Survey of US chiropractors' perceptions about their clinical role as specialist or generalist

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Abstract

Objective: The purpose of this study was to provide new information that describes chiropractors' professional identity relative to their perceived clinical role as specialist or generalist.

Methods: A pragmatic, descriptive, cross-sectional survey was performed of randomly sampled state-board licensed chiropractors in the United States during the period 2002–2003 to assess the chiropractors' perceptions of how their chiropractic patients see them, and how they see themselves, as specialist or generalist. For this exploratory study, we anchored the terms “back pain specialist,” “musculoskeletal specialist,” and “primary care generalist” to brief generic reference definitions in our survey instrument.

Results: Of our 2598 valid survey contacts, 1343 chiropractors returned their surveys either partially or fully completed, and a total of 720 chiropractor surveys were used in this study. Most of these chiropractors perceived that their new patients viewed them as “back pain specialists.” Chiropractors believed that their established patients (80%), more so than their new patients (58%), were likely to view them as a primary care generalist. Chiropractors described themselves as both specialist and generalist, and they expressed a greater capability to diagnose, rather than to treat, health disorders that were not musculoskeletal.

Conclusion: Chiropractic physician perceptions as reported in this study suggest that the nature of certain chiropractor-patient relationships may evolve profoundly over time, particularly as patients transition from new to established patients within the chiropractic practice. Understanding the complex nature of chiropractic health care provision may carry implications for advancing evidence-based chiropractic practice and clinical training, enhancing successful and comprehensive management of the complex health concerns of chiropractic patients, fostering beneficial sustained partnerships between chiropractors and their patients, and improving overall delivery of optimal integrative health care.

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Introduction

In an earlier study¹ we introduced the topic of chiropractic social or cultural authority by suggesting that the specific nature of that authority may vary

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somewhat across the profession. We suggested that local health care system conditions may differ by locale and therefore introduce variation in the socio-cultural roles experienced by doctors of chiropractic (DC) practicing in different areas. For instance, chiropractic patients in medically underserved areas may be more likely to use the chiropractor as a first point of contact with the health care system^{2,3} or chiropractic patients in rural areas may be more likely to seek care for nonmusculoskeletal health problems from their chiropractor.^{4,5} Similarly, the nature of the cultural/social congruence between DCs and their respective patient or market populations may also differ somewhat by locale, for instance rural versus urban, introducing another potential source of variation in the range of sociocultural roles experienced by individual chiropractors.

The purpose of this article is to present survey information regarding the perceptions of chiropractors about their roles as “back pain specialist” and/or “primary care generalist” relative to new versus established chiropractic patients and chiropractors’ perceived capabilities relative to diagnosis versus treatment of health problems not musculoskeletal.

Methods

We conducted a comprehensive multitopic survey of US chiropractors in the period 2002–2003 to assess their attitudes and behaviors on an encompassing range of various clinical and professional dimensions. Our study methods have been reported in extensive detail elsewhere.^{6,7} We drew our randomized survey sampling frame ($n = 5931$) from a master list of all US state-board-licensed DCs ($N = 67\,217$) and employed 3 mailings plus phone follow-up of nonrespondents. Of our mailed surveys to our sampled chiropractors ($n = 5931$), we could verify that 2598 surveys actually reached a valid survey recipient; that is, 3333 of our initial list were deemed as “invalid” survey attempts (eg, invalid surveys were returned to us from USPS as “bad address,” or we confirmed via follow up that surveys were not returned because the DC was retired or deceased, therefore invalid). Of 2598 valid survey contacts, 1343 chiropractors returned their surveys either partially or fully completed, yielding a final mail survey response rate of 52%, a rate comparable with that of other surveys of busy professionals.^{8–12} We analyzed our survey data using SPSS for Windows version 12.0 (SPSS Inc, Chicago, IL). This study was

reviewed and approved by the Palmer College Institutional Review Board.

We selected a randomly sampled subset of our surveyed chiropractors ($n = 720$) to receive the component of our survey instrument that asked them to rate their level of agreement with the statements presented in [Table 1](#), which queried various aspects of the chiropractor’s perceived role as specialist or generalist for their chiropractic patients. The SURVEYSELECT procedure in SAS (version 8; SAS Inc., Cary, NC) was used to select a simple random sample of chiropractors from the sampling frame.

