
STATE LICENSURE AND DISCIPLINE OF CHIROPRACTORS

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION	1
A PERSPECTIVE ON CHIROPRACTIC.....	2
SOME TRENDS IN PRACTICE.....	4
STATE BOARDS OF CHIROPRACTIC EXAMINERS	6
LICENSURE.....	8
THE STATES' REQUIREMENTS FOR LICENSURE	8
SCOPE OF PRACTICE DEFINITIONS.....	10
RECIPROCITY	10
VERIFYING BACKGROUNDS	12
DISCIPLINE	14
INCIDENCE AND TYPE OF DISCIPLINARY ACTIONS	14
TYPE OF VIOLATION.....	18
SOURCES OF DISCIPLINARY ACTION.....	20
ADMINISTRATIVE PROCESSES	21
INFORMATION SHARING	22
RECOMMENDATIONS	24
APPENDIX I	
BACKGROUND	29
APPENDIX II	
METHODOLOGICAL NOTES	32
APPENDIX III	
COMMENTS ON THE DRAFT REPORT AND	
OIG RESPONSE TO THE COMMENTS.....	34
ENDNOTES.....	43

EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES

The overall aim of this inspection was to promote a better understanding of State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. In regard to these practices, it sought to identify the extent and type of changes occurring, the major issues being addressed, and the kinds of improvements that might be made.

BACKGROUND

The inspection follows up on a similar inquiry that was conducted by the Office of Inspector General in 1985 and 1986 which addressed medical licensure and discipline. It is based primarily on three lines of inquiry: (1) telephone discussions with board members or staff of State licensure and discipline bodies in the four professional areas noted above, (2) a review of pertinent literature and data bases, and (3) discussions with representatives of national professional associations.

This report, which focuses on licensure and discipline of chiropractors, is the second in a series of reports to be issued as part of the inspection. Its organization and presentation closely parallel that of the first report, which addressed the licensure and discipline of dentists. A number of the findings and recommendations also parallel those set forth in the first report.

FINDINGS

- In both the licensure and discipline realms State board officials tend to feel that they are seriously constrained by insufficient funding and limitations on staffing and authority. As a result, the effectiveness of both licensure and discipline operations is compromised.

Licensure

- The definition of scope of practice--what a chiropractor is allowed to do and is prohibited from doing--differs substantially from State to State. Some enabling statutes are broad and nonrestrictive, whereas others offer a detailed description of what constitutes the practice of chiropractic.
- Diversity in defining the scope of chiropractic practice leads to diversity in requirements for licensure. As a result, State boards devote most of their time and resources to licensing activity, in particular to testing the clinical competence of each applicant.
- The boards' focus on testing allows for little attention given to investigating situations that might call for disciplinary action. Background checking for prior disciplinary activity in another State is seldom given major attention.

- Despite laws that allow for reciprocity, the boards are restrictive about granting it. In most States, reciprocity, if granted, covers only the basic and clinical science examinations. The applicant under reciprocity still must pass a clinical competence examination.
- Many practicing chiropractors strongly object to the boards' reluctance to grant reciprocity. They note that the absence of effective reciprocity inhibits their economic opportunity and freedom of interstate movement.
- The widely perceived inadequacy of the two national clearinghouses that collect and disseminate information on disciplinary actions taken against chiropractors serves to reinforce the boards' reluctance to grant reciprocity. Those board officials who were familiar with clearinghouse operations expressed serious reservations about the extent, quality, and timeliness of the information provided.

Discipline

- As of 1984, almost all State chiropractic boards had the authority to revoke or suspend a chiropractor's license if proper grounds were identified. Most boards, however, lacked the authority to restrict a license, to censure, to reprimand, to impose probation, or to impose fines.
- The annual number of State board disciplinary actions taken against chiropractors changed very little during the 3-year period we reviewed, 1984-1986. The number rose from 163 in 1984 to 174 in 1985, and fell back to 151 in 1986.
- The more serious types of disciplinary action--revocation, suspension, and probation--account for most of the disciplinary actions taken against chiropractors. They comprised about two-thirds of all actions in each of the 3 years from 1984 to 1986.
- The rate of disciplinary actions taken against chiropractors is higher than that for medical doctors, and almost equal to that for dentists. In 1985, chiropractic boards disciplined about 0.57 percent of all chiropractors, dental boards about 0.54 percent of their licensees, and medical boards about 0.42 percent.
- Comparatively low license renewal fees appear to be closely associated with low rates of disciplinary action. Of the 20 State boards with annual renewal fees of \$50 or less in 1987, 16 had 1984-1986 rates of disciplinary action below the median for all States.
- Billing abuses (relating to utilization or to fees) and advertising abuses are the two most common types of violation on which disciplinary actions against chiropractors have been based. Discipline of a chiropractor on the basis of clinical insufficiency is extremely rare.

- Consumer complaints are the major source of disciplinary actions against chiropractors. Few actions result from referrals by State chiropractic associations or from investigations initiated by the boards themselves.
- State chiropractic board officials tend to be supportive of the national data bank to be established under Public Law 99-660. However, they raise a number of concerns about its implementation. These focus on the accuracy, timeliness, confidentiality, and accessibility of the data.

RECOMMENDATIONS

- State governments should ensure that the State chiropractic boards have sufficient resources to carry out their responsibilities effectively.
- State governments should ensure that the State chiropractic boards have sufficient enforcement authority and a full range of disciplinary options available to them.
- State chiropractic boards should move toward the establishment and use of high-quality national licensure examinations.
- The Federation of Chiropractic Licensing Boards (FCLB), in consultation with the American Chiropractic Association (ACA) and the International Chiropractors Association (ICA), should develop guidelines for State chiropractic practice acts.
- The FCLB should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.
- The ACA and the ICA should foster professional review of chiropractor clinical competency by the several State associations.
- The national professional associations (ACA and ICA) should encourage more extensive and effective interaction between State associations and State chiropractic boards.
- The Public Health Service (PHS) should assist the FCLB to carry out a more effective leadership role in working with its member boards.

COMMENTS

The PHS, ACA and ICA were in general agreement with the recommendations directed to them. The ACA suggested that State chiropractic boards be granted the same "antitrust immunity" granted to hospital peer review boards under the Health Care Quality Improvement Act of 1986. The FCLB expressed a willingness to cooperate and assist State boards, but noted that they find it difficult to function beyond their current financial limitations. Detailed comments of these and other organizations as well as our responses to them appear in appendix III.

INTRODUCTION

In June 1987, the Office of Inspector General began an inspection on State licensure and discipline practices concerning dentists, chiropractors, optometrists, and podiatrists. The overriding purpose of the inspection was to provide the Federal and State governments and the respective professional communities with a better understanding of these practices. More specifically, it sought to identify the extent and type of changes taking place, the major issues being addressed, and the kinds of improvements that might be made. (For more background on why the study was undertaken, see appendix I.)

This report, which focuses on the chiropractic profession, is the second in a series of reports to be issued as part of the above noted inspection. It follows a similar report which focuses on dentists and, like that report, is based on three major lines of inquiry: (1) telephone discussions with board members or staff associated with chiropractic licensure and discipline bodies in 50 States and the District of Columbia (hereafter referred to as a State); (2) a review of pertinent literature and data bases, including journal articles, studies, and statistical compilations of public and private organizations; and (3) discussions (in person and by telephone) with representatives of various professional organizations. These include the American Chiropractic Association, International Chiropractors Association, Federation of Chiropractic Licensing Boards, Council on Chiropractic Education, and National Board of Chiropractic Examiners. (For more methodological background, see appendix II.)

Chiropractors, the largest group of primary care providers after medical doctors, are a growing presence on the health scene in the United States. In 1984, there were about 28,790 active chiropractors.¹ According to the American Chiropractic Association (ACA), the median net income of ACA members in 1984, excluding students, was \$50,833. This represented an increase of .06 percent from a year earlier.²

Under the Federal Medicare program the role of chiropractors is quite limited. The only treatment that can be covered is manual manipulation of the spine to correct a subluxation that can be demonstrated by x-ray.

Medicare Part B payments for chiropractors' services were \$80 million in 1983 and \$88 million in 1984.³ Although these amounts are small in comparison to the \$15 billion total supplementary medical insurance program, spinal manipulation was the ninth most frequently billed service in 1983, exceeded only by such services as laboratory tests and follow-up physician visits.⁴ The 1985 ACA survey identifies Medicare as the source for 7 percent of chiropractors' revenues.

Under Medicaid, the role of chiropractors and the level of expenditures for which they account are less prominent. As of October 1987, Medicaid programs in 46 States covered chiropractors' services, and 19 of these limited the coverage to persons who met the program's definition of categorically needy.⁵ Surveys of chiropractors indicate that Medicaid fees repre-

sent less than 1 percent of their total revenues, and that the Medicaid component has decreased by one-half of 1 percent during the 1980s.⁶

This report begins with a brief overview of chiropractic, its history and its current status, and of State regulatory boards for chiropractic. It then turns to an examination of the major changes and issues affecting licensure and discipline. It closes with some suggested areas of action.

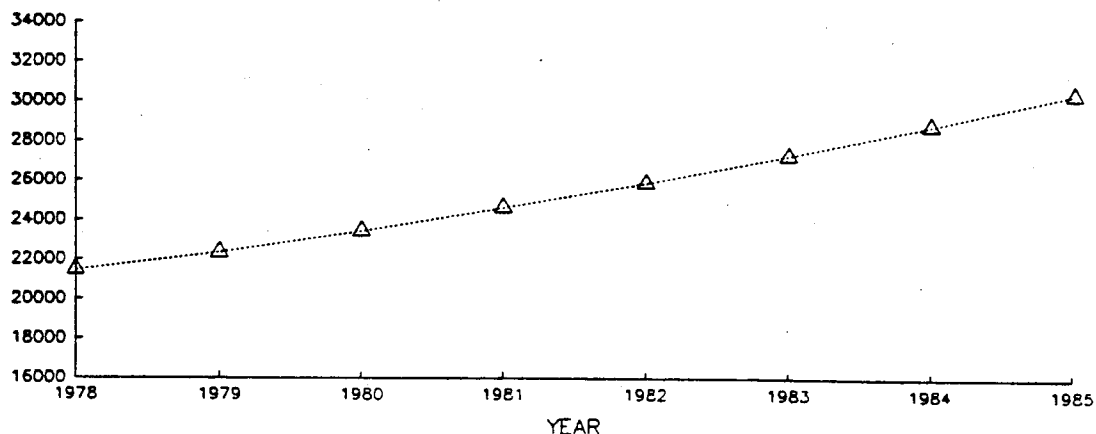
A PERSPECTIVE ON CHIROPRACTIC

The history of spinal manual therapy can be traced back at least to Hippocrates. Modern chiropractic traces its origin to the classic experiment at Davenport, Iowa in 1895 when Daniel David Palmer made a vertebral adjustment to improve the hearing of school janitor Harvey Lillard.⁷ Two years later Palmer had opened the first school of chiropractic in Davenport and counted 5 medical doctors among his first 15 students.⁸

Palmer's initial successes attracted attention and earned him 6 months in the Scott County jail for unlicensed practice of medicine. Yet, by the time of Palmer's death in 1913, Kansas had passed the first State law licensing chiropractors. Thirty-nine States had licensing laws for chiropractors by the 1930s. Louisiana, the last State to license the profession, passed its practice legislation in 1974.

The estimated 30,000 chiropractors in active practice in the United States at the end of 1985 is about 12.7 chiropractors per 100,000 total population. The 1985 numbers show a 42 percent increase from the 21,500 chiropractors active in 1978, a concentration then of about 9.8 per 100,000 population. The trend of a 6 percent average annual increase in the number of active chiropractors is reflected in figure I. The number of chiropractors per unit of population grew about 4 percent annually over the same time.

