Dynamic Chiropractic

EDUCATION & SEMINARS

Response to "Primary Care: An Educational Dilemma and a Practice Predicament" by Reed Phillips, DC, PhD

Meridel I. Gatterman, MA, DC, MEd

In response to the challenge posed by Dr. Phillips[1], I offer the following comments. His title, "Primary Care: an Educational Dilemma and a Practice Predicament" was well-chosen. I will attempt to address both issues from one who has debated the primary care issue in both Davenport and Washington during our centennial celebration and who initiated the seed material for the ACA consensus statement on the role of chiropractic in primary care. It was apparent by a show of hands that a large majority if the chiropractors attending the debates think of themselves as primary care practitioners. Whether they are confusing the term with primary (first) contact was not determined.

This point needs to be clarified, as Dr. Phillips noted, in reference to the point of entry into the health care system. While first contact is a necessary characteristic of primary care, it alone is not sufficient to fulfill the role defined by the Institute of Medicine document.

The educational dilemma is twofold. First is the lack of a common paradigm. Second is sufficient clinical training for chiropractors to fulfill the role of primary care practitioners. I believe the paradigm issue can be solved by adopting a patient-centered model that has been generated through consensus.[2] This paradigm provides for the "mental, emotional and social needs of the patient". The following six characteristics were agreed upon by a diverse group of chiropractic educators and researchers:

- Recognition and facilitation of the inherent healing capacity of the person.
- Recognition that care should ideally focus on the total person.
- Acknowledgement and respect for the patient's values, beliefs, and health care needs and expectations.
- Promotion of the patient's health through a preference for drugless, minimally invasive, and conservative care where needed.
- A proactive approach that encourages patients to take responsibility for their health.

- The patient and patient-centered practitioner act as partners in decision making, emphasizing clinically and economically effective care, based on predictable delivery, documentable outcome, and overall quality.

This paradigm, as modified by a multidisciplinary panel, stressed the criteria of integration, accessibility and accountability:

- Recognizing the individual's innate capacity for self-healing.
- Recognizing that care focuses on the total person in the context of the patient's life.
- Acknowledging and respecting the patient's perceptions, values, and health care preferences and expectations.
- Engaging with patients in a shared responsibility for their health and well-being, focusing the partnership on enhancing the patient's health through assessment, wellness promotion and the least invasive appropriate care.
- Communicating with integrity the scope and depth of skills, abilities and knowledge that the practitioner brings to the clinical interaction.
- Tailoring services to the individual; basing care on a variety of evidence, affordability, and accessibility.[3]

A patient-centered paradigm stresses a "sustained partnership" with the patient, where "health promotion" as well as back pain and subluxations are emphasized as much as treatment of the diseased body. The "crumbling of the disease-based paradigm" most certainly "opens a window of opportunity" for the traditional chiropractic view that the body has the intelligence and capacity to heal when the focus is on health promotion, maintenance, and early prevention, before conservative care is replaced by invasive drugs and surgery. Primary care practitioners should follow a paradigm where conservative care is foremost both for the patient's benefit and to promote a sustainable health care system.

The patient-centered paradigm is based on an integration of traditional chiropractic philosophical first principles, existing health care paradigms, and sociologists' observations of what chiropractors do in practice. It does not have to be invented but merely followed instead of the reductionistic biomedical model of treatment of body parts (back) and symptoms (pain).

Sufficient clinical training can only be provided by training chiropractors in busy practice settings where patients with authentic chiropractic problems are supervised by experienced practitioners. This does not occur in hospitals or commonly in existing student clinics. Most conditions seen by primary care practitioners are not those admitted to hospitals. Most emergency care patients self-select to the emergency room or are sent to hospitals after specialist referral. Training inexperienced chiropractic

interns in hospitals does little to build their confidence in the treatment of common conditions they see in practice. Unfortunately, in most college clinics there is inadequate training in many conditions seen in primary care. A preceptorship program in chiropractic primary care offices is needed to provide the necessary patient exposure.

As for the practice predicament, diversity and tolerance must replace the dualistic thinking that maintains that we must be either primary care or limited practitioners. Those that choose to limit their practice to musculoskeletal conditions or even back pain can still follow a patient-centered paradigm as suggested by Vernon[4], allowing those who wish to be primary care practitioners to rise to the responsibility.

Chiropractic has nothing to be gained by filling the niche medicine wishes us to fill. There are already plenty of physical therapists and occupational therapists to treat patients with musculoskeletal problems referred by primary care practitioners. I suggest that our survival in managed care is not in the role medicine would prescribe for us but in filling the void created by the medical specialists' abdication of the primary care role. Chiropractors following a patient-centered paradigm with an adequate preceptorship to provide appropriate clinical training can fulfill the duties of primary care practitioners in the patient's interest. This will require a shared vision by college presidents and implementation by a faculty tolerant and mature enough to see the potential in the diversity of practitioners. Behavioral objectives for a patient-centered paradigm have been described.[5]

The educational dilemma and practice predicament can be solved not by subservience to medicine, the insurance industry, or power- and status-seeking chiropractors, but by centering our paradigm and practice on the patient.

References

1. R.B. An Educational Dilemma and a Practice Predicament. Dynamic Chiropractic, July 1, 1996, p. 34-36.

2. M.I. A Patient-Centered Paradigm: a Model for Chiropractic Education and Research. J. Alternative & Complementary Med. 1991;1:371-386.

3. M.I. A Patient-Centered Paradigm: a Model for Complementary Medicine. Presentation; World Med. 96, Washington, DC, 1996.

4. H. Chiropractic: a Model of Incorporating the Illness Behavior Model in the Management of Low Back Pain Patients. J. Manip. Physiol. Ther. 1991;6:379-389.

5. M.I. Educational Objectives for a Patient-Centered Paradigm. J. Chiro. Ed. 1996;9:125-137.

Meridel I. Gatterman, M.A., D.C., M.Ed.