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Is chiropractic care primary health care?

ID Coulter, PhD*

The following paper sets out to examine three issues: primary health care, chiropractic care, and the challenges to both in the next decade. The current crisis of primary health within the health care system provides chiropractic with an opportunity to choose between functioning as primary care or primary contact care. Chiropractic has seldom met its potential, or its own rhetoric, with regard to holistic health care which would make the case for being primary health care much stronger. There have been numerous social and political factors that have influenced this but part of the problem is that chiropractic has failed to clearly articulate itself as primary health care, and in some instances, has denied that it was. New opportunities and challenges will force chiropractors to resolve the issue of whether chiropractic is a general model of health care, or a form of health specialty (the neuromusculoskeletal practitioner verses the primary health practitioner).
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KEY WORDS: chiropractic, manipulation, health care.

Cet article cherche à évaluer trois situations : les soins de santé, les soins chiropratiques et les défis qu'ils auront à relever durant la prochaine décennie. L'état de la santé au sein du système de santé actuel laisse une porte ouverte à la chiropratique, qui pourrait choisir d'être soins de santé ou soins de premier contact. La chiropratique ne s'est jamais pleinement exprimée quant à son approche de santé holistique, et tenter de le faire la rapprocherait des soins de premier contact. Plusieurs facteurs sociaux et politiques ont joué sur cette situation, mais la chiropratique reste à blâmer pour ne s'être jamais annoncée de façon claire comme étant de premier contact. Pire encore, dans certaines situations, la chiropratique a nié être de premier contact. L'avenir, avec ses occasions et ses défis, forcera la chiropratique à se définir : soit comme modèle de soins de santé, soit comme une spécialité (une pratique neuro-musculo-squelettique par opposition à une pratique de soins de santé).
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MOTS CLÉS : chiropratique, manipulation, soins de santé.

Introduction

The future of chiropractic will be heavily influenced by two factors, both somewhat within the control of chiropractors themselves. Firstly, chiropractors will be required to articulate, substantiate, and communicate their current role within the health care system. There is still widespread ignorance amongst the public, politicians and policy makers about what chiropractic is and where it fits in the overall health care system. Secondly, and just as importantly, chiropractors will need to continue to work to create for the profession an environment in which chiropractic can be all it can be. This will require educating the public to the full potential of chiropractic care and establishing non-restrictive legislation so that chiropractors can practice a broad based scope. These political and intellectual struggles will equal those of the past.

It will also mean taking advantage of those opportunities that present themselves. Collectively the outcome from these efforts will determine if chiropractic will advance as a specialty, (either parallel or subservient to medicine), i.e. chiropractors as neuromusculoskeletal practitioners, or whether it will go on to establish itself as a primary health care system.

Part of this process will depend on four aspects of conceptual clarification addressed in the following: the concept "primary care"; whether chiropractic constitutes primary practice; what a primary care chiropractic practice might look like; and the implications of primary practice for chiropractic education.

The primary care crisis

There exists, internationally, a reasonable agreement that there is a primary health care crisis, even if the the health professionals involved disagree on the specific nature of the crisis, its cause and its solution. This sense of crisis is especially acute in

* Researcher, Los Angeles College of Chiropractic; Health Consultant, Rand, Santa Monica. This paper was presented at the 50th Anniversary of the Northwestern College of Chiropractic, May 1991.

the United States but its universal nature was captured in the 1977 Conference On Primary Health Care in Industrialized Countries sponsored by the New York Academy of Sciences. The crisis in the U.S.A. is complex and involves at least the following issues: the accessibility and availability of primary health care to large segments of the population, in particular, those 30 million Americans without health insurance coverage; the internal disagreements within medicine about what constitutes a primary practitioner, what training is the most appropriate, and what role other health professions might play in the delivery of primary health care; and the broad philosophical debate about the biomedical paradigm and the newly emerging biopsychosocial paradigm and such things as the consumer perspective on health and the wellness movement.

