Chiropractic BioPhysics and Gonstead Technique for Spinal Health:
A Special Interview With Dr. Michael Hill

By Dr. Joseph Mercola

JM: Dr. Joseph Mercola
MH: Dr. Michael Hill

JM: Hi, this is Dr. Mercola helping you take control of your health. Today we're going to talk about chiropractic, but not any just type of chiropractic, a specific type that I think you might be particularly interested in.

I want to give you a backstory on this. A good friend of mine, Dr. Peter Martone, who's been a chiropractor for many years, pointed out to me about a year and a half ago now that he thought I had some problems with my cervical spine. He provided such a compelling story that I flew up to Boston to visit him. He took some X-rays. Sure enough, he was right. I had degeneration in my fifth and sixth cervical vertebrae, even though – here's the key point, folks – I had no symptoms, no symptoms at all. My pictures did not look really good.

The type of treatment that addresses that, which we're going to talk about today, is this very specific type of chiropractic care. We'll expand on the details in a bit. But I want to introduce you to Dr. Michael Hill, who is a chiropractic physician. He lives very close to me. I've been getting care for him for the last three months. I'm going to show you some pretty dramatic examples of what it's done. Welcome today and thank you for joining us, Dr. Hill.

MH: Thank you, Doc. I appreciate it. I'm glad to be here.

JM: Yeah. I'm glad to have you. Let me give a little more backstory just to frame it, so that you can start discussing what the differences are, because there are a lot of misconceptions about chiropractic. I'd like to have you help clear some of them up here today. Because there's a whole wide variety of clinicians. I had previously thought that taking an X-ray of the spine – because I'm trained as an osteopathic physician, so adjustments and manipulation are not foreign to me in any way, shape or form. I did them a lot in my practice. But we were never taught, in all our training, the type of therapy that you've been providing me, which is very specific, very precise and measured accurately with an X-ray, so you can guide your specific treatments.

I had always been opposed to X-rays. I don't think they were necessary. But now, I'm convinced that I think it's almost malpractice if you are seeking a long-term care program and you don't have these. The type of care that you're using is called Chiropractic BioPhysics® (CBP) and Gonstead. Why don't you discuss those and maybe the broader range of options that a typical person would find in their local chiropractor?

MH: Okay. One of the first things I always like to address is where the patient is coming from. When asking them, "What is your interpretation or experience with chiropractic?" I hear a variety of different answers. Some of them are very good and some are very far from what chiropractic

truly is. I graduated from Palmer College in Davenport, Iowa. That was "The Fountainhead of Chiropractic."

JM: Let me just stop you there. What really impressed me when you told me that because – unless you live in Florida, you wouldn't know this – Palmer, the one you went to in Davenport, Iowa, which is significantly far from Florida, because you're a home-born Florida resident. You were born here. There is a Palmer associate college that's not too far from where you live. You could have easily commuted there, but you didn't. You chose it. Why don't you expand on the reason why you chose that? Because I was impressed with that decision.

MH: Right. Well, my chiropractor growing up, I've been on chiropractor care since I was 9. Really, it just fell into my heart and hands knowing that with the experience with chiropractic and the benefits that I had received, once I realized what I wanted to do, I went off to college to North Florida. I wanted to kind of migrate north as slowly as possible to make that jump.

My chiropractor was actually a graduate of Palmer Davenport, Iowa. I went to North Florida, got a degree in nutrition and dietetics, and then made that big leap to Davenport, Iowa for four years. That's actually where I met my wife, who is a chiropractic here in the office too. I told her, I said, "You know, if we're going to take this serious, I am moving back home." But you know how that may have worked or not. I did convince her to move to Florida with me. That was in 2004 when we did that. We had these four hurricanes come through. I think we were just close to packing up with the peer pressure we had from her family. She's from Wisconsin. It was just one of those things that –

JM: She's a farm girl.

MH: She is. Born and raised on a farm, 160-acre vegetable farm. But what a humble life, and just an amazing family. When we moved back to Florida, I really wanted to give back to the community that I grew up in. We have, and it's been a blessing. We've got two beautiful kids. To take care of our community is amazing. At the same time, I didn't realize the discrimination that our profession had in fighting and helping to clarify what we really do. I think that's the thing. Education is inoculation for disruption. If we're not willing to be educated, then we just really stay in this disrupted mindset of not understanding what our profession is, but in a whole, how we can all work together as a team in all professions when it comes to your healthcare.

