COMMENTARY

Chiropractors in Australian Hospitals - How can it Work?

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Chiropractors working in public hospitals or indeed private hospitals in Australia are rare. There is no organised strategic plan to have chiropractors in public or private hospitals throughout this country. Indeed some would argue that there is a strategic plan not to have chiropractors in public or private hospitals in this country (1).

For this reason I feel somewhat privileged having worked over the past two years (1996-1998) as a chiropractor at a public hospital in Townsville, Queensland. During this time I have made a number of observations, which I believe could be included in a reasonable model, for the inclusion of chiropractors as members of a health care team in private and public hospitals throughout Australia.

Chiropractors are registered in every state of the Commonwealth, their education is provided at two universities, one in Victoria (RMIT) and one in New South Wales (Macquarie University). There are approximately 2500 registered chiropractors throughout the Commonwealth. Their status in the community is that of a primary health care practitioner and their legal status is similar to that of a physiotherapist or dentist both of whom enjoy hospital employee status.

Setting aside the medico-political problems associated with inclusion of chiropractors in the hospital system, should the inevitable occur and chiropractors be invited to participate I believe that their role should be in treating musculo-skeletal conditions particularly those of the spine. Further, the hospital setting would be an ideal teaching venue for both undergraduate and postgraduate study as well as research.

A new chiropractor on arrival at a hospital should undergo an orientation so that the practitioner is acquainted with the way the hospital works and the protocol (including ethics) involved in the smooth running of the hospital. An orientation also has the advantage of introducing the chiropractor to other members of the health care team and acquaints others with the chiropractor on a personal basis. This orientation should include the Chief Executive Officer (CEO) of the hospital and members of relevant departments such as anaesthetics, orthopaedic surgery, neurology, radiology, nursing and so on. Introduction to the hospital library is also of importance as different institutions usually have different usage protocols. There are of course more mundane matters, such as room and equipment usage, which need to be addressed upon orientation.

Other than as part of an undergraduate program, a chiropractor employed at a public hospital or private hospital should be experienced. This is because the nature of the complaints seen at hospitals appear (anecdotally) to be different from that of private practice. Hospitals are tertiary care centres, they attract people with long term or serious problems for which the practitioner must be skilled and experienced to cope with. For this reason the hospital is also an ideal teaching environment. Apart from the experience gained by the undergraduate practitioner by seeing serious and chronic cases there is also the potential facility to be able to witness orthopaedic surgery, undergo ward rounds with rheumatologists, sit in on radiology sessions and to attend grand round sessions. These possibilities should never be underestimated, and would give the inexperienced practitioner an overview of health and disease which they would not otherwise get in a teaching clinic of a chiropractic school. As a corollary the experienced chiropractor should receive remuneration consistent with their training and experience.

A chiropractor should be a team player in a hospital environment, they need to be able to work in conjunction with medical practitioners, with physiotherapists and other health professionals. This is very important, because they will not be working in isolation in a hospital environment as they often are in private practice.

Another advantage of this team situation is that the chiropractor will have medical back up at the highest level, state of the art facilities and the environment to be able to gain an understanding of health and disease from these practitioners and share with them ideas of their own.

So where in a hospital exactly would a chiropractor fit in?

As I have stated above from a teaching point of view there are many areas of the hospital where a young undergraduate should attend or even for that matter that the postgraduate could attend. But there needs to be a facility where the chiropractor could call home within the hospital. There is no one absolute area where the chiropractor should be within a general hospital, however a natural area is within a pain management clinic, a back

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pain centre or a rehabilitation centre within the facility.

It is important to note that in the hospital pain clinic setting it is likely that predominantly chronic patients will be seen. It is therefore important that the chiropractors have a good relationship with the Accident and Emergency department so that they can attend to the more acute cases. Therefore, the orientation of the chiropractor within the hospital should include accident and emergency staff introductions and protocols.

How do the hospital staff know what a chiropractor is able to do?

This can only be achieved by communication with all of the relevant staff preferably by the chiropractor giving a talk or seminar on a periodic basis to other staff within the hospital. It goes without saying that this talk must be evidence based and not based on anecdotes, suppositions, ideology or dogma.

