Core and Complementary Chiropractic: Lowering Barriers to Patient Utilization of Services

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ABSTRACT

Objective: The use of chiropractic services has stalled while interest in accessing manipulation services is rising. The purpose of this paper is to consider this dilemma in the context of the dynamics of professional socialization, surveys of public attitudes, and a potential strategic action.

Discussion: This is a reflection work grounded in the literature on professional socialization and the attitudes held regarding chiropractic in modern society, to include its members, and in original data on training programs. Data were interpreted on the background of the authors' cross-cultural experiences spanning patient care, research, education, and interprofessional collaboration. Recommendation on a strategic action to counter barriers in patient referrals was synthesized. Professional socialization is the process by which society enables professional privilege. Illustration of typical and divergent professional socialization models emerged that explain cognitive dissonance toward the profession. Questions of trust are commensurate with the experiences during patient encounters rather than with a common identity for the profession. Diversity among encounters perpetuates the uncertainty that affects referral sources. Commonality as an anchor for consistent professional identity and socialization through the content of core chiropractic, defined by training and practice, offers a means to offset uncertainty. Complementary chiropractic, analogous to complementary medicine, provides an outlet under professional socialization for the interests to explore additional methods of care.

Conclusion: The practice workplace is an effective lever for altering barriers to the use of services. Clarifying rhetoric through conceptualization of core and complementary practices simplifies the socialization dynamic. Further, it takes advantage of accepted cultural semantics in meaningful analogy while continuing to empower practical diversity in care delivery in response to evolving scientific evidence. (*J Chiropr Humanit* 2016;23:1-13)

Key Indexing Terms: *Chiropractic; Professionalism; Delivery of Health Care; Referral and Consultation; Socialization; Social Identification*

INTRODUCTION

A collective professional identity is a dynamic and strategic device through which the service of a profession is framed. Identity defines what a profession does. Its development should be an active strategy of professionalism^{1,2} that is, at its base, a rhetorical argumentation operationalized through daily practice. Ryynanen³ contends that the most important difference between individual and collective identities is that the former emphasizes difference and the latter frames commonality. "Social identity refers to the ways in which

individuals and collectives are distinguished in their social relations with others. In order to identify things, one has to have something in common, but also something that is distinct from the others."^(p30)

Few would disagree with the notion that history of the profession over the past century has been more invested in drawing distinctions than in the celebration of commonality.⁴⁻⁶ From the public's perspective, these intraprofessional distinctions are unnecessarily complex. They are equivalent to cognitive dissonance that creates a pragmatic confusion precisely at the level most highly valued by individual members of the profession—that of care utilization. We take a critical look at the emerging role of professional identity argumentation within chiropractic and offer observations on how a focus on core commonality with recognition of complementary chiropractic approaches respects both collective and individual identities and can clarify public perceptions, lowering barriers to chiropractic utilization.

To begin, a caveat is necessary. Although what follows is evidence informed and calls on the existing understandings of

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professions, professionalism, professional identity, professional socialization, and legitimacy, we do not contend that these observations are *a priori* evidence based. These are reflections from our readings, data, and cross-cultural experiences as members of several interprofessional communities in health care, including solo clinical practice, chiropractic colleges, professional associations, university faculty, integrated interprofessional spine care practice, and research settings, and professional socialization through memberships in the North American Spine Society and the Canadian Spine Society.

PROGRESS IN CULTURAL AUTHORITY

The status of the chiropractic discipline is evolving worldwide. Within each jurisdiction, debates continue on resource allocation for health care delivery and the social tradeoffs involving the inclusion of and compensation for services.⁷ With chiropractic services becoming increasingly available to all eligible veterans in the United States,^{8,9} a demonstration project is being prepared for the Canadian Armed Forces. Chiropractic is a stable component covered under the health system in Denmark¹⁰ and Switzerland.¹¹ Systems of health care delivery are experimenting with the inclusion of chiropractic services across networks of hospitals and clinics^{12,13} in the United States and community-based primary care in Canada.¹⁴ Similarly, social resources are increasingly finding their way to support musculoskeletal research related to chiropractic in the United States, Canada, Denmark, and Switzerland. Evidence of effectiveness for manipulation is growing. As noted by Weeks et al,¹⁵ benefits of manipulation for low back pain, neck pain, and headaches are now reflected in guidelines recommendations internationally. Some evidence suggests that chiropractic care provides cost savings¹⁵ and has been found to reduce the use of opioids and lower odds of developing long-term disability in workman's compensation patients.^{16,17} At least for lower back complaints, doctors of chiropractic (DCs) are increasingly being the first provider consulted.¹⁸ Indeed, as noted by the Government of Canada in 2015,¹⁹ the overall prospects for the profession are promising.

