Philosophy influences practice. The philosophical constructs that have largely guided the success of medicine in the twentieth century are reductionism, dualism, and determinism. Within this biomedical framework, a clinical practice model evolved that focused on the pathologic unit and evaluated management results on the basis of objective evidence. Although the objectivity of this model has lent itself to scientific appraisal of clinical outcomes and evidence-based medicine, it has also encouraged practitioner detachment and fostered patient-practitioner alienation. Growing disillusionment with the human face of medicine, the prevalence of chronic conditions in an aging population, and the financial demands of technologically advanced medicine have all contrived to change the focus from physician to patient.

Professional intervention targeted at addressing the patients’ needs has been subsumed under a multiplicity of terms, ranging from the well-accepted “patient-centered care,” “patient-focused care,” and “client-centered care,” to the less recognized terms of “individualization of care” and “knowing the patient.” Although the notion of patient-focused or patient-centered care first appeared in the literature in the 1980s, there is still no single accepted definition. A major dichotomy does, however, lend itself to 2 discrete groups of definitions. One category views patient-centered care as a reorganization of services around patient needs; the other focuses on understanding the patients’ perception of their health needs, priorities, and health care expectations. The former definition lends itself to reducing redundancy and the cost of service delivery; the latter, to defining client preferences. The former redesigns patient care delivery; the latter identifies preferred patient outcomes. It is this latter humanistic focus that is of relevance to chiropractic care.

PATIENT-CENTERED HEALTH CARE

The nursing profession was conceivably the first of the health professions to enunciate and embrace the notion of patient-centered care. It was perhaps their intimate involvement at the patient care interface and their ambiguity about medicine’s dominance of their clinical work that encouraged them to seek and adopt the philosophical constructs of holism, interactive monism, and indeterminism that underlie patient-centered care. In any event, patient-centered care has long been a defining characteristic of nursing, and it continues to be a primary focus for nursing theory and the development of its empirical knowledge base.

Definitions of nursing within nursing theories focus on meeting the health care needs of individuals and include care congruent with and responsive to patients’ wants, needs, and preferences; care focused on the expected outcomes of the patient; the collaborative effort of health professionals, family, friends, and the patient to achieve optimum healing; respect for the patients values; integration of care, emotional support, physical comfort, and communication that informs and educates.

Patient-centered care provided nurses with a focus that clearly distinguished their care from the disease-centered care of the medical profession and helped to establish their identity as a credible profession. Establishing their supremacy as providers of patient-centered care, without relinquishing the nursing role of implementing the physicians’ medical management instructions, served to establish a degree of autonomy for the nursing profession. Autonomy, a valued attribute among health professions, arises from the core characteristics of a service orientation and a professional knowledge base. Patient-centered care enhanced the service orientation of nursing and provided a framework upon which nursing could develop a discrete body of knowledge.

However, patient-centered care is not solely the prerogative of the nursing profession. The Canadian Association of Occupational Therapists has attempted to develop and implement guidelines for the practice of a client-centered approach to occupational therapy. Their key concepts of client-centered practice have been identified as individual autonomy and choice, partnership, therapist and client responsibility, enablement, contextual congruence, accessibility, and respect for diversity. Pharmacists have also embraced the construct and are working toward an integrated patient-specific model based on the ethical imperative that the patient must be central to any health-care endeavor. In fact, so pervasive is the move toward patient-centered care in conventional health care that it has been suggested that evidence-based and patient-centered medicine are
the two dominant paradigms of contemporary conventional health care.\textsuperscript{7}

In contrast to conventional health care, complementary medicine has a reputation of being more patient-focused. The chiropractic profession has long laid claim to offering patient-oriented health care. Long before the terminology of patient-centered care was coined, chiropractic’s philosophical constructs of vitalism, holism, humanism, conservatism, and naturalism lent themselves to a patient-centered, rather than physician-centered, form of care.\textsuperscript{9} An 8-member consensus panel characterized chiropractic’s patient-centered paradigm as including the following: self-healing; recognition of the patient as a unified whole; respect for the patient’s values, beliefs, and dignity; involvement of the patient as a partner in health promotion; and a natural and conservative approach to evidence-based care.\textsuperscript{9} This paper explores the dimensions of patient-centered care in Australian chiropractic clinical practice with respect to communication in the chiropractic consultation.

THE FRAMEWORK OF PATIENT-CHIROPRACTOR INTERACTION

A major feature of patient-centered care is the interaction between patient and practitioner. Instead of the prescriptive communication used to convey information to the patient in physician-centered care, bidirectional communication in patient-centered care involves an exchange of ideas. Carmichael\textsuperscript{10} described 3 distinct types of patient-practitioner interaction: the adversarial model, in which the patient seeks legitimation of the sick role; the clinical model, in which the patient assumes a dependent role, obediently following the directives of the authority figure (ie, clinician); and the relational model, in which a reciprocal relationship develops between patient and practitioner. In the clinical model, communication is physician-centered; in the relational model, care is more patient-centered.

