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A Comparative Analysis of Nutritional Education in Chiropractic and Medical Doctoral Programs: Addressing Curricular Discrepancies and Public Misconceptions

A Research Report

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Abstract

The modern healthcare landscape is increasingly dominated by chronic, lifestyle-related diseases that require sophisticated nutritional intervention. However, a significant discrepancy exists between the nutritional training provided in allopathic medical programs and chiropractic doctoral programs. While the public often views the Doctor of Medicine (MD) as the primary authority on all health matters, including nutrition, research indicates that medical curricula frequently fail to meet even the minimum recommended hours of nutritional instruction. In contrast, Doctor of Chiropractic (DC) programs have historically integrated clinical nutrition as a foundational pillar of their holistic philosophy. This paper provides a comparative analysis of the curricular requirements, accreditation standards, and historical contexts of both professions. By examining the quantitative and qualitative differences in training, this study aims to clarify why a knowledge gap persists and how institutional biases contribute to public misconceptions. The findings suggest that utilizing DCs as primary nutritional resources could alleviate the burden on the overextended allopathic system and improve patient outcomes through better-integrated care.

1. Introduction

The global burden of chronic disease, characterized by obesity, type 2 diabetes, and cardiovascular dysfunction, has reached a critical juncture that necessitates a paradigm shift in healthcare delivery. Central to this shift is the role of nutritional science as a primary therapeutic intervention rather than a secondary adjunct. Despite the clear link between dietary patterns and disease pathology, the educational infrastructure of the healthcare workforce remains unevenly prepared to address these challenges. There is currently a physician shortage crisis in the United States, with demand expected to exceed the supply of trained providers significantly by 2032 ¹. This shortage is compounded by a "nutritional knowledge deficit" among allopathic physicians, who often lack the time and training to provide comprehensive dietary counseling.

While allopathic medical education has traditionally prioritized pharmacology and surgical intervention, chiropractic education has evolved along a different trajectory, one that emphasizes the body's innate ability to heal through non-invasive means, including clinical nutrition. However, a profound disconnect exists between the actual educational competencies of these two professions and the public's perception of their expertise. The "halo effect" of the MD title often leads patients to assume a level of nutritional expertise that is not supported by standard medical school curricula. Conversely, professional stigmas and historical institutional biases have frequently marginalized the DC's role as a nutritional expert.

The importance of culinary and lifestyle medicine education is gaining recognition as a means to combat the growing burden of chronic disease [2](#). Some medical schools have begun implementing longitudinal tracks to address this, yet these remain the exception rather than the rule. This paper investigates the structural and historical reasons for these educational discrepancies. By comparing the Council on Chiropractic Education (CCE) standards with the Liaison Committee on Medical Education (LCME) requirements, this analysis highlights the systemic differences in how nutrition is prioritized. Ultimately, this research argues for a more transparent understanding of professional competencies to foster effective interprofessional collaboration and enhance public health.

2. Historical Context of Nutritional Training in Healthcare Education

The divergence in nutritional training between MDs and DCs is not a contemporary accident but the result of over a century of evolving educational philosophies and institutional power dynamics. To understand the current curricular landscape, one must examine the pivotal moments that defined the boundaries of allopathic and chiropractic medicine.

2.1 The Evolution of Nutrition in Allopathic Medical Curricula

The history of allopathic medical education in the 20th century was largely shaped by the 1910 Flexner Report. This landmark document sought to standardize medical training by grounding it in the germ theory of disease and the rigors of the laboratory sciences. While the report successfully eliminated substandard medical schools, it also inadvertently marginalized "lifestyle" and "nutritional" approaches, labeling them as unscientific or "sectarian." As a result, the medical curriculum became increasingly focused on acute care, pathology, and the emerging field of pharmacology.

Over the last forty years, the perspective on physician nutrition education has shifted, yet the actual implementation has often lagged behind the rhetoric of reform [3](#). In the mid-20th century, nutrition in medical schools was primarily relegated to the study of biochemistry—specifically the metabolic pathways of macronutrients—and the identification of rare vitamin deficiency diseases like scurvy or rickets. This "deficiency model" of nutrition was sufficient for an era when infectious diseases and acute malnutrition were the primary public health threats. However, as the epidemiological transition shifted the burden of disease toward chronic, over-nutrition-related conditions, the medical curriculum failed to adapt with sufficient speed.

