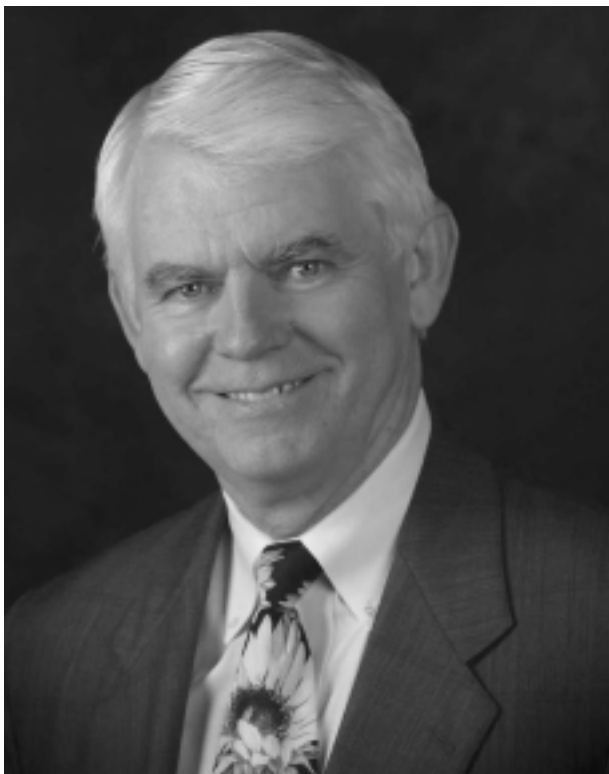


### Chiropractic: A Specialty with Limitations?

Reed B Phillips, DC, PhD, President, SCUHS



Dr. Reed B Phillips, DC, PhD  
President, SCUHS

#### *Present-day perspectives*

We live in tumultuous times when “all things shall be in commotion”, not only because of nature’s fury or the inhumanity of war, but according to the Biblical words of Paul to Timothy:

This know also, that in the last days perilous times shall come. For men shall be ... covetous, boasters, proud, ... unthankful, ... trucebreakers, false accusers, fierce, despisers of those that are good, ... traitors,

heady, highminded, lovers of pleasures more than lovers of God. (2 Timothy 3:1–4 KJV)

Managed care, in the name of good business, is driving many doctors out of practice. Disgruntled alumni are not encouraging others to follow in their foot steps. Enrollments in chiropractic education are significantly less compared to a decade ago. The market share of potential patients seeking chiropractic care has declined. Work Comp carriers are capping service and more people are avoiding needed care for the lack of any insurance at all.

The structure of chiropractic is fractured on many levels. Pressures external to chiropractic mingled with internal dissension have created dangerous fissures into which public thinking is falling. The enigmatic chiropractic health care provider himself is collapsing from defense fatigue. Landscapes are becoming littered with doomsday prophets, energetic publicists, academic theorists and occasional psychoanalytical historicity in an attempt to stabilize the hurricane of damage. The ACA carried out FEMA-level tenacity with its “Save Our Subluxation” scheme, while the ICA never thought it was lost. Our professional culture through multiple forms of media engulfs “Get Rich Quick” schemes and ignores the richness of our landscape with its own scientific evidence and the challenge of critical thinking.

But in the midst of these professional blackouts, daylight always comes with the new day. In the U.S., since the beginning of WWI chiropractic has sought the privilege of providing care to our soldiers. Since the end of WWI a similar battle has been waging for our veterans. Today, chiropractic claims victory on both fronts. The military and the veterans have access to chiropractic care. More battlefield victories from the political front will soon be ours as well.

Thirty years ago, there were but a handful of doctors of chiropractic with research training from graduate pro-

grams in major universities. That handful has grown significantly (and has need to continue to grow) and has begun to create a culture of evidence upon which chiropractic can seek a more firm foundation.

Chiropractic education has also brightened the landscape. Adhering to CCE Standards, educational institutions have “raised the bar” in quality education, compared to thirty years previous. More needs to be done, but the process is in motion. Our educational institutions have evolved from store fronts and back room clinics to modern and beautiful edifices equal in stature to many other higher educational institutions. With regional accreditation in the U.S. and university affiliation of chiropractic educational programs in the rest of the world, chiropractic education has a seat at the table with the rest of higher education.

