REPORT OF THE
DEPARTMENT OF HEALTH PROFESSIONS ON

Feasibility and Appropriateness of Establishing A Board of Chiropractic in the Commonwealth of Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 19

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Department of Health Professions

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December 18, 1992

TO: The Honorable Lawrence Douglas Wilder
Governor of the Commonwealth of Virginia

The Members of the General Assembly of Virginia

I am pleased to transmit this report which constitutes the response of the Virginia Department of Health Professions to House Joint Resolution No. 26 of the 1992 Session of the General Assembly of Virginia.

This report offers the results of the Board's study on the feasibility and appropriateness of establishing a Board of Chiropractic in the Commonwealth. Based on this study, the Board recommends that a Board of Chiropractic not be established.

Bernard L. Henderson, Jr.

BLHjr/lbb
Enclosure

pc: The Honorable Howard M. Cullum
Secretary of Health and Human Resources

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GENERAL ASSEMBLY OF VIRGINIA--1992 SESSION

HOUSE JOINT RESOLUTION NO. 28

Requesting the Board of Health Professions to study the feasibility and appropriateness of establishing a board of chiropractic in the Commonwealth.

Agreed to by the House of Delegates, February 9, 1992
Agreed to by the Senate, March 4, 1992

WHEREAS, the practice of chiropractic is defined as "the adjustment of the twenty-four movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy," but this practice does not include such treatments as surgery or the administering or prescribing of any drugs, medicines, serums or vaccines; and

WHEREAS, because the practice of chiropractic focuses on the treatment of human physical ailments or infirmities, it is, therefore, classified as a healing art and licensed in Virginia by the Board of Medicine; and

WHEREAS, the Board of Medicine regulates, through various levels of certification or licensure, not only chiropractors, but approximately 16 other professions and occupations, e.g., medicine, osteopathy, clinical psychology, naturopathy, physical therapy, occupational therapy, podiatry, nurse practitioners, physician assistants, and radiological technology practitioners; and

WHEREAS, chiropractors are represented by only one member on the 18-member Board of Medicine, which is heavily weighted toward the practice of medicine with each congressional district being represented by one medical physician; and

WHEREAS, as the population of the Commonwealth increases, the number of physicians on the Board of Medicine will concurrently increase, thereby further attenuating the professional input of the one chiropractor; and

WHEREAS, the scope of regulation administered by the Board of Medicine is diverse and may have exceeded any benefits provided by economies of scale; and

WHEREAS, in 48 states, chiropractors are regulated by a board of chiropractic, with only Virginia and Illinois subsuming the governance of these professionals under their medical boards; and

WHEREAS, a separate licensing board, composed of knowledgeable practitioners of chiropractic, could serve to improve the effectiveness and promote the efficiency of the administration and regulation of this profession; and

WHEREAS, the Board of Health Professions is charged, pursuant to § 54.1-2510, with evaluating all health-care professions and occupations in the Commonwealth and considering whether such professions or occupations should be regulated and what the level of such regulation should be; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board of Health Professions be hereby requested to study the feasibility and appropriateness of establishing a board of chiropractic in the Commonwealth. This study shall include, but need not be limited to, an examination of other states' structures for the regulation of chiropractors and the possible improvement in effectiveness and efficiency of regulation that such a separate board could have.

In its deliberations, the Board shall seek input from the general public and chiropractors licensed and practicing in the Commonwealth.

The Board shall submit its findings and recommendations to the Governor and the 1993 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

REPORT AND RECOMMENDATIONS

Background and authority

House Joint Resolution Number 26 of the 1992 Session of the Virginia General Assembly requested the Board of Health Professions to study the feasibility and appropriateness of establishing a board of chiropractic in the Commonwealth. The Resolution stipulated that the Board should include an examination of other states' structures for the regulation of chiropractors and the possible improvements in effectiveness and efficiency of regulation that such a separate board could have.

Chiropractors are licensed in all fifty states and the District of Columbia. In all but four jurisdictions (District of Columbia, Kansas, Illinois, and Virginia) the profession is regulated by a board of chiropractic which is independent of the regulation of medical and osteopathic physicians.

In Virginia, chiropractors are licensed by the Board of Medicine, a body comprising eleven medical doctors (MDs), one osteopathic physician (DO), one podiatrist (DPM), one clinical psychologist, one chiropractor (DC), and two citizen members. In addition to regulating medicine, osteopathy, podiatry, chiropractic, and clinical psychology, the Board of Medicine also licenses or certifies physical therapists (PTs) and physical therapy assistants (PTAs), occupational therapists (OTs), respiratory therapists (RTs), certified radiologic technology practitioners (CRTPs), physician's assistants (PAs) and correctional health assistants, and (jointly with the Board of Nursing) nurse practitioners (NPs). The Board also certifies optometrists who are authorized to prescribe therapeutic drugs. No other state board of medicine in the United States is known to conduct a regulatory program of this breadth.