Reflections on the positive gains are culturally consistent, in that the same conclusions have been reached both within the profession and by the public it serves. This agreement is embodied in the recent consensus exercises on professional identity for "spinal health care experts in the health care system"²⁰ and, as Palmer College envisions it, "primary care professionals for spinal health and well being."²¹ Surveys of the public concur.²²⁻²⁴

Most would agree that, despite the positive signs for valuation of the role of the profession in treating musculoskeletal disorders, particularly related to the spine, there remains a disconnect between the state of evidence and the rate of care utilization by the public. Although on the one hand, the evidence is far stronger than even 20 years ago, the

rate of utilization is relatively stagnant. Weeks et al¹⁵ reported that the prevalence rate for accessing DCs in the United States ranges from 3% to 16% and has not varied substantively over time. Referral, the lifeblood of a thriving practice, is affected by the public's perceptions of the profession as a whole. In the most recent Gallup survey of the public,²⁴ 29% reported being discouraged from going to a DC by family members. Although few indicated that other health care providers dissuaded them,²⁴ there is little evidence that active medical referrals play a substantial role in the average chiropractic practice growth.²⁵

BARRIERS TO PATIENT REFERRAL

Chief among concerns expressed as barriers to referral can be summarized under the term *expectations*. Referral sources are unsure what referred patients are likely to experience during their encounters, depending on the individual DC who is consulted.^{26,27} There are 3 primary factors underpinning this sense of uncertainty:

1. Concern over the trustworthiness or ethics of the individual practice, often expressed as whether the primary motivation for treatment planning is patient need versus provider interest.^{24,25}
2. The perception of diversity within the daily practice of chiropractic,^{9,25,28} including whether there is an evidence-based grounding of the practice.^{25,28}
3. Absence of a common lexicon for interprofessional interaction and discussion about the nature of the patient's condition and recommendations around its treatment.²⁹

Sociologists tell us that these barriers are equivalent to stigmas³⁰ that reduce the accord, prestige, and privilege normally provided to professionals.

It is instructive to observe that these stigmas are not grounded in strong reservations with respect to the collective professional identity outlining the profession's work. Rather, they are associated with the individual operationalization of practice within the office setting. Literature reports are reinforced in the experiences of those whose careers straddle interprofessional collaborations. There we must respond to patients as well as other health providers individually, within an interprofessional context, and as representatives at interprofessional conferences.^{9,29} To change the stigma to the collective identity, actions of individual practitioners need to elevate the profession where their engagement has the greatest leverage: the workplace or practice setting. Professions and organizations with high collective legitimacy survive longer and acquire more resources more easily.^{31,32} Career success is most often associated with clear professional identity construction³⁰ using conceptual brevity and simplicity.⁷ The desired outcome should be greater integration of DCs into the

network of health care and the promotion of an increased referral base commensurate with the known burden of musculoskeletal disease.³³ Directly addressing these perceptions as barriers to referral is critical for thriving practices of the future.

NORMS OF PROFESSIONAL IDENTITY AND ORGANIZATIONAL LEGITIMACY

Professional identity influences and is influenced by the social culture in which the profession exists (Fig 1). In sociological terms, the claims of a profession's primacy in its abstract knowledge provide legitimization and lead to a granting of cultural authority with relative autonomy.^{34,35} This is a living process that evolves with the maturation of the abstract knowledge base and society's values. Three standards are expected for legitimacy that is accorded by extension to a practitioner^{18,36,37}:

1. His or her knowledge and competence have been validated by a community (ie, the collective profession).
2. His or her knowledge and competence are based on rational, scientific grounds.

3. His or her judgment and advice are altruistic and oriented toward a set of substantive values that society upholds, such as health.^{3,35}

What individuals do and how they behave matter.³⁸

These behaviors constitute a social contract of professionalism that can be, and is, assessed. Professionalism is expressed in terms of core competencies and ethics, not in beliefs.³⁷ It holds reciprocal expectations and obligation between society itself and the profession.^{1,39} Once legitimization is achieved, usually signaled by regulatory authorization and oversight, the ongoing dialogue of patient access, service provision, economic compensation, and practice growth are conducted through the vehicles of professional socialization. The primary identity hinges on the core services^{39,40} of the profession acknowledging specialty emphasis within. Although all providers carry underlying beliefs and technical skills that influence their practice activity, those beliefs and skills are not the focus of the identity. Examples where beliefs and skill sets shape elective practice might include an individual gynecologist's decision not to engage in obstetrics or an orthopedic spine surgeon who elects to focus selectively on care for patients

Fig 1. Model of professional socialization dynamic typical to health care disciplines.

requiring decompression procedures while referring to others those who might want fusion.

