FQS FORUM: QUALITATIVE SOCIAL RESEARCH SOZIALFORSCHUNG

Volume 5, No. 3, Art. 17
September 2004

A Living History—A Qualitative Study of Experienced Chiropractors Treating Visceral Conditions

Joan K. Langlois, Richard H. Parrish II, Ronald Rupert & Dwain Daniel

Key words: chiropractic, qualitative study, visceral, healing, chiropractors, focus group, interview

Abstract:The purpose of this ethnographic study was two-fold: (1) to investigate the nature of chiropractic treatments used by experienced practitioners for visceral conditions; and (2) to compare and contrast two methods of data collection—focus group and individual interview methodologies. We identified participants from a list of chiropractors with active licenses in 2001 obtained from the Texas Board of Chiropractic. All participants were audio and videotaped during focus group and individual interviews. A person knowledgeable in chiropractic terminology transcribed all audiotapes and viewed the videotape simultaneously. Primary documents were entered into Atlas.ti, a qualitative data analysis software package. The experiences of these seasoned Texas chiropractors describe a practice world in which a confident healer: (1) listened to, palpated, and educated patients; (2) adjusted for visceral and neuromusculoskeletal problems; and (3) developed therapeutic relationships by successfully explaining and applying chiropractic principles. Their confidence as healers was a consistent and durable theme, supported by four other themes: chiropractic history and philosophy; doctor-patient relationship; independence; and therapeutics. Individual interviews generated richer description for the topic of visceral conditions. One or two participants tended to dominate focus group discussion who reduced the level of meaningful interaction between participants.

Table of Contents

1. Introduction

The practice of chiropractic has a rich social and therapeutic history (WARDWELL 1992; KEATING, GREEN & JOHNSON 1995). Relief of pain emanating from nerve interference and subluxation or partial vertebral dislocation is a central tenet of chiropractic philosophy. As chiropractic became a licensed profession by state boards in the United States, the scope of practice began to shift from holistic to specific neuromusculoskeletal therapeutics with a primary emphasis on back pain. According to the *2000 Job Analysis of Chiropractic*, pain in the head, neck, back, and extremities constituted 88% of all chief complaints of chiropractic patients (CHRISTENSEN, KERKOFF & KOLLASCH 2000). Chiropractors in this survey reported that they sometimes saw patients with respiratory conditions (such as viral infections, asthma, emphysema, and chronic obstructive pulmonary disease), hypertension, diabetes and obesity, and menstrual disorders. Moreover, while the subluxated joint etiology held the dominant view for neuromusculoskeletal conditions, chiropractors were divided evenly on its contribution in visceral conditions. Further, chiropractors were rarely responsible for the sole management of patients with visceral complaints. [1]

Current chiropractic teaching and practice emphasizes adjustments of vertebral subluxations. However, many chiropractors that practiced before state licensure learned to provide care for a variety of patient complaints not limited to neck and back pain. Moreover, these practitioners rendered chiropractic care to patients with visceral presentations because of their belief that referred or reflex visceral pain originated in the spine. Chiropractic's understanding of the application of these techniques may be lost to future generations of practitioners, patients, and society without an examination of the practices of experienced chiropractors who treated patients with visceral conditions and complaints. [2]

The purpose of this ethnographic study was two-fold: (1) to investigate the nature of chiropractic treatments used by experienced practitioners for visceral conditions; and (2) to compare and contrast two methods of data collection—focus group and individual interview methodologies. Researchers included two chiropractic educators (RR and DD), a sociologist (JKL), and an anthropologist (RHP). [3]

2. Ethnographic Study in Chiropractic—Why It Applies

KLEYNHANS (1998) called for chiropractic to embrace both quantitative and qualitative research paradigms, and stated that qualitative methods:

1. are the only means to study many questions, problems or issues relating to the humanistic aspects of chiropractic practice;
2. are applicable to investigate problems or questions relating to doctor-patient interaction, and patient and doctor experience in the healing environment using phenomenology, hermeneutics, and ethnography, among others;

3. combined with quantitative research, are necessary to improve chiropractic care; and
4. have a special role in addressing philosophical issues in chiropractic care relating to its vitalistic and metaphysical roots.

He further stated that chiropractic has a unique symbolism that derived from chiropractic concepts such as subluxation, innate and universal intelligence, adjustment, and toggle recoil. He further stated that chiropractic has a unique symbolism that derived from chiropractic concepts such as subluxation, innate and universal intelligence, adjustment, and toggle recoil. These terms base a philosophy of healing on misalignments of spinal vertebrae (subluxations) that can be corrected by adjusting vertebral positions. Innate and universal intelligence refers to the body's natural capacity to correct these subluxations or maintain a natural position after receiving chiropractic adjustments such as toggle recoil. Toggle recoil (also called HIO or hole-in-one) is a cervical vertebral adjustment created by B.J. PALMER, son of chiropractic founder D.D. PALMER. However, there are many other chiropractic techniques that use the concept of spinal misalignment for their therapeutic approach. The importance in this context is that all chiropractic approaches use a similar belief system to explain what they are attempting to remedy with their treatment. [4]

Qualitative research is a broad category of naturalistic scientific inquiry that, among its many methods, includes three primary data sources: (1) in-depth, open-ended interviews; (2) direct observation; and (3) written documents (PATTON 1990). The disciplines of medical sociology and anthropology have a history of ethnographic and qualitative research focusing on studies of: (1) disability, chronic illness, and terminal illness; (2) caring and curing; (3) ageing; (4) socialization into health care professions; and (5) the ethnography of ethics (CHARMAZ & OLESON 1997). Moreover, qualitative methods in health services research have emerged as an important means for understanding context and complexity in clinical health practice, including chiropractic (SHORTELL 1999). [5]

The patient-centered approach calls for an understanding of the whole person and his or her own unique experience of feeling unwell. Together, these concepts constitute the context of the patient's experience. McWILLIAM (1995) noted that the parallels between the patient-centered method and qualitative inquiry invite the application of this type of research to investigating patient-centered care practices. A patient-centered method is a process of acquiring understanding of a fellow human being. Patient-centered care focuses on the patient's illness and on the patient as a whole person. In humanistic inquiry, the researcher and the research participant together strive to capture the needs, motives, and expectations of the participant and together strive to capture the interpretation of their experience. The patient-centered processes of finding common ground and building a relationship also have similarities to the process of humanistic inquiry. In humanistic research, methodologies and clinical practice of the patient-centered method, interpretive or hermeneutic analysis is a central component of

achieving the desired outcome, be it good research or good care (GOOD, HERRERA, DELVECCIO-GOOD & COOPER 1985). [6]

