Dynamic Chiropractic

HEALTH & WELLNESS / LIFESTYLE

Two, Four, Six, Eight - Let's All Integrate: Sitting at the Front of the Bus

Anthony Rosner, PhD, LLD [Hon.], LLC

For years I have been impressed by the similarities between the growth of chiropractic into an accepted means of health care and the 1950s-1960s civil rights movement in the U.S. Just as Rosa Parks, in Montgomery, Alabama, was barred from seating in the front of municipal buses in 1956, so have chiropractors been denied the proper scope of practice or reimbursement for their services - despite full accreditation and credentialing. The respective emergences of either Afro-American populations or the chiropractic profession from oppression and intimidation by vested interests have followed many similar dynamics,[1] both relying upon major Supreme Court decisions, which then became historical benchmarks and foundations upon which to gauge progress.

You can ratchet-up this analogy a notch when you consider what Candace Campbell, the executive director of the American Association for Health Freedom, said before the White House Commission on Complementary and Alternative Medicine Policy. On December 7, 2001, she testified: "The term CAM is, we hope, a short-lived one that will eventually be outmoded by integration (emphasis mine)."[2]

Just as we thought we were getting a handle on CAM, we have integration to contend with. If you thought the terminology debates about "alternative" or "mainstream" were taxing (to say nothing of "subluxation"), try "integration" on for size. I guarantee that trying to put one's arms around "integration" will make the other terms look like small beer by comparison. Various conceptualizations (or accusations for the paranoid among us) run the gamut from active collaborations to passive aggrandizements. In a brilliant essay on chiropractic and integration, John Weeks, of the Collaboration for Healthcare Renewal, points out that a number of surveys have indicated that up to 85 percent of employers offer some sort of chiropractic coverage.[3] But the types of benefits run a country mile, ranging from the widely criticized affinity plans to the more liberal allowances - some of which even stipulate that chiropractors practice primary care.

The problems with integration so far, as Mr. Weeks argues, are that (i) chiropractic may be nominally included, but there is little MD referral; (ii) accepted use is only a fraction of the licensed scope of practice; and (iii) there is continued institutional exclusion (as when the Joint Commission on Accreditation of Healthcare Organizations developed pain guidelines, but totally omitted any reference to either chiropractic or manipulation as among the half-dozen "nonpharmacological" CAM approaches to reducing pain).3 This last point is no different from the AMA's notorious "amnesia" concerning manipulation, when that august body published its abridged version[4] of the AHCPR's low-back-pain guidelines,[5] or when the Harvard Pilgrim Health Plan somehow found a way to avoid any reference to manipulation ("My dog ate it") when it discussed treatment options for low back pain in a recent newsletter.[6] And Weeks' point (ii) spins my *chakras* to no end, when I realize how strong instructional programs in clinical chemistry have been at chiropractic schools like National or Northwestern - yet chiropractors seem to be intimidated from actively pursuing clinical chemistry profiles on their patients by either anti-phlebotomy laws in many states, a sense

of hopelessness, or both.

What needs to be understood is how far this recognition has to progress for chiropractic health care to gain meaningful acceptance. Its appreciation in terms of federal funding of research, termed virtually nonexistent just a decade ago,[7] has indeed been forthcoming with such federal agencies as the Health Resource and Services Agency; the Agency for Health Research and Quality; the Veterans Administration; and the National Center for Complementary and Alternative Medicine of the National Institutes of Health - providing in excess of $15 million in grants pertaining to chiropractic research in just the past few years. Recognition by the *media*, on the other hand, has often descended into vaudeville because it is based upon massive quantities of misinformation fed by politically motivated vested interests that, for now, shall remain nameless.[8]

Suppose we begin with training opportunities. Payments to support medical residencies through the hospital prospective payment system have just been calculated to be $7 billion per year, or $70,000 per resident.[9] Extrapolating what U.S. taxpayers pay to train each MD, that turns out to be $500,000 per MD.[10]

The comparison with training chiropractic equivalents in health care is downright embarrassing: except for a few internships that have been made available to outstanding chiropractic researchers in the past decade (which can be counted on the fingers of both hands), there have been no significant funds yet available to train chiropractic researchers.