Diversity within a professional's career is not, in and of itself, bad. Complementary medical practices are subsumed within the identity as an elective option available to the individual professional through additional training without a sense of stigma under society's lens. Indeed, a prominent example of this is Dr. Wayne Jonas, who arguably⁴¹ was the first successful head of the National Center for Complementary and Alternative Medicine. A part of the attraction for him as a medical physician to lead the Center within the National Institutes of Health in the United States was his interest and cross-training in nontraditional health fields, including homeopathy, bioenergy therapy, diet and nutritional therapy, mind-body methods, and electro-acupuncture diagnostics.

Within the complexity of these social dynamics, most professions engage in an active process of identity development of its members through professional socialization. The process is deliberate and begins shaping personal identity at the outset of training using academic content and the role modeling necessary for the core of practice as a professional. Identity development occurs in stages (ie, student, intern, graduate) and is continuously shaped through social agencies, including mentors, pa-

tients, colleagues, other health providers, payors, and policymakers. The sociocultural context of interactions with various health care stakeholders provides feedback, validating or shaping the collective identity.³⁰ It is the process by which individuals acquire the specialized knowledge, skills, attitudes, values, norms, and interests needed to perform their roles acceptably.³⁰ It is the process by which the level of legitimacy, with its benefits and privileges, is determined.

DIVERGENT IDENTITY FORMATION

For the profession of chiropractic, the social dynamics of legitimization are divergent (Fig 2). It is recognized that external social and political pressures and conflicts among historical figures within the profession have played a unique role in this regard. Figure 2 provides this context and the means to explore socialization, as it exists, as well as how experience shows that it may be influenced to alter the barriers to care.

We contend that 3 pivotal factors served to create the deviation in the profession's legitimization and are responsible in large measure for both the persistence in

Fig 2. Contemporary chiropractic professional identity—professional socialization cycle.

the barriers to utilization and the distorted professional socialization pathways. They are as follows:

1. Survival behaviors.
2. Dominance of individual factional identity, incorporating complex interactions between individual beliefs and treatment technique systems, over professional identity.
3. A stigmatized intraprofessional culture that fosters defensive behaviors directed toward established social structures of health care.

Survival Behaviors

To be sure, members of the profession historically have experienced substantial challenges precisely because the profession arose from outside the typical pathways of development.⁴² All efforts at professionalization that have chosen this path have been met with stiff resistance that favored the status quo,³⁴ in this context known as medical hegemony. The particularly virulent and unethical form of opposition to chiropractic was publicly disclosed through legal challenge using antitrust law in the United States in *Wilk v American Medical Association*.^{43,44} The practitioner response to this systematic suppression of typical professional socialization was to engage in what we term *survival behaviors*. Practice-building programs^{45,46} that commercialize care, believed to have begun with the conceptualization of maintenance care by Marlow ("Lesson No. V Why Chiropractors FAIL!" third unmarked page)⁴⁷ in the form of "controlled health service plans," grew increasingly strong through the latter part of the 20th century. Office waiting rooms were filled because of direct marketing often using predetermined scripts and case-based fee structures to foster subsequent visits. Prepaid treatment plans were offered using tactics perceived as high-pressure^{22,23} and designed to promote unnecessary care.⁴⁸ Prominent trifold brochures proffering unsubstantiated claims adorned the waiting room settings of many practitioners.⁴² Discounted fees and promotions offering free services or screenings in public places have been used.⁴⁹ These marketing practices, among others, fueled a public perception that the third tenet of the social contract between the public and any group of caregivers—that of patient-centered, altruistic recommendations—had been violated. Seeds of doubt were fanned by the antitrust lobbying of the medico-pharmaco-industrial complex, and a reputation challenging chiropractic provider trustworthiness was established.^{22,23,48,50} The profession as a whole was stereotyped.² As a side note, provider-centric advertising promoting care more for the benefit of the provider than the patient was not as evident for other health providers earlier in the 20th century. Ironically, subsequent exposure of this now widespread practice⁵¹ has not relieved the level of suspicion aimed toward chiropractic advertising per se. Rather, it has enhanced the downfall of medical sovereignty.³⁸

