Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

How Do You Compete With Being Just Another Commodity?

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Ever had a patient ask you for a good chiropractor down the block? Nothing personal, just that their insurance has changed and they need to find someone on the new plan. Some patients go the extra mile to stay with a doc they know and trust or to be sure they have that for their kids. But most people just "need" affordable health care when they need it, in the same way they need affordable car care when they need it. And that's the rub.

It's the instant society after all. Communication occurs in sound bites - text whatever you need, wherever anyone is, whenever it needs to be done. Everything is a linear cause-effect and the inconvenience of delays is well, inconvenient! And so, just scroll on down to the next option. Can quality chiropractic care ever be so ... modular? In fact, I'd suggest a whole lot of DCs have built their practices around "one-size-fits-all" interventions. And chiropractors helped invent it!

Anyone who has ever peer-reviewed chiropractic records has seen an awful lot of chiropractic records that were indistinguishable from one another, patient to patient or visit-to-visit. For all our blustering about the uniqueness of the services we provide, when you look at chiropractic records on the whole, you mostly see the same kind of exam, same X-rays, same care frequency, same SOAP notes with the same objective findings, and the same progress: "Improved, needs more care." This is one of the fundamental challenges we face as a profession when trying to convince others that robust, flexible chiropractic coverage benefits really need to be the norm. In fact, the norm seems to be just the opposite, and there is no shortage of chiropractors available to sign up patients for planned, canned regimens, or to sign themselves up for planned, canned plans!

Yeah, I know - there is the whole "chicken and egg" thing. We were cut out of the system and had to develop efficient, business-savvy approaches to perpetuate ourselves outside of medical referral loops, and then the drug companies (or surgeons, or outliers - always somebody else) ate the goose that was laying golden eggs. And now, just look at the mess we're in! The point is that just like those repetitive habits your patients develop in their postural activities or dietary choices, incremental, repetitive daily behavior is, in fact, what we all become.

So, doctors, for whatever reasons, you have contributed to your own commodification, but the question still remains: How do we compete with being just another commodity? In order to just maintain, you have to be the best "just another commodity" you can be. What is it about modularness that makes it attractive? Beyond the basic effectiveness of doing whatever job needs to be done, I'd argue it's primarily cost and convenience. All fast food fills you up and covers the four essential food groups of grease, salt, sugar and plastic toy. But the fast-food mongers chase the market perception "Holy Grail" of being the most appetizing food for the least amount of hassle and money.

In the case of the chiropractor, the high-value/low-hassle proposition applies to two constituencies: patient and payer. Further, the payer is not usually the purchaser! Often, it is an employer or "taxpayer." So, there are actually three clients who are seeking high value for low hassle. (Kind of

makes one-size-fits-all seem attractive, eh?) And to a certain extent, the lowest-common-denominator model needs to be applied. However, the trick in health care is to concurrently implement effective exception management. Make it easy to provide the easy stuff, but do it in a way that you can catch inadequacy before it becomes a problem.

Enter evidence-based practice resources. In practices in which the luxury of time and therapeutic trials were available to tailor care to individual needs, the time and experience of the expert clinical skill of the doctor balancing art, science and individual patient nuance was the order of the day. However, administration was cumbersome and expensive. Today, screening for red and yellow flags to identify those who might need to go down an exception path is where it's at. For the rest - and this is the critical factor in building a one-size-fits-all intervention - the intervention needs to be fast, cheap and the least involved as possible to get the job done.

That means all of our belief systems, technique preferences and practice philosophies now get filtered through this approach. As an example, whereas we used to think an X-ray on everyone gives us the ability to really see and measure what is going on, thus assessing a better way to deliver an adjustment, the commodified health system asks: Which patients will get a better and faster result (both short- and long-term, and at low cost) when a screening X-ray is used to determine how to provide chiropractic care? This needs to be compared to the outcomes for patients in which an X-ray was not used to determine how to provide the chiropractic care. If all chiropractic patients really do get better, faster and cheaper when chiropractic care is determined with radiographically derived information, then a case can be made for commonly using X-rays in most patients.

However, X-rays add cost, inconvenience and a tangible health risk (albeit small). There is generally consensus within science and practice that not all patients have better outcomes if chiropractic intervention is based on X-ray information.

As clinicians, we need to justify to the system when additional resources such as X-ray will lead to a better patient outcome. Although we have our personal opinions and experience on which to base that justification, the system needs information based on large populations to build one-size-fits-all interventions. These days, X-rays on chiropractic patients fit into exception-management pathways as opposed to the most common management pathways. To make changes to this will require scientifically derived evidence at the population (not individual) level that demonstrate better outcome, cost, safety and convenience compared to the most minimalist alternatives.

As a professional discipline, we need to focus our research agendas and our collective practice experience in finding ways to enhance our ability to build fast, cheap and effective "one-size-fits-most" care pathways that are conveniently implementable in practice settings, while assuring our capacity to readily flag patients who warrant exception management.

No, it's not practice the way it used to be, but it is the way commodity-oriented practice is now. While there will always be room for boutique practices and a certain number of "out-of-system" practices, the mainstay of delivering care to large numbers of people appears from all vantage points to be commodity-based delivery.

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