FIGURE I
ACTIVE CHIROPRACTORS IN THE UNITED STATES
1978 - 1985

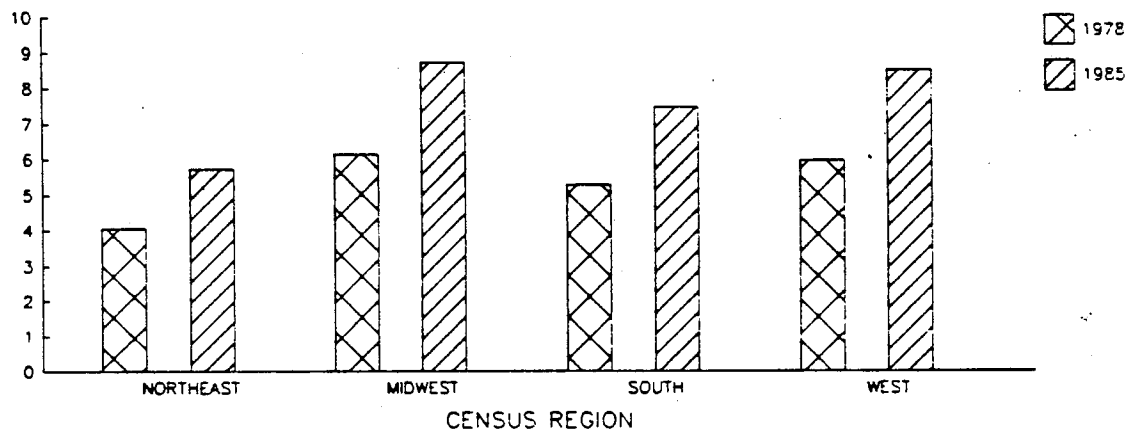


Source: SUPPLY AND CHARACTERISTICS OF CHIROPRACTORS, HHS, PHS, Health Resources and Services Administration, August 1986.

The geographic distribution of chiropractors is reasonably balanced among the four major census regions, with perhaps a slight under-representation in the Northeast (figure II-A). Adjusted for population, the concentration of chiropractors in each of the regions is shown in figure II-B. From this perspective, the South has the least and the West has the most access to chiropractic services.

FIGURE II-A
NUMBERS OF CHIROPRACTORS IN THE UNITED STATES
BY CENSUS REGION, 1978 AND 1985

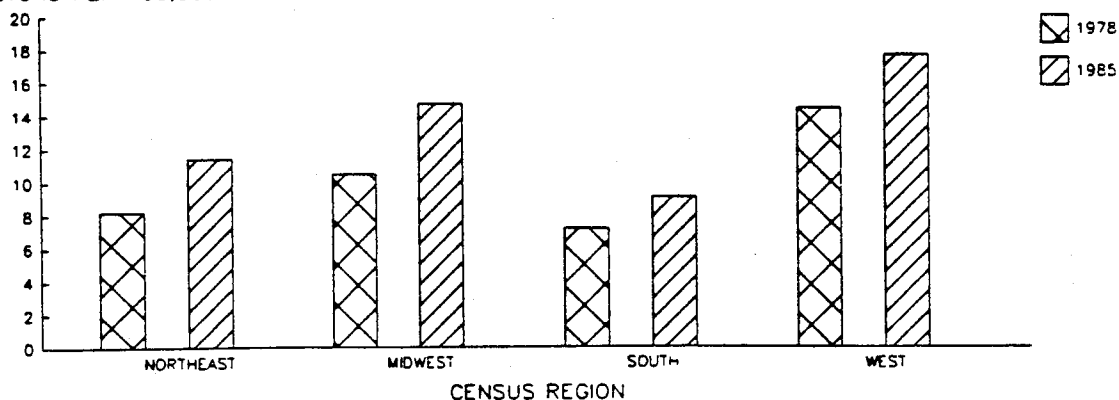
THOUSANDS OF CHIROPRACTORS



Source: SUPPLY AND CHARACTERISTICS OF CHIROPRACTORS, HHS, PHS, Health Resources and Services Administration, August 1986.

FIGURE II-B
CONCENTRATION OF CHIROPRACTORS IN THE UNITED STATES BY CENSUS REGION, 1978 AND 1985

CHIROPRACTORS PER 100,000 POPULATION



Source: SUPPLY AND CHARACTERISTICS OF CHIROPRACTORS, HHS, PHS, Health Resources and Services Administration, August 1986.

Virtually all of the increase in the chiropractor population consists of graduates of the 17 colleges of chiropractic in the United States. Fifteen of these colleges are affiliated with the Council on Chiropractic Education (CCE), whose Commission on Accreditation is widely recognized by State licensing boards and other entities as the authoritative body for determining that a college meets established criteria of educational quality.⁹ Two additional colleges in the United States are not affiliated with CCE. Two foreign schools, one in Canada and one in Australia, are accredited under reciprocal agreements with CCE counterparts in those countries.

Enrollment in chiropractic colleges grew 13 percent over the years 1980-84 and now approaches 10,000.¹⁰ During the early 1980s, the number of applications to chiropractic colleges consistently exceeded the number of acceptances by one-third and the number of enrollments by one-half. Nearly 90 percent of freshman enrollees have gone on to graduate.

Although a real decrease in graduations occurred in 1984, the numbers of new Doctors of Chiropractic (D.C.) have averaged almost 2,700 each year during the 1980s, or about 9 percent of the population of active chiropractors. This rate of production is well in excess of the 6 percent growth rate in numbers of active chiropractors noted above. Some of the difference seems to be made up of new D.C.s-- either U.S. citizens or foreign nationals--going to practice overseas. Most of the difference, however, represents new D.C.s who do not enter active practice. Instead, many choose careers in administration, education, government, or research.

Growth in the number of accredited chiropractic colleges has been even more marked than increases in student population. From the 2 accredited institutions when CCE was incorporated in 1971, the roll climbed to 12 schools by the end of 1985.¹¹ There were, in addition, three recognized candidates for accreditation also affiliated with CCE in 1985, as well as the two foreign schools accredited under reciprocal agreements.

SOME TRENDS IN PRACTICE

One of the most striking characteristics of practicing chiropractors is their relative isolation. Whereas medical doctors typically are on hospital staffs and thus interact frequently with their peers in the hospital environment, chiropractors usually confine their work to the office setting. Even within the office setting, the great majority of chiropractors now work alone. In 1986, for instance, about 68 percent of society members surveyed were in solo practice. Among the 26 percent of all chiropractors who work in groups or partnerships, two-thirds were in two-member associations, and only 2.5 percent were in groups of five or more. The remaining 5 percent of all chiropractors surveyed reported that they were employed by other chiropractors. This last group has increased steadily from 2 percent in 1977, in line with trends in other health care professions.

The isolation of chiropractors may soon change. During 1987, significant actions took place in a civil lawsuit, known as the *Wilk* case,¹³ originally filed in 1976. First, during June 1987, the American Hospital Association (one of the original defendants) entered into a settlement agreement in which it stated that it had no objection to a hospital granting privileges to a D.C.

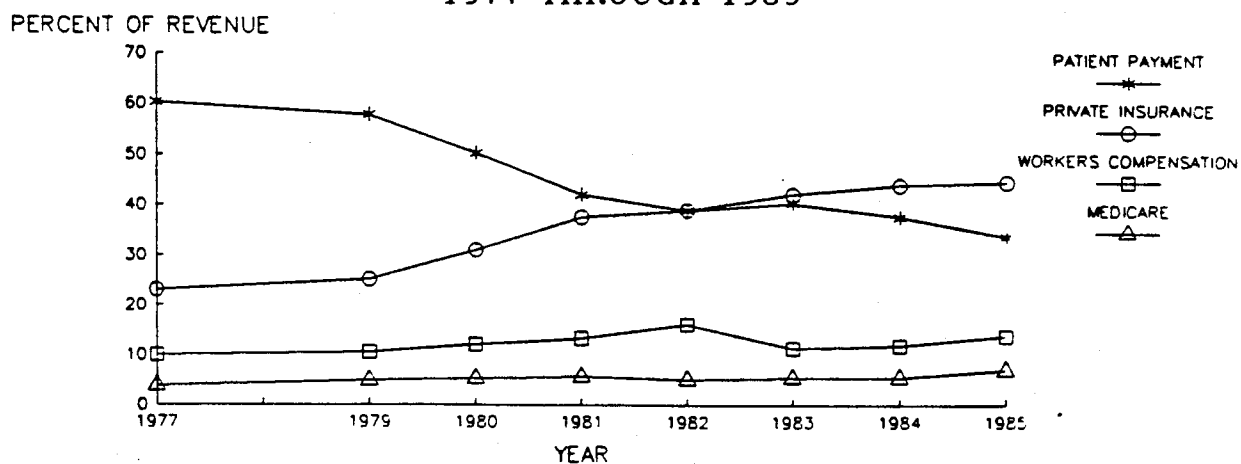
for treatment, chiropractic education, or diagnostic testing. Second, in September 1987, a Federal district court found in favor of the plaintiffs and issued an injunction barring the American Medical Association from impeding the freedom of its members to make an individual decision whether or not to associate professionally with chiropractors, chiropractic students, or chiropractic institutions.

In the sense customarily applied to the training of medical doctors, who spend one or more years as full-time residents within specialties at a hospital, specialization does not exist for chiropractors. Most chiropractors are, in a real sense, general practitioners, and this is in line with their self-perception as portal of entry primary care providers. Many chiropractors do participate in programs of training in advanced clinical competence and are certified by boards or councils in one or more specialties. In 1986, 22 percent of members surveyed by the American Chiropractic Association reported that they held certification in one of the chiropractic specialties, such as nutrition, orthopedics, or radiology.¹⁴

As their numbers have grown over the past decade, the chiropractors' own perception of the supply-and-demand situation has changed.¹⁵ In 1975, 40 percent of respondents to the annual survey taken by the American Chiropractic Association thought that there were too few chiropractors for the existing demand, and 8 percent thought there were too many in the town where they practiced. In 1986, only 9 percent of respondents thought there were too few chiropractors, and 27 percent thought there were too many. In all years, the majority agreed that supply and demand were in balance.

Along with the growth in numbers, the median net income of chiropractors has continued to climb, from \$35,167 in 1979 to \$50,833 in 1984.¹⁶ Among the main sources of revenue for chiropractors during 1985, private insurance was the largest, accounting for some 45 percent of the total.¹⁷ The second major source was direct cash payment from the patient, about 34 percent. The relative importance of these two sources of revenue to chiropractors has nearly reversed in the past decade (figure III). Government programs have been smaller and more constant contributors to revenue, with workers' compensation providing a little over 12 percent, and Medicare about 7 percent.

FIGURE III
SOURCES OF REVENUE FOR CHIROPRACTORS
1977 THROUGH 1985



Source: SUPPLY AND CHARACTERISTICS OF CHIROPRACTORS, HHS, PHS, Health Resources and Services Administration, August 1986

Because two States (Louisiana and Mississippi) did not license chiropractors in 1972 when the law was passed extending Medicare coverage to certain services provided by chiropractors, the Medicare law and regulations set out uniform minimum standards that must be met by a chiropractor in order to be eligible for Medicare reimbursement.¹⁸ No other profession defined as a "physician" in the Medicare law is subject to such a condition. Even today, State boards include among their activities certification to the Health Care Financing Administration of a chiropractor's eligibility for Medicare payment as the result of passing a board examination.

STATE BOARDS OF CHIROPRACTIC EXAMINERS

Two decades ago (when not all States licensed chiropractors) State chiropractic examining boards, like their counterpart State medical boards, were little noted instruments of State government. In many cases, chiropractic regulation was assigned to the State medical board. In this situation the boards were usually dominated by medical doctors; where independent chiropractic licensing boards existed, they tended to be dominated by the chiropractic profession.

Now, the picture is somewhat different. With the growth in the number of chiropractors, development of the consumer movement, widespread use of practice-building techniques (including advertising), and heightened concerns about the cost and quality of health care, State chiropractic examining boards function in a more visible environment with a greater degree of public accountability. Although the scope and intensity of the changes have not been as great as State medical boards, they have nevertheless been significant.

About 65 percent of State chiropractic boards are now part of a centralized State agency, and all but one have some non-chiropractor members.¹⁹ Nearly all the boards (90 percent) have responsibility for both licensure and discipline. Most States (49) recognize the certificate of the National Board of Chiropractic Examiners (NBCE) for the basic and clinical science portions of the testing requirements for licensure, yet all of the States, except Alabama, require an additional examination in clinical competency.²⁰ This latter examination may include some combination of written questions, a personal interview, and a demonstration of practical skills.

Clinical competency examinations of applicants for chiropractic licenses have long been developed and administered by the individual States. In the fall of 1987, NBCE introduced a national written clinical competency examination that many expect will be widely adopted by the States in the next few years.

In addition, as a means to ensure the continuing clinical competency of established chiropractors, 42 States now require some evidence of board-approved continuing education for license renewal.

The staff and financial resources available to the boards cannot be determined readily. About three-fourths of the States (38) report that they have no more than one full-time equivalent staff assigned to the board of chiropractic examiners, but in many cases this does not include

staff reporting to a central agency that may provide some assistance to the board. Similarly, the budget of a board is often obscured within the budget of a larger agency.