On June 30, 1992, the Virginia Board of Medicine licensed or certified 31,891 health care providers, including 818 doctors of chiropractic. Of these licensed chiropractors, 464 maintained residency in the Commonwealth.

Study Methods

The Virginia Board of Health Professions is a 17-member b created by the Legislature and appointed by the Governor to advise the Executive and Legislative branches in all matters related to the regulation of health professions in the Commonwealth. The Board comprises one member appointed from the membership of each of the twelve regulatory boards within the Department of Health Professions and five citizen members appointed from the Commonwealth-at-large.

This study was conducted by a special task force of the Board's Regulatory Research Committee. The task force was chaired by a citizen member and included two additional citizen members as well as the Board of Medicine and Board of Psychology members of the Board of Health Professions. Advisors to the task force included representatives of the major professional associations representing chiropractic (Virginia Chiropractic Association) and medicine (Medical Society of Virginia) in the Commonwealth. The task force also consulted with current and past chiropractic members of the Board of Medicine.

The formal study included the following elements:

- Literature Review. While a large body of literature exists on the history of chiropractic and on the conflict between chiropractic and organized medicine in the United States, no known studies have addressed the specific question of the most appropriate structure for the regulation of the chiropractic profession. The current study represents the first such attempt to focus the literature on this policy question.

- Public Hearing and Solicitation of Comments. The Board convened an informational public hearing in Richmond on August 19, 1992 and solicited comments from all chiropractors licensed by the Board of Medicine. In addition, the invitation to comment was widely distributed and published in newspapers of general circulation in the Commonwealth. The bulk of all comments came from chiropractors. The total volume of comments was small (13).

- Survey of Other States. A survey (see Appendix A) was distributed to all states and jurisdictions seeking information on the structure for licensing chiropractors, numbers of licensees, disciplinary data, revenues and expenses, scope of practice, and other questions of interest.

- Review of Chiropractic Discipline. The protection of the public health, safety and welfare is the sole legitimate rationale for the regulation of any occupation or profession. As a consequence, the task force carefully studied the history of recent enforcement and discipline affecting chiropractors in the Commonwealth and in all other U.S. jurisdictions.

- Statistical Modeling. Staff analysis of survey data and other information included the design of a causal model to explore questions regarding the influence of the structure for chiropractic regulation on: (1) regulatory effectiveness (defined in terms of disciplinary performance), (2) efficiency (defined as available resources to resolve disciplinary and other problems in a reasonable timeframe), and (3) other effects of interest to the chiropractic profession (e.g., presence or absence of continuing education or internship requirements, temporary license arrangements).

  The results of this statistical inquiry are at best suggestive since: (1) it is difficult to reach consensus on appropriate indicators and measurements of regulatory effectiveness and efficiency, (2) valid and reliable data are not readily available, and (3) the model leaves unexplored many variables whose effects may be significant.

With this information at hand, the task force and the Board of Health Professions focused attention on three sets of issues:

- regulatory structure and its effects;
- disciplinary effectiveness and the equitable treatment of licensees; and
- cost.

The Board's findings and its recommendation to the Director of the Department of Health Professions, the Governor, and the General Assembly follow.

Findings

The findings of the Board of Health Professions are based on an assessment of the validity of arguments for and against the creation of a separate board of chiropractic. The Board also considered alternatives to the creation of a separate board which might address concerns expressed by some members of the chiropractic profession.

Chiropractors who favor a separate board of chiropractic argued that regulation by a Board of Medicine comprised in the majority of allopathic physicians is inappropriate and inequitable. The current system, in their view, restricts the scope of practice of the profession, discriminates against chiropractors who may wish to practice in the Commonwealth, and inhibits chiropractic professionalization by blocking continuing education and internship requirements and temporary license arrangements.

Chiropractors supporting a separate board also believe that disciplinary processes and decisions related to chiropractic licensees by the Board of Medicine are inappropriate or unjust, resulting from a lack of understanding of the chiropractic profession and a predisposition to harass chiropractors. They also cite difficulties in arranging for the adjudication of chiropractic disciplinary cases with only one chiropractic member of the Board, and argue that case resolution time in Virginia is too long. Finally, they assert that Virginia chiropractic licensees can well afford licensure fees sufficient to sustain a separate board of chiropractic.

Other chiropractors, including the current and past chiropractic members of the Board of Medicine favor the continuation of the current arrangement, citing the benefits of interdisciplinary communication and opportunities to educate physicians about the benefits and scope of chiropractic. These opponents of a separate board believe that the Board of Medicine deals with chiropractic discipline equitably and appropriately, and they argue that a separate board would not be cost-effective.

During the course of the review, the Board of Health Professions attempted to ascertain whether other arrangements short of the creation of an additional regulatory board could address problems of concern to the Virginia Chiropractic Association and to other chiropractic supporters of a separate board. Among these alternatives were: (1) creation of one or more additional chiropractic positions on the Board of Medicine, and (2) the authorization in statute of an advisory board or committee on chiropractic to the Board of Medicine to assist in rulemaking and the adjudication of chiropractic disciplinary cases. The second alternative, modeled on the Board of Medicine's structure for the regulation of allied health professions, could be implemented with or without creation of additional chiropractic positions of the Board.

