Dynamic Chiropractic

Chiropractic Scope of Practice, Part II

OBJECTIONS

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Dr. Nelson's timely commentary is reprinted from the Sept. 1993 issue of the Journal of Manipulative and Physiological Therapeutics, Vol. 16, Number 7. Because of the original article's length, we've divided the article into three parts. The "pulls" (bolded quotes from the text in large type) have been done by "DC."

Obviously, my sentiments lie with the belief that chiropractors should describe themselves as portal of entry neuromusculoskeletal specialists. In arguing this point with my colleagues a number of objections are usually raised to this position. At the risk of setting up and knocking down some straw men, I'd like to examine those objections.

Objection 1: Some chiropractors practice in rural areas and are the only physician of any kind to serve their community. They must be allowed to act as PC physicians. The fact that a certain community may not have the usual contingent of health care providers does not ipso facto mean that those providers who do practice there can and should attempt to fill the voids that remain. In other words, the fact that a community needs a PC does not transform a DC who practices there into one. Assuming that a DC practices within the law regarding drug use, minor surgery, obstetrical care and so forth, the community will be underserved as far as its health care needs are concerned. Suppose for the moment that there are chiropractors practicing in such communities, and that they do it spite of the legal limitations imposed on them serve as the PC for that community, and further suppose that these chiropractors have achieved by virtue of their experience serving as a PC an expertise in this role equivalent to that of, say, a family practitioner. Having supposed all that, it remains true that this mode of practice represents a tiny percentage of the practice habits of chiropractors at large. These PC chiropractors are aberrations, anomalies and do not provide a useful model for the profession.

Objection 2: What we are really concerned about is portal of entry, and not primary care. However, the only way we can ensure portal of entry status is to claim to be primary care providers. If we retreat on the primary care issue, we will lose portal of entry. In other words, we must ask for this much (arms spread wide), knowing we won't get it, in order to get this much (arms held at shoulder width). The logic of this eludes me. In fact, I believe asserting that chiropractors are primary care providers will have precisely the opposite effect. This assertion is not one that can be convincingly argued. In any case, it hasn't been convincingly argued. There is no evidence that anyone outside the profession -- not patients, not policy makers, not other health care professionals -- believes this assertion to be true. By continuing to defend the indefensible, chiropractic undermines its own credibility, it prevents the profession from developing a coherent and credible scope of practice, and it invites others outside the profession to define the scope of practice for us. If there is one thing that most in the profession can agree on, it is that if we allow those external to the profession to define chiropractic, they will define it in a way that will be unacceptable to almost every chiropractor: something like what was suggested on the "20/20" program; chiropractors should treat patients with low back pain on referral from an MD after that MD has made a competent diagnosis.

Consider those professions that are ambiguously not primary care and equally unambiguously are portal of entry providers: dentistry, optometry and podiatry. Interestingly, these are often cited as precisely the types of profession that chiropractic does not want to become: "If we're just 'back doctors,' why, we'd be no better than dentists," this said with the tone of voice usually reserved for use when referring to some socially undesirable quality. I'm sure it would come as a great surprise to dentists to know that they were held in such low esteem by chiropractors. It would probably be a great source of amusement to them as well. In any case, these professions that make no claims to be PCs are far more secure in their POE status than is chiropractic. No one would seriously suggest that if you have a toothache, or if you need your vision examined, or if you need bunion surgery, that you should first go through an MD gatekeeper before seeing the appropriate doctor (More about dentists later).

There is a parallel argument that goes something like this: Sure, chiropractors see mostly patients with back pain, headaches, etc. But not all cases of back pain or headache are caused by mechanical/structural problems. There is a wide range of serious organic illnesses that can produce back pain or headache as symptoms and in order to make an accurate diagnosis, chiropractors must be diagnostic generalists. In fact, I believe that in many cases diagnostic generalists are less rather than more likely to make an accurate diagnosis than a specialist.