With chiropractic, one of the big components that I like to really help patients to move them from understanding that not in all cases do you have to fill that cabinet up in your bathroom, but help to understand where all health and healing comes from. That's obvious. We can't deny that the nervous system obviously coordinates all function and healing in the body. If we don't know how to take care of it, who's going to do that for you and help you understand the importance behind it? Education is one of our biggest components in our office.

Now, with the technique, chiropractic stands on three legs: the philosophy, science and art. When we take those three legs, and if we take one away, it's obviously easy to tip over. We've got to stay solid on those three components. With the science, understanding CBP and Gonstead technique, it's one of those approaches that really teaches –

JM: Sorry for interrupting, but CBP is Chiropractic BioPhysics®.

MH: That's correct.

JM: Yeah.

MH: Yeah. The training that I had received was actually not through CBP's seminar series, but over seven years with an organization that taught that specific adjusting protocols with CBP.

JM: So this is post-graduate educational course that you took after graduating Davenport?

MH: Yes. Through an association, a chiropractic association.

JM: Okay.

MH: And then Gonstead is a technique that is taught to students throughout the curriculum. You might hear like "The Palmer Package," but typically, there is a package of techniques that every student is taught. It really, I think, falls on the philosophy of the chiropractor. In my situation, my chiropractor was utilizing Gonstead. When I showed up at Palmer and I wanted to learn more about the technique, I realized there was a lot more than just Gonstead out there.

Gonstead and CBP have a lot in similarities, but a lot in differences. When it comes to understanding "structure dictates function," your spine is basically the framework of everything else that works off of that. Then it's important to understand that we need to identify any structural changes that are compromising the way we should function. The intimate relationship between spine and nervous system is just that. It's that intimate, in which if we don't take care of the spine, obviously, the next is going to fall short of expecting 100 percent function in health and healing. That's through proper nerve function supply.

JM: Thank you for sharing that. I've had, obviously as an osteopathic physician, an awareness of these principles. I have many good friends who are chiropractic physicians, yet somehow, the integration or the motivation to apply this on a regular basis wasn't sufficient enough. Even though I didn't have pain, I finally became convinced. I'm so glad I did. One of my biggest regrets is not doing it sooner.

I think maybe if you could reemphasize the structure-function component and how the nervous system is seriously influenced. The assumption is that if you're not having pain, that probably everything's okay. But the reality is, which is certainly true for medical diseases – I don't have the experience you do in treating musculoskeletal disease – but most of the time, you're 80 percent of the way there before you have a symptom.

MH: That's just it. That even research states that you have to lose 40 percent or greater of your health potential before there's a sign or symptom that actually is expressed. When my father had a heart attack, I didn't need to ask him, "Why did you put us here in the middle of the Ocala

National Forest?" Instead, just like any disease, it takes time for that manifestation into a symptom. So it's unfortunate that we are taught to treat and manage a disease as opposed to preventing them. If we prevented it, we actually wouldn't be even having the conversation about it. Being more proactive instead of reactive is the approach that I would rather have my family and I'd rather have patients who can trust in us to help them move in that direction. But yet, we're born into a society where it's treating and managing a disease.

JM: And, of course, one of the primary tools we use on our site is to help people understand how to choose the right foods, so that metabolically, they'll maintain their health, which of course integrates very tightly to the structural function. I'm wondering if you could expand, because we don't really talk a lot about the structure-function relationship, but it's clearly there.

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If your spine is out of alignment – Maybe you can give us an estimate from your experience with the percentage of the population that you see. I'm sure it represents a pretty common thread for most other populations. I don't know how many people are out of alignment. What are the consequences of that that you see and some of the things that you can prevent?

MH: Sure. Palmer just did a Gallup poll. Basically, the last report that I had read had shown anywhere from 8 to 12 percent of the population utilizes chiropractic. Whereas if you use that, say dentistry, I hope everybody's taking care of that. My dentist said actually, "Brush the teeth you only want to keep," right? When I translate that into chiropractic and spinal hygiene, I would only expect 100 percent of the population is utilizing some form of chiropractic care.

Structure dictating function, understanding that the spine has to be straight from front to back and from the side views. These curves are actually developed that we notice from the side view through the crawling phase, which involves other reflexes, like the cross crawl reflex during that developmental period. It's really important to understand the certain standard of deviations, like having a 45-degree curve is what's considered normal.

That's, for instance, in the neck, that's called lordosis, right? When you have a decrease in that curve, you have a hypolordotic curvature. If there's an increase in that curvature, you have hyperlordotic curvature. Knowing that there is a perfect normal to go from either extreme to less extreme, it's important to identify that. The reason behind that is because we've understood that when structure is sound, like, for instance, having that 45 degrees in the neck, the cord that travels through the spine is at its best position to allow that communication from above them, across, out to every organ and tissue and back up to the brain to send the signals through what's called an afferent and efferent message or pathway.