Trust improves with the exposure to chiropractic^{24,48,49} among the smaller proportion of the population that use their services. However, the general public²⁴ and referring health care providers as a group^{25,28} remain wary. They cite skepticism for extensive treatment plans and claims of efficacy in nonmusculoskeletal conditions,^{28,42,49} as well as the promotion, by some, of pseudoscientific stands on health practices.^{6,46,52-54} Skepticism extends to the reliance by some DCs on the as yet scientifically undefined concept of "subluxation" as the sole grounds for providing care.^{6,55} We are aware and supportive of recent work, such as that by Hawk et al⁵⁶ and Bronfort et al,⁵⁷ posing potential value of the work DCs perform with some patients who have primarily nonmusculoskeletal disorders. However, the evidence remains inconclusive⁵⁷ and inappropriate for establishing claims of primacy.

Patients as a whole, whether users of chiropractic or not, prefer to consult with a medical practitioner for advice on primary care.⁵⁸ Similarly, they favor medical sources for health information,⁴⁹ including referral for chiropractic care over direct access.^{48,58} In the case of musculoskeletal care, in contrast, there is strong and growing support for value of chiropractic service.^{15,48} However, even this value is tainted by the perceptions arising from practice-building tactics attempting to maximize visits. As the utilization statistics indicate, potential patients and referral sources often do not overcome the clinical encounter quandaries of expectation and trust. Rather than selecting a DC from the competitive pool of providers available within their communities, they opt for other care.

Factional Identity

A second source of reputational variability for the profession is that of individual self-identification with intraprofessional factions,^{6,54,55,59} including that of treatment technique systems. Differing schools of thought in health care, even factions, are not unique to the chiropractic profession. More commonly, they develop when professional groups are mature and beyond claiming primacy of competence in a field of abstract knowledge. Few would argue that spinal surgery is a legitimized professional identity for a subgroup of medical physicians. Similarly, within spinal surgery, there are competing schools of thought on the most effective method for contending with specific disorders, for example, in lumbar compressive neuropathy. Using patient clinical idiosyncratic details as rationale, some would offer posterior decompression alone, whereas others may argue for decompression combined with anterior fusion. In our experience at spine conferences, hackles will raise and preferred bodies of evidence will be presented in argumentation regarding which method is superior. Generally, none of this dialogue is public, and never is it elevated to the level of claim for primacy in legitimization. These are within-discipline dialogues conducted under the first (eg, knowledge

and competence are validated by a community) and third (eg, judgment and advice are altruistic) claims of legitimacy. The argumentation uses the natural tension of competing sources of evidence under claim 2 (eg, knowledge and competence are based on rational scientific grounds) until a preponderant consensus is clear. The self-identification in this example is with the profession of medicine through the individual professional socialization from the role—that of a spinal surgeon.

Stigmatized Intraprofessional Culture

Such self-identification as noted above contrasts, as shown in [Figure 2](#), with the dynamics observed within the chiropractic community. Here, factions evolved early^{46,59} and were often based on conflict between personalities and beliefs rather than clinical observation, rationale, or science. Even the bellwether principle most often associated with early chiropractic, the supremacy of nerves in modulating health, was a pragmatic device to differentiate the profession from that of medicine on legal grounds.⁶⁰ Without any guiding evidence as to the most effective methods, graduates splintered off, developed new schools of thought, and competed with their mentors for students.⁴⁶ Systems of technique emerged that were tied to individual personalities. Faced with multiple conceptual and pragmatic paths to membership in the profession, leaders began to demand fidelity to their “brand” of chiropractic. The self-identification of individuals with factions dictated by beliefs or techniques of practice became dominant. The patient encounter became distinctly different depending on the attending DC’s expression of faction beliefs around health and the methods of treatment. The variability and diversity of factional practice further disrupted the exercise of professional socialization by compounding the existing sense of referring sources as being ill-equipped to judge the quality of providers.^{26,27}