Terris[1] examined the causes of this crisis in the U.S.A. and notes that of the industrialized, developed nations, the U.S.A. has the most startling disparity in the supply of primary and other physicians among the neighborhoods of its cities. This arises partly as a result of a lack of centralized planning in the national health service and partly from the lack of national health insurance. The latter creates a tremendous difference in classes. The results are well-known: "a glut of physicians in the wealthy neighborhoods and suburbs and the virtual disappearance of physicians from the poorest areas of the cities."[1] (p. 138)

Graner[2] comments that the crisis has been complicated by the emergence of a new demand for more humanistic and compassionate medical care and a reaction against scientific, technological, and bureaucratized care. He sees this fundamentally as an antiscientific movement against the medical professional because of its close association with science. From the perspective of chiropractic however, the crisis provides an exciting opportunity.

Primary health care

Initially, primary health care was a term simply denoting the point at which the patient enters the health care system; debates about primary care are rather recent. As the health care crisis became a major concern, the discussions of what constituted primary care escalated. Kranz,[3] who to date has presented the most extensive discussion of the concept in chiropractic, has outlined some of this development. Part of the problem in the debate has been to establish a universal definition of the term primary care. Kranz notes three broad perspectives for viewing primary care in the health care system: a social/societal perspective; a provider/physician service perspective; a lay-patient/consumer perspective.

The social/societal perspective would include not only the normal delivery system (doctors, nurses, hospitals, etc.) but also the environmental, social/welfare, economic, personal health care, agriculture etc. This perspective is the one adopted by the World Health Organization (WHO). Here the total social and environmental context is considered an integral part of primary health care. Under this definition, all providers would be considered limited primary care since none could deliver all the services needed.[3]

The provider/physician perspective focuses on a personal health care subset. This is commonly divided into a primary level (entry level), a secondary level (ambulatory services of a specialist nature), and a tertiary level (the medical hospital center). The primary level consists of providers who are generally concerned with acute, chronic, frequently occurring conditions that require minimal care. This is the level usually identified as primary care. However, there is much debate about how separate the three levels are (some hospitals provide primary care); about whether the primary care can only be given by a medical practitioner (or should simply be supervised and monitored by them); whether it is illness care or health care; and whether primary care involves crisis care, preventive care and/or public health care.

The third perspective, lay-patient/consumer perspective, sees primary care as that care that is accessible, affordable, given by a constant practitioner who the patient knows and trusts, and who can deal with a broad range of their needs. For the most part this would be the family medical physician.

This third perspective has been the one held by the professionals that have dominated primary care. Kranz[3] surveyed health providers (and their associations) to obtain those attributes they thought were essential for quality primary care. They included:

- provides for the patients' general health care needs;
- involves direct contact: the primary provider serves as the point-of-entry into the health care system;
- primary care is accessible care: the providers are available and attainable 24 hours a day if required;
- acceptability: primary care provides care that is personal, individualist, and acceptable to the patient and the provider of the care;
- accountability: the providers are responsible for the care they render and hold themselves accountable to a recognized standard of care;
- education and counseling: primary providers teach patients, communities and societies about proper health and illness care;
- coordination of care: primary providers must be able to coordinate the patient's care with other providers and specialists, communicate with these providers, and integrate all the facts of the care;
- continuous: primary providers give continuous, on-going, health care;
- comprehensive care: primary providers should provide a wide range of services and a broad scope of treatment for the most frequently seen illnesses; and
- essential or basic care: primary care provides essential care to the patient. This is care that is deemed necessary and desirable for the well being of the patient and the community.

Kranz concludes:

"Primary care therefore would be care that provides for the general health needs of the patient; is a first or direct contact service; provides an assessment of health; is accessible to those who need it; is acceptable to the consumer of health care services; is accountable; provides education and counseling; provides coordinated, continuous, comprehensive and essential care."[3] (p. 33)

Chiropractic as primary health care

Kranz[3] points out that sociologists have proposed at least three distinct conceptualizations of the chiropractic role. Wardwell[4] originally saw the role as marginal and more recently as a limited medical profession. Coulter[5] proposed that chiropractic was a limited alternative form of care. Rosenthal[6] saw it as moving from a limited marginal role to a limited medical profession. Wardwell concluded that the chiropractor is not a primary health care provider: "Although they are not primary care providers, limited medical practitioners are 'portal of entry' to the health care system, since they are the point of first contact to patients who have not undergone a medical diagnosis."[4] (p. 37)

When the focus of the study has been the chiropractic health encounter, as opposed to the political arena, the descriptions of the chiropractor look very similar to that of the primary provider.[7,8]