When we look at structure not being in its proper place, like a malposition that chiropractors are only trained to identify, then utilizing certain tools at our advantage to be able to help us understand how we can help the patient and help them understand where we need to go from there. For instance, we use a surface electromyography (EMG) tool that basically allows us to monitor muscle balances and even thermography, which allows us to even see. On a neurological side, we can see things a little more in depth than just using – For instance, I'm big in instrumentation. One of the big tools with Gonstead is a Nervo-Scope.

Gonstead uses five parameters: X-rays, instrumentation, motion and static palpation and visualization. They're really important. You can probably see now that if you were in line at a grocery store and one person had a high right shoulder or a high left shoulder, you obviously know there's something wrong structurally. If the spine is the framework, then we obviously need to address the framework. Visualization is really important as well.

When we put those techniques in place and the tools that we have available, such as digital X-rays, then we can analyze those X-rays using the CBP and line analysis approach and the Gonstead. I like to merge the two. I really feel like we can cover everything utilizing those two techniques, as far as not just getting a patient to feel better, but get them to function better. If they're functioning better, this could translate to being able to play with your kids to looking at what 10, 20 years down the road looks like.

If anyone's ever been goal-oriented, you know that once you reach it, you don't just stop the habits that allowed you to get there. Like I said, I've always been on a chiropractic care. It's something that I would wish and hope that everyone who comes to our office and goes to any chiropractor, hopefully they're educating them that chiropractic care isn't just a season in life. It is part of life.

JM: Yeah, yeah. That's a good point. Part of the reasons you'd want to continue in care is that the compression that occurs on the nerves exiting the spinal cord from [misaligned] vertebrae can really cause some problems, specifically on the autonomic nervous system. I'm sure many people have heard of that, especially in the cervical area. If you have some compression there, then you can definitely have some consequences as a result of that. Maybe you can expand on that and then we'll talk a little bit about the X-rays.

MH: Yeah. Sure. Whenever you have a malposition of a – I'll just use this model here for example. If you have two vertebrae, right here, that are protecting obviously the nervous system, and the discs that are in between those two vertebrae, when you have proper alignment, you have the ability to hydrate that disc. That's called imbibition, or the ability to imbibate or hydrate that disc. When you lose the proper position of the spine, you lose the ability to hydrate or imbibate the disc. What tends to happen is the space in between the two vertebrae diminish.

As they diminish – the space that is – where does the disc go? It has to migrate somewhere. What happens is the disc then tends to bulge out over time, not age, because here's the step processes on how a spine can even degenerate. As the disc is actually attached to each one of these vertebrae, called Sharpey's fibers, these fibers, over time, will [inaudible 16:13], what happens is it changes the shape of the bone. No one's ever born with a heel spur, but yet if we know the dynamics of the foot and the arch that's dropped, it changes the tension on the tendons or the ligaments, then obviously we're putting stress on the attachment.

When it comes to the spine and the disc, as that bulge occurs, we actually change the shape of the bone, causing bone spurs. Those bone spurs are obviously a result of not self-neglect, but neglect and not knowing what you should have known if someone had the chance to educate you. That obviously forms many different things, such as the fibers that helped to define the disc that the

angular fibers that are obviously disrupted and the integrity of them are also weakened. That's where herniations can come into place.

In light of knowing a misalignment causing nerve pressure, but the soft tissue around there, such as the disc, can do the same as well. Again, understanding that we can address the cause by correcting the misalignment will allow us to be able to imbibate or hydrate that disc. We can actually help to restore it to a certain point, depending on the limitation of the matter or the condition of the bone. We're obviously not going to be able to eliminate what's already been destroyed. Actually, this is the body's ability to heal and stabilize, so it's a healing component. It's just that who wants to heal like this?

JM: Right. Absolutely. In fact, that is precisely what happened to my lower cervical spine and vertebral disc spaces. They were degenerating. I had degenerative disease in my fifth and sixth cervical vertebrae, which is actually reversing now, even after a short three months of therapy. Now, in the past, I had been reluctant to get regular treatments, because, mechanically, it just didn't seem to make sense that a little adjustment here is going to make a massive difference. But the issue is that it really needs to be done on a regular basis.

But not only that – this is what I really liked about your program – it's that it's integrated with home therapy. It always never made sense to me to rely on a chiropractor to adjust you periodically to solve the problem. I mean you've got to address something at home on a regular exercise program. That's what you did.