So if a chiropractor works within a pain clinic or rehabilitation facility within the hospital are they to be primary contact or are they to be secondary contact practitioners?

This is a rather contentious issue. It is more than likely that the general hospital protocol will prefer to screen these patients through the medical system prior to them presenting to the chiropractor. As chiropractors throughout this country know is not usually necessary in private practice to have patients medically screened before chiropractic and therefore it is a vexed question whether the chiropractor should be primary contact in a hospital or secondary contact after medical screening.

It is possible for chiropractors to be successful in the hospital using either method, however from a teaching point of view it would be useful if primary contact could be used and where necessary the patients referred on for medical attention. So, while preferable it may be politically ambitious to achieve primary contact status at this time.

One aspect of this issue is whether patients should be able to self refer to a pain unit within a hospital. In my view only those referred by a medical practitioner or chiropractor should be accepted into such a unit.

So how should the chain of command work?

The chain of command in a pain clinic would more than likely involve medical screening of the patient, a review by a medical consultant/specialist and then a referral to the chiropractor where appropriate. The indications and contraindications of chiropractic therapy become important at this point including a thorough knowledge of these by all relevant staff.

Follow review of the patient by the consultant and the chiropractor's recommendations relating to discharge some other form of treatment may occur when necessary.

How do chiropractors know what other staff can do?

It is important to recognise the abilities and fields of expertise of other practitioners within the hospital environment. Therefore, the concept of seminars by all members of staff is suggested. A case in point are chronic back pain patients who more often than not have psychological sequalae from their pain problems. Non-recognition of psychological problems may lead to serious consequences. For instance a long term chronic back pain patient with acute depression must be screened for suicidal ideation otherwise tragic consequences may ensue.

In my view the psychologist and psychiatrist are an absolutely essential part of the team for chronic back pain management within any centre. A necessary element of the back pain or pain clinic are regular meetings where each patient's case is presented to staff and a joint meeting discusses diagnosis and management. In this way everybody gains an understanding and is able to contribute to the diagnosis and management of any new patient.

Further, regular full staff meetings should review the progress of each patient, thereby allowing each staff member to gain a better understanding of each case and also providing an opportunity to improve their own skills of diagnosis and treatment of the pain patient.

Where patients are referred out of the immediate pain clinic, for further advice, and in order to improve their understanding, all correspondence from specialists back to the pain clinic should be shared and viewed by all members of the team, including the chiropractors. I stress, there should be a systematic approach to the diagnosis and management of each patient who attends the clinic and a sharing of all knowledge for the improvement of everybody's understanding.

JARGON

Another necessary element is the uniform language between practitioners. It is important to find common ground where the use of medical language and notes are used in common. Jargon is a waste of time if other practitioners, when reviewing a patients hospital file, are unable to understand it. Therefore, a systematic approach to medical terminology or nomenclature should be undertaken by all staff and an understanding arrived at.

Where possible diagnostic instruments of measurement should be used only where they are reliable and valid. Others should be used with caution and in the full knowledge that they may be of limited value. These matters are necessary discussion points for all staff at meetings.

RESEARCH

It is likely that hospital clinics will be undertaking research and it is important for staff to be able to have a good understanding of research fundamentals and to be able to contribute to the research being undertaken where necessary. As a consequence the chiropractor in the hospital environment should have some research training in their undergraduate year or postgraduate training.

EQUIPMENT

It is important that the chiropractor be supplied with all the necessary equipment required for their state of the art functioning. This includes adequate chiropractic tables, state of the art physical therapy equipment, diagnostic tools etc. Physical therapy equipment should include mechanical therapy such as traction and electro-therapies heat and cold, including interferential, diathermies and ultrasound.

CONCLUSION

Chiropractors are needed in Australian hospitals by patients. Whether they are wanted by hospital hierarchies is doubtful. But it should be noted that general hospitals are not owned by health professions, they are owned by the community. There is a role for chiropractors in hospitals just as there is the community. I hope this article stimulates some discussion regarding their inclusion.

REFERENCE

1. Brindle T. Chiropractors claim AMA boycott. Australian Doctor Weekly. April 17, 1998.