to produce a good post, or the type of patient outcomes that we achieve.
The goal should be to get optimum reductions, and to achieve this you must apply technique and principles in adjusting that are sound, logical and proven true in biomechanics and skill.

I do not understand where the writers would get the concept that only a handful of masters can provide benefit of upper cervical care to humanity. As mentioned above, you only need a 20% decrease to make a difference, no one says a patient can't respond as such to a minimal correction. If you want to become a master, it is your choice how hard you wish to work to achieve the skill level to meet your definition of master.

There was a great price paid by each certified doctor to achieve this level of proficiency. It did not come easy for anyone. No one said they will be perfect, or that they are God. They achieved a standard; minimum requirements necessary to demonstrate they have achieved a given skill level to meet these requirements. There can be many reasons films may not be the best or an adjustment, many times beyond our control. For example, when you have a new patient scheduled, you won't send him home because your x-ray man didn't show up with fresh solutions that you ordered, when he was supposed to Certified doctors are allowed not to feel well on occasion, or get tired for multiple reasons, which can affect performance. This is not indigenous to certified doctors alone.

Certification is something you need to achieve for yourself, if you so desire.
If you don't want to achieve it, don't develop a complex; this is a standard of proficiency.
I still believe the poorest NUCCA adjustment creates better changes in the criteria whereby we evaluate the condition of the patient, than the best rotary break someone can provide.

There is no error in logic, who says there is. We need to establish our standards. If standard outcomes can be achieved with an instrument, standing on your head or taking a shower, so be it, as long as the proof is in the post and objective standards are met. Who says anything is discarded out of prejudice, and by whom?????

I find it more appropriate to say that there are more ignorant and prejudiced mainstream chiropractors that have no desire to listen, and find joy in persecuting others that don't think like themselves. We know what **we** can do with what we have. This is TRUTH, not conviction. It can be consistently repeated.

It would be nice to remove the social impediment, but what do we need to compromise to remove it. Widespread acceptance would be wonderful, if it happens, it only will be only through our patients, and insurance companies. Proof is in the pudding, and maybe the scientific community, if we can overcome the prejudice and discrimination to get out research into peer-reviewed journals.

If mainstream chiropractic is moving away from the definition of who we were established to be, do we compromise ourselves by following them so we don't become righteously extinct, or do we stand for principles at the expense of not being politically correct? I feel that chiropractic, as we know it, will become extinct anyways, if we follow the allopathic route of most mainstream chiropractors today.

A map gives you landmarks to find your way. If Columbus turned back and sailed east, he could find his starting point (foundation). We know a lot about this work that Is true and logical. We must be certain we do not mix up map and terrain with symptoms and condition (function).

There are levels of competence in the NUCCA technic, or any technic. With certification, a certain requirement is established, defining a certain level of competence necessary to be able to demonstrate that a certain skill level has been achieved to produce what is necessary to meet these minimum requirements.

We must set standards for ourselves----what we try to achieve. Let everyone else match us. Are they up to the challenge? I sure wouldn't want to be in mainstream chiropractic; we have all seen what the outcomes of their manipulation are on the **condition** of patients we receive in our offices that have been subjected to this kind of care. I want to be unique, distinct, and most effective.

There are some people who "get it". It is our job to educate and to make upper cervical a household word. It is our job to infiltrate this work to the medical community and the population at large. Restoring structure and function is not illogical. How come you can move your big toe if the message comes all the way up far away in the brain? It is in our inadequacies as communicators at present, that the problem lies. The goal is to make the common understanding "a given". It is up to us to create a shift in the thinking of the healthcare paradigm.

I will be the first to agree that we are lacking help from large granting institutions funding research at the university level. We have no PhD's who have been educated in research methods.

This adds to our downfall. It is a main problem. This is where we need to focus our direction for the future if we are to survive. Our research needs to be published in peer-reviewed journals, as well as in our own journals. I think we all know it, we just don't know how to go about it.

We do not need flexibility (compromise) to move us forward, because truth (our foundation) doesn't change. We need ways (like through properly implemented research, for example) to bring the truth to the forefront, to continually modify and improve upon the knowledge we have at present.

I do not agree that it is neither critical nor appropriate that the entire profession use the same approach as we do .We will never receive respect or recognition if we are scattered or too diverse, because there can be no identification of **WHAT** it is they are recognizing of for what they are giving respect. We need to be a common body of practitioners, so the community knows WHO they are recognizing, and what we do.

I think we would be much better off, if we were defined, at least on the same page – only one true subluxation, only one true correction. Joint manipulation changes signs and symptoms, not CONDITION of the body.

Yet, this is too far-gone and will never happen, unless we break away from mainstream chiropractic and redefine ourselves as a new profession addressing integrity of the nervous system. With common established criteria to go by, I still believe that we can prove our approach is most efficient. I think we would be much further ahead in the eyes of the world if we practiced, as a profession as a whole, with an upper cervical definition.

We have given respect and tried to be politically correct for too long. We have never received respect. Even though we are a minority, if they don't agree with us, it seems they still can respect us. Why the double standard. Usually people won't agree if they don't understand.

It is time to challenge, overcome ignorance and prejudice, let's show them we have something better (which we do).

I think it is critical and appropriate that the entire profession go by the same criteria and outcome in function. Defining ourselves with accuracy, competence and consistency, and intertwining these with our art and philosophy, is necessary in delivering patient care. If we're all on the same page, we will gain our spot in the health field.

We are right. We need to define and compare criteria to everything else that are out there- to detect and correct the condition (or the level of function) of the body the subluxation creates.

Inquiry, investigation is ok and good. Qualified people who understand the work should decide on changes or accepted principles based on further research and their applied knowledge and skills. There needs to be some gate keeping to prior protocol. Any change should build on the foundation of principle, which we cannot deviate from.

There will be no chaos in this manner.

We have complex systems regulated by Intelligence. Chaos in an injury becomes stabilized with repair. There is the wisdom in the body that can do that. We need the constant flow of energy (life force) for life to be regulated by intelligence. **Full expression of intelligence is needed for complete functional integrity.**

With regard to the Delphi effect, it is true; averages are more reliable than the single.

Look at our clinical outcomes in our office. What is the result of taking pressure off the nervous system (functioning as a whole, as one organ of the body)? We create **consistent** changes in criteria determining subluxation (condition of the body), some of which are: reduction in pelvic torqueing, structural balance of spinal column, including leg balance, muscle tone, improved neurological function. These outcomes are found consistently in **multiple** NUCCA practices across the country. Who can argue with improving these standards in the body? Any health care professional with the patient's best interest at heart cannot argue these criteria.

We must focus not on spine straightening, but on the premise that nerves control muscles, and muscles move bones, thus we must clear out the Nervous System first.

I do not believe our work is FULL of unexamined assumptions and unproven assertions.
We have some, yes, but that's where we need to define it with research. Also, we need to build on prior studies other scientists have done. For example, how about the scientists that proved that when you clamp a nerve going to a muscle, the muscle would atrophy and the nerve would demyelinate due to diminished nerve supply and tissue damage.

We need to link our diminished nerve supply theory of subluxation to this study, and then connect it to muscular deteriorating and neurologically demyelinating (damaged nerves) conditions like muscular dystrophy and multiple sclerosis. How about all the conditions you hear about in the media, about diseases (including cancer) in today's research related to immune deficiency. Can you imagine, with the kind of work that we do, the profound effects that would occur if we could show neurological compromise affecting integrity of the nervous system?

We need to build on other people's work that has been previously done, and use it to get the word out about what we already know.

We also have many principles that have been defined in research in the last 50 years.

How about Gonstead, people who do rotaries, network? I would like to know what criteria they use to practice by. Is there ever a time when they will not "adjust?" How do our standards compare. I am not afraid of the challenge. This is where we grow and learn.

At least we are going in the right direction; we can show what we do on the Anatometer, post x-ray, instrumentation, etc.

We may not have complete proof, but we have good judgment and lots of logic, physics, and mathematical principles behind us.

It seems to me that electricity, has not yet been proven or is completely understood in the scientific community, yet they know that if it can be generated, you can get a light bulb to light up and you can light up your homes and expressways. Just because it is not 100% proven or understood, doesn't mean they don't use it. Again, I am tired of double standards.

Just recently a health and wellness reporter on the radio, who prefaced her report with the statement that she just spoke with the physical therapist who works in the chiropractor's office **that she goes to**, gave the list of top 10 avenues of relief that people seek for **chronic** health problems and aches and pains in the body:
Here is her list:

1.massage
2.hypnosis
3.guided imagery (happy thoughts)
4.acupuncture
5.biofeedback
6.hydrotherapy
7.physical therapy
8.transcutaneous electrical therapy (tens)
9.posture work (consciously concentrating on how you sit, etc. using exercise)
10.crystal therapy

(where is their research?)

And this list comes from someone that is supposedly a chiropractic patient, yet chiropractic was never mentioned!!!!!!!!!!
Also the co-anchor she works with (who goes to a mainstream chiropractor for this), suffers from constant migraines. We hear about her problems all the time on morning radio, or why she didn't make it to work that morning.
A while ago the health reporter even gave a report on new research she found that links migraines with nerve compression at the base of the brain. When I heard this, I even sent her a letter telling her how on-target she was with her report, sent her some of our NUCCA brochures and directed her to our website.

Did I get a response from her, NO. Was it ever mentioned in her report on the radio, NO.
Are we in trouble as a profession? **Absolutely yes.**

We must look at our experience as a health care provider so far, and relate it to our understanding of our current standing in society. An environment of inquiry and evaluation is good; it needs to be directed into proper channels. This is where our research should come in.

We need to convey the idea of correction and restoration of health.

Our clinical outcomes must be directly related to cause and effect- we all know it.

We need someone to help us compile the data we have in our offices. I feel it is best in the hands of the new doctors that have training in writing up case studies, and research methodologies, working with doctors in the field.
We do need to get this information into the scientific literature, even though I am not certain how we can counter prejudice and discrimination in this arena.

Yes, we need more than the post radiographs (and we have more) to convince the rest of the world, but it is a good element to have as one of our tools.

I do not believe our work is in its final form, yet, but hardly would I call it a baby, more like a teenager. I agree we are; not yet completely mature, and wonder if we will ever be, since knowledge is ongoing.

Even though the research over the past 50 years was conducted by our rules to satisfy our purpose, it does not make it wrong.

If anyone is familiar with the current popular composer *Yanni*, will know that he is a great composer of some magnificent music. He cannot read conventional music. He made up his own system of notes that **he** could understand; yet his music sounds wonderful. His concerts are sold out and his CD's are big sellers. It doesn't mean his system is invalid and his music is bad. The same way we get our results, even tough we are not in a lot of peer reviewed scientific publications thus far, and are not at present in their playing field.

More so, anyone familiar with composition can probably transcribe his music into conventional notes. I am certain a lot of our research over the last 50 years can be formatted without too much effort to meet conventional scientific requirements. We just need to find someone that can understand this and has means to implement it.

There is power in numbers. All the upper cervical approaches should define the things we have in common, and research our discrepancies, since many of our protocols are more similar than different. I think we have a common foundation.

We can examine our assumptions and assertions; many may be easy to prove.

Yes, we must make our stand as upper cervical practitioners because our work does point to possibilities that could profoundly improve delivery of healthcare in the world.

