

## *The Mastery of Patient-Centered Practice*

### **Do You Practice CBP™ or “CBP™ in Name Only”?**

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The quality and volume of research published by CBP™ provides for a compelling argument for care beyond the resolution of symptoms. The article by the same name published in the *Journal of Manipulative and Physiologic Therapeutics* in 1998 (Structural Rehabilitation of the Spine and Posture: Rationale for Treatment beyond the Resolution of Symptoms) certainly begged the question to the profession. In the conclusion of this article, the authors state,

*“...manipulation alone cannot restore body postures or improve an altered sagittal spinal curve. Therefore, postural chiropractic adjustments, active exercises and stretches, resting spinal blocking procedures, extension traction and ergonomic education are deemed necessary for maximal spinal rehabilitation.”*

*Chiropractic studies that demonstrate structural improvements are sorely lacking and needed. The use of passive treatment modalities as the sole means of chiropractic intervention for the management of patients suffering with neuromusculoskeletal dysfunction no longer has a place in modern chiropractic practice after the acute phase of healing has passed.”*

Since 1998, CBP™ has published a number of studies demonstrating conclusively the effective use of cervical and lumbar traction methods that improve the structure of the spine towards the normal spinal model. **All of the peer reviewed studies utilized data derived from traction and exercise protocols performed under supervision in the doctor’s or researcher’s office.**

Logical analysis of this valuable information leads one to conclude that in order to achieve same or similar results with patients one must adopt this same published protocol; herein the challenge. Many in our profession are using CBP™ research to justify extended care programs under the umbrella of CBP™ research yet are not practicing CBP™ as taught or as the published research demands. Many doctors are sending their patients home with traction devices (often only addressing the cervical spine) consisting of foam blocks and other contrivances as the patient's sole form of traction! These doctors defend their actions by ascribing the responsibility for traction to the patient. When the time comes for re-x-ray, and the change to the patient's spine is minimal (or in many cases worse than prior to beginning care due to "generic traction application") the doctor lays the blame for the lack of progress at the feet of the patient while at the same time attempting to justify the need for another year of care. This practice is, at best, disingenuous.

I do not dispute that home traction in most forms has a place in patient care protocols. My contention is that it should be adjunctive, not the primary form of traction employed in patient care. Home traction should only be used when the form of home traction actually matches the type of traction demanded by the patient's abnormal structure. All too often, the patient's mirror image configuration is ignored or overlooked in prescribing home traction.

In order to achieve optimal results with patients, in office traction, mirror image exercise and ergonomic education must all be employed. In order to deliver this level of care a doctor must commit to teaching patients appropriately, visit to visit, and in well-structured spinal care classes. The doctor must commit to a well thought out, functional office space, as well as an organizational system to deliver CBP™ care which allows for personal and professional balance as well as overall efficiency.

Each doctor must ask the question; am I practicing CBP™ completely, to the best of my ability, and based soundly in the principles and practices taught and published by CBP™ Seminars?

If you are not practicing optimally, and you have a conscience, your path is clear. Begin to implement appropriate in-office traction, mirror image exercise, and ergonomic intervention as dictated by the CBP™ protocols. Begin to teach patients, day in and day out, functional chiropractic philosophy that is directly relevant to them and their

problem(s). Teach a regular patient class with simple, basic concepts, which serve the needs of the patients without confusion or fear tactics. Use every tool at your disposal to deliver the care the patients deserve. Take a post x-ray after an appropriate period of care, and honestly present the results to the patient. Involve the patient in the decision for future care or maintenance care based upon pre-determined parameters that you have established.

When all the tools in the CBP™ “tool chest” are appropriately applied, the objective results, as well as the patient’s subjective improvement is often, spectacular. I contend the chiropractic principle is alive and well when CBP™ protocols are employed completely. The innate wisdom of the body utilizes the forces imposed or input into it, the musculoskeletal system structurally changes for the better; neurologic function improves and health returns. If you are not currently fully implementing the established CBP™ protocols in your office perhaps you need to re-assess your practice, otherwise, you are left practicing CBP™ ***“in name only.”***