REPORT OF THE
COUNCIL ON HEALTH REGULATORY BOARDS,
DEPARTMENT OF HEALTH REGULATORY BOARDS

The Need for the Regulation of Dietitians and Nutritionists

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 23

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HOUSE JOINT RESOLUTION NO. 150

Requesting the Department of Health Regulatory Boards to study the need for regulating dietitians and nutritionists.

Agreed to by the House of Delegates, February 7, 1986
Agreed to by the Senate, March 6, 1986

WHEREAS, the citizens of the Commonwealth of Virginia have become more aware of their health and fitness; and

WHEREAS, in the last few years a multimillion-dollar industry has grown to supply the demand our citizens have for sound nutritional advice; and

WHEREAS, studies conducted by the Congress and agencies of the federal government have concluded that often the public is subjected to fraud and deception regarding nutritional advice; and

WHEREAS, Congress has estimated that $10 billion dollars is spent each year on questionable and unjustified nutritional and medical claims; and

WHEREAS, several states, the District of Columbia and Puerto Rico are considering legislation which regulates persons who purport to be trained nutritionists or to be qualified dietitians; and

WHEREAS, the Department of Health Regulatory Boards is authorized to recommend the regulation of the health care professions and occupations to protect the citizens of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health Regulatory Boards is requested to study the need for regulating dietitians and nutritionists in the Commonwealth. The Department shall submit its findings and recommendations to the 1987 Session of the General Assembly.

INTRODUCTION

In response to House Joint Resolution 150 (HJR 150) of the 1986 Legislative Session, this report presents to the Virginia General Assembly the findings of a study of the need to regulate dietitians and nutritionists. Specifically, HJR 150 observed that federal studies have concluded that the public is "subjected to fraud and deception regarding nutritional advice," and that the Department of Health Regulatory Boards is "authorized to recommend the regulation of the health care professions and occupations to protect the citizens of the Commonwealth."

The study was conducted by a committee of the Council on Health Regulatory Boards (CHRB) which has responsibility to:

> Evaluate each health care profession and occupation in the Commonwealth, including those regulated and those not regulated by other provisions of this Title to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed. Whenever the Council determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Council shall recommend for approval by the General Assembly next convened a regulatory system necessary to establish the degree of regulation required. (Code of Virginia, Sec. 54.955.1)

The report consists of the following parts. Part I is an Executive Summary. Part II sets forth Legislative, Executive Branch, and CHRB policies, principles, and criteria governing health occupational regulation. Part III describes how the study was conducted and sets forth findings of the study. Part IV presents a summary of the Council's findings and recommendations.

The recommendations of this report were approved unanimously by the Council at its Annual Meeting on October 21, 1986. The text of the report has been approved by the Council's Executive Committee acting in accordance with an express delegation of authority. The Director of the Department of Health Regulatory Boards endorses the findings and recommendations of the Council as presented in this report.

PART I: EXECUTIVE SUMMARY

The Virginia Council on Health Regulatory Boards (CHRB) has studied the need to regulate dietitians and nutritionists in the Commonwealth. The study was requested by House Joint Resolution 150, passed by the Virginia General Assembly in March 1986.

The workplan for the study included an informational hearing; a review of the history of consumer complaints related to the practice of dietitians and nutritionists; a survey of the advertised activities and/or services of dietitians, nutritionists, and weight control businesses; a review of federal and state policies and regulatory programs related to dietitians and nutritionists; and a review of recent literature on this subject.

The study used as its evaluative framework the six formal criteria adopted by the Council in 1983 for evaluating whether a health occupation should be regulated. The most important of these is the determination of whether a risk for harm to the public health, safety, and welfare is created by the unregulated practice of a health occupation.

Based on its study, the Council concluded that the occupational practices of dietitians and nutritionists do not currently require state regulation. Objective evidence from the public record does not document widespread abuse of consumers by either unregulated or presently regulated providers of dietary or nutrition-related health services in Virginia. The small number of consumer complaints that have been documented fall into three categories, and appropriate mechanisms to protect the public exist for each type of documented abuse.

The first type of documented harm stems from those unregulated providers who violate the laws of the Commonwealth by diagnosing and/or treating conditions statutorily defined as within the scope of practice of licensed providers (physicians, pharmacists, psychologists, counselors, etc.). These problems are addressed properly through enforcement of the laws and rules covering currently regulated health service providers.

A second type of documented harm emanates from service providers of dietaryy and nutrition services who engage in fraudulent or deceptive business practices. Public protection against these abuses is best provided by enforcement of the Virginia Consumer Protection Act (Code of Virginia, Sec. 59.1-196 to 207), as amended by the General Assembly in 1986.

A final category of documented complaint pertains to the harmful practices of already licensed providers. The record demonstrates that when these occur and when consumers make formal complaints, licensed practitioners are appropriately disciplined. In the extreme, licenses to practice are revoked, and this action is reported to Commonwealth Attorneys and to the public.

The Council found that when consumers have made valid complaints of unlawful or harmful practice, existing public protection mechanisms have been sufficient to provide redress. Furthermore, public protection laws are being strengthened continually in the interest of consumers. Examples of efforts to strengthen public protection include new regulations proposed by the Board of Medicine to better protect consumers from prescription of dietary or nutrition supplements or treatments of no therapeutic value and amendments to the Consumer Protection Act adopted by the 1986 General Assembly to require fuller disclosure of information regarding business practices.

The Council's recommendations in this report focus on the use of means other than the occupational regulation of dietitians and nutritionists by the Commonwealth to address potential harm to consumers.

Professional associations serving dietitians and nutritionists and private credentialing organizations formed to enhance standards of care by these practitioners provide information to assist the public in the selection of qualified practitioners and appropriate services. These groups are encouraged to intensify public education activities and provide greater disclosure of relevant information to clients and consumers. The General Assembly may also wish to consider mechanisms to strengthen further consumer disclosure requirements in the Consumer Protection Act. The Council believes that strengthened requirements for disclosure of relevant information (educational credentials held by the practitioner, the nature and expected course of treatment, anticipated cost of services, and projected treatment outcomes) to consumers may be warranted in the rapidly growing industry offering dietary and nutrition services to consumers.

In the final analysis, state health occupational regulation is defensible only when it is demonstrated that the lack of regulation presents a substantial risk to the public health, safety, and welfare, and that members of the public cannot adequately protect themselves by making informed choices in the marketplace and by other means. Occupational regulation, when it is appropriate, comes at increased cost to the consumer, and it should be implemented only when other mechanisms such as strengthened enforcement of existing laws and rules, public disclosure, and consumer redress for documented abuse are not feasible. The Council respectfully submits that these conditions are not met in the present case. It is therefore recommended that no state regulation of dietitians or nutritionists be implemented in the Commonwealth at this time.

PART II: POLICIES, PRINCIPLES AND CRITERIA GOVERNING HEALTH OCCUPATIONAL REGULATION

Legislative Policies and Principles

The General Assembly of the Commonwealth of Virginia has enacted the following statement of policy to apply to the regulation of professions and occupations:

> The right of every person to engage in any lawful profession, trade or occupation of his choice is clearly protected by both the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when it is clearly found that such abridgement is necessary for the preservation of the health, safety and welfare of the public.
>
> (Code of Virginia, Sec. 54-1.17)

There are five fundamental means by which the public is protected in Virginia. The first two methods do not apply directly to occupational regulation, but may be selected in lieu of the registration, certification or licensure of individuals:

Private civil actions and criminal prosecutions: Whenever the state finds that existing laws are not sufficient to protect the public, it may provide by statute for more stringent grounds for civil action and criminal prosecution.

Inspection: The activities and premises of persons in certain occupations are subject to periodic inspections to ensure that the public's health, safety, and welfare are protected. Anyone is allowed to practice the occupation without meeting specific entry criteria. However, an injunction can be issued to prevent persons who do not meet the inspection standards from engaging in these occupations.

Registration: Under this type of regulation, any person may engage in an occupation, but he or she is required to submit information concerning the location, nature, and operation of the practice.

Certification: As a form of regulation, certification recognizes persons who have met certain educational and experience standards to engage in an occupation. Although any one may practice the occupation, only those who are certified may use the occupational title.

Licensure: Under this method of regulation, it is illegal for anyone to engage in an occupation without a license, and only persons who possess certain qualifications are licensed.

In addition, in Section 54-1.26.B., a number of general factors are designated for use in assessing the proper degree of regulation, if any, that should be established for occupations and professions. While these are general, the Council on Health Regulatory Boards has determined that they should apply to health professions and occupations and has published them in its procedural handbook adopted for use by organizations or others requesting evaluation of proposals for health occupational regulation. These factors are:

Whether the practitioner performs a service for individuals involving a hazard to the public health, safety, or welfare, if unregulated.

The view of a substantial portion of the people who do not practice the particular profession, trade, or occupation.

Whether number of states that have regulatory provisions similar to those proposed.

Whether there is sufficient demand for the service for which there is no substitute not likewise regulated and this service is required by a substantial portion of the population.

Whether the profession, trade, or occupation requires high standards of public responsibility, character, and performance of each individual engaged in the profession, trade, or occupation, as evidenced by established and published codes of ethics.

Whether the profession, trade, or occupation requires such skill that the public generally is not qualified to select a competent practitioner without some assurance that he or she has the minimum qualifications.

Whether the professional, trade, or occupational associations do not adequately protect the public from incompetent, unscrupulous, or irresponsible members of the profession, trade, or occupation.

Whether current laws which pertain to public health, safety, and welfare generally are ineffective or inadequate.

Whether the characteristics of the profession, trade, or occupation make it impractical or impossible to prohibit those practices of the profession, trade, or occupation which are detrimental to the public health, safety, and welfare.

Whether the practitioner performs a service for others which may have a detrimental effect on third parties relying on the expert knowledge of the practitioner.

The Council has employed these legislative principles and policies in evaluating the need to regulate operators of x-ray equipment in the health field.

Executive Branch Policy and Council Criteria

In addition, in evaluating proposals for health professional or occupational regulation, CHRB is guided by the following regulatory policy expressed by Governor Gerald L. Baliles in Executive Order Five (86):

> While recognizing that the state government has an affirmative and inescapable duty to enforce regulations that protect the public safety and welfare, it is the policy of the Commonwealth of Virginia to conduct required regulatory activities in a manner that intrudes to the least possible extent into the legitimate functions of private enterprise and individual citizens. It is also the policy of the Commonwealth to strive to draft, adopt and enforce regulations that do not unnecessarily burden the activities of private businesses and citizens.

Finally, since 1983, the Council has evaluated regulatory proposals using six formal criteria adopted by CHRB following an extensive study of the regulation of health occupations and professions in Virginia and in other states. These criteria are:

CRITERION 1*:
The unregulated practice of an occupation will harm or endanger the health, safety and welfare of the public. The potential for harm is recognizable and not remote or dependent on tenuous argument.

CRITERION 2:
The practice of an occupation requires a high degree of skill, knowledge and training, and the public requires assurances of initial and continuing occupational competence.

CRITERION 3:
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

CRITERION 4:
The scope of practice of an occupation is distinguishable from other licensed and unlicensed occupations.

CRITERION 5:
The economic impact on the public of regulating this occupational group is justified.