What is clear, however, is that in nearly all States the board revenues derive entirely from fees imposed on chiropractors and any other occupational groups covered by the board. These include application, examination, and various other fees. The major source of fee revenue is the license renewal fee imposed on practicing chiropractors. Renewal fees range from an annual level of \$10 to \$230; the median is \$75 and the average is \$80. For about half of the boards (24), fee increases either were imposed during the 2 years (1985 and 1986) or were scheduled during 1987. Conversely, three States lowered renewal fees in the years 1985 and 1986. Because boards typically are subject to the State budget process and to the same budgeting and personnel controls as other State agencies, fee increases do not necessarily mean increased resources for board activity. Thus, even though chiropractic licensure and discipline has grown to become an estimated \$6 million-a-year enterprise,²¹ many board representatives feel they are seriously underfunded in carrying out their extensive responsibilities.

LICENSURE

Licensing activity, in particular testing clinical competency of each applicant, remains the major focus for State boards of chiropractic examiners. Boards feel that individual specific testing is necessary because of substantial and widespread differences in perceptions of what a chiropractor should and should not do. These differences are reflected in the several State practice acts and again in the States' requirements for licensure. Because the boards are highly focused on testing applicant knowledge and skills, they have yet to recognize a similar need to conduct extensive checks on applicant backgrounds.

THE STATES' REQUIREMENTS FOR LICENSURE

In all States,²² an applicant for a license to practice as a chiropractor must supply evidence to show:

- *Education:* successful completion of an approved program of chiropractic education leading to the D.C. degree; and
- *Proficiency:* passing some examination(s) to demonstrate mastery of basic and practical elements of chiropractic as defined in that State.

In addition, 31 States retain a requirement of good moral character, 22 States specify a minimum age, and 4 States require that the applicant be a citizen.

Education

Most often the education requirement is met if the applicant has graduated from a college accredited by the Commission on Accreditation of the Council on Chiropractic Education (CCE). The practice acts in about half the States (26) require the licensing board to accept CCE accreditation as evidence that graduates of a school meet minimum standards of professional competence.²³ Of the 26 States that accept CCE accreditation, 8 mandate it and 4 of these require fully accredited status. In the remaining 25 States, the practice acts allow the licensing board to define the criteria for approval of a college program. All the boards accept CCE accreditation, but some add conditions, such as fully accredited status, exclusion of the foreign schools, accredited status at the time of attendance or graduation, and academic performance standards.

About half the States, including some of those that require the board to accept CCE accreditation, also allow the board to approve a school directly. Such authority is significant to graduates of the two U.S. colleges not affiliated with CCE. In marked contrast to the situation for other professionals, including medical doctors, very few applicants for chiropractic licensure are graduates of foreign schools, and the majority of these have graduated from one of the colleges in Canada and Australia that hold CCE status under reciprocal agreements. Most States (49) also impose a minimum preprofessional education requirement of 2 years' un-

dergraduate college training; but as this is usually a requirement²⁴ for admission to a CCE-accredited college, it rarely adds anything new at the licensure stage of a career. More recently, three States have required a bachelor's degree, and other boards report that they are considering adding this as a requirement for preprofessional education.

Proficiency

The States are less consistent about their proficiency testing requirements for licensure. A student in a chiropractic college today typically takes the basic science examinations (part 1) of the National Board of Chiropractic Examiners (NBCE) series near the end of the second year in professional school and the clinical sciences written examinations (part 2) at the end of the fourth and final year.²⁵ The NBCE examinations are optional, but almost all students take them. All except two of the States recognize the NBCE certificate for the basic and clinical science examinations requirement, and 16 States now require it.²⁶ The 33 States without this requirement offer separate examinations in the basic and clinical sciences to accommodate applicants who do not present an NBCE certificate. In 1986, 31 States contracted with NBCE to administer these State basic and clinical science examinations to about 650 applicants. The other States develop and administer their own tests for this purpose.

In addition to the science examinations, 50 States require that applicants give evidence of proficiency as chiropractors by passing an examination in clinical competency. These can be written tests, and can also include a personal interview and a demonstration of hands-on ability. The clinical competency examination may test the applicant in specialty subjects such as orthopedics and radiology, as well as in basic chiropractic technique. No single national set of elements for clinical competency examinations is now in place. Many board officials told us that they prefer to shift their testing emphasis from year to year, to address subject areas where they have noted weaknesses.

In the fall of 1987, NBCE introduced a written examination in clinical competency that might ease some of the testing burden on individual State boards. The national part 3 examination also holds promise for a more uniform testing base for all applicants. Still, many board officials with whom we spoke retain a real commitment to requiring some demonstration of chiropractic manipulative skills before issuing a license to either a new graduate or an experienced practitioner.

Testing of applicants thus looms large in the scheduling priorities of many boards. Of 24 States that identified some area of their licensing activity as an exemplary practice, almost half (11) cited practices concerning the preparation and administration of examinations. And 9 of the 20 States that identified some vulnerability in their licensing activities also cited some aspect of their examination process.

The smaller States, in particular, place heavy emphasis on applicants' demonstrating their practical ability in individual examinations. Yet many board officials from these States voice concerns about the objectivity of their examinations. Psychometric validation techniques are costly and time consuming and may be beyond the resources of the boards. The risk of due

process challenges to State tests is a concern. Some board members with whom we spoke even questioned the ability of the States to establish the fairness of their test questions and grading procedures. One went so far as to suggest that a national minimum standard to be met by all license applicants would be a good idea.

SCOPE OF PRACTICE DEFINITIONS

The States' practice act definitions of what a chiropractor may and may not do differ substantially across the nation. This variability seriously undermines the desire of many chiropractors to be regarded as a unified profession with clearly established standards for practice and treatment.

Although they give special attention to manipulation of the spine for treatment, chiropractors consider the person an integrated being and look upon chiropractic treatment as primary health care for the whole patient. Thus, the profession tends to resist restrictive provisions in State definitions of the scope of practice. Nevertheless, differing perceptions of the health conditions amenable to chiropractic treatment have led to divisions among chiropractors and a diversity among the States in defining their scope of practice.²⁷

The extent of variation among the States is striking. Some statutes are very sketchy, going little beyond a recognition that chiropractors exist, whereas others offer a detailed description of what constitutes the practice of chiropractic. Either formulation can be construed liberally, or strictly.

Within the chiropractic community this diversity can lead to confusion. A therapeutic measure quite legitimate in one State may well constitute a criminal offense, and grounds for board discipline, if carried out by the same chiropractor a few miles away across the State line.

In recent years changes in scope of practice acts for chiropractors have focused for the most part on precise definition of terms and on expanded listings of activity authorized for a chiropractor. Among the 12 States that reported recent changes in their statutes and the 17 that expressed strong interest in specific proposed legislation, there are repeated references to provision for temporary practice, especially for new D.C. graduates who work under supervision for several months while waiting to take the licensure examination. A regularized postgraduate intern-type training might be heralded by the growing popularity of these arrangements. In 1984, Illinois had already required 12 months of supervised work experience.²⁸

RECIPROCITY

Reciprocity refers to the practice of granting a professional license based wholly or in part on acceptance of a license already held in another State as evidence of education and proficiency. Strict reciprocity is conditioned upon the two States granting mutual recognition to each other's licensees. Endorsement accepts the existing license without imposing this condition.

For a professional, reciprocity allows freer movement among the several States as economic opportunities and career goals change. For the established professional, reciprocity substitutes established performance in the profession for the tests taken by new graduates in order to satisfy the proficiency requirement for licensure.

Chiropractic boards usually restrict the definition of reciprocity further by accepting the existing license from another State as substitute for some, but not all, of the examination requirements. The chiropractor applying for a license under reciprocity almost always is required to pass an examination in clinical competency which, of course, weakens the concept of reciprocity. In the words of one board official with whom we spoke, "Reciprocity doesn't work for chiropractors."

Even within the limited definition of the term as used by chiropractors, State boards are extremely restrictive in granting licenses on the basis of reciprocity. Most of the States add a condition that the requirements for licensure at the time of the applicant's original license must be essentially equivalent to the current requirements in the State to which the individual is applying. Other conditions, less frequently imposed, relate to the accreditation status of the chiropractic school at the time of graduation, or to the grading methods used (in the case of an applicant whose first license was based on State examinations in the basic and clinical sciences), or to the requirement of a supplemental test to compensate for differences in the practice acts among the States.

Given the near impossibility of determining the essential equivalence of another State's licensure requirements some years before, the practical effect of these conditions is the granting of chiropractor licenses by reciprocity only on an individual basis in 43 States. Three States report that licensing by reciprocity is technically possible, but practically impossible.²⁹

The boards' approach to reciprocity does not serve to strengthen the national examination process. The situation today reflects the boards' strongly felt need to ensure competence. In large part, however, it reflects also the variabilities among States in defining the scope of practice for a chiropractor and in setting requirements for licensure. The perception of that variability is so forceful that one board member in the Midwest voiced serious concerns about his State's capability to judge fairly applicants from East and West Coast colleges.

Only 10 States responding to our survey reported changes in the laws or regulations governing reciprocity during the past few years. Many of these changes clarified terms used in setting conditions on reciprocity, such as definitions of examination scores, and some set out new requirements for granting reciprocity. One State, Iowa, has adopted an innovative approach by granting a temporary certificate that allows a chiropractor from another State to practice for 3 years and then obtain an Iowa license. The idea of a transitional phase could ease some of the extensive examination burden for both applicants and boards. None of the board officials with whom we spoke included reciprocity among the topics they see as major initiatives for State government or as legislative priorities.

VERIFYING BACKGROUNDS

During the early 1980s State medical boards were shaken by scandals involving fraudulent credentials from two offshore medical schools and by breaches of security on some medical licensure examinations. State chiropractic boards have not had to face any comparable developments. Yet, particularly in the larger States and in those States with composite boards, there has spilled over to the chiropractic arena some sense of vulnerability about the adequacy of the background information they review on applicants for licensure. The validity of credentials cited in an application has rarely been an issue for chiropractors, although completeness of the information bearing on an applicant's professional conduct has been a concern.

Procedurally, boards now require more extensive documentation with the application. Yet the processing times for license applications have increased to reflect only the increasing numbers of applicants. Four States, citing administrative efficiencies, actually report decreases in processing time, and one State feels that the quality of applicants has improved so much that review of applications has been speeded up as a result. For most States, however, changes in the processing of license applications have been few, and the boards continue to emphasize checking for consistency. In the words of one board administrator: "We can't do much if they don't tell the truth on the application."

About one-fifth of the State boards report that they have implemented changes that call for more detailed information on application forms and/or more vigorous efforts in verifying credentials. Other boards now anticipate making changes of this sort. Most of these changes, actual and pending, call for a fuller accounting of applicants' time (before, during, and after schooling) and a disclosure of any disciplinary history. To limit opportunities for submission of altered records, a number of States now require that certification be sent directly to the board by colleges in the case of transcripts and by other States in the case of licensing history. A few boards undertake more diligent verification through telephone inquiries, finger-printing, and even Federal Bureau of Investigation checks.

Overall, however, the scope of the changes is limited and, many board officials suggest, inadequate. The major reason cited for failure to take more substantial action is the insufficient resources available to the boards, most often lack of funds to hire additional staff. The result, many report, is a review of the application for consistency and only a superficial check, if any, on background. The situation seems to present a particular vulnerability in the case of applicants who are already licensed in other States and who might have a history of disciplinary actions.

A second factor that inhibits more effective board action in reviewing applicants' backgrounds is the widely perceived inadequacy of the national disciplinary action clearinghouses maintained by the Federation of Chiropractic Licensing Boards (FCLB) and by the National Clearinghouse on Licensure, Enforcement, and Regulation (CLEAR). Only 18 (36 percent) of the boards reported that they used one or both of these clearinghouses, and many of these felt that the information was of only limited use. Primarily, this was because neither clearinghouse offers complete, or even nearly complete, listings of all disciplinary actions taken by

all 51 States. There were other reasons as well, bearing on the insufficient data held by the clearinghouses about chiropractors who have been disciplined, the time involved in sending the data to the boards, and in the case of the Federation, irregular newsletters which have led to boards having to make many specific inquiries. Consequently, use of clearinghouses is not a priority in most States. Two boards told us they were unaware even of the existence of clearinghouses, and eight others said the question of using a clearinghouse had never come up before.

DISCIPLINE

Over the years, the authority of State boards to discipline chiropractors has gradually been increasing, with respect to both the grounds upon which they can take disciplinary action and the type of action they can take. During the past 3 to 4 years, just over one-fourth of the boards have experienced some legislative or regulatory change concerning their disciplinary authority. Nearly all this change has increased their authority in one way or another; most often, it has served to expand the range of disciplinary options available to them.