Actually, you showed your spine, so I'm going to show my little toys here. From an evaluation of the lateral curvature, you provided me with one of these head devices that you just put on your head. It's got weights. I have about four of these 1-pound weights here that are attached to this, like a headband. In my case, I put it on the right side and I just wear this for like a half hour a day. That helps some compensatory changes going on. But the one I really like is this traction unit that you hang up on your door. This goes on your forehead. Actually, this goes behind, and this goes up here.

MH: No. Reverse. You've got to reverse.

JM: There we go.

MH: There you go.

JM: There we go. I do it every day, but you wouldn't know it. This is hung up there, and then you just put your body weight to put traction on your cervical spine. It's made a tremendous difference. Again, I didn't have any pain, but the X-rays are the key. That's what I want to talk about now. As I said, I don't think it's – I think it's really on close borders on malpractice not to do X-rays. When we're saying X-rays, we're talking about digital X-rays, because digital X-rays are going to reduce the radiation exposure by 90 percent. That's a whole other topic of discussion. We're not going to go into how you can remediate against some of that ionizing radiation metabolically, but you can. But if you're getting digital X-rays, it's not as much of an issue.

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Why don’t you talk about the X-ray component and how you can see these changes and the rapidity of which they can change? Because that was the other thing I learned. In our initial consultation, you showed me and my girlfriend, Erin, who’s also in care at your office, some pretty dramatic examples of patients you had previously treated, where the cervical curve should have been 45 degrees, which is the optimal normal that you mentioned earlier. Women specifically were coming in with like flat cervical straight [vertebrae]. It was like 0-degree curves, like Erin has. And then the woman specifically, as you pointed out and showed the pre- and post-, that they had really severe migraines. They disappeared once you were able to put some more curvature back in her spine. Maybe you can elaborate on that.

MH: Yes. When we take the X-rays, there are three that we take of the neck, and there’s two of the mid-back, and two of the lower back. Obviously, you’d want to take an anterior-posterior (AP) and a lateral, so a front and a side view, so you have a two-dimensional approach. With the align analysis that we use, we can determine exactly the curvature of the spine from the side view. If there is any scoliosis of the spine, we use an analysis called Cobb angle to determine and help to manage and improve the degree of scoliosis on those who have scoliosis.

JM: Which is a lateral curvature of the thoracic spine, right?

MH: Yeah. They can encompass the lower back.

JM: Okay. But typically thoracic.

MH: Yes. Most commonly. When we analyze these X-rays, we take all views and consideration. I know you had made note that for your head weight, we just used the lateral, but we actually use the AP as well, because if there’s a lateral deviation from the AP view, then we know exactly what side to put the weight on. CBP uses like a mirrored image. Exercise as well. That’s what we’re doing with you.

Like you said before, thank goodness for doing home exercises. Because the environment you came from is actually the environment that created the problem. Even the structural changes that we make in work places and other organizations that we’ve been able to be a part of, it’s allowing us to get in there and help people improve not only their work or ergonomics, but the ability to be able to sit down for prolonged periods, what have you, or play golf or whatever it is that you do for a living. But yeah, it’s really important to understand where you start and where you’re at, so that we can always change the sail if the wind changes direction to know that we’re still going to hit our target.

For you, just like any other person, we don’t want to say you’re going to get the 45-degree angle curvature back in the neck, for instance, because the damage is already there. We’re going to do our best to make sure that you cannot go further south and improve the curve from where you started. That’s what we’ve been able to see, even with you and thousands of patients that we’ve been able to take care of for years.

JM: Yeah. I tend to be relatively conservative and short on time. When I saw Peter in Boston, he had recommended getting care. I said, "Well, let's see what some conservative things would do." I was standing up and not sitting down anymore. I had integrated his sleeping position. We'll put a link to the video here in our article, so people can see that if they haven't already. I think you would agree with this, but the ideal sleeping position, from his perspective, is to lay flat, but then to support your cervical area.

I had done that for six months, and then we did a follow-up X-ray. The degeneration of my cervical spine actually worsened, which was like, "Okay. Now I've got to get serious about this." Because I know, inevitably, that there are going to be serious consequences from that. Maybe at this point, we can look at the X-rays, my initial X-rays. Do you have a set there where we can put up a copy on the screen?

MH: You hit the nail on the head on something. That it's not just one ingredient that makes up a recipe. I have patients who say, "Health comes from what you eat or how you exercise." I think that's a great component. But if you don't have your health, those things won't assimilate properly.

