Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Patient-Centered Care: Our Newest Spectacle

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Even though medical errors may result in 225,000 deaths per year in the United States, making this the third-leading cause of death, we still think our doctors are infallible. Few people are willing to admit the possibility that their doctor could make a mistake, perhaps a life-threatening mistake. It must be other people's doctors who cause iatrogenic death and other tragedies. Even though we all know that "doctors are only human," we are hopelessly awed by the spectacle of medical technological advances - a never-ending parade of new and improved lab tests, machines, surgical procedures and research findings. Surely, my doctor takes part in all this.

Those of us who are doctors or chiropractors are especially vulnerable to this state of dual consciousness. We often are even more trusting in our physicians than typical patients, because we share in the drive toward two modern developments: evidence-based care (EBC) and patient-centered care. Yes, my doctor is only human, but she certainly is very evidence-based and patient-centered. Isn't she?

Not necessarily. There is just too much evidence out there for the community doctor to assimilate and not enough incentive to try very hard. The implementation of evidence- and patient-centered care requires more than just reading. It requires informed assessment, developing effective patient treatment and monitoring plans, careful patient tracking and educational skills. Continuing education poses its own set of challenges, while the pressures of day-to-day practice place limits on the resources, especially clinician time, that are available for implementing evidence- and patient-centered care. And, as I will go on to explain, there can't really be patient-centered care without effective EBC.

I would like to tell the story of a patient I know well - a chiropractor - who takes pride in being evidence-based and patient-centered, in order to illustrate these points. This patient has a long history of renal disease, an autoimmune disorder. After having mostly been in remission for a long time, this patient experienced a major flare-up, resulting in nephrotic syndrome, and so consulted with a nephrologist. Now, this patient is no ordinary patient. He has a strong working knowledge of pathology, is experienced in retrieving and assimilating medical information and knows his exact diagnosis. Visiting the nephrologist, he was like a customer walking into an automobile dealership armed with a sheaf of Internet printouts on sticker vs. dealer prices for every car in the showroom and for every conceivable dealer-installed option.

Although the doctor wanted to immediately put the patient on immunosupressive treatment, he resisted, pointing out that the literature (literally in his hands) suggested this approach might change lab values but was not shown to prolong renal survival, let alone lifespan. Medical research supporting an immunosuppressive treatment approach for his diagnosis was, at best, equivocal. The nephrologist agreed to this patient trying out alternative strategies, including nutritional measures and chiropractic care. A month later, the patient still exhibited nephrotic syndrome, and what's more, had developed hypertension (150/100), presumably of renal origin. The nephrologist at this time insisted upon the immunosuppressive approach, recommending cyclosporin and prednisone. Against his better judgment, and feeling the pressure to try something in the face of deteriorating kidney function, the patient reluctantly agreed to follow the doctor's advice.

A few weeks later, while filling a prescription for a medication, the patient sat down at a blood pressure measuring station at the drug store made available as a service to the public. It recorded 234/140. The patient got off the machine, virtually accosted the poor drugstore clerk and snapped, "Don't you guys ever have your equipment calibrated?" Returning home to check his blood pressure with his own equipment, the patient was horrified to get about the same reading.

A couple of phone calls later, this patient was on clonidine within an hour, a drug which suppresses norepinephrine production, thus lowering blood pressure. He still is on it. Life with low norepinephrine is not what it used to be. Turning once again to PubMed for information, the patient discovered that cyclosporin is not only nephrotoxic, but produces hypertension in many if not most patients, sometimes to malignant levels (blood pressure high enough to produce organ damage). Although cyclosporin may be warranted to prevent organ rejection in transplant situations, as it is commonly used, using it to treat autoimmune disease is less established. It is not warranted at all if hypertension already is present, because in that clinical situation the potential benefit does not exceed the risk. Time will tell whether the cyclosprorin-related damage to his renal blood vessels will heal and this patient's blood pressure will drop down to pre-treatment levels. The hypertensive crisis is so severe that it is difficult to even remember the renal condition for which the patient originally sought care.

Although the instant availability of information has democratized and thus revolutionized the buying of new automobiles, the same can- not be said for health care, even when the patient walks into the doctor's office possessing the same information available to the doctor. The relationship between the doctor and the patient is implicitly hierarchical, not comparable to that between a consumer and an auto dealer. We assume the auto dealer is trying to take advantage of us, and thus arm ourselves against him. Whereas, we believe the physician is trying to help us and knows best what can and should be done to diagnose and treat a condition, even when we should know better.

