After 26 years as a non-DC attempting to serve chiropractors by advocating the patient’s point of view, it still astonishes me how much this profession is held back by its fractured in-fighting. And no wonder. After a recent seminar, in which I heard chiropractors using sloppy language while asking questions, it prompted me to identify some of the many distinctions that chiropractors make—either consciously or unconsciously, that produce the bifurcation in chiropractic:

D.D. or B.J. Are you more comfortable with the fundamentals advanced by the founder of chiropractic, with its metaphysical tenets and century-old philosophy, or are you aligned with the charismatic developer of chiropractic and his strange writings, thoughts and innate philosophy? Or neither, because these historical figures embarrass you or you prefer making chiropractic what you think chiropractic is?

Upper cervical or full body. I wasn’t around in the early days as B. J. Palmer attempted to herd this profession of cats, but way back when, chiropractors had to choose sides. Is the atlas/axis subluxation the only one worth attending to, or could you venture further down the spine, even to Logan Land in the sacrum?

Straight or mixer. Should you do anything other than reduce subluxation? Or can you provide other supportive services to enhance physical, mental or social well-being? Is heat, cold, electricity and light legitimate healing modalities? Or should chiropractic be limited to adjustment only?

Hands or instrument. You’d think that the word chiropractic, which comes from the Latin meaning “done by hand,” would be clear enough. But what if the hand is holding an instrument? What if your hands are so beat up after 20 years you need an instrument to assist you?

Subluxation or dysfunction. Does chiropractic address a neurological phenomenon or merely a mechanical dysfunction? Every chiropractor has to choose. Are you okay with the “s-word” or would you prefer to see it disappear?

Manipulation or adjustment. Generally defined as less specific than an adjustment, will
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you use the term manipulation instead? Many of the research articles affirming chiropractic-like interventions use this term. Language matters. Are you being specific or general? Are you intended or hazy? Focused or unsure?

Bones or nerves. Is the goal of chiropractic to “fix” patients and restore alignment, balance, symmetry and ideal curve? Or does chiropractic concern itself with the integrity of the nervous system? This is a huge distinction that is often lost on chiropractors who use adjusting techniques that they think put bones that are “out,” back where they belong—virtually ignoring why the body might have put the bones there in the first place. Have you considered going spineless?

Force or tonal. Can subluxations (or whatever you call your particular bogeyman), be reduced only by applying force along facetal joint planes, or can you use a touch or sustained pressure? Can you talk them out? Can you pray them out? Is one way superior to another? Are both approaches equally chiropractic?

Local or whole body. Is chiropractic merely a way of reducing the obvious symptoms local to the spine, or is it a discipline that mediates the integrity of the nervous system, which can have visceral, organic and whole-body effects? Is chiropractic appropriate when there are no symptoms present? Or must one wait for symptoms to manifest first?

Episodic or lifestyle. Is chiropractic allopathic or a lifestyle decision? In other words, is chiropractic merely a short-term diet to deal with bouts of obvious neuromuscular-skeletal problems, or a healthy, life-long habit? Is it appropriate to reduce non-symptomatic subluxations? Is it okay to adjust children even if they don’t yet have a “bad back”?

Patient or practice member. What will you call the people who show up in your office? The word “patient,” which comes from the Latin word meaning, “to suffer,” is probably where most people start. Or, do you have people who begin care observing that they’re “feeling great and want to be even better”? If you see people with these two different motives, you may need to make a clearer distinction with your language.

Treatment or care. Treatment, which is defined as a procedure to relieve illness or injury, is clearly medical language. The term “care” implies giving attention and direction, yet recognizing that the patient is the one doing the healing. Which one will you use?

Compliance or follow-through. This choice reveals the “headspace” of the chiropractor. Compliance suggests surrendering power; submitting to the wishes of another. Therefore, compliance is a doctor-centric view of the relationship. Follow through acknowledges the sovereignty and free-will choice of each patient and reflects the degree to which the patient chooses to complete or finish the suggested recommendations.

Self-pay or third party. And who will be your boss? The patient with whom you actually have a relationship, or a distant third party who doesn’t understand, respect or even like chiropractic and sees reimbursing for your services as a needless drain on corporate profits?

