Dynamic Chiropractic

PHILOSOPHY

Schmoozing with the Enemy? Well, Not Really

William F. Updyke, DC

I was staffing a booth along with three others for the ACA and the CCA at a California state association annual convention for family physicians in San Francisco a while back and had an interesting experience. Most of the time was spent handing out research on the effectiveness of chiropractic to the inquisitive MDs who stopped by. It was surprisingly non-confrontational and actually a lot of fun.

The vast majority of the conversations we had centered around positive things. Some stopped by to say how great it was to see our associations at their convention. Others just walked by and said with smiles on their faces, "It's about time you guys showed up here." More than a few had supportive statements about the doctors they worked with and how impressed they were with them. Sure, there were a couple of complaints about chiropractors, but they were infrequent and centered around a disgruntled MD saying, "Why do I never get a 'thank you' when I send a patient to a chiropractor?", or else something about a DC not referring the patient back to them when they were done with treatment.

I was surprised that no one overtly complained about our presence there. The main concerns voiced by the MDs had to do with what they occasionally thought was a higher frequency of care delivered by some of our colleagues. Each of us there had our own way of answering that question, and each method seemed effective at handling their concerns while conveying a positive image for the profession. Unfortunately, some of the examples they gave us forced us to punt and note that every profession has their "outliers." They understood, and at east one doctor came around and said, "Well, I guess we monitor blood pressure once a month for six months and charge for each office visit," obviously implying that some conditions required ongoing evaluation and treatment.

We spoke to a few DOs who discussed manipulation with us. Overall, I felt that they were very conservative regarding manipulating patients, often preferring to try medication or modalities prior to a trial of manual treatment. Some of them admitted that they did no manipulation in their practices because their osteopathic college did not teach it to them. Another memorable fellow admitted that he had all but stopped manipulation: "It's too much work. It is much easier to give someone a prescription for their problem." A sad statement indeed, but definitely true. If anyone has taken a look at the rates we pay for disability insurance lately, you know just how demanding our occupation is.

There were some huge (in my mind) wins made across the display table that day. One was the woman who worked for a rural health center on a native American reservation. She had been trying to hire a DC for over a year to come into their hospital and treat patients. During that time, the state of California's Medi-Cal department had been giving her the run-around. She was attempting to find out how to apply for the higher reimbursements that they allow for a chiropractor (the difference being that they typically paid $6 a visit, but for a "rural health care center" they would pay somewhere in the neighborhood of $40 for a DC visit) in this special situation. Fortunately, Sara Fighter, DC, knew of a man who specialized in setting up chiropractors in these situations and she put the woman in touch with him. Nice!

The other notable win was the medical director for what he described as a "large" medical group in central California who was fully at risk on their Medicare HMO contracts. He was interested in figuring out how to deny claims to chiropractors in this situation because of the new guidelines they would have to abide by. His thinking was that the key to get away with it would be to hire someone to say that the required x-rays were "normal" and did not demonstrate the necessary "subluxation" that Medicare required. He was set straight and advised of his realistic options, which included either contracting with or hiring DCs in his area, or contracting with a chiropractic IPA. We provided him with names of people to help him with his task and sent him on his way. That conversation alone likely put tens of thousands of dollars into the pockets of DCs every year.

Now to the guy who really upset me. This MD was friendly enough and I chatted with him briefly. He then began speaking with another of our booth's representatives and asked that doctor why we have our patients come back three times a week. Sometime around then I began speaking to another MD who had just walked up to the table. About that time the original doctor said, referring to why our patients come back three times a week, " ... because when I manipulate a patient and have them come back in two days they are still sore."

It was a good thing that his answer came from another of the booth's representatives and not me. He was advised in a much nicer way than I would have approached it that maybe he was not doing the best possible job.

That guy sent me into a mental tizzy that clouded my thoughts for long after. I fail to see how or why this MD thought that what he was doing was acceptable. If any of us continually noted that our patients were sore two days after their adjustments, I think we would know that taking a few technique seminars, along with practicing our technique, would be indicated. This guy was so uninformed that he did not know that he had a problem, and that was frightening. Since that time, a great article on the side-effects of manipulation has been published,[1] and in the future, using it as a reference would be helpful in outlining to an MD exactly what patients can expect in the way of side-effects from adjustments.

More important than his lack of insight on the issue is the fact that this doctor is doing a disservice to his patients by rendering unskilled manipulations to his unsuspecting patients. A recent malpractice case written up in AM News noted that a neurologist who was not experienced at a tricky procedure was liable for his patients' injuries after surgery entirely because he failed to tell the patient that he was inexperienced, and that a group of highly skilled neurologists were available just a short distance away. I think the same sort of thing applies here. If he is having complications to his procedures, he should be notifying his patients that there are DCs right down the street that could do this much better than he could. However, short of a malpractice decision on this topic, no one is going to be able to do anything about this problem.

Maybe what we need is a quality assurance organization that is created to review doctors for such purposes. Although the state and national boards are supposed to be testing our technical competency, no adjustments are ever delivered, so how is one to know that by viewing a set-up if the thrust would have been appropriately performed?

I have no answers, but offer this up as food for thought. I hope someone out there will have some insight on this issue and be able to do something about it, because judging from the number of manipulation seminars being delivered to non-DCs, this problem is going to get even more prevalent.

Reference

1. Senstad O, Leboeuf-Yde C, Borchgrevink C. Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997,22(4):435-400.

William F. Updyke, DC
San Francisco, California

SEPTEMBER 1997