If I may, let me descend to the level of anecdote to illustrate this point. Recently two patients, a 52-yr-old male complaining of low back pain and a 27-yr-old female complaining of headaches, were seen at the Northwestern outpatient clinic. The man had previously been seen by his internist and been diagnosed as having a lumbar sprain/strain. The woman had been seen by her family practitioner and was diagnosed as having migraine headaches. Both were unsatisfied with their respective treatments and became patients at the Northwestern clinic.

In truth, the man's back pain was the result of a metastatic prostatic carcinoma to the spine and the woman's headache the result of a benign brain tumor. These correct diagnoses were made by chiropractors (with the help of advanced imaging) soon after their admission to the clinic. There was nothing about these two patients that made the gravity of their conditions obvious. (In fact, the MDs who originally saw these patients could easily be forgiven for not making the correct diagnoses. They were, after all, relative amateurs dabbling in the neuromusculoskeletal system). Yet taken as a whole -- their history, their exam, their effect, their unresponsiveness to treatment -- their cases added up to more than the sum of these individual parts. The chiropractors treating them, by virtue of their training and experience, recognized at some intuitive level that there was something wrong. These chiropractors made the correct diagnoses not by being generalists, certainly not by being urologists or oncologists, but rather by being experts in back pain and headaches and thus recognizing the anomalous cases when they were seen.

Of course these cases prove nothing. But they do illustrate that good judgment is a product of many things, among them an intuition born of having examined and treated many, many patients, with a particular type of problem.

There are really two arguments that can be made in support of the position that chiropractors should be portal of entry (POE) providers for neuromusculoskeletal conditions: a) chiropractors are PC providers and therefore are obviously competent to act as POE providers for neuromusculoskeletal conditions, or b) chiropractors are the experts in the diagnosis and management of neuromusculoskeletal conditions and therefore are the most competent to act as POE providers for these conditions. The first argument is, I believe, unwinnable. The way chiropractors practice, the nature of their education, the statutory limitations placed on the practice of chiropractic, all make that argument a loser. The second argument is eminently winnable and is supported by the evidence. A colleague has taken this argument one step further

and suggested that, based on their lack of training and experience, medical PC providers are not competent to act as POE for neuromusculoskeletal conditions. Whereas it remains to be seen whether this would ever prevail as policy, it strikes me as an excellent tactical approach toward ensuring POE status for chiropractors.

Most chiropractors have had a variant of the following experience: You are talking shop with some members of the medical community (surgeon, physiatrist, physical therapist, etc.) and he mentions that a friend has shown him how to adjust low backs, and, hey, what do you know it really works! This is said with the intention of being conciliatory, as if to say, "Well, it looks like you guys aren't total quacks."

My reaction to this is, "What do you know about manipulation? Why don't you keep your hands off these people and let someone who knows what he is doing treat them?" Manipulation is not something that can be learned from a textbook or in a weekend seminar. Manipulation is something that can be done well or done badly depending on the training, experience and knowledge of the practitioner. The nuances and subtleties of diagnosing and managing a flexion/extension injury of the cervical spine cannot be grasped after treating one or two such patients. Why should patients accept a second rate manipulator or an amateur back doctor when they can have an expert?

I imagine a gynecologist would have the same reaction if I told him that I dabble in the palpation of breast lumps, or an internist said that I was an ECG dilettante. They would be right. If we feel that manipulation can't be learned from a textbook or in the classroom, do we believe that other procedures can be? Why should a patient go to a DC and receive a second rate gynecological exam when she can to to an expert and receive a first rate exam?

I am aware that there are members of our profession who do function quite effectively in this and in other areas not traditionally associated with chiropractic. I don't question their abilities. I do question whether they can serve as useful models for the profession as a whole.

Objection 3: To limit chiropractic, and specifically chiropractic adjustments, to the treatment of neuromusculoskeletal conditions is to abandon the enormous potential of chiropractic treatment for a wide range of conditions. To attract these "visceral patients" chiropractors have attempted to convince the public, insurance companies and the medical profession that DCs are PC providers and are fully qualified to diagnose, manage and treat a wide range of conditions. Given that chiropractors see only about 10% of the population to start with, and of this 10% only about 3-5% present with non-neuromusculoskeletal problems, I would judge the current model to be a spectacular failure in terms of reaching these visceral patients. If chiropractic is serious about seeing these patients, we must do several things.