These alternative suggestions were favorably received by the current and past chiropractic members of the Board of Medicine. They were opposed by the Virginia Chiropractic Association which argued that only a full and separate board of chiropractic could adequately protect the public and equitably serve the needs of the profession.

Few opinions were expressed by the public or by other professions. Two consumers benefitting from chiropractic care, encouraged the creation of a separate board as a means for increasing access to chiropractic services. The Medical Society of Virginia opposes creation of a separate chiropractic board.

Regulatory Structure and its Effects. The Board of Health Professions submits the following findings related to the structure for the regulation of chiropractic in the Commonwealth.

The assignment of chiropractic licensure to the Board of Medicine and the allocation of one position on that board to a chiropractor is the prerogative solely of the Virginia General Assembly. The General Assembly has determined that the current structure is appropriate not only for chiropractic, but for osteopathic medicine, podiatry, and clinical psychology.

The relationship between regulatory structure and scope of practice is indirect and complex. While the scope of chiropractic practice in Virginia is generally considered 'restrictive,' other states in which chiropractic is regulated by boards of medicine or boards of medicine and the healing arts have statutory scopes of practice which are 'moderate' or 'liberal.' The General Assembly may alter the scope of chiropractic practice without creating a separate board of chiropractic.

The relationship between regulatory structure and chiropractic/population ratios is statistically significant. States with separate chiropractic boards and boards with strong chiropractic representation have higher ratios, and, by inference, greater access to chiropractic care. These relationships are stronger in states which have separate boards or strong chiropractic regulation and liberal scopes of practice, and are strongest in states which also have a chiropractic school.

Regulatory structure is significantly associated with internship requirements, and with temporary license provisions, but not with continuing education requirements. These requirements and arrangements are favored by most chiropractors, but there is no available evidence that they contribute to the greater protection of the public health, safety or welfare.

There is a need for more effective peer review in the chiropractic profession, and there may be a need to better differentiate chiropractic from other professions by regulations which are more specific to the practice. These objectives may be accomplished without creation of a separate board of chiropractic.

Disciplinary Effectiveness and Equity. The Board of Health Professions is charged to "review periodically the investigatory, disciplinary and enforcement processes of the Department and the individual boards [within the Department] to ensure the protection of the public and the fair and equitable treatment of health professionals" (Code of Virginia Sec. 54.1-2510.11).

These processes, as they affect chiropractic, were examined closely during this review. Virginia disciplinary data were compared with all states and jurisdictions (51), with states in which chiropractors are regulated by boards of medicine or boards of medicine and the healing arts (4), and in states with separate boards of chiropractic (47).

The Board of Health Professions finds no evidence that a separate board of chiropractic in the Commonwealth would better protect the public or ensure more equitable treatment of chiropractors. Virginia compares favorably with all other states and jurisdictions in enforcing standard of care and professional conduct provisions which

protect the public. There is no evidence of inequity in the treatment of chiropractors by the Board of Medicine, and average case resolution times for chiropractic cases in Virginia compare favorably with other states, including those states with separate board of chiropractors.

While it is true that the single chiropractor on the Board of Medicine is barred from participation in all aspects of cases in which both informal conferences and formal hearings are required, the Board is authorized to use -- and frequently uses -- expert consultants whenever consultation is appropriate. In this regard, chiropractic does not differ from osteopathy, podiatry, or clinical psychology. In fact, when any case involving a medical specialty (surgery, psychiatry, orthopedics, etc.) which is not adequately represented on the Board is adjudicated, the Board generally contracts for consultation with one or more experts from that medical specialty.

Cost. The Board of Health Professions has compared the cost of operating the regulatory program for chiropractic in the Commonwealth with regulatory costs: (1) in all other states and jurisdictions, (2) in states in which chiropractic is licensed by boards of medicine or boards of medicine and the healing arts, and (3) in states with separate boards of chiropractic. In addition, the cost of operating a separate board of chiropractic in Virginia has been estimated based on actual costs of operating boards for other professions with similar numbers of licensees and disciplinary actions (e.g., Board of Nursing Home Administrators, Board of Psychology).

Virginia law requires that the direct costs of operating regulatory programs be met through licensure and other fees. Fees currently charged for chiropractic licenses are sufficient for the operation of the current regulatory program, and with minor increases could support the cost of a separate board of chiropractic. The larger, indirect costs of licensure comes from increased consumer prices which result from restriction of the supply of practitioners. No evidence was presented that indicated that consumer prices for chiropractic services in the Commonwealth were greater than in other states, even though the chiropractic/population ratio in Virginia is the lowest in the United States.

The Board of Health Professions does not believe that cost should be a determinant of the need for a separate board of chiropractic. A separate board should be created only if there is evidence that the current system fails to protect the public or to ensure the equitable treatment of licensees.

