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HEALTH & WELLNESS / LIFESTYLE

Chiropractic and Wellness Care, Part III

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The Dark Side of Wellness Care

There are a number of ways in which the wellness movement is not only ineffective, but actually self-defeating by making health and well-being more difficult to achieve. The most important of these self-defeating characteristics can be expressed in the phrase, "The ideal is the enemy of the good." Implicit in the wellness care doctrine is the notion that good health balances precariously on a knife's edge, and the extreme vigilance is necessary to preserve that balance. One gets the sense from reading the literature on wellness that good health can be achieved only through great effort: It is imperative that great care be taken in monitoring and regulating diet. Obviously no fatty foods of any kind are permissible and all food additives of any kind must be purged from the diet It would also be a good idea to get tested for any food allergies that might be causing problems. Don't forget the micronutrients. A finely tuned regimen of vitamins and minerals is essential. Eat a pizza? Sure. Why not just hold a gun to your head and pull the trigger? Finally, make sure you get that body fat percentage below 10 percent. A good cross-training program (about 90 minutes a day) of running, biking, swimming, and rowing should suffice.

I realize that I am describing a caricature of wellness, but it is one that contains elements of the truth. Particularly in the areas of diet and exercise, the amount of effort that is required to maintain good health has been greatly overstated. Most of the benefits of diet and exercise are achieved with minimal effort, by avoiding only the most extreme sorts of indolence and gluttony. This fact is obscured by the ideal model of the vegetarian, meditating, triathlete, an ideal that is unachievable by most people. I suspect many people are discouraged from trying to change their bad habits because they believe that it is only worthwhile if they can achieve this ideal.

In contrast, Table 2 describes a comprehensive wellness program that achieves virtually all the benefits of behavior-based health.

Table 2

This table might be modified slightly for different ages, sexes, or for pregnant women, but there really is very little to add. This list is intentionally vague and imprecise because that is all that is necessary. There is no advantage in attempting to fine tune diet and exercise for the individual, or in going to other extremes to promote health. In the first place, there is no reliable data upon which to base any fine tuning. In the second place, if we did have such data we would probably find that the benefits from this would be slim.

Another self-defeating aspect of the wellness movement might be called health care Calvinism: Good health can only be achieved and maintained through suffering and sacrifice and by observing

a strict code of behavior. This is made explicit in the utterly loathsome motto of the fitness brigade: "No pain, no gain." This bias in favor of asceticism and self-denial, can also be seen in the attitudes of health professionals toward alcohol use. One of the strongest predictors of heart disease found in the Framingham study was abstinence from alcohol. That is, nondrinkers were found to have significantly more heart disease than moderate drinkers. This finding has been confirmed in several other studies and there is agreement that the relationship is causal; moderate drinking (no more than two drinks a day) will improve health by a number of measures including lowering rates of heart disease and lowering mortality rates overall.[38,39] Indeed, the evidence for the beneficial effects of elevating serum alcohol appears to be better than the evidence for lowering serum cholesterol.

In a recent issue of the American Journal of Public Health, Stanton Peels, PhD, an expert in addiction and alcohol abuse, takes the public health community to task for failing to acknowledge the beneficial effects of moderate alcohol use. He blames what he call the "temperance mentality" (Calvinism) in the United States public health community for viewing alcohol use in either/or terms: either a person abstains from alcohol use, or he abuses alcohol. He note the difference between the U.S. and other "temperance countries" like Canada, Great Britain, and Sweden, and non-temperance countries, such as Italy, France, Spain, and Denmark, which regard alcohol use as a part of everyday life, as food. The non-temperance countries a) drink more alcohol per capita; b) have lower rates of heart disease; c) have lower rates of alcohol abuse.[40]

Despite the strong evidence in its favor, and despite Dr. Peele's arguments, there seems to be little appetite among wellness/public health professionals for discussing the beneficial aspects of moderate alcohol consumption. The only alcohol-related issues of interest seem to be drunk driving and alcoholism. While these are serious problems they are only part of the story. The other part of the story, that alcohol consumed in moderation is good for you, is not promoted, apparently because alcohol use is pleasant and enjoyable and does not require sacrifice.

In this regard, there is a competing value that must be balanced against the value of a healthy lifestyle: the value of pleasure. There is ample evidence that pleasure, the pleasure derived from eating, drinking, sex, and not exercising, is itself an important component of good health. It is I suppose possible to live without pizza and ice cream, and beer, but I certainly don't want to test that hypothesis. An element of enlightened hedonism needs to be added to the principles of wellness to restore a proper balance.