Phenomenologists strive to articulate a coherent, cohesive description of existence, or of being "in the world" (SWANSON-KAUFFMAN & SCHONWALD 1988). Understanding the research participant's personal experience necessitates active and extensive exploration of the participant's background, situation, and ongoing experiences. These experiences are interpreted in the context of time and space, with due consideration of historical, social, and physical dimensions of life. Meaning emerges out of the interactions between the individual and his or her world. The entire context and the individual's experience of it are considered together as creating the experience as a whole (HAMMOND, HOVRATH & KEAT 1991). [7]

Ethnography deepens the study of human suffering by reframing the experience of illness as interpersonal processes in a moral context. From the anthropological perspective, ethnographic methodology means describing a particular social context and interpreting its places, people, and other meaningful things. Medical anthropologist Arthur KLEINMAN (1992, p.127) said:

> "Although this may seem obvious and sensible to many, it is important to recognize that it [ethnography] goes against the grain of more standard forms of clinical research. It is not the traditional orientation of clinical care. In one sense, ethnography even involves a medical shift in the way that clinicians see (or socially construct) the object of medical work. Whereas physicians, nurses, and social workers center their enquiring gaze on the individual and his or her pathology, the ethnographer first describes the local world, and then, even if he or she is interested in particular persons, gives primacy not to the subjective reality of a single individual but to the social reality of a particular group. In health and illness, human development is shared emergence and patterned change within local worlds in which experience flows between, within, and around us." [8]

Anthropologists have come to term "etic" as those descriptions that use categories from outside the cultures studied and "emic" as those accounts based on concepts that come from within the culture that would be used or recognized by its members. Thick descriptions, a term coined by Clifford GEERTZ in anthropology, provide in close detail the context and meanings of events and scenes that are relevant to those involved with them. Thick description is intensive, small-scale, dense description of social life, through which broader interpretations and generalizations may be made. Ethnographic thick description proceeds on the assumption that context is not an obstacle to understanding but a resource for it (1983). [9]

Back and forth between collective and subjective understandings, the clinically oriented ethnographer describes the flow of interpersonal experience concerning the cause, longitudinal course, and consequences of core issues. These issues include practitioner's and patient's perceptions of the pathophysiology, its etiology and desired treatment, its prognosis, and what is most feared about the disease,

its course, and the treatment (KLIENMAN 1980; 1988). The result will be a view from up close in the words of the participants that captures the micro context of experience. This view is further contextualized by a view from afar that relates this highly focused perspective to the larger-scale political, socioeconomic, and cultural forces that impinge on the local world. The research focus rests almost exclusively on discovering the reality of patient's experience of unwellness (GOULD, WALKER, CRANE, & LIDZ 1974). [10]

Health oriented ethnographies have the initial advantage of being highly focused. They are mini-ethnographies in the sense that they are examining only a relatively narrow band in the cultural spectrum of local worlds. This is their potential weakness as well. Too narrow a focus could lead to a limited analytical framework that undercuts the purpose of ethnography: contextual analysis. [11]

An edict of qualitative research is "to collect data until saturation occurs." Saturation is defined as "data adequacy" and operationalized as collecting data until no new information is obtained. In qualitative research, there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation equivalent to those formulas used in quantitative research. Rather, in qualitative research, the signals of saturation are determined by investigator proclamation and by evaluating the adequacy and the comprehensiveness of the results (GUBRIUM 1995). [12]

Qualitative data, although initially appearing diverse and disconnected, in the process of saturation, form patterns or themes and begin to make sense. There are no specific guidelines for the a priori estimation of the amount of data required in each category or theme to create these patterns. Nor are there rules that guide the process of analysis regarding saturation, except that initially no data are discarded or ignored. In the initial stages of analysis, an investigator must give all data equal consideration in the analytical coding procedures. Frequency of occurrence of any specific incident must be ignored. The fact that participants may report some things repeatedly and report other aspects of the phenomenon less frequently is, at this stage of the analysis, inconsequential. It is more important for the researcher to "know it all" than to hear things over and over, forcing a false sense of saturation. However, when the domain has been fully sampled—when all of the data have been collected—then replication of data occurs, and with this replication, the signal of saturation. [13]

Qualitative ethnographic research methodology is particularly suited to a study of holistic health practitioners such as experienced chiropractors. Commentators outside of chiropractic have reported on the unique methods in which chiropractors develop a therapeutic relationship with their patients (KAPTCHUK & EISENBERG 1998). Moreover, BOLTON (2000) suggested that this type of relationship contains four elements of trustworthiness: (1) a qualified and sincere healer; (2) possesses knowledge and techniques; (3) powerful in their truth content; and empowered to make beneficial changes in the patient. [14]

3. Methods

Potential participants were identified (by RR and DD) from a list of chiropractors with active licenses in 2001 obtained from the Texas Board of Chiropractic. DD contacted potential participants by telephone using a uniform recruitment appeal. [15]

Upon arrival, all participants gave written informed consent after receiving oral and written explanation of the study, including releases for audio and videotaping. Each was offered the opportunity to ask questions of the researchers. Based on methodology described by KRUEGER (1988) and MORGAN (1997), we (RR, DD, JKL, and RHP) conducted a focus group consisting of six experienced chiropractors from the Dallas-Fort Worth, Texas area at the Research Institute of Parker College of Chiropractic in June 2001. In the focus group setting, an adjusting table was placed in front of the participants to serve as an environmental cue to stimulate the doctor's memories and conversation. JKL and RHP conducted individual interviews in the offices or homes of six experienced chiropractors during the week of July 15, 2001. One participant was included in both focus group and individual interview settings because the spouse, also a chiropractor, was an individual interview participant. Both focus group and individual interviews employed a semi-structured interview format (Table 1).