CRITERION 6:
There are no adequate alternatives to regulation (i.e., licensure, statutory certification, or registration) that will protect the public.

*A prerequisite for a health occupational group to be regulated.

PART III: STUDY OF THE NEED TO REGULATE DIETITIANS AND NUTRITIONISTS

House Joint Resolution 150

House Joint Resolution 150 requested the Department of Health Regulatory Boards to study the need for regulating dietitians and nutritionists in the Commonwealth. The Resolution observed that the public has become aware and concerned about health and fitness, and that a multimillion dollar industry has grown to meet this interest. HJR 150 observed further that federal agencies have found considerable "fraud and deception regarding nutritional advice" in the marketplace of these services and products. Finally, the Resolution observed that some states have enacted and some are considering legislation to regulate providers claiming to be "trained nutritionists" or "qualified dietitians."

Process of the Study

Upon receipt of HJR 150, the Council on Health Regulatory Boards requested its Regulatory Evaluation and Research Committee to undertake the study.

The Committee developed a workplan for the study to include (1) an informational hearing on the substance of HJR 150; (2) a review of the history of consumer complaints in the Commonwealth related to the practice of dietitians and nutritionists; (3) a survey of the advertised activities and/or services of dietitians, nutritionists, and weight control businesses; (4) a review of federal and state policies and regulatory programs; and (5) a review of the literature on this subject.

Information and evidence gathered by these research activities have been used to address the Council's criteria for evaluating proposals for health occupational regulation. These findings by the Council have been endorsed by the full membership of the Council on Health Regulatory Boards, and the Director of the Department of Health Regulatory Boards concurs in the substance and the recommendations presented in this report to the General Assembly.

Findings of the Study

In evaluating evidence presented at the informational hearing, in written submissions, in a special survey, and in a review of relevant literature, Council used six formal criteria adopted in 1983 for assessing whether health occupations or professions should be regulated. The first of these criteria is preeminent--when its conditions are not satisfied by substantial evidence, no further consideration is required under quidelines used by the Council.

> **Criterion 1: The unregulated practice of an occupation will harm or endanger the health, safety, and welfare of the public. The potential for harm is recognizable and not remote or dependent on tenuous argument.**

Presentations made at the informational hearing (in which both dietitians and nutritionists were well represented) and in later written submissions described isolated cases of harm or potential harm to consumers. This largely anecdotal evidence described problems of poor diagnosis and/or questionable treatment of nutrition-related and other illnesses and conditions by both currently regulated practitioners of the healing arts and by unregulated persons calling themselves either dietitians or nutritionists. These presentations regarding evidence of harm were used variously by contending interest groups to support or to oppose state regulation of dietitians and/or nutritionists.

Evidence assembled by the Council from all sources used in the study indicates that the small number of cases of documented harm or abuse to consumers from dietary or nutrition practice have consisted of three types. The first type involved unregulated providers who violate the laws of the Commonwealth by diagnosing and/or treating conditions statutorily defined as within the scope of practice of regulated providers (physicians and others licensed by the Board of Medicine; pharmacists and others licensed by the Board of Pharmacy; psychologists, professional counselors, and others licensed by the Boards of Psychology, Professional Counselors, and Social Workers; etc.). A second type of abuse results from providers of dietary or nutrition services who engage in fraudulent or deceptive business practices. A final type of documented abuse involves harmful practices of currently licensed providers (physicians, chiropractors, psychologists, pharmacists, or other regulated health professionals).

In order to evaluate how formal complaints and disciplinary actions are currently being handled in cases involving dietary or nutrition practice, the Council requested the Office of Consumer Affairs (within the Virginia Department of Agriculture and Consumer Affairs) to search its database for formal complaints regarding dietary or nutrition services filed over the past five years. That Office discovered only five complaints, all by consumers against weight control centers, with a single center being mentioned in four of the five complaints.

Each of the five complaints mentioned dissatisfaction with business practices such as unannounced closings and lack of cooperation in scheduling visits. Two complaints also mentioned lack of medical supervision of their weight loss programs, and unpleasant "side effects" of the treatments. Three complaints were referred to the Virginia Board of Medicine, all involving the same center. After investigating each of these cases, the Board determined that no violations of the statutes or regulations governing the practice of the healing arts had occurred. Some complainants also filed formal complaints with local Better Business Bureaus and Chambers of Commerce.

The Council also asked the Board of Medicine to search its files for complaints against licensees regarding dietary or nutrition-related diagnoses or treatments. The Board of Medicine regulates physicians, osteopaths, chiropractors, podiatrists, physical therapists, physician's assistants, acupuncturists, clinical psychologists, and respiratory therapists. The search produced six cases; these involved the questionable prescribing or sale of dietary supplements or questionable advertising. Two cases also involved the failure to refer patients to another physician for diagnosis and treatment, causing harm to the patients. In one of these cases, the physician's license was revoked; a request was made for reinstatement but was denied. In the other case, the physician voluntarily surrendered his license.

Another source of evidence--the Virginia Insurance Reciprocal, Inc., insurer of more than 80 hospitals and 3,000 physicians in Virginia--reports no claims involving dietitians over the past eight years.

In summary, the Council finds that appropriate mechanisms other than occupational regulation currently protect the public. These mechanisms are (1) enforcement of laws against the unlicensed practice of medicine or of other regulated health occupations; (2) enforcement of the Virginia Consumer Protection Act in cases of deceptive or fraudulent business practices; and (3) enforcement of the statutes and regulations of the various health occupational regulatory boards to protect consumers from harm at the hands of more than 30 regulated health occupations and professions in Virginia.

While this finding alone is sufficient to recommend against state regulation of dietitians and nutritionists in the Commonwealth at this time, the position of the Council in this matter may be better understood by a fuller discussion of a number of pertinent issues discovered during the study. These issues can be framed within the substantive content of the remaining criteria used by the Council for studies of the need to regulate health professions and occupations:

* **Unique Scope of Practice--Criterion 4 requires that regulated health occupations and professions be distinguishable from other licensed and unlicensed occupations.**

* **Level of Skills, Knowledge, and Training--Criterion 2 requires that the practice of regulated health occupations be characterized by a high degree of skill, knowledge, and training.**

* **Autonomous Practice--Criterion 3 stipulates that the functions and responsibilities of regulated health practitioners require independent judgement and that members of regulated occupational groups practice autonomously.**

* **Least Restrictive/Cost-Effective Public Protection--Criteria 5 and 6 require that the least restrictive mechanisms consistent with public protection be the regulatory provisions of choice, and that the substantial direct and indirect costs associated with occupational regulation be justified when regulation of an occupation is recommended.**

In the following sections, the evidence and findings of the study are discussed.

Unique Scope of Practice

The Council developed information relative to the scope of practice of dietitians and nutritionists from several sources in addition to the testimony solicited from the public. The Council reviewed definitions of "dietitian," "dietetic technician," "dietary manager," and "nutritionist" as employed by

the National Commission for Health Certifying Agencies (Appendix 1). The Council also consulted the Classification of Instructional Programs published by the National Center for Educational Statistics (Appendix 2), and information on the regulation of dietitians and nutritionists (including classes of health service providers exempted from regulation) prepared by the Council on State Government and the American Dietetic Association (Appendix 3).

The Council found from the evidence that a wide array of regulated and unregulated providers offer services to the public that may be subsumed under the overlapping titles "dietitian" and/or "nutritionist," or some variation of these terms. The material presented in Appendixes 1-3 illustrates that the boundaries between and among occupational titles in the field of dietary and nutrition practice are unclear.

Council members and staff consulted telephone directories and newspapers to determine how dietitians, nutritionists, and others advertised their services, and conducted an informal telephone survey of a selection of these providers. The survey included approximately 80 businesses and practitioners listed in telephone directory Yellow Pages under "dietitians," "nutritionists," and "weight control services" in the Lynchburg, Tidewater, Richmond, and the Metropolitan Northern Virginia areas.

In all areas, the greatest number of advertisers in Yellow Pages and in newspapers were weight control services. When questioned, the majority of these services said that they required some type of nutritional or health "assessment," that may or may not be conducted by a licensed health professional. In most instances, the licensed professional available for the "assessment" was a Licensed Practical Nurse (LPN) or other licensed nurse (RN). Most respondents indicated that a licensed physician was available within the organization, and could be requested by clients to supervise their treatment.

Information from the survey showed fewer listings under "dietitians" than under "nutritionists." Frequently, Registered Dietitians (RD) advertised under both titles, or only under "nutritionists." Also advertising under "nutritionists" were cardiologists, allergists, chiropractors, hypnotists, a dentist, distributors of nutrition products, and other types of services. This diversity is explained in part by the fact that, unlike the well-recognized title "Registered Dietitian" or "RD," that is popularly equated with dietitians generally, there is no clearly distinguishable definition of the title "nutritionist."

Since the title and concept of "Registered Dietitian" is popularly understood to refer solely to institutional dietetic services, it may be that the marketing appeal of the title and concept "nutritionist" is greater than that of "dietitian," explaining the favored use of "nutritionist" in advertising. With the growth in commercialization and direct marketing of health services and with the steady growth in supply of health professionals providing nutrition and dietary services, providers of services may seek to exploit commercially valuable titles and popular trends such as dietary supplements and diets.

There may be understandable--and unavoidable--public confusion regarding the use of various overlapping occupational titles in the field. It is clear, however, that the use of state occupational regulation to address this confusion over scope of practice would be ineffective. Tabulations of programs used by the states to regulate dietitians and/or nutritionists reveal that in 1986, 15 states, Puerto Rico, and the District of Columbia regulated one or both titles; all of these included in their statutes numerous exemptions for health and nonhealth occupations, agencies, and businesses from their regulatory provisions.

Citations for exemptions included physicians and surgeons, nurses, chiropractors, dentists, dental hygienists, pharmacists, physical therapists, dietetic students under supervision, nutrition and dietary consultants, clinical instructors, employees and owners of weight control businesses and health food stores, federal, state, county, and city nutrition educators or employees in nutrition-related programs, and others. Although widespread exemptions are a consistent feature among these states' regulatory programs, no consistent rationale is apparent in whether dietitians and nutritionists, dietitians alone, or nutritionists alone are regulated, or by what level(s) or regulation.

The existence of these numerous exemptions reflects significant conflict over scopes of practice, emphasizing the difficulty of identifying a unique scope of practice. Some states have appropriated as a model or included within their definition the ADA standards and requirements for the title and/or practice of "Registered Dietitian." In some instances, the title and/or practice of "nutritionist" have been subsumed under the definition of Registered Dietitian. In these instances, however, numerous exemptions for other occupations and agencies were also listed, further supporting the Council's finding that neither nutritionists nor dietitians have a unique scope of practice distinguishable from other licensed and unlicensed occupations.

Level of Skill, Knowledge, and Training

The Council consulted compendia of occupational titles, scopes of practice, and accreditation and instructional programs to determine what standards of education, training, and competence exist for dietitians and nutritionists.. Dietitians, nutritionists, and members of related occupations practice in an exceptionally broad range of settings, from biochemistry laboratories and industry, hospitals, nursing homes, and school cafeterias, to private clinics, weight control businesses, and fitness and wellness centers.