Enuf Said- Irene Adamczuk, D.C.

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Dear Drs. Thomas and Scholten,

Thank you for your paper on the current issues in the practice of upper cervical chiropractic, but more particularly, thank you for the opportunity to respond.

Since I did not renew my membership in NUCCA, my response may not be legitimate, but then, that is part of my response. I can't afford to belong to NUCCA.

When I left Palmer College in 1951, I had served an internship in the B.J. Palmer research clinic. I knew first-hand of the effects of upper cervical subluxation on the human condition. I had studied the field research that had been done twenty years before on 5000 cases by 259 field doctors showing the effectiveness of upper cervical chiropractic.

I had a seatmate at Palmer (we sat in an assigned, numbered seat for every class) who would stand with me and debate upper cervical to anyone who wanted to challenge us, be it full spine adjuster or "mixer". I went on active duty in the U.S. Navy Reserve when I left Palmer and my seatmate went back home to practice. Less than two years later I visited his office and he was using all types of adjusting, as well as some other modalities. When I asked "Why" he said, "I got hungry." It is my opinion that this is still why so few Doctors of Chiropractic do cervical work. Economics!

You state that the rest of the profession has not stood still in the intervening decades. Where is their validation? How much has been published in indexed literature about the rest of the profession? Is it possible that the entire profession is enjoying the success of upper cervical?

"Upper Cervical Subluxation Complex" by Dr. Kirk Eriksen is an excellent review of the published literature on upper cervical work. The percentage of results published by B.J. in 1934 appears to be holding up.

"The disenfranchisement of the internal membership"—<u>in my opinion</u> is our primary problem. The creation of a presumptive incompetence has alienated a lot of good upper cervical chiropractors from the cervical groups, and also resulted in a lot of doctors resorting to "easier" techniques.

Except for the scientific protocols of upper cervical work, chiropractic would have long ago been relegated to a physical therapy modality. Chiropractic is the correction of spinal subluxation! That's all we have, everything else can be used or practiced by other professions. All of chiropractic is good – it works. Upper cervical subluxation correction is the ultimate chiropractic. It is easy, we know why it works and how it works, and the creation of presumptive incompetence divides us.

I adjust a ninety-seven year old chiropractor who practices upper cervical chiropractic three days each week. He has the only side posture table in a town of twenty chiropractors. He has not attended an Upper Cervical Seminar in over fifty years. He is a successful chiropractor.

Dr. John F. Grostic stated that when you were ready to deliver the adjustment, 80% of the work had been done. The differences between the different upper cervical groups are primarily concerned with that 20% involved with delivering the adjustment. Even those who do not take post x-rays still get favorable results with upper cervical adjusting. I may not like it but it is still Chiropractic!

I am enclosing a copy of the "News Sheet" of the Palmer Standardized Council dated September, 1937, in which Dr. Labachotte discusses "standard" and "discipline" and the idea that some do not deliver the adjustment according to the rules.

Your paper is an excellent dissertation on the status of upper cervical, not only of NUCCA, but all of upper cervical. D.D. Palmer gave us philosophy, B.J. Palmer showed us the science to back up that philosophy. Grostic, Gregory, and many others responded on the science, and gave us ways to develop the Art. But, as any artist will tell you, "I can't paint your picture", but I can paint my own, and together we can start a gallery.

We all have the Philosophy and Science...that is what the world needs to know...then the Art would be easy.

Thank you for the opportunity to express myself.

Sincerely,

Hugh L. Crowe, D.C.

**Editor's Note:**
*The following is a reformatting of the papers sent in by Dr. Crowe. Not included is a "Council Register" which was placed in the bulletin directly after the text reproduced below, listing all the members of the Council, from thirteen states, Canada, England, and Mexico. Total number of names on that list (in 1937) was twenty six. Our sincere thanks to Dr. Crowe for his eloquent response and for sharing this piece:*

N E W S  S H E E T

September 1937

SEND IN NAMES OF HIO PLEASE!

For your future convenience and service to our members, we are building files of Council-Approved HIO Chiropractors.

The first essential in building these files is your cooperation. Please send us name and address of any Chiropractor you know is strictly HIO and I mean STRICTLY on ALL cases), and who is of good moral character, and a staunch fighter for Chiropractic. We want only the names of those who are 100%. Upon receiving name, we will check further at this end and the name may or may not appear on our approved list, depending on our final decision.

Unless we are strict in compiling this list, some day you will recommend a patient to one listed and later find out your patient did not get HIO, and then blame us. PLEASE BE CAREFUL! If you have the slightest doubt about the Chiropractor whose name you are about to send to us, DO NOT SEND IT, but keep him under observation until you are positive one way or the other. I personally would not recommend some of my best friends for this list. Do not let friendship influence you. Look the facts squarely in the face, and be hard boiled about it. Either he is, or he isn't! Be sure! If you ARE sure, shoot those names and addresses to me as quickly as possible.

If the name is finally okayed, it will be listed, subject to being dropped if HIO is not strictly followed in his practice in the future.

Thank you for your cooperation!

DISCUSSION BY DR. ROY G. LABACHOTTE

The question of discipline in our organization is the key. Still it is a matter of considerable discussion because it has never been used in Chiropractic ranks. It is a strange and fearful word to any group of people who have never known discipline. However, without it, no organization can progress. As much as the average Chiropractor cusses and damns the medics, they are going right ahead pushing us farther and farther towards the edge of our nest, and they are successful- - because they use discipline within their ranks. Still their product is of a very inferior quality. The Chiropractor really has a high-class quality of service, but he has to take a back seat because EACH Chiropractor is a law and a "STANDARD" all by himself. We all run wild and only stop when we arrive at our own PERSONAL limits, wherever that might happen to be. We can never get anywhere until we form a solid front, and proceed in a solid body and every side and angle to that body is solid and exactly like the rest.

Our group will be small, but it is best that way because it will not be too cumbersome. We are all more or less inexperienced at handling an organization of such possible power, and it is better that we start small for that reason - - if for no other. We will make mistakes- - but we will also do much more constructive work and as time goes on and we become more experienced, we will be able to use greater power with greater numbers.

Getting back to that word "discipline" again. I had a very prominent lawyer for a patient a number of years ago, who asked me why it was that PALMER (meaning B.J.) didn't whip his own graduates into line, and MAKE them behave after they went into the field. Later, as I remember, he asked B.J. that same question personally. His idea was that when a student graduated from the P.S.C., he would be made to sign a contract or pledge of some sort that he (the student) would conform to the Palmer teachings; the penalty for violation was suggested to be the dispossessing of the graduate of his Palmer diploma. Of course B.J. couldn't hear of such a thing. The reasons are obvious. However, the lawyer had the germ of an idea. He belonged to the "Bar Association" of his state, and there is plenty of discipline there. He KNEW that it was a necessity to have some sort of DISCIPLINE for members of ANY profession. His interests not being Chiropractic interests, he had no reason to continue to think along the lines of disciplining the Chiropractic profession. He had sprung his idea on fertile soil, however. Our present organization is the result of his original idea. That same lawyer is now going to write up a rough draft of our constitution and by-laws.

I have been asked whether it is absolutely necessary that the corporation own the equipment (Standard equipment) I feel personally that it is necessary. However, I do feel that problem should be worked out by the members themselves under the advice of B.J. It is B.J. and Chiropractic whom and which we are trying to help, and we, the members, should and must conform to B.J.'s desires on such grave and far-reaching matters. This organization has within it the power to ruin it. Let's be very cautious- -particularly in the beginning. Let's weigh every possibility for good and bad very thoroughly. We can afford better to do it in the beginning than to try to pick up the wreck of it later. Let us not let the possibility of personal financial gain blind us to possible dangers to Chiropractic and B.J. Let's go down in history as ONE Chiropractic organization which DID SUCCEED.

We will establish Chiropractic as a scientific health method, thereby making it a dignified work, which in turn will build the student bodies of good schools; the students going to these schools from our Clinic will have the RIGHT mental attitude, and they will retain it at school, which I am sorry to say is not the case at present.

The national broadcast will be a great factor in educating the various classes of people as to what real Chiropractic is, and they will not be misled into thinking that it is a hodge-podge, and that Chiropractors are "rubbing doctors", as is now the case. How many times have we had some well-meaning citizen come in and ask for a "GOOD RUBDOWN", or a "GOOD GOING OVER"? Our clinics will gradually dispel such a concept of Chiropractic.

All, or practically all advertising done now, including radio advertising, is NOT LIVED UP TO in actual results accomplished, despite any claims made for the efficiency of Chiropractic. The average Chiropractor perhaps means well BUT he does not deliver the goods which he claims for Chiropractic. Too few in our ranks are COMPETENT as adjusters. The discipline in operation of our clinics will stop up that weak link in our chain.

During the last Pre-Lyceum, I watched what was supposed to be adjustments given on the auditorium platform. Outside of perhaps four or five attempts, the spectacle was disheartening to say the least, and that Pre-Lyceum group is supposed to be the best in the country. What I mean to say, however, is that that group of which our organization is composed, will stop up THEIR efficiency. Not only will they do it of their own accord, BUT THEY MUST BE EFFICIENT BEFORE THEY CAN OPERATE A "STANDARD CLINIC". The idea being that CHIROPRACTORS must be built before CHIROPRACTIC can be built by these same Chiropractors. There is no question but what it is as easy physically to give a GOOD adjustment as it is to make a "big splash" and do nothing for the patient; and with a little patience and work, this group will develop into better Chiropractors than the world has ever known. It will pay in every way. "Nothing succeeds like success", and that is what this group will do.

When there are Clinics scattered all over the American Continent, it will be easy for B.J. and others to recommend patients to a place where they will get COMPETENT Chiropractic service. As the situation now stands, we cannot safely recommend patients to but very few. For example, a patient wanted me to recommend a Chiropractor in Vancouver, B.C., only yesterday. I was unable to do so. No telling what possibilities were involved in that inability to recommend anyone in that city. Perhaps a life was shortened, and a period of pain and misery was extended. Who knows? Although many do not take it seriously, ours is a GREAT responsibility. We cannot play with dynamite. At least, I would not recommend it for the nursery. However, that is little different than for me to recommend a patient to an incompetent Chiropractor. No - - we must build Chiropractic by building GOOD Chiropractors FIRST. Our Clinics will do exactly that.

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Dear Michael and Jeff,

There are two different yet related challenges that your excellent paper addresses. One is how to encourage and develop new and current NUCCA doctors, keep them from getting discouraged or frustrated, and open our organization to new ideas, while at the same time preserving the integrity of the work. The second challenge is how to better make the case for NUCCA to the world.

My experience with NUCCA is that it takes years to grasp the basics of the work. I think we need more teaching emphasis on how to manage the feelings that arise when the goal of perfect corrections meets the reality of not being there yet. While becoming Part III Certified may not be a goal, or attainable for every doctor, striving to produce the best patient results should be. Framing the NUCCA Certification Program as an intensive five or ten year residency program, with incredible rewards for those who persevere, would perhaps change the expectations of immediate mastery, and ease some of the frustrations for new and experienced doctors.

