Understanding Wellness in a Contemporary Context of Chiropractic Practice

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ABSTRACT: *Purpose:* To present a model that facilitates the contemporary shift towards wellness care in chiropractic practice. *Methods:* The Chiropractic Identity statement achieved by the World Federation of Chiropractic through consensus methodology was purposively reviewed in light of evidence-based categories of chiropractic practice and a developing understanding of the breadth of neural dimensions of human wellbeing. *Results:* A model is presented that is aligned with the WFC Identity statement including the brand platform and the particular brand pillar of patient-centred care that emphasises the mind/body relationship in health. Four groupings are given to categorise the type of care provided in any particular patient encounter. They are (i) event-related treatment reflecting a management plan developed in response to an identified event producing injury or dysfunction for which the patient demonstrates objective clinical indicators that lead to a diagnosis; (ii) symptomatic treatment being a sporadic application of treatment driven by the patient's subjective demand for relief from a recurring problem; (iii) maintenance care being the ongoing provision of care in the absence of a subjective complaint but with objective clinical indicators, implemented following either event-related or symptomatic treatment; and (iv) prophylactic care, implemented in the absence of both subjective and objective clinical indicators in the expectation of achieving enhancement of health. *Conclusion:* The model presented in this paper adds meaning to the WFC Identity statement and represents a tool to help chiropractors understand wellness and how it fits into contemporary practice. The adoption of this model will facilitate chiropractic's paradigm shift towards wellness by allowing different approaches to chiropractic practice to sit beside each other within any one of the four groupings.

INDEX TERMS: HEALTH SURVEY; PREVENTIVE HEALTH SERVICES; EVIDENCE-BASED CHIROPRACTIC; WELLNESS.

Chiropr J Aust 2008; 38: 12-16.

INTRODUCTION

The World Federation of Chiropractic (WFC) has successfully completed a global consultative process to develop and agree on a common identity for the profession.[1] The full statement is given in Table 1. In summary,[2] chiropractic is a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the functions of the nervous system and general health. There is an emphasis on manual treatments including spinal adjustment and other joint and soft-tissue manipulation.

Not all chiropractors, however, agree. Some[3-5] take the view that the profession should concentrate on the spine and its attendant problems of back pain, neck pain and headache. By way of contrast, writers such as Hawk[6-9] and Jamison[10-12] put forward a convincing case for chiropractic to lead a transition to wellness-based health care. There is an increasing body of evidence demonstrating the multifaceted nature of health.[13] Such evidence brings with it the inherent implication that a holistic wellness-based approach is needed for effective understanding and management of health.[14]

Discussion is now appearing in the discipline's literature[15] about how chiropractic education must also change to remain supportive of these new directions, however a divide remains evident between the paradigm put by Hawk[6-9] and Jamison[10-12] that represents a broad scope of chiropractic and the limited scope, restricted to the spine, favoured by a few.[3-5]

This paper argues the emerging scope of chiropractic practice delineated by Jamison and Hawk and supported by Gatterman[16] is the most appropriate paradigm for chiropractic. There is a common acceptance that at some time in the typical clinical encounter most chiropractors will do something with or to the spine. If we accept that chiropractors are likely to offer a clinical intervention about the spine, we can accept that the WFC Identity statement[1] (Table 1) is fairly close to the mark.

Regardless of their individual approach in practice, chiropractors demonstrate a strong belief that the health status of the spine has some relationship to the health status of the patient.[17-19] If this is true, then we must try to understand how to overcome any disagreement about identity in the face of common core clinical behaviours.

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Table 1

THE WFC IDENTITY STATEMENT OF CHIROPRACTIC

The Pole (brand platform)

The spinal health care experts in the health care system

The Ground (brand pillars)

Ability to improve function in the neuromusculoskeletal system, and overall health, wellbeing and quality of life

Specialized approach to examination, diagnosis and treatment, based on best available research and clinical evidence with particular emphasis on the relationship between the spine and the nervous system

Tradition of effectiveness and patient satisfaction

Without use of drugs and surgery, enabling patients to avoid these where possible

Expertly qualified providers of spinal adjustment, manipulation and other manual treatments, exercise instruction and patient education

