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Review Article

The Kaleidoscope Model of Integrative Healthcare as a collaborative paradigm for cardiology and chiropractic: a call to action

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ABSTRACT

This review article proposes a model of integrative care for cardiovascular patients in institutional settings. We review relevant historic and contemporary examples of medical–chiropractic cooperation and a brief review of the literature illustrating the clinical benefits of chiropractic care for patients with cardiovascular disease. The groundwork proposes a distinct research and clinical practice model incorporating the doctor of chiropractic (D.C.) as a synergistic partner with the medical cardiologist coined the Kaleidoscope Model of Integrative Care (KM). While a traditional kaleidoscope does not alter the nature of light itself, the observer does see the ‘raw data’ of colors and shapes, wavelengths, etc. contained within the “potential” of the light itself; left unrecognized, even subtle re-orientations of the instrument changes the perspective. Similarly, the KM is intended as a conduit for slight reorientations to traditional medical–chiropractic–patient hierarchies, thus creating new treatment options and generating robust changes in inter-professional perception of the patient’s condition(s) and treatment options. It is hoped that this model will not only serve future patients within hospitals, but that institutions will serve as incubators for better collaboration and research among the majority of free-standing medical and chiropractic practices ultimately benefitting the patient with cardiovascular disease.

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1. Introduction

Heart disease is the leading cause of death in USA with total expenditures accounting for current treatments including healthcare services, financial costs and lost productivity estimated at upwards of $200 billion dollars/year.[1,2] While ongoing treatments currently involve lifestyle changes, medicines, medical/surgical procedures, and cardiac rehabilitation,[3] this situation clearly calls for any plausible avenue providing improvement. Thus far, no format for collaborative guidelines and co-care with chiropractic and cardiology has been ascertained in an evidence-based medicine (EBM) environment with solid evidence and outcomes assessments to jointly improve upon a more effective treatment model of cardiovascular disease. The Kaleidoscope Model of Integrative Care (KM) places cardiologists and chiropractors *within* a cardiology division of a major teaching hospital by framing a systematic concept modeling side-by-side approaches for individualized treatment and prevention priorities.

2. Historical and contemporary models of medical–chiropractic collaboration

Although limited data have been available for such constructs, chiropractic institutions such as the Clear View Sanitarium of Davenport, Iowa integrated a conventional psychiatric assessment with chiropractic intervention as early as 1926[4] by conducting initial patient evaluations and pharmaceutical interventions concurrently with daily chiropractic evaluation and adjustments administered as the primary intervention. The medical and ancillary employees maintained extensive records, but many were lost to the research community during the closing of the sanitarium in 1961 (though some research publications, however, were anthologized in a 1973 collection).[5] Another long-standing example of inter-professional cooperation can be found in Louisville, Kentucky at the Kentuckiana Children's Center,[6,7] a cooperative non-profit center maintaining operations for special needs children by providing chiropractic care in conjunction with nutritional evaluation, visual therapy, physical and occupational therapy, dental services, and special education with off-site medical/allied health professions since 1957, which has published a number of case studies and case series.[8–11] The Spears Chiropractic Hospital of Denver, Colorado opened by Leo Spears, D.C. in 1943 differentiated itself from the specialized patient populations of Clear View and Kentuckiana by offering chiropractic care to the general patient population[12] while providing medical services through doctors of osteopathy despite intense opposition by medical interests in Colorado until the hospital's closing in 1984.

In more recent times, we periodically find research training opportunities in major venues such as the 1975 NINCDS (National Institute of Neurological and Communicative Disorders and Stroke) conference[13] as beacons for shifts in integrative care. Several larger institutional studies involving multi-site multi-disciplinary settings have also found similar successes; one found more significant long-term benefit compared to existing hospital-based therapists[14] while another patient-assessed D.C./M.D./P.T. (physical therapy) study found their D.C.'s care as excellent resulting in improved spine care and promotion of care coordination resulting in reduced unnecessary testing, costs and procedures with standardization of low back pain (LBP) management.[15]

3. Viability for creating the Kaleidoscope approach

By modeling KM research within a training platform to encompass acute step-down, cardiac rehabilitation, recidivism, cost-effectiveness, and true prevention programs, a more contemporary understanding of chiropractic's interdisciplinary healthcare shows:

- Documented overall low safety risks with extremely low adverse incidents of chiropractic treatment[16–22]; D.C.'s are accepted by Medicare as federally licensed and accredited primary portal-of-entry physicians while participating providers in most insurance programs and do not require referrals *ex lege*.
- Chiropractic, as a profession, consistently documents overall cost-effectiveness and high patient satisfaction[23–27] while aligning with hospital goals as included in the American Hospital Association (AHA) Recommendations.[28]
- The American Health Care Policy And Research (AHCPR), recognized as funding the development of "gold standard" clinical practice guidelines and the source of unbiased, science-based information on what works and does not work in healthcare,[29] found that accredited chiropractic curriculum standards met or exceeded comparable classroom hours in anatomy, physiology, rehabilitation, nutrition and public health compared to their M.D. counterparts.[30,31]
- A federally licensed consensus document of accredited U.S. chiropractic college presidents from the Association of Chiropractic Colleges, a leadership organization of chiropractic educational programs in the U.S., Canada and endorsed by the World Federation of Chiropractic (WFC), a non-governmental international consulting body affiliated with the World Health Organization representing chiropractic to the international health care community[32] strongly encourages relationships with other healthcare providers and various healthcare disciplines supporting student learning, research and evidence-based informed practice.[33]
- While LBP (low back pain) is not a primary focus of cardiology, cardiac rehabilitation is relevant to inevitable step-down scenarios posed within KM settings. Large broad scope institutions such as the VA (Veterans Administration),[34] Cleveland Clinic,[35] the Osher Center for Integrative Medicine,[36] and the University of South Florida (USF)[37] successfully offer chiropractic intervention while both the Winchester Hospital[38] and Cancer Centers of America[39] offer an even more inclusive approach including chiropractic along with standard medical care.
- The National Committee for Quality Assurance (NCQA), an independent 501(c)(3) non-profit organization in the United States that works to improve healthcare quality through the administration of evidence-based standards, measures,

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