Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Clinical Experience, Not Philosophy, Produces Competence

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Time and again one hears interns and recent graduates discuss "philosophy" as it relates to their preparedness for practice. The sentiment most often expressed concerns the importance of "believing in chiropractic" as a key to successful practice (success in terms of clinical outcomes and financial rewards). Similar ideas echo through the chiropractic century. Consider for example the words of T.F. Ratledge, D.C., a 1907 graduate of the Carver College:

"... most important part of the chiropractor's education is to be thoroughly convinced that chiropractic is a science. If all doubt about the applicability of chiropractic to human health needs is erased from his mind, he goes out into the world of health service with the highest respect for his professional fellowman and for himself. And with that vibrant enthusiasm inspired by knowledge and belief in his science and in his ability to apply its principles, he is prepared ..."[1]

As a licensed doctor (clinical psychology), such rhetoric truly goes against the grain. I can't imagine my professors, clinical supervisors or classmates suggesting that "psychology works," or that "belief in psychology" was critical for success. We often discussed factors believed important to becoming competent clinicians; chief among these was the extensiveness of our patient exposure under supervision of respected clinicians. We were concerned with developing our own personal competence. We did not talk about "millions of satisfied patients," but rather about patients who didn't seem to respond to routine methods. We argued the relative merits of various techniques and theoretical orientations (behavioral, client-centered, psychoanalytic; what the chiropractor might call competing "philosophies"). We discussed particular patients, and our regular participation in case conferences and clinical management reviews provided lots of shared exposure to diverse cases. We presented cases and treatment plans in detail to our supervisors. We were pleased when clinical plans could be based on published data, but usually such information was unavailable. Most often we relied on knowledge of basic subjects and on clinical experience. We developed confidence in our individual abilities to apply the best that the science of psychology had to offer, but were keenly aware of the discipline's limitation.

No less importantly, we were extensively and intensively supervised in our student clerkships and internships. Here's an outline of my supervised clinical experience:

First Year: observed clinical interviews and discussed cases one afternoon/week throughout the school year.

Second Year: one day/week in an in-patient psychiatric unit at a veterans administration medical center; primary responsibility for clinical intakes, psychological testing and writing up assessments and tentative treatment plans; met two hours weekly with staff clinical psychologist at the VA, and one hour weekly with my university supervisor.

Third Year: one and one-half days/week at a child guidance center; responsible for evaluation and treatment of various troubled children; on-site supervision by chief psychologist of the center (one

hour); university-based supervision by graduate program clinical faculty; tape-recorded therapy sessions; supervision often involved considerable time spent in reviewing the audio record.

Fourth Year: served two days/week as assistant staff psychologist at the University Counseling Center; met for one hour daily with my clinical supervisor to discuss cases.

Fifth Year: full-time internship at the Albany Medical College and its affiliated psychiatric center; three clinical rotations (out-patient psychiatry, an in-patient ward, and the child and adolescent psychiatry service) were supervised by three separate clinicians (two psychologists and a psychiatrist); discussed cases and strategies with my "major supervisor" weekly to discuss patients and my progress in the program.

This training (plus course work and dissertation) qualified me for the doctorate. However, qualifications for examination for licensure required an additional year of full-time, supervised, postdoctoral practice. It was my good fortune to serve as staff psychologist at a physical medicine and rehabilitation specialty hospital, where I saw a broad range of neurological, musculoskeletal, neuropsychological, and urological disorders. And, I might add, I was supervised up the "wazoo" by everyone from the physiatrists and physical therapists to the psychologists, social workers, and nursing staff.

Against this background, my exposure to chiropractic education has often left me troubled. I look at the extent of my clinical training (I'm not a physician) and compare it to the typical nine- month clinic experience of most chiropractic interns, and I tremble. Are these people really prepared to function as physicians, primary care or portal of entry providers? After recruiting all their friends and family to the student clinic in order to give X number of adjustments and Y number of x-rays, have they really seen enough? Do the mini-practices they establish within our college clinics provide the breadth of patient problems they will encounter in the field? Are the overworked, underpaid, and sometimes too inexperienced clinical faculty we employ able to slow down long enough to provide quality supervision? Is the chiropractic internship long enough to provide some degree of clinical confidence for the soon-to-be chiropractor?

I suspect our interns and graduates are also troubled, although they may not realize what the problems are. The college internship often seems to leave students with an urgency to get into practice and find out what their skills can accomplish. I recall a DC friend who confused me thoroughly by talking about his "first patient." Only after a time did I realize that he was not speaking of his internship, but of the first person to come to his private practice. I'm reminded also of students returning from field (externship) settings who marvel at how much "philosophy" they're getting from their field doctor supervisor, so much more than they learned in the student clinic. What they are experiencing, perhaps is an intensive dose of clinical reality under the supervision of a seasoned clinician who has the time to provide them with feedback. In this climate they develop confidence as they experience success in practice. They call it "philosophy."

I'm reminded also of those many students, interns, and graduates who flock to "philosophy" seminars and technique workshops in search of clinical confidence. They may find it too, although it may be a false confidence, born of dogmatic belief in "true principles" or proficiency in some sure-fire clinical recipe that offers unbridled enthusiasm and little critical thought. A more appropriate confidence comes with competence born of extensive clinical experience under the watchful eye of a competent, veteran chiropractor. It takes time; there are few short cuts to competence.

An associateship with a senior doctor can provide this kind of training, but it really ought to take place in our college clinics. Funding is a major problem here, for it takes lots of money to employ

an adequate number of very experienced clinicians. Since our schools, for the most part, continue to be academically isolated, tuition-driven, shoestring operations, funds are limited and so is the chiropractic internship. This is rather ironic, from an historical perspective, since Old Dad Chiro's first school evolved from his Davenport infirmary. Many chiropractic colleges since then, however, have not seemed interested in the health care business. Our college clinics are too often looked upon by administrators as a financial drain, rather than as a vibrant source of "clinical material" and revenue for the institutions. Unfortunately, when I've discussed clinic limitations with administrators at various colleges, I'm usually told that that particular school's clinical experience meets CCE standards and/or is as good as anywhere else. I can't seem to get my point across: "good as anywhere else" is not necessarily so good. Chiropractors need more quality clinical experience (lots more) before they graduate and are licensed to practice independently.

Some schools are trying to alter this pattern, but are so strapped financially that the best of intentions yields little change. Some jurisdictions are also trying to influence the extent and quality of chiropractic clinical training. I understand that Swiss chiropractors are required to serve an apprenticeship with an experienced doctor in order to qualify to take the licensing exam. Scuttlebutt has it that one or more of the American state boards may impose similar requirements. Although this tactic is sometimes criticized as merely a means of keeping new graduates out of the state (which it may be), it is also an excellent way to insure more qualified licensed chiropractors.

Philosophy seminars will not produce competence, but lots of quality, supervised clinical experience will.

Reference

1. Smallie P: Introduction to Ratledge Files and Ratledge Manuscript. 1990, p 52, World-Wide Books, Stockton, CA.

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