The relational practice model, which involves a mutual exchange of ideas and seeks to involve patients in their health care, is further subdivided according to the degree of patient centeredness. In the guidance-cooperative mode, patients actively participate in their health care but are largely guided by the practitioner. In the mutual participation variant, patients assume greater autonomy and take more personal responsibility. The mutual participation mode of the relational model epitomizes patient-centered care. An international study based on case studies of 22 chiropractors, each interacting with 4 or 5 of their patients, found that although the practitioners were using more than one practice model, all favored a relational practice model.\textsuperscript{11} A more detailed Australian study of 208 patient-practitioner interactions by 34 chiropractors supported this finding and identified a preference for the guidance-cooperative mode of this model.\textsuperscript{12}

In contrast to Carmichael, the Emanuels envisage 4 clinical practice variants,\textsuperscript{13} designated from most to least patient-centered: informative; interpretative; deliberative; and paternalistic. In the paternalistic variant there is little or no patient participation. In the informative variant, the practitioner provides the patient with relevant information (ie, the facts); the patient, in accordance with his or her own values, selects the preferred intervention, which is then implemented by the practitioner. The interpretative variant differs from the informative option insofar as the practitioner elucidates the patient’s values and desires, and then helps with selection of an intervention. In the deliberative variant, the practitioner provides factual information and clarifies the types of values embodied in each option. There is less patient participation than in the interpretative variant because the practitioner explains why certain health-related options are “more worthy” and should be aspired toward. The previously mentioned Australian study found that the chiropractic consultation, although characterized by extensive behavioral participation by patients with regard to data collection, is associated with limited patient participation with respect to management decisions.\textsuperscript{12} Such behavior would suggest that chiropractors tend toward the deliberative variant.

COMMUNICATION AS THE MEDIUM FOR PATIENT-CENTERED CHIROPRACTIC CARE

Chiropractors have long recognized that clinical variables other than the adjustment have a profound influence in chiropractic care. “The quality of interaction between the physician and the patient can be extremely influential in patient outcomes, and, in some (perhaps many) cases, patient and provider expectations and interactions may be more important than specific treatments.”\textsuperscript{14} A therapeutic alliance, forged in an environment of emotional support, fosters growth of the belief that the problem is manageable. Patient-practitioner agreement with respect to the clinical problem and the proposed intervention appears to create a sense of congruence characterized by shared therapeutic goals and collaboration. Chiropractors create the expectation of a positive outcome by the personal conviction that they can help, by providing information on how they intend to help, and by implementing an impressive therapeutic ritual.\textsuperscript{15}

So successful is the chiropractic clinical consultation that most patients in an Australian study considered that the consultation had met or exceeded their expectations.\textsuperscript{16} Despite this resounding endorsement of the chiropractic consultation, a case study with 9 practitioners that explored 173 patient-practitioner dyads found a less than 50% congruence between the perceptions of patients and their practitioners.\textsuperscript{17} In this study, congruence was sought with respect to the patients’ perceived stress levels, the importance of injury as a causative factor in the presenting complaint, and the responsibility patients should take in “getting themselves well.” Furthermore, another case study of 25 chiropractors found that the majority of the 124 patients in the study were unable to provide a coherent response when asked how chiropractic works.\textsuperscript{18} This, despite 96% of the 25 chiropractors in the study providing their patients with very plausible explanations of how chiropractic works! The study concluded that, although patients expect a satisfactory explanation, kinesthetic awareness of the potency of the chiropractic adjustment to achieve a change may be a more important consideration than an intellectual appreciation of the mecha-
nism underlying chiropractic care. It is not what is said to the patient that is important; it is, rather, how the clinical encounter makes the patient feel.

It has been ascertained that only 35% of the meaning in a communication situation comes from the actual verbal symbols. Communication is an attempt to get meaning; it is a personal transactional process—personal because the understanding acquired is unique for each individual, and transactional because both parties are simultaneously giving off signals that may be perceived by the other. Both perception and attention are selective. The process of decoding or receiving messages and of constructing or encoding messages is strongly influenced by personal experience and current needs. Factors that influence encoding include the speaker’s communication skills, attitudes, knowledge, social system, and culture. Similar factors influence decoding of the message; however, the nature of the factors influencing the receiver may be vastly different from those of the source. The message is influenced by the source’s selection of content and level of skill in verbal and nonverbal communication. It is also modified by the receiver’s interpretation of verbal and nonverbal content.

Meaning is conveyed through signs, signals, and semiotics. Signs have a one-to-one relationship, such as a stop sign means halt. Symbols, however, take on diverse meanings; they can be manipulated to stand for whatever we wish. Advances in mind-body medicine suggest that processing within the nervous system does not distinguish between symbols and physical structures or signals, and that the neurobiology of the brain can be altered by perceptions. Even in animal experiments, perceptions developed in response to conditioning have been shown to activate somatic processes with pathophysiologic repercussions. The production and modulation of neuropeptides and their receptors is postulated to provide the biological pathways linking mind and body, symbol and soma.