Kranz uses an alternative approach, applying the criteria listed earlier for primary practice and assessing the extent to which chiropractic shares these features. Clearly, chiropractic is primary contact and provides initial health care assessment (even if we may debate whether this is a full differential diagnosis). With regard to the criteria of accessible, acceptable, accountable, continuous, coordinated, counselling, Kranz[3] concludes that no data exists to substantiate chiropractic's claim to these. However, Kelner et al.[7] and Coulehan[8] do provide substantive data for these features. Yet for Kranz,[3] the most troubling criteria for chiropractic are the ones of comprehensiveness and essential care. It is difficult to make a case that chiropractic gives comprehensive care (although as he notes neither medicine or chiropractic is socially comprehensive). Kranz concludes that chiropractic does not provide comprehensive care (he also notes this was the conclusion of both the Webb Report in Australia[9] and the New Zealand Commission of Enquiry.[10]) The conditions chiropractors deal with are seldom life threatening; whole parts of the globe survive without any chiropractic care. Futhermore, data on chiropractic utilization show that chiropractors in the main, are used for a limited range of health problems. In the study by Kelner et al.[7] back related problems accounted for 53% of all the presenting problems. Shekelle and Brook[11] showed that back pain and injury accounted for 42% of chiropractic visits (although the range was from 69% in one region to 41% elsewhere).

Kranz concludes: "Chiropractic in the learned community runs the risk of misrepresenting to the public if it assumes the responsibility for primary care but is unable to deliver it."[3] (p. 56) Although Kranz's critique is excellent, it is also conceptually flawed. Kranz acknowledges the distinction between illness care and health care but does not use this distinction to examine whether it gives rise to two distinct forms of primary practitioner. Just as it is legitimate to ask whether chiropractic meets the criteria, and to suggest that data to support chiropractors as primary do not exist, it is equally legitimate to ask what data exists to support the claim that primary care medicine is also comprehensive. With regard to health care (i.e. wellness care) the data does not support the claim medical doctor's are comprehensive. There may exist two types of practitioner: an illness practitioner focused largely on disease (pathology) and trauma (injury) and another focused on wellness. This is not to suggest that the focus is exclusively one or the other (quite clearly illness practitioners also focus on prevention, just as wellness practitioners also must be concerned about pathology, etc.) but does suggest that the thrust of the care is in different areas. The question would then arise of whether the two practitioners provide primary health care but in different arenas. It is this question that will be examined next.

The wellness practitioner

In an earlier publication, Coulter[12] suggested that an opportunity exists for chiropractors to establish themselves as primary, wellness practitioners. The discussions of the wellness practitioner in the literature portrays the wellness practitioner as the antithesis of the present medical practitioner. The wellness practitioner would be holistic (non-reductionist), humanistic, naturalistic (i.e. use natural remedies), therapeutically conservative, equalitarian, personable (using a low level of technology), and caring. Further, such a practitioner would practice in settings that reinforce the dignity of the patient and personalizes care, with a minimum of bureaucracy.

Writers on holistic medicine such as Gordon,[13] have postulated a new paradigm for medicine (a holistic one) to provide a counter model to biomedicine. For Capra[14] this can only occur if medicine transcends the biomedical model. Kidel[15] notes that this involves much more than simply a change in techniques, but a fundamental change in the concepts of care and wellness. Kidel notes: "Much of holistic medicine . . . still regards physical illness as something to be avoided at all costs and many so called holistic treatments seem to offer little more than an escape from immediate physical symptoms."[15] (p. 20)

It is this same "holistic" model that writers, such as Engel,[16] have postulated as a biopsychosocial model suitable for primary health care practitioners. Brody[17] argues that the biopsychosocial model returns medicine to an appreciation of the patient, and for illness to be understood within the full context of the patient's life. He also notes that at the conference on Family Medicine held in Keystone, virtually all the participants were enthusiastic about some version of this model. He further notes that there is some data to suggest positive health and social outcomes arise from the use of this model. Brody states: *"The*

key to a national health policy initiative led by an aggressive primary care movement is that we must have enough faith in our conceptual model, and enough faith in our proven track record with our patients, to believe that a clearly articulated national health policy will either *be based on a central role for primary care practice according to the biopsychosocial model,* or else will be obviously irrational and unworkable."[17] (p. 44)