• Were you taught any special technique(s) that are not in common use today?
• Were any of these used with visceral conditions?
• Did you develop any special technique(s)?
• Please tell us about these or demonstrate them.
• Most unusual practice experiences?
• Most unusual patients?
• What was their formula for maintenance care? (if applicable)
• Most important type of research they would like to see in the future?
• What are the most dramatic changes in chiropractic today versus your early years of practice (going to jail, hospitals, etc.)?
• Treatments used in practice (esp. early years) magnetic healing, physical therapy, etc.)? Practices later banned by Food and Drug Administration etc?
• Practice management groups or consultants used and their value?
• What important question(s) we did not ask that they feel is important that helps portray the uniqueness of the early years of chiropractic?

Table 1: Semi-structured interview format areas [16]

A person knowledgeable in chiropractic terminology transcribed all audiotapes and viewed the videotape simultaneously. JKL reviewed and entered the primary documents into Atlas.ti, a qualitative data analysis software package (MUHR

2001). Primary documents from the focus group and individual interviews were coded using the same code list (JKL) generated during repeated reading of the primary documents using the microanalysis methods described by STRAUSS and CORBIN (1998). RHP entered the coded documents into the semantic network function of the program to visualize the relationships between codes. [17]

The "big picture" network is a synopsis of shared codes for all five themes. It shows the codes that occur in conversational proximity. Themes and codes are linked to form the network. Codes already linked to each other from a prior analysis are incorporated in the network. The main themes are CAPITALIZED. Codes are in small case letters. Lines between codes indicate linkages found from quotations within each code. [18]

4. Results

Five general themes were discovered in the analyses of focus group and individual interviews with experienced chiropractors. These themes are (1) confidence as a healer; (2) history and philosophy; (3) independence; (4) patient/ chiropractor relationship; and (5) therapeutics. The theme, "CONFIDENCE AS HEALER", is the most tightly linked theme in both individual and focus group settings. We have given an assumed name to the doctors in order to disguise their identities. [19]

4.1 Focus group

Figure 1 shows the "big picture" for the focus group setting from the Atlas.ti program generated network function. Table 2 summarizes the linkages. Chiropractors discussed visceral conditions when they were talking about "specific problems", "unusual treatments", and "miracle patients." Several representative quotations from the focus group highlight the origins and treatment approaches to visceral complaints.

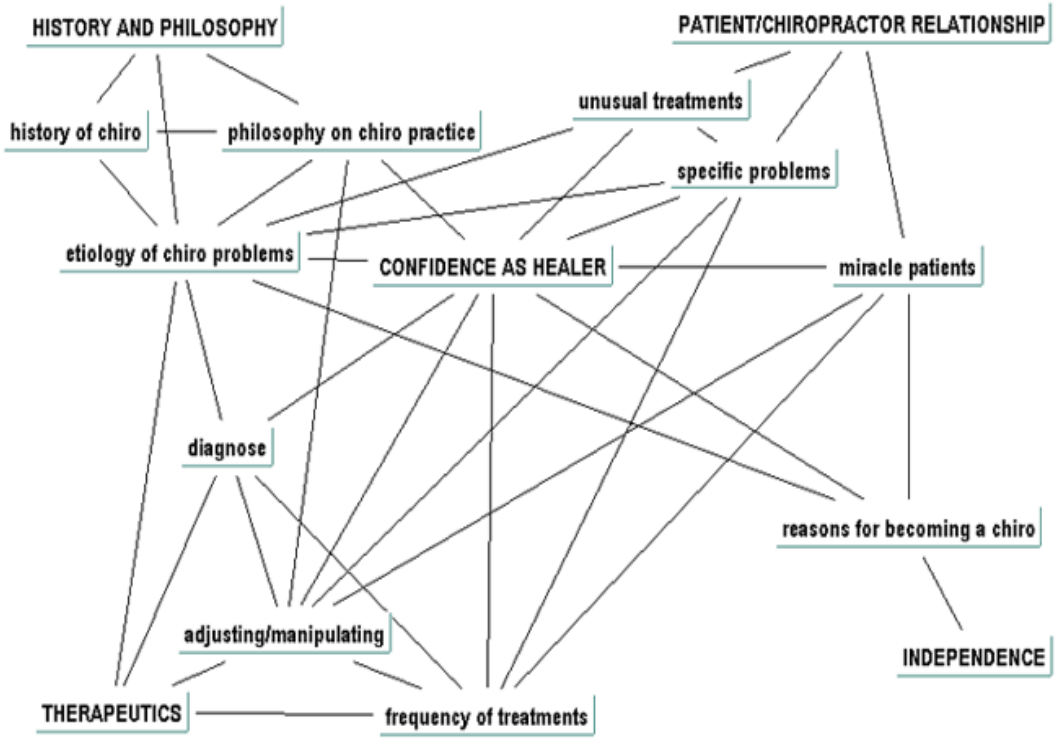

Figure 1: The "Big Picture" Network

Themes	**Shared Codes**			
And “HISTORY AND PHILOSOPHY”	History of chiro	Etiology of chiro problems	Philosophy on chiro practice	
And “INDEPENDENCE”	Reasons for becoming chiro			
And “THERAPEUTICS”	Adjusting/ manipulating	Frequency of treatments	Diagnose	Etiology of chiro problems
And “PATIENT/CHIROPRACTOR RELATIONSHIP”	Specific problems	Miracle patients	Unusual treatments	

Table 2—Thematic Linkages to "CONFIDENCE AS HEALER" [20]

4.1.1 Spinal-visceral reflex theory

Several chiropractors discussed the significance of this theory in relation to the understanding of and explanation of visceral complaints. Practitioners emphasized the interconnectedness of healer and patient in the process of care through adjustments involving the vagus nerve. They described these adjustments as almost panaceas or remedying whatever ailed the patient.