JM: Yeah. Also, what I neglected to mention, I was doing photobiomodulation on my neck. We had a pretty high-powered machine. We're doing near-infrared saunas and doing some exercises that I thought would help, but it didn't work. I mean I really needed a very specific, precisely targeted and customized prescription for my neck.

MH: Yes.

JM: I'm very grateful because it's been enormously – I can see the progress. Subjectively, I haven't seen any changes, although I might have noticed a bit in my heart rate variability, which I'm impressed with. I'm doing a lot of things, but it's definitely improved. That is one thing you would expect, because heart rate variability is a function of your autonomic nervous system primarily. This is what you'd expect if you have improved cervical function.

Can you describe some of the X-ray changes you've seen on me? Because we're going to throw up a graphic of the image, so that people can see my pre and post.

Okay. On your screen, you can see my initial X-ray on my first consultation with Dr. Hill. Can you describe some of these angles? In the five and six there, you see my fifth and sixth cervical vertebrae. But unless you have a lot of familiarity. It looks like some bones, but it's difficult to understand it. Why don't you walk us through that and show where I was at the beginning?

MH: Sure. Absolutely. One of the key things that I want to point out is the palate line, which is the roof of the mouth. We want to keep that as level as possible, so that pre- and post- X-rays are going to have very little air there as well and evaluation. Typically, what we'll do is we'll drop a line down from the back of C2, which is that long line that you see there, extending on down to the tracheal shadow. And then, we'll also – This is the backside of the vertebrae, which is also, you can follow the backside of the vertebrae, which is called a George's Line. We're doing that right there at the back of C7 as well. And then we compute our anglization, which we get a 27-degree curve here.

JM: Ideally it should be 45, and I was 27. It wasn't terrible, but it's not great.

MH: Exactly. Most of your curve makeup is right in between the C3 and C4. That also explains why C5 and C6, which is also, I'll point out, a common area. But we don't want to use that as a, "You know, well it's common or it's normal." A lot of people are told that's normal because of your age, or C5 and C6 is normal to degenerate, but it's not. It's actually common and it's not normal, if that makes sense. It's a play on words, but we get so many times where people explain this is because of age relationship. That C5 and C6, if that's age relationship, then why isn't every other disc space degenerating at the same rate as C5 and C6?

JM: These black or darkened spaces between the vertebrae, you can see this is almost like a normal disc size, and then when you get to the fifth one, it's like squashed. The sixth one is also squashed.

MH: That's why the shape of the vertebrae are actually changing, because of the attachment of the Sharpey fibers.

JM: Which is the lipping right here, which is a sign of degenerative changes.

MH: That's correct.

JM: Even though I had no symptoms, my cervical spine was going to hell.

MH: There's no one that, once we take the X-rays, that I would ever ask or say, "Why did you allow this to happen?" Because like you said, there are never truly any symptoms leading up to the point where we found the condition of your spine. Now, right below, is the C2 angle, which you want to be anywhere from 0 to 10 degrees. You were within the normal limits there.

JM: Yeah. That was good.

MH: Yes.

JM: Again, it is easy for a chiropractic physician with not much principles to cheat on this by changing the jaw angle here.

MH: Absolutely.

JM: This just keeps you honest.

MH: Absolutely. Also if you went down the C3, you'll see the malposition or the extension position right there at the corner, where your cursor's at, how that's sitting back. If you were to follow George's line, that's actually extended back beyond the C4, or George's Line.

JM: It is. Yeah. Ideally, it shouldn't. It should sit more flatly in this curve. It's bent there unnecessarily.

MH: Absolutely. Like you see C4 or C5, if you follow the back edge of the vertebrae, they should all line up.

JM: But this one's not.

MH: Exactly.

JM: Okay.

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MH: That would be considered like a disruption of the George's Line.

JM: Okay. This is what you started with. Now, we're going to shift over to another one, which I believe is here. This is my current one. You can see a big difference. Actually –

MH: The extension view of C3, the George's Line, is much better in degree.

JM: Right here.

MH: The degree, obviously, is much better. The ideal is 45. Your C2 angle is zero.

JM: We're up zero. Is zero the best or it doesn't matter?

MH: Anywhere between 0 and 10 degrees.

JM: Okay. So it doesn't matter if it's zero or it's eight. It's pretty similar.

MH: Correct.

JM: Okay. I got up about 34, which is an improvement of 6 degrees in the angulation of the spine. But I don't know if it was measured on the last one, but the disc space increased considerably. You may even notice the difference here, how it looks bigger and hydrated. It got fluffier. Now, the degenerative changes are still there, but it's still an improvement, a pretty radical improvement for a few months.