In chiropractic, this type of practitioner comes very close to that described by Kelner et al.,[7] Coulehan[8] and Coulter.[12] Although chiropractors would seem to have many of the attributes of primary practitioners, and virtually all the aspects of the wellness practitioner, chiropractic does not claim to be comprehensive for illness care. However, with respect to wellness care (health care) a case can be made that chiropractic is (or potentially is) more comprehensive than medicine (especially with regard to such things as nutrition, posture, exercise, weight, etc.). It does not compete with regard to serious pathology or trauma.

Vernon[18] has used this distinction to develop an illness behavior model for chiropractic, drawing on the work of Waddell.[19] Further, he suggests that chiropractor's success with back problems may depend on their ability to affect the illness and not just disease (where the illness refers to the social/phychological expression and disease is the biological state). As Vernon notes, there is now sufficient literature to establish that patients treated by chiropractors demonstrate a faster reduction of pain, a faster return to work, that the care is cost effective, and that patient satisfaction is very high. Vernon[18] therefore suggests that in the therapeutic setting chiropractors should consciously strive to treat both the illness and the disease. This is an attempt to apply Engel's biopsychosocial model to chiropractic care. In this model back pain is the disease component but the disability is the associated illness behavior. Waddell[19] has suggested that medicine has all but ignored the illness component of low back problems.

The opportunities

In some ways the opportunities for chiropractic will differ from country to country. However, this article will focus on two fundamental opportunities that exist in the United States on the grounds that the U.S.A. has the most entrenched chiropractic delivery system (and the biggest) and that what happens there will have consequences elsewhere.

The first opportunity is the one Norman Cousins[20] termed the holistic health explosion, and which has been termed here, the wellness movement. Although many holistic paradigms predate this explosion, the impetus is coming not from the practitioners but from the consumers. Patients are seeking and demanding changes. For chiropractic to participate and establish itself in the minds of the public as a wellness based practice (and perhaps as *the* wellness practitioner) requires giving up traditional concepts (such as holism); articulating chiropractic concepts in terms more acceptable to the public and more readily integrated with the literature on wellness; and to participate more actively in the discussions, conferences, and publications of the wellness movement.

The second opportunity revolves around the debate in the U.S.A. about a national insurance scheme. This is the same opportunity that is being suggested for family medicine (primary health care). While there is still some disagreement in medicine whether this type of practitioner should be the old time family physician, or a new styled, residency trained, family specialist, they agree that the primary practitioner should be pivotal for any national health care scheme.

This was articulated most clearly in an editorial in the Journal of Public Health Policy:[21] "The primary care practitioner must be seen as the key person in the provision of personal health care: the most highly trained and the most responsible, combining diagnostic and therapeutic skills and knowledge, sympathy, willingness and ability to communicate with patients, and an orientation toward health care rather than merely the treatment of illness."' (p. 130) The same editorial concluded that the old time general practitioner was not competent to provide high quality care of this kind.

Terris[1] suggests that a national health service with nationally planned and regionally integrated health centers and hospitals would be the solution but failing that, a national health insurance should be established. The services to be covered would be predominately primary care. At the Keystone conference this same suggestion was made. Brody[17] states: "It is not within the power of the primary care movement to frame a national health care policy unilaterally . . . However it does seem feasible for the primary care community to undertake to stimulate this political process in productive ways." (p. 43) Rosenblatt[22] also concludes; "Society would also be better served if organized family medicine put its collective strength behind the development of a universal health care plan, from a selfish perspective I believe that the development of a rational national health care system would do more to enhance the role of the primary care physician than any number of relative scales." (p. 50)

In short, the national debate provides an opportunity but this opportunity is also seen by others (including osteopathy and family medicine) as a way for advancing their claim as primary practitioners. Chiropractic will not only have to decide if it will participate in this debate but also what role it will articulate publicly for itself within a national system.

The educational challenge

In medicine, family practice and primary care, has largely been viewed as being at the bottom of the academic totem pole. Further the academic setting, especially the acute care teaching hospital, has been viewed as an inappropriate one for training for primary care. The major resources for research, residencies, etc. were not traditionally given to family medicine. Recently, however this has begun to change. Residency programs have emerged, new more appropriate training centers are being utilized.