There is great disparity in the content of education of these practitioners. The review of journal literature, testimony in the informational hearing, and written submissions indicate that there is disagreement about the professional and clinical use of scientific research and research findings in nutritional assessment, dietary counseling, and provision of services, as well as disagreement about what effect(s) state credentialing might have on the development and use of knowledge in the nutrition and dietary professions.

At the hearing and in written submissions, some commentators suggested that any regulation defining nutrition or dietary practice would threaten or eliminate some educational and research programs, and thereby limit the diversity and availability of services to the public. Others suggested that the educational, training, and competency requirements currently used for the private credentialing of Registered Dietitians by the Commission on Dietetic Registration of the American Dietetic Association (ADA), as well as the accreditation standards for educational programs used by the ADA, are appropriate guidelines for state regulation.

The Council reviewed recent literature in order to evaluate these contentions. Currently, significant challenges are being made to earlier opinion in the nutrition sciences that in the past had been considered conclusive. New research and new interpretations of past research findings are being called for in such fundamental areas as the function of nutrient requirements (Required Dietary Allowances, RDAs), the use of dietary supplements, and the many and complex influences on dietary and nutrition-related diseases and conditions. Scientific uncertainty suggests the need for caution in establishing regulatory requirements that may preempt clinical and research findings regarding the valid practice of nutrition and dietary care. Appendix 4 presents a bibliography of recent articles that describe these controversies.

In short, the Council concluded that there is a noticeable lack of uniformity with respect to the degree of skill, codified knowledge, and/or training required of dietitians and nutritionists. These persons practice in a wide diversity of settings, under different scopes of practice, with different types of educational preparation, and under a variety of supervision arrangements. There is no existing single set of standards for education and practice for all dietitians and nutritionists. If the public does require assurances of initial competence of dietitians and nutritionists, it is not clear what these standards should be.

Autonomous Practice

The Council found that within the diversity of scopes of practice and practice settings, there is a substantial clustering of dietitians and nutritionists in institutional employment where autonomous practice is not characteristic. Furthermore, most of those who practice in noninstitutional settings, such as private consulting or weight control centers, practice within a larger system of health care that includes physician referrals and supervision.

The American Dietetic Association's 1984 survey of dietitian members showed that 35 percent of dietitians worked in hospitals, 19 percent worked in nursing homes, and 11 percent worked in educational settings. According to these data, 65 percent of the dietitian members of ADA were employed in institutional settings. The Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association reported that 80 percent of all dietetic technicians (who assist dietitians) worked in hospitals, 15 percent worked in nursing homes, and the remainder worked in other health care settings; nursing homes employed nearly two-thirds of all dietetic assistants. These data indicate that a large number of dietitians do not practice autonomously but are controlled by medical and administrative policies and supervision in these settings.

The Accreditation Manual of the Joint Commission on the Accreditation of Hospitals (JCAH) describes Dietetic Services as food service management for nutritional aspects of patient care, requiring supervision by a dietitian who may or may not be qualified by the private credential "Registered Dietitian." The Manual identifies explicit and extensive supervison requirements, inservice training, and institutional policies and procedures for the practice of dietetics. These requirements may be found in Appendix 5.

A 1985 "Survey of Consulting Nutritionists in the Metro Area" (Metropolitan Northern Virginia) provided by the Virginia Dietetic Association (Appendix 6) reported that 50 percent of "consulting dietitians" in private practice have contracts with physicians and that the main source of all referrals are physicians. The survey also indicated that 17 of 24 consulting dietitians practice within hospital or physician offices. It is important to note that the language of the report uses the titles "consulting nutritionist" and "consulting dietitian" interchangeably, reflecting the difficulty in distinctly defining these practices. The survey also showed that most dietitians surveyed did not have specialty practices. Among the respondents to the informal survey conducted by the Council, most indicated that they have received referrals from physicians, and/or have referred clients to physicians.

From this evidence the Council concluded that in many private practice settings the functions and responsibilities of dietitians are monitored or supervised by referring physicians, other licensed health professionals, or health care institutions.

Of concern to the Commonwealth is the growth of noninstitutional dietary and nutrition services, including weight control, wellness, and fitness businesses. An ADA "Dietetic Manpower Demand Survey" (1979-1981), showed demand increasing only slightly for dietetic workers in hospitals, and decreasing for workers in some other institutional settings such as education. With increased public demand for health, fitness, nutrition, and dietary services, as noted in HJR 150, and the growth of advertising and direct marketing of these services to the public, some practitioners may not operate these services with sufficient professional training and judgement or with appropriate medical supervision to protect the public from harm.

The Council determined that there may be need for increased public disclosure of information regarding the expertise and training of practitioners and the claims of dietary and nutrition treatments and services, to assist the public to make informed choices in seeking and selecting dietary and nutrition services. Public disclosure is especially needed as new research unfolds, present professional opinion is challenged, and new findings from research as well as popular trends are discussed in the media.

Virginia statutes protect the public from misrepresentation of services and fraud, and include requirements for disclosure of information about products, procedures, and professional services. The Virginia Consumer Protection Act (Code of Virginia, Sec. 59.1-196 to 207), most recently amended in 1986, prohibits the fraudulent representation of goods and services with respect to sponsorship, approval and certification, characteristics and

quality, uses, and benefits. The Act also maintains requirements for disclosure of information to the public, and for the full reporting of policies and procedures relative to refunds or other forms of redress for dissatisfied consumers. If a need can be reliably documented for increased public disclosure of information related to dietary and nutrition services and practice conducted either in supervised or unsupervised settings, attention should be directed to the provisions of the Consumer Protection Act.. The adoption of state occupational regulatory programs represents an overly restrictive approach to meeting the public need for consumer information.

Least Restrictive/Cost-Effective Public Protection

The potential economic impact of regulation is closely related to any possible alternatives to regulation. In economic theory regulation is defensible only when the resulting benefits in public protection substantially outweigh the costs of such regulation .

A prominent feature of the marketplace of dietary and nutrition services is the tremendous volume of information available, through bookstores, libraries, health food stores, grocery stores, magazines, newspapers, television, and by word of mouth. This may be a major source of poor or harmful advice, and a large source of the risk for harm that regulation would be designed to manage. The Council recognizes, however, that free speech rights protect the production, availability, and dissemination of this information. Therefore, health occupational regulation would not prevent this production and distribution of information.

Enforcement of consumer protection laws, however, should effectively protect the public from fraudulent representation of dietary and nutrition products and services in speech, advertising, and dissemination of information. An example of the effectiveness of this type of consumer protection against fraud in dietary and nutrition services is presented in Appendix 7. Also, enforcement of laws against the illegal practice of medicine should protect the public from tangible harm at the hands of licensed providers of health services as complaints are filed and fraudulent practitioners are removed from practice.

In its search to identify alternative forms of public protection the Council also reviewed the recommendations of the U.S. Congressional Subcommittee on Health and Long-Term Care of the House of Representatives Select Committee on Aging, in its 1984 report on quackery. Recommendations were made to Congress, the Department of Health and Human Services, the Food and Drug Administration, the Federal Trade Commission, the Department of Justice, and the states. In no case was state occupational regulation of dietitians and/or nutritionists recommended. Fraud in selling dietary-related remedies and supplements, as observed in HJR 150, constitutes a large portion of the quackery investigated.

Specific recommendations to the states included (1) the strengthening of medical practice statutes, and clarifying language describing the unlawful practice of medicine; (2) requiring the use and review of informed consent procedures for patients, when nonstandard treatments or diagnostic procedures are used; (3) adopting statutes establishing criminal sanctions for quackery; and (4) establishing liaison with Federal agencies to keep states advised of

new actions and findings in the area of quackery. Generally, these recommendations seek to expand the availability of information to the public in order to facilitate informed choice in seeking and selecting practitioners and services, rather than to restrict entry to dietary and nutrition practice. It is important to note that the report refers to private agency efforts, such as Better Business Bureaus and consumer advocacy organizations, as being "among the most effective and determined" programs for protecting the public. Selections from the report may be found in Appendix 8.

In its review, the Council discovered that agencies of the government of the Commonwealth are aware of their responsibilities for protecting the public from harm at the hands of persons offering dietary and nutrition services. The Board of Medicine is currently proposing regulations to prevent the use of treatments of no known therapeutic value and to require informed consent from patients treated by use of experimental or nonorthodox procedures. Also, the General Assembly in 1986 strengthened the provisions of the Consumer Protection Act affecting business practices.

Private associations of dietitians and nutritionists, such as the Virginia Dietetic Association, have conducted programs of consumer education to improve public awareness of dietary and nutrition-related conditions, good nutrition habits, and ways to avoid fraudulent practitioners. For example, chapters of the VDA have sponsored "Dial-a-Dietitian" services to increase consumer access to information about dietary concerns.

The identification of these and other alternatives to regulation supports the Council's finding that alternatives to the regulation of dietitians and nutritionists that will protect the public do exist, and that the potential economic impact of regulation on the public is not justified.

The Council respectfully submits that, in the present case, enforcement of existing or strengthened consumer protection laws, rules regarding public disclosure, and mechanisms for consumer redress for documented harm, and programs of consumer education, are feasible alternatives to state regulation of dietitians and nutritionists.

PART IV: SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Council on Health Regulatory Boards makes the following findings and recommendations based on its study of the need to regulate dietitians and nutritionists.

1. The Council finds, using its formal criteria for evaluating the need to regulate a health occupation, that there is currently no need for state regulation of dietitians and/or nutritionists in Virginia, and recommends that no regulation be implemented by the General Assembly at this time.

2. The Council finds that much dietary and nutrition information and advertising of services is available and distributed freely in the media, through many types of businesses and educational programs, as well as by dietitians and nutritionists. Much popular information is conflicting or questionable, contributing to risk for harm to the public. Appropriate disclosure of information about services is necessary for the public to make informed choices in seeking and selecting dietary and nutrition services, but occupational regulation (licensure, certification, or registration) is not the preferred means to the end of appropriate disclosure.

   The General Assembly may wish to consider amendments to the Consumer Protection Act regarding disclosure of information to consumers, perhaps by requiring that disclosure statements include the education and training of the practitioner; a description of the proposed treatment and anticipated outcomes; financial arrangements and requirements; lists of acts of unprofessional conduct; disclosure of the client's right to refuse any part of the treatment; and complete disclosure of the limits of any confidentiality provisions.

3. The Council finds that dietitians and nutritionists practice in a wide diversity of settings--from laboratories to weight control businesses--and that no single set of standards for education and training for all dietitians and nutritionists exists. Professional associations and private credentialing organizations serving dietitians and nutritionists may establish training standards and bring research findings into clinical practice. These associations and organizations should encourage the initial and continuing competence of their memberships.

4. The Council finds that existing mechanisms for reducing risk for harm to the public are working. The Office of Consumer Affairs, the State Board of Medicine, and other health regulatory boards are enforcing existing statutes and regulations that reduce risk for harm from dietitians and nutritionists. These agencies, along with Chambers of Commerce, Better Business Bureaus, and other agencies and organizations are available for the public to make inquiries and complaints regarding harm from dietitians and nutritionists.