MH: Yeah. That's the ability of resorption. The word's in the dictionary. In understanding the physiology of the body, resorption is the ability to rehydrate, in this case, the discs. That's through the action of imbibition. Once we can help create a better structure, the ability to imbibate or hydrate that disc and be able to move is going to be able to help that as well.

JM: You've made a pretty compelling argument for everyone to be in chiropractic care. I would have to agree with that, that it's better to be proactive. You absolutely have noticed this, that even though you've got perfect structure, which virtually no one does, you would benefit from it, especially if you're in competitive athletics. I mean it's crazy. For an athlete, it's going to give you an unfair advantage almost, because you're going to be functioning at a higher level.

You find many professional athletes are under chiropractic care, probably a higher percentage than the normal population, I would think. What's your experience? Because one of your sports is golf, and you treat a lot of professional golfers in your office, because there are a lot of golfers in Florida.

MH: Yeah. Absolutely.

JM: Why don't you tell us your experience with athletes?

MH: Like I tell them, if you were even one degree off from your goal, that can make a big difference in your paycheck for them. I really want everyone to understand that the degrees of change that you made, for some may not seem significant. I always ask them, "If that's case, the difference between 211 degrees of water and 212 is boiling water. That's 1 degree, and yet that boiling water makes steam, and steam is what drives a locomotive."

Honestly, if we can look at the fact that the degrees of changes that you've made in such a short period of time, and for even the professional athletes who we take care of, that can even be the moms, is that the quality of life is huge and important. I think that's the side effect of chiropractic. This pain relief is just a secondary component to correcting a structural change in someone and in their health.

For instance, the nerves in the neck travel down the arm, forearm and hands, so that the same nerves go to organs and so forth, communicating between the parasympathetics and the sympathetics to help with that heart rate variabilities that we talked about earlier. It makes a huge physiological change in everyone's life. For athletes, I did mixed martial arts through the '90s all the way up into the 2000s. I knew that if I didn't have my ability to have the flexibility, I was going to get tapped out. I was always on the chiropractic care that didn't just allow me to have the flexibility, but I knew that every joint in my body was moving and articulating the way it was designed to.

For those, for instance, who have spinal degeneration, like in your neck, like many others, one of the chief complaints that you hear, and one of the measurements that we take into consideration, is the loss of range of motion. You're going to have a change in range of motion with this type of spinal degeneration, depending on the severity as well. We also create scar tissue in there, which a lot of times is called crepitus, like a frozen shoulder. Sometimes we have to get in there, and over repetition, we've got to break it up. It's been a huge change for myself, for the athletes, for the patients that we've been able to see and even the changes that you see on our website. A lot of pictures are on there to show you the pre and post.

JM: Sure. We'll put a link to that. I want you to address now the elephant in the room, because obviously, it's a relatively small percentage of the population under chiropractic care. Probably some of that is related to a bad reputation that the profession has had from some unscrupulous characters who aren't practicing the type of care that you are and others. There's a certain segment that you want to avoid. Why don't you talk about that? And then we'll help people identify the process of how to find someone like you locally.

MH: Sure.

JM: It needs to be locally. You're not going to be flying in to see Dr. Hill. I mean you could, but you need to be seen initially three times a week, and then twice a week. You've got to have to find someone good locally, which is why Dr. Martone found you for me. I'm so grateful for him for doing that.

MH: Absolutely. That's the big thing. It's when we have patients who say, "Well, my aunt needs care," and I go, "Where does your aunt live?" "In Nashville." "Okay. Let's do our best. Because this isn't about me. This is about your aunt getting the cure that she needs and to trust someone who we can put her in the hands of," like doc did for you. Definitely thank him for that. Yeah.

Going back to your original question, "How do you find someone?" What I always ask is if a patient even comes from another chiropractor, I always like to make sure that we're moving our profession forward by not talking badly about one. I always just say, "Whatever they did was not wrong or incorrect, but what we have to offer is exactly what you need," so that they know that they're in the right place.

For me, the type of care I want for my family is the type of care that I was taught at Palmer College. One of them is that the utilization of X-rays and all other components of our initial examination are very important. But if we look at X-rays, we look at X-rays like a contractor and a sub-contractor would look at blueprints. Without these blueprints, where would we know where to lay the plumbing and electrical? When it comes to your health, which is much more important than that, your X-rays tell us a big story.

