Ethical Considerations in Chiropractic Practice

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Abstract

Purpose: To define the need to review ethical decision making processes in the chiropractic profession. To discuss ethical issues that complicate everyday practice.

Method: Review of issues discussed in chiropractic literature.

Discussion: Ethical considerations of the following topics. Client Management of issues involving informed consent. Business Ethics involving allocation of service restriction by third party payers, advertisement and management consulting groups. Academic and profession responsibility for the regulation of future doctors and client care.

Conclusion: The need for logical analysis of issues in preliminary chiropractic education to produce appropriate decisions when in practice. Academic and Professional regulation determines public policy and scope of practice.

INTRODUCTION:

The topic of chiropractic ethics, in the past, seems to have been an underlying code. The governing bodies and educators have assumed educated chiropractors are intelligent enough to be doctors and therefore should know the difference between right and wrong. This assumption continues to plague the profession. As education increases, the perceived definitives become more abstract and decisions become more complicated. The human race must have some rules to live by and these rules are theorized through a logical method of analysis. Time is continually changing the way society thinks about life and duty, and this desensitizes the psyche to inputs that push the ethical envelope. The evolution of the concept of bio-medical ethics therefore developed. It is a systematic review of decision-making guidance used within the healthcare model. (1)

The early 1990's showed great growth in the healthcare industry. Many political changes had occurred to support chiropractic's placement within this growth period. Rapid growth inspired proactive thought of academia into future plans for the profession. The majority of writing regarding ethics occurred during this time, but has since dissipated as the healthcare crises of the later 90's developed. Perhaps a review of past concerns is in order to preserve the future of the profession.

The scope of this discussion, encompasses three divisions of issues and the following subject matter, as discussed previously in chiropractic literature: Client management, business ethics, and academic and professional organizations.

Client management defines doctor-client interaction which is managed through. Informed consent. Attorney Richard Steinecke discusses the components of informed consent within the Canadian system. (2) What issues are involved with special populations? John Markham discusses the considerations involving geriatric clients. (3) Do chiropractors need to provide all the alternatives to our care when we know the medical practitioners do not discuss our alternative to their clients? Robert Sherman and C. Jacob Ladenheim discuss legislative regulations supporting chiropractic intervention and the M.D.'s legal responsibility to provide all conservative options available, when obtaining consent to care, medicinally. (4) Chester Wilk discusses the fraudulant aspects of nondisclosure by the medical community and the impact on the profession and society. (5)

Informed consent is a major issue when caring for people. Attorney Richard Steinecke gives six major components of informed consent which should be provided to the client:

1. The nature of the treatment or assessment should be discussed. Exams and procedures should be explained before performed.

2. Who is providing the procedure? It is appropriate to disclose the credentials of the person performing the exam and sometimes the gender of the person may be a factor, for client sensitivity.

3. The reason for the procedure should be discussed.

4. The risks and side effects of the procedure should be explained, anything that may pose a risk to the client's well being.

5. The alternatives to having the procedure. It should be remembered even if the alternatives are not accepted by the practitioner, it is still the patient who decides whether to proceed or to pursue another route.

6. The consequences of not having the procedure is always an alternative, even though most doctors like to assume the client will follow with the treatment plan.

A form is no longer enough; the client must understand a clear explanation of the coming activities. Often they are nervous and/or in so much pain they have difficulty following the conversation from start to finish. Brief, easy to understand language, verbally and written by the doctor, are the keys before achieving consent. (2) Special populations including elderly, pediatrics, foreign or disabled clients are problematic. According to John Markham, the elderly may have difficulties understanding because of age related hearing loss or cognitive deterioration. A primary care giver or custodial charge must be present for consent to uphold his/her wishes. (3) Pediatric care can be complicated, with the number of divorced families rising. Dual custodial care is often given by the courts so there is need for both parents and guardians to provide consent. Foreign language and physically disabled pose other difficulties, routinely these clients bring assisting partners to the exam process. When taking the appointment it is important to stress to the potential client the need for assistance and be able to offer help with a local agency trained for these situations. American sign (deaf communication signing) and foreign language interpreters can be arranged. It is important to know these groups and have good relations to call upon their services when needed. When given a few days notice, they can be the best allies when introducing a new doctor to the client and bring

them to life-long care.