Conclus

The [illegible] of Health Professions was requested to study th feasibi and appropriateness of establishing a separate board or chiropr[illegible]c in the Commonwealth. While such a board is feasible, the Boa[illegible]oes not believe that the evidence submitted or collected during review supports the propriety of establishing such a board. [illegible]ere is no evidence that Virginia's citizens are insuffi[illegible]tly protected by the current regulatory structure, and there [illegible]o evidence that they would be better protected by a separat[illegible]ard of chiropractic.

Th[illegible]ard also considered alternatives to the creation of a separat[illegible]ard, but these alternatives were not acceptable to the majorit[illegible] chiropractors who presented comments and opinions during this r[illegible]w. For this reason, the Board's recommendation is confine[illegible] the single question of whether a separate board of chiropra[illegible]c should be created in the Commonwealth.

The[illegible]ard of Health Professions recommends against the creati[illegible] of [illegible]eparate board of chiropractic in the Commonwealth at th[illegible] tir[illegible]

I. INTRODUCTION TO THE STUDY

Chiropractic Defined

Chiropractic is defined by the chiropractic profession as a primary health care intervention with a specific focus on spinal manipulation and "non-medical care" (Cassata, 1992; Leffler, 1983). The scope of chiropractic, as defined in state law, varies widely among the fifty states and the District of Columbia. A common feature of statutory definitions is the exclusion of drug therapy and surgery from the legal scope of practice, but these exclusions are not universal. For example, the scope of chiropractic practice in the State of Oregon includes minor surgery, and "all recognized and accepted chiropractic diagnostic procedures and the employment of all rational therapeutic measures as taught in approved chiropractic colleges." By contrast, the statutory definition of chiropractic established in Virginia statutes is more restrictive:

> **[The] 'practice of chiropractic' means the adjustment of the twenty-four movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy, nor the administration nor prescribing of any drugs, medicines, serums or vaccines.**
> (Code of Virginia Sec. 54.1-2900)

In Figure 1, ten procedures employed by chiropractors are identified including: spinal manipulation and the use of x-ray for diagnostic purposes; the use of specific therapies and analytic tests; the recommendation or dispensing of food or food supplements; provision of first aid, performance of minor surgery, and; public health functions such as signing health or death notices. Figure 2 classifies states as "liberal," "moderate," or "conservative" in terms of the numbers of these procedures which are included in legal scopes of practice in each state or jurisdiction.

Figure 1

Chiropractic Scope of Practice
Selected Procedures

1. Spinal Manipulation and diagnostic X-ray
2. Electrotherapy
3. Light, Heat, and Water therapy
4. Colonic therapy
5. Blood or Urinalysis
6. Recommend Food or Food Supplements
7. Dispense Food or Food Supplements
8. First Aid
9. Minor Surgery
10. Sign Health or Death Certificates

Figure 2

Chiropractic Scope of Practice
By State and Procedure
(ACA, 1990; FCLB, 1992-93)

State	*Interventions*									
	1	2	3	4	5	6	7	8	9	10
(Liberal)										
Oregon	x	x	x	x	x	x	x	x	x	x
California	x	x	x	x	x	x	x	x		x
Florida, Illinois, S.Dakota	x	x	x		x	x	x	x		x
Missouri, Nebraska, Oklahoma	x	x			x	x		x		x
Connecticut, New York Wisconsin	x	x	x		x	x	x	x		
(Moderate)										
Kansas, New Hampshire, N. Dakota, Minnesota, Montana, Tennessee, W.Virginia, Wyoming	x	x				x		x		x
Alabama, Alaska, Maryland	x	x	x			x	x	x		
Idaho, Louisiana, Rhode Island	x	x	x		x	x		x		?
Kentucky, Vermont.Washington	x	x	x		?			?		x
Indiana, New Mexico	x	x			x	x		x		
Arizona, Arkansas	x	x	x		x			x		
Delaware, Utah, Texas	x	x	x		x	x				?
Colorado, Iowa, Maine, Massachusetts, Nevada, New Jersey, Ohio, Pennsylvania	x	x	x		x			?		?
(Conservative)										
Georgia, Hawaii, N.Carolina, Michigan, S.Carolina,	x	x	x			?		?		
D. Columbia, Mississippi, Virginia	x	x	?		x			?		

Demography

The U.S. Department of Health and Human Services establishes chiropractic as the second largest primary care provider group in the United States (Office of Inspector General, 1989); its numbers are exceeded only by allopathic physicians (MDs). In Virginia and elsewhere, chiropractors outnumber osteopathic physicians (DOs), the third largest category of "the healing arts." As in the case of allopathic and osteopathic physicians, chiropractors are unevenly distributed among the states and within state jurisdictions.

In 1991 there were 62,921 active chiropractic licenses in the United States (Federation of Chiropractic Licensing Boards, 1992-1993). Since many chiropractors are licensed in more than one jurisdiction, the unduplicated number probably lies between 45,000 and 49,000. According to Schifrin (1992) there are about 47,500 chiropractors in the United States; the RAND Corporation (1991) reported 45,000. These figures show increases of 26 and 15 percent respectively, from 1988, when 39,000 chiropractors were licensed to practice in the U.S. (Department of Health & Human Services, 1990). Of the worldwide number of chiropractors, 80 percent practice within the United States.

