

## **Practicing Evidence-based Chiropractic and Increasing Referrals**

***Ron Feise, DC***

### **Improved Results**

Evidence-based Chiropractic (EBC) must become the preferred practice in our profession for one simple reason -- it offers the best opportunity to deliver the best patient results. EBC does this by helping practitioners integrate those therapies most likely to provide patient benefit while avoiding those that are less likely to provide benefit.

A recent prospective study compared the effectiveness and cost-effectiveness of care modalities for acute low-back pain.<sup>1</sup> The researchers concluded that compared with good usual care, evidence-based care (including manipulation) for acute low-back pain produces:

1. greater reduction in pain,
2. greater patient satisfaction,
3. greater rates of full recovery,
4. less expense, and
5. less need for continuing care.

### **Demanding Proof**

Unlike many chiropractors, EBC practitioners demand data from vendors and are not convinced by marketing promises. If a vendor claims that an analytical/diagnostic tool provides "accurate clinical information", an EBC practitioner will ask to see published peer reviewed research that demonstrates the tool's reliability, validity and clinical value. Likewise, if a vendor claims that a treatment technique provides "beneficial results," an EBC practitioner will ask to see evidence proving these benefits. Armed with this information, EBC practitioners can avoid less effective interventions and thereby save their patients unnecessary expense and trauma. For example, EBC practitioners have known for over a decade that Ephedra demonstrates no long-term benefits. By avoiding this product, these doctors have saved their patients from wasting money and possibly suffering serious harm.<sup>2,3</sup>

### **Not Just Data**

EBC is not a cookbook process in which patients are treated according to some strict scheme derived exclusively from research. Rather, EBC regards research information as an important component in the health care decision making process. Such information should be used in conjunction with clinical experience and judgment, clinical circumstances, and preferences of the patient.

Practicing EBC means choosing an action after weighing the risks and benefits of all the alternatives. While all clinical decisions are made under conditions of uncertainty, the degree of uncertainty decreases when clinical decisions are based on directly relevant, valid evidence.

### **Enhancing MD Alliances**

In addition to the satisfaction of providing optimal patient results, how can practitioners benefit from EBC? One of the primary ways is through enhanced relationships with medical doctors. Over the last two decades, great strides have been made in the public's acceptance of chiropractic. Researchers have found that most patients who visit chiropractors are seeking treatment for spinal conditions, but approximately three times as many patients visit medical professionals for such conditions.<sup>4,5</sup> So the majority of spinal cases are still within the control of our medical colleagues. Furthermore, medical practitioners are more likely to have professional dealings with physiotherapists than with chiropractors.<sup>6</sup> But savvy EBC practitioners can alter the physiotherapist referral pattern by forging evidence-based alliances with MDs.

Health care observers have noted that treatment of spinal complaints is the chiropractic profession's strength and the medical profession's weakness. Moreover, general practitioners are not interested in treating back pain cases and want help managing these patients.<sup>7</sup> Only 5% of general practitioners claim to have good knowledge of chiropractic, and three out four say they would be interested in receiving more information.<sup>8,9</sup> Therefore, the time is ripe for us to communicate.

### **Providing the Right Information**

Medical doctors are seeking alliances with practitioners who provide high quality communications, because good communication between health care professionals improves patient care.<sup>10</sup> But communications between primary and secondary health care professionals, including chiropractors, are far from ideal.<sup>11-13</sup>

MDs rate most written reports from chiropractors as poor.<sup>8</sup> Furthermore, they dislike chiropractors' technical jargon (eg., subluxation) and their dogmatic adherence to certain practice protocols: extended treatment schedules for all patients, charging "front end" lump sums for treatment programs, encouraging patient dependency, radiographic examination (and re-examination) of all patients, advocating against vaccination, and treating outside a musculoskeletal scope.<sup>8,9,14,15</sup> Obviously, attempting to "educate" a medical practitioner regarding these protocols would be counterproductive.

