Dynamic Chiropractic

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The Need to Know

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Recently, a chiropractic colleague made a comment in passing that caused me great professional pain - and considerable pondering. The comment had to do with the ability of our profession to unify (at this point in time) the level of national education (i.e., chiropractic didactic training) among all current practicing chiropractors.

When I worked for the government, a "need to know" policy was in effect. Simply put, this meant that what applied to some did not necessary apply to all: The ability to access certain information was dependent on your level of training or security clearance.

My bright, intelligent colleague who made the aforementioned comment attended the same alma mater as I, yet unlike myself, he was discouraged by our profession and disgruntled by the lack of knowledge or "information access," as it applied to current chiropractic practitioners. His position applied his knowledge to those in private practice, as it related primarily to HMO access. He was aghast at the "ignorance" or lack of knowledge he perceived in those practitioners whose claims and treatment plans he reviewed. His student loans were nearly paid off, and he was considering leaving the profession entirely. He was unable to gain the rewards we private practitioners receive on a daily basis from those who matter most - our patients.

In the absence of reinforcement, all he was subjected to was the negativity or "ignorance" (or is it a lack of financial gain for submission of a reported treatment plan?) in classroom subjects, such as didactic clinical reasoning. He perceived that "most" chiropractors were lacking in their diagnostic ability, as reflected in their reports. According to him, this opinion was supported by his daily review of other chiropractic HMO treatment plans/reports. Adding to his dour opinion was the current legislative approach to limit chiropractic access to California workers' compensation patients (considered to be limited by medical referral); the lack of more procedures chiropractors could perform (when the current procedural terminology coding is owned by the AMA); and the ridiculous assumption that within this competitive health arena, naturopaths and physical therapists (who are undertrained, in comparison with a chiropractor's didactic curriculum) could soon outperform our profession.

I wondered what he was doing about it; then I began to wonder what I have done about it, or have failed to do (for my profession). I know our chiropractic schools have attempted to unify this knowledge base in their didactic curriculum, but for that change to reflect, we must first see our own student doctors enter into private practice. As many of us are painfully aware, this may easily take five years, after receiving a doctorate degree. This is currently a most difficult political health arena to enter into. I recall my own difficulty several years ago in gaining equipment, financing, office location and insurance access. Today, it is more challenging to enter into private practice, but in fairness, it is equally challenging for our medical colleagues. Another medical colleague of mine sold his practice, only to re-enter it as an employee, under corporate control. This challenge is compounded by the fact that most MDs treat in several practice locations, which may create unnecessary hardships in their family life, their personal life, and on their patients' ability to access them in a timely fashion. Yet another MD friend of mine recently became employed again when his contract ran out with another medical group and was not renewed - he was forced to sell his home

and move his family to an area that was underserved, but not necessarily one in which he had hoped to raise his children.

For those not cognizant of the hardships faced by other health specialties, I suggest you visit your neighboring medical doctors one morning a week for two or three weeks; talk to them, and you will soon recognize that chiropractors are not alone in this whole dilemma. Even U.S. health-care giants make patient-care management among various specialties and subspecialties extremely difficult for private practitioners.

As I manage patient cases and care referral, I increasingly find I end up managing (and diagnosing) those cases that, by all rights, should be managed and recognized (emphasis on the latter) by the primary-care MDs. Is this a lack of didactic training or "ignorance" on the part of the MDs, or is it merely representative of the time constraints in patient care; poor insurance financial reimbursements; expensive malpractice and liability premiums; and HMO constraints and restrictions to which all health-care practitioners are subjected?

Recently, a national insurance carrier refused to pay for health services I rendered, consisting of an examination and X-ray due to my diagnosis: "Chiropractors can't make that diagnosis," was the carrier's contention. (I am sticking to my reimbursement claims, however, - as they often "stick it to me.") Sadly, the patient only needed a spinal radiographic diagnosis - completely within my training and qualifications - and the matter is still being pursued.

Based on the medical reports I have seen in mutual patients, I also am disgruntled by the "apparent lack of didactic reasoning" from our own medical counterparts in private practice. Time after time, I make a differential diagnosis that was overlooked, and am able to support it clinically with objective data, diagnostics and/or laboratory analysis. Ironically, I am subjected to sending the patient back on a medical referral. The MD repeats what I have done and receives a somewhat higher insurance reimbursement, based on my work, referral and diagnosis! So, what really drives up health-care costs? Recall the insurance company that failed to reimburse me for a so-called "not chiropractic diagnosis." Should I have told the company my state board test case was based on amlyotrophic lateral sclerosis (Lou Gehrig's disease)? Gee, is that something we see every day in private practice?

In addition, my DC colleague complained on the current marketing practices of chiropractic consulting groups and their marketing tactics (Yes, you are their market!), the ones that purport increased referrals through "marketing strategy breakthrough." He also complained about chiropractic seminars that blatantly advertise similar "marketing practice techniques to generate patient referrals." This made me think about my own comparison of medical seminars versus chiropractic seminars.

I honestly do not have any immediate solutions for our profession, other than to advise my chiropractic colleagues in private practice to not give up the fight or the rights we have, as indicated by our level of didactic training. Our patients need us. Simply put, they come to us for our didactic reasoning and for our vast knowledge. How many times have we seen failed back surgeries in which the symptom complaints derived from myofascial roots, lack of conservative care, or an entirely different diagnosis?

I am reminded of a schizophrenic patient (a retired engineer) who complained tirelessly of burning feet and low-back pain. I finally succeeded in getting him a medical referral for workup and special diagnostics, only to have him return to me a few short weeks ago. I discovered he had been housebound for six months, without his medications, and his legs had open ulcerations and his feet were quite swollen. Most mental-health patients are poor historians; it takes a high level of clinical

suspicion to determine what is relevant in the history and what is not. I referred him again for a "mini" mental exam, prescription referral and medical workup for his pedal edema. I also called his MD, ultimately obtaining an urgent referral.

The cause of his lower-extremity causalgia? The pedal edema was a result of right-sided heart failure. The urgent referral and the blatant objective findings dictated the medical necessity for treatment this time (ideally, before he enters into left heart or congestive heart failure and his lungs fill up with fluid).

With didactic reasoning and a high index of clinical suspicion, private practitioners do, in fact, possess the ability to render the correct diagnosis. Now it is up to our own quality-assurance private-practice parameters in how we follow up on patients like the one just described - particularly as it relates to the successful closure of that patient's initial complaint and our management plans. In the current economy, all private practitioners, regardless of their professional status - MDs, DOs or DCs - with the ability to render a diagnosis must not sacrifice their patients' health status simply because the economy dictates or encourages us to do so.

I thank God every day for my ability to practice chiropractic and serve my patients. I remind them, "I am only a chiropractor," because that is what those in health-care management - those who seek to limit your ability to practice - would have you believe. I thank God when I hear my patients protest, "No, you are more! You are my chiropractor and have taken better care of me than even my MD! That's why I come to you; that's why I want your opinion." I suppose that just about sums up why we do what we do; just don't let health-care economics dictate how you go about it. As for me, I promise to return to more challenging chiropractic case studies in my next column.

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