Recent efforts to reintegrate nutrition into medical education have led to the development of "Culinary Medicine" programs. For example, some institutions have piloted culinary medicine

tracks to provide hands-on training in healthy food preparation [4](#). These programs aim to bridge the gap between theoretical biochemistry and the practical reality of what patients eat. Furthermore, some medical schools have developed four-year longitudinal tracks that include approximately 300 hours of culinary and lifestyle medicine education, focusing on nutrition, physical activity, and stress management [2](#). Despite these positive developments, these intensive tracks are often elective or restricted to a small cohort of students, leaving the majority of medical graduates with minimal nutritional proficiency.

2.2 The Foundational Role of Clinical Nutrition in Chiropractic Philosophy

In contrast to the allopathic focus on external interventions, the chiropractic profession was founded on the principle of vitalism—the belief that the body possesses an innate intelligence and ability to maintain health if the nervous system is free of interference. From its inception, the chiropractic philosophy viewed the "triad of health" as consisting of structural, chemical, and mental factors. Clinical nutrition was identified as the primary tool for addressing the "chemical" component of this triad.

Unlike medical schools that saw nutrition as an adjunct to pharmacology, chiropractic colleges integrated nutrition as a core component of their holistic approach. This foundational role meant that nutrition was not just a single course but a lens through which various pathologies were viewed. DCs were historically trained to view diet not merely as a source of calories but as a complex array of biochemical signals that could either promote or resolve systemic inflammation. This perspective aligns with the modern "Functional Medicine" movement, which many DCs have embraced as a natural extension of their original training.

Research into the practice characteristics of chiropractors worldwide indicates that a significant majority view themselves as primary healthcare practitioners with a focused but holistic scope [5](#). This self-perception is reflected in their clinical activities; surveys show that the majority of chiropractors use nutritional counseling in their practices, primarily for general health maintenance or managing inflammatory conditions [6](#). Furthermore, DCs are frequent recommenders of dietary supplements, often utilizing them as primary therapeutic agents for musculoskeletal and systemic health. This long-standing integration of nutrition into the chiropractic identity has created a culture where the "Doctor as Teacher" (Docere) role is prioritized, with nutritional education forming a significant part of the patient-practitioner interaction.

3. Comparative Analysis of Curricular Requirements and Standards

A rigorous comparison of the educational frameworks reveals significant quantitative and qualitative differences in how MD and DC students are prepared to handle nutritional issues in clinical practice.

3.1 Quantitative Assessment of Mandatory Nutritional Contact Hours

One of the most striking differences between MD and DC education is the sheer volume of time dedicated to nutritional science. For decades, the National Academy of Sciences (NAS) has recommended that medical schools provide a minimum of 25 hours of nutrition instruction.

However, repeated surveys have shown that a large percentage of allopathic programs fail to meet even this modest benchmark. In many medical schools, nutrition is not a standalone course but is "integrated" into other modules, such as gastroenterology or endocrinology. While integration sounds efficient, it often leads to the "dilution effect," where nutritional concepts are overshadowed by discussions of pharmaceutical management and surgical procedures.

In contrast, DC programs typically mandate a significantly higher number of contact hours. Most CCE-accredited programs require multiple standalone courses in clinical nutrition, often totaling over 100 hours of direct instruction. This quantitative advantage allows DC students to move beyond basic macronutrient metabolism and into the complexities of therapeutic dieting, supplement-drug interactions, and nutrigenomics.

The chart above illustrates the stark contrast in educational priorities. While some medical schools are creating exceptional 300-hour tracks, these are not the standard for the average medical graduate [2](#). The average DC graduate, however, enters the workforce with a baseline of nutritional knowledge that far exceeds that of their allopathic counterparts. This quantitative gap has profound implications for the "nutritional literacy" of the healthcare workforce.