> *Dr. Smith*: It's hard to separate chiropractic into individual diseases for the simple reason that they all come back to spine, and we treat the spine, it's a cure-all for all things ... it doesn't matter what nomenclature you put on the disease, it goes back to the spine.
>
> *Dr. Marks*: I think anything you do that will beneficially affect the vagus nerve, regardless of what spinal level you get to it, or whether you go in the front. The branches, you've got the spinal with the vagus coming out of the head. They're innervations of the visceral, upper visceral. I think that anything ... there again, it's about the patient and your fingers ... but the influence is probably the vagus nerve. [21]

4.1.2 Gastrointestinal complaints

According to participants, gastrointestinal complaints may originate in either the organ or spine. The patient may experience pain in the spine as a result of organ dysfunction as well as pain in the area of the organ related to spinal subluxation affecting its innervation. For example, complaints distant from an origin or source of subluxation, like headaches resulting from visceral affectation in the abdomen, are common explanations for relating treatments to remediation.

> *Dr. Marks*: All matter of pancreas, spleen, stomach, duodenum, lungs and heart, those are the reflex pain that everybody says, Oh, I hurt in there so bad. When people come in with a crick in their neck ... associate the spinal-visceral reflex pain patterns. Mayo did this forty years ago and put out a nice little book called Pain Patterns. That has been rocked out of our teachings like palpation.
>
> *Dr. Smith*: The textbooks say the temporal reflex is under the right shoulder blade. That would be your rhomboid muscles, the upper thoracic area. It doesn't stop there. If it gets bad enough, it comes up and follows this. (points to the area) And you would be amazed at how many people who come to you with headaches, if you know stomach reflexes and hiatal hernia reflexes, you can check this side of the neck and just go right down here. (again, points to the area) The pain runs down into their arm and the side of the head, but it's mostly reflexes from hiatal hernia, duodenal ulcers, too much acid ...The hiatal hernias and things will show up in there. I just base my practice, after 45 years, I've started talking stomach problems, gallbladder problems, sometimes maybe a lung problem with smokers. You get to be amazed with everybody who comes to you with neck and shoulder problems that's coming with visceral reflexes. Most of them would show up in the thoracic spine too. [22]

4.1.3 Dysmenorrheal complaints

> *Dr. Craig*: Dysmenorrhea can really be helped with chiropractic. The thing that causes the cramping is the iliopsoas muscle. It's nearly always rotated, and if you direct your attention to that second lumbar and third, and you work on the psoas muscle. Especially as a young student learning to palpate, you've got to get the patient in position that will make the leg way up here and you've got to go down to the crest of the ileum, deep down in there. You've got to raise their leg so you can feel the psoas contracting and expanding. Women with dysmenorrhea, the minute you touch that psoas they'll scream. You have to work on that muscle and that second

> lumbar vertebrae, their periods just straighten right out ...Your treatment has to be so cautious the first three or four times you work on them. I don't know what makes it so inflamed, but it really does affect it. I think every chiropractor routinely working on the second lumbar vertebrae will get good results, you know ... Just a simple adjustment to that, it's always rotated.

Visceral pain that manifested in the pancreas, spleen, gall bladder, stomach, duodenum, lungs and heart, as well as menstrual irregularities, was conceived as resulting from subluxations at the spinal level where the innervation originated. In addition, stomach reflexes could manifest as neck and shoulder problems. Knowledge of these spinal-visceral reflex pain patterns and application of the art of palpation were essential for the practitioner to understand and treat visceral problems. In describing their treatment approaches, these experienced chiropractors demonstrated adjustment techniques they used. [23]

4.2 Individual interviews

Figure 2 shows the summary network or "Big Picture" for individual interviews. As in the focus group, chiropractors participating in individual interviews voiced similar origins and approaches to visceral complaints. However, the individual interviews conducted in the treatment setting stimulated more conversational depth about visceral problems and treatments. Moreover, in this setting, chiropractors remembered and described treatments in connection to their therapeutic relationship with specific patients.

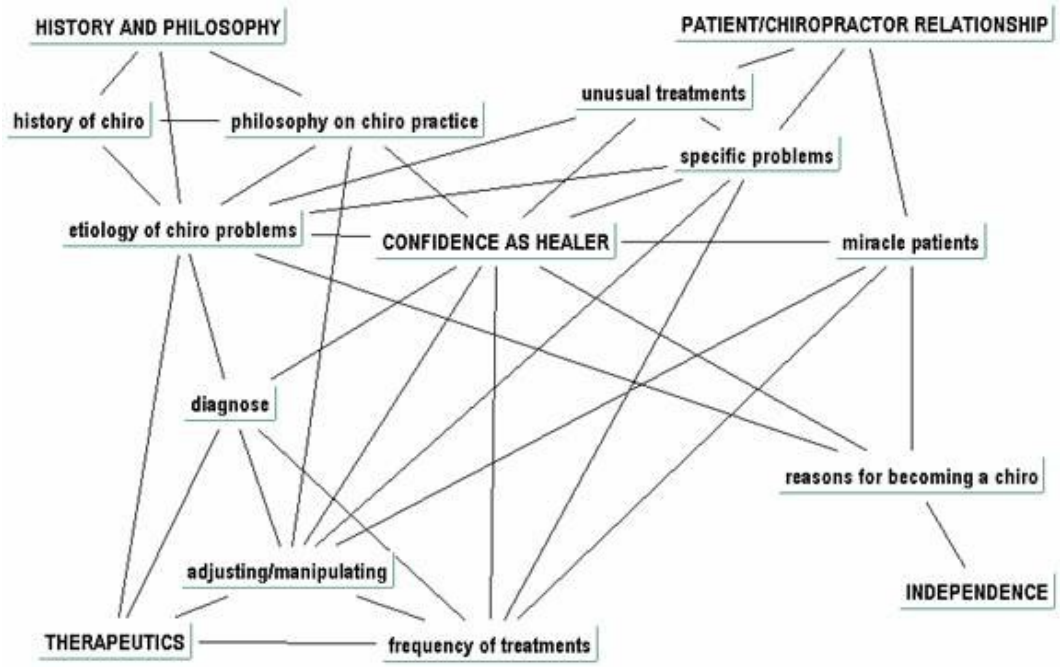

Figure 2: "Big picture" for individual interviews [24]

4.2.1 Abdominal complaints

Doctors attributed many gastro-intestinal and reproductive complaints to nerve energy flow problems or "nerve supply problems" to the viscera. To them, regardless of source, the healer searched for interconnectedness between two possible symptom manifestations, stimulate the anatomical innervations they share, and relieve the patient's suffering.