INTERPROFESSIONAL DISCOURSE

The profession has never been better positioned to communicate its value in care delivery. The accumulation of evidence across the spectra of epidemiologic, economic, clinical, and mechanistic foundations has risen dramatically over the past 2 decades. Interprofessional communication is often related to effective interprofessional teamwork on behalf of a patient or when presenting a case for the profession to groups of different providers, payors, or policymakers. Every discipline has its semantic world,⁶¹ and the intended communication must take place as a translation between these semantic worlds. Translation, to be most effective, should focus on common areas of overlapping lexicon. Where patient care is the purpose, what is common is the patient’s context, symptomatology, and treatment goals. For presentations, the commonality

may be a spectrum of the patient’s condition (eg, neck pain with headache) and the evidence supporting or refuting a particular approach. Rarely is it effective to step beyond patient-centeredness, for example, providing discourse to “prove” chiropractic. Successful communication will be focused on its purpose through the features in common to achieve translation. The challenge is about enabling integrated and seamless care that is perceived as effective by patients and is an acceptable part of the working practice of all the professionals involved.⁶² Thistlethwaite et al⁶³ pose the broader purpose of effective interprofessional communication rather consistent with the profession’s oft-repeated preferences:

We are familiar with the call to break down the silos of uniprofessional learning and working and the desire to dismantle the hierarchy of professional roles, by expanding scope of practice, blurring role boundaries and acknowledging variable leadership models, in which the medical doctor is not automatically the dominant profession.^(p50)

Communications should anticipate continuing dialogue, providing persuasive narrative.⁶⁴ Too often, even targeted interprofessional communications are sabotaged from the start. They are muddled by either defensiveness or the use of jargon. Within context, peers communicate about patient findings, diagnoses, and treatments in technical detail. The terms of jargon are good shorthand for knowledge and information transfer within disciplines. Jargon is a key barrier, however, to effective communication, especially when the topic is complicated⁶⁵ or unfamiliar to the receiving party. In these situations, comprehension rates generally are low and never reach adequate thresholds for information transfer.⁶⁶ Having been ineffective, the communication’s purpose is defeated. Anecdotally to this point is one example of a request from a spine surgeon to a DC, working interprofessionally, to interpret a report submitted by a different DC. The attending surgeon making the request asked for an “interpretation of the chiro babble.”

Defensive and indefensible correspondence is quite problematic, especially when compounded by unrealistic demands^{46,66,67} that are the antithesis of interprofessional collaboration. For example, doctors and therapists of all varieties are increasingly under scrutiny for justifying continued care. When faced with this challenge, many within chiropractic forget that this is not isolated to a single profession. As a result, those whose careers straddle interprofessional collaborations are often asked to assess responses from colleagues that are laced with invective or soliciting approval for protracted treatment programs that are indefensible.^{9,29} The result is further disruption of the professional socialization necessary for clear expectations within the interdisciplinary sphere of practice.

CONSUMER COGNITIVE DISSONANCE

A disrupted professional socialization cycle, such as that depicted in Figure 2, influences behavior as a consequence of how the individual provider interprets feedback.^{68,69} For the DC, the antichiropractic actions of political and academic medicine and subsequent public suspicions as fueled by survival behaviors have had their toll. Faction self-identification has been amplified into “perceived group victimhood.”⁷⁰ Group members develop blinding trust and attribute negative feedback to professional bias and prejudice. Envisioned career options are considered to be limited, and members who participate beyond those limits are looked on with suspicion.³⁰ Together they raise the tendency for nonconstructive, even antiscientific and pseudoscientific^{46,67} responses that put patients in the middle, confusing them and isolating the individual DC and the profession further.

Where individual faction identities predominate over the collective identity, legitimization of the collective as a whole is muted from its full expression. Individual differences are emphasized rather than the commonality of the collective.³ As a result, we contend that the public is confused by the diversity of identity encountered as they socialize with family, friends, and health advisors over what it means to visit a DC in a practice setting. When there is dissonance over expectations, doubts are raised as to the type, amount, and quality of care, especially for nonmedical providers.⁷¹ In essence, the profession as a whole is suspect and stigmatized.^{30,41,72}

No studies have yet been undertaken to directly measure public dissonance. However, the evidence accumulates in the surveys of the public’s opinions on when, why, and what to expect from visiting a DC. In the late 20th century, public survey rated the DC as third on a trustworthiness scale after physicians and physical therapists.⁵⁰ In the more recent report by Weeks et al,¹⁵ only 52.6% of those surveyed felt trusting of recommendations from DCs. Although just more than two-thirds of respondents felt they had “a good idea” about what DCs do, when asked to specify, the public held a clear voice declaring treatment of musculoskeletal disorders, particularly involving the spine.^{24,48} Only 21.4% indicated an interest in consultation for care other than that associated with back and neck pain. This is markedly different from the findings in surveys of DCs by McGregor et al^{6,55,73} or McDonald et al,⁷⁴ who reported that 54.9% and 89.8% of the profession, respectively, believed that broader health problems are within the domain of chiropractic services. Assuming that the difference in view of the definition of appropriate professional work is surmounted, there is more confusion. Keating et al⁴⁶ list 66 treatment systems as “some” of those with which DCs self-identify and promote to the public.