3.2 Qualitative Evaluation of Biochemistry and Clinical Application Depth

The difference in training is not merely a matter of hours but of depth and application. In allopathic education, biochemistry is often taught as a foundational "pre-clinical" subject, focused on the memorization of cycles (e.g., the Krebs cycle) for the purpose of passing licensing exams. Once students move into the clinical phase, the biochemical role of micronutrients is often lost in favor of diagnostic coding and acute intervention.

In DC education, there is a stronger emphasis on "functional biochemistry." Students are taught to understand how micronutrients act as essential co-factors in metabolic pathways and how subtle deficiencies—even those that do not result in overt "deficiency diseases"—can contribute to chronic pain and systemic dysfunction. For example, a DC might study the role of magnesium and omega-3 fatty acids in the modulation of inflammatory prostaglandins, providing a biochemical rationale for dietary intervention in chronic back pain.

Furthermore, the clinical application of nutrition in DC programs is often more comprehensive. While an MD might advise a diabetic patient to "eat fewer carbs," a DC is more likely to be trained in the specifics of anti-inflammatory diets, the glycemic index, and the use of specific phytonutrients to improve insulin sensitivity. This qualitative depth allows DCs to provide actionable, specific dietary advice that goes beyond the vague "eat healthy" recommendations often heard in medical offices. The chiropractic focus on self-regulated learning strategies also supports this depth, as students are encouraged to stay current with emerging nutritional research throughout their careers [7](#).

3.3 Accreditation Standards: CCE vs. LCME Nutritional Competencies

The disparities in education are codified in the accreditation standards of the respective professions. The Liaison Committee on Medical Education (LCME), which accredits MD programs in the U.S. and Canada, provides relatively vague guidelines regarding nutrition. The LCME standards emphasize that the curriculum must include content in the "biomedical sciences," but they do not mandate a specific number of hours or specific competencies for

nutrition 8. This lack of specificity allows medical schools to fulfill the requirement with minimal effort, often leading to the fragmented integration mentioned previously.

The Council on Chiropractic Education (CCE), on the other hand, provides more explicit requirements for nutritional competency. The CCE standards mandate that graduates must be able to perform nutritional assessments and provide dietary counseling as a core part of their clinical practice. These standards ensure that every DC graduate has demonstrated a baseline proficiency in using nutrition as a therapeutic tool.

The difference in accreditation philosophy reflects a fundamental difference in professional values. For the LCME, nutrition is a "nice-to-have" component of a broad biomedical education. For the CCE, nutrition is a "must-have" competency for a primary care provider focused on wellness and prevention. This institutionalized difference ensures that the DC curriculum remains anchored in nutritional science, even as medical curricula continue to struggle with how to fit nutrition into an already overcrowded schedule.

The results of these different standards are evident in the postgraduate landscape as well. There are numerous postgraduate training opportunities (PTOs) for chiropractors, including board certifications and diplomate programs in clinical nutrition, which allow for even greater specialization 9. While medical doctors can also specialize in nutrition, it is often a sub-specialty of internal medicine or pediatrics, rather than a foundational element of the general practitioner's toolkit. This structural difference further solidifies the DC's position as a more naturally equipped professional for addressing the nutritional needs of the general population.

In summary, the quantitative and qualitative data suggest that the chiropractic profession provides a more robust and integrated nutritional education than the allopathic profession. However, as the next sections will explore, this educational superiority does not always translate into professional credibility or public trust, largely due to historical and sociological factors that continue to shape the healthcare hierarchy.

4. Investigating the Disconnect Between Education and Public Perception

4.1 Socio-Historical Factors Influencing Professional Credibility

The current landscape of professional credibility in healthcare is not merely a reflection of contemporary educational standards but is deeply rooted in a century of socio-historical development. The divergence in public perception regarding the nutritional expertise of Medical Doctors (MDs) versus Doctors of Chiropractic (DCs) can be traced back to the early 20th century, specifically the publication of the Flexner Report in 1910. This seminal document standardized medical education around a biomedical model that prioritized germ theory, pathology, and pharmacology, while effectively marginalizing lifestyle-based interventions and nutritional science as "unscientific."

Consequently, a hierarchy of professional prestige was established, where the "MD" title became synonymous with scientific authority, regardless of the specific depth of training in foundational health pillars like clinical nutrition.