According to the patient-centered care model, patients become active participants in their own care and the doctor focuses on their individual needs and preferences. Yes, doctors are supposed to be responsive to their needs and preferences and treat them as partners in health care decisions. However, for this to result in better health care, the patients would require equal knowledge and experience for their preferences to carry the same weight. When push came to shove, the kidney patient I described wound up giving in to a dangerous care plan. He didn't want treatment that might change lab values but not alter the course of the disease. After he expressed that preference very clearly, that is exactly what came to pass.

Many of the attributes of patient-centered care that we hear about make perfect sense and, no doubt, result in more convenient care and perhaps in better health outcomes. These attributes include improved access to care, patients being provided more information on alternative treatment options, having more access to medical records and more instructions for self-care. Patient-centered health care is more coordinated, with good communication between the primary physicians, specialists, nurses and other health care professionals. Post-hospitalization follow-ups and support are provided. Unnecessary and duplicate tests and procedures are avoided. Patients are encouraged to provide feedback to doctors and patients can use the Internet to obtain information on physicians that helps them choose practices that meet their needs.

All of this is necessary and appropriate, but we are left with the following insuperable complication in implementing patient-centered care: Patients, even the most knowledgeable among them, are in no position to assert and enact their preferences when inconsistent with those of the doctors. There is no way of getting around the fact that society is going to have to depend fundamentally on the doctors to deliver patient-centered care, by developing a strong sense of ethics that puts the

needs of the patient first. None of this is possible without practicing evidence-based care, good intentions notwithstanding. Short of finding the time to read, to pursue continuing education and to develop evidence-based practice protocols, even chanting the Hippocratic Oath daily will not allow the implementation of patient-centered care.

As for the patients, having physicians who acknowledge their preferences is not very reassuring if these physicians, be they medical or chiropractic doctors, do not really know how best to proceed, especially if they are prepared to use the power and credibility implicit within their degrees and multiple titles to overpower even the knowledgeable patients.

The following description of evidence-based chiropractic care is available at: www.oregon.gov/OBCE/publications/EMEBC_standards.PDF:

1. The patient-centered chiropractor acts first and foremost in the patient's interest.
2. The patient-centered chiropractor approaches the patient as a whole being.
3. The patient and patient-centered chiropractor act as partners in decision-making that encourages the patient to take responsibility for his/her health.

There it is: Chiropractors and their patients are to be "partners in decision-making." However, can a doctor and a patient really be partners when their knowledge base is unequal? Aren't the credentials of the doctor likely to trump the preferences of the patient, even when the knowledge base concerning a particular matter is equal?

It likely is that most physicians are able to effectively manage most patient complaints and conditions and do so within the parameters of the patient-centered model herein described. However, when a patient has a complex condition or perhaps a number of conditions that are related to varying degrees, it becomes more difficult to get effective care, let alone patient-centered effective care. I would recommend those patients who are fortunate enough to reside reasonably near a teaching hospital or clinic seek treatment there. In my experience, I have found the doctors who function in these types of clinical settings are more likely to be aware of not only the most recent evidence and procedures, but also are more likely to acknowledge the individual situations and needs of the patients. That is what the kidney patient featured in this article did, and he is pleased to have found a doctor who treats him with the same respect and ability that he strives for in treating his own chiropractic patients.

Dr. Mootz (www.chiroweb.com/archives/22/14/15.html) tells a story, in some ways the opposite of the story I tell, of how he found a competent patient- and research-oriented primary physician: "I received personalized, competent care in which evidence was used, both to guide the outcome and facilitate my compliance, resulting in an effective, conservative intervention." Dr. Mootz wonders, "Might such an approach serve as a model for evidence-based chiropractic-care encounters?"

I would suggest that chiropractors really listen to their patients and find out their needs and concerns. In order to provide the best and most personalized care, they will have to be up on the evidence. Again citing Dr. Mootz, there is cause for concern: "Looking at the agenda of most chiropractic meetings, practice management seminars and publications; you would think that the chiropractors' first obligation is to us." (www.chiroweb.com/archives/24/05/12.html) According to Mootz, "We need to get about using the immense talents within our profession to develop, refine and disseminate ethical, successful practice and/or business models that readily incorporate tools for evidence-based decision making and meaningful outcomes management that can be applied to individual, group and integrated practice settings."

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