The disconnect between public perception and provider faction identity is itself cognitive dissonance and strong evidence of undermined trust⁵² in organizational legitimacy. Open identity dissension by the profession within the public

view is often expressed in the form of beliefs^{6,54} rather than its core competencies, which are the currency of professional identity.³⁷ The consequence is reservation with respect to utilization. The expression often takes the form of concern for how to identify individual DCs who can be “trusted” to reflect the identity that incorporates the 3 claims for legitimacy and who will reliably fulfill the social contract.⁷¹

MOVING FORWARD

Societies evolve. Health care delivery and the expectations of health care providers change through countervailing forces to traditional practice with an emphasis on interprofessional collaboration and increased accountability.⁷⁵ These pressures are external and internal. They come from clients, courts, and regulators⁷⁶ and from competition from other practitioners⁷⁷⁻⁷⁹ taking up manual care. They are interprofessional, as groups jostle over jurisdictions,^{6,73} where outcomes and skill are most often the mediators.⁸⁰ To be relevant in the future and satisfy the demands being made on the profession by its stakeholders, we must transcend the insularity and multiple messaging of the past counterproductive professional socialization dynamic. As noted recently in *Time* magazine,⁸¹ the biggest problem the image of the profession faces today is the diversity in public observations from individual practice behaviors. Actions within the practice setting matter.³⁸

We argue that the public perception, as perpetuated by the profession itself, is unnecessarily complex and a function of the trustworthiness challenge to the reputation of the profession. Further, we contend the profession has the capacity to clarify its rhetoric, simplifying the cognitive processes defining legitimacy while continuing to empower the practical diversity of care options. The strength of what we propose lies in its grounding within the existing semantics of modern health care as an accepted construct for patients, policymakers, and health care providers. To be achieved, it will build on the hard work already accumulated through the many surveys of the public, research studies on attitudes toward the profession, and experiences of leaders who have represented the profession with government and payors. To be successful, the work must be translated to the public and actively asserted at the core level of chiropractic service, the practice workplace of care delivery.

Four specific conceptualizations within the profession, about itself, are necessary to restructure the professional socialization cycle:

1. The focus within chiropractic care delivery must be consistently expressed through being results and solutions oriented, shedding the vestiges of practice-building programs that direct service utilization and its appearance.
2. The commonality of core chiropractic, which is evidence based, must be embraced as the primary

individual professional identity to reassert the claim of primacy in its application.

3. The factional identities must be subsumed to their appropriate role as beliefs and technical and complementary practices that remain as options for care delivery to an informed patient.
4. An empowerment of the profession and its members must be recognized through action as collaborative managers of patient health, sharing the common health lexicon and shunning the legacy of a victimhood culture.

Will challenges and competition within the marketplace for musculoskeletal care continue? Most certainly, they will. However, the profession's abstract knowledge base is stronger than ever before. The case will be made, if not by the profession then by its competitors. Will DCs continue to experience scrutiny and suspicion? Yes, in the interim. The change agencies of leadership, education, research, and regulation for professions³⁴ have already been engaged on its behalf. To be sure, those efforts need continued strengthening. However, the rank and file now can assume ownership, acknowledging that there has been intellectual and political discrimination but recognizing that the "victim with minor guilt" status⁸² within our culture is unhelpful. Reversing victim mentality, taking individual responsibility for our collective image, and removing the sources for challenge of trust with the public will strengthen the case against continued discrimination.

Why should we have confidence that this approach will change our status? We have experienced it, for example, with the case of stroke after manipulation to the cervical spine. Scientifically, this issue is essentially resolved both on epidemiologic and mechanistic terms.^{81,83,84} The evidence is now percolating through society's filters with recognition in medicine⁸⁵ and the court systems. After years of discrimination and abuse of scientific association, the profession took ownership and has provided the necessary evidence to alter its own course.