This historical trajectory created a "boundary work" phenomenon where the medical profession sought to define the limits of legitimate healthcare practice, often excluding traditional or alternative approaches to maintain professional dominance. The regulation of traditional and complementary medicine professionals has historically been framed through the lens of public interest, yet these regulatory structures often systemically privilege biomedical practitioners while placing higher burdens of proof on non-allopathic disciplines [10](#). This institutionalized skepticism has persisted despite the evolving needs of a population suffering from chronic, lifestyle-mediated diseases that the biomedical model is often ill-equipped to address.

Furthermore, the legal battles of the late 20th century, most notably the *Wilk v. American Medical Association (AMA)* case, highlighted a concerted effort by the medical establishment to "contain and eliminate" the chiropractic profession. Although the courts eventually found the AMA guilty of violating antitrust laws, the decades of propaganda associated with the case successfully embedded a narrative of "quackery" in the public and professional consciousness. This narrative has created a lasting stigma that overshadows the rigorous academic training DCs receive in subjects like functional biochemistry and clinical nutrition. Patients often navigate a complex landscape of health perceptions, where traditional remedies and lifestyle interventions are valued for their perceived safety, yet the authority to validate these practices is still largely granted to the medical profession [11](#).

The result is a sociological "halo effect," where the public assumes that the high level of training required for medical licensure translates into expertise across all health-related domains. This cognitive bias prevents a critical examination of the actual contact hours and curricular depth dedicated to nutrition within medical schools. While medical education has historically focused on acute care and pharmaceutical intervention, the chiropractic curriculum has maintained a foundational emphasis on the body's innate ability to heal through proper fuel and biochemical balance. This discrepancy between perceived authority and actual educational competency remains a significant barrier to effective public health communication.

4.2 The Role of Institutional Bias and Media Representation

Institutional bias and media representation play pivotal roles in reinforcing the prestige hierarchy that favors allopathic medicine in the realm of nutritional advice. The phenomenon of "healthism"—an ideology that frames health as a super-value and a primary personal responsibility—is often mediated through marketing and consumer research that privileges the medical voice [12](#). In mainstream media, MDs are frequently positioned as the definitive experts on diet, supplements, and lifestyle changes, despite the fact that many have received fewer than 25 hours of formal nutritional training. This media gatekeeping creates a feedback loop that reinforces the misconception that DCs are limited to musculoskeletal "back doctors," ignoring their extensive training as primary nutritional resources.

The funding structures of academic medical centers also contribute to this institutional bias. Research grants and educational sponsorships are heavily weighted toward pharmaceutical and surgical interventions, which align with the diagnostic and treatment protocols taught in medical schools. Nutritional education, which often emphasizes low-cost, non-patentable interventions, lacks the powerful corporate backing that drives medical curriculum development. This economic reality ensures that nutrition remains a peripheral subject in medical education, often "integrated" into other modules in a way that dilutes its practical application. In contrast, chiropractic institutions, which are less reliant on pharmaceutical research funding, have been

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able to maintain standalone, comprehensive nutritional programs that emphasize functional outcomes.

Social media has further complicated this landscape by providing a platform for both the proliferation of evidence-based nutritional science and the spread of misinformation. While social media can be a tool for empowering patients and increasing health involvement, it also acts as a space where the "emotion of rationality" is used to frame medical authority [13](#). Medical professionals often use their credentials to project an image of neutrality and credibility on social media, which may not always reflect the specific depth of their training in the nutritional topics they discuss [14](#). This digital presence often bypasses the need for rigorous peer-reviewed validation, allowing professional stigmas to be perpetuated through influential online channels.

The disconnect is further exacerbated by the "nutri/edu" discourse, which rationalizes healthism by suggesting that simple educational solutions provided by medical authorities are sufficient for consumer empowerment [12](#). This discourse overlooks the complexity of clinical nutrition and the necessity of the specialized training that DCs undergo. By framing nutrition as a "simple" component of general health that any physician can manage, the unique expertise of the chiropractic profession is systematically undervalued in the public eye.