In many ways chiropractic faces the same challenges as

family medicine but does so with some advantages. In two earlier articles Coulter[23,24] has argued that the clinical settings in which chiropractors are trained more closely resemble their practice settings than do medicine's. Furthermore, in examining the needs of the chiropractic physician for the 21st century, chiropractic education already has many of the features identified as missing in medical education.

However, if chiropractic is to retain this advantage there is a need to seriously rethink the nature of its education program. Much of the present program has more to do with legitimation than with preparing the student for the type of role envisaged here. It has been estimated that 70% of the current chiropractic curriculum is identical to that of medicine. If the argument pursued here is correct, this is an anomaly.

In many ways chiropractic finds itself in a similar position to osteopathy. During recent years osteopathy has begun to re-examine whether its education program truly reflected either the health care needs of the population or the principles of osteopathy. Ward[25] concluded: "The common educational concept emphasizing normal structure, function, and homeostasis, with its inherent rhythmicity and need for efficient communication networks, has been cast aside for worship at the feet of etiologic diagnosis of disease." (p. 414) A reexamination of the curriculum leads to the conclusion it neither reflected the health needs of the nation or the principles of osteopathy. For example, less than 10% of the curriculum dealt with problems with an ambulatory focus (the bulk of osteopathic patients) while 90% focused on illness and trauma that constitute 1% of the population that go on to hospitalization. Although the neuromusculoskeletal system makes up 60% of the body, it made up only 5% of the curriculum (Korr and Olgie).[26]

At the Texas Osteopathic College this lead to a revolution of sorts. The curriculum has been reoriented to a health curriculum. They have established 12 transfers of emphasis:

- from therapy to prevention
- from later stage illness to early departure from health
- from pathologic medicine to physiologic medicine
- from intervention in biologic processes to seeking their optimal operation by improving the conditions under which they operate
- from focus on parts of the body to the total person
- from the physician to the patient as the source of health and the agent of cure
- from the preoccupation with the disease process to concern about the disease origins, from causes to the factors that permit them to be causes
- from specificity and multiplicity of diseases to susceptibility to illness in general
- from acute crisis and episodic treatment to long term care
- from addressing acute episodic problems in isolation to dealing with them in the context of the total life and health status of the patient
- from an emphasis on depersonalized technology to a heightened awareness of human values and individual uniqueness.

In terms of the actual changes in the curriculum it meant more attention was given to factors influencing health, positive or negative, a focus on human development, and a focus on effective communication (sociology, psychology, education). With regard to clinical education they reduced hospital based training and increased ambulatory, community based, training. The goal was to prepare the student for primary practice not hospital practice. Such an approach reflects the fact that osteopathy also sees a niche for itself as a primary health deliverer. It also highlights, by its contrast, some of the problems with contemporary chiropractic education.

Conclusion

This paper set out to examine three issues: primary health care; chiropractic care; and the challenges to both in the coming decade. It would seem obvious that primary care will have an increased importance in the next century. What form it will take, and who will deliver it, will depend on a host of complex factors, not the least of which will be which groups seize the opportunity being offered. At least one branch of allopathic medicine, family medicine, has already staked out a claim as has osteopathy. Chiropractic is currently well positioned to deliver much of the primary care for health.

Two factors should give cause for conern. Firstly, our educational programs have not been articulated specifically for this task. Secondly, there are grave doubts about whether our current students are practicing up to the level of the present educational scope. Much of the blame for the latter must be laid at the door of the profession, many members of which persist in telling the student that in the real world of practice they will have to give up holistic notions and concentrate on patient flow. There is widespread belief promulgated to the students that cracking backs is the only approach to "make it" economically. This is further exacerbated by the fact that many thrid party payers will only cover manipulation.

The paper has suggested that two opportunities exist in the wellness movement, and the national health debate, for chiropractors to try to change this corner into which they are being painted (and painting themselves). However, all opportunities come disguised as hard work. Chiropractors first face a fundamental decsion – do they wish to be identified as a specialty or as a general health care model engaged in delivering primary care. If the decision favors the latter then they must find new, and urgent, ways of articulating this and ways of ensuring they are competent to practice it.

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