My perfect NUCCA world would allow for differences in the art of delivering the adjustment, but maintain the standards used to evaluate the effectiveness of the correction. My acupuncturist has a unique style and method of approaching each case, but her results are what keeps patients referring and returning. An expert in martial arts may develop a unique style, but must first learn the basics.

I would like to eventually have a monitor where the patient would watch their cervical spine being adjusted, and could see it returning to the vertical axis. The challenge would be what to tell them if a correction wasn't achieved.

How do we better make the case for NUCCA to the world? Most of my patients tell others that they're seeing a NUCCA specialist, not a "regular" chiropractor. Like the drink 7-Up creating a paradigm shift with the "un-cola," we could develop an ad campaign with well-known public figures extolling the merits of the NUCCA specialist.

Paul Chek has developed the CHEK method of personal training, and his practitioners are trained to send their clients for a NUCCA adjustment when it is indicated by their assessment. Paul Chek should be invited to our NUCCA seminars, and we should reach out to other organizations that are able and willing to promote us.

I have felt for some time that anyone fortunate enough to experience a NUCCA adjustment would accept nothing less, and would be excited about their results. All interested chiropractic students should be offered NUCCA care. Most of the students I talked to at the last seminar in Chicago had not experienced the NUCCA adjustment. A campaign offering NUCCA care to the medical and research world might be a great public awareness tool.

Mastery of NUCCA is a most difficult, lifelong process. Members of NUCCA include people of the highest integrity, intelligence, and character. One selling point for doctors and students looking to do this work is the opportunity to join this elite group. We could then promote to the general public the fact that we are an elite group of specialists, which would attract both new patients and new doctors.
Thanks, Michael and Jeff, for your energy, commitment, and caring about the present and future of NUCCA.
Please feel free to use all or part of my ideas and comments in any way that you need.

Yours for a better NUCCA,

Brad Hirschhorn

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Dear Dr. Thomas,

Thank you for your paper that is filled with words of wisdom. I can relate to most of your concepts.

A couple of years before his passing, Dr. B.J. Palmer wrote a small book entitled, "Shall Chiropractic Survive?". His concerns then are my concerns now. In the interval of time the profession has muddled along, but the "Removal of Cause" chiropractic is gradually losing ground to the "Symptom Treaters". True Chiropractic is an endangered species. This is especially true of Upper Cervical Chiropractic. Too many still "think medicine" as does the general public. It is a stretch to hope that someone will believe that most of his or her ailments are caused by misplaced bones. It is a greater stretch to get them to believe it is all caused by just a few joints of the spine, the upper cervical area. It is imperative that we convert other Chiropractors and the general public with overwhelming results.

If the trend continues, in about 50 years Chiropractic will be limited to "Back Symptom Treaters". There are many who will sell out their chiropractic souls for recognition and third party pay. If this happens, the practice guide lines would dictate that you could lose your license if you took a case of asthma, migraine or trigeminal neuralgia.

There is hope. On page 6, first paragraph of your paper, you state that upper cervical chiropractic has remained a viable career because of the incredible power of the upper cervical adjustment. How true! Therefore, the survival of "Removable of Cause" chiropractic is dependent upon upper cervical doctors improving our performance to high enough level to blow them away with results. We have a way to go but we are nearly there.

Dr. Ralph Gregory, in an article in the "Monograpn", stated that maximum results would not be obtained unless the correction was at least 80%. I agree.

We have doctors, using the new instrument, who are getting close to averaging 80%, but we need to reach a skill of getting a minimum of 80% corrections on each adjustment attempt.

If we reach that plateau of skill, our survival will be patient driven, "By our works they shall know us". We will spawn many Greg Buchanans and Louella Harrises. We will also have a good chance of attracting funds to research our premise.

It is clear that the only hope for survival lies with two groups, NUCCA and Orthospinology, because they are the only ones who can quantify their degree of corrections.

About NUCCA: On page 7, paragraph 5 in your paper, it states, "After 60 years, there are still very few doctors who can be called masters of the work." This is not a negative reflection on the many dedicated doctors who have really worked hard in the work. The fact is that what we are attempting to do is very difficult. The fact remains that unless some change is made the performance is stuck and will remain at current levels.

A move that NUCCA could make is to set aside dogma and acquire a Torque Specific Adjusting Instrument and research it. The "R" in NUCCRA stands for research. The overwhelming evidence is that the instrument gives us the best

chance to achieve a higher plateau of corrections. It was designed specifically for the NUCCA/Grostic procedure. A doctor who knows the work can make good corrections after a few minutes instruction.

On page 14, paragraph 4, you state "We are all doing the best we can with what we have". But you don't have the instrument. Page 15, paragraph 2, "We all have some learning and unlearning to do". True. Think of the instrument as you read page 16, paragraph 1 and 2.

Dr. Gregory treated me completely differently after he saw my instrument's pre and post x-rays. Those of you who are negative to instruments, I will challenge you to a game of pool. You hit the cue ball with your pisiform bone, I will use the cue stick, and I will beat you every time.

About Orthospinology: Those doctors need to get off their duffs and inform the thousands of dedicated "removal of cause" doctors what an advanced procedure they teach.

I took the Grostic work in 1951 and attended classes every year until his passing and attended some NUCCA classes under Dr. Gregory. I watched good dedicated doctors by the dozens take the work, go home and couldn't bear to see their post x-rays, so consequently drop out of the work. Some rationalized that the system didn't work. Personally, I found that if I got a good correction, the patient got well. If I did poorly, the patient did poorly.

No one worked harder than I to master the thrust and by 1954 I was averaging 37 % corrections. A practice sustaining level but not nearly good enough. By then, I reasoned that since we were attempting to send force down a predetermined path, through space, an instrument could be built to do this chore. In starting this research, I pledged never to seek profit from my fellow chiropractors. This pledge has served me well, as it has opened many doors.

The first workable invention was the solenoid powered hand adjuster. I shipped them to nearly every state and some foreign countries. I shipped them at little less than my cost. It was my gift to the upper cervical patients. This little adjuster brought a lot of doctors back into the work and helped keep the upper cervical work going.

Before I retired, I was averaging over 70% corrections with the hand-held adjuster, a far cry from 37%.

Now that we know how hand adjusting torque works and have incorporated that function in an instrument, we're reaching new heights of accomplishments.

I applaud anyone who is attempting to hand adjust, but this work can be hazardous to the doctor's health. Think about the amount of time your body trunk and neck are horizontal in 30 years of practice, counting the time you work over a coordinator. Surely, your mid-cervical area is going to be damaged to the detriment of your health. The use of an instrument solves this problem. I have taken out the difficult part of the procedure and made it achievable by anyone.

The upper cervical correction is the greatest single thing that can be done to restore human health. It would be a tragedy for future suffering humanity not to have this service available to them. I am in my eighties now and in the twilight of my life. There is not much more that I can do. It will be up to others to carry on. My instrument seems now to be the best hope. Perhaps someone will come up with a better solution.

The late Dr. Earl Striplin used to say, "How great is our responsibility and how wonderful is our opportunity".

Sincerely,

Cecil Laney, D.C.

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I felt that the subject matter of the document warranted the time required to read it entirely. I will be interested to read the comments that it will generate.

All evolutionary changes to the technique must be based on sound biomechanics. Everything must be shown to work in more than one case and be reproducible by others.

I support the idea of creating a forum where well thought out ideas and concepts can be presented and discussed.

Phil Kanwischer

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The first thing I would say or even shout it from the roof tops is that I am thankful I found NUCCA for myself and my family. It is the most powerful tool in healthcare today. What can you find in the world that usually works! What do you know that can create so many changes with one procedure in or out of the healthcare field. There are several reasons we are in the place we are at this time. If everyone had a NUCCA adjustment, we could collapse conventional medicine. It would be similar to someone coming up with an engine that ran on water and we didn't need gasoline anymore. If the population just felt 10% better overall, think of the cut in over the counter or prescription sales or the decrease in therapeutic procedures. Think of the jobs and number of companies it would effect along with the drug companies and other peripheral businesses even the insurance industry. Is there a possibility that if we surfaced too soon, that we would be mashed to bits by other stronger entities. Is there a possibility that we do not have someone that is willing to pay the price like Dr. Gregory and dedicate everything to NUCCA. Someone that has the respect and power to draw the right people and money to our cause. Will our time ever come.

Internally, NUCCA, like any organization is full of egos and fracturization (did I make that word up), not to mention the fact that we still don't know exactly what we are doing to a human body that creates change and we have not been able to scientifically define that. This creates doubt. One person says it's this way and the other says the other way. I still say its similar to the Christian religion - the master dies and the disciples have been trying to figure out what he said ever since. Its time to realize that the master didn't finish the job and it's left up to us to carry on. Another quote you might use by Mark Twain is "The hardest thing I've ever had to do is to forgive the people that helped me the most". Until we come to a meeting without prejudice and bias, we will never discover the real truth. That is probably an idealistic thought but a good thought. We also need to seriously connect with our upper cervical brothers and sisters in the other groups to add strength.

Chiropractic Community. You can force the spine to change - manipulation. Or you can change the spine with a force - NUCCA. That is a statement I have made in the past separating us from the Chiropractic mainstream. I also say that somewhere is a place where upper cervical chiropractic and mainstream chiropractic meet. We will have to check our egos at the door to find this one. I think we should go to the leaders in mainstream Chiropractic and ask them what they think about us and ask them what we need to do to go mainstream. Once we have an idea, we can decide if it fits and something we are willing to do. We need outside viewpoints!

Personally. Dr. Lisa Strickland takes my x-rays and many times I let her analyze my post film. I ask her to be completely unbiased and real with me. What is my average degree of correction? She says 65%. I think overall that is a little high. My point is I can do the adjustment, I have a good business. I take 1 or 2 posts and if I've got the misalignment reduced and headed in the right direction, I'm done. The only reason I would take more posts is if I was really screwing up or trying to get certified. And when you are seeing 4 new patients a day and completing them that day, those extra posts get in your way. So I have to change my patient care system (that really works well) to get certified and expose people to more x-ray. Is this an excuse for being stalled at Part 2 certification? Maybe. Many times I take another post at the end of the healing cycle and the misalignment is further reduced or even sometimes perfect. I have taken NUCCA as described by Gregory, Brooks, Denton, Berti, Cripe and others and created a system that works for me and my patients. I check patients for postural distortion using leg check, visualization, and the Anatometer. I have "zeroed" a patient and then adjusted them in a week because of postural distortion. The "one adjustment" doesn't happen very often to me and considering that a patient has been in an imbalanced pattern for all or most of their life, I doubt that greater precision of my adjustment will make a big difference in what I am experiencing. I truly believe that the more we learn about frequency and energy medicine will bring us new insight and understanding about what we are doing. I know there are doctors out there that don't agree with some of the things I said, but I sleep good at night knowing that I help people and do my best. I believe the NUCCA adjustment is the most powerful tool in healthcare today.