PROGRESSING THE IMPACT OF IDENTITY THROUGH ACKNOWLEDGING CORE AND COMPLEMENTARY PRACTICES

Core Chiropractic

As Rynnanen's work³ would predict, there is commonality across the entire profession on which collective identity can be recognized. The core of chiropractic is that which is taught in the majority of institutions and practiced by the majority of its members.⁴⁰ To identify the key elements, we draw on data from background work for earlier presentation^{6,55,73} in the form of surveys and publications from several sources. They include direct survey of attendees to the World Federation of Chiropractic Education Conference (details of the survey are

reported by McGregor-Triano⁷³), chiropractic college catalogues and course syllabi (1997-2000) of 16 US programs, profession-wide surveys conducted by the National Board of Chiropractic Examiners,^{86,87} and the Agency for Healthcare Policy and Research report.⁸⁸ The time frame of these sources was selected in context as the interval just before and during the professional identity initiatives of the World Federation of Chiropractic and the Palmer College of Chiropractic.

Core to the profession is the management of patients with musculoskeletal complaints, particularly of the spine. The majority (83%) uphold the clinical diagnosis, in the sense of both the International Classification of Diseases and the Quebec Task Force.^{89,90} Therapeutically, the emphasis of the profession has been on manual therapy procedures, with approximately 14% of the fully accredited DC programs targeting the spine and extremities. These are augmented by the next largest component—physiological therapeutics involving modalities and exercise—accounting for 2.5% (both being based on program catalogues). More recent surveys are consistent but also add wide practitioner utilization of lifestyle advice.^{87,91}

To get at the core adjusting and manual therapy techniques of the profession, chiropractic program syllabi and National Board surveys were used. Of the 66 named systems directly associated with chiropractic,⁴⁶ 27 were represented within the curricula. Based on the reasoning assuming at least a plurality of training, an arbitrary cutoff of 50% was assumed to define a system as core. Four systems met this goal based on the syllabi; 3 focused on the spine (eg, diversified, Gonstead, Thompson) and 1 on extremities. Diversified was found in 100% of programs, whereas extremity procedures were represented in 94%, and Gonstead and Thompson were at 56% each.

Alternatively, using the same cutoff of 50%, the survey from the National Board⁸⁶ yielded slightly differing results. (Subsequent surveys collapsed named technique systems into the category of professional function—adjustment). Practitioners reported utilization rates for diversified (95.5%), extremity adjusting (95.5%), activator methods (62.8%), Gonstead (58.5%), Cox/flexion-distraction (52.7%), and Thompson (55.9%). All of these are manually applied maneuvers targeting joints and periarticular tissues. Four fall within the classification⁹² of high-velocity/low-amplitude maneuvers, with activator being instrument assisted. Cox/flexion-distraction is a motion table-assisted cyclical maneuver, with or without auxiliary pressures (Fig 3).

Thus, the evidence suggests that core chiropractic for the modern era consists of diagnostic and treatment services to patients with musculoskeletal problems, particularly involving the spine. Core treatments are represented by the 6 manually applied methodologies, all of which biomechanically apply loads to the targeted joints to influence function or symptoms. This core conceptualization further reduces the cognitive dissonance of factional identifications based on techniques. These methods are comparable dynamic

Fig 3. Biomechanical classification of manual procedures commonly used by chiropractors during a patient encounter. *Motorized table assisted. **With/without auxiliary contact pressures.

treatments that differ scientifically, not by intent but by mechanical dosage characteristics (Fig 3) that must be determined by clinical judgment tailored to each case. The strategic value of a core professional identity is that it resonates with the public's observation of what the collective does in its professional work. Techniques are bundled for brevity and simplicity⁷ at the identity level and unpacked in application at the individual patient encounter using shared decision making with informed consent. The named technique systems within are the individualized care prescription. From the public's perspective, this is remarkably analogous to the familiar professional identity of the orthopedist who specializes in spine care and has a series of surgical tools within his or her skill set. Indeed, it is the reputation of skill in achieving results that seems to be the driving factor for a patient to select a given provider who specializes in manual care.⁸⁰ Given such commonality, should patients be thrust into the position of having to select a provider based on a procedure that might be offered? Might they be served better knowing that their provider can assess them and determine appropriate need? Should all DCs be trained sufficiently in all core approaches to offer a balanced perspective, advising a patient about the pros and cons of each to make an informed shared decision?

Complementary Chiropractic

Complementary practices are well-established conceptualizations within the modern health care arena. Their widespread use among the public is well known. Considerable thought has been given to how they may be grouped for study and referenced. Perhaps the most experienced in this

regard is the US National Center for Complementary and Integrative Health.⁹³ At their roots in modern semantics, complementary approaches are methods of addressing health that are in addition to the core or traditional practices. Most are categorized into the use of natural products (eg, herbs, vitamins, minerals, and probiotics) and mind-body practices (eg, yoga, meditation, relaxation, acupuncture, movement therapies). Other approaches such as Ayurvedic medicine and traditional Chinese medicine are systems of health care, often with their own identities, and used as alternatives to traditional care but, at least, are not readily fit into other complementary groups.