> *Dr. Jones*: The viscera have to be nourished with nerve energy just like it has to be nourished with food. Any part of the viscera. You go back to the spine and stimulate nerve energy, and that takes care of all parts of the anatomy. It's very simple in our profession, but most people make something hard out of it. Let's just say you have a bad case of indigestion. Hydrochloric acid, pepsin and renin feed the stomach, the digestive juices. Say the nerve supply is not flowing to the stomach properly. Do you give them something to correct the digestion, or do you just go in there, correct the nerve supply and let the stomach produce its own enzymes?
>
> *Dr. Brooks*: Ulcer, whether it's gastric or duodenal...I found that the gastric ulcers give people more problems. Both are bad, but the gastric stomach ulcers seem to be more involved and hard on people, where you can get the perforation. When you get a perforated ulcer, it goes into the pelvis and the abdominal cavity. Many times you have to have surgery. You have to know where to draw the line. For example, and this is another visceral problem, but shingles. Herpes zoster is the technical name—herpes simplex is the cold sore. With herpes zoster, we sometimes do a remarkable job on that. I think the most severe and toughest one to handle with the herpes zoster was with the facial nerve. Extremely painful. But visceral problems, yes, colitis. You have to use your sense and tell people about their diet. It's extremely important. [25]

Many doctors treated adult and child patients with respiratory problems with great success and derived personal and professional gratification. They described these encounters as if the patients were in their offices in front of them at the interview, motioning their hands and, in some cases, their arms and whole bodies, to demonstrate palpating and adjusting techniques. In addition, they also knew their limitations, and expressed a "team approach" to difficult cases, especially referring patients to doctors of osteopathy (DOs) in those requiring injections of medications.

> *Dr. Porter*: A mother walked in, and she said, "I need to talk to you before you work on him." He was a youngster about six. I said, "All right." She said, "He reads, and he'll know everything you say." I said, "All right." I had a big chart above my desk on muscles. He walked in the room and the first thing he said was, "What's that muscle chart?" You had to be real careful with him because he could read as fast as you could. (RHP) What were you seeing him for? (Dr. Porter) Asthma.
>
> *Dr. Brooks*: The youngest patient I ever had was three weeks old, born with asthma symptoms. We got marvelous results. I got a home run. (JKL) How did you treat the baby? (Dr. Brooks) Spinal, adjust the vertebrae. But you never twist a baby's neck. It's always a superior adjustment, and then you don't hurt it. They cry, but you're not doing any harm. If you take a baby and pinch it, it's going to cry. Of course, visceral

problems, sometimes we'd get colicky babies. It's probably best to put them in that category. Colitis, indigestion problems. Chiropractic can cover a multitude of problems, it really can. You'd be surprised at the tremendous amount of result you can get. You have to get results or you wouldn't get any business. It's very rewarding, when you think that you can take your hands and analyze the patient, palpate the spine and analyze the visceral reflexes, the motor points, it's amazing what you can accomplish with that. Without any drugs, surgery, you use God's given hands.

Dr. Jones: (RHP) You mentioned asthma. For those kinds of situations, you again do the same kind of process. Do you use reflexology for that? (Dr. Jones) You use everything you can on that one, but there are definitely subluxated vertebrae involved. Let me cite a case about asthma, this is a very interesting case. Same neighborhood these people lived in, a husband and wife, and he worked for the city. His wife had asthma so bad, that these people who had the little girl had recommended this couple to me. He brought her over, he had taken her everywhere. She was about 28 years old. When she had an attack of asthma, I mean, she couldn't breathe, she had to get shots. There are times that doctors have to work together to save people's lives. I mean, we're interested in saving people's lives and keeping people healthy, I don't care what your philosophy is. As long as you're doing what you're supposed to do and you know what you're doing, it's all right with me. But there is a need for surgery, there's a need for all kinds of doctors. This lady had asthma so bad, a few times in my office I'd have to call a buddy of mine to come give her a shot, a DO who would give her a shot to relieve her and relax her to where she could breathe. She'd been going to the doctor, the medical doctor, and I don't recall his name. She'd been going to him for years, and she'd gotten progressively worse. They were becoming desperate to seek some other avenue of relief. Consequently, I happened to be recommended. I treated this lady for about a year and a half. This doctor said, if he corrects your asthma, I'll pay your whole bill and you don't need to worry about. That woman, we corrected her asthma, and I will tell you...I followed her for five years after, and she never had asthma again. [26]

Several practitioners mentioned the MERIC system as another theory for practice and healing in the approach to visceral treatment.

Dr. Kahn: Back when I was first in practice, I don't really know how I found out that gallbladder conditions could be helped. I had some very interesting experiences. I didn't do it very much, but I found that by making a contact up under the rib cage, if there was quite a bit of tenderness high up under the rib cage, it would be a matter of giving an adjustment in the upper back. Maybe you've never heard of what is called the Meric system? Dr. Meric developed this—actually, I have a book that just says, as you go down the spine, here is the heart place, the liver place, the kidney place, the gallbladder place. In other words, that particular area, the nerves go to that particular part of the body. Anyway, in a few cases, I had some real good luck with improving a person's gallbladder problem. (JKL) So you would treat the spine, and then also the front, under the ribs? Is it like a pressure point under the ribs? (Dr. Kahn) Yes, a pressure point deep and high up under the rib cage, almost making contact with the arc of the gallbladder itself. Just a little deep pressure on that area. [27]

Doctors also treated infants and children for various visceral conditions. They remembered many of these cases in the context of "miracle patients," and showed great expressions of emotion to us when describing the treatments for children. In these cases, patients and their families achieved results with chiropractic after unsuccessful treatments by other types of practitioners. The experienced chiropractor often treated whole families, separately and at the same visit, if that would remedy the situation.