As of 1984, the latest year for which aggregate data are available, almost all the boards had the authority to revoke or suspend a chiropractor's license if proper grounds were identified. In many States, however, the additional types of disciplinary action that could be imposed were limited: 15 had the authority to restrict a license, 7 to censure, 15 to reprimand, 19 to impose probation, and 6 to impose fines ranging from a low maximum of \$500 to a high of \$10,000. Only 31 State boards had explicit authority to refuse to issue a license to an applicant. A few boards could require continuing education, supervised work, some hours of public service work, or payment of the costs of the disciplinary hearing.³⁰

Since 1984, these numbers have increased, with more States having a greater range of disciplinary actions available to them. Yet many States still lack a full complement of options. Few have such basic powers as the authority to issue subpoenas or to suspend immediately the license of a chiropractor who poses a clear and present danger to the public.

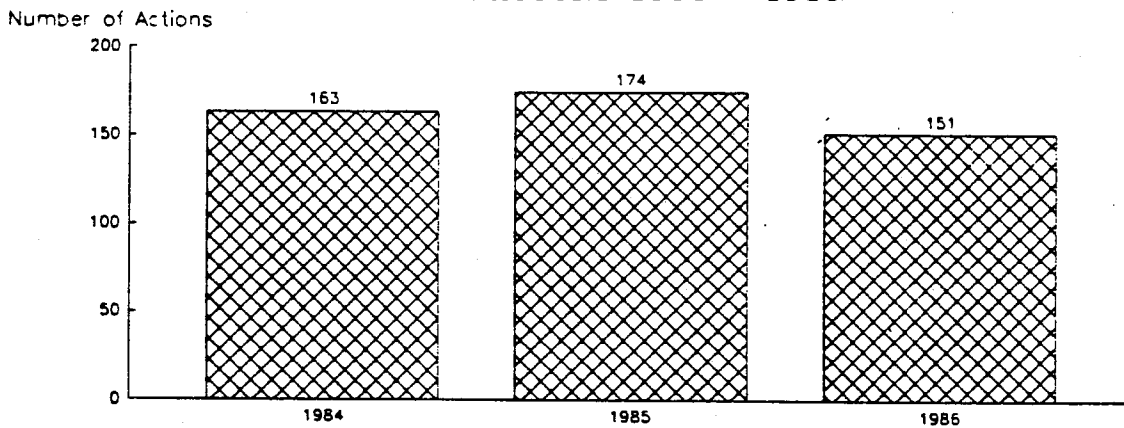
INCIDENCE AND TYPE OF DISCIPLINARY ACTIONS

How many and what type of disciplinary actions are being taken against chiropractors in the United States? The question, although basic, is one that we learned could not be answered. The existing information bases were too limited even to provide reasonable estimates.³¹

Accordingly, in our discussions with representatives of the 51 State boards, we asked them to indicate the number and type of disciplinary actions imposed on chiropractors during each of the previous 3 years. We received data from 50 States, (all except Georgia). For 1984, one State (Oklahoma) had no information available, and two others (New York and Texas) had no detail by type of action, only 1984 totals. A fifth State (Minnesota) provided no detail by type, only annual totals for each of the 3 years 1984-1986.

The data provided by the State boards on numbers and types of disciplinary actions during the 3 years 1984-1986 are summarized in figure IV.

FIGURE IV
STATE DISCIPLINARY ACTIONS AGAINST
CHIROPRACTORS 1984 - 1986



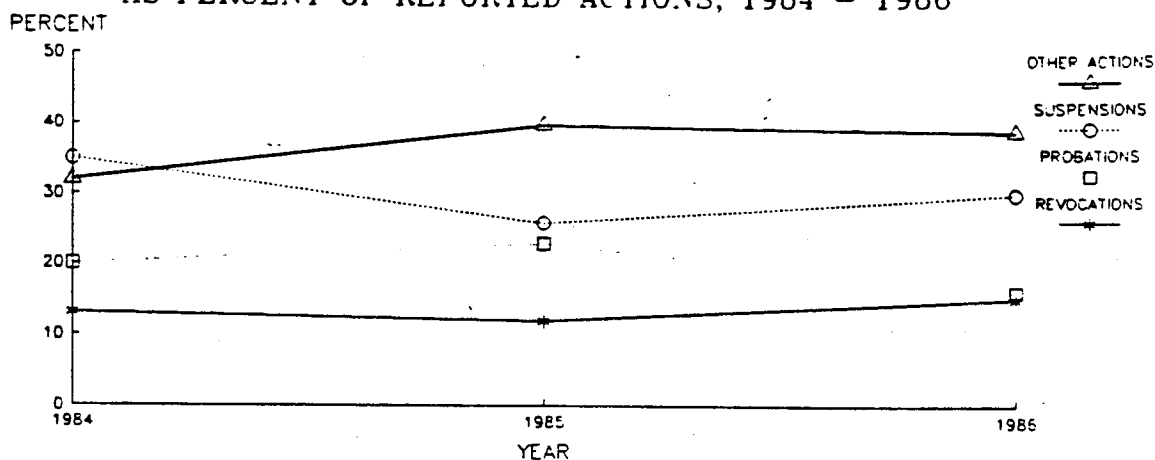
Source: State Boards of Chiropractic Examiners
as reported to the Office of Inspector General

What is most striking about the picture presented is that during a period when the numbers of chiropractors were steadily increasing, and national concern about the quality of health care was growing, the annual number of disciplinary actions imposed on chiropractors by State boards changed very little. From 163 actions taken in 1984, the number increased to 174 in 1985, and then fell back to 151 in 1986.

We compared the incidence of disciplinary actions reported to us by the State chiropractic boards with those reported by the boards that regulate medicine and dentistry. In 1985, the latest year for which comparative data are available, chiropractic boards reported taking disciplinary actions at a rate of 5.7 per 1,000 active chiropractors.³² On a comparable basis, dental boards disciplined dentists at a rate of 5.4 per 1,000 active dentists,³³ and State medical boards disciplined doctors at a rate of 4.2 per 1,000.³⁴ The incidence of disciplinary actions by State chiropractic boards exceeds that for the dental boards by 5.5 percent and that for the medical boards by 36 percent. In considering this comparison, we feel that it is important to recognize that since very few chiropractors or dentists are subject to hospital peer review, the activities of the State chiropractic and dental boards may be of greater overall significance.

In this 3-year period, Tier 1 actions--the more serious ones involving revocation, suspension, or probation--have regularly accounted for about two-thirds of all disciplinary actions by State chiropractic boards (figure V). The Tier 2 actions--involving less serious punishments such as reprimands and fines--account for the remaining third of all actions.

FIGURE V
STATE DISCIPLINARY ACTIONS AGAINST CHIROPRACTORS
AS PERCENT OF REPORTED ACTIONS, 1984 - 1986



Source: State Boards of Chiropractic Examiners
as reported to the Office of Inspector General

Over the 3-year period for which we collected data, the relative frequency of each category of disciplinary action was more or less fixed. Our results show no trend in board preference toward either more severe sanctions or the less severe actions of Tier 2.

Suspension is the most frequently occurring Tier 1 action for chiropractors, accounting for about 30 percent of all actions. Revocation of a license, in principle the most severe penalty available to a regulatory board, was imposed in nearly 13 percent of the reported cases.

The character of disciplinary actions taken against chiropractors contrasts significantly with the corresponding patterns for medical doctors and dentists. Whereas the relatively severe Tier 1 disciplinary actions have held steady at almost two-thirds (65 percent average) for chiropractors, they declined for medical doctors from 63 percent in 1982 to 53 percent in 1985.³⁵ For dentists, in contrast, the relative frequency of Tier 1 disciplinary actions increased from 53 percent in 1984 to 60 percent in 1986.³⁶

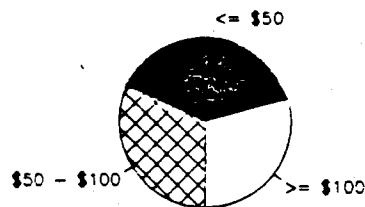
Variations in disciplinary performance are no less apparent when State chiropractic boards are compared among themselves. Since year-to-year fluctuations may be misleading, we aggregated and analyzed the data over the 3-year period, 1984-1986. The rate at which State boards disciplined chiropractors during this period varied from a low of zero (11 States) to a high in excess of 5 actions per 100 chiropractor licenses (2 States). The average, for the 3-year period, was 1.02 and the median was 0.56 disciplinary actions per 100 licenses.

No evident correlation appears between a State's size or regional location and the rate of disciplinary action. We did note that small States dominate the extremes. The 11 lowest positions and the 6 highest rankings by rate of disciplinary action are all occupied by small States.

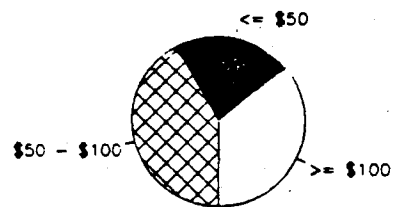
Why is the rate of disciplinary action higher in some States than in others? Is it because practicing chiropractors in some States are more competent, more honest, or more professional than others? Is it because of differing levels of board commitment to action? Is it because of operational constraints associated with insufficient authority or inadequate resources? Each of

these factors may be explanatory to some extent, but in the case of one--insufficient financial resources--we have some data to suggest an association (figure VI).

DISTRIBUTIONS OF CHIROPRACTOR LICENSES, 1985, AND OF STATE DISCIPLINARY ACTIONS, 1984-1986 BY ANNUALIZED LICENSE RENEWAL FEE GROUPINGS



DISTRIBUTION OF CHIROPRACTORS
LICENSES.



DISTRIBUTION OF STATE
DISCIPLINARY ACTIONS.

Source, for licenses: OFFICIAL DIRECTORY 1985-
1986 Federation of Chiropractic Licensing Boards
for fees & actions, State Boards of Chiropractic

Lower than average license fees are directly correlated with lower than average numbers of disciplinary actions by State chiropractic boards. We assigned each of the States to one of three fee groupings determined by the current annualized license renewal fee for a chiropractor. Approximately one-third of all chiropractors in the United States fall into each of the groupings: low fee (\$50), intermediate, and high fee (\$100). Yet the low-fee States account for only 20 percent of all disciplinary actions over the 3-year period. The data strongly suggest a causal relationship. Lower funding means fewer disciplinary actions.

We can examine the same data from another perspective to measure the adequacy of the boards' financial resources. Of the 21 State boards with annual renewal fees of \$50 or less in 1987, 16 had a rate of disciplinary action during the 1984-86 period below the median rate for all State boards. At the other end of the funding scale, 15 of the 20 State boards with renewal fees of \$100 or more disciplined chiropractors at rates above the median. Yet, three of the States with renewal fees of \$100 or more reported no disciplinary actions for 1984 through 1986. A comparatively high renewal fee in itself, then, is no guarantee of a higher level of disciplinary activity.

Also in the area of funding for disciplinary activity, we noted two practices that might be considered exemplary from the point of view of the regulatory boards and that might warrant consideration by other boards. Almost all boards with which we spoke cited the costs of due process--paying for investigators, attorneys, legal services, and hearings--as a major factor in conducting disciplinary activity. The Hawaii and New Jersey initiatives suggest possibilities for constructive approaches in this matter:

Hawaii assesses licensees in all professions an annual fee (currently \$50) for the complaint resolution fund. This pool of money is available to all regulatory boards to pay for due process costs.

New Jersey provides investigators and attorneys to the regulatory boards through the Attorney General's office. These specialists are paid out of the Attorney General's budget. Fee revenues are not expended for due process costs.

Finally, it is important to recognize that State boards are not the only forum for disciplining chiropractors. Another, as noted in appendix I, is the Office of Inspector General (OIG), which can impose sanctions on professionals who have committed fraud or abuse. During the past 5 years, OIG sanctions against chiropractors have averaged about 1.6 percent of all OIG sanctions. The number of OIG sanctions imposed against chiropractors during Federal Fiscal Years 1982 through 1986 ranged from a low of one in 1984 to a high of seven in 1985.

TYPE OF VIOLATION

Board officials in 17 States identified excessive utilization of services and associated fee abuses as 1 of the 2 most common types of violation for which disciplinary actions against chiropractors have been taken. In nine States, officials cited advertising abuses. Together, these two categories account for a substantial majority of the disciplinary actions taken by State chiropractic boards.