#### *A Model for Chiropractic*

A major cause for chiropractic struggles is the absence of internal consensus. This has become a topic for discussion of late given the Identity Project spearheaded by the WFC. According to their world-wide survey results they have offered the following international identity for chiropractic: (WFC Press Release July, 2005)

*The Pole.* The pole should be:

The spinal health care experts in the health care system.

*The Ground.* The ground should be:

- a) Ability to improve function in the neuromusculoskeletal system, and overall health, wellbeing and quality of life.
- b) Specialized approach to examination, diagnosis and treatment, based on best available research and clinical evidence, and with particular emphasis on the relationship between the spine and the nervous system.
- c) Tradition of effectiveness and patient satisfaction.
- d) Without use of drugs and surgery, enabling patients to avoid these where possible.
- e) Expertly qualified providers of spinal adjustment, manipulation and other manual treatments, exercise instruction and patient education.
- f) Collaboration with other health professionals.
- g) A patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the

self-healing powers of the individual, individual responsibility for health, and encouraging patient independence.

*The Personality.* The personality should be a combination of:

Expert, professional, ethical, knowledgeable; and  
Accessible, caring, human, positive

Coinciding with the WFC release, Nelson et al.<sup>1</sup> published their views on the “Chiropractic Identity Crisis.” In summation, they offer the essential characteristics of their model of chiropractic:

- a. Spinal care as the defining clinical purpose of chiropractic
- b. Chiropractic as a portal-of-entry provider
- c. The acceptance and promotion of Evidence Based Health Care
- d. A conservative clinical approach
- e. Chiropractic as an integrated part of the health care mainstream
- f. The rigorous implementation of accepted standards of profession ethics.

They liken their model to that of dentistry and make the distinction, “chiropractors are dentists of the back.”

The position taken by Nelson et al. is one of the four options rendered by Walter Wardwell in his history of the chiropractic profession (1992). In his concluding chapter he offered four scenarios for the future of chiropractic:

1. Remain unchanged in its relations with medicine and the rest of the health care system, i.e. remain marginal
2. Become ancillary to medicine
3. Follow osteopathy by expanding its scope of practice to include the use of as many drugs and as much surgery as states and hospitals will permit
4. Evolve to the status of a limited medical profession.<sup>2</sup>

Wardwell favored option four, as has Nelson et al., believing it would result in:

1. Interdisciplinary research
2. Standardized curriculum in chiropractic education to include diagnosis and hospital care

3. Standards of care that would reduce conflicts of scope of practice
4. Third party payer agreement on proper scope of chiropractic care
5. Chiropractic fitting into the national health care system
6. Enlightenment of chiropractic leadership<sup>3</sup>

By way of personal experience as a member of the Chiropractic Oversight Advisory Committee to the Department of Defense (U.S. military) and as the Chair of the Federal Advisory Committee on Chiropractic to the Veterans Affairs (U.S.) I have wrestled with this issue of, “What role do we have inside a large health care system?” Because of the size of the systems, and for various other reasons, change was not easily obtainable. It literally took an Act of Congress to make it happen.

Strongly ingrained in both the military and veteran’s health care systems was the concept of a single entry pathway. While many titles existed, essentially access into the health care system required an evaluation by a primary care manager, usually a family practice physician but also a physician’s assistant or nurse. In both systems, chiropractic argued for primary access status but was flatly denied on every occasion. There was a strong perception doctors of chiropractic are inadequately trained to perform a diagnosis.

Without primary access, chiropractic, by default, became “ancillary to medicine”. The fear of being “starved” for patients due to ignorance or prejudice, or both, on behalf of the primary access provider, gave chiropractic a sense of doom pending their future in these two behemoths.

As it has turned out in most cases (not all) the need and the desire for chiropractic care has overruled the prejudice and ignorance and chiropractic providers, for the most part, are under greater demand than they can fulfill. Medical providers and even some physical therapists have praised the presence of the doctor of chiropractic and a niche for care has been carved that is in harmony with the surgeon and the therapist.

Thus, in large health care systems where care is prepaid, the demand for care is overwhelming and a large portion of patient problems are musculoskeletal in nature, chiropractic can and has found a niche. Initially as an ancillary service to medicine but as trust and confidence has

increased between providers, in reality, chiropractic has become a limited specialty in the field of health care, not unlike the dentist.