> *Dr. Michels*: When a baby is born, they turn that head so far, to pull the first shoulder out, and then they turn the head back around to pull the second shoulder out, it's a wonder they don't break their necks. Then they get them out and everything is just fine, they've got ten toes and ten fingers, they're fine. Then we start changing the diapers, pulling their feet up and putting all the pressure on the neck and head, increasing that pressure every time we change a diaper. You know about SIDS ...We [chiropractors] were instrumental in that, because we knew that when the babies are sleeping on their stomachs, their heads have to be turned one way or the other to get air. That's pitiful. I had a little girl who was 17 months old when they brought her in here. The doctor that delivered her lost his grip on her and threw her against a wall trying to deliver her ... Her dad came in to talk to my dad [a chiropractor] about it, and left the baby in the car with her mother. My dad said, "I want to tell you something. Anytime they leave the patient in the car when they come to talk to you, it's always twice as bad as they claim." And it was. This baby had never made a sound. She opened her eyes, her bowels moved, her kidneys worked, and she could suck, and that was all. My dad told him, you know, after 17 months, we don't know how much damage has been done. He was a car dealer, and he said, "Doc, I don't want to leave this girl without knowing I've done everything I can. It's no problem to examine her, she'll stay right where you put her." We found that her neck was nearly broken. She was tough, or she'd have never lived that long. She had been examined by experts, and I never will forget. My dad went in to adjust her, and his hands were large. He adjusted her with his chiropractic index finger [middle finger]... she cried for the first time. I get emotional, damn it, every time I tell that story ... She's 48 years old now. Her dad is dead. She lives with her mother, and she's a loving, useful human being. The only thing, her voice is a little deep and she walks with her knees bent. That's all. And we had the right to say, No, we won't treat her, she's too bad. I could cite case after case after case like that. The nerves to their respiratory system have pressure on them.
>
> *Dr. Jones*: Another case that I'm ... I could cite a thousand like this, but another case was...I lived not too far from here, and my next-door neighbor was a captain with a major airline. We all became real close, and come to find out that his next-door neighbor had two children with muscular dystrophy, in bad shape, really bad. They were like nine and ten, and they were in wheelchairs. Pretty sad, pretty sad. Anyway, the mother, they were from a very poor family background. They'd had them everywhere that money could take these children to try and seek help, to no avail. The etiology of muscular dystrophy is unknown. Anyway, I volunteered my services. I said, let me try to adjust them. I'm not sitting here to tell you we corrected their muscular dystrophy, because we didn't. But the daughter had asthma, and when I adjusted her it released just like that. You'd think with her nervous system the way it

was, it wouldn't be that easy. She couldn't breathe, and the mother called me at all hours of the night sometimes. I felt like a punching board at times, because I had to go get them and relieve them. They didn't have much to fight with to start. I'd go adjust her and block her—here again we're talking about inhibitor pressure reflex—it would straighten her right out. But then, they had a baby, another child. I'd come in a lot of times, this dad was so proud of this little boy, when he was about a year old, he'd always have him in a room massaging his back. I'd get home from the office maybe at, well, whatever, still daylight, and I'd look in there, he'd be in there massaging that kid. This captain of this airline thought I walked on water with some of the results we'd gotten. I was watching this dad, he was a dedicated dad, he really was, really hammering on this little kid, really massaging him. One day I told the airline captain, tell Dave, the dad, that I'll be glad to adjust that child for nothing if he'll do one thing, to try and keep him from getting muscular dystrophy. I know that's what he was doing, because the other two had it. He wanted a son that was healthy. I started, and they came over in five minutes. I started adjusting this child, and for about three years I adjusted him, just like the other patient I'm talking about. Same theory, they had to take the nutrition I recommended or I wouldn't do it. He never developed it. We don't know whether it was what I did or not. Why should it? He had the same blood, same genes as the previous two. But I think chiropractic built his immune system up before he even developed it. We still don't know what the etiology that causes muscular dystrophy is. Something happened. It has to be in the genes some way or another, the nervous system not letting something function right. That was very rewarding. That kid grew up and he hung around me like we were good buddies. The two that had muscular dystrophy, they lived to be 50 years of age, both of them. They were in a wheelchair early in life. I adjusted them forever. The one sad part of the story about this family ... I may be talking too much. Am I? (JKL) No, this is wonderful. (Dr. Jones) Anyway, I'd gone to New York, my son lived in New York. I hadn't heard from this family, they'd sold and moved from Dallas to Henrietta or some part of Oklahoma. The day before I came back from New York, Anita, the daughter who had muscular dystrophy, they wheeled her into my office. She'd always come by and tell me goodbye. She knew she was about to die. She came by ... I miss her, it just killed me. She died two weeks after that. That's a sad story, but I guess she knew that she'd gone it long enough. She didn't have anything left. I could just go on and on and on. It's so rewarding. [28]

Patients with diabetes were given whole spine adjustments over long periods of time in order to effect a positive result.

Dr. Jones: (RHP) People with diabetes. Any stories about people with diabetes? (Dr. Jones) This is another story, and this is a true story, and I'm surprised that I can relay it to you. My mother had diabetes so bad she nearly died before I got out of chiropractic school. She had to have the shots all the time, insulin shots. You know, it's a control situation, controlling the insulin. There's a part in the pancreas called the Islets of Langerhorn that produces insulin. My mother, when she had one of these attacks and would pass out, her breath would be as cold, just like ice. I came home, I'd just graduated from chiropractic school, and she had one of the worst attacks. It was horrible. I thought she was going to die. I decided I was going to do what I could to get her over this. I finally, totally corrected her diabetes. Totally. We had four

> doctors that treated her, and after, she never had diabetes after that. I put her on a lot of nutrition, and I adjusted her constantly. But she totally got over it, never had any more attacks. Even the blood work was normal. We're talking about a matter of four or five years, we're not talking about two months. It took a long period of time. But if you have diabetes long enough, a lot of other bad things can happen to you, so you've got to be very careful. You don't heal fast; there are a lot of things that are the downside of diabetes. (RHP) So in her particular case, you adjusted her frequently. By that you mean ... (Dr. Jones) Constantly. I mean, at least three times a week. We watched her diet, constantly checked her urine, and constantly did everything that we were supposed to do. I fed her a lot of strong nutrients. She totally got over it, but we're talking about years later. We're not talking about six months afterward; we're talking about years later. (JKL) You would adjust her whole spine, then? (Dr. Jones) Whole spine. I didn't want to leave anything undone. [29]

Liver problems were not common to the chiropractor's patient population; however, several cases were mentioned as connected to other body systems like the lungs.