Research and Marketing. For 2 years I worked with a man named James Payne on this very topic. I had numerous emails and telephone conversations with this man. He was in his 90's and as sharp as they come. He is a marketing genius and a research consultant. He once gave me a 10 page document that laid out a plan to take NUCCA to every household in America. It was a step by step approach to create the dream we all have. I really thought we were getting somewhere. I had even found a foundation to provide the first $100,000 to begin this plan. I had a meeting with several doctors in Atlanta to discuss my next move. I went to Life West and met with Dr. Clum and recruited his research department to help. I was on the verge of something that could make a difference at least. However, certain stipulations around the financing with the foundation that had offered the money went sour. I personally was not ready to take on the responsibility of that much money without a precise plan and people in place. NUCCA in all its years of existence has not hired a consultant that could put it in the research journals and in front of the public. this is what we need - people on the inside of this game. We need money to pay a consultant and the research team. We need money to create a marketing plan and to implement it once our research is in place. It would take at least 2 years. I estimate that we need $500,000 to make a good start with research and marketing. We can definitely start with less, but we can't finish for less.

Finally. I have been on the board of directors for all most 10 years. I was President of NUCCA for 5. In 1989, I have sat with Dr. Gregory at his wife's grave for 2 hours discussing NUCCA and its people. I led NUCCA through some tough times. I thought I would close my presidency with a research and marketing program that would take us into the future we so desire and deserve. I worked the entire 5 years for that one dream. It hasn't happened. I have a unique view of the NUCCA organization and its participants. We can have all the meetings we want, but if we are not having a meeting about funding a consulting entity to take us where we want to go, we are pissing into the prevailing wind. We can't do it ourselves, that is evident. We can fund the hiring of a consultant group or person to help us find the money and implement this plan. Dr. Brooks is in the right place. He has better organizational skills than I and he is better connected in the Chiropractic community. And he doesn't have two young kids at home. But the task that I am talking about needs a professional. Someone to lead us through the maze of research publication and public awareness. We have to find where we are blocked and get rid of our baggage. We need someone on the outside looking in to do this. We can make this happen and we will.

Sincerely, Bobbe Goodman, X-pres.

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I admit I didn't send my response right away because I was afraid of it not being good enough, and because I have so much awe for the intelligence of many of the doctors in the organization, I felt like people would read it and say, "duh, no kidding." Which they may anyhow, so I'm writing it anyhow.

For me, this movement is about bringing NUCCA out of the dark. And yes, when compared to the general public's knowledge of NUCCA, chiropractic's knowledge, the medical profession's knowledge, our own patient's understanding and truly even our own knowledge of what we do, we are very much in the dark. It's about increasing the membership, filling the struggling practices and growing the larger ones. It's about improving on Dr. Gregory's work, especially if it takes finding places where we can say he was wrong.

I feel that NUCCA's next big step is to develop peer reviewed research of some sort. This may not even be symptom related, we may have to begin with a study on upper cervical anatomy done "by the NUCCA organization", or as is suggested in the paper, what is the real and measurable effect of 5 cervical, lead-filtered x-rays on a human cell, how would these compare to the acceptable radiation limits, the radiation of a chest film or CT scan. I sure would like to know. The objections to NUCCA may well be our greatest signal for where to begin.

Thus our current scant funds and must be geared accordingly. This is not in an attempt to blend with or be accepted by the medical profession, physical therapy, etc, but rather to be accepted by mainstream media. When the media can read NUCCA research, the public will take it on as if it were the gospel. The media loves what we do because it's gentle with more permanent results, they just can't say they buy it. I've been on local news 4-5 times in Las Vegas, and they always have to phrase things such as, "Dr. Luzod says NUCCA helps low back pain patients," versus, medical research has proven it. That would create an entirely different result. From there, we can begin a larger awareness campaign. This awareness campaign might involve the individual practices approaching their high profile clients for testimonials or appearances.

From these high points of validity, it could be taken back to the schools and ultimately to the students. As in the best selling book, The Tipping Point, when a small but influential group takes hold of a great idea, the masses are given permission to follow. From this may flow corporate sponsorship and or University funding.

So this might begin with an internal search for a group capable of developing this research, hiring outside consultants and including those people who understand how to network with trade journals. I'm confident that getting published is not just on merit alone, that there is some "who you know" that's involved as well. With an understanding of what must be done and whom we need to be involved, we can appropriate a budget, create a committee and a make a plan. Inherent in this process would be the examination of our most essential assumptions, and as with all growth, would require courage and honesty.

I love the point that we feel we are right and everyone else is wrong, I find myself putting chiropractors on different levels all the time, and seldom am I really aware of how this not only isolates us, but is absolutely a false statement.

Each year I'm asked to speak at a Low Back Pain Medical Conference held in Las Vegas, and each year I return to talk on the theory of proprioception, brain stem irritation and dentate ligament stuff. Even now I'm beginning an outreach campaign of sending monthly newsletters to local doctors on chiropractic and NUCCA, in an attempt to bridge the communication gap. But I'm asked over and over, where is the research? I think Kent and Gentempo said it best, "Well, what research would you be willing to accept?"

As was the original intent of this project, I hope this response generates further discussion, opinion and criticism, and I eagerly encourage others to participate in the future, as well as contact me directly should this paper inspire them in any way.

In Progress and On Purpose,
Devin Luzod, DC

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Dear NUCCA Friends,

I have been privileged to have been a part of the evolution of Upper Cervical HIO. Grostic. and NUCCA, as well as the divisions over the last 44 years. We have not grown the way I thought we would because of many reasons. We tend to generalize and jump to conclusions about our experiences often based on the flimsy evidence of just a few cases. One of the most common criticisms is that we have not been published in peer reviewed journals and it is no wonder when the scientific method is not followed. The X-ray has been our proof but the quality and replication of our films have been unsatisfactory. These are easily corrected with the use of the proper filters, factors, Bb's, horizontal line charts and due care and attention to alignment and procedure. The Bb's on the ear lobes to check the head position's consistency with the neutral standing posture has helped me tremendously, thanks to Marshall Dickholtz, Sr. We have the best answer to the Subluxation complex but only if proper procedure is followed. We have lost some great people from this technique because of ego and a lack of proper training methods. We must reinforce and enhance our presence Life west by referring students and giving financial support to them. Life West gives us academic credibility and it is in jeopardy if we do not support them. As we evolve and separate the wheat from the chaff it will become self evident that our procedure is the best answer to the atlas subluxation complex and the salvation of humanity. Thank you Michael and Jeff for your dedication and hard work.

Patrick Foran, DC.

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**Editors' Note:**
*Dr. Crowe originally wrote some of the following comments in red to distinguish them from the quotes he inserted from the paper. Since we are publishing in black ink only, the editors have changed his red marks into italics and his italics into bold.*

Thanks for publishing and the opportunity to respond (in [italics]).

>page 4, paragraph 4< "Individual investigation and experimentation are the genesis of any new scientific process." *And required to adapt to an old scientific process to be able reproduce it consistently.*

>page 5, paragraph 7< "He heralds diversity and recognizes the danger of limiting our avenues of investigation." *Thus, the original idea was born via McAlpine, J.D. Grostic, J.K. Humber, T.O. Humber, H.L. Crowe, et al, 20+ years ago which eventually spawned the AUCCO.*

>page 6, paragraph 1< *...and yet we can't even convince the majority of chiropractors of this* **incredibly powerful chiropractic!**

>page 6, paragraph 2< "While class time at the seminar is not the proper time to delve into a diversity of viewpoints regarding the protocols, we believe there should be some venue for this process." *There is! The AUCCO, which stopped having their "gatherings" each Spring as laid out in the by-laws; timely; not every few years because each "upper cervical chiropractic organization" acts as though its agenda is more important than the others, eg, April 30-May 2, Orthospinology in Atlanta while NUCCA is in Chicago. Same time, Springtime, opposite ends of the country.*

>page 6 paragraph 3< *"It all works.", Colleagues told me. I told them that winged aviation and chiropractic were approximately the same age. The Wright brothers were flying, but that's not the plane I want to take to California. Also, all the horses are working. Some are pulling plows and some are thoroughbreds. B.J. said "Give them thorobred (sic) ChiropracTIC."*

>page 7, paragraph 1< "...what sort of physiological changes can be consistently expected under our care." *Name one. BP? Post pictures? Cessation of bladder control problem? Blood tests? More & more diagnoses to prove something we and our patients already know?*

"...the efficacy of different interventions can be compared." *We're all flying. What's your aircraft preference? Douglas didn't demand that Boeing do it like Beechcraft do it like Cessna do it like Lockheed.*

"There is a plethora of wonderful healing stories that come out of the chiropractic profession in every technique." *D.D. Palmer---Harvey Lillard, Wright bros.---Wright Flyer...wonderful stories...the best way today?*

>page 7, paragraph 2 , 1st sentence< *Roy Sweat & colleagues? Cecil Laney? Ed Owens? Roger Hinson? All of us in studies, articles, texts, showing up each day and continuing to learn from & about the human condition? We're not static.*

" Health is multi-factorial..." *This is probably why you won't get that* ***universal standard*** *in the previous sentence.*

*>page 7, paragraph 3, 1st sentence< They may not be wrong, but they don't know what we know and apparently aren't interested in learning because they've already decided we're wrong. So "dumb it down" like the public school system in order to fit in & be accepted?*

*>3rd sentence< Chiropractic continues to move away because they are integrating ideas (accepting the rest instead of teaching the best). Also, a "wider scope" of procedures & techniques attracts more students in order to get more $$$tuition$$$, patronize the medica controlled boards, and be "accepted" by the "scientific community". It's no secret that the AMA has wanted to eliminate chiropractic for years. So, "righteously extinct" or unrighteously and unmercifully wiped out (think Life U.). Our "righteousness" is earned & backed by truth, not hate & envy. B.J. Palmer, "If 250 million people have a bad idea, its still a bad idea."*

>page 7, 4th paragraph< Upper cervical chiropractic is simple in initial concept but difficult to truly understand at the level of practical competence. It is also difficult to perform as a consistent and accurate physical act. .....few who can be called masters of the work. *You could say the same thing about playing the saxophone or baseball. What separates the professional from the amateur, the major league from the minors? Study & practice, practice, practice!*

Some practitioners find they are unable to produce the results they know are possible with hand adjusting and begin to use an instrument. *Some practitioners find they* **are able** *to produce & reproduce the results they know are possible with hand adjusting and* **still** *begin to use an instrument. This way, they are able to help the patients even more in quality and quantity. I didn't switch to the saxophone because I couldn't play the clarinet, but because I could, therefore being able to produce more abundant music for the listeners. It's still thoroughbred chiropractic, the same correction, not some "fluff" to "bump up the bill" by using an instrument to eliminate the c1 subluxation.*

>same para. continued on p.8< Qualities *assessed and evaluated by whom? Some self proclaimed expert?*

The "open forum" is certainly a step in this direction. *Again, part of the reason we formed the AUCCO in1994.*

>page 8, 1st paragraph under **The Map...**< The correlation between correction on film and return to health is so profound that it has led to the use of post film analysis as an equal synonym for a return to health, among upper cervical doctors. *Only among some U.C. doctors who have become so proficient at this one objective finding, and thus the "expert" at it. The post*