An appreciation of semiotics brings another dimension to the chiropractic consultation. Semiotics is the study of communication signals and is classified according to the 6 senses. Visual semiotics includes the study of kinesics (body movement), proxemics (personal space), and graphics. Kinesics includes facial expressions, gestures, posture, locomotion, and parakinesics (kinesic behavior that modifies the meaning of behavior, such as the intensity, duration, and scope of a movement or gesture). Proxemics distinguishes between the intimate (<45 cm), personal (45-120 cm), social (1.2-2.1 m) and public zones (2.1-3.5 m). The intimate zone is subdivided into near intimate, which includes contact to less than 15 cm, and far intimate, which extends from about 15 to 45 cm. The near intimate zone is reserved for intimate friends, parents, children, and chiropractors. Acoustic semiotics includes linguistic sounds and paralinguistics—the nonverbal acoustic behavior that accompanies speech. Paralinguistics considers rhythm, intensity, pitch, tempo, silences, and accent.

Because successful communication in the chiropractic clinic cannot be solely attributed to verbal communication, the role of nonverbal communication of symbols and semiotics deserves particular attention. Interaction conducive to wellness in the chiropractic clinic would appear to be achieved through a diversity of nonverbal triggers. Although the symbolic component of healing has long been recognized to be well developed in chiropractic practice, the extent to which the chiropractic clinical outcome benefits from nonverbal communication may not yet be adequately appreciated.

**Ambiguities in the Delivery of Chiropractic Patient-Centered Care**

It would appear that it is the chiropractor’s demeanor rather than the content of the message that is important. One would expect that both the verbal explanation and the chiropractor’s demeanor would be influenced by chiropractic’s philosophical constructs, which have divided the profession into mechanists and vitalists. The verbal explanations of these two groups differ, with the mechanist likening the body to a jammed gearbox and vitalists explaining how they remove interference to allow the healing power to flow; however, both chiropractic groups seek out and correct subluxations. Although vitalists anticipate a more pervasive benefit, both groups believe they can help the patient.

It is furthermore postulated that it may be this conceptualization, rather than the actual therapeutic intervention, that may be construed as chiropractic’s holistic approach. Taken in isolation, the process of identifying and correcting is essentially a reductionist activity, even though chiropractors may modify their technique to accommodate the patient’s physique. Chiropractic holism has more to do with explanation than biomechanics. It is only when the chiropractic adjustment is undertaken in the total symbolic context of the chiropractic clinic that chiropractic can be construed as holistic and conforming to the patient-centered criteria of facilitating the person’s inherent healing capacity.

Partnership in decision-making has also been identified as a criterion for recognizing patient-centered care. The extensive behavioral participation by patients in data collection does not extend to substantial participation in arriving at management decisions. Patients were expected to assume a cooperative role as they are guided by their chiropractor with respect both to the proposed adjustment and selection of a self-care strategy. When chiropractors were asked how patients might participate in their own health care, the most popular responses were that they keep their appointments and do their exercises. Two in 3 patients who were asked a similar question indicated that their chiropractor did expect them to work on their health problems by avoiding doing further damage, assuming correct postures, keeping their scheduled chiropractic appointments, having an appropriate diet, and exercising. Such care goes beyond correcting subluxations but falls short of the comprehensive care framework of patient-centered care offered by nurse practitioners at the consumer-health care system interface.

Awareness of the patient’s health needs and expectations is another characteristic of patient-centered care. A previ-
ously-cited case study found that when 124 patients were asked whether they had let their chiropractor know what they expected from chiropractic care, 20% indicated they had never done so. Furthermore, although most of the responding patients reported discussing their treatment goals with their chiropractor, 7% indicated they had never done so. Despite many chiropractors offering somewhat prescriptive spinal care classes, a case study involving 15 practices and 210 patients concluded that the chiropractic profession did not appear to have established itself as an important health information resource in the mind of chiropractic patients. It may further be surmised that the high patient flow and brevity of the consultation in many chiropractic clinics may serve as an impediment to establishing a comprehensive patient-centered approach.

CONCLUSION

The desired outcome of chiropractic care is improved patient function rather than disease cure. Instead of objective scientific appraisal, the ethos of care within both chiropractic and patient-centered care is empathetic understanding. Although chiropractors are singularly successful at conveying such understanding, it is unlikely that this is attributable to their verbal messages. In fact, although communication in the chiropractic consultation is not physician-centered, neither is it consistently patient-centered. Management is often directive when verbal, and the delivery of the chiropractic adjustment requires a relaxed compliant patient. The recognized communication skills of chiropractors may indeed be more a result of their non-verbal behavior than their explanations. Chiropractic patient-centeredness appears to result more from the impact of chiropractic beliefs on clinical demeanor than on any conscious attempt to conform to conventional health care’s guidelines for patient-centered care.

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