First, we must do clinical research on specific conditions and that research must demonstrate that there are benefits to chiropractic care. In the absence of such research there is no possibility of ever increasing that 3-5%. If there is one thing that is clear about how the health care system is changing, it is that without clinical research to demonstrate effectiveness of care for specific conditions no one, not MDs, not DCs, will be reimbursed for treating those conditions.

The second thing we must do is redefine our role relative to these patients. Assume for the moment that there is solid clinical research that shows that patients with peptic ulcers benefit from chiropractic adjustments. In that light, consider the following scenario: An internist calls you and tells you he has an ulcer patient whom he thinks would benefit from manipulation. He would like to send this patient over to you for your opinion and if you think you can help the patient, to go ahead and treat him. In other words, the internist has diagnosed the patient as having an ulcer and would

like you to treat the patient with you role being essentially that of a -- I will speak the forbidden syllables -- therapist. Would you be insulted by this suggestion? Would you hang up in disgust? I certainly would not and I don't know why any chiropractor would. I think we all intuitively know that in many cases our appropriate role is that of a therapist, a treatment giver. This is no different from the internist calling the surgeon and telling him he has an ulcer patient who needs his stomach removed. The surgeon is merely acting as a therapist or technician. He does not have overall responsibility for the diagnosis and management of the patient.

This is the key to gaining access to those "visceral patients." We must recognize that many if not most of these patients require joint DC/MD care. Given that, we should further recognize that in most of these visceral conditions the MD has more training and experience in diagnosis and management of these conditions. To some of you, this sounds as if we are taking a subordinate role, which you may find offensive. Good clinical judgment suggests that in some cases our role should be secondary. In many cases it is primary. Our role in caring for patients should be defined by their needs, not by our egos.

You might argue, what are the chances of getting these referrals from MDs? Certainly, it's a daunting task. It will require much time and much effort to cultivate these referral sources and then only after we have demonstrated some effectiveness in treating these problems. I wouldn't predict any sure or rapid success, but what have we got to lose? The number of these patients that are currently seen by chiropractors must be very close to an irreducible minimum. It would be difficult to do worse than we are doing now.

Objection 4: Many chiropractors are uncomfortable managing anything other than neuromusculoskeletal conditions, but many others are quite at ease with a broader scope of practice. It should be up to the individual doctor to know his or her own limits. The scope of practice must remain broad enough to allow all these different types of practices to exist. This is essentially the state of affairs that now exists. The scope of practice is so ill-defined that everyone can, within limitations, do as he pleases. It is not possible, or even desirable, to create a perfectly uniform profession under rigorously defined scope of practice. There must be room for individual doctors to pursue particular areas of clinical interest or not as they choose. But it is unacceptable to leave the question of the scope of practice open-ended as it is now. Except for the statutory limitations imposed by the various state licensing boards, there are virtually no conceptual boundaries surrounding chiropractic. Health policy makers can be forgiven if they throw up their hands in frustration and exclude chiropractic from their calculations. It is not enough to simply say that each chiropractor will define himself according to his own abilities, interest and philosophy. The profession must provide a coherent and credible definition of itself (scope of practice) before those external to the profession can be expected to consider chiropractic as an important part of national health care policy.

Objection 5: You're missing the whole point. Chiropractic is not about problems or conditions; it is not a subset of the health care community. It is an entirely distinct, unique and autonomous profession. Chiropractors do no diagnose neuromusculoskeletal conditions or anything else for that matter. Chiropractors find and correct subluxations, and thus have a scope of practice as broad as the human nervous system. Here we come to the major schism of chiropractic, areas where there is no possibility of mutual understanding. I suspect there is little likelihood of anyone on either side of these questions changing their minds. It really doesn't make any difference whether I believe these things or not, but it does matter what the rest of the world thinks. I am quite confident that no one outside chiropractic who deals in health care issues is in the least bit persuaded by quotations from BJ or DD or by talk of the philosophical foundations of chiropractic.

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Editor's note: The third and final installment of Dr. Nelson's article will appear in the March 25th issue.

FEBRUARY 1994