Informed consent also includes educating the client of the options in receiving care and the different outcomes. It could be assumed, practitioners would refer clients to chiropractic to avoid pharmaceutical and surgical intervention, to maintain the body's integrity, but this is often not the case. Robert Sherman and C. Jacob Ladenheim discuss the 1989 congressional creation of the Agency for Health Care Policy and Research (AHCPR) within the U.S. Department of Human Service. This group oversees the development of guidelines for clinical practice and quality care. In 1994, AHCPR developed guidelines for low back pain, which included chiropractic. According to the article, chiropractic care is recommended for the initial phase of care for acute low back pain not prescription medications, as is currently being prescribed. Many medical doctors are not disclosing this option to the client before medicating and are therefore breaching clinical guidelines. (3) Chester Wilk believes that this act in itself is fraud and he believes this is the most common fraud abused. The withholding of appropriate client care has consequences on the client's health and well-being. He sites numerous studies throughout the article of published studies quoting the efficacy of chiropractic care. He believes the medical doctors purposefully overlook and therefore withholding information from patients. (4) Both writers believe chiropractors should take more active measures to uphold the client's right to care; reminding medical practitioners of the guidelines that have been enacted and notifying local health administrative bureaus. (3) (4)

Business ethics of the chiropractic practice has many facets. What problems complicate chiropractic's appearance to clients and other professions? Avery Jenkins, a chiropractor with marketing experience, discusses the reasons behind advertising ethics regulation and professional image. (6) John Markham, a certified Activator Methods educator, discusses geriatric chiropractic care considerations regarding the allocation of services and the effects on the practice. (3) Do practice management groups promote unethical behaviors? Attorney George McAndrew's letter to the ACA journal, in January 1990, stirred great debate among many chiropractors. The debate was subsequently printed in the April edition, the pros and cons of practice management groups. (7)

Avery Jenkins discusses the doctor's motives in advertising. He quotes from the ACA Code of Ethics: "Doctors of chiropractic may advertise but should exercise utmost care that such advertising is relevant to health awareness, is accurate, truthful, not misleading or false or deceptive, and scrupulously accurate in representing the chiropractor's professional status and area of special competence. Communications to the public should not appeal primarily to an individual's anxiety or create unjustified expectations of the result. Doctor of chiropractic should conform to all applicable state laws, regulations and judicial decisions in connection with professional advertising." He refers back to the beginning when chiropractic was actively denounced; advertisement was the only method of attracting new clients. Today, doctors are more profit driven and advertising attracts paying patients. Jenkins agrees with another primary care physician, Dr. David Hilfiker, who has made it his life work to provide care for the indigent. He asserts that medicine has abandoned the poor and has crossed into chiropractic boundaries. (6)

John Markham believes chiropractors feel restrained to provide appropriate care by third party payers. In elderly care, health choices are shaped by government regulation instead of the people's freedom of choice, because of the client's inability to pay out of pocket. Doctors feel they must restrict their services and are "beaten down" by bureaucratic red tape. He feels this is a dangerous method of cost-containment, with increased liability to the doctor providing care and dangerous to the patient. He also fears the elderly fall prey to fear-based sales techniques, as the pressure to produce profit drives doctors to unethical practices. (3)

As profit deems to reign over chiropractic practice, more young doctors join practice management groups. There is great debate within the profession of the ethics involved in the training for these programs. The attorney for the ACA, George McAndrew's, sent a letter to ACA journal, in 1990, critiquing the motives and ethics around practice management organizations, specifically; Peter Fernandez's Practice Management Associates. The letter promoted debate among readers that was published in the following issue. The debate was mainly the motives of doctors who participate in consultant groups, if overutilization and fear-based, hard sales techniques were utilized. Dr. Fernandez felt the argument was unjustified. He debates management groups have provided doctors the knowledge, to level the playing field, by teaching appropriate medical billing practices already established by M.D.s. Doctors may utilize techniques taught by management groups, but it is the doctor who decides the marketing strategy in the end. John Whitney, of Whitney Transitions, argues that McAndrew's was using a "broad brush when painting his response." He feels there are bad groups, but to group all consultants is unfair and misrepresentative. (7)

Chiropractic academic organizations, professional organizations, professional accreditation institutions, national boards and the state-licensing officials are the controlling factors governing the future role of chiropractic in the healthcare market. What are the professional institutions doing to promote accountability and respectability of the profession to the public and to the healthcare industry from the field doctors perspective? Ploutz-Snyder, Mayer and Druger surveyed 450 practicing doctors to reveal the doctors' attitudes toward their education and how well they were prepared for client and practice management after graduation? (8) Research activity in chiropractic colleges provides evidence to the healthcare community of efficacy of care thus shaping the scope of practice: Marchiori and etal discuss faculty participation and Zhang discusses student interest in participation and importance to the profession. (9) (10) Herbert Vears compares U.S. and Canadian methods of addressing the development of universal standards of care through academics and scope of practice allowed by states and provinces. (11) The March 1985 issue of JACA discusses chiropractic college accreditation and how it effects the field doctor. (12) What is the role of the National Board of Chiropractic Examiners? The president of NBCE discusses its mission in future chiropractic accountability. (13)