Diagnosis or analysis. This is where brushing up against the allopathic third-party industry has rubbed off onto many chiropractors. Analysis is defined as procedures designed to reveal the presence, location and character of a vertebral subluxation along with any contraindications to chiropractic adjustments. Diagnosis is a medical procedure to identify a disease by its signs and symptoms. Which is fascinating, since most state chiropractic licensure laws specifically prohibit chiropractors from engaging in the treatment of disease.

Mechanism or vitalism. Are the people who show up in your office merely mechanisms and chemical reactions with a limited number of cellular replications and they die, or are they greater than the sum of their parts, respond to prayer, are self-healing and regulating and have nervous systems that learn and adapt?

Anecdotal or evidence-based. What will you choose to believe about chiropractic? Is the linear, double-blind “gold standard” used in medicine, especially drug testing, appropriate when judging chiropractic? Or will case studies and anecdotal reports be sufficient in proving the value of chiropractic?

Integrated or separate. Is chiropractic something that should fit into the mainstream health care paradigm or is it an entirely different healing discipline? Before you answer, be sure to check the language of the practice act that grants you the right to be a chiropractor. (Clue: chiropractic wouldn’t even exist if it weren’t for B.J.’s foresightedness to make it separate and distinct.)

Sorry to burden you, especially since you probably got into chiropractic because you just wanted to help others—not be a pawn in some esoteric philosophical battle! But you are. In fact, your inclination to keep your head down, use sloppy language and ignore its implications, not only blunts the impact of what you do, but your carelessness could jeopardize the profession!

My guess is that no other healing art offers so many choices of what to believe. And while there are strategies currently in play to eliminate many of these choices in an effort to bring unity to chiropractic, my fear is that the result will be more mechanism and less vitalism, more spine and less nervous system, more Newtonian and less quantum and sadly, more therapeutic and less chiropractic.

Or have I missed something?

(Originally posted by Bill Esteb on his website blog, 5/4/2007. Reprinted with permission.)
Longevity and Lifestyle

Lifestyle has been long assumed to greatly impact longevity but there has been a lack of highly correlated data to base opinions on. More recently there has been a flood of highly objective data which has greatly clarified the longevity/lifestyle relationship.

A large prospective study recently provided some of the most objective data in this area. The study followed 2357 men who were healthy at about age 70 years. Both survival and “healthy” survival were strongly related to lifestyle factors. On the negative side, smoking had the greatest impact increasing the chance of death before 90 years by 110%. This was followed by diabetes (86%), obesity (44%), and hypertension (28%). Those who did not smoke had a 54% probability to surviving to 90 years while those with a combination of 5 negative lifestyle factors had only a 4% probability. Regular exercise had the greatest impact on the likelihood of survival to 90 years increasing the probability by 30% over those who did not exercise.

Quality of life was impacted similar to longevity. Those with the positive lifestyle habits and the absence of the negative factors above had fewer chronic diseases at 90 years, had a 5 year later average onset of any chronic disease, had higher physical functioning scores, and high higher scores of mental well being. It does seem as if “fate” is often just choices.

Yates et al. EXCEPTIONAL LONGEVITY: MODIFIABLE FACTORS ASSOCIATED WITH SURVIVAL AND FUNCTION TO 90 YEARS. Archives of Internal Medicine, 2008:168;284-290.

Longevity Begins During Childhood

While the relationship between different lifestyle related parameters such as body mass index (BMI) and longevity is established in middle aged adults, the relationship actually appears to be well established during the adolescent years. A study of 230,000 adolescents found a dramatic relationship between BMI during the teen years and subsequent death rates during adulthood.

Compared to those with a BMI below the 25th percentile, those between the 25th and 85th percentiles had dramatic increases in death rates from a broad spectrum of some of the more common causes of adult deaths. Deaths from ischemic heart disease were 190% and 270% higher for males and females respectively. The respective increases for these groups for colon cancer and... Continued on page 7
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respiratory disease were 100% and 170%.

The increased risk of death from a spectrum of common adult diseases suggests that there is an almost universal negative relationship between chronic disease risk and body fat/weight. It is likely that individual factors such as genetics are key in the particular disease that excessive weight may cause in an individual, but the excessive weight is the common generator in the majority.