APPENDIX 1

DEFINITIONS OF PRACTICE AND ACCREDITING ORGANIZATIONS FOR DIETARY MANAGERS, DIETETIC TECHNICIANS, DIETITIANS, AND NUTRITIONISTS, A SOURCEBOOK ON HEALTH OCCUPATIONS, 1985, NATIONAL COMMISSION FOR HEALTH CERTIFYING AGENCIES

DIETARY MANAGER

Responsible for the safe, effective management of food services for institutional patients and clients, the dietary manager is an experienced generalist capable of assuming responsibility for all aspects of food service operations other than the clinical and business aspects. Gathers, documents and files nutritional data of patients, provides nutritional education, hires and supervises food facility personnel, and is largely responsible for such food operations management functions as: food material and production management, nutritional sciences utilization, and food facility personnel development.

Accreditation:

CERTIFYING BOARD FOR DIETARY MANAGERS
4410 West Roosevelt Road
Hillside, IL 60162

Contact: Jean S. Denwood
Executive Director
(312) 449-2770
(800) 323-1908

Certification:

CERTIFYING BOARD FOR DIETARY MANAGERS
(See above)

* education
* experience
* examination

Contact: Jean S. Denwood
Executive Director
(312) 449-2770
(800) 323-1908

Association:

DIETARY MANAGERS ASSOCIATION
(See above)

Contact: Jean S. Denwood
(312) 449-2770
(800) 323-1908

DIETETIC TECHNICIAN

Provides services in assigned areas of food service management and nutritional care to individuals or groups in hospitals, nursing homes, in-school lunch programs and other facilities providing assistance in areas of menu planning, production schedules, receiving and storing of food supplies, and processing of dietary orders. The dietetic technician obtains and evaluates dietary histories of individuals in planning nutritional programs. Provides dietary counseling under direction and supervision of a dietitian.

Accreditation:

COMMISSION ON ACCREDITATION OF THE
AMERICAN DIETETIC ASSOCIATION
430 North Michigan Avenue
Chicago, IL 60611

Contact: Philip Lesser
(312) 280-5000

Certification:

COMMISSION ON DIETETIC REGISTRATION **
AMERICAN DIETETIC ASSOCIATION
(See above

* education
* experience
* examination

Contact: Patricia Babjak
(312) 280-5102

Association:

AMERICAN DIETETIC ASSOCIATION
(See above)

Contact: James Breeling
(312) 280-5000

DIETARY MANAGERS ASSOCIATION
4410 West Roosevelt Road
Hillside, IL 60162

Contact: Jean S. Denwood
(312) 449-2770

** NCHCA Member

DIETITIAN

Applies the principles of nutrition and management in administering institutional food service programs; plans special diets at physician's request and instructs individuals and groups in the application of nutrition principles in the selection of food. May function as administrative, clinical, community, educator or research dietitian.

Accreditation:

COMMISSION ON ACCREDITATION OF THE
AMERICAN DIETETIC ASSOCIATION
430 North Michigan Avenue
Chicago, IL 60611

Contact: Philip Lesser
Administrator
(312) 280-5000

Certification:

COMMISSION ON DIETETIC REGISTRATION **
AMERICAN DIETETIC ASSOCIATION
(See above)

* education
* experience
* examination (written)

Contact: Patricia Babjak
Executive Director
(312) 280-5102

Association:

AMERICAN DIETETIC ASSOCIATION
(See above)

Contact: James Breeling
Executive Director
(312) 280-5000

AMERICAN SOCIETY FOR PARENTERAL
AND ENTERAL NUTRITION
1025 Vermont Avenue, N.W.
Washington, D.C. 20005

Contact: Barney Sellers
Executive Director
(202) 638-5881

** NCHCA Member

NUTRITIONIST

A general title for health professionals concerned with food science and human nutrition. Adapts and applies food and nutrient information to the solution of food problems, the control of disease, and the promotion of health. Performs nutrition research, instructs groups and individuals about nutritional requirements, and assists individuals in developing dietary patterns to meet their nutritional needs.

Accreditation:

N/K

Certification:

AMERICAN COUNCIL OF APPLIED
CLINICAL NUTRITION
P.O. Box 28224
St. Louis, MO 63132

Contact: Clarence T. Smith, Ph.D.
President
(314) 291-5466

* education
* examination (written)

Association:

SOCIETY FOR NUTRITION EDUCATION
1736 Franklin Street
Oakland, CA 94612

Contact: Sara Berkowitz
(415) 444-7133

APPENDIX 2

INSTRUCTIONAL PROGRAMS FOR DIETITIANS AND NUTRITIONISTS,
A CLASSIFICATION OF INSTRUCTIONAL PROGRAMS, 1985,
NATIONAL CENTER FOR EDUCATION STATISTICS

19.05 ***Food Sciences and Human Nutrition.*** A group of instructional programs that describe the role of food and nutrition in personal and family living, and in commercial and institutional food services, with emphasis being placed on food handling techniques, purchase and storage of food, planning, preparing, and serving meals to meet the needs of individuals and families.

19.0501 *Food Sciences and Human Nutrition, General.* An instructional program that generally describes the role of food and nutrition in personal and family living, and in commercial and institutional food services, with emphasis being placed on food handling techniques, purchase and storage of food, planning, preparing, and serving meals to meet the needs of individuals and families.

19.0502 *Food/Food Sciences.* An instructional program that describes food properties during processing, storage, marketing, and use.

19.0503 *Dietetics/Human Nutritional Services.* An instructional program that describes the translation of the science of nutrition into practical solutions for the dietary needs of people and the preparation of professionals to deal with the role of nutrition in human health and the vitality of individuals.

19.0504 *Human Nutrition.* An instructional program that describes the physical and biological sciences as applied to human nutrition.

19.0599 *Food Sciences and Human Nutrition, Other.* Any instructional program in food sciences and human nutrition not described above.

20.01 ***Consumer and Homemaking Home Economics.*** A group of instructional programs that prepare individuals at all educational levels for the occupation of homemaking, emphasizing the acquisition of knowledge and the development of understanding attitudes, standards, values, and skills relevant to individual and family life, Includes instruction in consumer education, food and nutrition, family living and parenthood education, child growth and development, housing and home management (including resource management), and clothing and textiles; that emphasize the improvement of the home, the quality of individual and family life, and enhance potential employability. These programs prepare individuals for the multiple roles of homemaker and wage earner.

20.0108 *Food and Nutrition.* An instructional program that prepares individuals to understand the principles of nutrition; the relationship of nutrition to health and well-being; the selection, preparation, and care of food; meal management to meet individual and family food needs and patterns of living; good economics and ecology; and optimal use of the food dollar.

Food Production, Management, and Services. A group of instructional programs that prepare individuals in managerial, production, and service skills used in institutional, commercial, or self-owned food establishments or other food industry occupations. Includes instruction in planning, selecting, storing, purchasing, preparing, and serving quantity food and food products; nutritive values; safety and sanitation precautions; use and care of commercial equipment; serving techniques; special diets; and management of food establishments.

20.0401 *Food Production, Management, and Services, General.* An instructional program that generally prepares individuals in managerial, production, and service skills used in institutional, commercial, or self-owned food establishments or other food industry occupations. Includes instruction in planning, selecting, storing, purchasing, preparing, and serving quantity food and food products; nutritive values; safety and sanitation precautions; use and care of commercial equipment; serving techniques; special diets; and management of food establishments.

20.0402 *Baking.* An instructional program that prepares individuals to engage in the preparation of bakery food products for use in commercial food establishments, for retail distribution, or for special functions. Includes instruction in making, freezing, and handling baked products, decorating, counter display; and service and packaging of bakery products.

20.0403 *Chef/Cook.* An instructional program that prepares individuals to engage in the preparation and cooking of a variety of foods to main nutritive values and quality control. Instruction is given in the determination of quantity of food to be prepared and the size of servings for different types of foodservices; the use and care of commercial equipment; adherence to sanitation procedures for storage, preparation, and service of foods; the observation of health, safety, and sanitary precautions in the cooking areas; and the use of equipment or utensils.

20.0404 *Dietetic Aide/Assisting.* An instructional program that prepares individuals to utilize nutritional knowledge in preparing and serving meals to individuals with specific dietary needs under the direction of a professional dietitian. Includes instruction in selecting and using specific pieces of equipment for particular tasks in food preparation and services; preparing and serving simple foods according to diet instruction; examining assembled trays for conformance with diet regulations and nutritional values; handling foods, beverages, equipment, utensils, and table settings in order to prevent contamination; observing safety and sanitary standards and regulations; following appropriate emergency procedures; and assisting in the management of dietary facilities. Programs prepare dietetic aides to work under the direction of an assistant and a professional dietitian in performing the less complicated dietetic tasks; programs prepare dietetic assistants to work under the direction of a professional dietitian.

20.0405 *Food Catering.* An instructional program that prepares individuals to engage in booking, planning, and managing the preparation and service of food for special occasions. Includes instruction in arranging for equipment, tables, space, decorations, and entertainment, and for transportation of food and equipment; supervising cleanup; assisting in taking inventories; storing food and supplies; observing safety precautions; and following food handling procedures as specified by health and sanitation regulations. Programs prepare individuals both as food caterers, who perform managerial tasks and are recognized as experts in specialty food preparation and products, and as food-caterer aides, who work under the direction of food caterers.

20.0406 *Food Service.* An instructional program that prepares individuals to select, purchase, prepare, or produce food in quantities; preserve nutritive value of foods; follow standard recipes for quality control; prepare and serve quantity foods; receive, store, and issue foods and supplies; select and use commercial equipment for production and services; observe safety precautions and sanitation regulations; store and handle food and equipment; clean food preparation and service areas; take inventories; and work in or manage food-service establishments.

20.0407 *Food Testing.* An instructional program that prepares individuals to select and correctly use proper tools and equipment for specified food tests, usually under the direction of food scientists, technicians or home economists. Includes instruction in identifying qualities of various foods; collecting and testing food samples as directed; making elementary statistical calculations; recording test results; comparing test results with samples or prepared standards; reporting variations from standards to director of quality control; and checking and calibrating various testing instruments.

20.0408 *School Food Service.* An instructional program that prepares individuals for overall planning, supervising, purchasing, preparing, and serving goods and food products in school food-service establishments. Includes instruction in planning appetizing and nutritional menus suitable for school-age students; creating an enjoyable and pleasant environment for serving of foods; recording meals served and food used on a daily basis; taking inventory of supplies and equipment; assisting in cleaning school food-service facilities; and performing dishwashing tasks and storage of equipment or food according to health, safety, and sanitation regulations.

20.0499 *Food Production, Management, and Services, Other.* Any instructional program in food production, management, and services not described above.

26.0608 *Neurosciences.* An instructional program that describes the anatomy, physiology, biochemistry, and molecular biology of nerves and nervous tissues and their relation to behavior and learning.

26.0609 *Nutritional Sciences.* An instructional program that describes the science of food in relationship to human needs, the nutrients and other substances of food, and the processes by which the organism ingests, digests, absorbs, transports, utilizes, and excretes food substances.

26.0610 *Parasitology.* An instructional program that describes the structure, reproduction, development, distribution, and control of plant and animal parasites.

26.0611 *Radiobiology.* An instructional program that describes the nature and effects of radiation on organisms and biological systems.