Chiropractic academia holds the responsibility of creating future doctors that emulate the profession's vision for the future and to provide good doctors for patient care within their scope of practice. An academic institution's longevity is based on adequately producing successful professionals. Curriculum enhancement is a constant process to maintain current educational needs. Students are acutely aware of the limitations of their abilities with their existing knowledge base and fear is generated regarding future

success. This fear stirs extensive criticism, from the students, regarding the quality of education they believe they have received. However, after five years of practice, many doctors felt they were well educated by their institution to perform the needed activities required of a doctor. Poutz-Snyder and etal, in 1997, produced a survey of 450 doctors who graduated in the mid 1990's. Doctor's were randomly picked from the National Directory. Around 150 replied, mostly Palmer graduates, discussing their preparation by the school for the future. They felt well prepared in the management of musculoskeletal disorders, but weakness with visceral disorders. According to the study, musculoskeletal specialty was the educational focus, at that time. (8) Chiropractic education shapes policy and procedure for decades to come, thus effecting scope of practice today. Great changes are underway to broaden this scope.

Academia maintains clinical standards of practice. The changes in standards are dependent on the research produced by the schools. Chiropractic lacks research beyond the musculoskeletal arena. The greatest problem noted in chiropractic literature is lacking interest to complete research. Marciori, Hawk, and Meeker discussed faculty participation in research comparing chiropractic institutions and other professions. They showed the lack of participation by chiropractic schools considerably less than the other professions. The reason, provided by faculty, was lack of time to dedicate to research while staffing appropriately for student needs and maintaining the increasing paperwork load required for accreditation. (9) The article's presentation, at the ACC conference in 1999, discussed incentive programs, such as paid residency to improve motivation for faculty to do research. Zhang discussed student attitudes toward research in the profession. The survey questioned students, from Sherman College, in the areas of

relevancy of research and if they would be willing participants. The students showed considerable interest in research and understood its necessity as they progressed further into the program. However, they felt time constraints due to class and clinic workload to participate in activities. Less advanced students felt lacking in knowledge base of the clinical aspects of practice to produce good research. (10) Logan's present incentive of $5000 for publishing still draws very few students' interests into the research arena.

Work on a universal standard of care was being produced to show organizational commitment to the healthcare community and the public, in the late 1980's. Herbert Vears discussed the process involved with the development of the standard of care with the U.S. and Canada. The standards of practice were broken down into two categories; education of accredited colleges and the standards dictated by statutes. He believes the ever-changing environment of third party policy may have tendency to overlook the innate purpose of care, the patient's right. (11) The standard of care discussed was the framework of the ACA Code of Ethics, utilized by state regulatory commissions and is recognized by insurance and government institutions.

The evolution of managed care and the restrictions produced the change of chiropractic education and restructured the whole profession. Accreditation by regulatory boards allowed continuity of care to be achieved and legal accountability. In 1985, the ACA published a discussion of the effects of accreditation on the field doctor and legal accountability. This discussion alerted doctors of the necessity of good documentation and the increase in regulatory changes of the future to improve continuity of care between of doctors. (12) Self-regulative organizations were developed, such as the NBCE, in 1987, to begin to establish a standard for the reference of knowledge of all

doctors practicing. Peter Ferguson, NBCE president, defends the value of the National Board as, "valid, legally defensible third party certification of chiropractors." The vision of the National Board was to work with the state licensing board to produce an examination of the basic knowledge of chiropractors that is universally known and taught in chiropractic education. Not only does the U.S. utilize this examination, but it is also recognized by other parts of the world, including Australia and Europe. (13) As consequence, it provides clients with doctors of comparable intellect that extend through international borders.

Discussion:

Ethics is a branch of moral philosophy. It is concerned with the decision making process used in determining the right and wrong behaviors. Although ethics is not a specific course in the curriculum of Logan College of Chiropractic it is referred to in every aspect of the education and the profession. The textual components of ethics, the theories utilized and principles taught, are not the scope of this paper. However, the familiarity with the concepts in an undergraduate curriculum prior to program admittance should be required to provide the student, and future doctor, the skills necessary to reason logically, through situations he/she faces in practice.

Poor decision making in business has three components; ignorance, ambivalence and fear. Ignorance means lack of education to make the appropriate decision. Ambivalence is from exhaustion due to bureaucracy. Fear is of not providing income sufficient for the lifestyle believed to provide personal happiness. All of these reasons are manageable if morality is utilized and the greater good is sought for the patient.

Conclusion:

Chiropractic organizational groups and academia must the take the helm with a focused plan for the future of the profession. With this guidance, the new doctor will have greater faith in the stability of the community in which they have invested their time and money. In education as in practice, decisions and patient management training should have emphasis on ethical client management.

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