> *Dr. Jones*: There are so many great experiences I've had. I'll tell you about one other case I had. It was probably, I knew this couple and had known them for a long time ... He was a paint contractor. Wonderful couple. She had developed some problem; to this day I'm not sure exactly what she had. Liver trouble and everything. One day I walked in the front, and he had her in his arms bringing her in the office. He said, I've taken her everywhere and nobody can help her. I'm going to come to you. Can you help her? I said, I don't know, but let's see what we can do. I started adjusting her. A year and a half later ... we kept her alive, fortunately, and at the end of about eighteen months she started feeling good. She got all right. We never did know, she had liver trouble, she had lung problems, she was almost like a skeleton. We finally got the nervous system regenerated to the point where her body took over. She lived a long time after that. I never will forget when he walked into my office. He was kind of a frail guy himself, and he had her in his arms, carrying her just like you'd carry a sack of flour or something. He said, "You've got to help me." That was also very rewarding. [30]

Dysmenorrhea results from a lack of both menstrual and nerve energy flow, according to the experienced practitioners.

> *Dr. Jones*: (JKL) So if a woman came to you with menstrual pain, what chiropractic procedure would you use to treat her? (Dr. Jones) If a lady has menstrual problems, usually it's contracture of the uterus, which affects the menstrual flow. That means a lack of nerve energy into that part of the anatomy. We reflex it by pressing on the abdomen, with pressure points to release and relax the muscles and the tissue around the uterus. We also manipulate the spine in the area that controls the uterus to release pressure. It works beautifully. In fact, I had two yesterday, and they both had tremendous relief. [31]

4.3 Comparison of focus group and individual interview methods

Although the same fifteen codes were used for both individual and focus group networks, linkages within "big picture" networks are different. For example, in the individual interview network, "adjusting/manipulating" is linked to "reasons for becoming a chiropractor" and "miracle patients." In the focus group network, "adjusting/manipulating" is linked to "miracle patients", and to "specific problems," "philosophy on chiropractic practice", "diagnose", and "frequency of treatments". It is not linked to "reasons for becoming a chiropractor." [32]

Reasons for differences in these linkages may be due to interactions between researchers and participants in the focus group and in the individual interviews. The researchers guided individual interviews to a greater degree and developed a rapport with each participant. In the focus group, participants were more comfortable talking in general terms than about their own unique application and individual perspective. We cannot ignore the fact that, even though their professional belief system is similar, they each have unique experiences in their personal and professional lives that may give them very different perspectives from others in their cohort. The focus group participants may not have felt comfortable expressing their own perspective in a group setting without first knowing the others' perspective. [33]

In another example, "miracle patients" has greater linkage in individual interviews than in the focus group. These differences in linkage may be due to the more personal nature of the individual interview as well as the environment. Individual interviews were conducted at the participant's choice of location. The focus group was conducted at the research institute of the chiropractic college. These participants may have taken on the "educator" role because of the college environment. [34]

5. Discussion

The experiences of these seasoned Texas chiropractors describe a "practice world" in which a confident healer: (1) listened to, palpated, and educated patients; (2) adjusted for visceral and neuromusculoskeletal problems; and (3) developed therapeutic relationships by successfully explaining and applying chiropractic principles. As one doctor said: "Take your hands and analyze the patient, palpate the spine and analyze the visceral reflexes, the motor points. It's amazing what you can accomplish with that." Many chiropractors expressed a concern about the education of today's chiropractors. The therapeutic focus of chiropractic has gravitated toward a predominance of mechanical devices over human touch. Although the use of radiography and other diagnostic devices were mentioned, these practitioners derived meaning in their practice from the use of their hands as therapeutic instruments. Observational studies of chiropractors have highlighted the manner in which a doctor-patient relationship develops. Our findings support the general theme that experienced chiropractors are confident healers, that they articulate a philosophical base for practice, and that they relate to patients as whole persons, not as discrete diseases. These experienced

practitioners attributed their success to the bond of trust they formed with patients. [35]

Trust in health care providers is under suspicion today. Many doctors in this study talked about the changes in the practice brought on by third party insurance and governmental agencies. Their concerns about practices of future doctors are affected by the lack of physical palpation in college curricula. In their practice world, these factors would seem to distance the doctor from the patient, and, as a result, diminish trust and healing. [36]

Many of these doctors currently practice, and made time within their busy schedules for our interviews. Those currently in practice seemed to provide a richer depth of information and communication about specific patients. Alternatively, those retired from active practice tended to discuss chiropractic philosophy and history. Nevertheless, their explanations followed a consistent pattern that may have been structured by their patient care process, rather than by the inquiries of the researchers. No matter how we questioned them to elicit specific answers, they always referred back to their manner of relating to patients. [37]

6. Conclusions

The practice world of experienced Texas chiropractors included patients with a variety of visceral complaints, as well as neuromusculoskeletal problems. These doctors reported that visceral complaints typically manifested as pain, and that spinal subluxation and nerve conduction problems were responsible for referred pain in organ dysfunction. Their confidence as healers was a consistent and durable theme. This theme was supported by four other themes: chiropractic history and philosophy; doctor-patient relationship; independence; and therapeutics. Doctors treated patients' visceral presentations with a therapeutic approach similar to neuromusculoskeletal complaints. [38]

Individual interviews generated richer description for the topic of visceral conditions. One or two participants tended to dominate focus group discussion. The focus group method did not produce a significant level of meaningful interaction between participants. Future research should address the application of specific adjustment techniques for visceral conditions where no treatment of choice or effective therapies currently exist (see OTHS 1994). [39]

References

Bolton, John (2000). Trust and the Healing Encounter: An Examination of an Unorthodox Healing Performance. *Theoretical Medicine and Bioethics, 21*(4), 305-19.

Charmaz, Kathy & Oleson, Virginia (1997). Ethnographic Research in Medical Sociology. *Sociological Methods and Research, 23*(4), 452-494.

Christensen, Mark G.; Kerkoff, Darla & Kollasch, Martin W. (2000). *Job Analysis of Chiropractic, 2000: A Project Report, Survey Analysis, and Summary of Chiropractic Practice Within the United States* (pp.77-112). Greeley, Colorado: National Board of Chiropractic Examiners.

Geertz, Clifford R. (1983). Thick Description: Toward an Interpretive Theory of Culture. In Robert M. Emerson (Ed.), *Contemporary Field Research: A Collection of Readings* (pp.37-59). Prospect Heights, Illinois: Waveland Press.