Collaboration with other health professionals

A patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the self-healing powers of the individual, and individual responsibility for health and encouraging patient independence

The Personality (tone)

A combination of:

Expert, professional, ethical knowledgeable

Accessible, caring, human, positive

From: http://www.wfc.org

In the early 1990s the outcomes of a study of the case-mix of Australian chiropractic practice were reported.[20-22] The US-based National Board of Chiropractic Examiners (NBCE) has also explored and reported the nature of chiropractic practice in both the USA[23] and Australia.[24] There are no surprises in these reports, which confirm that chiropractors variously see a spectrum of presentations, ranging from treatment for event-related trauma with very clear clinical indicators for intervention and well-defined outcomes measurements, to a less evidence-influenced type of care.

The authors reason that if it were possible to look at chiropractic practice through a tool that provided a system of groupings into which a management plan could be placed, then it should be relatively straightforward for the discipline to appreciate that there were a number of groups into which a practitioner could comfortably place each individual patient and their particular management plan.

METHODS

The data sources for this paper included the WFC Identity statement,[1,2] the reported data of an Australian study of the case-mix of Australian chiropractic practice,[20-22] and the reported findings of structured surveys of chiropractic practice in both the USA[23] and Australia.[24]

Elements were identified within the WFC statement that were indicative of broad clinical groupings. Two contexts of care were extracted from the statement, *a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system and the effects of these disorders on the functions of the nervous system and general health* and related sub-statements that identified a need to *improve function in the neuromusculoskeletal system* on the one hand, and *quality of life* on the other.

Table 2

GROUPINGS OF CHIROPRACTIC MANAGEMENT	
	Disease Context
1	Event-related treatment being a defined course of treatment reflecting a management plan developed in response to an identified event producing injury or dysfunction for which the patient demonstrates objective clinical indicators that lead to a diagnosis.
2	Symptomatic treatment being a sporadic application of treatment driven by the patient's subjective demand for relief from a recurring problem that may: a – be a residue from event-related treatment described above, or b – reflect a subclinical disease process or a repetitive mechanical injury process.
	Health Context
3	Maintenance care being the ongoing provision of care in the absence of a subjective complaint but with objective clinical indicators, implemented following either event-related or symptomatic treatment.
4	Prophylactic care, implemented in the absence of both subjective and objective clinical indicators in the expectation of achieving enhancement of health.

From Ebrall PS. A descriptive report of the case-mix within Australian chiropractic practice, 1992. Chiropr J Aust 1993; 23:92-7. These groupings were originally reported as categories.

The broad types of presenting conditions of patients reported within the case-mix study[20-22] and the NBCE reports[23,24] were reviewed. A previous report[21] that demonstrated it was possible and practical for chiropractors to classify or categorise their patients into one of four categories was noted. The categories used in that study are given in Table 2.

RESULTS

A natural fit became apparent between the four categories of patient presentation reported earlier[21] and the WFC Identity statement. A closer alignment was found by stratifying those four categories as being either in a disease context or a health context as reflected in Table 2.

It is important to note the original categories were developed out of a clinical research project that documented and explored some 2,500 clinical encounters and the informed feedback of the participating practitioners on specific questions about assigning patients to specific groupings. In this sense they are evidence-based groupings with relevance to real-world practice. While they represent a sample limited to Australia they parallel the autonomous NBCE data.[23,24]

With regard to the stratification of the WFC Identity statement to a context of either disease or health, the authors accepted the statement, *to improve function in the neuromusculoskeletal system* as implying the presence of a dysfunction in the presenting patient. We see this as being broadly representative of the disease context of chiropractic.

On the other hand, the authors accepted that the WFC statement to *improve ... quality of life* as implying an enhancement of health in the presenting patient. While we see this as being representative of the health context of chiropractic, we are wary at this time about making inference as to what aspects of chiropractic may represent elements of health and wellness care.

In summary, our purposive but critical analysis of these data sources allows a schemata of groupings that should facilitate the categorisation of the nature of each patient interaction into one of these groupings. In turn, this should allow all chiropractors to accept the WFC statement as an overarching identity with a level of finesse providing for the full spectrum of chiropractic approaches to patient assessment, treatment and management.