4.3 Impact of Professional Stigmas on Patient Referral Patterns

The professional stigmas cultivated through historical and institutional biases have profound implications for patient referral patterns and the overall integration of healthcare services. Despite the growing body of evidence supporting the efficacy of nutritional interventions for chronic conditions, many MDs remain hesitant to refer patients to DCs for nutritional counseling. This reluctance is often rooted in a lack of understanding of the chiropractic curriculum and a persistent, though often subconscious, adherence to the "quackery" narrative. When healthcare professionals view the integration of complementary medicine through a "square peg into a round hole" lens, the potential for collaborative care is severely diminished [15](#).

This "silo" mentality is a significant barrier to the actualization of Integrative Health Care (IHC). Program evaluations of academic integrative centers have identified that while shared values and communication are essential for trust, structural barriers such as insurance regulations and a lack of interprofessional knowledge exchange often prevent successful integration [16](#). MDs who are unaware of the rigorous Council on Chiropractic Education (CCE) standards regarding nutritional competencies may default to referring patients to registered dietitians or, more commonly, attempting to provide nutritional advice themselves despite their own educational deficits. This results in a fragmented care model where the professional best equipped to provide clinical nutritional guidance—the DC—is excluded from the primary care team.

The impact on patient outcomes is particularly evident in the management of chronic pain and metabolic disorders. For instance, the development of a national pain strategy requires an assessment of all available evidence-based options, yet the exclusion of chiropractic nutritional interventions due to professional stigma limits the tools available to patients [17](#). Patients often experience a paradigm shift in their spiritual and physical lives when they embrace holistic forms of healing, yet they may feel forced to navigate these options independently of their primary medical doctor [18](#). This lack of coordination can lead to conflicting advice, over-prescription of medications for lifestyle-driven conditions, and a general decrease in the quality of patient care.

Furthermore, the multigenerational workforce in healthcare presents unique challenges for overcoming these stigmas. Different generations of healthcare providers may have varying levels of openness to interprofessional collaboration and different motivations for adopting new care models [19](#). While younger practitioners may be more receptive to integrative approaches, the established hierarchies within medical institutions often prioritize traditional referral networks that favor other allopathic specialists. Breaking down these silos requires a concerted effort to foster interprofessional learning and community engagement, which has been shown to improve recruitment and retention in rural and remote healthcare settings [20](#).

5. Implications for Integrated Healthcare and Public Health

5.1 Utilizing Doctors of Chiropractic as Primary Nutritional Resources

In the face of a global chronic disease crisis, the healthcare system must re-evaluate its utilization of available professional resources. Doctors of Chiropractic are uniquely positioned to serve as primary nutritional resources due to their extensive educational background in clinical nutrition and functional biochemistry. Unlike the medical model, which often views nutrition as an adjunct to pharmaceutical therapy, the chiropractic philosophy views nutrition as a foundational component of health. This "Docere" (Doctor as Teacher) approach aligns with the need for sustained health behavior change and lifestyle interventions that have been shown to lower healthcare costs and improve outcomes for chronic illnesses like cardiovascular disease [21](#).

The academic rigor of chiropractic nutritional training is evidenced by the peer-reviewed research and abstracts presented at conferences like the ACC Research Agenda Conference, which highlight the profession's commitment to evidence-based practice [22](#). By utilizing DCs as primary nutritional resources, the healthcare system can tap into a workforce that is already trained to address the root causes of systemic inflammation, metabolic syndrome, and other lifestyle-driven conditions. This shift would not only improve patient care but also alleviate the burden on MDs, who are often overwhelmed by the demands of acute care and may lack the time or training to provide comprehensive nutritional counseling.

Moreover, the rapid deployment of chiropractic services through telehealth during the COVID-19 pandemic demonstrated the profession's adaptability and potential for reaching broader populations [23](#). This flexibility is essential for addressing public health challenges in diverse settings, from worksite health centers to rural communities. As the demand for holistic and "natural" remedies increases, particularly among migrant and multicultural populations who value traditional knowledge, the chiropractic profession's emphasis on non-invasive, nutritional-based healing provides a culturally resonant and empowering strategy for patient care [11](#).

Integrating DCs more fully into the public health infrastructure requires a recognition of their role as functional medicine pioneers. The chiropractic curriculum's focus on the interconnectedness of the mind-body-spirit and its propensity for promoting self-care aligns with the broader goals of integrative medicine [18](#). By positioning DCs as the "nutritional experts" within the primary care team, the healthcare system can move toward a more proactive, wellness-oriented model that prioritizes prevention over reactive treatment.