Good, Byron J.; Herrera, Henry; DelVeccio-Good, Mary-Jo & Cooper, James (1985). Reflexivity, Countertransference, and Cultural Ethnography: A Case from a Psychiatric Cultural Consultation Clinic. In Robert Hahn & Atwood Gaines (Eds.), *Physicians of western medicine* (pp.177-192). Dordrecht: Riedel Publishing.

Gould, Leroy C.; Walker, Andrew L.; Crane, Lansing E. & Lidz, Charles W. (1974). *Connections: notes from the heroin world*. New Haven, Connecticut: Yale University Press.

Gubrium, Jay F. (1995). Taking Stock. *Qualitative Health Research, 5*(3), 267-269.

Hammersley, Martyn (1995). *Ethnography: Principles in Practice* (2nd ed.). London: Tavistock.

Hammond, Michael; Howarth, Jane & Keat, Russell (1991). *Understanding Phenomenology*. Oxford: Basil Blackwell.

Kaptchuk, Ted J. & Eisenberg, David M. (1998). Chiropractic: Origins, Controversies, and Contributions. *Archives of Internal Medicine, 158*, 2215-2224.

Keating, Joseph C.; Green, Bart N. & Johnson Claire D. (1995). "Research" and "Science" in the First Half of the Chiropractic Century. *Journal of Manipulative and Physiological Therapeutics, 18*(6), 357-378.

Kleinman, Arthur (1980). *Patients and Healers in the Context of Culture*. Berkeley, California: University of California Press.

Kleinman, Arthur (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kleinman, Arthur (1992). Local Worlds of Suffering: An Interpersonal Focus for Ethnographies of Illness Experience. *Qualitative Health Research, 2*(2), 127-134.

Kleynhans, Andries M. (1998). A Chiropractic Conceptual Framework. Part 2: Beliefs. *Chiropractic Journal of Australia, 28*(4), 135-45.

Krueger, Richard A. (1988). F*ocus Groups: A Practical Guide for Applied Research*. Newbury Park, California: Sage.

McWilliam, Carol L. (1995). Qualitative Approaches that Illuminate Patient-Centered Care. In Moira A. Stewart, Judith B. Brown, W. Wayne Weston, Ian R. McWhitney, Carol L. McWilliam & Thomas R. Freeman (Eds.), *Patient-Centered Medicine: Transforming the Clinical Method* (pp.204-215). Thousand Oaks, California: Sage.

Morgan, David L. (1997). *Focus Groups as Qualitative Research* (2nd ed.). Thousand Oaks, California: Sage.

Muhr, Thomas (2001). Atlas.ti version 4.1. Released August 4, 2000. Scientific Software Development at http://www.atlasti.de/ (last accessed on August 12, 2001 for ptch5159.zip upgrade).

Oths, Kathryn S. (1994). Communication in a Chiropractic Clinic: How a D.C. Treats His Patients. *Cultural Medicine and Psychiatry, 18*(1), 83-113.

Patton, Michael (1990). *Qualitative Evaluation and Research Method*s (2nd ed.). Newbury Park, California: Sage.

Shortell, Stephen M. (1999). The Emergence of Qualitative Methods in Health Services Research. *Health Services Research, 34*(5) Suppl, 1083-1089.

Strauss, Anselm & Corbin, Juliet (1998). *Basics of Qualitative Research* (2nd ed.) (pp.57-121). Thousand Oaks, California: Sage.

Swanson-Kauffman, Kristen M. & Schonwald, Elizabeth (1988). Phenomenology. In Barbara Sarter (Ed.), *Paths to Knowledge: Innovative Research Methods for Nursing* (pp.97-105). New York: National League for Nursing.

Wardwell, William (1992). *Chiropractic: History and Evolution of a New Profession*. St. Louis, Missouri: Mosby.

Authors

Dr. *LANGLOIS* is a qualitative sociologist in her research company, JKL Research Associates, Tampa, Florida. Her research focus includes the care giving experience (with emphasis on male caregivers and medication management) and mental health issues. She frequently consults with academia and the pharmaceutical industry on the application of qualitative methodologies to the understanding of medication use, health care behaviors, and care seeking behaviors.

Contact:

Joan K. Langlois, PhD

JKL Research Associates
8801 Hunter's Lake Drive, Suite 1112
Tampa, FL 33647 USA

E-mail: jklresearch@netscape.net

Dr. *PARRISH* is interested in studying the narrative nature of therapeutic relationships, and recently completed his first book, *Defining drugs*: *How government became the arbiter of pharmaceutical fact* (New Brunswick, New Jersey: Transaction Publishers). He is now a medical anthropologist and assistant professor at the Bernard J. Dunn School of Pharmacy at Shenandoah University, and consulting pharmacotherapist at Selma Medical Associates in Winchester, Virginia.

Contact:

Richard H. Parrish II, PhD

Shenandoah University
Bernard J. Dunn School of Pharmacy
1775 North Sector Court
Winchester, VA 22601 USA

E-mail: rparrish@su.edu

Dr. *RUPERT* is Director of Research for Parker College of Chiropractic in Dallas, Texas. He is responsible for physical and clinical science research at Parker College, and is the originator and developer of MantisTM, a chiropractic literature database.

Contact:

Ronald Rupert, MS, DC

Research Institute
Parker College of Chiropractic
2500 Walnut Hill Lane
Dallas, TX 75229 USA

E-mail: rrupert@parkercc.edu

Dr. *DANIEL* is Associate Director of Research at Parker College of Chiropractic in Dallas, Texas. A licensed Texas chiropractor, Dr Daniel directs clinical and practical research for Parker College.

Contact:

Dwain Daniel, DC

Research Institute
Parker College of Chiropractic
2500 Walnut Hill Lane
Dallas, TX 75229 USA

E-mail: ddaniel@parkercc.edu

Citation

Langlois, Joan K.; Parrish II, Richard H.; Rupert, Ronald & Daniel, Dwain (2004). A Living History—A Qualitative Study of Experienced Chiropractors Treating Visceral Conditions [39 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *5*(3), Art. 17, http://nbn-resolving.de/urn:nbn:de:0114-fqs0403170.