26.0612 *Toxicology.* An instructional program that describes the nature, source, identification, and characteristics of poisons, toxic substances, and exogenous chemical agents which can cause death, illness, or injury upon contact with, or ingestion into the body, including the detection and measurement of their effects and the use of antidotes and other curatives.

26.0699 *Miscellaneous Specialized Areas, Life Sciences, Other.* Any instructional program in specialized areas of life sciences not described above.

APPENDIX 3

STATE REGULATION OF DIETITIANS
COUNCIL OF STATE GOVERNMENTS, 1986

LAWS THAT REGULATE NUTRITIONISTS
AMERICAN DIETETIC ASSOCIATION, 1986

STATE REGULATION OF DIETITIANS FROM

STATE REGULATION OF HEALTH OCCUPATIONS AND PROFESSIONS
COUNCIL OF STATE GOVERNMENTS, 1986

State	Regulation of Dietitians
Alabama	Certification
California	Certification
Georgia	Licensure
Iowa	Licensure
Louisiana	Certification
Maryland	Licensure
Montana	Certification
North Dakota	Licensure
Oklahoma	Licensure
Texas	Licensure
Puerto Rico	Licensure

Source: Health Professions Licensure Information System, December, 1984

LAWS THAT REGULATE NUTRITIONISTS

State	Year Passed	Type: M, V, T (a)	Regulates: D, N, DT(b)
AL	1984	T	D N
CA	1982	T	D
DC	1986	M	D N
GA	1984	V	D
IA	1985	M	D
LA	1982	T	D
ME	1985	T(c)	D DT
MD	1985	M	D
MS	1986	M	D N
MT	1983	T	D
ND	1985	V	D N
OK	1984	M	D
PR	1974	M	D N
TX	1983	V	D
UT	1986	V(d)	D
TOTALS:		6 4 5	15 5 1

Notes:

(a) M - Mandatory licensure (practice act): establishes a state board to protect the scope of practice and professional titles.

V - Voluntary licensure: regulates use of professional titles through a state board.

T - Title act (entitlement): protects use of professional titles.

(b) - D - dietitian N - nutritionist DT - dietetic technician

(c) - Maine's registration law is similar to a title act.

(d) - Utah's certification law is similar to voluntary licensure.

STATE ASSOCIATION GOALS: LICENSURE

Regulation Type	Current Laws (No.)	Current Goal (No.)	Totals(a) (No.	%)
Mandatory	6	29	35	69%
Voluntary	4	3	7	14%
Title	5	2	7	14%
To be determined	--	5	5	10%
None(b)	--	3	3	6%
Totals:	15	42	57(c)	113%(c)

Notes:

(a) No. of respondents to survey question = 51.

(b) A political climate not conducive to licensure was one reason given.

(c) Totals are more than 51 (100%) because some states with laws intend to strengthen them in the future.

APPENDIX 4

BIBLIOGRAPHY OF SOME RECENT ARTICLES
ON
DIETARY AND NUTRITION RESEARCH AND PRACTICE

GENERAL

"A Scientific Look at the Claims About Diets and Nutrition," Victor Herbert, MD, The Washington Post Health Magazine, 1986.

"The New Science of Hunger," Ellen Ruppel Shell, American Health, March, 1986.

"Providing Nutrient Information: In Search of Innovative Approaches," Wade Lancaster, et al., Family and Community Health, May 1986, V9/N1.

"Tougher Rules for a Healthy Heart, National Association Issues New Diet Guidelines," Sally Squires, The Washington Post Health Magazine, 1986.

"Heart Disease and Coffee, New Studies Disagree About the Dangers of Caffeine," Sally Squires, The Washington Post Health Magazine, September 16, 1986.

"Dietary Fiber," Harvard Medical School Health Letter, August 1986, V11/N10.

"How Important is Dietary Calcium in Preventing Osteoporosis?" Science, August 1, 1986, V233.

DIETARY GUIDELINES CONTROVERSY

"The Battle Over the Revisions of the Recommended Dietary Allowances," entire issue, Nutrition Today, November/December 1985, V20/N6.

"Dietary Guidelines for Cancer Prevention: The Etiology of a Confused Debate," Henrica de Vet and Flora Van Leeuwen, Nutrition and Cancer, 1986, V8/N4.

"A Member of the Dietary Guidelines Revision Committee Dissents," Frederick Stare, MD, Nutrition Today, January/February 1986, V21/N1.

"A Plea for a Scientific Rationale for Rejection of the RDA Report--1985," Dr. Henry Kamin and Dr. Frank Press, Nutrition Today, March/April 1986, V21/N2.

"Selling New Diet and Health Directions," Philip L. White, ScD, Nutrition Today, July/August 1986, V21/N4.

"Nutrient Recommendations for Man--Theory and Practice," Proceedings of the Nutrition Society, September 1986, V45/N3.

"Toward Harmonization of Dietary Biochemical and Clinical Assessments: The Meanings of Nutritional Status and Requirements," George H. Beaton, Nutrition Reviews, November 1986, V44/N11.

BUSINESS

"Losing the Battle of the Bulge," James Adams and Jeffrey Trachtenbery, Forbes, November 17, 1986.

"Girth of a Nation," Alison Thresher, Nation's Business, December 1986.

"Optimal Health for Whom?" Lisa Gubernich, Forbes, August 25, 1986.

"How Unfortunate," Frederick Stare, MD, Nutrition Today, September/October 1986, V21/N5.

"Marketing a Nutritional Revolutionary Breakthrough," Frederick Stare, MD, The New England Journal of Medicine, October 9, 1986, V315/N15.

"Role of Scientists in Marketing Firm Sparks Controversy," The Wall Street Journal, October 10, 1986.

"Scientists Get Flak Over Diet Plan," Science, November 1986, V234.

APPENDIX 5

"DIETETIC SERVICES"
FROM THE
ACCREDITATION MANUAL FOR HOSPITALS, 1987
JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS

Dietetic Services (DT)

Standard

DT.1 The dietetic department/service is organized, directed and staffed, and integrated with other units and departments/services of the hospital in a manner designed to assure the provision of optimal nutritional care and quality foodservice.*

Required Characteristics

DT.1.1 The relationship of the dietetic department/service to other units and departments/services of the hospital is either specified in the overall hospital organizational plan or described in writing elsewhere.

DT.1.2 The scope of the dietetic services provided to inpatients and, as appropriate, to ambulatory care patients and patients in a hospital-administered home care program is defined in writing.

DT.1.3 The dietetic department/service is directed on a full-time basis by an individual who, by education or specialized training and experience, is knowledgeable about foodservice management.

DT.1.3.1 The director is responsible to the chief executive officer or his designee.

DT.1.3.2 The director has the authority and responsibility for assuring that

DT.1.3.2.1 established policies are implemented;

DT.1.3.2.2 overall coordination and integration of the therapeutic and administrative aspects of dietetic services are maintained; and

DT.1.3.2.3 the quality, safety, and appropriateness of the dietetic department/service functions are monitored and evaluated and that appropriate actions based on findings are taken.*

DT.1.4 Dietetic services are provided by a sufficient number of qualified personnel under competent supervision.*

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.1.5 A qualified dietitian supervises the nutritional aspects of patient care and assures that quality nutritional care is provided to patients.*

DT.1.5.1 Qualified dietitians or qualified designees participate in committee activities concerned with nutritional care.

DT.1.5.2 When the services of a qualified dietitian are used on a part-time basis, this individual provides such services on the premises on a regularly scheduled basis.*

DT.1.5.3 The regularly scheduled visits are sufficient to provide for at least the following:

DT.1.5.3.1 Liaison with the hospital administration, medical staff, and nursing staff;

DT.1.5.3.2 Patient/family counseling as needed;

DT.1.5.3.3 Approval of menus, including modified diets;*

DT.1.5.3.4 Any required nutritional assessments;*

DT.1.5.3.5 Participation in the development of policies and procedures;

DT.1.5.3.6 Participation in continuing education programs; and

DT.1.5.3.7 Evaluation of the dietetic services provided.*

DT.1.5.4 When a qualified dietitian serves only in a consultant status, this individual regularly submits written reports to the chief executive officer concerning the extent of services provided.*

DT.1.5.5 When dietetic services are provided by an outside food management company, the company complies with all applicable requirements of this *Manual*, and the contract specifies the compliance requirements.*

Standard

DT.2 Dietetic services personnel are prepared to conduct their assigned responsibilities through appropriate orientation, education, and training.

Required Characteristics

DT.2.1 The education, training, and experience of personnel who provide dietetic services are documented and are related to each individual's level of participation in the provision of dietetic services.

DT.2.1.1 A formal training program may be required as a prerequisite to employment.

DT.2.2 New personnel receive an orientation of sufficient duration and substance before providing dietetic services without direct supervision.

DT.2.2.1 The orientation is documented.

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.2.3 As appropriate to their level of responsibility, new personnel receive instruction and demonstrate competence in the following:

DT.2.3.1 Personal hygiene and infection control;

DT.2.3.2 The proper inspection, handling, preparation, serving, and storing of food;

DT.2.3.3 The proper cleaning and safe operation of equipment;

DT.2.3.4 General foodservice sanitation and safety;

DT.2.3.5 The proper method of waste disposal;

DT.2.3.6 Portion control;

DT.2.3.7 The writing of modified diets using the diet manual/handbook;

DT.2.3.8 Diet instruction; and

DT.2.3.9 The recording of pertinent dietetic information in the patient's medical record.

DT.2.4 Dietetic services personnel participate in relevant in-service education programs.

DT.2.4.1 Personnel from all work shifts participate.

DT.2.5 The director of the dietetic department/service or qualified designee participates in planning and conducting in-service education for dietetic personnel and, as appropriate, for other hospital personnel.

DT.2.5.1 In-service education includes safety and infection control requirements described elsewhere in this *Manual.*

DT.2.5.2 Outside educational opportunities are provided as feasible, at least for supervisory dietetic personnel.

DT.2.6 The extent of participation of dietetic personnel in continuing education is realistically related to the size of the staff and the scope and complexity of the dietetic services provided.

DT.2.6.1 Participation in continuing education is documented.

DT.2.6.2 Education programs for dietetic services personnel are based, at least in part, on the results of dietetic department/service evaluations.

DT.2.7 The training of dietetic students and dietetic interns is conducted only in programs accredited by the appropriate professional educational organization.

DT.2.7.1 Individuals in student status are directly supervised by a qualified dietitian when engaged in patient care activities.

DT.2.7.2 When the hospital provides clinical facilities for the education and training of dietetic students from an outside program, the respective roles and responsibilities of the dietetic department/service and the outside educational program are defined in writing.

Standard

DT.3 Written policies and procedures specify the provision of dietetic services.*

Required Characteristics

DT.3.1 There are written policies and procedures concerning the scope and conduct of dietetic services.

DT.3.1.1 Administrative policies and procedures concerning food procurement, preparation, and service are developed by the director of the dietetic department/ service.

DT.3.1.2 Nutritional care policies and procedures are developed by a qualified dietitian.

DT.3.1.2.1 When appropriate, concurrence or approval should be obtained from the medical staff through its designated mechanism and from the nursing department/service.

DT.3.2 Policies and procedures are subjected to timely review, revised as necessary, dated, and enforced.

