Dynamic Chiropractic

PHILOSOPHY

Counsel in Dissent, Part III

TO DIAGNOSE AND REFER DOES NOT A PRIMARY CARE PHYSICIAN MAKE

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I recently heard Dr. Andrew Weil state on national television that at least 80 percent of the health problems that come into the doctor's office do not require drugs or surgery. Dr. Weil is a Harvard MD specializing in what he terms "natural and preventive care." Note the pivotal word "and."

"Wellness care" alone does not leave much in the way of specific services for a doctor to perform. As I did in "Dissent, Part I," I refer you to the article, "Chiropractic and Wellness Care" (Vol. 4, No. 1, Journal of Chiropractic Humanities). Without the "natural care" aspect of practice one cannot be considered a primary care physician (PCP).

How do we define PCP? Dr. Reed Phillips recently addressed the definition of PCP promulgated by the Institute of Medicine (see below). The IOM has offered several definitions of PCP. A prior definition to that addressed by Dr. Phillips came into issue with the demise of the Southern California College of Chiropractic (aka Quantum University). The Council on Chiropractic Education (CCE) denied the school accreditation in a resolution adopted June 16, 1994. The primary rationale for the denial was the school's purported "misinterpretation of the concept of the preparation and education of the doctor of chiropractic as a primary health care provider."

From July to Oct. 1995, I served as the part-time vice president for institutional advancement and as general counsel for Quantum University. A response to the "resolution" of the CCE was presented to the Calif. Board of Chiropractic Examiners in a brief hearing,[1] where I argued, among other things:

1. The Foundation for Chiropractic Education and Research had in a 1991 report declared that chiropractors "generally (are) found to be lacking" in the qualifications for PCP status under the then existing definition by the Institute of Medicine (IOM).[2]

2. The "CCE has substituted the concept of diagnose and refer for diagnose and treat."[3]

This error is being perpetuated in the argument in favor of the wellness paradigm.

At an Oct. 1995 meeting of the Calif. Board of Chiropractic Examiners, Quantum University Chancellor Dr. Floyd and I presented to the Board a preliminary version of the vision which is being developed in this series of articles. We requested that the Board ignore the lack of Quantum's CCE accreditation, to allow the school to develop and refine its vision to move in a different direction with the education of its students. We had about 10 minutes to present this new vision, obviously not sufficient time to develop the concept.

Even based on the limited presentation, three of the seven Board members voted in favor of our request. Based on the questions and comments from the Board members, I believe that three of the five DC members voted in our favor; the other two DCs, plus the two lay people voted against us. I'm grateful to the three members who voted with us. Thank you.

I now turn to a series of three articles relating to the primary care/wellness issue that appeared in Dynamic Chiropractic. It would be well worth your time to review these articles. I will present only a limited response, and use three terms: primary care physician (PCP); portal of entry physician (PEP); referral-based independent practitioner (RBIP).

Article #1: "Primary Care: An Education Dilemma and a Practice Predicament," DC, Sept. 1, 1996, by Reed Phillips, DC, DACBR, PhD, president of the Los Angeles College of Chiropractic:

Dr. Phillips presented an extended analysis of the Institute of Medicine's (IOM) definition of a PCP which was promulgated in March 1996. He noted that "chiropractic had no representation" in the processes undertaken by the IOM towards producing their definition. Why not? Did anybody demand or even ask to participate? Was any legal action ever contemplated to enjoin the IOM from proceeding without our participation? I for one did not take any of these actions.

Dr. Phillips quotes extensively from the IOM definitions:

"Primary care is the provision of... health care services by clinicians ... addressing a large majority of personal health care needs,...

"... personal health care needs refers to the essential characteristic of primary care clinicians: that they receive all problems that patients bring, unrestricted by problem or organ system, and have the appropriate training to diagnose and manage a large majority of those problems and to involve other health care practitioners for further evaluation and treatment when appropriate..." (emphasis added).

We have three choices, he concludes: 1) change to comply with the IOM definition (doesn't make specific suggestions); 2) ignore the IOM and go our own way; 3) use and refine the definition of the wellness paradigm. He does not explain how this would qualify us to be considered PCPs: it simply does not.