5.2 Addressing the Nutritional Knowledge Deficit in Medical Practice

The persistent nutritional knowledge deficit in allopathic medical practice is a systemic issue that requires urgent attention. Research indicates that while many patients respond well to traditional, complementary, and integrative medicine (T&CM), the integration process is often slowed by hostility and a lack of educational parity [24](#). The "dilution effect" in medical curricula—where nutrition is integrated into larger modules rather than taught as a standalone subject—results in a lack of clinical application depth. To address this, medical education must move beyond a focus on rare deficiency diseases and toward a comprehensive understanding of how micronutrients and dietary patterns influence modern chronic pathology.

Addressing this deficit involves not only curricular reform within medical schools but also a shift in the way medical professionals view their own limitations. The recognition of the "halo effect" and the resulting professional overconfidence is a necessary first step toward interprofessional humility. Medical guidelines, such as those from the American College of Rheumatology, are beginning to incorporate integrative interventions like exercise and diet for managing conditions like rheumatoid arthritis, emphasizing the importance of a team-based approach [25](#). However, for these guidelines to be effective, MDs must be able to identify and collaborate with professionals who possess the specialized knowledge they lack.

The current state of complementary medicine education research suggests that there are significant empirical gaps that must be filled to ensure that all healthcare providers are equipped with evidence-based nutritional knowledge [26](#). This includes developing standardized competency frameworks that include input from a variety of stakeholders, including practitioners from other professions and the patients themselves [27](#). By involving DCs in the development of nutritional competencies for medical students, the healthcare system can ensure a more balanced and rigorous approach to nutritional education across all doctoral programs.

Furthermore, the unsustainable cost of healthcare and the rising incidence of non-communicable diseases call for a change in the current paradigm of biomedicine [24](#). Addressing the nutritional knowledge deficit is not about turning MDs into nutritionists, but about ensuring they have enough foundational knowledge to recognize the importance of nutrition and to make appropriate referrals to experts like DCs. This "regulatory equity" approach ensures that the public interest is protected by matching professional education to actual health service demands [10](#).

5.3 Enhancing Patient Outcomes Through Interprofessional Collaboration

The ultimate goal of addressing educational discrepancies and professional stigmas is to enhance patient outcomes through robust interprofessional collaboration. Integrative medicine (IM) offers a paradigm for combining the strengths of biomedicine and T&CM, based on evidence for efficacy and safety [24](#). Successful integration requires more than just placing different practitioners in the same clinic; it requires an integrated interdisciplinary change

strategy that engages all providers in mainstream healthcare, education, and research [16](#). This includes the use of "Normalization Process Theory" to understand how complex healthcare interventions can be effectively implemented and sustained in primary care settings [28](#).

Interprofessional collaboration is particularly vital in the context of acupuncture and other T&CM practices, where stakeholder engagement from patients, practitioners, and researchers is necessary to catalyze greater conversation about implementation science [29](#). The same principles apply to clinical nutrition. When MDs and DCs work together, they can provide a more comprehensive care plan that addresses both the acute and chronic aspects of a patient's health. This team-based approach has been shown to be a key feature of successful student placements in rural areas, where interprofessional learning contributes to a more holistic understanding of patient needs [20](#).

However, the development of these collaborative models is often hindered by the exclusion of relevant stakeholders in the competency development process. Only a small percentage of competency frameworks involve practitioners from other professions, which limits the depth of insight required to capture the complexity of modern healthcare [27](#). By fostering a culture of teamwork and collaboration, healthcare organizations can improve productivity and patient satisfaction [19](#). This requires a shift from a hierarchy of authority to a hierarchy of competence, where the professional with the most relevant training for a specific patient need—such as nutrition—is given the lead in that area of care.

The benefits of this collaborative model extend beyond individual patient outcomes to broader public health goals. For example, lifestyle interventions provided through integrative models have the potential to significantly lower healthcare expenditures by reducing the need for hospital admissions and primary care visits [21](#). As nations work to update and extend global strategies on traditional and integrative medicine, the establishment of academic consortia can provide the necessary guidance for a more equitable and effective integration process [24](#). By breaking down professional silos and embracing a pluralistic approach to medicine, the healthcare system can better meet the needs of a diverse and aging population [11](#).