For the purpose of professional socialization, we contend that there is a strong semantic foundation recognizing that what is not traditional (eg, core) is complementary and that the notion of complementary is broadly understood. In medicine, nontraditional practices including manipulation procedures are complementary to medicine. In chiropractic, what is not core (eg, traditional) chiropractic is complementary to it, as is medicine. In either case, the characteristic is that fully qualified health care professionals, with additional training in a specific approach, validly may utilize complementary procedures. We again invoke as example the earlier described case of Dr. Wayne Jonas,⁴¹ whose core practice of medicine (eg, diagnostic health evaluation, prescription of pharmaceutical agents, lifestyle counseling, and coordination of health resource access for patients) was augmented by obtaining additional training in several complementary fields.

The DC may augment his or her core practice (eg, diagnostic evaluation, manually applied maneuvers targeting joints and periarticular tissues, lifestyle counseling,

coordinating community health resources) through training by offering additional services. Such services will be bounded by jurisdictional regulations that govern practice if offered strictly within the construct of a chiropractic license. Additional roles and services are available through cross-training sufficient for an individual to qualify under complementary professional identities. This avenue of career expansion exists today, based on jurisdiction, in the form of DCs who also have become certified in acupuncture, physical therapy, or naturopathy, for example. Thus, the extent of complementarity may be conceived as expansive and diverse for the DC as it is for the medical physician but in the opposite direction. Career path options continue to include solo and group single-discipline practice, which might add less common manual treatment methods, nutritional counseling, or mind-body practices. They may also range to engagement in traditional multidisciplinary practices offering core and complementary chiropractic services or cross-trained specialty service, up to and including medicine in addition to chiropractic service, where jurisdictional requirements have been met.

As chiropractic itself has evolved in status within the health care system, it has done so based on the strength of accumulating evidence for its core emphasis and modalities of care.⁹⁴⁻⁹⁶ As complementary practitioners build their database of evidence, they too will move as may be appropriate. Substantiated complementary methods will become core and a preponderance of negative evidence⁵⁷ will lead to abandoning of some.

Limitations

This paper provides insights and discussion about the data and references that have been collected. This discussion is limited to the resources used. Others may interpret the data or include other materials, thus resulting in differing viewpoints. The intent of this paper is to promote discussion regarding identity and chiropractic practices that are reported as problematic to referral. As the profession and the literature evolve, it is anticipated that the perspectives on constructs of core and complementary identities regarding this work will evolve as well.

CONCLUSION

We contend that the professional socialization of chiropractic is mutable and within the sphere of influence of the profession itself. As Abbott³⁴ has reported, strategic change for the collective community of a profession involves concerted effort through all 5 of the levers available to it: leadership, education, research, regulation, and the practice workplace. Continued leadership and institutional investments in education and research are critical to bolstering the professional identity and clarifying valid, safe, and effective practice. Regulators need to continue strengthening their

focus on shielding the public from predatory practices. However, resolving the public's confusion and repairing the sense of trust will reside primarily at the practice workplace and in the hands of practitioners, one patient at a time, breaking stereotypes. Public surveys continue to show a substantial proportion of individual clinical encounters being problematic, perpetuating negative typecasting. Only practitioner engagement, taking ownership for the collective reputation of the profession, remains as the least activated lever of change. Continuing under the rubric of current behaviors is not sustainable. Strategies of personal responsibility for the reputation of the profession and a professional socialization dynamic revolving around core and complementary chiropractic offer a strategic advantage at precisely the level of interest its members care about most—patient access and care utilization in the practice setting.

As the chiropractic profession advances, we expect that the evidence will and should influence what is core and what is complementary. Central to those details, we see core and complementary identifications offering 3 distinct advantages. They clarify the professional identity and service of the DC unambiguously; empower and respect the interest of the individual professional to explore complementary practices; and respect the rights and preferences of the patient in an evidence-based approach that provides real informed choice. The keys are fealty to the social contract through which professionalism is assessed with patient-centeredness expressed through results and solutions-oriented care.

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Practical Applications

- Professional socialization enables referral sources to the degree that they trust the profession.
- Practice behaviors are the basis for most distrust toward the profession. Individual identification with technique systems and practice building obscure professional identity.
- Conceptualization of core and complementary practices fit the public's accepted semantics and are proposed as a means to reduce the cognitive dissonance in public attitudes.

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