Besides correspondence about patients, medical practitioners want presentations and scientific literature pertaining to safety and effectiveness, clinical referral guidelines and your clinic's outcome data.<sup>8,9,14</sup> Additionally, they have a predisposition towards referring their patients to those professionals who are most closely aligned with their own medical training. For example, chiropractic referral for musculoskeletal care enjoys substantial support. Whereas, referral

for chiropractic intervention in visceral conditions continues to be largely opposed by members of the medical profession.<sup>16</sup> To create a lasting collaboration, we must consider the factors our medical colleagues value.

### **Generating EBC Referrals**

Successful medical referral programs bring together the values of evidence-based chiropractors and medical practitioners. In fact, chiropractors using a specialized EBC referral program have been able to generate an average of about 60 more new patient referrals per year from MDs.<sup>17</sup> An EBC referral program is an integral component in practice development and an emerging and underused economic model for our profession.

*Dr. Feise is president of RJF Consulting, [www.chiroevidence.com](http://www.chiroevidence.com), which aims to educate chiropractors in the assessment and application of health-related knowledge. Dr. Feise can be reached at [rjf@chiroevidence.com](mailto:rjf@chiroevidence.com).*

### **References**

1. McGuirk B, King W, Govind J, Lowry J, Bogduk N. Safety, efficacy, and cost effectiveness of evidence-based guidelines for the management of acute low back pain in primary care. *Spine* 2001;26:2615-22.
2. Bent S, Tiedt TN, Odden MC, Shlipak MG. The relative safety of ephedra compared with other herbal products. *Ann Intern Med* 2003;138:468-71.
3. Shekelle PG, Hardy ML, Morton SC, Maglione M, Mojica WA, Suttorp MJ, Rhodes SL, Jungvig L, Gagne J. Efficacy and safety of ephedra and ephedrine for weight loss and athletic performance: a meta-analysis. *JAMA* 2003;289:1537-45.
4. Coulter ID, Hurwitz EL, Adams AH, Genovese BJ, Hays R, Shekelle PG. Patients using chiropractors in north America: who are they, and why are they in chiropractic care? *Spine*. 2002;27:291-8.
5. Media General Chiropractic Survey. Richmond, Virginia, February 2002.
6. Simpson JK. A study of referral patterns among Queensland general medical practitioners to chiropractors, osteopaths, physiotherapists and others. *J Manipulative Physiol Ther* 1998;21:225-31.
7. Schers H, Wensing M, Huijsmans Z, van Tulder M, Grol R. Implementation Barriers for General Practice Guidelines on Low Back Pain. A Qualitative Study. *Spine* 2001;26:E348-53.
8. Langworthy JM, Birkelid J. General practice and chiropractic in Norway: How well do they communicate and what do GPs want to know? *J Manipulative Physiol Ther* 2001;24:576-81.
9. Brussee WJ, Assendelft WJ, Breen AC. Communication between general practitioners and chiropractors. *J Manipulative Physiol Ther* 2001;24:12-6.
10. Peters R. Steun voor intercollegiale communicatie [Support for communication between colleagues]. *Med Contact* 1995;50: 746-7.
11. Jamison J. Chiropractic's functional integration into conventional health care: some implications. *J Manipulative Physiol Ther* 1987;10:5-10.
12. Matthews A, Langworthy J. Anticipating change: an opinion survey of the membership of the British Chiropractic Association in the Year of the Chiropractors Act. Reading, England: British Chiropractic Association; 1996.
13. Mainous AG, Gill JM, Zoller JS, Wolman MG. Fragmentation of patient care between chiropractors and family physicians. *Arch Fam Med* 2000;9:446-50.
14. Curtis P, Bove G. Family physicians, chiropractors, and back pain. *J Fam Pract* 1992 ;35:551-5.
15. Menke JM. Integrating chiropractic in health systems. In: Faass N, editor. Integrating complementary medicine in health systems. Gaithersburg (MD): Aspen Publishers; 2001. p.594-600.
16. Jamison JR. Chiropractic referral: the views of a group of conventional medical practitioners with an interest in unconventional therapies. *J Manipulative Physiol Ther* 1995;18:512-8.
17. Feise RJ. Evidence-based chiropractic: the responsibility of our profession. *JACA* 2001;1:50-2.