DISCUSSION

The application of the classification scheme first presented in 1992[21] and now refreshed and aligned as reported in Table 2 appears to offer a reasonable way forward for most, if not all, styles of practice within the discipline. Indeed, this integration of the WFC Identity statement allows a more useful understanding of contemporary practice.

Each chiropractor, being a member of a discipline that is typically *concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system*[1] and who then do something to the spine[17-19] in the belief that they may rectify *the effects of these disorders on the functions of the nervous system and general health*[1]

are thus able to lay claim to being more of a Group 1 or 2 practitioner working in the evidence-influenced disease or injury paradigm, or more of a Group 3 or 4 chiropractor working towards the health paradigm of maintenance and preventative or prophylactic care.

For example, mechanical low back pain secondary to work-related repetitive strain would clearly fall into Group 1. The nature of all elements can be quantified; the causative factors, the level of pain and disability, and the outcomes measures from the therapeutic intervention such as increased work capacity. On the other hand, a patient who presents periodically for an adjustment in the belief from the perspective of either the patient or the practitioner that it will maintain their health, perhaps along with changed behaviour such as improved diet, could fall into Group 4.

It is readily apparent that the practice of chiropractic within the disease or biomechanical dysfunction context sits comfortably within the view of Nelson and others[3-5] that the profession has specialised expertise with the spine and its attendant problems of back pain, neck pain and headache.

It is more difficult, however, to understand and describe the practice of chiropractic in the health context, and this represents a conundrum for the work of Hawk[6-9] and Jamison.[10-12] It also presents a challenge for the current authors who are attempting to identify and measure colloquial measures of wellbeing in a typical Australian chiropractic practice.[25]

The juxtaposition of four categories of chiropractic encounter against the WFC Identity statement as reported in this paper reveals a continuum of care that ranges from fully evidence-based (dysfunction) to metaphysical (health). In turn this suggests the continuum may be more objective/less abstract (Newtonian) at one end and less objective/more abstract (quantum) at the other.

A recently published scheme of neural change[26] thought relevant to chiropractic practice provides a way of mapping stages along this continuum (Figure 1). It is a graphic depiction of ranking and relationships of neural change that attempts to demonstrate that patients present to a chiropractor with a range of clinical complaints or desires. These can be placed on a continuum that progresses from evidence-based practice (more Newtonian) with full quantitative documentation through to evidence-influenced and perhaps pre-evidence practice (more quantum), where greater reliance is placed on qualitative dimensions.

We can now graphically appreciate that a patient exercising an abstract notion of health in a belief the chiropractic adjustment may benefit their cognitive, affective or evaluative function, is equally anchored on the chiropractic continuum of care as is the patient fully within the objective dimension evidenced by quantifiable reflex and sensory change, for example.

The final challenge is to relate the continuum of objective-subjective-abstract dimensions to the types of care the patient may receive from their chiropractor. Figure 2 is our attempt to do this; the progressive scheme of found dimensions of neural change is matched against the four distinctive groupings (types) of care described in this paper. For completeness,