*film is* not *an equal synonym to the return to health, but certainly one of the best objective findings for such. In our desire to appear "purely scientific", we must not forget the individuality of each patient, i.e., limitations; activities of daily living; diet; lifestyle; etc.*
**The map must not be confused with the terrain itself.** *At least you've got a map. Any other techniques got a map?*
>3rd para. under **The Map...**< *It all works. Dig a hole using 30 men with shovels & some instruction or 1 man with a backhoe & a map. Which is best? You still end up with a hole.*
>4th para.< A map can only take a person into areas that have explored and chartered by others. *Or the reader of the map can deduce* from *the map* combined *with "uncontrollable variables"...again as with flight, wind/magnetic deviation/the FAA, etc.*
....Columbus looked at his map....*Maybe Columbus was the map maker. With the Palmer Speleological Society explorations, we had no map when we entered the caves in Tennessee, but we had one when we came out.*

>page 9, 2nd para. under **Paralysis...**< Our methods of awarding competence to the certified doctors have created a presumptive incompetence among uncertified doctors. *Not necessarily among uncertified doctors, but about uncertified doctors* by *certified doctors.*
The result has been....*This small number of doctors* assumed *all doctors would not take on the responsibility for competency* individually *,therefore they had to carry the responsibility by themselves and thus started the disconnectedness. I have to be at the height of my competency daily for my patients and my livelihood, not some certification program for a resume` enhancer.*
*>next para.< What started out to make all as good as B.J.,ie, reproducibility, evolved into "my way or the highway".*
>4th para, The reasons...< *The patients know.*
>5th para., There have been no...< *Money fed/greed; product sales(drugs) peddled by M.D's(service) vs an adjustment (service only, helping others for a lot less "dough").*

>page 10, 2nd para< ...communicating this news...has largely failed. *Follow the money.*
>3rd para.< *Those outside the "community" can't share what they don't know.*
...lost its voice...*because of accreditation rules & lust for tuition money.*
...the number of organizations representing this voice presents a challenge to cohesive process. ***A**cademy of **U**pper **C**ervical Chiropractic **O**rganizations*

>6th para.< We remain the best kept secret in healthcare. *Can't compete with pharmaceutical cos. People want money. Students can earn more after graduation without doing the extra work towards competency, ie, the path of least resistance. 48 visits for manipulation instead of 12 (or less) for an adjustment pays more & don't have to work as hard. Modern day lack of commitment to excellence & discipline. 2500 students if my school teaches 6 techniques=$250,000,000.00 300students if I teach difficult upper cervical=$30,000,000.00 A d.j.'s cheaper than a band.*

>page 11, 1st para.< ...the burden of proof is ours. *There is no plaintiff or judge asking for proof. We have more than post radiograph---scanning palpation, leg check, thermograph, improved health & cessation of symptoms!*
>2nd para.<...stability arises out of "chaos"...*We learned in physics---**universal perfect organization constantly working towards entropy***

>page 14, para.2< ...prove our assertions. *To whom? Someone who is not interested because it could cut off their "gravy train"?*
>page 14, para.3< *Did someone say elite, disassociated, disenfranchised?*
>page 14, para.5,1st sentence.< *Not worth the trouble & expense to the average D.C. graduate.*

*THAT IS ALL. THANKS AGAIN!*
Dr. Keith Crowe

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Dear Michael,

First let me say that you and Jeff did a wonderful job. It is evident that a lot of thought went into the creation of this paper. I am very much in agreement with almost all of the content of this work. I will send you some simple thoughts that I have been thinking about for a while.

I am of the opinion that for some time now we the people of NUCCA have been working under the assumption that we are scientific. We do have a great body of clinical and investigative evidence that we are on the right track. I mean most assuredly no disrespect to the work or memory of Dr. Gregory, but his work as far as the scientific community is concerned, never really got past the investigation part of discovery. Unfortunately, Upon Dr. Gregory's death almost all NUCCA research into the biomechanics of the C1 subluxation complex has stopped. I feel this for one of two reasons.1) Some actually believe that all the necessary biomechanical discovery was found by Dr. G.. Therefore there is no reason to pursue further efforts to identify new lines of reasoning. (Dr. G. would be very disheartened by this.).2) Most NUCCA DC's are clinical practitioners. We are not skilled in the protocols of scientific research. Very few, myself included, have the personality to just sit and play with numbers and look for trends and truths. This I lay at the doorstep of NUCCRA. Not that I think all is bad, but I feel that this body has lost its focus a little bit. As I understand the NUCCRA charter, This body was and is given the responsibility of researching and advancing the body of knowledge and refining the correction of the C1 subluxation complex. I personally don't feel that outcome studies for the efficacy of chiropractic to help certain conditions has very much to do with the NUCCRA mandate Yet from my perspective this body seems to make it fairly difficult for anyone with a new possibility to get either ear or investigation

I believe that we need to put our research in the hands of someone schooled and skilled in the language and protocols of true scientific research. Or, if this person is already among us, then give them the authority to organize a research program, set up a project, write grant proposals and them organize the results so that we can receive the published papers that will help our recognition. You say that this is expensive! I agree, but we are not getting anywhere the way we are going. We are not proposing any biomechanical research projects, the work being done is, at least so far, not acceptable for publication in any journal that counts. I for one would find it much easier to get behind and work for a defined program of projects.

My last area of comment concerns the "proving" of chiropractic. I do not think that we will ever prove chiropractic (whatever that means) trying to correct diseases. So far outcome studies do show that we have some success in this endeavor, but so do other disciplines and other techniques. I believe we will find our place quicker by finding how our bodies relate biomechanically and physiologically to the force field of gravity. Gravity is the most constant force our body has to deal with. Dr. John Dunn has started a little into this with his pedal stroke study done on cyclists. We are upright biped animals and we fight the force of gravity daily. It takes a great deal of energy consumption to stand and then constantly adapt and adjust as we move. I personally feel that the more perfectly we align with the pull of gravity the more physiological energy there is to expend on "living". The greater the disrelationship with the pull of gravity the more of the energy pool required to remain upright, therefore the body simply functions under greater duress. This allows the same misalignment pattern to result in very different disease processes in different folks. All chiropractic adjustments can only work by changing the body's relationship to the gravity field. When they do change it, the body's own ability to restore balance both structurally and physiologically is markedly expanded. NUCCA (Upper cerv.) practitioners seem to have some evidence that we do make that correction more efficiently and can quantify the results better than most techniques at this time. How to quantify this relationship between structure and function is the issue. There does seem to be a direct connection as borne out by studies such the Rand 56 and others that show marked overall health changes recorded by people after care.

I do not propose to know how to bring about what I feel needs to be looked at but I do believe NUCCA and NUCCRA are in a position to find the answers or at least some of them. We should expand our borders to include our brethren in the other upper cervical groups. I feel that we have so much more in common than we do differences. We should work to build on our like knowledge and discuss our differences so that the bugs will be shallow. I will willingly work to do what I can to uphold what we do know and work to forward any FOCUSED and ORGANIZED attempts to further our knowledge and properly disseminate it to the world(scientific and/or real).

Yours for chiropracTIC,

Milt Steele

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Dr. Michael,

In an attempt to provide you with a response to your paper, I'll have to start out by saying that I'm not fully sure that I really know what point you are trying to make or what you want a response to? I'll give it my best shot.

Would it be of value to further research our technique and its benefits? Yes I think so.
Is there a problem with the different levels of expertise in our work? Yes I would agree.
Does the process of Certification alienate doctors that are not certified? It is a possibility, but I think it is an individual's problem, and we shouldn't point the finger at the certification process for being the cause of the problem. I wouldn't say that the Professional Golfers Association should be disbanded because the Pro's that are winning all the tournaments set the bar too high and make me not want to golf because I'm an inferior player.

Is there room for non certified doctors to participate in forwarding NUCCA's goals, projects, research...? Absolutely bring them on, it's a party and everyone's invited.
Can new ideas be formulated and research be done by doctors at any level of certification or other chiropractic technique. Yes but If the nature of the research involves some sort of vectored analysis and pre and post x-rays were being used as part of the study, I think it would be important for the researcher to know how to be able to make an accurate comparison with their pre and post x-rays. I have seen presentations where doctors were using pre and post x-rays to document the validity of their work and the x-ray views could not be compared due to errors in patient positioning and analysis. Being thoroughly trained to make such a comparison through a program like certification could be invaluable to an individual participating in that type of research.
I like the idea of more eyes but we should be careful, having "more eyes" doesn't always produce a valid solution. Columbus would have never sailed because the majority would have told him not to go because they saw a flat world. The majority of the eyes of the Medical profession see the next breakthrough in health care coming in the shape of a tablet inside of a bottle. The majority of the U.S. population see's McDonalds and thinks they are eating right.

It is always good to ask the vital questions and I think you are off to a good start here and as an organization NUCCA is fortunate to have the input and ideas of both yourself and Dr. Scholten.

I hope this is the type of feedback you were looking for and I was not too far off base.
Thanks for the opportunity,

Dr. Marshall Dickholtz, Jr.

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Dear Dr. Thomas,

I believe your paper has a lot of valid points. I too struggle with the entire issue of elitism vs. critical mass. There needs to be a critical mass of NUCCA practitioners to even give us a chance of survival in the new millennium. However, the nature of the upper cervical work is such that it requires a complete correction. I know I help patients with corrections in the 40 – 50% range but I "clear" patients when I exceed 70 – 80 % reduction of all the misalignment factors. I have reached the conclusion that I must learn what it takes to become certified. When I have a patient drive 7 hours one way, I must have the skill to work them down to complete correction. The certification process has helped me to do so but I admit it is slow. In the past 2 years I have put in many hours and spent thousands purchasing new x-ray equipment, new cassettes and screens, and have been to more than one office to have training on x-ray positioning and technique. At the past NUCCA conference I took off my teacher hat and put on a student hat and picked up some valuable points to implement in my adjusting and biomechanics rationale. I am now achieving better corrections. I will become Part III certified and it will make me a better doctor.

There is nothing like a "clearing" correction. A complete NUCCA correction can't be duplicated by any other doctor in the world nor is there any other single intervention that can change the health of an individual like a NUCCA correction. Unfortunately, there are too many patients who leave the NUCCA office (mine included) without a correction sufficient to impact their health in a way that I know is possible. I believe we owe it to the world to develop a training regimen that will lead every NUCCA practitioner to be able to achieve the level of expertise required by certification.

If we could find a way to get 100 doctors Part III certified then there would be a critical mass necessary to set up mentoring, training centers, internships, etc. to lead others. If the 20 or so Part III certified doctors would make a commitment to

duplicate themselves once in the next 2 years, we would have 40. If those 40 would duplicate themselves in the following 2 years we would have 80. If we take out the original 20 and the remaining 60 duplicate themselves in the next 2 years we would have 120 certified doctors in 6 years. It would be a huge commitment on the part of the certified doctors and the doctor under their tutelage, but it can be done.

Dr. Gregory's research accurately identified what is necessary for a successful NUCCA correction. In 18 years of practice I too have found that my practice and reputation in this area of the country continue to expand when I am getting high level of corrections. I don't believe it would be in the best interest of NUCCA or chiropractic to lower the standard necessary to be the elite in our profession, the doctors who help those that no one else can. I applaud Dr. Dickholtz for his commitment to advance the certification but I believe we need more than his effort in this. The organization must develop a systematic approach to developing more NUCCA docs to achieve certification. I believe this can be done. What the mind can conceive, and believe, it can achieve!

With love for you and NUCCA!

Dr. Kerry L. Johnson

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Thank you for your paper. The perspectives given on the current state of NUCCA and upper cervical chiropractic provided insight for me.