DT.3.3 The policies and procedures relate to at least the following:

DT.3.3.1 The responsibilities and authority of the director of the dietetic department/service and, when the director is not a qualified dietitian, the qualified dietitian.

DT.3.3.2 Food purchasing, storage, inventory, preparation, and service.

DT.3.3.3 Diet orders, which are recorded in the patient's medical record by an authorized individual before the diet is served to the patient.

DT.3.3.4 The proper use of and adherence to standards for nutritional care, as specified in the diet manual/handbook.

DT.3.3.5 Nutritional assessment and counseling, and diet instruction.

DT.3.3.6 Menus.

DT.3.3.7 The role, as appropriate, of the dietetic department/service in the preparation, storage, distribution, and administration of enteric tube feedings and total parenteral nutrition programs.

DT.3.3.8 Alterations in diets or diet schedules, including the provision of foodservice to persons who do not receive the regular meal service.

DT.3.3.9 Ancillary dietetic services, as appropriate, including food storage and kitchens on patient care units, formula supply, cafeterias, vending operations, and ice making.

DT.3.3.10 An identification system designed to assure that each patient receives the appropriate diet as ordered.

DT.3.3.11 Personal hygiene and health of dietetic personnel.

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.3.3.12 Infection control measures to minimize the possibility of contamination and transfer of infection.*

DT.3.3.12.1 These measures include

DT.3.3.12.1.1 the establishment of a monitoring procedure to assure that dietetic personnel are free from infections and open skin lesions;

DT.3.3.12.1.2 the establishment of sanitation procedures for the cleaning and maintenance of equipment and work areas; and

DT.3.3.12.1.3 the washing and storage of utensils and dishes.

DT.3.3.13 Pertinent safety practices, including the control of electrical, flammable, mechanical, and, as appropriate, radiation hazards.*

DT.3.3.14 Compliance with applicable law and regulation.*

DT.3.4 The role of the dietetic department/service in the hospital's internal and external disaster plans is clearly defined.

DT.3.4.1 The dietetic department/service is able to meet the nutritional needs of patients and staff during a disaster, consistent with the capabilities of the hospital and community served.

DT.3.4.2 For requirements of the hospital's disaster plans, refer to the "Plant, Technology, and Safety Management" chapter of this *Manual.*

DT.3.5 A qualified dietitian develops or adopts a diet manual/handbook in cooperation with representatives of the medical staff and with other appropriate dietetic staff.*

DT.3.5.1 The standards for nutritional care specified in the diet manual/ handbook should be at least in accordance with those of the *Recommended Dietary Allowances* (1980) of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences.

DT.3.5.2 The nutritional deficiencies of any diet that is not in compliance with the recommended dietary allowances are specified.

DT.3.5.3 The diet manual/handbook serves as a guide to ordering diets, and the served menus should be consistent with the requirements in the diet manual/ handbook.

DT.3.5.4 The diet manual/handbook is reviewed annually and revised as necessary by a qualified dietitian, dated to identify the review and any revisions made, and approved by the medical staff through its designated mechanism.

DT.3.5.5 A copy of the diet manual/handbook is located in each patient care unit.

DT.3.5.6 All master menus and modified diets are approved by a qualified dietitian.*

DT.3.6 Current reference material is available to all dietetic personnel and is conveniently located.

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Standard

DT.4 The dietetic department/service is designed and equipped to facilitate the safe, sanitary, and timely provision of foodservice to meet the nutritional needs of patients.*

Required Characteristics

DT.4.1 Sufficient space and equipment is provided for the dietetic department/service to accomplish the following:

DT.4.1.1 Store food and nonfood supplies under sanitary and secure conditions.

DT.4.1.2 Store food separately from nonfood supplies.

DT.4.1.2.1 When storage facilities are limited, paper products may be stored with food supplies.

DT.4.1.3 Prepare and distribute food, including modified diets.

DT.4.1.4 Clean and sanitize utensils and dishes apart from food preparation areas.

DT.4.1.5 Allow supportive personnel to perform their duties.

DT.4.2 The facilities and equipment of the dietetic department/service are in compliance with applicable sanitation and safety law and regulation.*

DT.4.3 The following sanitation precautions are taken in the handling and preparation of food:*

DT.4.3.1 Food is protected from contamination and spoilage.*

DT.4.3.2 Foods are stored at proper temperatures, utilizing appropriate thermometers and maintaining temperature records.

DT.4.3.3 Lighting, ventilation, and humidity are controlled to prevent the condensation of moisture and growth of molds.

DT.4.3.4 Methods to prevent contamination are used for making, storing, and dispensing ice.

DT.4.3.5 Separate cutting boards are provided for meat, poultry, fish, and raw fruits and vegetables.

DT.4.3.5.1 Cooked foods should not be cut on the same boards used for preparing raw food.

DT.4.3.5.2 Separate cutting boards may not be required when there are boards in use that are nonabsorbent and can be cleaned and sanitized adequately, and when the cleaning and sanitizing procedure is performed properly between usage for different food categories.

DT.4.3.6 All working surfaces, utensils, and equipment are cleansed thoroughly and sanitized after each period of use.

DT.4.3.7 Adequate hand-washing and hand-drying facilities are conveniently located throughout the department/service.

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.4.3.8 Dishwashing and utensil-washing equipment and techniques that result in sanitized serviceware and that prevent recontamination are used.

DT.4.3.9 Plasticware, china, and glassware that have lost their glaze or are chipped or cracked are discarded.

DT.4.3.10 Disposable containers and utensils are discarded after one use.

DT.4.3.11 Traffic of unauthorized individuals through food preparation and service areas is controlled.

DT.4.3.12 Garbage is held, transferred, and disposed of in a manner that does not create a nuisance or a breeding place for insects, rodents, and vermin or otherwise permit the transmission of disease.*

DT.4.3.12.1. Garbage containers are leakproof and nonabsorbent with close-fitting covers.

DT.4.3.12.1.1 The use of impervious plastic liners is desirable.

DT.4.4 The following safety precautions are implemented:

DT.4.4.1 Walk-in refrigerators and freezers can be opened from the inside.

DT.4.4.2 Insulation or protection from hot-water and cold-water pipes, water heaters, refrigerator compressors, condensing units, and heat-producing equipment is provided.

DT.4.4.3 Food and nonfood supplies are clearly labeled.

DT.4.4.4 A review is conducted of the hospital's preventive and corrective maintenance and safety programs as they relate to the dietetic department/service.*

DT.4.4.4.1 Actions are taken based on the findings of the review.*

DT.4.4.4.2 The review and actions taken are documented.*

DT.4.4.5 All food is procured from sources that process food under regulated quality and sanitation controls.

DT.4.4.5.1 The use of local produce is not precluded.

Standard

DT.5 Dietetic services are provided in accordance with a written order by the individual responsible for the patient, and appropriate dietetic information is recorded in the patient's medical record.

Required Characteristics

DT.5.1 The qualified dietitian or authorized designee enters dietetic information into the medical record as specified, and in the location determined, by those performing the medical record review function.

DT.5.1.1 These determinations are made by the medical record committee when one exists.

The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.5.2 At the request of the appropriate medical staff member, the qualified dietitian or authorized designee documents appropriate nutritional information in the medical record.

DT.5.2.1 Such documentation may include the following:

DT.5.2.1.1 A summary of the dietary history and/or nutritional assessment when the past dietary pattern is known to have a bearing on the patient's condition or treatment;

DT.5.2.1.2 Timely and periodic assessments of the patient's nutrient intake and tolerance to the prescribed diet modification, including the effect of the patient's appetite and food habits on food intake and any substitutions made;

DT.5.2.1.3 A description of the diet instructions given to the patient or family and an assessment of their diet knowledge; and

DT.5.2.1.4 A description or copy of the diet information forwarded to another institution when a patient is discharged.

DT.5.2.1.4.1 If nutritional care follow-up reverts to the practitioner's office practice or a health care agency, this should be noted in the patient's medical record.

DT.5.3 Within 24 hours of admission and within 24 hours after any subsequent orders for diet modification, the diet order is confirmed by the practitioner responsible for the patient receiving oral alimentation;

Standard

DT.6 Appropriate quality control mechanisms are established.*

Required Characteristics

DT.6.1 At least the following quality control mechanisms are implemented:*

DT.6.1.1 All menus are evaluated for nutritional adequacy.

DT.6.1.2 There is a means of identifying patients who are not receiving oral intake.

DT.6.1.3 Special diets are monitored.

DT.6.1.4 Not more than 15 hours elapse between the serving of the evening meal and the next substantial meal for patients who are on oral intake and do not have specific dietary requirements.

DT.6.1.5 As appropriate, the nutrient intake of patients is assessed and recorded.

DT.6.1.6 As appropriate, patients with special dietary needs receive instructions relative to their diets, and an indication of the patient's (or family's) understanding of these instructions is recorded in the patient's medical record.

DT.6.1.7 As appropriate, patients who are discharged from the hospital on modified diets receive written instructions and individualized counseling before discharge.

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.6.1.8 Before discharge, patients are given instructions about and are counseled on potential drug-food interactions.

DT.6.1.9 A maximum effort is made to assure an appetizing appearance, palatability, proper serving temperature, and retention of the nutrient value of food.

DT.6.1.9.1 Whenever possible, patient food preferences are respected and appropriate dietary substitutions are made available.

DT.6.1.9.2 Surveys to determine patient acceptance of food are encouraged, particularly in the case of long-stay patients.

Standard

DT.7 As part of the hospital's quality assurance program, the quality and appropriateness of patient care services provided by the dietetic department/service are monitored and evaluated, and identified problems are resolved.*

Required Characteristics

DT.7.1 The dietetic department/service has a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care services and for resolving identified problems.*

DT.7.1.1 The director of the dietetic department/service, with medical and nursing participation, is responsible for assuring that the process is implemented.*

DT.7.2 The quality and appropriateness of patient care services are monitored and evaluated in all major functions of the dietetic department/service.*

DT.7.2.1 Such monitoring and evaluation are accomplished through the following means:

DT.7.2.1.1 Routine collection in the dietetic department/service, or through the hospital's quality assurance program, of information about important aspects of dietetic services;* and

DT.7.2.1.2 Periodic assessment by the dietetic department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care.*

DT.7.2.1.2.1 In DT.7.2.1.1 and DT.7.2.1.2, the dietetic department/service agrees on objective criteria that reflect current knowledge and clinical experience.*

DT.7.2.1.2.1.1 These criteria are used by the dietetic department/service or by the hospital's quality assurance program in the monitoring and evaluation of patient care services.*

DT.7.3 When important problems in patient care services or opportunities to improve care are identified,

DT.7.3.1 actions are taken;* and

DT.7.3.2 the effectiveness of the actions taken is evaluated.*

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

DT.7.4 The findings from and conclusions of the monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported.*

DT.7.5 The actions taken to resolve problems and improve patient care services, and information about the impact of the actions taken, are documented and, as appropriate, are reported.*

DT.7.6 As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the dietetic department/service is evaluated.*

DT.7.7 When an outside source(s) provides dietetic services, or when there is no designated dietetic department/service, the quality and appropriateness of patient care services provided are monitored and evaluated, and identified problems are resolved.*

DT.7.7.1 The chief executive officer is responsible for assuring that a planned and systematic process for such monitoring, evaluation, and problem-solving activities is implemented.*

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

Note: For other standards related to dietetic services, refer to the following chapters of this *Manual*: "Home Care Services," "Infection Control," "Medical Record Services," "Pharmaceutical Services," "Plant, Technology, and Safety Management," and "Quality Assurance."