Using a midrange estimate of 46,000 chiropractors in the U.S. in 1991, the national chiropractor/population ratio is 1.85 per 10,000 population, but the range is wide. Figure 3 shows that the highest ratio is in Vermont (6.24:10000), and the lowest is in Virginia (1.16:10000).

The low chiropractor/population ratio in Virginia persists despite dramatic increases in the number of chiropractic licensees over the past two decades. In 1970, there were 80 chiropractors licensed by the Commonwealth; the number increased to 208 in 1980. Today, there are 818, of whom 464 maintain residence in the Commonwealth.

Figure 3

Chiropractic Per Capita Ranking
By State per 10,000 population:1990

1. Vermont: 6.24
2. Oregon: 5.48
3. Arizona: 5.45
4. Colorado: 4.25
5. Hawaii: 4.14
6. Wyoming: 4.08
7. Iowa: 4.02
8. Pennsylvania: 4.01
9. Montana: 3.91
10. Florida: 3.80
11. Missouri: 3.76
12. Minnesota: 3.69
13. New Hampshire: 3.41
14. New Jersey: 3.23
15. New Mexico: 3.13
16. California: 3.12
17. Oklahoma: 3.11
18. Washington: 3.07
19. Kentucky: 2.98
20. Maine: 2.95
21. Georgia: 2.88
22. Alaska: 2.79
- **23. Kansas: 2.71
24. Michigan: 2.58
25. Connecticut: 2.41
26. Wisconsin: 2.33
27. Delaware: 2.29
28. S. Dakota: 2.27
29. Utah: 2.25
30. New York: 2.24
31. Nevada: 2.23
32. S. Carolina: 2.19
33. Massachusetts: 2.13
34. N. Dakota: 1.97
35. Idaho: 1.83
36. Arkansas: 1.80
- **37. Illinois: 1.78
38. Texas: 1.77
39. N. Carolina: 1.65
40. Rhode Island: 1.64
41. W. Virginia: 1.52
42. Alabama: 1.47
43. Maryland: 1.41
44. Mississippi: 1.35
45. Nebraska: 1.32
- **46. D. Columbia: 1.31
47. Indiana: 1.27
48. Louisiana: 1.26
49. Ohio: 1.22
50. Tennesee: 1.21
- **51. Virginia: 1.16

Non-Chiropractic **

(Sources: FCLB; U.S. Bureau of the Census, 1990)

Chiropractic Regulation

Entry requirements and the scope of chiropractic are regulated in all 50 states and the District of Columbia by **licensure**, the most restrictive form of occupational and professional regulation, reflecting the potential risk for harm to the public that could result from unregulated chiropractic practice. Licensure confers upon a specific occupational group a monopoly over a legally protected scope of practice.

In all but four states, the profession is regulated by a board of chiropractic operating independent of the regulation of allopathic and osteopathic physicians. In one of these four jurisdictions, Kansas, chiropractors are governed by a state board of the healing arts. In another, the District of Columbia, the medical board regulates chiropractors through an advisory board of chiropractic. The profession is regulated solely by the state board of medicine in only two jurisdictions, Illinois and Virginia. In a fifth jurisdiction, New Jersey, a board of chiropractic replaced a non-chiropractic licensing board in 1990.

The representation of chiropractors on chiropractic licensing boards also varies. On average, separate boards of chiropractic had five chiropractors and one public member during the 1988-91 timeframe. Among the four non-chiropractic boards regulating chiropractors, there were, on average, two chiropractors and two public members. In Virginia, one chiropractor is seated on a board comprising eleven medical doctors (MDs), one osteopathic physician (DO), one podiatrist (DPM), one clinical psychologist, and two citizen members.

The Virginia Board of Medicine is unique in the nation in its regulatory scope and breadth. The Board regulates medical and osteopathic physicians, podiatrists, chiropractors, and clinical psychologists, as well as physical therapists (PTs) and

physical therapy assistants (PTAs), occupational therapists (OTs), respiratory therapists (RTs), certified radiologic technology practitioners (CRTPs), physician's assistants (PAs) and correctional health assistants, and (jointly with the Board of Nursing) nurse practitioners (NPs). The Board also certifies optometrists who are authorized to prescribe therapeutic drugs.

Figure 4 shows the numbers of individuals regulated by the Board of Medicine in 1992, along with the number of each group, if any, who serve on the Board.

Discussion of chiropractic regulation in Virginia may be better understood by a brief review of the history of the Board of Medicine.