My response to your work involves the importance that was stressed upon making known NUCCA - "the best-kept secret in healthcare." I believe that it is achievable to continue the high standards set by the NUCCA organization and allow NUCCA to grow. NUCCA's high standards are an integral part of its practice.

The key is not in relaxing standards, but in educating the public. In my experience as a graduate from Western States Chiropractic College, and as a first year chiropractor, I have discovered that a great number of chiropractors have heard of NUCCA, but have no idea what it is.

Publication of articles, in peer-reviewed journals, in other health-care literature, and in publications for the general public is what I believe to be important in helping NUCCA care reach as many people as possible.

Thank you. In Health,
Margaret A. Munsey, D.C.

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I hope you are getting a good response.
I wish I had time to systematize my thoughts here but I have been too busy to sit down.

So I am going to hit some key points in my mind:

X-ray...
We know X-ray is the foundation of NUCCA... without it... no NUCCA... that much acknowledged.

X-ray is not a strong foundation and my dream has been to be able to go beyond the need for X-ray.

... knowing that the complete elimination of X-ray or its equivalent is probably out of the question.

I have found a couple of things that are really important in my work.

One is: the levator scapula sign. If one palpates the levator scapulae.... superior medial corner of the scapula...one often finds one side more tense than another. This I have invariably found corresponds to the lower angle on x-ray. This can be very helpful. It is much easier to perform than a leg check and in the patients mind it is a more dramatic check... and you make a better connection with people.... When things start to clear up in the c spine... the levators balance.

Another ( but not quite so reliable ) sign is based on Anatometer findings. The pelvis check..... there seems to be a correlation between what I call flank tone and laterality. Just above the iliac crest the tone tends to collapse on the side of laterality. You can palpate this by hand by pressing over the iliac crest.

The same loss of tone applies below the mastoid in association with compression or c1 laterality. This can be correlated to x-ray or also correlated to infrasound findings.

Compression at C1 is the major critical finding and much easier to pick up without x-ray than generally recognized.

If a person is incorrect in their analysis....it may take a little longer for results but other findings will help one determine if one is one track or not.

Thermography:
I have found the Titronics instrument very useful indirectly. Although it is not completely reliable: the reading from it mirrors the functioning of the cervical sympathetics. IT DOES NOT PROVIDE DIAGNOSTIC INFORMATION. But does offer useful feedback.

The newer software is very distracting and I don't use it. I use the old DOS software which gives me a thin lined temperature read out.
The key to the Temp graph (normal/ healthy) is that both sides lean right and the center line follows the middle.

One remarkable and new finding I have made with the Titronics is the information it provides about c2. C2 shows up as a major problem when a clearly balanced asymmetrical temperature reading is picked up with the Titronics. In other words, the center line does not follow the middle line but runs down one side or the other.

I have occasionally found this to be the only problem... NO C1 compression at all. I discovered this to be true the first time on my son. There was a big shift in
his energy following his first C2 only adjustment.... and the graph completely went to center.

Another thing about the Titronics instrument that is useful is how quickly things go to the midline balance point once a good adjustment is made. But it can be challenging and frustrating to want to see this happen.

The surface temperature of the neck is an incredibly sensitive indicator...in fact so much so... I have become somewhat overdependent on it in my practice.

The other thing about it that is a problem is: one can sometimes get an apparently clear reading on the neck temperature and there can still be problems.

Infrasound:
Still in progress

Brainstem Pressure;
Horseshit.....

Autonomic dysfunction,,,, Dysponesis.....
closer to it....

Cranial Problems

Can be a higher source of imbalance than C1 but not usually.....leg checks will often quickly and reliably show cranial problems and C2 problems as well.

Philosophy:

I like Erich Schiffman's... famous yoga teacher..... "moving into stillness" philosophy.....
After all C1 .... T12.... and the Sacrum are the major spinal still points.

Diet:
Without Dietary change.... we are probably wasting our time.
The positive effects of the right diet are unequivocal. The problem:
gradual results.... no instant gratification.

Breathwork:
Like diet....without it... we are missing the boat.

Movement:
Ultimately what we are on the ground floor teaching. The C1 subluxation is basically a movement disturbance.

More later.... I am anxious to learn about what you are learning....

the devil is in the details,

John Wynhausen, D.C.

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Your paper outlines a number of problems that the authors perceive as obstacles to the growth and dissemination of Upper Cervical Chiropractic in general and NUCCA specifically. In this discussion I think It is important to delineate whether we are addressing concerns regarding the system and work developed by Dr Gregory or the NUCCA organization as it currently exists, these may not be necessarily the same.

In order to provide a backdrop to some of my comments I would like to review some of the underlying concepts that are the basis to NUCCA as we currently know it that not all readers may be aware of.

The underlying principles of NUCCA are not the triceps pull adjustment, or the four basic types, or the parallel forces, or the restoration principle. The underlying concept that NUCCA was based on was to align Chiropractic with the physical Sciences. We must not forget that Dr Gregory's background was that of an engineer. Paramount to the physical sciences is measurement and key to scientific protocol is to be able to demonstrate outcome utilizing the same measurements that were used to define the problem initially. A second concept key in Dr Gregory's work was that procedures were supported by a data base and that the results were reproducible by the same doctor and by other doctors also.

**"We are Right and The Rest of the Profession is Wrong or Should Wake Up'**

Is this not the attitude that most Chiropractors have towards medicine.? Do we for one moment think that the Pettibon D.C.'s don't feel this way about their technical approach? What about the C.B.P. doctors or the Gonstead doctors? What do you think the attitude of B.J. Palmer was when he introduced to the profession the concept of the H.I.O. in 1934? I would suggest that any doctor who is passionate about what he does, how he practices, is going to feel this way. As a former full spine practitioner for ten years I am well aware that Chiropractic works well and I think that one of our assets is that you can have four Chiropractors on four different corners of an intersection. Based on how they practice a patient may well have difficulty recognizing they were even from the same profession .I find the tolerance of this diversity refreshing. This kind of original thinking is not tolerated well in medicine.

We clearly feel that the work developed by Dr's Grostic and Gregory adds a significant dimension to the practice of the science of Chiropractic. Why else would we do it? I would hope in the final analysis that we all recognize that each technic is an expression of the same underlying philosophy, that it all produces results and that each and every technic makes significant contributions to improvement of the human condition.

**"We Need To Be Published in Peer Reviewed Journals"**

This definitely seems to be the consensus of opinion. Having said that I have over the years often questioned the rational behind such statements. Certainly the process of developing a study for publication in a peer reviewed journal necessitates careful attention to research protocol, and the fact that it will be subject to expert scrutiny adds to the perceived level of validity. Yet I have read articles in peer reviewed journals that were in my clinical judgment highly questionable. Having submitted papers to such journals, wait the good part of a year to find that they have lost the submitted paper, I have certainly learned that doing the research is only one small part of a complex and involved process. I have asked myself are we undergoing this process to impress someone? I certainly hope not. Medicine has little interest in us no matter how well researched we are. Many M.D.s will still deny the efficacy of Chiropractic in the treatment of low back conditions despite more than 20+ published papers. Our patients are certainly not reading these journals and after 26 years in practice I have not found research journals to constitute a major resource of information in clinical practice. I think there is validity in the argument that it does provide a scrutinized resource to document work done for future researchers and clinicians. It also provides material to defend our protocols and procedures in the event of legislative challenges.

Currently our profession has only one peer reviewed journal that is listed in Index Medicus. This journal has at times demonstrated a bias against aspects of how we practice. We still have to deal with politics and bias which in itself raises questions about that which is published in such journals. In all fairness to these journals what degree of readership interest would a study of lets say 200 cases on the relationship of the central skull line and its intersection with odontoid on a nasium view have anyway?

This discussion also raises the question of in what direction should we be expending our limited research resources anyway. To develop studies that document the ability of our approach to obtain improvement in the treatment of certain named conditions serves what purpose? On the other hand research that expands our understanding of the ASC, will improve the quality of corrections we can obtain and shorten the learning curve for the new doctors to this work. Unfortunately this kind of research is not very publishable in peer reviewed journals. I would suggest the latter type of "research" if I can use that term, will in the end advance our work ultimately far more than the former.

**"Instruction and Protocol Codified time to Allow Diversity of Opinion."**

Procedures and protocols should be dynamic and within certain parameters continually be re-examined and updated to reflect new information. It is very important that they do not become codified. This does not exclude consistency in instruction and training methods. It has been my experience that there has always been diversity of opinion in NUCCA. It is when the opinion extends beyond that of an opinion. Becomes an alternative agenda that exists outside the underlying principals of NUCCA as outlined in the introduction of this paper. Then we are dealing with something other than NUCCA. This is not to suggest that the alternate agenda is less than good Chiropractic.
Only that when inconsistent with the underlying principals of NUCCA it is out of context.

As an organization NUCCA has always taken seriously its responsibility to provide a curriculum and environment that facilitates the shortest possible learning curve to D.C.'s committed to learning this work. There has never been a shortage of opinions on better ways to do things. The problem is that these are generally one doctor's untested opinion. These ideas or opinions may be clearly flawed to the seasoned doctor yet to the new doctor to this work appear to offer a refreshingly simplified shortcut to solve an unnecessarily complicated subject. To suggest that the new idea that is being suggested is really not new, that it has been suggested and tested before which is why we teach and do what we do the way we do it is to be labeled old school, old fashioned and not open to new ideas.

**The Safety And Efficacy of taking Pre and Post X-rays.**

The authors would suggest that this has not been established in the literature. I would beg to differ with them on this point. There has been a string of papers published in the literature establishing the reproducibility of our x-ray analysis. The exposure dosage to ionizing radiation is a known and measurable entity. Compared to CAT scans that are routine throughout the world our dosages are low. The only element that is up for contention is the benefit to risk ratio. This will always be up for debate. It matters not weather it is the medical profession who have absolutely no interest in acknowledging any virtue in a profession that it considers attempting to enter what it considers it's turf through the basement, or our fellow Chiropractors who through a lack of understanding our work unwittingly fight against us. You cannot prove the ASC. They cannot prove the vertebral subluxation. Medicine is a science that boasts levels of success that makes them the #4 cause of death in the

U.S.A. They masquerade as science and what we do is something else? There are some things that cannot be proven in the literature. The good news is that this not a necessary perquisite to widely known or accepted by the public.

**Clinical Goals as They Relate To Optimum Health**

The problem as we define it in NUCCA is based on physical and roentgenological measurements. We do not define the problem based on history or named condition. Likewise we measure outcome utilizing the same measurements that defined the problem initially. We do not define outcome in terms of return to health or optimum health. This is another discussion entirely. I fail to see how this has caused irreparable harm in the Chiropractic community. I am also not aware that Chiropractic is moving away from structured Chiropractic and unfortunately no references or examples were provided to support this statement.

**Certification Creates a Presumptive Incompetence of Uncertified D.C.s**

One must ask in who's mind and why would this be so? In an academic setting those students that are in the masters program do not feel incompetent as a result of the presence of Ph D's. It certainly would be questionable for the students in the Masters program to be instructing in the PhD program unless they had some area of expertise that the academic faculty recognized as qualifying them to make that presentation. They certainly would not be allowed to teach on the program simply because the had an idea that they wanted to share. So then why would we have this " .....general sense of disconnectedness, even disenfranchisement, among the rest of the membership." If this is the case I think the answer lays elsewhere.