APPENDIX 6

SURVEY OF CONSULTING NUTRITIONISTS IN THE METRO AREA, 1985
SUBMISSION OF THE VIRGINIA DIETETIC ASSOCIATION
JUNE 12, 1986

1985

SURVEY OF CONSULTING NUTRITIONISTS IN THE METRO AREA

24 Consulting dietitians in private practice participated in this survey. Only 4 had been in practice more than 5 years and only 5 claim to have a full time private practice. 12 of the 19 part-time pratitioners said they would be interested in a full-time business if they could earn a "full-time" salary.

1. Clients are counseled in a variety of settings: 7 counsel in their homes only, 8 only in physician's offices, 6 both at home and in a physician's office, 3 have offices within hospitals and some CNs will go to a client's home for a higher fee.

2. 50% of the CNs have contracts with physicians. Arrangements range from flat out rental space, paying physician a % (25-33%) of fees collected, having free space, being paid as a hospital employee receiving a fee for a specific service.

3. All see individual clients. 6 offer group classes (3 thru hospitals) and 5 are considering developing group classes for weight control.

4. Main source of referrals is the physician, then word of mouth from other clients, followed by referrals from other CNs.

5. Advertising is generally disappointing with only 1 report of satisfaction with a yellow pages add. Other forms of advertising were listings in the Physician's Directory and the sending of announcements. Articles in the newspapers always result in at least temporary increases in clients.

6. 18 have answering machines or services and the rest report they are planning to purchase one.

7. 13 provide nutritional analysis, some routinely, and 7 have their own compute Average fee for a nutritional analysis is reported at $15.

8. 10 report that at least some of their clients have attmpted to obtain third party reimbursement. Few report success and all would like more information about working with the insurance system.

9. 7 require a physician's prescription before seeing a client. 2 require prescriptions for most clinical diets, but do send follow-up letters to the physician, 10 do not require a prescription, but all stated that a prescription would be required in complex cases or specific situations.

10. 16 use educational materials published by service organizations as well as those developed personally, 6 used only materials published by others and 2 used only their own. Everyone states that they individualize materials for the client.

11. Most are generalists, but some have specialities: diabetes (4), pediatrics (2 hypertension, obesity, cardiology, health promotion and general physical hand caps (all 1 each).

12. Fees vary greatly. Initial visits range from $15-$50 with most at $30 (6) and $40 (6) for a one hour visit. Follow-ups range from $15 to $30. Charges for computerized diet analysis range from $10 to $15 with some CNs charging fees for research and special projects ($15-$20 per hour)

APPENDIX 7

ACTION OF A CONSUMER AFFAIRS OFFICE
THE WASHINGTON POST, NOVEMBER 14, 1986

Weight-Loss Company to Alter Ads

Agreement Is Reached With Montgomery Consumer Office

By Chris Spolar
Washington Post Staff Writer

A national weight-loss firm with eight locations in the Washington area is revamping advertising claims that clients can achieve "fast, easy weight loss." The changes are a result of an agreement with the Montgomery County Office of Consumer Affairs.

Physicians Weight Loss Centers, which operates three centers in Montgomery and five in Arlington, Fairfax and Prince George's counties and Alexandria, agreed to the change after the consumer office investigated the firm's advertisements and sales practices.

According to the agreement, Physicians Weight Loss Centers in the Washington area also will not use the term "physicians" unless it discloses that centers here are not operated by medical doctors. Phrases such as "medically proven maintenance programs," "medical team" and "patient" also will not be allowed in ads, according to the agreement.

In addition, the centers cannot claim "quick," "easy" or "fast" weight loss or that clients will lose three to seven pounds a week under the program. A company spokesman said yesterday that the centers instead will emphasize "effective weight loss" and say that clients "may lose three to four pounds a week."

"Although no centers in Montgomery County are owned or operated by doctors, we've never received an official complaint," said Cliff Kocian, executive vice president of the weight-loss company.

According to company records, 30 of 220 Physicians Weight Loss Centers around the country are owned or operated by physicians. About 20,000 clients visit the centers weekly, a company spokeman said.

Susan Cohen, a Montgomery County consumer affairs staff member, conducted the investigation over 10 months by collecting advertisements and visiting centers in the area. She began the investigation, she said, "because I know billions of dollars are being spent by people on weight-loss programs .... You can't really guarantee anybody's weight loss."

During one point in the investigation, Cohen said she sent an office intern to two centers. The young woman, who was 5-foot-7 and weighed 125 pounds, was told by personnel at one center that she needed to lose 12 pounds. At another center, the woman was told she needed to lose seven pounds, Cohen said.

Cohen said she sent the woman to a doctor for a checkup and weight evaluation. There, she was told she didn't need to lose any weight, Cohen said.

"You don't get complaints about these kind of things. You don't get complaints about dating services or weight-loss centers. People are too embarrassed to complain," Cohen said.

APPENDIX 8

STATE AND LOCAL GOVERNMENT, AND
PRIVATE ENFORCEMENT ACTIVITIES,
AND
"RECOMMENDATIONS TO THE STATES"
FROM THE U.S. CONGRESSIONAL REPORT ON QUACKERY, 1984

98th Congress, 2d Session House Document 98-262

QUACKERY
A $10 BILLION SCANDAL

A REPORT
BY
THE CHAIRMAN
OF THE
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE
SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES
NINETY-EIGHTH CONGRESS
SECOND SESSION

MAY 31, 1984

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APPENDIXES

E. State Enforcement Activities

STATE ATTORNEYS GENERAL

Primary responsibility for controlling quackery and health fraud on the state level resides with the State's Attorney General. The Committee attempted to assess these activities by a questionnaire sent to the Attorneys General of the fifty states, Puerto Rico and the District of Columbia. These questionnaires were followed up with telephone surveys.

Consumer protection activities reported by the states varied enormously. Resources dedicated to consumer protection ranged from 1.5% of the attorney general's budget in North Carolina to 16.5% in Maryland. Consumer fraud efforts measured in FTEs ranged from 1 FTE (Delaware) to 106 (Illinois).

Despite these differences in efforts directed at controlling quackery and other consumer frauds, the Attorney General's perception of the problem was nearly unanimous. Every state but one, Pennsylvania, reported a significant increase in consumer fraud complaints in the four-year period surveyed. Nine states reported complaints had more than doubled in the four-year period. Illinois reported the most complaints (30,000) and Puerto Rico the fewest (105).

The Attorneys General reported the overwhelming majority of their cases were generated from consumer complaints. The majority said they spent less than half their time in proactive investigations. In fact, no source other than consumer complaints generated more than 15% of the total complaints in any state.

About two-thirds of the Attorneys General reported their offices' investigations concluded 51% or more of the complaints received were valid. The vast majority of these cases were settled informally.

More than two-thirds of the states responding indicated their authority in the area of consumer protection was limited to civil remedies. Only 29 criminal convictions for consumer fraud were reported by all the states. Twenty-two of these were developed by 2 states (Florida and Wisconsin).

States reported anywhere from 10% to a third of total consumer complaints received were related to health fraud or quackery. If the overlapping category of deceptive advertising were added to these responses, the total would exceed 50% in every state.

Every State but one reported mail order fraud as a particular problem. In every state responding, more than three-fourths of all consumer fraud cases involved false advertising and mail order fraud.

Every state but one, Puerto Rico, said seniors are especially vulnerable to health frauds and reported more actual instances directed at the elderly than complaints received. Every state responding estimated the dimensions of quackery and other health frauds to be in the billions.

The response from the California Attorney General seemed to sum up the experience of most of the Attorneys General responding to the Committee's survey: "Unquestionably senior citizens are especially vulnerable to all kinds of consumer frauds," the Attorney General wrote. "Unquestionably there are many more instances of consumer fraud against the elderly than are reported. Unfortunately, state budgets do not permit substantial perusal of advertising. The victims of phony arthritis and cancer advertising seldom complain and often, desperate to find a solution to their despair, defend the worthless cures they have purchased."

STATE CONSUMER AFFAIRS OFFICES

Responses from surveys to state consumer affairs offices mirrored the reports of the Attorneys General. Every state but one reported significant increases in consumer frauds. All but one state reported more than 50% of the complaints they received were valid.

Every state reported settling the majority of complaints informally. These informal agreements were estimated to account for from 51% to 100% of all complaints received. No criminal sanctions were reported by these offices.

All of the state consumer affairs offices indicated health frauds and quackery posed a serious problem to which seniors were particularly vulnerable. Every office responding to the question measured the dimension of this problem in the billions.

STATE OFFICES ON AGING

The State Offices on Aging, as might be expected, were even more concerned about the problem of health fraud and its impact on seniors. Two thirds of the offices reported seniors were frequently victimized. All agreed seniors are particularly vulnerable to consumer frauds. A geriatric nurse practitoner in Dayton, Ohio, offered an explanation of the problem:

> I find in my work with Adult Protective Services that many of our clients are particularly trusting of people who assume a mantle of authority—ministers and evangelists, physicians, and anyone who styles himself "expert" or wears a white coat on TV or in pictures. All our clients are abused, exploited, or neglected, or at risk of such abuse, exploitation or neglect. I see those with problems involving health care needs.
>
> I find that clients choose to believe in those methods which support their own experiences—logically enough. If someone has had a bad experience with conventional medical care—has been treated by brusque professional, or undergone surgery without the optimal results, or whose perception of what was to be expected was basically unrealistic—it is likely he'll find a "magical" answer in Reverend Al or the products of Rondale Press.

When asked to rank 12 consumer frauds, quackery and the deceptive advertising associated with quackery were ranked first as the area of abuse of most concern and with the greatest impact on seniors. Every state office but one, Puerto Rico, said there were many more instances of quackery and other consumer frauds than are reported.

The Director of the New York State Office on Aging, who had asked for additional responses from all allied aging organizations

in the state, including Area Agencies on Aging, Legal Services Program Directors, Regional Ombudsmen and supervisors, expressed the consensus of the aging network on this point. "These responses indicate strong agreement that older citizens are especially vulnerable to consumer fraud," she wrote, "and that a great number of cases are never reported, possibly involving more than a billion dollars each year."

Every state office on aging responding to the question estimated quackery was a multi-billion dollar problem. One of our respondents took a longer view. "What is fraud anyway," the Director of a midwest agency asked. "Is it fraudulent that Anacin, Bufferin and Bayer all talk about "more pain reliever" or "more of the ingredient doctors recommend" without identifying that ingredient as aspirin? Many of my clients take all three of these, and also Tylenol, for relief of pain. They think they're taking different things, and that the combination will speed relief of their pain. Then they complain of upset stomach, and take some Alka Seltzer for that.

"Maybe the real fraud is the idea that we can live lives free of pain and discomfort, never smelling bad, never being less than perfect or beautiful. I think my clients are beautiful, though not perfect. But they don't. They think they are ugly, and mourn for their lost bodies, lost mobility, lost finances and lost acceptance."