The first professional regulation in America occurred in Colonial Virginia in 1639; its purpose was to control physicians' fees (Hogan, 1979). Virginia also led the nation more than two centuries later in establishing entry standards and defining the scope of practice of health professions by creating a state board of medical examiners in 1884. The scope of practice of medicine, then as now, was plenary:

> **The practice of medicine . . . means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.** (Code of Virginia Sec. 54.1-2900)

Other states rapidly imitated this model which firmly established allopathic medicine as the dominant healing art. Over time, the scopes of practice of scores of other health professions were "carved out" or exempted from definition as the practice of medicine.

Figure 4

Virginia Board of Medicine
Professions Regulated
1992

License	In-state	Total	Members
Medical Doctor	13,329	22,218	11
Doctor of Osteopathy	221	420	1
Doctor of Podiatry	244	432	1
Doctor of Chiropractic	469	818	1
Clinical Psychologist	976	1,181	1
Optometrist	185	204	0
Physical * Therapist	1,778	2,263	0
Physical * Therapist Aide	415	480	0
Occup. * Therapist	639	699	0
Respiratory * Therapist	1,080	1,162	0
Physicians * Assistant	326	327	0
Nurse * Practitioner	2,104	0	0

* Advisory Board or Committee

State licensure of chiropractic was first established in 1914 (American Chiropractic Association, 1991-1992a), but chiropractors were not regulated in Virginia until 1920. Tensions and conflict related to chiropractic licensure has continued since that time, evidenced by a synopsis of minutes of the Board of Medicine from 1908 to 1990:

1913

First discussion of chiropractors. Reference to prosecutions of chiropractors in Roanoke area for the unlicensed practice of medicine.

1914

Chiropractors practicing until 1913 were not under the jurisdiction of the Board of Medicine. Chiropractors were exempt from licensure examinations. Informal registration was established.

1920

The Board of Medicine, at its own discretion, could examine and admit to practice graduated chiropractors whose preliminary education and training were equal to that of Virginia students.

1921

In preparation for discussions with the Legislature, the Board of Medicine established a committee to oppose the creation of a separate board of chiropractic.

1925

The Board of Medicine was notified that chiropractors were intending to introduce a bill asking for a separate Board of Chiropractic.

1940

The Board of Medicine was again notified that chiropractors were intending to introduce a bill asking for a separate Board of Chiropractic.

1942

The Board of Medicine reported that there was a House Joint Resolution creating a study to investigate and report to the General Assembly on changes to the

Medical Practice Act. This investigation recommended changes in the structure for the regulation of the healing arts and specifically recommended the creation of a separate Board of Chiropractic.

> This recommendation was not implemented through legislation; however, two positions were created on the Board of Medicine to be filled by two chiropractors.
>
> 1944
>
> Two chiropractors were appointed to the Board of Medicine.
>
> 1944
>
> Temporary licenses were granted to chiropractors until December 30, 1949. These chiropractors were to be examined prior to December 30, 1949 for permanent licensure. The examination was administered on October 15, 1949.
>
> 1965-1966
>
> The composition of the Board of Medicine was altered from two chiropractors to one chiropractor.
>
> (Commonwealth of Virginia, Minutes of the Board of Medicine 1909-1990)

The legally defined scope of chiropractic in Virginia has been perceived historically as narrow and restrictive by the chiropractic profession. According to a 1990 American Chiropractic Association compilation, Virginia's statutory definition of chiropractic is one of the most restrictive in the nation.

Ironically, in a 1944 report to the Virginia General Assembly, the Board of Medicine defined a chiropractor as; "[one who] holds himself out to treat and cure (or ameliorate) difficult diseases from which the human body may suffer, and to achieve this end, to apply to the sufferer a specific treatment through the technique of the chiropractic act appropriate to the specific disease from which he, the patient, suffers." The

current, legally defined scope of practice (see page 1) is considerably more restrictive.

Wardwell (1981) and others believe that the structure for chiropractic regulation among the states was influenced by the branch of chiropractic profession which was dominant at the time enabling statutes were enacted.

History of Chiropractic

Historically, the chiropractic profession has been divided among those whose practice consists exclusively of spinal manipulation ("straits"), and those whose practice included other interventions and procedures ("mixers"). These differences resulted in two accrediting bodies for schools of chiropractic, and in divisions of opinion as to whether broader scopes of practice should be codified in state law. Current predictions are that these divisions will disappear in the near future, and that broader scopes of practice will be sought in all jurisdictions.

Although spinal manipulation therapy can be traced to Hippocrates (Office of Inspector General, 1989), chiropractic as an independent profession began in America in 1895 when D.D. Palmer manipulated the spine of a janitor with a resulting increase in hearing after years of deafness. The Palmer infirmary was established in 1897; its first graduating class included licensed physicians.

In the early years of the development of the profession, chiropractic education may have comprised anatomy, physiology, pathology, toxicology, diagnosis, obstetrics, nerve tracing, palpation, and chiropractic philosophy and technique, with limited dissection and chemistry (Wardwell, 1981). Not all chiropractic colleges taught a broad curriculum. The course of study was often short, lasting from a few weeks to 18 months.

Paralleling changes in university-based medical education made in response to the influential "Flexner Report" in 1910, chiropractic colleges also revised their curricula. Many chiropractic colleges closed or merged with others.