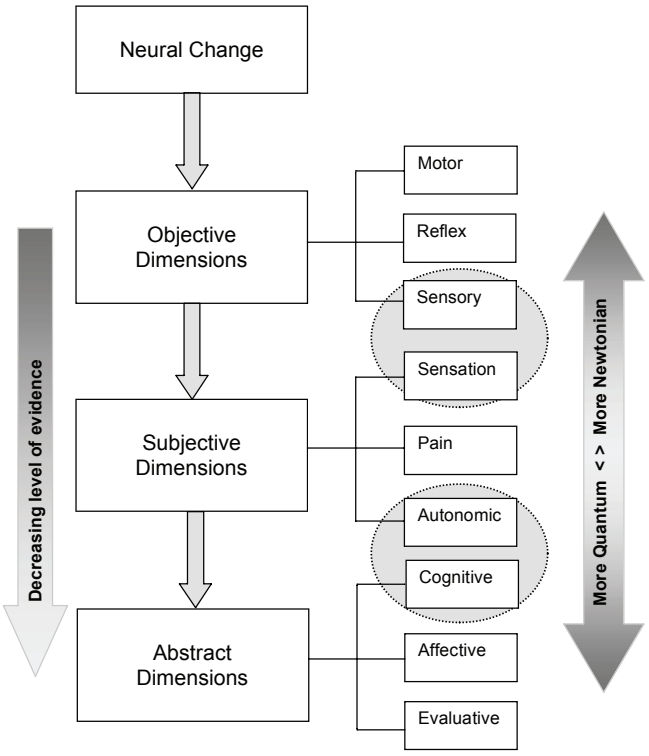

Figure 1 A scheme of neural change. A graphic depiction of ranking and relationships of neural change. The dash circles indicate transitional vectors between dimensions. The figure demonstrates that chiropractic patients may present with neural change that may offer more or less objective, subjective and/or abstract dimensions, or any combination thereof.

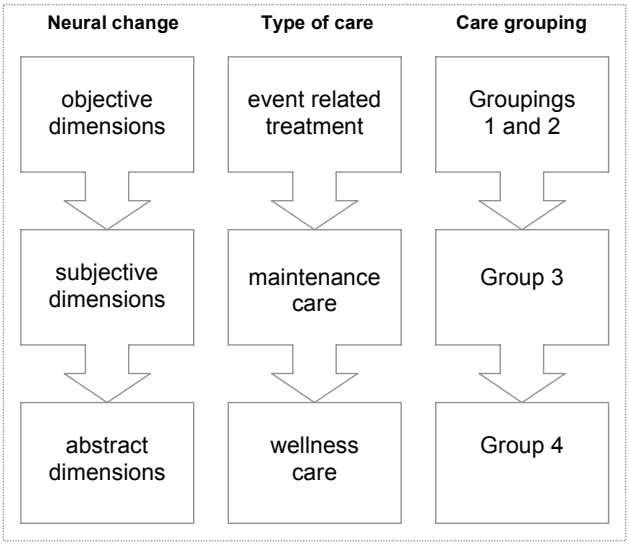

Figure 2 Neural change and groupings of care. The relationship of the dimensions of neural change to type and grouping of care.

numbered care groupings are also given in the figure, but these may well be incidental and irrelevant.

By reading Figures 1 and 2 it can be seen that a chiropractor may consult patients with basic reports of motor weakness, pain and altered physical function, through to altered cognitive, affective or evaluative function. The figures demonstrate how this progression matches the type of care a chiropractor may provide, from objective, quantifiable, event-related treatment through to subjective, qualitative treatment, which is the field of human wellbeing.

This model of groupings is aligned with the WFC statement reached through a valid consensus process and given in Table 1. This model allows full alignment with the brand platform (Pole) of the Identity statement, which positions chiropractors as the spinal health care experts in the health care system. An understanding and application of this should allow Nelson and his colleagues[3-5] to comfortably work with the objective dimensions around event-related treatment with defined outcomes acceptable to third-party payers.

The model incorporates the brand pillar *a patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the self-healing powers of the individual, and individual responsibility for health and encouraging patient independence*.[1] This respects the work of Hawk,[6-9] Jamison[10-12] and others who are exploring the subjective dimensions of human wellbeing under the guise of wellness care in addition to urging the uptake by chiropractors of broad public health issues.

The point where the objective elements of the chiropractic encounter shift towards the abstract dimensions of human wellbeing remains unclear, however when chiropractic is understood in the terms of this new model, a powerful set of research opportunities can be created on the topics of wellness and wellbeing.

CONCLUSION

The shift towards wellness and human wellbeing in chiropractic practice is likely to be unsustainable unless there is a commensurate shift in the way the profession understands itself. Ongoing argument as to whether chiropractors should be at one end or the other of a spectrum of human neural change is pointless.

The model presented in this paper adds meaning to the WFC Identity statement and presents a tool to help chiropractors understand wellness and how it fits into the practice of chiropractic.

It allows a non-threatening description of a contemporary paradigm for chiropractic that can incorporate the variety of individual practice styles. Some practitioners may elect to practise only in one grouping to the mutual exclusion of other groupings, but it is not unexpected that most chiropractors would probably find they already function across all four groupings to a varying degree in any practice day.

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