One of the most serious problems with wellness care as it is currently conceptualized can be summarized by the phrase used by the British Medical Journal regarding cholesterol testing: "turning healthy people into patients."[12] In every health person it is possible to identify aspects of their physiology or behavior that depart from the ideal: their cholesterol or blood pressure is a bit high, they're a few pounds overweight, they drink too much coffee or eat too much fat, their spine is not in perfect alignment. By identifying these departures from the ideal it is possible to convince an otherwise healthy person that they are unhealthy and thereby detrimentally transform them from a healthy person to a patient. This is known as the labeling effect.

The labeling effect has been most extensively studied in hypertension. If you compare hypertensive patients who are aware of their condition (they have been labelled), to hypertensive patients who are unaware of their condition (have not been labelled), the labelled group has a measurably lower quality of life. They have higher rates of absenteeism from work and show more signs of depression and anxiety than the unaware group.[41] This would not be a problem if it were obvious that the aware patients clearly benefited by being diagnosed. It is certainly worth a little anxiety to prevent

strokes or heart attacks.

It is not that simple, however. The overwhelming majority (70-75 percent) of diagnosed hypertensives are classified as having mild hypertension. The additional risk of heart disease and stroke in this group is very small. A recent study of the treatment of mild hypertension (diastolic blood pressure between 90 and 99) found no statistically significant differences in the rate of what were called "major clinical events" (fatal and nonfatal heart attacks, fatal and nonfatal strokes, and other cardiovascular mishaps) between drug treatment groups and a placebo group after a 4.4 year follow-up.[42] A previous British study estimated that it was necessary to treat 850 mild hypertensive patients in order to prevent one stroke.[43] A review of the treatment of mild hypertension concluded that, "the current approach to the management of high blood pressure involves treatment of very many persons to measurably benefit only a few."[44]

It is reasonable to assume that this effect is present anytime a person is labeled with a particular disease or condition. The individual is transformed from viewing themselves as a healthy person to viewing themselves as hypertensive patient, a high cholesterol patient, an overweight patient, or even a subluxated patient. Thus, there is an additional burden that must be met by any wellness intervention: Do the likely benefits of the intervention outweigh the very real harm that can be done by labeling? There seems to be the belief that preventive or wellness interventions are intrinsically without possible adverse side effects. As shown, this is not true. It is quite possible to harm while providing wellness care. The principle of "First, do not harm," must apply to wellness care as well as to disease care.

Perhaps the most pernicious element of wellness care, at least practitioner-based wellness care, is that it reinforces and strengthens the physician's dominant status relative to the patient. The idea of wellness care suggest that a physician is needed to achieve wellness, a principle that is objectively false. In effect, it places the physician between the patient and wellness: one more hurdle that must be cleared by the patient. Indeed, there are times when a patient is distinctly dependent upon a doctor, usually when that patient is actually sick or injured. Staying healthy is one area where the physician is virtually irrelevant. Physicians should abdicate this role and encourage patients to pursue wellness independently, as they are perfectly capable of doing.

What's Wrong with Disease Care?

Victor Sidel, MD, a past president of the American Public Health Association, makes an important differentiation among health care services that sheds light on this discussion.[45] He divides health care into four distinct components:

1. Medical care. The treatment of individual patients for specific problems, e.g., an MD treating a case of strep throat or a chiropractor treating a patient with low back pain. (Dr. Sidel did not consider chiropractic in his analysis, but it is fair to say that in this sense the two professions are equivalent. We might also call this component disease care.)

2. Preventive medicine. Physician provided guidance or services for individual patients in promoting good health and preventing disease, e.g., patient education, disease screening, immunization, etc. This is the component that has been under discussion here: practitioner-based wellness care.

3. Public health. Policies and services directed at populations, e.g., sanitation, hygiene, anti-

smoking campaigns, legislation regulating seat belt use.

4. Social well-being. Socioeconomic factors that relate to health, such as employment, income, housing, crime, and so forth. I'd prefer to call this the socioeconomic component.

