Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Something, Anything-Based Practice

Robert Mootz, DC

The practice within a health care profession is supposed to be based on something, isn't it? It seems there is no shortage of things upon which we can base it. Practice can be based on principles or evidence. In chiropractic, we might base it on subluxation or musculoskeletal conditions. Perhaps practice is based on our training or our clinical philosophy. Maybe it's based on ethics; business efficiency; prevention; maintenance care; new patients; theory; or community. How about a family; pediatric; sports injury; geriatrics; workers' compensation; personal injury; insurance; cash; or NOOPE-based practice? Of course, one might have a practice based on technique: Gonstead; Activator; applied kinesiology; diversified; SOT, etc.

So what does it mean to base your practice on something? Does it mean that once you choose the basis of your practice you cannot deviate from it, regardless of circumstance? If there are no randomized controlled trials upon which to determine if extremity adjusting is effective for some wrist pain syndrome, does that mean an evidence-based practitioner should refer that patient with such a problem to a medically-based physical therapist or a subluxation-based chiropractor? Or what if a patient fraught with psychosocial chronic pain behavior presents to a subluxation-based chiropractor, should that doctor refuse to consider anything but spinal lesions?

Obviously, very few of us would embrace whatever base we gravitate toward to the point of absurdity. Still, the buzzword concepts of evidence-based this or subluxation-based that are intended to convey a core set of characteristics that our patients, health care purchasers, other providers, and the community we serve can use to better understand what we offer. But pragmatics of the real world necessitate that regardless on what we base things, that base is really just that: the base or starting point. Unfortunately, simplistic perceptions can prevail, and who among us does not have a war story about someone trying to use a starting point as an absolute?

Evidence-based medicine is becoming the state-of-the-art for defining how health care should be delivered. For the most part, I think this is a good thing, and it is certainly the obligation of health care professionals to stay abreast of the latest and greatest scientific information, and consider it when working with patients. Recent history, however, has extracted much of the obligation for how evidence is used in clinical settings to surrogates and defined processes in the insurance world. Reasons for this change have been debated endlessly and include the realities of escalating pharmaceutical costs; abuses by a few bad apples; medical errors; evolving high-cost technologies; allocation of diminishing resources; and litigation. But Americans now spend one out of every seven dollars on health care, making it, not housing, the biggest purchase most of us will make in our lifetime.

The next big thing in health care in my opinion will be value-based health care purchasing. As an aging population requires more health care services, demand for those services will increase. As health care delivery continues to be flavored by administrative and business realities, more innovations and competitiveness seem likely to spring forth into the health care marketplace. Value in health care has traditionally been defined as quality received for the money spent (V=Q/$). However, quality, to the extent it is perceived to be a luxury, is the first thing the mass consumer considers discretionary when money gets tight. In that situation, value becomes outcome for the

money spent. "Good taste" can quickly succumb to "tastes good" in a value equation when dollars are scarce.

So I will toss a new buzz-term into the fray, at least for the intellectual exercise, if not for colloquial adoption by the greater health care world. Instead of basing our practice on things, I prefer having our practices informed by them. Evidence-informed practice, or subluxation-informed practice, just makes more sense to me conceptually. Rather than what you base a practice on, the value received by those paying the bill will become increasingly important. With governments and employers representing the largest health care purchasing entities (as distinct from the patients who consume the services), I expect to see those communities increasingly defining what goes into the value equation. I suspect that getting the biggest bang for the least buck will be the priority. If we think preferences of doctors and patients have been placed on the back burner so far, just wait.

Health care is not typically a discretionary purchase. Yet consumers' discretionary dollars must increasingly be devoted for higher premiums, out-of-pocket expenses, or various taxes. Because health care costs have started escalating again, the next few years will probably begin to see employers cutting back on benefits or shifting a larger proportion of the costs to direct co-pay or contributions to premiums from employees. Government programs and many health plans have tried to deal with the problem on the backs of doctors by simply reducing what is reimbursed. Unfortunately, the previous decade cut out the bulk of the fat in doctors' offices, and further cuts are dramatically impacting access and patient services. The hassle factor and lowered incomes are driving doctors away from patient care in many places. The predictable way the market will respond is by diverting even more money toward health care. That means costs to patients and purchasers will go up, or benefits will be reduced.

Whether it is patients, or government regulators who must make the tough choices about how health care dollars will be spent, you can be sure that regardless of what doctors base their practices on, their clinical efficacy and efficiency will be what everyone looks at. Issues important to us, like range of motion, reduction of subluxation, or pain relief seem unlikely to have as much currency to purchasers and regulators as things like returning to work or the need for additional health care services.

For both market positioning and purposes of prioritizing research for our profession, I believe a concerted effort is needed to learn to use those things on which we like to base our practices to help improve our outcomes, rather than to justify our existence. Simply justifying the need for services, documenting that they were provided, or demonstrating how happy a customer was with the service will become less important than the big picture of how effective and efficient they were. Chiropractic continues to exist primarily outside of mainstream settings, so it is likely that our needs will not routinely be default considerations of the greater system. That makes it ever more important for our research and how we position ourselves in the market place, to assure that what we are offering is relevant to the external world.

Robert Mootz,DC
Olympia, Washington
thinkzinc@msn.com

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