F. County and Local Governmental Efforts to Control Health Frauds

COUNTY CONSUMER AFFAIRS OFFICES

The Committee surveyed a sample of county consumer affairs offices across the country. Thee offices reported a total of 119 cases of quackery and 2586 cases of deceptive advertising. They all agreed quackery posed a serious problem which particularly impacted the elderly.

The county offices reported limited targeting and proactive investigations (no more than 20% of cases). The response of a county official from Houston, Texas, was typical. "Due to limited funding," he wrote, "our local efforts are reactive in nature and they are quite limited in number. . . Although I would like to be active in the area suggested by your inquiry, the subject has no priority with our local or state funding officials to act at my level."

Like the Attorneys General and State consumer affairs offices, the county consumer affairs offices reported there were more cases than reported and that most of the cases reported were settled informally. "The elderly are ripped off and never know it," wrote a Kansas respondent, "Medical frauds are our biggest problem." In all, the county offices sampled reported 126 criminal convictions for consumer frauds.

While their enforcement activities were limited by jurisdiction and resources, the county consumer affairs offices, like the others surveyed, fixed the dimension of quackery and health frauds in the billions.

METROPOLITAN POLICE

To complete the review of the governments response to quackery and health frauds, the Committee surveyed a sample of metropolitan police departments, representing responses from the local level which validated previous findings.

Two thirds of the police departments responding said the problem was increasing. All agreed the vast majority of complaints are consumer generated. All but two said at least 75% of these complaints are valid.

With one exception, the police departments indicated the elderly are particularly susceptible to health and other consumer frauds. All but one of the respondents said that health fraud and quackery were billion dollar problems.

G. Private Efforts to Control Quackery

There are a number of private agencies involved in investigating and controlling quackery and health frauds. They range in interests and activity from the general consumer activities of agencies like the Better Business Bureau and Action Line Reporters to the more focused activities of professional associations like the American Medical Association and philanthropic associations like the Arthritis Foundation and the American Cancer Society.

Though these activities are not supported by public funds, they are among the most effective and determined adversaries of quackery and its purveyors. What follows is a brief discussion of the activities of some of these agencies in this area.

Action Line Reporters

Over 900 Action Line Reporters were surveyed by the Committee. Respondents rated quackery, health fraud and deceptive advertising as the most important and numerous of the frauds against the elderly. About two-thirds of the respondents said half the complaints they received involved the elderly.

Anna Lee Brendza, Hot Line Columinist, The *Times Reporter*, New Philadelphia, Ohio, stated the problem this way:

> In the 11 years I have been doing the Hot Line Column, I have found that senior citizens are the group most likely to be swindled and the group least likely to complain. They appear to be reluctant to let anyone (especially their adult children, neighbors and friends) know that they have been "ripped off" and they tend to keep it secret. I would estimate less than a quarter of victimized seniors ever complain about it. Most senior citizens are honest and trusting and they tend to assume, erroneously, that everybody can be trusted. Most of them grew up in an era where honesty prevailed and they are still assuming that the door to door salesman is honest, that the ad in the magazine is truthful and that nobody would defraud them.

Thomas H. Sheridan, Action Time Editor, *Chicago Sun-Times* seemed to agree. He wrote:

Seniors have the same problem as the rest of us but may be less able to deal with them. Therefore a problem that might affect a lot of people—such as mail order—may affect seniors in a worse way because that mail-order may be one of their principal means of purchasing goods. Plus they are more likely to be living on fixed incomes.

Why do seniors citizens sometimes find themselves in a bind? Often its because they reached adulthood under different (and better) set of values than they live with today. Trust was more common; a man's word was his bond. Even during the Depression, there seem to have been less advantage taken of people and more pulling together than there is now. All of which leads seniors to sometimes be less wary in situations such as home repair, health fraud.

Like our other respondents, Action Line Reporters agreed mail order fraud was particularly a problem. "Since elderly persons are often shut-ins or restricted in their movement," wrote a producer with KABC-TV, "we find mail-order problems quite common—usually TV-ads and print ads appearing in such publications as the *National Enquirer.*"

"Unquestionably, the majority of our complaints involve mail order," wrote the author of a "Help" column in Connecticut. And since it seems most of our mail comes from older readers it would seem that this is particularly a problem that isn't being addressed."

"Tell it to Bud" in the *Anchorage Times* agreed and gave the Committee an example. "An elderly woman sent a post card for information from the Fifth Avenue Hearing Aid Company. Two salesmen showed up at her door ready to fit her. The $1,600 she was charged for these hearing aids was refunded after the *Times* intervention."

THE AMERICAN CANCER SOCIETY

The American Cancer Society is a national voluntary health organization of 2 and one-half million Americans dedicated to the control and eradication of cancer through balanced programs of research, education and patient service. Founded in 1913, the ACS has a budget of $220,000,000. Its national headquarters are in New York City and there are 58 incorporated subdivisions throughout the country.

The American Cancer Society is one of the largest sources of cancer research funds in the United States, second only to the National Cancer Institute, an agency of the Federal Government. The Society supports more than 700 key cancer researchers in nearly 150 American hospitals, universities, medical schools and other institutions through institutional, research, and personnel grants. The cost of its research program in 1982 was over $59 million.

Programs of research, education and service to cancer patients are planned by a national board of 116 voting directors representing all divisions of the Society. At least half of this board must be medical or scientific professionals. The other half are lay persons.

In 1954, the American Society began a program to help fight cancer quackery. At that time, there was little factual information concerning this problem and there were no state laws to combat it.

A Committee on Unproven Methods of Cancer Management was formed to serve as a central coordinating force in this field. The Committee is concerned with public and professional education as well as legal matters. Its membership includes experts in these fields. The Committee has issued many reports on individual unproven cancer remedies and tests. Its "State Model Cancer Act," modeled after the California anti-quackery act, has encouraged passage of laws against cancer quackery in several states, but some of these have been partially superseded by laws which protect laetrile.

The National Office of the American Cancer Society has established an information clearinghouse which contains one of the country's largest collections of information about cancer quackery. Material from its files is used to answer thousands of inquiries from health professionals, writers and the general public. Information about unproven methods is also published in *Ca—A Cancer Journal for Clinicians* which is distributed, free of charge, to more than 400,000 physicians, medical students and nurses in the United States. Close liaison is also maintained with the FDA, the National Cancer Institute, the U.S. Postal Service, the U.S. Customs Service and other interested parties—both government and private.

THE ARTHRITIS FOUNDATION

The Arthritis Foundation is the only national voluntary health association that is trying to do something about all forms of arthritis and other rheumatic diseases. Its programs include support for scientific research, training specialists, public information and education, and help within the community for people who have rheumatic diseases.

The local chapters and divisions of the Foundation are sources for information about rheumatic diseases and their treatment. They can guide you to specialists in treatment, to clinics, and to other agencies and authorities to help with physical, financial, and emotional problems caused by arthritis.

The chapters encourage and support a variety of local services for people with rheumatic diseases and their families. These include information and education programs, support groups, arthritis clinics, home care programs, and rehabilitation services.

The Arthritis Foundation believes, "People with arthritis are among the most exploited victims of health fraud in the United States". To address this problem, the Arthritis Foundation has established a Subcommittee on Unproven Remedies. The Arthritis Foundation's unproven methods subcommittee and related activities are under the direction of its Committee on Public Education, chaired by Dr. Wilbur J. Blechman of North Miami Beach, Florida.

The Subcommittee has several functions. If questions are brought to the Subcommittees attention concerning the practices or therapies of a clinic, for example, the Foundation sends a team to investigate. Advertisement, and information relating to the sale or distribution of unproven remedies are reviewed and analyzed. Eval-

Recommendations to the Department of Justice

The Department of Justice should take the lead in establishing an anti-quackery task force. The task force, composed of representatives of the FDA, FTC, Postal Service and liaisons from appropriate private agencies, should target significant resources toward the control of fraudulent health remedies, focusing on repeat offenders, interstate and international promoters, and schemes with a significant impact on the health and well-being of our citizens.

Recommendations to the States

Despite the number of Federal agencies involved, major responsibility for controlling quackery lies with the states. States should consider the following:

1. *Adopting state cancer acts,* similar to the model state cancer act prepared by the American Cancer Society. The purpose of this act would be to establish a cancer advisory council within each state's department of health. The responsibilities of this council would include approving for use in the state those drugs which have been proven safe and effective for treatment of cancer, denying approval of unproven remedies, and reporting the use of unproven remedies to appropriate enforcement agents.
2. *Adopting model solicitation statutes* governing the activities of foundations and others soliciting for charitable donations. At minimum, these statutes should include strong disclosure and reporting requirements, identifying the potential application of funds generated, the actual application of funds previously generated, the nature of the governing board and the affiliation of the foundation with any treatment center.
3. *Strengthening medical practice statutes,* clarifying language describing the "unauthorized practice of medicine and, at minimum, classifying the practice of medicine without a license as a felony. The use of any treatments, including drugs, diagnostic procedures and surgical practices not established as standard therapy by such agencies as the Food and Drug Administration or peer review organizations, should require written informed consent by the patient. Copies of such informed consent, describing the risks and known benefits of treatment, should be maintained in the patient's record and available to the appropriate designated state health officials.
4. *Adopting statutes establishing criminal sanctions for quackery.* At present, two thirds of the states are limited to civil remedies in addressing this problem.
5. *Establish appropriate liaison with federal agencies* to keep the state advised of Federal actions and prevent the introduction of discredited remedies into the state.

APPENDIX I

MEDICAL QUACKERY

The following are questionnaires sent to District Attorneys, State Consumer Affairs Offices, State Attorneys Generals, State Legislative Committees, State Offices on Aging, Police Chiefs the Postmaster General, the National Institute of Arthritis, and the Department of Justice.

SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES
CLAUDE PEPPER, CHAIRMAN

MEMORANDUM

June 16, 1981

To District Attorneys

From Claude Pepper, Chairman

Re Questionnaire on Consumer Fraud Efforts

Your assistance in a matter of importance to the House Select Committee on Aging would be most appreciated.

Our Committee is in the process of investigating the subject of frauds against the elderly. We have found that senior citizens are easy victims for con men who peddle phony stock sales, questionable land sales, medical quackery remedies of all kinds, work at home schemes, phony business opportunities, and a host of other schemes that you hear about on a daily basis.

We have already written to the Attorney General of your state asking for his perspective on this issue. We wanted to correspond directly with you because of your wide experience in consumer fraud. We are enclosing a questionnaire which indicates the parameters of our concern. We would appreciate your completing the questionnaire and returning it to us at your earliest possible convenience.

You will note that we have asked you to send copies of complaints or cases that you have resolved successfully or to provide examples of successful restitutions or prosecutions. Please send us newspaper clippings or anything else you can think of which will indicate the extent of the problem in your area and what you have been able to do about it.

If you will note, at the end of our questionnaire we have asked whether you would be willing to testify before our Committee on one or more consumer fraud issues which relate in whole or in part to the elderly. Please let us know if you would care to help in this way.

If you have any questions, please contact our Senior Counsel Val J. Halamandaris at (202)225-9451. We will be most grateful for your assistance and cooperation in this matter.