When one tallies up the awards from the National Center for Complementary and Alternative Medicine, the results are equally sobering. From the data available from the NCCAM website, one can readily identify how individuals from alternative centers for chiropractic research have been awarded. The breakdown according to award type over the past two fiscal years (FY) is as follows:

Award Type	Number, FY 2000[11]	Number, FY 2001[12]
Predoctoral National Service (F31)	8 (0)	9 (0)
Career Development Award (K01-K30)	13(2)	6(0)
Centers (P30)	15(2)	4(0)
Research Projects (R01)	58(3)	24(0)
Research Program Projects (P01)	2(0)	0(0)
Conference Grants (R13)	2(0)	5(2)
Academic Research Enhancement Awards (R15)	1(0)	0(0)
Exploratory/Development Grants (R21)	20(3)	56(4)
Education Project Grants (R25)	6(0)	5(0)
Small Business Innovation Research (R42-R44)	9(9)	8(8)
Institutional National Research Service (T32)	6(1)	6(1)
Continuing Education Training Grant (T15)	1(0)	0(0)
Cooperative Agreements (U01)	6(0)	0(0)
Totals	147(20)	115(7)

The numbers in parentheses represent either small businesses or institutions that can be readily identified as grounded in different fields of alternative medicine. While there was an appreciable increase in minority institutions receiving awards in FY 2001, it is apparent that the percentage of recipients from clearly identifiable institutions of learning in alternative medicine is appallingly low - 14 percent in FY 2000, and even lower (six percent) in FY 2001. Rather than jump to the conclusion that these figures represent outright bias, one needs to account for the possibility that

the number of qualified applications from alternative medical institutions is low.

Furthermore, the major multimillion-dollar center grant at Palmer University is not shown, since that award was made prior to FY 2000. Nevertheless, the irony remains that only a minuscule percentage of applicants based at institutions in alternative health care received grants from the federal center specifically created for alternative medicine.

To address many of these concerns, the White House Commission on Complementary and Alternative Medicine Policy was created to deliver a report to Congress for the purpose of generating legislation to address many of these shortcomings. In its final report, released on March 26, it is gratifying to see that many of the concerns myself and others presented to that body found their way into the text; in particular, recognizing the importance of patient-practitioner interactions, tailoring treatments to individual patients, recognizing multiple treatment effects, and promoting wellness behavior. To its credit, it insists that third-party payors need to understand published evidence before making their decisions on reimbursement. However, what appears to have been overlooked are (i) recognizing the comparative strengths and weaknesses of experimental design - many of which I described in this space previously,[13] and (ii) insisting that professional training opportunities be put on an equal level to those currently provided for allopathic medicine, as argued above.

Finally, to create an ongoing infrastructure that would create Congressional action beyond the lifetime of the White House Commission, which would also allow for continuous networking and policy monitoring among the diverse federal agencies, a National Policy Dialogue to Advance Integrated Health Care convened at Georgetown University in November 2001. A broad coalition (including myself) representing CAM schools, academic medicine, insurance companies, and professional organizations of CAM providers, researchers and consumers was present. One can only hope that the crossing of professional boundaries and the wide scope of organizations in this coalition will help to advance the agenda for a realistic scope of practice for chiropractic, and other forms of healthcare delivery not associated with mainstream medicine. In the meantime, as was duly noted by Wardwell[1] and others, and which is being carried forward in both legislation and lawsuits so valiantly spearheaded by the American Chiropractic Association in the U.S., chiropractors (as Rosa Parks insisted on being granted access to the front seats of the bus) must assert their civil rights by appropriate civil actions.

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Anthony Rosner,PhD
Brookline, Massachusetts
rosnerfcer@aol.com

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