Dynamic Chiropractic

PHILOSOPHY

Everybody Wants to Go to Heaven, but Nobody Wants to Die

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Chiropractic is now in its centennial year. As if perfectly timed for this birthday, the weight of scientific evidence is now validating chiropractic's reason for existence as a separate discipline.

Neuromusculoskeletal ambulatory medicine is the focus of more attention than ever before. Spinal manipulation, so long maligned by the medical establishment, is now being reconsidered by those very doctors in the light of new evidence. And chiropractic physicians are becoming more widely recognized as leaders in biomechanical care.

With the publication of Acute Low Back Problems in Adults by the Agency for Health Care Policy and Research, with several favorable controlled clinical trials published in the most reputable journals, and with the Guidelines for Chiropractic Quality Assurance and Practice Parameters (Mercy Conference report) now published for all to use, one might expect that a golden age has begun. It has not. The reasons certainly include a variety of outside antagonistic forces. But chiropractors would do best to focus on the role we have played, are playing, and can play in the unfolding of events.

We Can't Build on Ground That We Don't Own

"Medicine," generically defined, encompasses a very broad landscape. Chiropractors have a clear and legitimate claim to a small piece of that turf.

Our claim must be asserted powerfully. To the extent that we build solidly, we prepare for a future where this turf is enlarged. If instead we are distracted by claiming territory which is not ours or by seeking the unattainable, we risk losing everything.

Not long ago, for instance, the chiropractic profession's scientific leadership was focused on responsibly reporting the ground breaking RAND report, The Appropriateness of Spinal Manipulation for Low-Back Pain. However, so many chiropractors and chiropractic organizations misquoted the results of that report that the main author Paul Shekelle, MD, PhD, was forced to publicly disavow[1] these distorted promotions. We succeeded only in snatching reprimand out of the jaws of vindication.

Non-researchers often underestimate the sensitivity of those who publish concerning the precise reporting of their findings. In chiropractic, specifically, there is a history of non-researchers misunderstanding the entire enterprise of scientific experimentation. When studies which took years of enormous dedication to produce are used simply as tools in ideological battles, we alienate the very community of investigators on which we so depend.

Chiropractors, on the whole, have resisted the simplicity of clearly demarcating our territory and building only on that. Limitation of any kind reminds us of the long, secret, and illegal AMA campaign to "contain and eliminate" the chiropractic profession. But our preoccupation is of little interest in today's lightning-paced world of restructured medical care.

Where Do Chiropractors Fit?

Often outsiders can see what we cannot. It was the sociologist Walter Wardwell who first clarified the "limited medical" practitioner model for chiropractic in the New England Journal of Medicine in 1980.[2] He suggested that chiropractors' ideal, achievable future could best be compared to dentists and psychologists, both recognized groups of doctors outside the medical doctor's aegis whose specialized expertise is fully accepted.

Craig Nelson, DC, took this model further in an influential 1993 JMPT article.[3] He drew the significant distinction between "primary care" and "portal of entry care." Often treated as synonymous, these are two quite different concepts. Primary care has come to refer to comprehensive medical care. Portal of entry care simply means care that does not require referral. Nelson clarified why virtually all the current debate within the chiropractic profession regarding scope of practice has become obsolete. He outline the importance of accurate self-definition as a prerequisite to participation in medicine's future.

The response to his article exposed how much intransigence can still be found even at the highest levels of leadership within the profession. Even the director of research at the Foundation for Chiropractic Education and Research raised the false hope4 that there are ways to avoid the discipline Nelson proposed.

Portal of Entry Care

The issue of when patients have direct access vs. when patients have only referral access to particular practitioners has taken on a new significance in the managed care era. Managed care contracts typically require referral from a primary care physician (PCP) prior to seeing any specialist. Within many HMOs no exceptions to this rule are allowed.