This analysis makes clear the difficulty chiropractors, or any other physicians, have in defining themselves as wellness providers. Component 2, provider-based wellness/prevention, comprises a rather limited range of services of limited effectiveness. Education alone is unlikely to be effective in changing behavior, and other specific preventive services have only marginal value. Effective wellness/prevention programs are not based on practitioner care, they're based on policies, services and factors that are far removed from the doctor's office. In fact, the less a wellness program relies on individual patients and physicians, the more successful it is likely to be. Indeed, the very phrase "wellness provider" is something of an oxymoron. You can talk about wellness, you can encourage it, you can be in favor of it, but you cannot provide it. It is components 3 and 4 that are most likely to be effective in the wellness/prevention area: raising the cigarette tax, legislating seat belt use, passing tougher drunk driving laws, building safer freeway ramps, and so on.

Coulter argues that wellness care, like illness care, requires a practitioner-based system. "It is likely that individual responsibility for wellness will be no more successful than individual responsibility for illness and that if we are to be serious about wellness it will also require a delivery system that is practitioner based."[1]

There is every reason to believe precisely the opposite. Recent history has shown that individuals are quite capable of identifying and changing behavior appropriately. Wellness or public health programs are effective precisely to the extent that they do not rely on practitioner-based delivery.

The single most dramatic improvement in our nation's health in the decade of the 1980s was achieved through a component 3 measure. The incidence of accidental deaths in infants and children was reduced by 65%. This was achieved through the use of infant and child restraints in automobiles. This change in behavior, the increased use of these restraints, was accomplished by making the non-use of these restraints illegal.

Even more important is socioeconomic status, component number 4. It is a frequent criticism of our health care system that in spite of spending more per capita on health care than any other country, the U.S. trails many industrialized countries in most indices of health: infant mortality, longevity, etc. This is true but misleading. If you make the same comparisons, but do not consider the 10% at the bottom of the socioeconomic ladder in each country, the U.S. emerges at or near the top of these same indices. The major health problems of the U.S. are those that are directly related to the social pathologies that plaque our country: poverty, crime, drug abuse. These social pathologies, and their associated health problems, will not be solved my MDs, DCs, or nurses, nor with antibiotics, CT scans or spinal adjustments. The leading cause of death among young black males is homicide. What can the health care system (components 1 or 2) offer to remedy this situation? Better emergency room treatment of gun shot wounds? The solution for this appalling state of affairs is not going to come from the health care system. The solutions will involve social scientists, political scientists, economists, and even politicians. Physicians of every stripe should be concerned about these social pathologies, but as citizens, not as professionals who have any particular expertise or insight regarding these problems.

I would add one further differentiation in Dr. Sidel's analysis. That is, I would separate components 1 & 2 from components 3 & 4. They are distinctly different. The first two are what we might call

biological health care: health care that is directed at physiological functions of patients and delivered by professionals trained accordingly -- physicians. Components 3 & 4 could be called sociological health care: health care that is directed at how we live, how we work, how safe are our neighborhoods. It is important to recognize this differentiation. Sociological problems will not yield to biological solutions.

The advocates of wellness care are probably most persuasive when criticizing our current health care system. There is much to be critical of. It is too expensive, too reliant on technology, too impersonal, too uncertain of its outcomes. But the prescriptions offered are often no better than the problems they attempt to correct. While a lecture on the evils of cholesterol is, I suspect, cheaper than bypass surgery, replacing an expensive, high-tech, and often ineffective therapy with a cheaper, no-tech, ineffective, and unnecessary procedure is hardly a satisfactory solution.

It is also a legitimate criticism of our health care system to state that it places too much emphasis on disease care and not enough on prevention or wellness care. It does not necessarily follow however that this imbalance is corrected by changing the practice habits of individual practitioners, whether they are DCs or MDs. Rather it suggests a shift in emphasis away from practitioner-based services and toward public health or socioeconomic solutions to many of our health care problems.

The reality is that good health is not something that is provided by doctors and it is not something that can only be achieved through a rigid adherence to certain behavioral guidelines. Rather, good health is primarily the product of affluence, of genetic good luck, and of a casual adherence to a moderate life style. In other words, good health is available free of charge and with minimal effort, at least for those lucky enough to be middle class and living in Western democracies. For the rest of the world, good health will be achieved only through improvements in economic status. To some this might be an uncomfortable conclusion, but it is a conclusion that is supported by the facts. For all of us who make a living selling health care services, it suggests that we will be held to a higher level of accountability than has previously been the case.

Most of this discussion on wellness has been in terms of life span and mortality rates, in other words, quantity-of-life outcome measures. Wellness is certainly not just a measure of quantity of life, but of quality of life as well. The problem is that it is much more difficult to measure quality of life. There is certainly less data on wellness programs and quality-of-life outcomes. It might be argued that many of the limitations associated with quantity-of-life wellness programs are more easily overcome with quality-of-life wellness programs. Perhaps. However on the face of it, the problems appear to be the same. There is still the question of how practitioner-based wellness care would be delivered and what those services would consist of. There is still the problem of how to effectively change behavior, if that is the goal. And there is still the question of whether physicians can deliver the relevant information more efficiently or economically than others, e.g., the mass media.