For instance, when we talk about your lower back, in many cases, if we had just taken one view, like an AP, we would have never seen the two-dimensional viewpoints of the lower back to understand, "Was there a translation of L4 or L5 that would not be an area that would actually motion out well?" Without X-rays, why would we want to be adjusting in that area if it was considered like a Grade 1 through 4 spondylolisthesis? Which is the slipping of vertebrae on top of the other, which is a disruption of the George's Line, even in the lower back. X-rays and all these details to the examination are super important. If patients aren't getting that, I would be concerned.

No different than I was telling you the other day that if you called into an office and the front desk answered the phone, ask, "What type of technique does the chiropractor utilize?" If the staff isn't aware, then I would be very concerned. With the fact that your staff isn't in tune with what you do and how you help patients, I would be concerned.

JM: Yeah. I guess the two questions, at least if you want to have some of the care I've received and you're providing would be Chiropractic BioPhysics®, or CBP, and Gonstead. That would be the two keys. If they haven't heard of it, the staff, then you say, "Well, yeah. Okay. Thank you, but no thanks." Go find someone else.

MH: They make a very strong structural correction program.

JM: Right.

MH: That's for sure.

JM: I just want to say too that – Is it fair to say that about 30 percent of the chiropractors are using this technique?

MH: I don't know the numbers.

JM: Probably.

MH: But I would say that it's not enough. That's for sure.

JM: Yeah, yeah. It's certainly not the majority.

MH: Correct.

JM: I don't want to give the misimpression that this is the only way that chiropractic's going to work. It isn't. The one thing that I really admire and respect about the profession is there are so many innovators in there and we get so many techniques. But the other primary alternative that seems to work pretty well is Network, developed by Donny Epstein. There's maybe just as many people doing Network, which is a totally different approach, but frequently get similar results. I just decided to focus on this. There are others. Like you said, you just want to avoid a clinician who is not really assiduous, proficient and consistent in providing it.

[-----40:00-----]

One of the other things that impressed me with your office is that you're really pretty well-automated. You give all your patients a card, an electronic card that looks like a hotel card. You can swipe it in so you don't have to sign. Well, you still have to put your name on the list, and then you bring up the patient medical record, electronic record in your office. It's very efficient. Your staff is incredible.

I just learned yesterday of a – I was always wondering what was in this one room, but you showed me. This is a decompression machine that you also have available that is quite pricey. The closest one is like, I don't know, an hour and a half away from us to get that therapy. But it's pretty impressive. You made the commitment to buy this expensive piece of equipment because there was a woman who you couldn't help, who had really severe, I think it was cervical pain. Was it hip?

MH: She had signs of a lumbar disc herniation.

JM: A lumbar disc, which is classic, because that is the No. 1 cause of what we're going to describe, which is that you couldn't help her, for whatever reason. You, wanting the best for your patient, referred her out to actually a physician, a medical doctor, who prescribed opioid analgesics, which is the conventional standard of care. The clinician probably did nothing wrong, but she wound up dying from the No. 1 cause of death in someone in her age group, which was opioid addiction. You felt just terrible. Why don't you discuss that a little bit? Because I was [not only]

impressed with the commitment to care, but then the implementation of how to prevent that from happening in the future.

MH: Well, I know there are limitations to all matter in that we have to acknowledge that once we get to a point where we've got to do something different and if it's not in our hands, we've got to put it in the hands of someone we would trust. In her situation – I've had previous patients just like her, other than they responded very well, who had these bulges and herniations. In her case, she had a very bad disc herniation that migrated. She had no insurance. She was really stuck in this catch-22. She couldn't afford the surgery. I didn't have spinal decompression. I understand quality of life is really important. She had sought out a doctor.

I was taking care of her and her boyfriend. He was downstairs cooking dinner. She didn't respond, so he went up there to check on her. She was at the edge of her bed kneeling as if she was praying. She had, I guess, passed away with a heart attack. I kind of took it on as a personal note. That if I had any chance of avoiding that situation. If I had any part in that, would there have been a tool that I could have helped her with? That "What if?" is what just took me to that tipping point to know that I needed to make an investment in a tool that could have possibly have helped her.

It's no different than like the dinners that we do once a month. I had an existing patient, still a patient, say to me one time, "I'm not going to come, because I've gone to them many times and I know they're expensive." I said, "Mary, I don't look at the expense. I look at the expense of that child, like Liam, who had 27 seizures the week prior to coming in." The only reason why he came in is because he was invited to one of our community dinners. If his family didn't understand through the educational component that we provide, that we could help him, then he would be continually having seizures.

I had one doctor who was a patient – I was sharing that story with Ami – "Well, show me the research." I said, "I can actually give you his mom's phone number if you want, because his mom's the one who has to live through those seizures, as well as that little boy Liam." When it comes to the cost of an equipment or the things that we do in the community, there's no cost when it comes to someone's health and changing lives.