Currently, chiropractic education and practice emphasize drugless health interventions focused on correction of the neuromusculatory system, in conjunction with proper nutrition and hygiene (American Chiropractic Association, 1991-1992a; Biedeman, 1991). Chiropractic is taught in fourteen colleges accredited by the Council on Chiropractic Education (CCE) and in three colleges accredited by the Straight Chiropractic Academic Standards Association (SCASA).

Chiropractic education consists of four years of didactic classroom and laboratory courses (Weiant & Goldschmidt, 1975; Department of Health & Human Services, 1990). A standard pre-requisite for admission is the completion of two years undergraduate study in a curriculum designed to award a baccalaureate degree. In one state, Florida, the pre-requisite is completion of the baccalaureate degree.

According to the Western States Chiropractic College (WSCC, 1992), the Cleveland Chiropractic College of Kansas City (CCCKC, 1991-1993), and the New York Chiropractic College (NYCC, 1991-1993) catalogues, chiropractic education trains future practitioners to maintain health through natural, conservative, drugless interventions and non-incisive surgery. The modern chiropractic curriculum includes nutrition, biomechanics, skeletal systems, voluntary muscular systems, neurological systems, hematological system disorders, dermatology, gastrointestinal, renal, cardiovascular, respiratory, endocrine, musculoskeletal as well as radiology and roentengology (Biedeman, 1991; WSCC, 1992; NYCC, 1991-1993; CCCKC, 1992-1993).

Patient care includes spinal analysis, care of the body in both health and disease, and consultation with or referral to other health care providers (Biedeman, 1991). The greatest emphasis in training is on the interaction between the nervous system and the spine, and on X-ray technique. In contrast to allopathic, osteopathic and podiatric medicine, which teach pharmacology (Black, 1987; Stark & Tilley, 1975; Medical College of Virginia/Virginia Commonwealth University Bulletin, 1992; Ohio College of Podiatric Medicine, 1992-1993), chiropractic education does not include this "medical" component of the healing arts.

The major distinction between allopathic/osteopathic and chiropractic care is that MDs and DOs commonly prescribe drugs, including controlled substances, while chiropractors (DCs) do not. The major difference between the **physical** modalities employed by osteopathic physicians and chiropractic care is the type of manual manipulation used. Osteopathic care may use more range of motion, and long lever care, as well as some quick thrusting manipulation. Chiropractic uses more of the quick thrusting technique (RAND, 1991).

The type of care taught at the chiropractic colleges limits chiropractors to treating conditions such as headaches, tendonitis, temporomandibular joint dysfunction, some scolioses, whiplash, sciatic conditions, and back and neck strain (WSCC, 1991). Postgraduate education is offered at both chiropractic colleges and symposia conducted by private agencies. Postgraduate education is available to prepare for specialty practice including nutrition, orthopedics or radiology. In both undergraduate and postgraduate chiropractic education, chiropractors are trained to limit their practice to exclude surgery, medication therapy, and specific emergency interventions (Cassata, 1992; American Chiropractic Association, 1991-1992).

Chiropractic licensure requirements in Virginia

Virginia shares with other states two standard requirements for licensure: (1) graduation with a degree of Doctor of Chiropractic from a chiropractic college accredited by the American Chiropractic Association, and (2) a passing grade on the National Chiropractic Boards, parts 1 and 2 (Federation of Chiropractic Licensing Boards, 1992-1993). Virginia does not require a specific clinical/practical examination (as forty-five other states do), and the Commonwealth is one of only six states without a continuing education requirement as a condition for license renewal (FCLB, 1992-1993).

Chiropractic Efficacy and Cost-Effectiveness

House Joint Resolution No. 26 is focused on the potential **regulatory** effectiveness and efficiency which might result from a separate Board of Chiropractic in the Commonwealth, and not on the efficacy or cost-effectiveness of chiropractic per se. Nonetheless, arguments favoring a separate board frequently refer to research directed to establishing the efficacy or cost-effectiveness of chiropractic care. In addition, these arguments often refer to patient satisfaction with chiropractic care.

Chiropractic patients describe their treatment favorably (Shifrin, 1992; RAND, 1991). Most of the care they receive is for low back pain, and involves spinal manipulation and multiple visits. The most authoritative current review of chiropractic utilization and efficacy was published by the RAND Corporation in 1991. The study investigated three conditions treated by chiropractors: (1) acute low back pain, (2) subacute low back pain, and (3) chronic low back pain.

Analyzing the methods and findings of 76 research studies, the RAND study reached mixed conclusions. To date, although the efficacy of spinal manipulation by chiropractors has

been neither validated nor disproved, the RAND study concluded that for acute low-back pain with and without sciatic nerve root irritation, and for subacute low back pain without sciatic nerve root irritation, spinal manipulation may offer a short-term benefit in terms of pain relief (RAND, 1991: 7-11).