I cannot see the difference between choices 2 and 3. Either we meet the IOM definition or we do not. Any attempt to independently redefine what constitutes a PCP is to go our own way; this is true even if another group buys into the wellness paradigm.

The IOM position is in effect that to be a PCP you have to be able to diagnose and treat a large majority of all existing problems; either directly yourself or by "involving other health care practitioners." Wellness or health promotion relates primarily to the limitation of future problems, not existing problems, nor does it relate to all types of conditions.

Nowhere in the three articles I'm discussing is the subject of our legal scope of practice addressed. Where does a chiropractor derive the legal authority by "involving other health care practitioners"? The legal question cannot be ignored. The FCER's conclusion that DCs cannot qualify as PCPs was based in part on their analysis of the legal issues.

If you are not a PCP, what are you: a PDP; a RBIP? A portal of entry physician is one who can work directly with patients without the necessity of referral from some other physician. Of course that will satisfy the interest of many of you reading this article, but what about the rest?

Article #2: "Response to 'Primary Care: An Education Dilemma and a Practice Predicament' by Reed Phillips," DC, Dec. 16, 1996, by Meridal Gatterman, MA, DC, M.Ed, New York College of Chiropractic professor.

Dr. Gatterman's responds to Dr. Phillips' article emphasized the need for a patient-centered model

of health care, and the need for a broader clinical training for chiropractic students. This is a significant contribution to the definition of chiropractic. She also stressed: "Chiropractic has nothing to be gained by filling the niche medicine wishes us to fill." Right on!

She does not address the question of how we increase the number of tools in our doctor bag, or recognition of the use of additional tools by many DCs today.4 Again, this is a necessary step for those DCs who wish to practice as PCPs.

Article #3: "Are We Preparing Our Students for the Future of Chiropractic," DC, Jan. 1, 1997, by Jean Moss, DC, president of the Canadian Memorial College of Chiropractic.

Dr. Moss addressed the wellness paradigm, but does not add anything specific to the definition of that concept. She emphasized the need to:

1. change the chiropractic curriculum to place more focus on the conditions that respond to chiropractic care (she appears to mean musculoskeletal specialist care);

2. bring the chiropractic message to segments of the population which have not previously used our services for musculoskeletal problems (e.g., geriatric patients);

3. prepare students to participate "as an equal member of the health care team" as a primary contact provider.

These are worthy goals, but do not constitute primary care practice. Is it realistic to think that DCs can be both equal members of the health care team and primary contact providers? I'm not sure of the sense in which she is using the term "primary contact provider."

So long as our paradigm is founded primarily on the spine, we are precluded from being the referring physician by that part of the definition which refers to "unrestricted by problem or organ system."

The limitation of PCPs to those who are not "restricted by problem or organ system" was not as far as I can find part of the definition of PCP until the IOM version released in March 1996. It seems at least in part directed at DCs.

My understanding of how managed care operates in the U.S. is that specialists work on referral from a PCP. This would make us a RBIP. How realistic is this?

There is no room for PCPs (alternative or otherwise) who do not have tools to address a majority of common health care problems. The 80 percent figure used by Dr. Weil should meet the "majority" of common health care standards, but how do we meet this standard?

References

1. This brief is on file with the Board and anyone can look at it. In Sept. 1995, I filed a legal action on behalf of Quantum University against the Calif. Board of Chiropractic Examiners. On Oct. 17, 1995, I informed the school that I had a conflict of interest (which I cannot disclose) and could no longer continue to represent the school or its students. I resigned as vice president. I think that lawsuit could and should have been won in the long run, but I'm not privy to what has developed since.
2. Brief, pp. 20-22, and Exhibit "N" (part of FCER report, pp. 113-114).
3. Brief, p. 14.
4. The CATO Institute Policy Analysis, The Medical Monopoly, Protecting Consumers or Limiting Completion? indicated that there are some 1,000 homeopaths in the U.S. The 1993

Job Analysis of Chiropractic by the National Board of Chiropractic Examiners showed that 36.9% of the respondents used homeopathic remedies. Projected over 50,000 DCs, that is approximately 18,000. Why are such facts invariably ignored by spokesperson for this profession, the media, and governmental agencies?

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