Chiropractors and other critics of the health care system often make the point that what we have is not a health care system, but a disease care system. If by health care system we mean physician-based services, this observation, if not the conclusion, is accurate. Clearly most of the time, money, and effort is spent taking care of people who are already ill or injured. Why is this considered a bad thing? The assumption seems to be that that much of what people are treated for can be prevented, that every incidence of a disease represents a lost opportunity to prevent that disease. But this assumption isn't true, or at least no convincing case has been made that it is true.

The discussion on wellness argued that good health is not difficult to achieve, at least if you are lucky enough to be living in the latter half of the 20th century in an industrialized country.

Inevitably however, even the healthiest person will become ill or injured and some people, because of bad luck or bad genes, are chronically or frequently ill. This will occur no matter how many resources are devoted to delivering wellness care, whatever that is, and no matter how wholesome our lifestyles. What are we to do when we do become ill if not seek care or treatment from a disease care physician? The fact that disease care is the type of health care service that is delivered by both chiropractic and medicine should not be surprising or alarming. It is perfectly appropriate. Caring for the sick and injured has always been the primary purpose of physicians and there is no reason to believe that the role should change.

An Alternate Model

There is an obvious point that needs to be made. That is, the chiropractic is a profession, a vocation, not a way of life or a philosophy. The profession exists only to the extent that there is a market for its services. Thus in any discussion of chiropractic principles or paradigms we must ask a vulgar question: "What will future chiropractors do to earn a living so they can pay back their student loans, so the schools can remain viable, so those schools can hire people like me to write articles like this?" The advocates of wellness care have not explained precisely what wellness services chiropractors can provide for which they can be paid. For advice and information about wellness? I don't think so. For programs of behavior modification to alter lifestyles? It would be lovely if chiropractors had such programs that were effective, but we do not and we are not particularly well trained or positioned to develop them. For simply being advocates of the principles of wellness? No.

How then will chiropractors earn a living in the 21st. century? I suspect that chiropractors, and every other type of physician, will earn a living by doing essentially what they are doing now: treating people with symptoms; people with problems; people who are not well. The profession will flourish and thrive to the extent that we demonstrate effectiveness and economy in treating these unwell patients.

If wellness is not an appropriate model for chiropractic, is there any other principle that might serve instead? There is the sense that the profession needs an identity beyond simply "back doctor" if it hopes to prosper. There are a number of health care principles that the profession can apply in defining itself. First, the profession must acknowledge that good health is a function of many factors and that no one doctor or profession can adequately serve a patient's every need. Patients need to know that when they go to a chiropractor they will receive, either directly or by referral, whatever it is they need: manipulation, exercise, medication, surgery, psychotherapy, or whatever. Conforming to this principle would require that chiropractic abandon its reductionist view that an absence of subluxations equals good health.

Another idea that chiropractors can embrace is the conservative principle that less is more when it comes to health care. Less drugs, less surgery, less chiropractic. The above discussion argues that good health is not primarily a function of health care. It is a function of many factors, if which health care is but one relatively minor component. Health care providers should recognize this fact and not do more than is absolutely necessary to achieve the desired clinical outcome. Chiropractic begins with a distinct advantage in this regard. Its diagnostic and therapeutic procedures are intrinsically conservative, noninvasive, and economical. Assuming a comparable or better clinical outcome, a half-dozen chiropractic adjustments is always preferable to a surgical procedure or an extended course of anti-inflammatory medication.

Chiropractic is also vulnerable on this point. While chiropractic has the potential for being a conservative provider, it has a long history of doing the opposite, of trying to deliver as much treatment to each patient as possible. Some practice management consultants measure a practice's

success by the number of visits that can be extracted from each new patient. We've all heard the following after introducing ourselves as a chiropractor: "Oh, I went to a chiropractor once. He helped a lot but he wanted me to come back forever." This reputation has been richly deserved by the profession. There is even a light bulb joke that captures this sentiment. "How many chiropractors does it take to change a light bulb? Only one, but it takes 24 treatments." The profession also needs to seriously address its use of x-rays, our one diagnostic tool that is distinctly not conservative. Much of the profession continues to use radiographs to detect subluxations in the absence of any sound justification for doing so.

