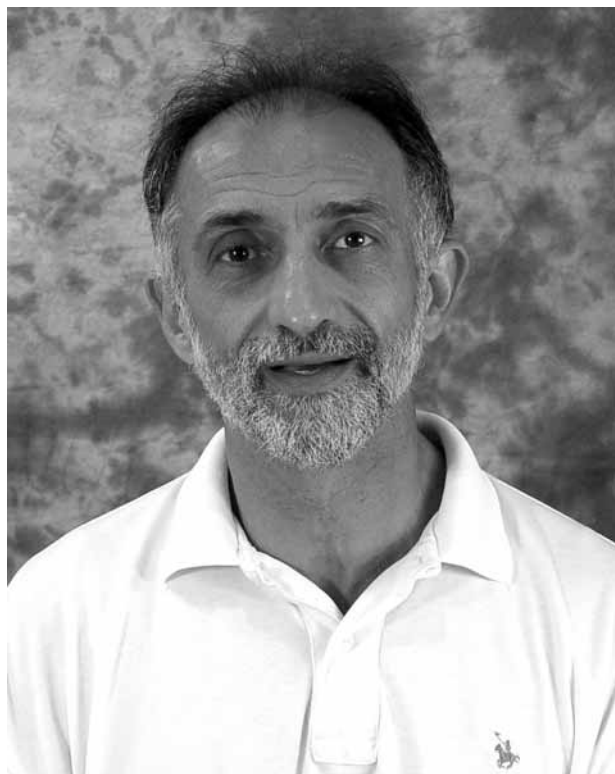


From Multidisciplinary to Interdisciplinary – it's all about patient outcomes

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For a few years I, along with Dr. Kopansky-Giles, have been fulfilling my CMCC faculty role at the outpatient chiropractic clinic integrated into the Department of Family and Community Medicine, St. Michael's Hospital (SMH). Besides caring for patients referred by SMH family physicians, HIV Positive Care Clinic, and Employee Health, we collaborate in patient education programmes with our physiotherapist colleagues, participate on hospital projects and committees, and provide in-service pres-

entations about chiropractic and musculoskeletal (MSK) conditions. With other allied health practitioners, we conduct interprofessional teaching (captured in the terminology of interprofessional education, IPE) of family practice residents about interdisciplinary collaborative patient-centred care (ICC), and, at the request of their SMH family practice rotation co-ordinator, of medical clerks about assessment and chiropractic management of common MSK presentations.

Medical schools have committed to introduce the knowledge, skills and attitudes for ICC in the curriculum by 2009.^{1,2} Governments have budgeted for development and implementation of models of ICC and for corresponding research.³ International conferences and journals are dedicated to ICC and IPE. SMH has been in the forefront of “walking the talk” by facilitating related staff training and promoting the integration of IPE and ICC in departmental programmes.

It may therefore appear that many knowledgeable people are convinced that IPE and ICC can really deliver the goods: better patient outcomes. Like the kid who always gets chosen last when teams are being picked in the playground, chiropractors have long contended to the uninterested snobby star players that they have a lot to contribute as a member of the health care team. It appears that the climate is changing, and we may now be valued as bona fide team members.

Of course, some are slower to embrace interprofessionalism. We haven't yet arrived at Nirvana.

Last year I supervised a CMCC student investigative project on chiropractic management of patients with ankylosing spondylitis (AS). As Dr. Shaikh mentions in his excellent overview in this issue of the JCCA,⁴ symptoms of AS can have the patient present initially to a chiropractor, yet the strongest published evidence on chiropractic

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management of AS is case reports.⁵⁻⁹ The student investigator had reasonably modest expectations of the number of chiropractic AS patients he would be able to prospectively assess outcomes in, using standardized indices. I thought he was also reasonable in his forecast of the number of AS patients not receiving chiropractic care he would be able to recruit as a control cohort, assessed with the same instruments.

While he approached the local arthritis society for aid in recruiting control subjects, I tried to facilitate this recruitment by contacting the busy SMH AS specialist. Initially eager to co-operate, even discussing co-authorship, she subsequently withdrew from collaboration, citing conflict of interest with her upcoming international conference presentation, which would include discouragement of chiropractic care of AS patients. No, I did not ask what evidence she based her edict upon. The arthritis society proved just as helpful.

Seems they already knew there's no benefit to AS patients from chiropractic (synonymous with spinal manipulation to them). Why waste time and money to prove it? Why facilitate research by allowing access to potential subjects among the many more patients who are seen by rheumatologists than by chiropractors? And why inform chiropractors?

Dr. Shaikh⁴ did not submit this article to the JCCA because he cannot get published in a medical journal. Rather, writing within his scope of expertise, it was to inform the target audience of fellow health practitioners who also care for AS patients what the state of the (medical) art of diagnosing and managing AS patients is. With this knowl-

edge, I will be able to make more valid decisions with any AS patients I may have under my care regarding potential benefits and risks (including cost of treatment) of available interventions for their individual presentations.

Dr. Shaikh's motivation for submitting this article to the JCCA reflects the ultimate goal of IPE and ICC: better patient health outcomes.

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