The other striking finding of this study is that many teens in the middle group are defined as only overweight and not obese. Twenty pounds of excessive weight at age 18 years seems to be almost as risky as is 50 lbs. The concern here is that most persons who are simply “overweight” think that their weight is within the normal range. Now that 66% of the population is overweight, 2 of every 3 persons we see in a day, or the majority, are overweight. Once we see enough of anything, we tend to recalibrate that particular appearance as “normal”. While there may be different gradations of “overweight” based on classification standards, there is only one gradation of mortality. If we look at it that way, the risk is much better understood. When the data is considered, allowing children to become overweight could be looked at as abuse and neglect.

Bjorge et al. BODY MASS INDEX IN ADOLESCENCE IN RELATION TO CAUSE-SPECIFIC MORTALITY: A FOLLOW-UP OF 230,000 NORWEGIAN ADOLESCENTS. American Journal of Epidemiology, 2008:Advanced publication, 5/13/08.

Objective Measure of “Longevity Factors”

The above study suggests that much of longevity is importantly a function of modifiable lifestyle issues versus simply the commonly held duo of genetics and fate. Measures of “lifestyle” would therefore be helpful in knowing ones progress towards optimum lifestyle and longevity. One of the emerging objective measures is muscle strength.

A study of 8762 men between the ages of 20 and 80 years of age looked the relationship between muscle strength and all cause mortality. Participants were followed and average of 18.9 years. Compared to the weakest third of men, death from all causes were reduced by 28% and 23% for the middle and highest strength groups respectively. Respective cardiovascular disease deaths were reduced 26% and 29% respectively and those for cancer deaths were reduced 28% and 32% respectively.

Two important points reinforce the relationship between strength and death rates. The first was that the groups were adjusted for other disease factors such as general physical activity, smoking, alcohol consumption,
Risk Factors for the “Disease Spectrum”

When the data from the above studies are looked at together, a striking feature emerges; there is an apparent inter-relatedness to many of the common life shortening diseases and that the link may relate to shared risk factors such as weight, diet and other lifestyle factors. Two more recent studies support this hypothesis.

The first study examined the prevalence of colorectal neoplasms in patients with newly diagnosed coronary artery disease (CAD). The study examined 415 adults who were undergoing coronary angiography. Of the total, 207 had positive exams for CAD while 208 had negative exams. All subjects then underwent colonoscopy. The results were also compared to the rates of positive colonoscopy in the general population to provide yet another “control group”.

A positive test for colorectal neoplasm occurred in 34% of the CAD positive group. A positive exam included either polyps or actual cancers. This compared to rates of 18.8% and 20.8% in the CAD negative and population control groups respectively. This is a rather striking 70% increased prevalence in those with CAD versus both those without the disease and the population as a whole. The actual cancer rates showed a very similar correlation with rates of 4.4%, 0.5% and 1.4% in the CAD positive, CAD negative and general population groups respectively (a 3 to 8 fold increase in the former).

This strong correlation between these two serious diseases naturally leads to the hypothesis that there are likely common underlying mechanisms. The top of this list includes lifestyle related factors. Both diseases have already been associated with body weight/BMI; many dietary factors such as fiber intake, total fat energy, fatty acid ratios and several others; nutrient intakes such as vitamin D and calcium.

Poor diet and lifestyle don’t absolutely predict that one will get a certain disease. What it may predict with much greater certainty is simply that one is likely to get one of a spectrum of serious chronic diseases.

Another study on the concept discussed above recently looked at the correlation between skin cancer rates and the risk of developing colorectal or breast cancer. The study examined over 26,000 adults diagnosed with one of the three most common skin cancers. These patients were studied by the lifetime accumulated skin exposure so they served as a population to study the relationship between exposure volume and other cancers.

There was a strong correlation between lifetime sun exposure and colorectal cancer. Those with the highest calculated accumulative sun exposure had 30-40% reductions in colorectal cancer rates. While this was thought to be a factor in their skin cancer risk, it was actually protective against colorectal cancer. The relationship between breast cancer and sun exposure was less clear not allowing adequate conclusions.

The link between skin cancer and reduced colorectal cancer risk is thought to be mediated by vitamin D. In humans the majority of circulating activated vitamin D (25 OH D) is derived from the production in the skin from cholesterol by ultraviolet light. Humans have typically derived less from the diet. While we have become both a more indoor population and perhaps “sun-phobic” when we do venture outside, dietary vitamin D levels have declined rather than compensating for the decreased endogenous contribution. The result has been almost epidemic levels of low serum 25 OH D and an increase in several serious diseases related to it.