JM: Yeah. So you were able to help with the seizures. I didn't realize.

MH: Absolutely.

JM: One of the other tools that you can use. Typically, I would approach it metabolically with putting him on a very high-quality fat diet and getting his brain to burn ketones. But that doesn't mean you can't do it another way and work synergistically by addressing the structural component.

MH: Yeah. I'm a proponent of all of that.

JM: Yeah.

MH: Definitely.

JM: With your undergraduate degree in nutrition, I would have believed so.

MH: Sure.

JM: That's the other thing that impressed me. Maybe one that might give you caution as you're seeking to find someone like Dr. Hill, is to see how they look. I mean, do they look healthy? If you go to Dr. Hill, he and his wife are just health studs. I mean they really are in phenomenal shape. I mean they're glowing with health. This is what happens when you eat the right way and you get regular chiropractic care and you're taking care of yourself. That's a big clue. If the chiropractic clinician you're seeing is overweight or disheveled, I'd be cautious about committing to a care under that type of clinician.

MH: Sure.

JM: Would that make sense from your perspective?

MH: Yeah. Absolutely. I appreciate that.

JM: You can't be a hypocrite. Because these stuff, we know this works. There's just no question about it. I mean clearly it's effective. Because your body wants to stay healthy. If you give it what it needs, stay away from stuff that it doesn't and you address this structural component, which I fully didn't appreciate until later in life. I have some deep regrets about that, but I'm not going to beat myself up about it, because I know my body is really healthy and can prove it, like we've seen in three months. I've had improvement. Hopefully, I'll get back to the 45 degree and resolve most of that cervical degeneration.

MH: Yeah. The sooner you started it, the better.

JM: Yeah. The sooner, the better.

MH: Yeah. Absolutely. Health is a relationship. You have to constantly work at it. If you don't work on your health, just like any relationship, it'll go south on you. You know, you touched on something that I like to tell patients. It's that this mom and son walked up to Gandhi one day. The mother asked, "Gandhi, would you tell my son to stop eating sugar?" You've heard the story. I'm sure of it. Gandhi said, "You know what? Come back in two weeks."

The mom walked with the son through this long processional line and came back up to Gandhi two weeks later and said, "Can you tell my son to stop eating sugar?" Gandhi looked at him and said, "Stop eating sugar." She said, "Why didn't you tell me that two weeks ago?" He said, "Because I had to do the same." When it comes to your doctors, definitely, you want to make sure they're practicing what they preach.

JM: Yeah. That's such an important principle. This is the first time I've heard about your community dinners. I hadn't encountered that before. Maybe you can expand on that too, because I'm sure a lot of people might be curious.

MH: Yeah. We do community dinners at Stonewoods, which is a nice restaurant.

JM: It's one of the nicer ones in our community. Right.

MH: In our community. Absolutely. Once a month, we invite our patients to come and bring a guest. We have hand-selected the menu to the best choices possible. While the dinner is being cooked, there is no obligation. I actually just talk about health in general. They can make a decision if they want. If they trust in us, then obviously we want to be able to be available to them.

But at the end of the night, it's just a great night of fellowship, a chance to meet people who we normally wouldn't have been able to meet. Otherwise, it's very hard to get out in a community when we're in here in our office serving the community that's coming into it. It's a great way to extend ourselves out to the community.

JM: Great. That's a good strategy. I'm sure it's helped a lot of people being exposed to the work you're doing. As a result, they've gotten into care and improved their health, which is really the focus and the goal of the whole process. Anything else you'd like to add to this before we close?

MH: No. I just want to say thank you for having me here. Thank you for allowing me to take care of you and Erin. I just thank our community for trusting in my wife and I, our family and our team to be able to help them and help them see how chiropractic can help them, and tear down those walls of discrimination. I'd love to see every doctor, every former doctor in this office to help them as I know they've been able to do – they saved my dad's life – that five-way bypass. I definitely commend everyone who obviously has been able to take charge of their health and trust us.

JM: Yes. Take charge or take control, as we like to call it.

MH: Absolutely.

JM: It's putting you in control. But also recognizing that structure does have a significant influence and impact on your health. If you fail to appreciate that and implement strategies to address that, certainly home exercises are a phenomenal way to do it, and it works synergistically with a good type of chiropractic care program. I want to thank you for what you're doing and what you've done for me. You keep up the good work, because you're helping a lot of people.

MH: Thank you, Doc. I really appreciate it.

[END]