LET'S ALL SPEAK "ENGLISH"

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Can you imagine what a nightmare it would be if ICAK research papers from non-USA doctors were all published in their native languages? No one would understand what anyone else was talking about.

And yet we suffer from exactly this same dilemma within the use of our own English language. We all use different terminology from each other in describing what we do. These various terminologies can only be understood by those initiated in a particular style of practice. Followers of one instructor use one set of terms, those of another instructor have another, and other groups still another terminology.

There are two major problems with this predicament. First, when we speak or write, the diverse terminologies may as well be foreign languages. Few doctors are linguists who are fluent in all AK and para-AK related terms. And second, physiologists, neurologists, anatomists, and other establishment professionals all use terminology which is standardized in global conferences that are held every so often for just such purposes.

Imagine the trouble foreign ICAK members, for whom English is a second or third language, have with our terminology, much less non-ICAK members and those in other professions. If we are to reach the masses of patients who can be benefitted by our unique skills, then we must first reach the doctors who treat these patients. We cannot do this without a common language.

GAMMA 1, GAMMA 2, BUCKLE MY SHOE . . .

In my early days of practice, I was as guilty of promoting proprietary terminology as anyone, so I will use one of my own offenses as an example. In 1985 and 1986, I first presented my findings regarding doctor-started and patient-started muscle testing, calling these "gamma 1" and "gamma 2" type testing, respectively. These terms were based on the supposition that the two different types of gamma motorneurons were involved in the two different types of testing. Who knows if this is, in fact, true?

In 1990, Dr. John Bandy and I realized that we were each doing a different type of test and calling it "gamma 2" testing. In fact, we now had three types of testing. What were we to call the third type of testing? Certainly not "gamma 3" because there is no such thing as a gamma 3 motorneuron. We had painted ourselves into a corner (or at least, I had) by trying to describe a procedure in anatomical terms when there is only speculative evidence that the gamma motorneurons are implicated. It is far better to describe our procedures in descriptive terms such as "doctor started testing" (the old gamma 1), "patient

started testing to maximum" (the old gamma 2), or "patient started submaximal testing" (the new, third method). Equally appropriate terms could be "eccentric testing", "concentric testing to maximum contraction", and "concentric testing submaximal" respectively.
From 1985 to 1990 we have used the terms "gamma 1 and 2" and it was time to change these.

For simplicity's sake, and for continuity's sake, we are trying to call the three types of testing "G-1", G-2", and "G-2 submaximal". Since 1999, we have been calling the three types of testing Type 1 (G-1), Type 2 (G-2), and Type 3 (G-2 submaximal) and these are the peer-reviewed published terms for these different types of testing. (Schmitt, W.H., & Yanuck, S.F. Expanding the neurological examination using functional neurological assessment part II: neurologic basis of applied kinesiology. Intern J Neuroscience, 1999, 97, 77-108.)

In the future, I hope we all can avoid such pitfalls by labelling what we do in descriptive terms. Therapy localization is such a term - it describes where we are going to direct our therapy. We can always use abbreviations for record keeping, such as "TL", but we need to define these abbreviations whenever we write so that people who are not familiar with our language can read our papers.

. . . CATEGORY 3, CATEGORY 4, CLOSE THE DOOR

Our failure to employ standard terminology can hamper our acceptance amongst other professionals within and outside the chiropractic profession. Hence their patients will never get the benefits of our more optimal approach to care. How many chiropractors know what a category 1, 2, or 3 pelvis is, much less those in other professions?

If you are reading an article which describes "solar pathway introduction technique - S.P.I.T." you will have no idea what is being discussed. (Because I just made it up.) But if you see "seasonal affective disorder" followed by its abbreviation "SAD", you may have some idea.

There is a tendency for us to try to be cutesy with our terminology. We shouldn't.

There is a tendency for us to make anatomical assumptions. We shouldn't, unless we can prove them.

There is an elitist tendency for us to make up terms which only we can understand. We shouldn't unless we want to close the door on what we do to only our closest colleagues.

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The international by-laws of the ICAK state that all business of the organization shall be conducted in English. The designation of one language for an international organization is essential for the communication and the growth and development of the group.

So is the development of a uniform terminology which is descriptive in nature and which can be understood by other health professionals who are non-ICAK members, much less by ourselves.