The relationship between low serum 25 OH D levels and several cancers relates to the function of this hormone/nutrient in cell cycling. A broad spectrum of cell types have vitamin D receptors which influence cell differentiation, proliferation and growth. Insufficient control of this process by vitamin D is thought to be an important factor in “dysfunctional” cell reproductive cycling. Some researchers have even suggested that low chronic sun exposure levels may actually be a contributing mechanism in some skin cancers as skin cells are one of the cell types that use vitamin D for growth regulation. The problem may be more one of infrequent but intense skin exposure versus frequent less intense exposure.

The above debate continuing, dietary vitamin D management appears to have taken on an increased importance. Animal based foods have the highest levels of vitamin D with wild fatty fish being the best. While the commercial message is “milk builds strong bones”, one would have to drink 2 quarts/day of fortified milk to obtain the dietary amount recommended by the best scientific evidence.
Vitamin D and Breast Cancer

As the above study suggests, there is considerable interest in the relationship between several cancers including breast cancer and vitamin D levels. Proving the relationship has been difficult with breast cancer but the data suggesting an association continues to mount up. A recent study of 790 breast cancer survivors has added yet more data to the association.

The study measured serum 25 OH D levels in a multiethnic group of survivors. A striking 75.6% had low 25 OH D levels. After adjustment for other breast cancer risk factors such as BMI, age and physical activity, 25 OH D serum levels inversely correlated with the stage of the disease with more advanced disease occurring in those with the lowest levels.

The authors concluded that given the growing association between breast cancer and 25 OH D serum levels, and now the association between the serum level after diagnosis and the stage or aggressiveness of the disease, that “clinicians might consider monitoring vitamin D status in breast cancer patients, together with appropriate treatment, if necessary”. Perhaps this approach before the disease begins would be even wiser.

Newhouser et al. VITAMIN D INSUFFICIENCY IN A MULTIETHNIC COHORT OF BREAST CANCER SURVIVORS. American Journal of Clinical Nutrition, 2008;88:133-139.

Omega-3 Fatty Acid Intake and the Risk Of Type 1 Diabetes in Children

Type 1 diabetes is well established as an autoimmune condition where the immune system...
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destroys the pancreatic beta cells resulting in insufficient insulin production. Given the growing awareness of the influence of nutritional factors on immune function, it seems reasonable to study the relationship between the disease risk and dietary immune modulators. A recent study did this looking at the risk of developing type 1 diabetes and the intake of omega-3 fatty acids.

The study examined auto-antibodies related to type 1 diabetes in 1770 children at risk because of other direct family members with the disease. Dietary intake of both omega-3 and omega-6 fatty acids were analyzed. The risk of type 1 diabetes was inversely related to omega-3 fatty acid intake. Those with the highest intake had a risk reduction of 55% compared to those with the lowest intake. A cohort who had the most stringent testing to confirm type 1 diabetes, those with 2 or more auto-

antibodies present, had an even stronger relationship. In this cohort the highest omega-3 intake was associated with a 77% reduction in risk.

An important observation was that the risk reductions remained the same after adjustment for omega-6 fatty acid intake. This would suggest that the total omega-3 fatty acid intake is more important in immune regulation than is the omega-6 to omega-3 ratio. While we cannot change the genetic predisposition for type 1 diabetes, it expression by management of an important environmental “trigger” is very manageable. Perhaps the risk could be further reduced with high omega-3 exposure in utero. This will need to be determined by correlation with maternal intake and subsequent risk of the offspring.

Norris et al. OMEGA-3 POLYUNSATURATED FATTY ACID INTAKE AND ISLET AUTOIMMUNITY IN CHILDREN AT RISK FOR TYPE 1 DIABETES. JAMA, 2008:298;1420-1428.

California Case Will Likely Impact Future of Expert Testimony

By Arthur C. Croft, PhD(c), DC, MSc, MPH, FACO

Harrison v. Smith

In what may very well become a landmark case out of San Mateo County, CA, the California Court of Appeals, First Appellate District, upheld a lower court’s exclusion of expert testimony by defense’s Ph.D. biomechanist and M.D. who also claimed some expertise in biomechanics. This case, which hasn’t yet been officially published, will very likely have a stultifying effect on the standard defense strategy in low velocity motor vehicle crash injuries. This is potentially huge.