Results

Of the DCs that we surveyed on this topic, 95% ($n = 684$) generally agreed with a perception that their new patients viewed them as a “back pain specialist” or “musculoskeletal specialist” ([Table 1](#)). When asked whether their chiropractic patients also viewed them as “primary care generalists,” 58% of DCs agreed that their new patients viewed them in this way, whereas 80% of DCs generally agreed that their established patients viewed them as “primary care generalists.” Whereas 80% of chiropractors considered themselves as back pain or musculoskeletal specialist, only 73% of chiropractors also considered themselves as primary care generalists. Regarding their perceived ability to diagnose versus treat a broad range of health disorders not limited to musculoskeletal or back, 90% of DCs generally considered themselves capable of diagnosing and 79% considered themselves capable of treating such conditions.

Discussion

Our study findings may offer additional insights into an important potential source of variation in the perceived clinical roles of chiropractors as primary care generalists, a perception that may change over the length of time invested in long-term sustained relationships between chiropractors and their patients. For instance, perceptions may evolve over time as a function of shifting patient expectations or preferences, as patients become more familiar with their chiropractor or with chiropractic. The passage of time during a sustained relationship may also allow for more actionable opportunities for chiropractors to demonstrate to their patients a clinical expertise beyond the

Table 1 Chiropractor perceptions as specialist vs. generalist for their chiropractic patients

	Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
Generally, my new patients initially view me as a “back pain specialist” or a “musculoskeletal specialist,” i.e. possessing specialized expertise for the care of pain or disorders of the back or musculoskeletal system.	53%	33%	9%	2%	2%	1%
Generally, my new patients initially view me as a “primary care generalist” capable of caring for a broad range of conditions or disorders not limited to musculoskeletal or back.	6%	18%	34%	15%	17%	10%
Generally, my established patients view me as a “primary care generalist” capable of caring for a broad range of conditions or disorders not limited to musculoskeletal or back.	20%	35%	25%	8%	8%	4%
I consider myself a “back pain specialist” or “musculoskeletal specialist,” i.e. possessing specialized expertise in pain or disorders of the back or musculoskeletal system.	55%	18%	7%	2%	8%	10%
I consider myself capable of diagnosing a broad range of conditions or disorders not limited to musculoskeletal or back.	36%	37%	17%	5%	6%	5%
I consider myself capable of treating a broad range of conditions or disorders not limited to musculoskeletal or back.	30%	27%	22%	6%	6%	9%
I consider myself a “primary care generalist.”	25%	26%	22%	9%	8%	10%

singular diagnostic or therapeutic clinical services typically rendered during specialty care of limited acute pain episodes. During a continuing relationship with a personal health care provider, patients are more likely to disclose other problems¹³ or new patient health problems may simply arise over the course of time. In such scenarios, the chiropractor may demonstrate to his or her patients an expertise in conservative nonmedical treatment approaches to management of problems other than nonmusculoskeletal; or the chiropractor may render a timely “first pass” diagnostic workup and referral for medical attention as needed. Such actions could impart to chiropractic patients a reasonable expectation that their chiropractor serves them in a generalist as well as specialist capacity.

According to these findings, chiropractors themselves believe that they may serve their patients as both back pain specialist and primary care generalist to some extent. It is important to note as well that doctors of chiropractic seem to express a greater confidence, or willingness, to diagnose rather than to treat nonmusculoskeletal health problems in their chiropractic patients, a finding that likely reflects a reasonable understanding by contemporary chiropractors that many nonmusculoskeletal conditions may not be amenable to chiropractic intervention or may be more appropriately managed medically.