In our earlier review of State medical boards we found that the inappropriate writing of prescriptions was by far the most common violation for which disciplinary actions were taken against medical doctors. Violations related to self-abuse of drugs or alcohol were a distant second. Together, both accounted for about three-quarters of all disciplinary actions against medical doctors.

The situation for chiropractors is very different. The chiropractic principle implies treatment without drugs. Only in isolated situations have chiropractors even had the authority to prescribe drugs; consequently, there have been almost no these practices. More specifically, it sought to identify the extent and type of changes taking place, the major issues being addressed, and the kinds of improvements that might be made. (For more background on why the study was undertaken, see appendix I.)

Not surprisingly, then, only nine State boards reported that a rehabilitation program is available for chiropractors, and all of these were affiliated with medical board or society programs. At the annual meeting in February, 1988, the Federation of Chiropractic Licensing Boards designated a committee to study opportunities for boards to identify and assist impaired practitioners.

Billing Abuses

Insurance companies dealing in health coverage and in workers' compensation traditionally have looked to the State chiropractic boards as a resource when they are unable to adjudicate a series of chiropractic claims after the question of overutilization or excessive fees arises. Adding to the incentives for an insurance company to make a referral to a board is the implied deterrent effect. Insurers' reports have on occasion led a board to investigate further and to sanction the chiropractor involved. Still, a substantial majority of these cases have been closed with nothing more than an informal admonition to the chiropractor.

The billing abuse cases that have led to formal disciplinary action by the boards have involved patterns of excessive office visits, or visits continued beyond their established period of usefulness. A very few cases involved overuse of x-rays or improper dispensing of drugs. Some boards also have cited chiropractors for what they determined to be excessive fees.

Advertising

Advertising continues to play a prominent role in chiropractic professional affairs. The professional associations used to have strict ethics code rules against advertising. As in many other professions in recent years, these restrictions fell because of efforts by the Federal Trade Commission to promote competition. The associations still have ethics codes that call for truth in advertising, but enforcement actions are rare because of uncertainty about just when association action becomes restraint of trade. Complicating the picture was the fact that the old strict ethics code restrictions were removed at the same time the profession was expanding rapidly. Many younger chiropractors have felt a need to advertise aggressively in order to establish a widely based community practice.

Two advertising methods that have attracted attention from the boards are offers of free introductory examinations and no-out-of-pocket-expense (NOOPE) billing. The latter, which amounts to waiver of co-payment, calls into question the fairness of charges submitted to the insurance companies. Some States have begun to require disclosure by NOOPE billers, to patients and to insurers, and have recommended that the practice be taken into account in setting reimbursement amounts.

The current popularity of practice-building seminars has contributed to the growth of chiropractic advertising. The seminars encourage efforts to expand the patient base and to increase the number and intensity of services for a patient. No board recognizes the seminars for credit as contributions to continuing education in clinical competency. Many boards regard them as an irritant, but one they cannot counter with disciplinary action.

Competency

Rarely are clinical competency issues referred to the boards. Only 18 States reported that they had disciplined any chiropractors primarily on the basis of clinical competency during the 3 years (1984-1986). Collectively, the boards identified only 21 actions (out of 488 total for the

3 years) as based on competency issues. Among these 21 cases, however, they included such matters as sexual aggressiveness toward a patient, mental deterioration, and operating outside the scope of practice. Only 12 cases appear to have involved core competency issues. Most of these cases involved inferior or unnecessary x-rays.

None of the boards undertakes specific ongoing efforts to identify or assist chiropractors whose clinical skills may become deficient. Some States offer remedial seminars, but boards often prefer to stipulate remedial education in a formal disciplinary action rather than encourage chiropractors voluntarily to seek out counseling and training for self-recognized clinical weaknesses. Most of the States (42) continue to rely on continuing education requirements for license renewal to ensure the clinical competency of practicing chiropractors.³⁷ The usual continuing education requirement is 12 hours per year.

Professional Peer Review

Peer review is coming onto the scene as a meaningful board authority to promote competent practice. Before 1980 the State and local chiropractic associations used to serve as peer review bodies, providing opinions on fees, utilization rates, standards of care, and competency. Usually the referrals came from insurance companies. The State association opinions were widely respected and often binding, although the national association did provide an appeal forum. In the 1980s, a number of court decisions brought the association peer review activity to an abrupt halt by bringing it under antitrust protection.³⁸

In the *Perino* case, the U.S. Supreme Court held that the State association peer review activities did not fall within the scope of "business of insurance" as that term is used in defining an exemption to the prohibition against restraint of trade. The result has been to open the way for an aggrieved party to sue an association for its peer review activity and to seek triple damages under the Clayton Anti-Trust Act. The risk of legal action has had a chilling effect on State association peer review activity.

Some States took the initiative to assign authority for the peer review function to the regulatory boards, and by 1986 about half the States had given the boards this authority. (Many of these authorities are too new to have resulted in disciplinary actions during the 1984-1986 period, and so did not affect our data.) Officials with whom we spoke were very supportive of this role for the boards, but they were cautious about the costs in money, administrative staff time, investigator and attorney time, and expert witness commitments. Often, those boards in States without peer review authority identified it as a legislative priority.

SOURCES OF DISCIPLINARY ACTION

Consumer complaints are the major source of disciplinary actions against chiropractors. In about three-fourths of the States, chiropractic board representatives reported that more actions are attributable to consumer complaints than to any other source. This observation held regardless of the State's size or regional location. Many of the respondents attributed the pat-

tem to a nationwide trend in consumer activism in recent years, both in health care and in other fields.

Two other sources have produced appreciable numbers of complaints. Other chiropractors were mentioned as the first or second most frequent source by 12 States. These complaints often were prompted by the competitive situation and related to advertising practices or fee arrangements (NOOPE practitioners). On the other hand, none of the boards was aware of a chiropractor reporting on a matter of questionable clinical competence on the part of a peer. This was true even in an environment of increasing malpractice activity. Although chiropractors remain far less exposed to malpractice charges than are medical doctors, nevertheless an average of 1 in 23 chiropractors is sued each year.³⁹ Malpractice charges are ten times more frequent than are disciplinary actions by chiropractic regulatory boards.

The third significant source of complaints has been the insurance companies, including workers' compensation carriers, who traditionally look to the boards as a forum to mediate fee and coverage disputes. As we noted above, the insurers tend to rely more heavily on the boards in the absence of effective peer review by the professional societies.

About a dozen States have laws or regulations calling for other agencies to report problems to the chiropractic boards, usually in connection with malpractice cases. Even when such provisions exist they are often ignored.

ADMINISTRATIVE PROCESSES

Board representatives in 32 States identified some vulnerability or constraint arising from the administrative process. For the most part their comments focused on insufficient funding and staff time, on due process problems in both formal and informal hearings, and on the need for peer review. Some respondents called for regulatory consistency, pointing out that definitions ought to be, if not identical in the several States, at least more compatible.

Some States have introduced reforms in the administration of disciplinary functions by the boards:

Hawaii has created by statute a regulated industries complaint office which has its own staff of investigators and attorneys. This office insulates the board from charges of prejudice that might be brought against it.

Illinois, which continues to emphasize a proactive approach to identification of problem areas for all licensees, encourages a peer review team to participate at the earliest stage of an investigation.

Massachusetts uses investigators to prescreen complaints for adequacy before sending them on to the entire board.

Washington assigns a case manager to control the progress of a complaint through the administrative process. The manager can be an expert, pro-tem board member. The board has authority to conduct a practice review on-site at a subject's office (with or without the participation of the case manager.)

INFORMATION SHARING

"We often forget a little common sense during the licensing process. Why would you issue a license to someone who didn't supply full information about his background?"

As reflected in this comment from a State board official, the boards are becoming more appreciative of the fact that licensure applicants do not always tell the truth or provide all pertinent background information. They are coming to appreciate the advantages of a comprehensive and current clearinghouse for records of disciplinary actions. For the most part, boards find the data bases maintained by the Clearinghouse on Licensure, Enforcement and Regulation (CLEAR) and by the Federation of Chiropractic Licensing Boards (FCLB) to be inadequate; only 18 boards reported using them. Simply put, most chiropractic boards discount the current clearinghouses as relatively ineffective mechanisms and tend to rely more heavily on informal direct communications among themselves.

In response to our survey, 28 of the boards reported that they regularly send information on disciplinary actions to CLEAR and/or FCLB. Of these, 10 report only to FCLB, 13 only to CLEAR, and 5 to both. The number of boards sending reports to FCLB has increased recently in response to new initiatives and encouragement for reporting at a special session held during the 1987 annual meeting. Nevertheless, many States when asked about reporting returned with comments like these:

"The matter never came up."

"No reason. We just don't do it."

"We have no knowledge of a clearinghouse."

"There is no reliable database for sharing."

"CLEAR never sought out our State."

In addition to this low level of voluntary participation, a number of other factors severely limit the effectiveness of the two clearinghouses. State boards typically do not report on license denials or on informal actions. Many do not report in a timely manner, sometimes waiting months before sending data to a clearinghouse. Adding to the administrative delay, some boards are obliged to report through an umbrella agency or through the Attorney General's office.

When a report is made, the data provided on disciplined chiropractors is limited. Often omitted are professional associations, Social Security number, chiropractic college, and even date of birth. Although reports usually specify the type of disciplinary action taken, they display widespread variations in how the underlying violations are described and, indeed, in the

type of disciplinary action imposed for a particular type of violation. Among the several States, only 16 boards noted that they have a clearly defined set of guidelines for determining the appropriate level of disciplinary action. Most of the guidelines are contained in board rules and procedure manuals.

The great majority of board officials with whom we spoke were supportive of the soon-to-be-established national data bank under the Health Care Quality Improvement Act of 1986 (title IV) and the Medicare and Medicaid Patient and Program Protection Act of 1987 (section 5). They tend to see a data bank as a helpful national response to the need for better information sharing on disciplinary actions. At the same time they raised questions that reflect concerns about implementation of the data bank. These questions are quite similar to those raised by State dental boards. They primarily concern the accuracy, timeliness, confidentiality, and accessibility of the data to be stored in the data bank. Chiropractic board officials also voice a concern that chiropractors and other health professions have a say in clearinghouse operations.

Finally, it is important to recognize that the information sharing that occurs within a State is also of significance. The main vehicle for dissemination of chiropractic disciplinary actions in many States is a newsletter published by either the board or the professional association. In either case the information is directed to licensees. Only a very few States routinely issue a press release in an effort to reach the public at large; but at least two, North Dakota and Washington, require a press release in connection with any final disciplinary action. In contrast, some States make no effort at affirmative publicity, attributing their reluctance to precedents set by old lawsuits, or citing State privacy acts. These States typically handle information requests through the Attorney General.

RECOMMENDATIONS

Given the situation described in the previous pages, we make two central recommendations. The first is as follows:

- State governments should ensure that State chiropractic boards have sufficient resources to carry out their responsibilities effectively.

In most States, that is not now the case. In both the licensure and discipline realms, resource limitations (mainly, staff limitations) are undermining the capacity of the boards to do their jobs. With the forthcoming implementation of the national data bank and the additional responsibilities it will place on the State boards, the strains generated by the current resource shortfall are likely to become even greater.

Since most of the revenue of the State boards derives from renewal fees charged to practicing chiropractors, they are probably the best source for generating additional revenue. As noted earlier, the median annual renewal fee in 1987 was only \$75.

Our second central recommendation is as follows:

- State governments should ensure that State chiropractic boards have sufficient enforcement authority and a full range of disciplinary options open to them.

In many States, the boards need a fuller range of disciplinary options and a greater degree of enforcement authority. It is important that they have the power to issue subpoenas and to suspend immediately the license of a chiropractor who poses a clear and present danger to the public. It is also important that they carry out existing enforcement authorities more rigorously. They must not only react swiftly and effectively to complaints and referrals but also must assume a more active investigatory role of their own.

Such strengthening is important primarily because it will help boards protect the public from those few chiropractors who perform in an unprofessional, incompetent, or fraudulent manner. Not to be overlooked, however, is the fact that it would also support the case for licensure based on acceptance of another State's license. If State boards had more confidence in one another's enforcement and discipline efforts, they could more readily adopt policies that allow for reciprocity.

In addition to our central recommendations concerning resources and authorities, we have other important recommendations directed to the State Boards of Chiropractic Examiners, the Federation of Chiropractic Licensing Boards, the two national professional associations, and the U.S. Public Health Service.

Each of these recommendations relates directly to the theme running throughout this report: the chiropractic profession is fragmented by widely varying definitions of practice and require-

ments for licensure, and by differing effectiveness of disciplinary activity around the country. These are important matters for the chiropractic profession to address and could have an important bearing on the continued coverage of chiropractic services under Medicare and Medicaid.