Why so important? Because the most successful defense strategy in these cases has been to hire an auto crash reconstructionist (ACR) to determine the likely crash velocity. Then, either he or a biomechanical expert will testify that, in the numerous experiments of human subjects exposed to crash tests at those speeds or below, no significant or long-term injuries have ever been reported. Completing the syllogism then, it follows that the plaintiff, therefore, is not likely to have been injured. There are, of course, other tricks of that trade which I have discussed elsewhere 1, but this association between delta V and risk is the underlying theme and the crux of the issue in Harrison v. Smith. I would hasten to add that there are other problems with this reductionistic thinking, but most plaintiff attorneys and most plaintiff experts aren’t able to argue these points effectively, and that’s why this case is potentially so big. In the future, they might not have to argue at all because the court may reject the defense’s velocity-vs.-risk argument de jure.

In this case, Smith (the defendant) offered the standard defense arguments. Specifically that Harrison’s (the plaintiff’s) change in velocity or delta V would have been only three to four miles per hour; that the forces the spine was exposed to would not have been beyond normal activities of daily living; that the [normal] ROM in the cervical spine would not have been exceeded, and that injury to the neck, discs, etc. wouldn’t have occurred. A delta V of 8 mph is necessary to cause disc injury, said their biomechanist. Head injury would also not be possible from the acceleration produced.

The trial court ruled that the orthopaedic surgeon, Dr. Paul Mills, could not testify as to the relationship between delta V and injury risk. Likewise, the biomechanist, Jeffry Lotz, Ph.D., was not allowed to testify as to the risk for injury based on delta V. This ruling, of course, fundamentally gutted the defense, because it hinged on crash velocity alone. The jury awarded a modest six figure award and the defense predictably appealed the case to the higher court, arguing that the lower court had erred in excluding their experts’ testimony.

It should be pointed out that the chief issues here are not whether an ACR or biomechanist can testify in such a trial. The specific exclusion in this case is that they were not allowed to make the jump from their estimated delta V to the probability of the plaintiff’s injuries. But, from a practical standpoint, if an ACR or biomechanist CAN’T testify as to delta V and risk, they aren’t going to be much use to the defense in most low speed cases. And, since the “science” of this correlation lies at the heart of the question, an orthopaedic surgeon’s or any other expert’s testimony would similarly be limited.

The lower court presented compelling reasons to exclude their testimony. The plaintiff...Continued on page 13
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challenged their testimony on the basis that the “delta V method,” as they called it, was not generally accepted within the scientific community. And, as far as the Appellate Court was concerned, the defense failed to offer any compelling reason to that lower court to believe that it was generally accepted in the scientific community. This, of course, is one of the fundamental tests used in Daubert and in Frye (which is what we use in California).

Interestingly, there has never been any good evidence that crash velocity is strongly correlated with risk for injury, severity of injury, or the risk for long-term outcome so long as we are considering a narrow range of collision velocities from about 2-20 mph. This is because at slower collision velocities, cars are relatively stiffer and much of the impulse is transmitted to the occupants. At somewhat higher collision velocities of 9-20 mph, the collisions become less elastic and more plastic. They are longer in duration and associated with structural deformation of the vehicles. This deformation both serves to absorb energy and increase the duration of the crash, offering the occupants important time to ride-down the crash. Acceleration is equal to the ratio of delta V and the duration of the crash. The longer the duration, the less the acceleration. As a result, we see some people in relatively low velocity crashes with injuries and some people who conversely manage to evade injury even in crashes with a large amount of property damage.

Factors that are known to be much more deterministic vis-à-vis risk are human factors. These include a history of neck injury or neck pain, headaches, having the head turned at impact, being female, being caught unaware, etc. This is why we so often see cases in which only one of two occupants are injured, or cases where one person recovers quickly, while another develops long-term symptoms. ACRs and biomechanists often are not privy to this material, or they are not knowledgeable in human risk analysis, or, as is often the case, they realize that discussing these factors would undermine their defense theories so they ignore this topic completely, pretending that velocity alone is a sufficient determinant.