Limitations and suggestions for future research

This study was conducted as a pragmatic, descriptive, cross-sectional survey of attitudes of doctors of

chiropractic. The 720 chiropractors surveyed may not necessarily represent accurately the entire chiropractic profession. We also note that we limited our survey sampling frame to only those DCs licensed and practicing in the United States, therefore surveys of licensed chiropractors practicing in other settings or in non-US health care systems may produce different results. Based on our systematic comparison of survey respondents with nonrespondents reported elsewhere,⁶ respondents to our mail survey may be younger, more likely to be in group rather than solo practice, and more likely to belong to their state or national professional association than nonrespondents, therefore this may limit to some extent the generalizability of our study findings. As well, this survey was of doctor perception and not patients’ perceptions, therefore it is possible that patient perceptions of their chiropractors are different. More accurate measurement of patient perceptions should be attained by directly surveying the chiropractic patients about their own perceptions.

We did not define nor specifically operationalize, a priori, the terms “new” patient, “established” patient, or “conditions/disorders not limited to musculoskeletal/back,” so it is possible that our survey respondents in self-defining these terms may have imbued the concepts with varying meanings. Similarly, although we did anchor the terms “back pain specialist,” “musculoskeletal specialist,” and “primary care generalist” to basic reference definitions in our survey instrument, these base definitions were brief and generic for the purposes of this very exploratory

pragmatic survey. Future studies would be better advised to “unbundle” one from the other, more specific definitions for “back pain specialist,” “musculoskeletal specialist,” “primary care,” and “generalist,” as well as to better validate the definitions for all terms used in such surveys (eg, testing the convergent or discriminant validity of specific measures for operationalizing the constructs). For instance, rigorous convergent/discriminant validity testing may better inform our understanding of the relatedness of the 2 distinct concepts “primary care” and “generalist” as perceived by various clinicians or patients. Further, certain of our exploratory queries attempted a convenience-sampling measurement “1 degree removed,” in that we asked chiropractors to report their perceptions of their patients’ perceptions, about the chiropractors’ expertise as specialist versus generalist.

Future study along this line of inquiry might test additional related hypotheses such as the possible relationship between chiropractors’ perceptions and other characteristics, such as their disciplinary chiropractic education, their individual specialized clinical training, their age or years of experience in clinical practice, their state scope of practice, or other factors related to the chiropractors’ market service areas from which they draw their patients.¹⁻⁵ The robustness of our study findings could be more rigorously tested across the substantive, methodological, and conceptual domains of validity.¹⁴ Substantively, convergence with respect to situational context(s) may be assessed by examining whether the perceptions of chiropractors in solo practice differ measurably and systematically from the perceptions of chiropractors in chiropractic group practice or those in multidisciplinary group practice. Methodologically, psychometrically sound measurement of chiropractor and patient attitudes about “specialist” versus “generalist” chiropractic health care might be explored by comparing the performance of variant measures such as Likert scales and semantic differentials.

Conducted simply as an atheoretical substantive pursuit described above, further empirical work in this area would likely yield important, useful, and practical information to help guide chiropractic education, profession, and policy direction. In addition to such atheoretical “applied” scientific research, further theoretically grounded pursuit in this topical area may also be informed by, and help to inform, such social sciences as psychology or sociology. Examples of conceptual paradigms from psychology with possible relevance to quantitative study of the attitudes of chiropractors or their patients might include those of behaviorism (eg,

the presumption that cognitive activities are governed by the same principles that govern observable behavior, stimulus, and response) or those of functionalism (eg, the presumption that the mind functions to adapt the individual to the environment through conscious experience). Sociological theories arising from the general perspective of structural functionalism may also offer useful conceptual frameworks for understanding the chiropractor-patient relationship as a voluntary interaction between 2 individuals faced with a variety of choices about how they might act, choices that may be influenced or constrained by a number of physical and social factors. As behaviors are repeated in multiple interactions, expectations may become more entrenched or institutionalized, thereby creating a normatively regulated social “role” for each of the participants in a given social interaction.

Conclusion

Doctor of chiropractic perceptions as reported here suggest that the nature of certain chiropractor-patient relationships may evolve profoundly over time, particularly as patients transition from new to established patients within the chiropractic practice. As such, our findings carry important conceptual, methodological, and substantive implications to guide further inquiry directed toward truer modeling and better understanding the disciplinary, clinical, social, and sociocultural roles of chiropractors,¹⁵ particularly in those cases or instances where chiropractors may serve as a continuous usual source of care provider^{16,17} for their chiropractic patients.

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