In 1989 we had 10 certified doctors. Today we have 20, twice that number yet the organization is not twice the size it was in 1989. Given that only one in ten of the doctors graduating intending on practicing NUCCA will actually be practicing NUUCA five years latter. Maybe 30% of the doctors sitting in our seminar programs at any given time truly limit their practice to correcting the ASC exclusively. I think that solving these problems is what is necessary if we seek to achieve greater acceptance presence within our own profession. I do not believe that the answer to this is more published articles in peer reviewed journals nor do I think it is opening the organization up to a free for all in terms of modifications of the technical aspects of our work. I personally think that these problems are better addressed by further developing our understanding of the ASC, improving our corrections and shortening the learning curve.

Dr. Lee Yardley

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Letter to Dr. Michael Thomas
and Dr. Jeff Scholten,

In response to the published paper, "A shift in the Prevailing Winds."

I have read your paper on a number of occasions and I would like to accept your invitation to respond to your paper. The length and depth of your paper reflects a tremendous amount of effort on your part. I congratulate you on these efforts. You raise a number of important questions, which may or may not have answers at this point. In response to **some** of these questions:

Do we need more research? **Definitely.**

Do we need to understand the details of our work more? **Definitely.**

Do we need additional dialogue and communication with the members of our organization and share the depth and breadth of unique and diverse knowledge that they bring? **Most Definitely**.

Does our organization face challenges? **Yes** and likely, we always will.

I sensed from reading your paper that there is a degree of anxiety that our organization may face extinction and removal from the health care field primarily because we lack scientific validation and the size of our organization is too small to notice. It is my suspicion that we will always remain a small group; relatively speaking, but our impact is very significant and meaningful. I do not feel we will be extinct because we offer a unique, valuable and meaningful service.

The work we do is unique and the path of a NUCCA or upper cervical practitioner is a challenging one that leads people into a highly accountable system of care. To fully engage oneself in the process of life-long learning and ultimately mastering the art of the practice of NUCCA can be a very humbling process. In my experience, I have had to come to terms with the vast amount of knowledge and skill that I do **not** possess. Learning to be with the unknown. Learning to accept the truth of what the current state of my skill, understanding and practice is. These things have been and continue to remain a constant challenge in a process that is a very personal journey.

As I went through the certification process fifteen years ago with Dr. Gregory, these were the main challenges that I had to face. What this process offered me was a level of knowledge and internal confidence to take the next step forward in the ongoing process of learning. Certification was not the final step for me but the beginning step. The learning process and the continual deepening of my work is endless. I choose a path of learning that does not constantly bring in new information but takes established information to greater degrees of depth and understanding. For me, this has refined the art of the adjusting, x-ray analysis, biomechanics and patient education. This is what our certification process can offer to others who may choose this pursuit. It is valuable and worthwhile.

Because we are a relatively small group, I do not feel this diminishes the value of what we contribute to health care. I foresee that if we follow down a path of ONLY scientific pursuits as a measure of validation and acceptance, we may fall further into a serious trap I see health care is caught in today. To exemplify this, I would like to share an excerpt from a profoundly helpful book I recently read. This excerpt talks about healing and most importantly, what I feel is a critical component of a current dilemma of chronic health issues that many people face. The larger question of, "where does healing come from?"

**From: Under Saturn's Shadow The Wounding and Healing of Men' By James Hollis**
Published by: Inner City Press
**Page 110-112 :**

**What is healing, and Who is the Healer?**

Before we can realistically address the healing of [people], we must first examine what healing means and where in our time healing agencies may be found.

Franz Kafka wrote a prophetic story at the beginning of this century titled "The Country Doctor." A physician is called out in the middle of a raging snowstorm to attend a patient. When he arrives, the villagers are all crowded around a young man. The youth says to the physician, "Save me, save me." The doctor examines his patient and proclaims that he can find nothing wrong; no apparent wound or diseased condition. Again, "Save me, save me," the youth cries. The doctor looks again and sees a gaping sore in the patient's side, with multiple rose-red layers. Worms as thick and as long as his finger wriggle to the light. After a further examination, the doctor explains that he cannot save him. The villagers are incensed and engage in a ritual divesting the doctor of his powers. They chant, circle him, strip off his vestments and throw him out into the wild. Struggling to find his way back through the darkness, the physician thinks:

> That is what people are like in my district. Always expecting the impossible from the doctor. They have lost their ancient beliefs; the parson sits at home and unravels his vestments, one after another; but the doctor is supposed to be omnipotent with his merciful surgeon's hand. Well, as it pleases them.

Kafka's story has metaphoric and prophetic meaning. The power of the clergy has waned, supplanted by a new superstition and a new priest, in a white coat instead of black. But the new religion, medical science, cannot save either. Only upon closer examination does the symbolic rose-red wound become visible. Science, with all its marvelous powers, is powerless to heal such a wound. Thus the physician becomes another dismantled servant of a discredited divinity. Kafka warns us against placing our faith precisely where the twentieth century has placed it-in the external, quantifiable world. Our wounds are to the soul, and only that which reaches it can heal.

The physician is a servant of *Physis* (nature). The physician does not heal; nature heals. (Form Latin we get *medicus*, "healer," *mederi*, "to heal" and *docere*, "to lead.") When the body is broken the physician may promote conditions that facilitate healing, but cannot heal wounds to the soul.

Decades ago D. H. Lawrence realized this:

> I am not a mechanism, an assembly of various sections.
> And it is not because the mechanism is working wrongly, that I am ill.
> I am ill because of wounds to the soul, to the deep emotional self
> And the wounds to the soul take a long, long time, only time can help
> And patience, and a certain difficult repentance,
> Long, difficult repentance, realization of life's mistake, and the freeing of oneself
> From the endless repetition of the mistake
> Which mankind at large has chosen to sanctify.

As each one of the NUCCA members and the NUCCA organization as a whole, continues its' journey of evolution and growth, we encounter obstacles, challenges, and sometimes struggle. This is a part of the journey along with our success. At the end of the day I feel we all share a common goal which is, **reducing human suffering**. For some people, a spinal correction is everything and their life is completely changed as a result of the correction of the atlas subluxation complex. The enormity and complexity of healing is such that, I am not sure that we will ever fully understand that process which is often mysterious and magical.

As I have said before, "we know more than we can prove". After twenty-four years of practice, I feel quite confident with the level work that NUCCA has achieved so far and the contributions that I can make on a daily basis. I see the results regularly in my office and this is very reassuring to me. My learning has come from the support and help of the NUCCA organization.

The work we do has tremendous value and meaning. It is my hope that we are able to evolve and grow and create a solid foundation that can weather the storms as we steer into the new and uncharted territories. This would be as our ancestors before us, who also had to steer into similar rough waters. They survived and we will too!

I also keep in mind the quote of Niccolo Machiavelli who wrote in 'The Prince' in 1513;

> "there is nothing more difficult to execute nor more dubious of success, nor more dangerous to administer than to introduce a new system of things. For he who introduces it has all those who profit from the old system as his enemies and he has only lukewarm allies in all those who might profit from the new system."

There is no real destination to this journey and therefore we will never really arrive. We will continue the journey together seeking greater understanding through further research and awareness through shared ideas with that sole purpose of helping to ease human suffering. We can achieve this with further work together as a group of committed practitioners working to care for patients and some involved in research to deepen our understanding. It is eclectic, diverse and a wonderful challenge. **Who** we become in the process is the true test and perhaps the greatest gift.

I thank you for the opportunity to respond to your paper and thank you for the work that you have put forth in starting this conversation and dialogue to further the growth the NUCCA organization and upper cervical care.

Sincerely,

**D. Gordon Hasick, D.C., F.P.A.C**

Board Certified NUCCA Instructor

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What a great time in the evolution and development of chiropractic to write a paper about the social and organizational perspective of Upper Cervical Chiropractic! I am expecting your paper to have a major impact in the upcoming years. It will help us do what is necessary to deliver our life-affirming service. It will also make visible the knowledge and wisdom gained from years of investigation which can be discovered and used for humanity's collective health and well being physically, mentally, emotionally, spiritually and socially.

Both Dr. Thomas and Dr. Scholten have done a masterful task in creating an objective perspective of upper cervical chiropractic. They have made many salient and provocative points. Some of these ideas have come from years of experience with the educational and training processes that have given them the skills to perform their art for the benefit of their patients.

This paper has asked us to examine some of our basic assumptions and assertions as well as some of our procedures and protocols. It is asking for us to use the rigors of science, knowing that science and the scientific method are sometimes flawed. It has asked us to also use a different model of investigation using the strength of our collective years of experience to continue to develop our procedures by allowing our members to have a voice in the development of our work. This will take a renewed attitude of openness and a movement away from having to be "right" and everyone else is "wrong."

I have divided my response into what I consider the major points of the paper and my responses to those ideas. The outline form represents the points of the paper and my responses are in prose in paragraph form. Thank you for writing this paper and for your interest in and respect for upper cervical chiropractic.

**Assumptions and Assertions, Procedures and Protocols**

*I.* Our work is still full of unexamined assumptions and unproven assertions to the world outside of the experience of upper cervical chiropractors even though upper cervical chiropractors have done as much or more to validate our selves through investigation as any other work in chiropractic

*II.* If we must re-examine the assumptions and assertions that drive NUCCA both scientifically and socially then what are these assumptions and assertions?

*III.* Assumption - the work is in a "final" form and must be formalized in order to prevent loss of the foundation

*IV.* Assumption - Our major concepts are set and the basic protocols established

*V.* Assumption - if the misalignment factors are unchanged, reduced disproportionately, or increased, then the intervention has failed to improve the health of the patient

*VI.* Assertion - Excellence in NUCCA has become defined as attention to detail and consistency of all of the various sub protocols

*VII.* Assertion - Our gold standard is the radiological measurement of maximal and proportional reduction (correction) of misalignment on post x-ray analysis

*VIII.* Assertion - Extreme accuracy in the application of incomplete protocols still results in real limitations for the potential improvement of patient care delivery

The creation of an "Open Forum" for the discussion of ideas must be kept to the basic rules of human organization. These rules are an equal voice for everyone and that each of us speak from our own experience. For example: "this is what I observed, this is what I did, and this is what happened." It is the inherent right of the individual, introduced to this information, to "sort it out." It is a violation of individual freedom to condemn any idea without investigation. To loosely quote the paper:

"The caliber of practitioner that forms an upper cervical doctor is rigorous enough to demand a person that is not the general population and it is this caliber of individual that has the ability to create solutions for any problem that arises in our field and not paying attention to the ideas and suggestions of our members is not only an error but an impediment to our development."

In this way our assumptions and assertions can be challenged, validated, modified and / or new and better ways of addressing the Atlas Subluxation Complex (ASC) can be developed. This will also solve one of the current inherent social problems of losing our best minds when there is no provision for their developments and discoveries. It is this inherent curiosity and love for adventure that drive the most profound discoveries. And it is this sense of being able to make a contribution that encourages even more activity among our members. This also has served to create other upper cervical groups based on our differences, which are minor compared to our similarities.