This standard defense subterfuge of pretending that there is a direct correlation between crash velocity and risk and that, most importantly, there is a threshold below which injury will not occur, has succeeded chiefly on the intuitive logic of jurors and has been amazingly effective. In fact, most plaintiff lawyers have all but given up trying to fight it because they simply don’t know how. This landmark case, however, may finally level this playing field. It has ruled that the “delta V method” lacks scientific underpinning and therefore cannot be relied upon by experts in personal injury trials. That means that we can finally get back to the real (i.e., pathomechanical and physiological) issues in these neuro-musculoskeletal cases.

There are two interesting sidebars in this case. The first is that one of our papers was... Continued on page 20

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Do New Consumer Product Safety Commission Regulations Force Your Patients to Sleep In Toxic Chemicals?

By Lee Carter

Regulations from the Consumer Product Safety Commission (CPSC), 16 CFR 1633, which went into effect on July 1, 2007, require mattresses to resist ignition from open flames. While resisting ignition from open flames appears to be a desirable requirement, there is concern that it will also result in people sleeping on known toxic chemicals. Such chemicals include Ammonium Polyphosphate, Antimony Trioxide (a heavy metal that mimics arsenic), Boric Acid (roach killer), Decabromodiphenyl Oxide (a known carcinogen banned in two states), Formaldehyde (a known carcinogen), Vinylidene Chloride, and Melamine (the substance recently found in pet food that killed many pets). In addition, the CPSC does not require labeling of these chemicals by mattress manufacturers. The manufacturers may use whatever chemicals they see fit, while the consumer is potentially left uninformed and unaware.

Knowing that the chemicals that the mattress industry will use are known toxicants, the CPSC performed an in-depth risk assessment of these chemicals and their effects on humans. In this assessment, they proved that people will absorb these chemicals into their bodies and admitted that potential health risks are not yet completely known. Based on their own calculations for ADD (Average Daily Dose) and ADI (Acceptable Daily Intake), they concluded that sleeping on chemical-laden mattresses is safe. However, some of the absorption data and risk data used by the CPSC are different from the calculations compiled by the Center for Disease Control and the Environmental Protection Agency.

Some question whether or not the CPSC was looking out for the consumer in this matter.

- In a year long survey of serious mattress shoppers at Sleep Essentials where they were presented this information, nearly 100% of these shoppers indicated that they would prefer to have a mattress without the chemicals and to assume the minute risk of dying of a mattress fire, which is estimated at somewhere between 1 in 3 and 1 in 14 million. However, the CPSC chose not to give consumers a choice between flameproof and non-flameproof mattresses.

- The CPSC does not require mattress manufacturers to disclose what chemicals they use on the mattress label.

- In order for mattress manufacturers to meet the new standards, each mattress specimen must be submitted to a burn test at a designated testing facility. During this test, two propane burner flames are put to the mattress, which are purported to mimic burning bedclothes. Some question the advantage of a flameproof mattress if the sheets and blankets still burn.

Two groups clearly benefit from 16 CFR 1633:
1. The regulation benefits fire retardant chemical producers, represented by the Fire Retardant Chemicals Association.
2. The International Sleep Products Association, which primarily represents large domestic mattress manufacturers and fire-retardant chemical manufacturers, who supported the new regulations.

If these new regulations force imports and small mattress manufacturers out of business because of financial burdens that they cannot absorb, the large manufacturers will obtain more business. A case-in-point is the store chain W.S. Badcock. Quoting a 5/16/07 Furniture Today article, “Top 100 store chain W.S. Badcock said today it will close its bedding factory rather than make a “major expansion” that would be required to meet new federal flammability regulations.” In the next paragraph the article states, “Badcock said it will begin outsourcing all mattress manufacturing to International Bedding Corporation, a Top 10 bedding producer.” The larger producer gained from the small producer’s loss.

Another case-in-point is an article published by newsreview.com on 06/07/07. The article states that, “There are currently only 600 mattress manufacturers in the United States, and the new safety codes could eliminate a third of them.” This further suggests that 16 CFR 1633 benefit large domestic mattress manufacturers by eliminating their smaller competitors.

The bottom line is that there is more involved in purchasing a new mattress than just comfort and support. What are the pros and cons of FR chemicals? Do the new regulations provide consumers with added protection that is needed and desired? What were the motivations behind the new regulations? Consumers are best served to consult with their chiropractor who is informed on the subject before buying their next mattress.