More often thought, certain specialists have come to be exempted from the PCP requirement. This departure from the norm seems to have been developed, in most cases when each of the following conditions were present:

1. consumer pressure for a particular type of medically necessary care was sufficiently strong;

2. this demand could not be met by the available PCPs;

3. the specialty's field of expertise was sufficiently distinct from the PCPs to raise questions whether the PCP was in a position to refer appropriately;

4. the specialty practitioners demonstrated the capacity to manage utilization in some other way.

Not surprisingly, successful examples include both the dentists and the psychologists referred to above. There is a down side however. This "exempt" status is often based on the separation of the specialty's coverage from overall medical benefits.

By current definitions we are clearly ineligible for inclusion within the primary care physician category. It remains to be seen whether we can make a sufficiently strong case for portal of entry

status anywhere except in traditional indemnity products. Obviously, though, alternative solutions, such as educating PCPs to facilitate appropriate referrals, will be strong contenders in the managed care marketplace.

Acceptance Cannot Be Legislated

The keys to acceptance in today's insurance climate can now be identified. For any medical practitioner they are similar and rather simple:

1. a track record of strategically discerning conditions requiring treatment from those which do not;

2. clear and clearly documented treatment regimens which appropriately respond to specific situations;

3. objectively demonstrable and reliable results;

4. a professional self-definition which corresponds to the known scientific data, i.e., practice organized around core clinical competencies.

The late Joseph Janse, DC, one of the true visionaries of the chiropractic profession, would often quote the motto of his chiropractic school: esse quam videri (to be rather than to seem). With this approach we can achieve the recognition Dr. Janse always sought: to be regarded as we are, as he would so often say, "Nothing more and nothing less."

In the past, for the believers there were no questions and for the unbelievers there were no answers. The resolution of our place in medicine will not come from either zealotry or prejudice. Instead, chiropractic's lasting place in medicine is being built on the solid foundation of scientific evidence. Cooperation with our medical colleagues and mutual respect for the challenges of properly responding to patients should characterize this coming period.

But our profession is deeply divided, ambivalent about accepting the discipline of protocol-based practice. While everybody wants the rewards of inclusion, a large number of us have incompatible or contradictory commitments.

The Wave

Far from being the first and only medical group to be under scrutiny, we are one of the last. While it is true that the methods for ensuring our compliance are substantially different from other specialties, most of the expectations we now face are already quite established throughout the rest of medicine.

Every specialty within medicine's enormous spectrum is now at one stage or another in the process of implementing guidelines and standards. From these evolve the protocols which will soon set future expectations.

Health care reform is proceeding inexorably, perhaps even faster than it would have under any national legislation considered last year. The current restructuring can be summarized as the triumph of the outcomes movement. The movement has been described[5] as being propelled by

confluence of three forces:

1. market pressures toward cost containment;

2. competition -- especially as prompted by new managed care organization (MCO) configurations (IDNs [integrated delivery networks], PHOs [physician hospital organizations], staff model HMOs, IPAs, and an infinite variety of hybrids);

3. quality research and new tools of analysis -- especially regarding variations in practice approaches and, following from that, practice guidelines;

The tidal wave driven by these combined forces is unstoppable. It is sweeping away established ways of delivering services in every branch of medicine and in every setting where care is delivered. in Southern California, for instance, in the last five years 40 hospitals have closed and many of the remaining 279 are in dire financial straits.[6] Doctors underestimate these forces at their own peril.

Research and Its Relationship to "Medically Necessary" Care

Most chiropractors are familiar with the market pressures and the MCOs from the popular press and personal experience. Unreported for the most part, though, have been the new tools of analysis.

Behind the influential figures in health care reform reported in the popular press (e.g., Ellwood and Enthoven) are the innovators in the monitoring and evaluating health services (e.g., Ware, Wennberg, Deyo, etc.) and the overlapping group of innovators in crafting the consensus model of practice guidelines development (e.g., Brook, Chassin, etc.).

The meticulous "small area analysis"[7] of internist and epidemiologist John Wennberg (and others) beginning in 1973, documented significant variations in the application of specific surgical procedures in various communities. These variations, he points out, could not be justified by any known or accepted variables.

