Core and Complementary Chiropractic: Lowering Barriers to Patient Utilization of Services

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ABSTRACT

Objective: The use of chiropractic services has stalled while interest in accessing manipulation services is rising. The purpose of this paper is to consider this dilemma in the context of the dynamics of professional socialization, surveys of public attitudes, and a potential strategic action.

Discussion: This is a reflection work grounded in the literature on professional socialization and the attitudes held regarding chiropractic in modern society, to include its members, and in original data on training programs. Data were interpreted on the background of the authors' cross-cultural experiences spanning patient care, research, education, and interprofessional collaboration. Recommendation on a strategic action to counter barriers in patient referrals was synthesized. Professional socialization is the process by which society enables professional privilege. Illustration of typical and divergent professional socialization models emerged that explain cognitive dissonance toward the profession. Questions of trust are commensurate with the experiences during patient encounters rather than with a common identity for the profession. Diversity among encounters perpetuates the uncertainty that affects referral sources. Commonality as an anchor for consistent professional identity and socialization through the content of core chiropractic, defined by training and practice, offers a means to offset uncertainty. Complementary chiropractic, analogous to complementary medicine, provides an outlet under professional socialization for the interests to explore additional methods of care.

Conclusion: The practice workplace is an effective lever for altering barriers to the use of services. Clarifying rhetoric through conceptualization of core and complementary practices simplifies the socialization dynamic. Further, it takes advantage of accepted cultural semantics in meaningful analogy while continuing to empower practical diversity in care delivery in response to evolving scientific evidence. (J Chiropr Humanit 2016;xx:1-13)

Key Indexing Terms: *Chiropractic; Professionalism; Delivery of Health Care; Referral and Consultation; Socialization; Social Identification*

INTRODUCTION

A collective professional identity is a dynamic and strategic device through which the service of a profession is framed. Identity defines what a profession does. Its development should be an active strategy of professionalism[1,2] that is, at its base, a rhetorical argumentation operationalized through daily practice. Ryynanen[3] contends that the most important difference between individual and collective identities is that the former emphasizes difference and the latter frames commonality. "Social identity refers to the ways in which individuals and collectives are distinguished in their social relations with others. In order to identify things, one has to have something in common, but also something that is distinct from the others."(p30)

Few would disagree with the notion that history of the profession over the past century has been more invested in drawing distinctions than in the celebration of commonality.[4-6] From the public's perspective, these intra-professional distinctions are unnecessarily complex. They are equivalent to cognitive dissonance that creates a pragmatic confusion precisely at the level most highly valued by individual members of the profession—that of care utilization. We take a critical look at the emerging role of professional identity argumentation within chiropractic and offer observations on how a focus on core commonality with recognition of complementary chiropractic approaches respects both collective and individual identities and can clarify public perceptions, lowering barriers to chiropractic utilization.

To begin, a caveat is necessary. Although what follows is evidence informed and calls on the existing understandings of professions, professionalism, professional identity, professional socialization, and legitimacy, we do not contend that these observations are *a priori* evidence

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based. These are reflections from our readings, data, and cross-cultural experiences as members of several interprofessional communities in health care, including solo clinical practice, chiropractic colleges, professional associations, university faculty, integrated interprofessional spine care practice, and research settings, and professional socialization through memberships in the North American Spine Society and the Canadian Spine Society.

Progress in Cultural Authority

The status of the chiropractic discipline is evolving worldwide. Within each jurisdiction, debates continue on resource allocation for health care delivery and the social tradeoffs involving the inclusion of and compensation for services.[7] With chiropractic services becoming increasingly available to all eligible veterans in the United States,[8,9] a demonstration project is being prepared for the Canadian Armed Forces. Chiropractic is a stable component covered under the health system in Denmark[10] and Switzerland.[11] Systems of health care delivery are experimenting with the inclusion of chiropractic services across networks of hospitals and clinics[12,13] in the United States and community-based primary care in Canada.[14] Similarly, social resources are increasingly finding their way to support musculoskeletal research related to chiropractic in the United States, Canada, Denmark, and Switzerland. Evidence of effectiveness for manipulation is growing. As noted by Weeks et al,[15] benefits of manipulation for low back pain, neck pain, and headaches are now reflected in guidelines recommendations internationally. Some evidence suggests that chiropractic care provides cost savings[15] and has been found to reduce the use of opioids and lower odds of developing long-term disability in workman's compensation patients.[16,17] At least for lower back complaints, doctors of chiropractic (DCs) are increasingly being the first provider consulted.[18] Indeed, as noted by the Government of Canada in 2015,[19] the overall prospects for the profession are promising.

Reflections on the positive gains are culturally consistent, in that the same conclusions have been reached both within the profession and by the public it serves. This agreement is embodied in the recent consensus exercises on professional identity for "spinal health care experts in the health care system"[20] and, as Palmer College envisions it, "primary care professionals for spinal health and well being."[21] Surveys of the public concur.[22-24]

Most would agree that, despite the positive signs for valuation of the role of the profession in treating musculoskeletal disorders, particularly related to the spine, there remains a disconnect between the state of evidence and the rate of care utilization by the public. Although on the one hand, the evidence is far stronger than even 20 years ago, the rate of utilization is relatively stagnant. Weeks et al[15] reported that the prevalence rate for accessing DCs in the United States ranges from 3% to 16% and has not varied substantively over time. Referral, the lifeblood of a thriving practice, is affected by the public's perceptions of the profession as a whole. In the most recent Gallup survey of the public,[24] 29% reported being discouraged from going to a DC by family members. Although few indicated that other health care providers dissuaded them,[24] there is little evidence that active medical referrals play a substantial role in the average chiropractic practice growth.[25]

Barriers to Patient Referral

Chief among concerns expressed as barriers to referral can be summarized under the term *expectations*. Referral sources are unsure what referred patients are likely to experience during their encounters, depending on the individual DC who is consulted.[26,27] There are 3 primary factors underpinning this sense of uncertainty:

1. Concern over the trustworthiness or ethics of the individual practice, often expressed as whether the primary motivation for treatment planning is patient need versus provider interest.[24,25]
2. The perception of diversity within the daily practice of chiropractic,[9,25,28] including whether there is an evidence-based grounding of the practice.[25,28]
3. Absence of a common lexicon for interprofessional interaction and discussion about the nature of the patient's condition and recommendations around its treatment.[29]

Sociologists tell us that these barriers are equivalent to stigmas[30] that reduce the accord, prestige, and privilege normally provided to professionals.

It is instructive to observe that these stigmas are not grounded in strong reservations with respect to the collective professional identity outlining the profession's work. Rather, they are associated with the individual operationalization of practice within the office setting. Literature reports are reinforced in the experiences of those whose careers straddle interprofessional collaborations. There we must respond to patients as well as other health providers individually, within an interprofessional context, and as representatives at interprofessional conferences.[9,29] To change the stigma to the collective identity, actions of individual practitioners need to elevate the profession where their engagement has the greatest leverage: the workplace or practice setting. Professions and organizations with high collective legitimacy survive longer and acquire more resources more easily.[31,32] Career success is most often associated with clear professional identity construction[30] using conceptual brevity and simplicity.[7] The desired outcome should be greater integration of DCs into