An obvious omission in this paper was the effect of an upper cervical adjustment on the functioning of the central nervous system. A possible error on our part may be the idea that there is only a single mechanism for the adverse effect of mechanical tension on the central nervous system. There may be biomechanical complications with possible degeneration of body structure, which may be progressive. And, there may be vascular, neurological and chemical complications of the ASC, which we vaguely comprehend. It is imperative that we revisit our basic assumptions and assertions, develop more effective ways to create professional competence and to begin the lengthy process of discovering all of the diminishing health effects of the ASC. This is no small task, but to take the lead in the chiropractic profession it must, can and will be done.

We must consider changing our organizational model to include the people trained in the acquisition of funds, in designing and running research projects and in publishing those findings in a place where they are visible to the world whether in print or electronically. This challenge is there for all of us: to support our organizations financially and to form alliances with other orthogonal based chiropractic organizations with which our procedures and protocols are more similar than different.

**Research**

*I.* Creating a way to move forward while maintaining the integrity of the work and ensuring patient safety is imperative

*II.* Our duty is to examine new concepts and periodically re-examine the foundational concepts in order to clarify our foundations and validate our work and document what we know as well as what we don't know

*III.* The official protocols will always lag behind the cutting edge

*IV.* A cloistered existence has led to a "self evident" sense of proof that also cannot be shared with others outside of the upper cervical community who have not shared the same experiences

*V.* We have the burden of proof because we are a minority

*VI.* Because chiropractic educational institutions are for the most part under manned, under funded and under trained we lack the expertise of PhD's, granting institutions, or research methodology

**Our relationship to other Orthogonal Based Groups**

*I.* Within the orthogonal approaches, the protocols are more similar than different of the variations based on divergent perspectives

Some of the deeper issues of the paper delve into the connections to chiropractic and healthcare. It is not enough for us to continue this investigation without the rest of the world knowing about what we are doing. Yes, we do need to publish our research and yes, there are areas that we know nothing about in the scientific and publishing world, but the paper missed the basic issue and that is that none of us signed up to be researchers or scientists. We signed up to be chiropractors and this is our nemesis. We are not trained as researchers or scientists and even though the paper mentioned the flaws in the chiropractic world of published research, what we have is the responsibility to create the funding and the designs for researchers to investigate and publish what we are doing. This takes money. None of us will be able to fund this research out of our individual patient care income and it is necessary to fund our organizations and to find outside sources of funding, again an area in which none of us have any experience.

### Science and Healthcare

*I.* If we are looking for access to the mainstream of the scientific community we must begin to do more than concentrating on optimizing our x-ray techniques and maintaining parallel forces in our adjustments, which is critical but not enough to assure the sustainability of this work beyond our generations

*II.* Error occurs in the deep-seated conviction among many upper cervical chiropractors that restoration of health cannot occur without reduction of the upper cervical misalignment factors as measured on film analysis and this error in logic created nearly irreparable harm to our standing in the chiropractic community and in healthcare at large.

*III.* The routine resolution of dis-ease after correction of the upper cervical subluxation complex remains outside the realm of possibility for both the medical community and for the general population at large

*IV.* We remain the best-kept secret in healthcare

*V.* Real science does not make polarized stands without massive and long-term over-whelming data in favor of a proposition

*VI.* In any scientific endeavor, the goal is to move toward progressive clarification of understanding regarding our observations

*VII.* Upper cervical chiropractic has demanded a shift in understanding that has no context within the current healthcare paradigm

*VIII.* There has been much change in understanding in health care in the literature from an understanding of complex and nonlinear systems as well as new mathematical models

### Publications and the *Monograph*

*I.* The voice of upper cervical chiropractic is essentially silent outside of its own Borders for reasons that are historical, technical, political, financial and social.

*II.* Small number of practitioners few of whom have any training in research methodology, no real university funding, current level of maturity

*III.* Little has been published in peer reviewed, indexed literature

*IV.* Difficult to gain access to publication because our protocols involve radiating patients and the safety and efficacy of taking pre and post films has not been established in the literature

*V.* The *Monograph* may become the open forum for the distribution of the investigations of our established protocols and for the new ideas that will come from the doctors practicing the upper cervical procedures

It is possible now for the National Upper Cervical Chiropractic Association (NUCCA) to move into an era of electronic media and to use the whole brain research to change the ways in which we are able to help students and doctors become masters of our procedures and protocols. Even though the paper did not discuss possible reformation of our seminars and educational materials directly, it demonstrates a need to provide a more effective way to learn to master the skills necessary to provide competent patient care. The paper although critical of the certification process did not mention that the certification process has itself become the third tier of learning beyond the basic understanding and the advanced classes that deal with what to do if something does not fit the standard protocols.

**The Certification Process**

*I.* Upper cervical chiropractic is simple in initial concept but difficult to truly understand at the level of practical competence and has been difficult to perform as a consistent and accurate physical act (after six decades there are relatively few masters)

*II.* The certification process which continues as a successful attempt to develop this biomechanical, kinesthetic and intellectual understanding of our work and essential to produce a more competent practitioner has created another problem, which is social in context

*III.* Awarding competence to the certified doctors has created a presumed incompetence among uncertified doctors leaving a small number of doctors charged with tremendous responsibility and a general sense of disconnectedness, even disenfranchisement, among the rest of the membership this may have led to our relationship to chiropractic in general

*IV.* The teaching of the protocols requires some uniformity of action so that a core of shared knowledge can be created and so that the teachers have a depth of common experience to help the student master the task at hand

These changes in our instruction and education will only be the tip of the iceberg of what may be the use of the orthogonal measurement systems to create some validation of the other chiropractic techniques and to enable those of us who have been using measurement, observation and reason for many years to take a leadership role in the profession of chiropractic. When first exposed to the idea that it was possible to use measurement to not only believe in the principles inherent in chiropractic, it was only an intangible idea that it was possible to be able to know the misalignment factors of the subluxation and to determine when an adjustment was restoring the spine to a normal position.

Even the idea that the spine had a normal position and if it was in that position was a milestone breakthrough. If the chiropractic profession were able to move from the efficacy of spinal manipulation therapy or even the subluxation / adjustment model where the only evidence of the effectiveness of the treatment was the increased mobility of the segments of the spine and some changes on thermography to the ability to objectively quantify the measurement of the subluxated spine, our profession could make a quantum leap in patient care, research and the scientific validation that we so desperately need for the involvement of the nervous system and its effect on health and well-being.

It is imperative that we hold the vision for the possibilities of upper cervical chiropractic and continue to work on these programs, projects and plans until our service is known to the world at large. The essential ingredients for our organization are empowerment and inclusion. We must begin to place the talents and skills of our members in the appropriate places to be of service and to make a difference.

## NUCCA as a Social Organization

*I.* There are aspects of the work that cannot be changed without loss of the integrity of the work itself. These must be kept clear and inviolate. **In our desire to hold onto our legacy, we may lose the flexibility required to move us forward**

*II.* In order to grow our organization we must honor diversity and stop limiting the avenues of investigation and honor the discoveries of any doctor regardless of their degree of certification or acceptance in our organization

*III.* Restriction of conversation, ideas or innovations by doctors regarding aspects of the work only serves to disenfranchise the members of our community; very often behaviors that are appropriate at one point in time (ie. To protect the work) become the very behaviors that restrict further evolution of it in the future

*IV.* Current challenges that upper cervical chiropractic faces as a minority, is in becoming able to enlarge our perspective and not demand that other procedures fit our mold

*V.* Blinded division and unproven prejudice only serves to dilute our pool of talent, frustrate innovation and stall progress (we must be willing to speak from and to share our own experience and allow others to speak from their own experience and observations)

*VI.* A strictly hierarchical model of organization is the traditional form of coordinating a group of people engaged in a process

*VII.* In a social organization, stasis, or the attempt to concretize process into some "final" rigid form causes a loss of vitality. It results in a lack of innovation and evolution. Socially a great deal of energy must be expended to "hold" the form in place

*VIII.* ***The "Delphi Effect" is that within a given population of observers, the averaged opinion of these observers is much more reliable that that of any single (randomly chosen) observer within the population - "Given enough eyeballs, all bugs are shallow"***

*IX.* We can together create an open forum for individual effort to be supported, critiqued, argued over, celebrated, modified and enhanced

We are currently becoming better organized, learning to respect and honor diversity, challenging the organizational model and gaining momentum toward our future. This paper represents the beginning of new landscapes and possibilities and even though it addressed some of the current obstacles or interferences within our organization, it is with sincere and earnest optimism that I can represent NUCCA as its president, knowing that our time has come and that we are gathering the resources to bring our service to the people of the world.

Dr. Robert Brooks

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# Afterward

The responses engendered by our paper have produced a hearty diversity of comments. Our paper was designed to ask questions and open these questions up to the population of doctors who practice in the upper cervical context for their own analysis, not to present answers to all of the sundry issues raised. We invite, encourage and will participate in the continuation of dialogue regarding the various issues raised within both the paper and the responses from the field. Aside from the papers we directly quoted, we have cited no references in our paper in an attempt to open up a discussion with an informal tone. Some of the statements we made were interpreted very differently by the various respondents. This is a reasonable outcome considering the diverse perspectives that comprise upper cervical work. It is precisely because of this diversity of thought that we believe our intellectual progress may at this time, best be served by continuing to encourage discussion in this sort of informal manner, generating new ideas and reassessing old ones. Discussions of this sort can greatly expedite the maturity of our thought processes, our inter- and intra-professional relations, our concepts, and ultimately, our protocols.

It is our love for, and commitment to, upper cervical chiropractic that caused us to begin this process of discussion. We deeply understand that measurement, precision, accuracy, repeatability, consistency, and mature understanding are critical to this work. We both find the NUCCA certification process to be essential to our progress, both individually and collectively. Examination of our assumptions and assertions is the outgrowth of our honest commitment to our work. NUCCA has never been about a "true believers" mentality. A healthy skepticism and inclination to objective verification and reproducibility of results is at the core of scientific thought; it is also the intellectual legacy of Dr. Gregory to NUCCA.

We wish to thank those who took the time to put pen to paper (fingers to keyboard) and begin a process of introspective examination regarding "what we know" and "what we think we know", "what we know we don't know", and most difficult of all, "what we know that turns out to be wrong". This paper and the various responses are only the beginning of a process which can help us to redefine our work and reconnect us to the science of our day and current paradigms of thought. As Gregory wrote in the very first Monograph when introducing NUCCRA:

*"The purposes for which NUCCRA was formed are to engage in a comprehensive research program designed to establish a scientific basis for the practice of chiropractic; to establish a body of acceptable knowledge that is testable, relevant to fact, and compatible with established and accepted scientific premises, beliefs and assertions; to establish an acceptable and scientific body of knowledge regarding the subluxation, its causes and its physiological and pathological effects on the human organism; to design and develop equipment for the measurement of physical phenomena that have been observed to exist concurrently with the vertebral subluxation, and to assist chiropractic colleges, organizations and practitioners."*

This edition of The Upper Cervical Monograph inaugurates a shift in the way we use this publication. We hope it is the first of many such dialogues in its pages. Aside from this use, The Monograph is still an appropriate place to publish papers that would not be of interest to "peer reviewed" journals but are paramount to our own processes.

Respectfully submitted,

Drs. Thomas and Scholten