State Chiropractic Boards

- State Chiropractic boards should move toward the establishment and use of high-quality national licensure examinations.

Among State chiropractic board officials, this is a very sensitive topic because it involves States' rights and prerogatives. Yet, from an overall perspective, the existence of separate State examinations parallel to the three parts of the national boards has become increasingly counterproductive:

- (1) It suggests that the professional community cannot agree on the minimum level of knowledge and skills necessary to practice as a chiropractor.
- (2) It results in a duplication of resources devoted to testing.
- (3) It restricts mobility of practicing chiropractors.
- (4) It diverts State board attention and resources that could be devoted to enforcement and discipline activities.

Other professional boards have successfully mandated national licensure examinations. The time has come for State chiropractic boards to move in the same direction.

A structure already is in place that would help the boards to move in this direction. Almost all chiropractic students today take the basic (part I) and clinical science (part II) tests to earn a certificate from the National Board of Chiropractic Examiners. In 1987 Delaware became the first State to require all applicants to take the newly introduced National Board written examination in clinical competency (part III). The full set of three National Board examinations is now necessary for licensure in that State.

Among State chiropractic board officials some sentiment was expressed for a national licensure examination. One official commented cautiously, "Some national minimum standard to be met by all applicants might be a good idea. Variation between States is difficult to accept for a unified profession with objective practice and treatment standards." And another board member urged the creation of "a national examination through NBCE to allow full reciprocity, free movement from State to State."

The professional associations also are on record in support of the concept of uniformity. As early as July 1974, the American Chiropractic Association recommended universal acceptance

of the National Board of Chiropractic Examiners certificate.

- State chiropractic boards should explore workable cost-effective approaches to continuing competency assessment.

Although continuing education requirements appear to be losing support across the country, interest is increasing in other approaches such as self-assessment examinations, periodic reexamination, chart audits, peer review, and computerized simulation techniques.⁴⁰ The State boards should explore such approaches to ensure that practitioners maintain a minimum level of competency and to help avert disciplinary actions taken on the basis of deteriorating clinical performance.

In that context, States might also consider investing boards with the authority to require that a licensed chiropractor take and pass a clinical examination when sufficient cause exists to believe that his clinical skills have fallen below professional standards.

- State chiropractic boards should continue to strengthen their credential verification processes.

Several boards have already moved in this direction, but, as many State board officials indicate, more must be done to increase: (1) information requested from licensure applicants and (2) verification undertaken by board officials. Without additional safeguards, many boards will remain too vulnerable to irregularities that can result in some undeserving individuals receiving a chiropractor license and in public confidence in the entire licensure process being undermined.

Federation of Chiropractic Licensing Boards

For a quarter of a century the Federation of Chiropractic Licensing Boards (FCLB) has provided a forum for State board officials to address common concerns and to chart directions that are in their mutual interest. In recent years these officials have used the FCLB to establish a national clearinghouse of disciplinary actions and to collect and share information on the status of chiropractic in each of the States. It is important, we feel, for the FCLB to supplement these actions by taking initiatives that will help individual State boards move in the directions we recommend. Given that many State boards must clearly improve their enforcement and disciplinary efforts, it is particularly important that the FCLB exert leadership to support the State efforts. Our specific recommendations follow:

- The FCLB, in consultation with the American Chiropractic Association and the International Chiropractors Association, should develop guidelines for State chiropractic practice acts.

Notwithstanding the American Chiropractic Association's 1974 vote in favor of uniform licensure legislation, no accepted guidelines to the essentials of a practice act for chiropractors are

in common use among the States today. The FCLB, as the representative of State chiropractic boards, is in a good position to exert leadership in establishing an up-to-date set of general guidelines that the States could use as helpful reference points in reviewing and revising their practice acts for chiropractors. In this regard, it is particularly important to develop a standard definition of the scope of chiropractic practice and to specify the extent and type of enforcement and disciplinary powers that should be held by State boards.

Some officials noted that the definitions of scope of practice and licensure requirements are sensitive areas in which States' rights need to be respected. Others noted that the chiropractic profession's experiences with antitrust actions prompt caution before taking any step that could be construed as activity in restraint of trade. In making this recommendation, we recognize the concerns raised by both arguments. Nevertheless, there is considerable precedent involving model State practice acts in other fields, including medicine,⁴¹ dentistry,⁴² and accounting.⁴³ In these and other fields, State boards and legislatures have made effective use of such documents.

- The FCLB should accumulate and disseminate, on a regular basis, changes in State practice acts and regulations.

Information of this kind would be extremely useful to the State boards. It would enable them to stay more fully abreast of developments in other States and to assess what if any significance such developments had for their own States. It would serve as a valuable more comprehensive supplement to the interaction that now occurs by word of mouth and by the FCLB newsletter.

- The FCLB should identify and disseminate to State boards the most effective techniques of credential verification.

Because this is not now a crisis area, it is an easy one to overlook. Yet it involves a potential vulnerability that should be addressed. The FCLB can help individual boards in this regard by identifying and distributing information about some of the best practices undertaken by member boards.

The American Chiropractic Association and the International Chiropractors Association

Because these are two leading national professional organizations in chiropractic, we address these recommendations to both of them.

- The American Chiropractic Association (ACA) and the International Chiropractors Association (ICA) should foster peer review of chiropractor professional competency by the several State associations

After antitrust developments led the State and national professional associations to drop their informal effort to perform peer review in the early 1980s, professional peer review of

chiropractor competency has languished. Only a small proportion (12 out of 488) of State board disciplinary actions during 1984-1986 was based on a judgment of inadequate clinical performance. The ACA has encouraged States to assign peer review to the boards as part of their disciplinary functions. Board officials generally welcome the opportunity, and about half the States have now enacted peer review laws. But there is still an important role for the profession, as the ultimate peer of the practitioner, in identifying, assisting, and (when needed) acting against those chiropractors whose skills fall below accepted standards for treatment and practice. An active professional peer review effort by the State associations, similar to the activity taking place in medicine, dentistry, and other health care professions, can foster public confidence and can serve as a source for referrals for State board action when needed.

- The national professional associations (ACA and ICA) should encourage more extensive and effective interaction between State associations and State chiropractic boards.

Such encouragement is important because most State associations at present make few referrals to State chiropractic boards. The national professional associations should encourage the State associations to work more closely with State boards, and in particular, to make referrals to those boards in instances involving possible violation of State practice acts.

The Public Health Service

- The Public Health Service (PHS) should assist the FCLB to carry out a more effective leadership role in working with its member boards.

The PHS has long provided such assistance to professional bodies but has had little association with the FCLB, the national body that is most closely and directly tied to the State chiropractic boards. Now is an opportune time to extend whatever support is possible to FCLB to help it play a more effective leadership role vis-a-vis its member boards. This is particularly important with respect to the enforcement and discipline areas, where the need for such leadership is compelling.

APPENDIX I

BACKGROUND

The licensure and discipline of health care professionals is a traditional function of State Government: it dates back to the pioneering efforts of the American colonies in the 1600s. But it did not gain permanence until the late 1800s, when Texas passed the first modern medical practice act (1873) and the U.S. Supreme Court upheld West Virginia's act as a valid exercise of State police powers (1889).

In recognition of this traditional State role, Congress, when it established the Medicare and Medicaid programs in 1965, left it to the States to determine whether physicians and other health care professionals were legally authorized to participate in these programs. Subsequently, Congress has empowered Health and Human Services (HHS) and its predecessor Health, Education and Welfare (HEW) to impose sanctions on those professionals (and other provider groups) who have abused or defrauded these programs. The Federal Government, however, has continued to depend on the States to serve as the disciplining agent for transgressions that do not directly relate to the Medicare or Medicaid programs.

Thus, States have been providing an important front line of protection for beneficiaries of these two Federally funded programs. This protection has been at no cost to the Federal Government and at only minimal cost to State Government. Nearly all the costs have been covered by licensure fees imposed on the health care professionals.

As Medicare and Medicaid expenditures have grown to a point where they now account for more than one-fourth of U.S. health care expenditures, Federal interest in the effectiveness of State licensure and discipline practices has increased. For the most part, this heightening interest has focused on those practices concerning medical doctors. In essence this is because they are the most prominent of the health care professionals and because they account for a larger share of Medicare and Medicaid expenditures than any of the other groups. More specifically, serious concerns about the adequacy of State medical licensure and discipline practices were raised by General Accounting Office reports, media investigations, and scandals involving fraudulent medical credentials from two Caribbean medical schools.

Accordingly, in 1985 and 1986, the Office of Inspector General (OIG) conducted an inspection examining the activities of State medical boards. Based primarily on visits to 14 State boards and telephone discussions with the executive directors of another 10, the inspections sought to provide an overview of the major developments and issues facing the boards. The final report, issued in June 1986, received widespread publicity and helped generate reforms to improve the effectiveness of State medical boards, particularly with respect to their disciplinary practices.

Given the positive response and effects of that inspection, the OIG decided that a similar one directed to other health care professionals eligible for Medicare or Medicaid reimbursement

would also be warranted. For these other professionals, no less than for medical doctors, State licensure and discipline boards offer a vital front line of protection for the beneficiary.

We chose dentists, podiatrists, chiropractors, and optometrists as a focus because, like medical doctors, they are direct care professionals who have diagnosing and prescribing responsibilities, who can receive direct Medicare reimbursement, and who, overall, represent a major presence on the health care scene. Dentists, podiatrists, chiropractors, and optometrists, together with doctors of medicine and osteopathy, are the six groups of health care professionals defined as "physicians" under Medicare law.

Recognizing the value of obtaining a better national picture of the licensure activities of these and other health care professions, HHS (through the Public Health Service) awarded a 3-year contract in July 1984 to the Council of State Governments (CSG) and the National Clearinghouse on Licensure Enforcement and Regulation (CLEAR) to develop a composite State-by-State information system on the credentialing of health professions. The project generates informational reports on the various professions, drawing primarily on State practice acts and State board regulations. The reports present data in separate tables that address such matters as the organizational pattern of the State boards, the administrative and enforcement functions of the boards, the types of examinations required, and the fees imposed. Overall, the descriptive information provided focuses more on licensing than on disciplinary activity. The CSG and CLEAR have published reports on each of the four groups to be addressed in this inspection--chiropractors (1986), podiatrists (1986), dentists (1987), and optometrists (1987).

The CLEAR, which is composed of State officials involved with occupational licensing and regulation issues, also runs the national disciplinary information system (NDIS). This is an interstate service that provides participating State agencies with bimonthly reports on disciplinary actions taken against licensed professionals in a number of professional disciplines. Dentists, podiatrists, chiropractors, and optometrists are among the occupation groups included in the system. The disciplinary actions taken against these and other groups are sent to NDIS on a voluntary basis and at this point involve only 32 States. The Federation of State Medical Boards operates a similar but more detailed and complete system that focuses on disciplinary actions taken against medical doctors.

Two recent congressional actions provide an important stimulus toward the further sharing of data on disciplinary actions. First of all, the Health Care Quality Improvement Act, (P.L. 99-660), passed in 1986, calls for the establishment of a national data bank to be run by the HHS Secretary (or a designee thereof). It stipulates that entities making malpractice payments associated with the work of physicians and other licensed health care professionals must report pertinent information concerning those payments to the data bank. Similarly, it mandates the reporting of disciplinary and peer review actions taken against medical doctors, osteopaths, and dentists. The information maintained in the data bank is to be available, upon request, to State licensure and discipline boards, health care entities, attorneys who file a malpractice complaint with a court against a specific practitioner, and individuals interested in records on themselves.

The second pertinent congressional action (P.L. 100-93) is the Medicare and Medicaid Patient and Program Protection Act. Passed in 1987, this legislation includes a provision that would extend the national reporting responsibility of State licensure and discipline boards to encompass disciplinary actions taken against podiatrists, chiropractors, optometrists, and other licensed health care practitioners.

Thus, on the basis of the authority provided by these two acts, State boards will be able to draw upon a national data bank to determine if any disciplinary actions have been taken against an applicant for licensure. It is expected that this data bank will be operating in 1988.

Finally, with respect to chiropractors, on whom this report focuses, it is important to add that the Federation of Chiropractic Licensing Boards (FCLB) operates a national clearinghouse on disciplinary actions taken by State boards. A special session at the Federation's 1987 annual meeting encouraged expanded voluntary participation in the clearinghouse. The boards were urged to report on all disciplinary actions and some did so, but the latest available (1985-1986) official directory of the Federation lists license revocations in only eight States. No other disciplinary statistics are regularly published for chiropractors. Because of the potential for lawsuits FCLB is reluctant to share even the disciplinary data it has with anyone but the boards, and then only in response to a specific request.