Lee Carter is president of Sleep Essentials, Inc., a retail store in Roanoke dedicated to providing mattresses that support spinal and overall health. A contribution of each mattress sale resulting from a VCA Member’s recommendation is forwarded to the VCA. Visit www.perfectionmattress.com and www.sleepessentials.com or the Sleep Essentials booth at the VCA/VSC Fall Convention in Richmond.
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<th>Ray Tuck</th>
</tr>
</thead>
</table>

**Gold ($600 to $999)**

<table>
<thead>
<tr>
<th>Christopher Brown</th>
<th>John Clayton</th>
<th>Garry Collins</th>
<th>Elliot Eisenberg</th>
<th>William Todd Fisher</th>
</tr>
</thead>
</table>

**Silver ($400 to $599)**

<table>
<thead>
<tr>
<th>Larry Bompiani</th>
<th>Edward/Paula Carlton</th>
<th>Christopher Frey</th>
<th>Susan Martin</th>
<th>Glenn Stark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Thoma</td>
<td>Adam Wilding</td>
<td>John Willis</td>
<td>Howard Wilson</td>
<td></td>
</tr>
</tbody>
</table>

**Emerald ($200 to $399)**

<table>
<thead>
<tr>
<th>J. Kenneth Bowman</th>
<th>Don/Robin Bresnahan</th>
<th>Christopher Bruno</th>
<th>Phillip Connolly</th>
<th>Lincoln German</th>
</tr>
</thead>
<tbody>
<tr>
<td>T. H. Gillenwater</td>
<td>Michael Haas</td>
<td>Richard LaBarbera</td>
<td>Christopher Oliver</td>
<td>Stewart Rawnsley</td>
</tr>
<tr>
<td>Lonnie Slone</td>
<td>Jan Stephen Sumner</td>
<td>William Theiser</td>
<td>Charlene Truhlik</td>
<td>William Ward</td>
</tr>
<tr>
<td>Jerry Ray Willis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bronze (Up to $199)**

<table>
<thead>
<tr>
<th>Scott Banks</th>
<th>Karen Cerwinski</th>
<th>Danny Joe Dales</th>
<th>Gary Dennis</th>
<th>Robert Hedgepath</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carmen Johanning</td>
<td>Elizabeth Kautz Koch</td>
<td>Thomas Skelton</td>
<td>Steven VeGodsky</td>
<td></td>
</tr>
</tbody>
</table>

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---

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- Supports the AMA Guides
- Measures Joint Range of Motion
- Multiple Data Storage and Viewing

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To validate the data, the AMA Guides suggest up to six readings of which at least three need to be within 5 degrees or 10% of the mean.

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James McLelland, D.C. / 804-360-2447
Continuing Education: Not Just for Credit

By Anna Madland, DC

There are many ways for us to reach our commitment of continuing education credits each year, including attending seminars, taking online classes, and reading research. With the expansion of online seminars, webinars and the like, our need to leave the office and sit in a classroom for a weekend has significantly diminished. I love that we have the availability and options to complete our hours in any fashion that we choose, but I still think that face-to-face learning is the best for most topics.

I am a student of all types, I read research on my own, I have taken online courses and have attended many programs sponsored by the VCA and other private organizations. Although I would rather be learning in the comfort of my office or home, there is something about being in a conference setting that increases the thinking curve. Maybe it is being surrounded by fellow chiropractors, maybe it is the coolness of the hotel conference room, or maybe it is the free snacks, I am not sure. There is just something about attending a conference and being with our colleagues that makes a seminar special.

I love to see whole families make a weekend of the seminar event. The children can enjoy the sites of the city and the spouse can have a little relaxation time. It is so difficult to take our precious time from our families on seminar weekends, but what a good example to our children. Education is important and it never ceases.

I know that I have just brushed the surface of all of the great reasons to attend a seminar, and I hope that you find your own reasons!

Dr. Madland practices in the Richmond area and is VCA’s Education Committee Chair. For a complete calendar of VCA seminar and training programs for DCs and their staff, go to www.virginiachiropractic.org and click on Education and Events.