There is nothing conservative about a treatment regimen of three times a week, forever. If the profession wants to define itself as conservative, and I think it should, it must approach the question of utilization from an entirely different perspective. Rather than asking, "How can I justify more treatments for this patient?" we must ask, "How few treatments can I get away with and still achieve the desired results? How can I reduce my x-ray use? How can I charge less and still make a good living?" Imagine a profession whose reputation was for providing effective, brief, inexpensive, noninvasive treatment: a minimalist health care profession. I dare say the percentage of the public that regularly uses chiropractic services would increase dramatically beyond the current 10 percent.

A final principle that can and should be embraced by the chiropractic profession is the principle of outcome-based practice guidelines. In the past several years three of the world's leading medical journals (JAMA, BMJ, N Eng J Med) have published commentaries to the effect that most medical care that is delivered is not based on any knowledge of the clinical outcomes of that care.[46,47,48] This point is particularly well made in the JAMA commentary, "Evidence-Based Medicine," that describes this realization as, guess what, a paradigm shift of the Kuhnian variety. The old paradigm emphasizes the understanding of basic mechanisms of disease, unsystematic clinical observations, and clinical traditions and common sense as the basis for formulating clinical guidelines. The new paradigm recognizes the limitations and inherent unreliability of these methods and in their stead stresses the importance of outcomes-based clinical research, of regularly consulting original literature, and of understanding certain rules of evidence in order to evaluate that literature.

Chiropractic has taken some grim satisfaction in medicine's admissions of ignorance, but this satisfaction must be tempered by the recognition that our own ignorance about what we do is at least as profound as medicine's. This shift away from theory and conjecture and tradition, and toward evidence-based health care is one of global proportions. All health care professions will be judged and will prosper accordingly by their ability to demonstrate the effectiveness of their interventions.

It is too late for chiropractic to claim unique ownership of this principle of outcomes-based health care, but it is not too late to jump on the bandwagon. Indeed we have little choice in the matter. If the profession fails to acknowledge the primacy of evidence or outcomes-based health care over theory-based health care, we risk being relegated to the status of, say, homeopathy, within the health care system: a quaint relic of the 19th century.

Conclusion

The limits of chiropractic, practitioner-based wellness care can be summarized as follows:

1. Manipulation as prevention is an untested hypothesis.

2. Not all disease is preventable. In fact, among affluent countries, most morbidity and

mortality is not preventable. In a society that is healthy enough to have an aging population, high rates of cancer and heart disease are inevitable. It is not evidence of a failed health care system.

3. Most of the preventable morbidity and mortality is preventable through measures that are not practitioner-based.

4. The causal relationship between many risk factors and the disease is uncertain. The risk factor, say, elevated cholesterol, may simply be an epiphenomenon that is a reflection of some other underlying disorder. Changing the risk factor may have no effect on the underlying disorder.

5. Most of the risk is associated with the extremes for each factor. In other words, there are a very few people who are at a relatively high risk, while most people, even those considered to be outside the "normal ranges," are at relatively low risk.

6. The potential benefits of behavior modification for most of the population, even assuming ideal treatments, is small. The net benefits from actual treatment programs are even smaller or nonexistent.

7. Identifying a behaviorally-based risk factor does not necessarily lead to a change in that behavior. Interventions, if based on lifestyle modification, are frequently ineffective in changing the risk factors because of poor patient compliance.

8. The principles of a healthy lifestyle are easily understandable and achievable without benefit of physician guidance.

9. Disease screening has not been shown to be very effective at changing morbidity and mortality from those diseases.

Wellness care as a model for chiropractic presents many difficulties, primarily that wellness care is not a practitioner-based system. The most important factors in wellness are functions of socioeconomic systems (housing, working conditions), of public health measures (sanitation), or of individual behaviors (smoking), none of which are effectively addressed by individual practitioners. The profession as a whole can and should participate in the debates that guide public health policy and individual practitioners should not ignore patients' behavior that adversely affects their health. However, given the limitations of practitioner-based wellness care, it seems unlikely that chiropractic can define itself as, or transform itself into, a wellness profession.

In place of wellness are several principles that the chiropractic profession could adopt in defining itself. These are the principles of non-reductionism, conservatism, and of outcome-based clinical guidelines. Admittedly, these principles do not have quite the elan or pizazz of wellness, and they can't readily be collapsed into any one word or phrase, but they do have the virtue of being comprehensible, achievable, and defensible.

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