APPENDIX II

METHODOLOGICAL NOTES

We held discussions with representatives of 51 State boards. Usually, we talked with the executive director of the board. Often we talked with a board chairman or other member of the board. Our aim was to obtain information and discuss issues with a board representative who was well-informed about board activities both at present and over the past 3 to 4 years.

The major area in which we sought quantitative information from the board officials concerned the disciplinary actions taken by the boards against chiropractors in 1984, 1985, and 1986. Here, we asked for the number of formal actions taken and a breakdown of the type of actions--designated as revocation, suspension, probation, or other.

Forty-six of the boards were able to provide us with totals for disciplinary actions taken in each of the 3 years. One State (Minnesota) provided only annual totals, with no breakdown by the type of action. Two other States (New York and Texas) had only totals for 1984, but did provide breakdowns for the 2 later years. Finally, Oklahoma had no data available for 1984, and Georgia could not provide the data within a sufficient time frame.

We cannot confirm that the information is all-inclusive or completely accurate. We did stress, however, that we sought all board disciplinary actions against chiropractors, and we checked back when we suspected there might be errors. Board officials were typically responsive in checking their records and providing the data in a timely fashion.

In analyzing the differential performance of the States in disciplining chiropractors, we decided to aggregate the disciplinary data over the 3-year period. We felt that comparisons over only a 1- or 2-year period would be of questionable value because of the distortions that might be associated with year-to-year fluctuations.

In this context, we treated performance as a dependent variable and considered two major independent variables: size and region. With respect to size, first of all, we identified the number of chiropractic licenses in each State and then, using variance analysis, identified four clusters of States differentiated on the basis of the number of active chiropractors. The clusters and associated States are as follows:

1. Small: AL, AK, AR, CT, DE, DC, HI, ID, IN, KS,
LA, ME, MD, MS, MT, NE, NV, NH, NM, ND,
RI, SC, SD, TN, UT, VT, VA, WV, and WY.
2. Medium: AZ, CO, GA, IA, KY, MA, MI, MN, MO, NJ,
NC, OH, OK, OR, TX, WA, and WI.

3. Large: FL, IL, NY, and PA.

4. Extra-Large: CA.

With respect to region, we used U.S. Bureau of the Census categorizations to identify four regions of the country. The categorizations and associated States are as follows:

1 Northeast: CT, ME, MA, NJ, NH, NY, PA, RI, and VT.

2 South: AL, AR, DE, DC, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV.

3 Midwest: IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD and WI.

4 West: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, and WY.

APPENDIX III

COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE

We received comments on the report from four organizations outside the Department of Health and Human Services (HHS): the American Chiropractic Association (ACA), the International Chiropractors Association (ICA), the Federation of Chiropractic Licensing Boards (FCLB) and the National Board of Chiropractic Examiners (NBCE). In addition, we received comments from two HHS components: the Public Health Service (PHS) and the Health Care Financing Administration (HCFA). In this appendix, we present each set of comments in full and our response to the issues raised by the first four sets of comments.

ACA COMMENTS

In general, we found the report to be balanced and fair and the report's recommendations to be sound. We at the ACA believe that the public and profession benefit from strengthened disciplinary review and we applaud the efforts of your office in this regard.

We would, however, offer the following comments concerning the draft report and its recommendations.

The Effects of the Patrick Decision

In May of this year the U.S. Supreme Court entered a decision in *Patrick v. Burget*, 100 L.Ed. 2d 83 (May 16, 1988) which directly affects the operations of State authorized peer review panels. Much of the draft report concerns itself with the role State agencies may play in the disciplinary process. We suggest that it is essential that the impact of the *Patrick* decision be incorporated into the report's analysis.

Essentially, the U.S. Supreme Court drew closer limits upon the extent to which a state authorized peer review panel may claim federal antitrust immunity under the so-called "state action doctrine." The Court ruled that there must be direct and ongoing State supervision for such immunity to apply. Given the narrowing of the federal antitrust immunity for essential peer review activity, we would suggest that State chiropractic licensing and peer review board be granted explicit antitrust along the same lines currently being granted to hospital peer review board under the Health Care Quality Improvement Act (P.L. 99-660) (see specific recommendations below).

The Significance of Instigated But Not Finalized State Board Disciplinary Actions

The draft report paints a picture of State chiropractic licensing boards which take relatively few actions against offending licentiates. However, the report centers on simply "final actions." We suggest that a major portion of state board enforcement activity involves initiated actions which are settled or otherwise result in something less than a "final" disciplinary ac-

tion. Without consideration of all types of actions taken by disciplinary boards we question whether the draft report completely paints the full picture of board activity.

The report itself reflects upon this deficiency by stating:

"How many and what type of disciplinary actions are being taken against chiropractors in the United States? The question, although basic, is one that we learned could not be answered. The existing information bases were too limited even to provide reasonable estimates."

We agree that specific information may not be available, however, we believe that it is important to discuss the fact that other types of disciplinary actions (other than those that result in "final actions") are routinely taken by chiropractic boards and in some instances comprise a significant portion of their enforcement activity.

ACA RECOMMENDATIONS

1. As discussed above, the *Patrick* case has significantly altered the extent to which peer review activities can be protected from Federal antitrust liability under the state action doctrine. Given the report's emphasis on the importance of effective state authorized disciplinary and peer review, we suggest the final report include the following additional recommendation:

State chiropractic boards and those individuals serving upon them should be granted explicit federal antitrust immunity for all activities involving good faith disciplinary and peer review in the same manner hospital peer review boards are immune under the Health Care Quality Improvement Act of 1986.

2. The draft report recommends that the states should "ensure that state chiropractic boards have sufficient resources to carry out their responsibilities effectively." We agree. We also suggest that the Federal government has a role to play in assisting the important national goal of assuring high professional standards. We, therefore, suggest the final report include the following recommendation:

The Federal government should assist the states to assure that chiropractic boards have sufficient resources to carry out their responsibilities effectively.

3. Given that much of the report and some of its recommendations are very much in line with existing ACA policy on peer review, we suggest the report formally and jointly adopt ACA's policy as an official HHS recommendation to the public and the chiropractic profession. We believe this action by HHS would dramatically encourage and accelerate development of effective disciplinary and peer review panels in the various states. We, therefore, suggest the final report include the following recommendation:

The Department of Health and Human Services formally and jointly adopts the policy statement of the House of Delegates of the American Chiropractic Association on Non-profit Peer Review under State authority as a means to encourage and accelerate the development of State authorized disciplinary and peer review panels.

4. The report mentions in passing the *Wilk* litigation. The *Wilk* case has had a profound effect on the chiropractic profession and has clearly demonstrated the conspiracy to "constrain and eliminate" the chiropractic profession by the AMA and other professional medical groups. The ACA feels that while improved professional disciplinary and malpractice reporting programs are essential, such programs should be done by the chiropractic profession in conjunction with state authorized boards.

Under the provisions of the Health Care Quality Improvement Act (P.L. 99-660) and the Medicare and Medicaid Patient and Program Protection Act (P.L. 100-93), the AMA or one of its related counterparts may become the central clearinghouse for all disciplinary and malpractice actions against medical doctors and all other licensed health practitioners including doctors of chiropractic. From a chiropractic perspective, this is like handing the inmates the keys to the asylum.

We, therefore, suggest the final report include the following recommendations:

That the Health Care Quality Improvement Act and the Medicare and Medicaid Program Protection Act be amended to provide for the establishment of a separate national data bank to report and collect data on chiropractic disciplinary and malpractice actions to be run by the HHS Secretary or a designate thereof within the chiropractic profession.

Finally, the draft report makes some specific recommendations to the ACA. It suggests the ACA should "foster professional review of chiropractic clinical competency." We feel we are fostering such review through our policy on peer review, however, as stated in ACA recommendation 3 above, the joint support of HHS would serve as a positive push in our efforts.

The draft also suggests we consider developing guidelines for state chiropractic practice with the International Chiropractors Association (ICA).

A united view of chiropractic is a goal that the ACA has long pursued. We are in the process of continuing merger discussions with the ICA which we hope will lead to this goal. The recommendation of the draft report in this regard is very well taken and we have been pursuing this recommendation for over 10 years in our overall process toward unity within our profession through merger.

The last recommendation suggests ACA encourage more effective interaction between state associations and state chiropractic boards. Again, this recommendation has merit and we agree. However, it is essential that such interaction be protected from antitrust attack. Therefore, we

again urge that the final report reflect our recommendation outlined in ACA recommendation 1, above.

I look forward to the final report and I will forward it and its recommendations to the ACA board of governors for consideration.

OIG Response

The major concern expressed by the ACA concerns the liability of those involved with peer review actions. In this context it suggests that State chiropractic boards be granted the same "antitrust immunity" granted to hospital peer review boards under the Health Care Quality Improvement Act of 1986.

The ACA, we feel, raises an important point. The above-noted act establishes a limitation on any damages associated with professional review actions and extends legal protection for those providing information bearing on competence or professional conduct to professional review bodies. However, the act restricts this limitation and protection to professional actions concerning physicians. Given the importance of professional review actions in all health care fields, we agree that the same limitation and protection offered to physicians under the Health Care Quality Improvement Act should be extended to other health care practitioners. We will pursue the introduction of a legislative proposal that will achieve this end.

At the same time, we believe, it is important to distinguish peer review, carried out by professional chiropractic associations from the review and investigatory work of State chiropractic licensing and discipline boards, which are governmental agencies charged by State legislatures with the enforcement of laws concerning chiropractors. Medicine, dentistry, and other professions conduct active peer review efforts under the auspices of their professional associations. It would appear timely for the chiropractic profession to move increasingly in this direction. As we noted in the report, such efforts can foster public confidence and serve as a source of referrals for State board action when needed.

The ACA's concern about resources is, we believe, best directed to the State boards, which have the responsibility for licensing and disciplining chiropractors. Our lead recommendation in the report is that State governments assure that State boards have sufficient resources to carry out their responsibilities effectively. States, we believe, can benefit by funding FCLB sufficiently so that it can play an effective leadership role.

In that context, we did urge PHS to provide assistance to the FCLB and, as it explains in its response to our draft report, it concurs with our recommendation.

The ACA's concern about the objectivity of the contractor selected to run the national disciplinary action data bank and its call for a separate data bank directed to chiropractors go beyond the scope of our study.

Finally in accord with ACA's comment, we recognize that there are a number of State board actions "which are settled or otherwise result in something less than a 'final' disciplinary action." However, we have no basis for knowing whether or not, as the ACA suggests, these lesser actions account for "a major portion" of State board enforcement activity. Moreover, it is not clear to us what type of cases are handled in this matter.

ICA COMMENTS

This is in response to your letter of July 29, 1988 inviting comments on your agency's draft report: *State Licensure and Discipline of Chiropractors*. We welcome the opportunity to view the contents of the report at this "draft" stage, and we have been most appreciative of the continuing contact your staff has maintained with our association throughout the course of the research process.

After careful review of the contents of this draft report, we feel it is with few exceptions, a thorough, well-written, and overall, an objectively balanced report. We compliment you and your staff for your efforts. The information contained in this document will, upon publication, prove to be of great value to the chiropractic profession, and the complex of state regulatory bodies dealing with the difficult subject of licensure and maintenance of the highest professional standards for chiropractic.

There are however, several portions of the draft report which we believe would benefit from some explanation and amplification of statements made by your staff. First and perhaps foremost we are concerned with the impression given in the text of the section, SOME TRENDS IN PRACTICE, page 5, wherein the statement is made that "chiropractors usually confine their work to the office setting." Coming in the context of a discussion of the hospital and clinic experience of medical doctors we believe it is important to note that the relative isolation chiropractors find themselves in has not been a matter of free choice. For decades organized medicine sought to confine and ultimately eliminate the chiropractic profession through the process of professional isolation and other anticompetitive means, some of which have been found to have been illegal in the course of the *Wilk* case, awareness of which you note in the trends and practice section and footnote 13. With few exceptions chiropractors as individuals are anxious to establish professional relationships with all other health care providers in an effort to provide the highest level of quality care to every patient. Clearly an integration of professions in the care delivery process is in the patients' and communities best interests. The International Chiropractors Association supports the concept of close inter-professional cooperation between all professions, in a health care team effort. We only hope that the residue of the anti-chiropractic programs carried on for so many years by organized medicine will not continue to hinder such developments.

