Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

The Chiropractor as Health Care Manager

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There is growing concern regarding how the chiropractic profession can ethically increase its market share of the health care industry. Most studies indicate that chiropractors are treating approximately 10 percent of the adult population. The past 30 years has shown a negligible increase in chiropractic utilization despite recent positive media PR, not to mention the milestone Wilk et al. decision. Curiously, the utilization statistics do not vary appreciable even during negative PR years.

For the last seven or eight decades, our resources and energies have been directed towards a fundamental concern -- survival -- professionally and legislatively. Today we think and proceed towards intraprofessional advancement, research and amplification of our educational facilities and postgraduate programs. Regardless of how we've been perceived by the public and the health care industry, our utilization still remains approximately 10 percent of the adult public. Perhaps this is our manifest destiny.

Concomitantly, it may be suggested that the chiropractic profession has become complacent with simply addressing the 10 percent patient pool -- the tip of the iceberg -- while never treating the large majority, the 90 percent hidden below the surface.

But substantial opportunity may be available to the chiropractic profession for participation, advancement, and for amplified opportunity to be of service to our public if we examine our relationship to the medical referral complex.

We graduate some 3,000 DCs a year, representing approximately a six percent yearly increase in the number of practitioners. Confined for whatever reasons to essentially 10 percent of the adult public, our utilization is basically a dissection of this market into smaller pieces each year, as the new DCs are absorbed into the chiropractic family. Obviously we require expansion of our participatory perimeter in the health care market place.

In the last two decades, as we have improved our educational facilities, increased our acceptance by the public and the health care industry, we have created musculoskeletal subspecialties in our profession. The "specialist" profile was professionally rewarding to the entire profession; we have all benefitted from these efforts. Those individuals among our ranks who chose to pursue additional training have then invariably distributed this knowledge back to chiropractic practitioners as postgraduate opportunities.

While we hold these individuals in the highest esteem, we have never been successful in having our subspecialties utilized by either our profession or the health care industry. We had anticipated that our subspecialties would be integrated, as they have in other health fields.

Beginning immediately after World War II, the National Institutes of Health (NIH) began providing funds and facilities for research, which subsequently generated amplification of existing medical specialties and creation of new fields of medicine. But our subspecialties remain peripheral to the industry. Having proceeded as we did (which perhaps was a question of resources), our lack of

participation in some dimensions may have inadvertently served to fixate our perimeter of participation. This has ultimately resulted in our low utilization ratios. With the notable exception of heroic individuals who have contested adversity and persevered, we do not participate nor share in the phenomena of the medical referral system.

Of course we make timely referrals when indicated in all instances to our medical contemporaries for services which we do not perform, or for a dimension of care which supplements our service. This is professionally correct, ethically and in some instances legally mandated as our responsibility and a provision of our malpractice coverage for decades. Traditionally, we have referred patients but seldom has this been reciprocated in the health care industry.

Clearly understand, we are not discussing barter of human beings here, nor do we advocate any form of surreptitious private relationship with physicians where human beings are exchanged according to some pre-arranged agreement which essentially constitutes barter or any other violation of ethics or law.

We do not participate in the medical referral complex as a matter of basic policy with clearly defined perimeters and protocols. Subsequently, we do not benefit as participants in that system either. We are seeing patients as a primary service portal in many instances and in this context our experience and our responsibility is compatible to the general practice physician.

As primary contact physicians, we can manage health care in a more cost-effective way then our medical counterparts, the MD family physicians. Though there seems to be a need for family practitioners, their numbers are decreasing despite the increased demand. One theory is that family residence is more private practiced based than institutional based. The MDs facing a residency choice must overwhelmingly choose more institutional based programs like cardiology, orthopedics, and internal medicine.

This lack of interest and numbers in MD family practitioners creates a prime opportunity for doctors of chiropractic. We have approximately 45,000 DCs already in a network across the country that could fill the need.

The practice of medicine fits into the specialty approach nicely. Its premise of treating a symptom with a specific agent or procedure designed to address the insult lends itself well to a specialist-type delivery system. However, chiropractic, which has its roots deeply entrenched in a more generalist or wholistic philosophy, quite frequently finds itself frustrated or limited in the specialist approach.

We as a profession, need to re-emphasize our generalist approach to practice, and put our emphasis on health care managing. Being a health care manager does not necessarily mean having the ability to prescribe drugs or give immunizations. But to be in a position of primary contact, health care managers must be capable of evaluating the patient to the point of system review to ascertain deviations from normal and referral determinations when necessary.

This generalist refocusing would increase our market, as well as introduce us into the medical referral ring. I'm sure when the various medical specialties see that they will have the potential to receive more referrals from approximately 48,000 practices (with 3,000 potential new practices each year), it will more than cover the expected outrage that will be created by the lesser number of MD family physicians (whose numbers grow about 800 per year).

It might be argued, because of chiropractic's currently specialized emphasis, we will need some transitional, generalized, educational offering and credentialing. If that were the case, there could

be a program set-up and co-sponsored by our colleges and various geographically convenient hospitals to put on a four to six month field program or a six month to a year residence program for students.

In conclusion, I believe the future of chiropractic depends on expanding the market and de-emphasizing the generalist philosophy of health care. This would put the chiropractor in the position of seeing the patients before unnecessary drugs or surgery are prescribed.

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