Wennberg theorized that the public would be better served by more scientifically based and uniformly applied criteria for specific interventions. His work set the agenda for generation of researchers. It is this body knowledge that will inform the work of those analyzing chiropractic utilization patterns.

Approaching the same questions from a different angle, the RAND Corporation, among others, developed the consensus model for setting appropriateness standards. It provides a vehicle for the transition from haphazard utilization patterns to care informed by national "best practices."

In the Mercy Conference process, chiropractic has simply been utilizing this universally recognized vehicle. Fortunately, it was the leadership of the chiropractic profession that had the foresight to begin this journey relatively early.

Some have argued that chiropractic should be exempt from such "medical" strictures. However, this position ignores the legal requirements of participation, at any level, in insurance-reimbursed medicine, regardless of any overt "managed care" provisions.

As "insurance equality" laws were passed, starting decades ago, chiropractic's coverage brought with it new responsibilities. The day, for instance, when the statute mandating chiropractic inclusion in Blue Cross and Blue Shield of Rhode Island became law in 1987 was also the day began our obligation to meet their "medical necessity" standards.

"Orthopractic"

The gravity of chiropractic's predicament is illustrated by the emergence of a so-called orthopractic brand of chiropractic manipulation. This attempt by a small group of medical doctors to define what are and are not acceptable practice within chiropractic as well as to assume control of the spinal manipulation market has been seen by some as a major threat.

Orthopractic is not a mighty predator; it is simply an opportunistic scavenger. It waits only to see if there is any life in us. In other words, are we able to identify and remedy the serious internal problems that threaten the capacity of our entire profession to function within medicine? Are we able to carry the Mercy Conference process forward? If we act promptly and with self-respect, their influence should be inconsequential.

Orthopractors are attempting to take credit, without adding anything original, for what our own chiropractic scientific leadership has accomplished.

100 Years and Beyond

There are, of course, many legitimate concerns about limiting ourselves. No provider specialty in the world is, or should be, held strictly to doing only that which is conclusively demonstrated in the literature. Yet every specialty must now clearly define its own practice parameters in relationship to that literature.

The relative strengths of the competing specialties and special interests are, of course, far from equal. Nevertheless, in the current health policy struggles, the best way for us to leverage our strengths is to know them. We need to correlate our clinical practices as closely as possible with those that have been demonstrated to be most effective. In other words, we must unequivocally commit ourselves to protocol-based and defined care.

We should not do this in order to placate insurers. We need to act for our patients' sake, out of principle, and in defense of our own professional integrity. Nevertheless, to the extent that they are outcomes oriented, the insurers' interests intersect with those of the chiropractic profession as a whole.

Chiropractic cannot advance by misconstruing the literature. The policy-making establishment is currently reassessing its traditional antagonism toward chiropractic. Under no circumstances, however, will they or should they sanction inaccurate or overstated promotions.

The United States is already well into the "era of assessment and accountability."[8] Chiropractic in the centennial year is playing catch up.

We cannot defend the indefensible. We can certainly claim our ground, building on what we do best: treating patients with neuromusculoskeletal problems. By this we prepare to contribute in the restructured environment ahead.

References

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9. About the author: Charles H. Rybeck, DC is president of Spine Protocol Systems, Inc. (SPS), a utilization management firm. SPS specializes in interpreting scientific practice procedures and developing practitioner networks. SPS is currently completing the implementation of the Mercy guidelines for Blue Cross and Blue Shield of Rhode Island, the first state-wide effort of its kind in the United States.

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12. Dr. Rybeck has been studying and writing about managed care since 1975 when he was at the Institute for Policy Studies in Washington, D.C. He is a member of the Patient Oriented Management System (POMS) Working Group to develop a next generation framework integrating information systems across the health care value chain. The POMS initiative is an advanced technology program of the National Institute of Standards and Technology.

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