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The committee and commitment is as much or as little as you want it to be. I have great ideas and contacts. We have really gotten the ball rolling in Virginia...just need a little help in creating some inertia! Please let me know if you are interested by emailing me at dr.anna@atleechiropractic.com or calling my office at 804-730-7010. I am also going to be at the Fall Convention in Richmond. I would love to talk with you there!

-- Dr. Anna Madland, Mechanicsville, serves as VCA's Education Committee Chair and Backpack Safety Committee Chair.
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Who is the Certification Board and are they Accredited?
The ACA recognizes the American Chiropractic Neurology Board as the Sole Authority for Credentialing in Neurology for the Chiropractic Profession. The ACNB is fully accredited by the National Commission for Certification Agencies, the International Standard for Accreditation and is recognized by the National Organization for Competency Assurance.

Will this program help me?
Yes. This program will help you help others in a superior fashion by increasing your abilities to serve humankind. The increases in your clinical abilities will prepare you to serve more people and act as a consultant to other professionals. There are not enough trained and credentialed clinicians in this specialty area.

What will I learn?
Our learners become fluent in the ability to describe the process of neurological diagnosis with an emphasis on application of treatment specific to the nervous system of humankind. Applications are largely non surgical and non pharmaceutical approaches to a brain based treatment system.

What conditions will I learn how to Diagnose and Treat?
Our learners are trained to understand, diagnose, treat and manage the spectrum of neurological disorders that are associated with the integrated sensorimotor system. These disorders include dizziness, ototoxicity, balance impairment, gait impairment, tremor, positional vertigo, migraine, labyrinthine contusions, vestibulopathy, Meniere’s disease, cerebellar degeneration, cortical degeneration, anxiety, motion sickness, syncope, ocular motor disorders, dystonia and others.

What is the Program Structure?
Our program is a practical one of hands on learning. Clinicians work with patient scenarios and develop a mastery of the diagnostic and therapeutic modalities necessary in modern practice. Our instructors demonstrate procedures, which are practiced by the clinician. Our practical sessions are complimented with weekend residencies and on-line learning to ensure that the breadth, depth and application necessary for the specialty are mastered.

How long is the Program?
You must complete a minimum of 300 hours of credit in order to be eligible for the ACNB examinations. Many candidates attend all knowledge area modules or just the ones most relevant to their learning needs. We present our modules in convenient 15 hour 2 day and 25 hour 3 day immersion blocks so that our learners can complete their studies in a minimum amount of time. Using a tried and tested formula of weekend residencies and online learning, clinicians can attend all the modules or just the ones most relevant to their learning needs.

Do I need to take the entire Program?
No. Many learners elect to study certain courses, which allow them to become better clinicians without entertaining Board Certification in Neurology.

April 12-13, 08: 802 - Neuromuscular Applications:
May 17-18, 08: 824- Chiropractic Adjusting Techniques for Chiropractors:
June 21-22, 08: 803 - Peripheral Nervous System:
July 19-20, 08: 804 - Spinal Cord:
August 23-24, 08: 805 - Reflexogenic Systems:
September 20-21, 08: 806 - Autonomic Nervous System
October 25-26, 08: 807 –Cerebellar Cortices
December 6-7, 08: 808 - The Brain and Its Environment

Persons who are Board Certified Neurologists recognized by the American Chiropractic Neurology Board, or who are eligible to sit for the Board exam, receive a tuition discount.

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Learner Tuition $325 per 15 credit hour module if received 30 days in advance
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[Joined 6/19/08-9/5/08]

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Boothe Chiropractic Clinic
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P 276-783-7005
E samboothe@hotmail.com
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Willis Chiropractic
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Membership Type: 2nd yr
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Webb, Jr, DC, Kevin M
Machipougo, VA
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E KMW_01@yahoo.com
Membership Type: Student

Please note correction in the phone number listed in the summer issue for:
Vializ, Jasmine
INTEGRATED PRACTICE SOLUTIONS
Burke, VA
P 703-738-6898
jvializ@integratedpracticesolution.com
Membership Type: Supplier
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- Dr. Scott Banks on the Latest Nutrition Research
- Bill Esteb on “Why We Can’t Get Along”
- Dr. Art Croft on The Future of Expert Testimony
- New Consumer Product Safety Regulations that May Affect Your Patients
- New Members & Sponsors
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