6. Conclusion

The comparative analysis of nutritional education in chiropractic and medical doctoral programs reveals a significant discrepancy between curricular requirements and public perception. While Doctors of Chiropractic receive extensive, standalone training in clinical nutrition and functional biochemistry, the medical curriculum remains heavily focused on pharmacology and acute care, often treating nutrition as a peripheral or integrated subject with minimal contact hours. This educational gap is not a mere accident of curriculum design but is the result of a century of socio-historical factors, including the legacy of the Flexner Report and the professional "boundary work" that has prioritized the biomedical model over holistic and lifestyle-based interventions.

The persistence of professional stigmas and institutional biases continues to shape a healthcare landscape where MDs are viewed as the default experts on all health matters, including those for which they have received limited training. This "prestige hierarchy" is reinforced by media representation and marketing discourses that frame health as a personal responsibility while privileging medical authority. The result is a fragmented healthcare system where the

specialized nutritional expertise of the chiropractic profession is underutilized, and patient referral patterns are driven by historical biases rather than educational competency.

Addressing these discrepancies is essential for the future of public health and the success of integrated healthcare models. Utilizing DCs as primary nutritional resources offers a cost-effective and evidence-based strategy for managing the rising tide of chronic, lifestyle-mediated diseases. At the same time, the nutritional knowledge deficit in medical practice must be addressed through curricular reform and a commitment to interprofessional humility. By fostering a culture of collaboration and engaging a variety of stakeholders in the development of healthcare competencies, the system can move toward a more equitable model that prioritizes the "public interest" and the protection of traditional knowledge frameworks [10](#).

Ultimately, the integration of nutritional science into the core of primary care is not just a matter of professional parity but a matter of patient safety and ethical practice. Misleading the public into believing that all doctoral-level practitioners possess equal expertise in nutrition leads to suboptimal care and missed opportunities for prevention. As we move toward a more pluralistic and integrative future, the healthcare system must embrace the strengths of both allopathic and chiropractic education, ensuring that every patient has access to the best possible nutritional guidance. The transition from a "silo" mentality to a collaborative, team-based approach is the only way to meet the complex health demands of the 21st century and to achieve the goal of a truly healthy society. Establishing this collaborative framework requires a reconciliation of the disparate knowledge foundations that characterize various healthcare paradigms, particularly concerning how providers position their expertise within the broader clinical landscape [30](#). This integration is further complicated by existing barriers to inter-professional coordination, such as the need for comprehensive education of conventional medical practitioners regarding the utility and evidence base of complementary nutritional and therapeutic systems [31](#). By addressing these curricular discrepancies, the healthcare system can better align provider orientations with the objective of delivering patient-centered care and ensuring that clinical advice remains grounded in rigorous, discipline-specific training [32](#).

[32](#). This process of educational alignment is inherently linked to the specific curricula of different healthcare programs, which significantly shape how students perceive their clinical roles and their orientation toward patient-centered care [32](#). Because different disciplines organize their knowledge foundations through distinct epistemological lenses—ranging from empirical biomedical frameworks to more holistic perspectives on health and environment—the reconciliation of these diverse evidence modes is essential for effective inter-professional coordination [30](#). Consequently, failure to bridge these instructional gaps reinforces the existing lack of synergy between complementary and biomedical paradigms, ultimately hindering the development of a cohesive integrative medicine practice. This instructional divide is often rooted in the distinct epistemological lenses through which different disciplines organize their knowledge, such as the reconciliation of empirical biomedical data with holistic perspectives on the patient's environment and internal intuition [30](#). Research suggests that the specific curriculum of a health profession plays a decisive role in shaping a student's orientation toward either person-oriented or technique-oriented care, directly influencing their capacity for empathy and assertive clinical communication [32](#). Consequently, the lack of standardized nutritional training and the presence of significant barriers to inter-professional education continue to prevent conventional practitioners from fully understanding the evidence base and utility of complementary therapeutic systems [31](#).

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Respectfully,



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