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*The Mastery of Patient-Centered Practice*

# Presenting ***Defendable*** Care Options To Patients

By Dr. Scott J. Heun

Patients present themselves to chiropractors with a genuine need. Generally, patients are focused on one thing: getting out of pain. Most patients are unaware of the true nature of chiropractic or the legitimate options available to them to address their problem or problems. Our role as doctors of chiropractic is to first investigate the patient's problem (or problems) from our unique health care perspective. Therefore, an examination is performed, conclusions are derived from the data collected, and a care plan to address the patient's needs is formulated. Today, there are many care plans being offered to patients in chiropractic offices, however, one disturbing trend in the profession has been to promote extended care plans with questionable scientific support.

If you practice CBP utilizing all the technique demands you have undoubtedly experienced spinal change from severely abnormal to near normal in a very short period of time (less than 10 weeks). You have likewise experienced patients who presented seemingly simple abnormal postures; which by any reasonable estimate should respond very well in a short period of time, only to determine at follow-up radiographic examination that the patient did not make any structural change at all! Regardless your level of clinical expertise, you must realize that in employing any attempt to estimate a patient's potential rate of change is merely guessing. CBP care is not about guessing.

Defendable options for patient care include: simple, temporary relief of pain and or return to pre-injury status; and, the option to rehabilitate the patient's spine to normal or as near normal as possible within the limitations of matter.

The consensus in the literature is quite clear on the patient's first option for care; the relief of pain with manipulation or perhaps some


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combination of manipulation, soft tissue therapy and ice (some doctors may choose to also use additional modalities). Maximum benefit is likely to be achieved in 12-15 visits over a three to four week period of time. Unfortunately, the majority of the studies relevant to manipulation and pain hide many variables relevant to patient care. For instance, the average improvement in pain level on a visual analog scale (VAS) is not as good in these studies as in the outcome studies published by CBP. The CBP outcome studies suggest that in some instances, manipulation may very well continue to be beneficial for much longer periods of time. Regardless these facts, if the stated goal of care is symptom relief or resolution, care *beyond* the point of symptom resolution, is difficult to defend because little if any objective change will be achieved with more manipulation and or more soft tissue therapy.

The patient's second care option, spinal rehabilitation, is supported in the literature. The outcome studies published by CBP clearly establish that the patient's response to care in these studies falls into the "bell-shaped-curve". Approximately one third of the participants in the studies make little if any change, approximately one third of the participants make significant structural improvement and one third are normal or near normal following a 10-12 week or 36-38 visit regimen of CBP care. At this point in time, CBP science cannot predict which individuals will fall into which category. Therefore, any attempt to do so by presenting a six-month or longer care plan is not a legitimate option to present to a patient.

There are patients who will require a year of appropriately applied CBP care. There are patients who require more than one year of care. However, there are also many who will require only weeks or at most a few months to achieve near normal or certainly as near normal as possible considering their level of permanent structural adaptation or damage.

Based upon the literature, the best compromise for a care plan is to present the "rehabilitation option" as an initial 9-12 weeks of care, at a frequency of 3-4 visits per week for a total of 36 office visits, followed by a re-x-ray to determine the need for additional therapeutic intervention. In many cases, a few more weeks of care is all that is likely to be required, however, based upon the outcome studies I previously referenced, at least some of the patients you see will require an additional 9 weeks of care prior to a second re-x-ray.


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It is not defendable for a doctor to attempt to "get the money issue" out of the way up front, with any pre-pay plan. This invariably hurts the overall retention of the patient, and, therefore, the patient ultimately suffers. Patients who actually reach the end of their pre-pay period and are asymptomatic often have little or no motivation to continue care. Furthermore, once the "money issue" is handled, the teaching and focused attention of the doctor declines or stops altogether. Unfortunately, the patient is not taught the "why" of chiropractic and without the "why", there is little if any long-term "comply" (compliance) with care.

Paying for care on an "as delivered basis", or at most (merely for convenience) on Mondays, for the upcoming week, makes much more sense. It keeps the doctor focused on teaching functional chiropractic philosophy, and the patient learns in a non-threatening fashion why their care is so important. When maximum structural improvement is reached, the patient may very well have been taught well enough to understand why they may want to continue on a maintenance care basis. In the long term, this model of practice better serves the patient's needs, is a more stable practice, is a practice which encourages referral and is a defendable model based upon current CBP research.

The practice of "selling" a patient on six months, one year, or lifetime care is next to impossible to defend. Until such time as clinical research provides the practicing doctor with the tools to accurately predict the volume and duration of care, the best care model is a pay per visit plan that includes a planned point to stop and check on the degree of objective spinal, postural change. This care model allows for the variables relevant to rate of improvement that we know exist from patient to patient. The pay per visit model requires the doctor to communicate with sincere, relevant information, and thereby eliminates the need for tactics that attempt to coerce or to convince a patient of their need for care.

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