#### *One size shoe fits all feet?*

While adopting the role of a limited practitioner within an institutional setting seems to have merit, what happens when the practitioner steps outside the institution? I believe it is fair to assume the majority of chiropractic practitioners function in a private office, at times with associates in house, but more often isolated from peers of all types in health care delivery. Being dependent upon referrals (the limited practitioner model) for patient care would only work if self-imposed isolationism was overcome and the practitioner was able to build a network of fellow providers from which such referrals could be generated. Some managed care companies entice struggling new practitioners to join their network on the promise of many referrals.

Even with direct access privileges, the private office setting would only flourish if chiropractic could remove the stigma of being “marginal” and enhance public trust. The dentists have done it – so it can be done.

Isolated cases of success using this limited practitioner model may exist but evidence supporting the premise that most practitioners have successful practices based on this model is lacking. Rather, practices remain founded on word-of-mouth referral from patient-to-patient, and marketing. For practitioners in even more remote, non-urbanized settings, building a referral network of providers could offer even greater challenges. Perhaps in time, changes toward the “dental” model could be developed.

If chiropractic were to assume the “limited practitioner” model, should other professions under the label of “alternatives” consider doing likewise? Would patient care be improved if it offered a smorgasbord of provider types, all with a “limited” service? Or would such professions as acupuncture and naturopathy fill the role of the “alternative” to traditional medicine, while chiropractic chased after the same piñata as the doctor of physical therapy?

There is yet another twist to the “chiropractor as the dentist of the back” model. Dentists are limited anatomically but not therapeutically. Should the “dentist of the back” be allowed to prescribe pharmaceuticals or perform surgery, even as a subspecialty in chiropractic, much like

the dental surgeon? Dentists deal with form and function, pathological changes, trauma and even cosmetic procedures and surgery. Will the “dentist of the back” be satisfied with manual medicine therapeutics only?

#### *Summary*

As a graduate of National College of Chiropractic in the early 70s, my training was patient-centered care. The spine was a focus for therapeutic measures but diagnostic skills were inclusive of the patients’ signs, symptoms, history, laboratory and radiographic findings. A good adjustment had a soothing response and if, as we purport, it had an effect on the nervous system – then as a profession we are responsible to define and determine just what that effect is and how it can best be used to benefit the patient.

My education was not limited to adjusting the spine or even adjusting the extremities, however. While not accepted by medicine or the general public at the time, my education encompassed therapeutic nutrition, physical rehabilitation, life style modification and the value of good, clean, wholesome living. Change has occurred. In the early 70s you had to search for a health food store to buy a bottle of vitamins. Today vitamins are pushed on TV, at the grocery store and yes, even in the medical doctor’s office.

With the flood of spas and their massage therapists and fitness centers with personal trainers, people are obsessed with life style issues, good diets, proper exercise, safe recreation, appearance, and overall general fitness. It is unlikely the “dentist of the back” would be looked upon as the preferred provider trained to meet certain special needs related to general well being. A segment of the population who could benefit from chiropractic care would go elsewhere if the “dentist of the back” limited care as implied by the title.

The “limited practitioner” model has a place, but if our health care delivery system was so parsimonious, then I could accept it as the only model for the future of chiropractic.

#### *References*

- 1 Nelson CF, Lawrence DJ, Triano JJ, Bronfort G, Perle SM, Metz RD, Hegetschweiler K, La Brot T. “Chiropractic as Spine Care: A Model for the Profession” Chiropractic & Osteopathy, BioMed Central Ltd., <http://www.chiroandosteo.com/info/content/13/1/9>.
- 2 Wardwell W. “Chiropractic: History and Evolution of a New Profession.” Mosby, St. Louis, 1992, pg. 275–6.
- 3 Ibid., pg. 282.

## Support Chiropractic Research

Your gift will transform chiropractic

*Become a member of the  
Canadian Chiropractic Research Foundation and help us establish  
university based Chiropractic Research Chairs in every province*

Contact Dr. Allan Gotlib

Tel: 416-781-5656 Fax: 416-781-0923 Email: [algotlib@ccachiro.org](mailto:algotlib@ccachiro.org)