Likewise, that portion of the report dealing with the wide variations in state licensure (Scope of Practice Definitions, page 11), would perhaps be better understood if some recognition were given to the process by which the various states came to grant licensure to doctors of chiropractic. That there are major differences between licensure statutes from state to state should not be surprising. The battle for official recognition was one that was carried on over

many decades by the chiropractic profession, in the face of enormous political opposition from traditional medicine and its organizations. Largely through patient pressure, one by one, the states separately granted official status to the chiropractor. The historic forces shaping the licensure process in the 50 states ended up in most cases with compromise solutions, with few of the final outcomes subject to the wishes of the chiropractic profession, no matter what our desire for standardization may have been.

In sharp contrast, one area which recently has largely been under the control of the chiropractic profession, is that of chiropractic education. Unhindered by a competitive political legislative process, the chiropractic profession has proceeded quickly to establish strict and increasingly demanding educational standards for its students, through the Council on Chiropractic Education. I believe it is significant to note that this has been accomplished virtually entirely through self funding, whereas the other health professions have enjoyed very generous state and Federal support.

As a result of efforts in the area of chiropractic education chiropractors are without a doubt the beneficiaries of far more specialized training on the structure and function of the human spine than any other health professional. The primacy of this skill is recognized by the fifty states as all licensure statutes empower chiropractors as spinal care specialists, whether or not other procedures and practices are authorized.

Finally, please note several minor technical corrections:

1. On page 9, reference is made to the Committee on Accreditation of the Council on Chiropractic Education. This should be the Commission on Accreditation of the Council on Chiropractic Education.
2. On page 28, reference is made to the International Chiropractic Association, rather than International Chiropractors Association.

The International Chiropractors Association welcomes discussion in the difficult areas of professional discipline and peer review as well as the other recommendations contained in the report. We are committed to taking direct and swift action in any and every direction possible in an effort to improve the quality of the health care services our profession delivers to the public. This report has given us much to think about and has provided a basis for discussion within the profession that will no doubt yield positive results.

OIG RESPONSE

We recognize the ICA's concern about the reasons for the relative isolation of chiropractors, but feel that our discussion of the *Wilk* case on page 5 makes it clear that the isolation is not necessarily of chiropractors' choosing. We also appreciate the ICA's point about the historic forces shaping the State licensure process and about how they have contributed to the current fragmentation. Notwithstanding those forces, it is important as the ICA recognizes, that the profession and the States now move toward greater standardization.

With respect to the technical corrections noted by ICA, we have made the specified changes.

FCLB COMMENTS

It appears that your recommendations relative to state licensing laws overemphasize the power and resources of the FCLB in relation to state laws. It is not, and never has been our intention to interfere with the states' rights to govern themselves in a manner they deem to be in the best interest of their citizens.

However, we are willing to cooperate and assist state boards in this endeavor when requested.

In relation to discipline and other matters, we have greatly augmented and increased the activities of the FCLB to address these matters in a greater capacity. This, in the best manner relative to our income and resources.

You may be aware that a larger portion of our income is obtained from state board membership dues. Funds for this purpose are limited in state budgets. We find it difficult to function beyond these financial limitations.

If you can suggest funding by other agencies we would be glad to consider this as an answer to increase our staff and activities.

OIG Response

We did not call for or even imply that FCLB should "interfere with the States' rights to govern themselves." Since FCLB is the entity that represents the individual State boards, we felt that it was reasonable to look to it to be actively involved in developing guidelines for State practice acts, in regularly accumulating and disseminating to the States information on changes in State practice acts and regulations, and in identifying the most effective techniques of credential verification. Associations representing State boards in other fields have undertaken such initiatives and have done so without infringing on States' rights.

NBCE COMMENTS

The draft report "State Licensure and Discipline" has been reviewed by myself, the NBCE management staff, and made available for review by members of our Board of Directors.

Relative to licensure, the report addresses the very essence of the difficulties of reciprocity in observation of varied scopes of practice from State to State. With this diversity, considered a State's rights issue, the goal of more open reciprocity among states may be difficult to actually achieve.

In response to your comments pertaining to the need for more uniform guidelines, this is difficult to address due to the States' individual rights to determine scopes of practice. The

leadership in the chiropractic profession does not have the authority or power to address this issue.

As recognized in your report, the NBCE is now providing national standardized examinations in six basic science subjects (Part I), six clinical science subjects (Part II), and a complete Written Clinical Competency Examination (WCCE), the latter results of which are available for use by any State licensing board in their review of individuals' credentials for licensure.

At present, as a part of their licensing process, thirty-one States have opted to either accept or require successful completion of this WCCE, which is analogous to Part III of the national Board of Medical Examiners exams. We believe that the WCCE, which was developed at the request of the FCLB and following extensive research and response from every State and adhering closely to broadly accepted testing standards, is an excellent vehicle to strengthen some uniformity among States' licensure requirements. Some States, Illinois for example, have moved to solely require successful completion of the NBCE Parts I and II and the WCCE for licensure. This allows more time and resources for monitoring jurisprudence and other discipline issues, and in other States, allows for application of hands-on demonstrations of proficiency.

As chiropractic is a hands-on, therapeutic application of education and experience, the need for practical testing for licensure screening continues to be of interest and importance to most State examining boards. To date, the NBCE has not been formally requested by the FCLB to develop any program to impact this need although a few individual States have made inquiries into this area due to passage of third-party testing legislation.

We offer these comments for consideration in your final report on chiropractic, and we certainly thank you for the courtesy of reviewing the draft. We will anticipate receiving a copy of the final report as soon as it is available.

OIG Response

We recognize that the individual States have the right to pass the kind of practice acts they choose. Yet, as we have indicated in the report and in response to ICA comments, we believe that the professional associations and the FCLB, by exercising leadership, can be influential in fostering greater standardization in State practice acts.

PHS COMMENTS

OIG Recommendation

The Public Health Service (PHS) should assist the Federation of Chiropractic Licensing Boards (FCLB) to carry out a more effective leadership role in working with its member boards.

PHS Comment

We concur. PHS recognizes the FCLB's need for assistance and will continue to work through the Health Resources and Services Administration (HRSA) with all the chiropractic professional organizations to improve the discipline's quality assurance programs.

HRSA has requested funding for a fiscal year (FY) 1989 contract to develop a classification of disciplinary actions and guidelines for use by State chiropractic licensure boards in their credential verification activities. In this respect, guideline development fund awards for podiatrists and pharmacists have been recently approved. Fund requests for guideline development in the chiropractic and other health professions are currently in abeyance pending availability of FY 1989 funds.

HCFA COMMENTS

We have reviewed the draft which focuses on State licensure and discipline practices concerning chiropractors. The major finding in the report is that in both licensure and discipline realms, State board officials tend to feel they are seriously understaffed and, as a result, the effectiveness of both licensure and discipline operations is compromised. Since none of the recommendations in the report require action by HCFA, we have no specific comments to offer.

We concur with the report's findings and recommendations, and we support the efforts of the OIG to improve the current State practices. Thank you for the opportunity to comment on this report.

ENDNOTES

1. U.S. Public Health Service, Health Resources and Services Administration, *Supply and Characteristics of Chiropractors*, August 1986. Based in large part on data from the American Chiropractic Association annual surveys.
2. American Chiropractic Association, *Demographic and Professional Characteristics of ACA Membership, 1985 Annual Survey*, November 1985, pp. 1, 6, and 19.
3. U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Statistics, as reported to the Office of Inspector General.
4. *Medical Economics*, September 7, 1987, p. 69.
5. Commerce Clearing House, *Medicare and Medicaid Guide*, Chicago, IL, Medicaid State Chart, p. 6504, Sec. 15504.
6. Reference 1, Table 5.
7. C. A. Wilk, *Chiropractic Speaks Out*, Wilk Publishing, Park Ridge, IL, 1973, pp. 19-25.
8. J. Langone, *Chiropractors: A Consumer's Guide*, Addison-Wesley, Reading, MA, 1982, pp. 13, 14.
9. The Council on Chiropractic Education, *Annual Report, 1985*, p. 1.
10. Reference 9, pp. 61ff.
11. Reference 9, p. 61.
12. American Chiropractic Association, *Demographic and Professional Characteristics of ACA Membership, 1986 Annual Survey*, Arlington, VA, December 1986, p. 3.
13. The lawsuit [Wilk et al. v. AMA et al., Civil Action 76 C 3777; 671 F. Supp. 1465 (N.D. Ill. 1987)] was brought during 1976 in the U.S. District Court for the Northern District of Illinois, Eastern Division, by certain chiropractors and their professional associations against medical and hospital associations and certain named medical doctors.
14. Reference 12, p. 7.
15. Reference 12, p. 7. Also, reference 1.

16. Reference 1, Table 6.
17. Reference 1, Table 5.
18. Social Security Act, as amended, Sec. 1801 (r); Code of Federal Regulations, Title 42, Sec. 410.22.
19. Here and elsewhere in this report, unless otherwise noted, the data derive from our survey of the 51 States. See Appendix II.
20. Federation of Chiropractic Licensing Boards, *Official Directory, 1985-1986*, Glendale, CA, p. 75.
21. We developed the \$6 million estimate as follows: For each State, we multiplied the total number of chiropractor licenses (from Reference 20) by the renewal fee determined in this survey. This resulted in a total of \$3,974,280. We then assumed that renewal fees accounted for two-thirds of overall fee income from chiropractors. Accordingly, we multiplied the above noted total by 3/2. This resulted in a new total of \$5,961,420.
22. The Council of State Governments, *State Credentialing of Health Occupations and Professions*, Lexington, KY, 1986, p. 63.
23. Reference 22, p. 57.
24. The Council on Chiropractic Education, *Educational Standards for Chiropractic Colleges*, Des Moines, IA, January 1987, p. III-D-2.
25. *National Board of Chiropractic Examiners, Annual Report, 1986*, Greeley, CO, p. 4. See also Langone, reference 8.
26. National Board of Chiropractic Examiners as reported to the Office of Inspector General.
27. For a concise summary of the practice statutes in plain English see Langone, reference 8. More current summaries of the practice acts can be found in the *Official Directory* of the Federation of Chiropractic Licensing Boards, reference 20. A recent commentary on the variability in chiropractic licensing statutes can be found in Medical Economics reference 4.
28. Reference 22, p. 57.
29. Reference 22, p. 57, and reference 20, p. 75.
30. Reference 22, p. 59.

31. The national data bank now being established under Title IV of the Health Care Quality Improvement Act of 1986 (P. L. 99-660) will provide a basis for answering this question in the years ahead.
32. See Reference 1, Table 2, p. 9 for the numbers of chiropractors in 1985. The numbers of disciplinary actions by State chiropractic boards are taken from this study.
33. The numbers of active dentists in 1985 are given in the *Fifth Report to the President and Congress on the State of Health Personnel in the United States*, HHS, PHS, March 1986, p. 5-35. Disciplinary actions were reported to the Office of Inspector General by State dental boards. See the first report for this study, *State Licensure and Discipline of Dentists*, HHS, OIG, in draft.
34. The numbers of active medical doctors in 1985 are given in the *Fifth Report to the President and Congress on the State of Health Personnel in the United States*, HHS, PHS, March 1986, p. 3-115. Disciplinary actions were reported to the Office of Inspector General by State medical boards. See the report *Medical Licensure and Discipline: An Overview*, HHS, OIG, June, 1986.
35. Data supplied during HHS/OIG discussions with the Federation of State Medical Boards and summarized in HHS/OIG report, *Medical Licensure and Discipline: An Overview*, June 1986.
36. HHS/OIG report, *State Licensure and Discipline of Dentists*, in draft. The first report in this inspection.
37. Reference 20, p. 75.
38. See T.R. Daly, *Peer Review--Recent Judicial Developments*, *ACA Journal of Chiropractic*, July 1983; *Union Labor Life Insurance Company v. Perino*, 102 S. Ct. 3002 (1982)
39. See, for example, reference 4.
40. The Council of State Governments, *State Regulation of the Health Occupations and Professions: 1985-1986*, Lexington, KY, March 1987, p. 5.
41. Federation of State Medical Boards of the United States, *A Guide to the Essentials of a Modern Medical Practice Act*, 1985 Revision, Fort Worth, TX, 1985.
42. The Council of State Governments, *State Regulatory Policy: Dentistry and the Health Professions*, Lexington, KY, 1979.
43. American Institute of Certified Public Accountants and National Association of State Boards of Accountancy, *Model Public Accounting Bill*, November 1984.