The findings of studies of cost-effectiveness seem clearer, but the findings are not universally accepted as authoritative. Meade (1990) studied chiropractic versus allopathic medical interventions involving low back pain. The outcomes support chiropractic as a cost-effective alternative to allopathic care and intervention. Similarly, Nyiendo, Rosenberg and Lamm (1991) studied chiropractic versus allopathic medicine on low back pain using retrospective analysis of Workers' Compensation claims. Their conclusions demonstrate an overall advantage for chiropractic care in terms of loss of work and compensation costs.

Chiropractic and Medicine: Complementary or Competitive?

The question of whether chiropractic and allopathic medicine are complementary or competitive is germane to the review requested in House Joint Resolution No. 26. Physicians often refer to chiropractic as an adjunct to medical diagnosis and treatment. When patients express a desire to see a chiropractor, these physicians may refer the patient for specific treatment interventions. In this sense, at least some segment of the allopathic profession sees chiropractic as a complementary function.

Chiropractors, on the other hand, generally express the view that chiropractic and medicine are in competition, and that the regulation of chiropractic by a board comprised predominately of MDs is akin to the "fox guarding the henhouse." A definitive analysis of the issue of complementarity vs. competitiveness is

beyond the reach of the current study, but substantial guidance is available from the legal record.

In August, 1987 the United States District Court for the Northern District of Illinois, Eastern Division issued a permanent injunction order against the American Medical Association in Wilk, et al. v. American Medical Association, et al. The Court found with respect to antitrust laws:

> **Under the Sherman Act, every combination or conspiracy in restraint of trade is illegal. The court has held that the conduct of the AMA and its members constituted a conspiracy of trade based on the following facts: the purpose of the boycott was to eliminate chiropractic; chiropractors are in competition with some medical physicians; the boycott had substantial anti-competitive effects; there were no pro-competitive effects of the boycotts; and the plaintiffs were injured as a result of the conduct. These facts add up to a violation of the Sherman Act.** (Emphasis added)

While this decision has had profound effects upon the activities of organized medicine relative to chiropractic, there is no evidence in the decision of the Court that any state or other governmental jurisdiction was guilty of antitrust with respect to the treatment of chiropractic and chiropractors.

II. METHODS AND FINDINGS OF THE REVIEW

HJR 26 requested the Board of Health Professions to study the feasibility and appropriateness of a separate Board of Chiropractic in the Commonwealth, to include "an examination of other states' structures for the regulation of chiropractors and the possible improvements in effectiveness and efficiency of regulation such a separate board could have." The Resolution requested the Board of Health Professions to seek input from the general public and from chiropractors licensed and practicing in the Commonwealth in its deliberations.

The Board of Health Professions review included the following:

- Literature Review. While a large body of literature exists on the history of chiropractic and on the conflict between chiropractic and organized medicine, no studies have addressed the specific question of the most appropriate structure for the regulation of the chiropractic profession. The current study is therefore a substantive contribution to the regulatory literature.

- Public Hearing and Solicitation of Public Comment. The Board convened an informational public hearing on August 19, 1992 in Richmond, and solicited comments from chiropractors in a mailing to all chiropractors licensed by the Board of Medicine. In addition, the invitation to comment was widely distributed and published in newspapers of general circulation in the Commonwealth. The bulk of all comments received came from chiropractors.

  Those chiropractors who presented oral testimony at the hearing were divided on the issue of a separate board. While the majority favored such a structural arrangement, others, including two chiropractors who were seated on the Board of Medicine in the past opposed a separate board. The current sitting chiropractic member of the Board of Medicine also opposes a separate board.

The public hearing/public comments identified a number of issues which were explored in subsequent research and inquiry.

Survey of Other States. A survey (Appendix A) was mailed to each state seeking information on: the structure for licensing; numbers of licensees; complaint, investigation and sanction data; fees, revenues and expenses; scope of practice, and other relevant questions of interest.

Thirty-nine of the 51 licensing authorities responded, providing information for the 1988-1991 timeframe. All four states which regulate chiropractors through a non-chiropractic board responded. Thirty-five of 47 states (74 percent) with separate boards of chiropractic responded.

Staff analysis of data from this survey and other comparable data included design of a causal model to explore the following questions:

1. How does the composition of the licensing board influence regulatory effectiveness (defined in terms of complaint and sanction performance)?

2. What licensing structures are most strongly associated with regulatory effectiveness (discipline) and regulatory efficiency (defined as available resources to resolve complaints in a reasonable timeframe)?

3. How are other regulatory variables (i.e. presence or absence of internship requirements, temporary license arrangements, continuing education requirements) associated with effectiveness and efficiency as defined in 1 and 2, above?

4. What is the relationship between regulatory efficiency and regulatory effectiveness?

The results of this statistical inquiry are at best suggestive since: (a) consensus on indicators and measurements of regulatory effectiveness and efficiency is difficult to reach, (b) valid and reliable data are not readily available, and (c) the model leaves unexplored many variables whose effects may be significant (for example, the autonomy of a separate board of

chiropractic may nonetheless be enhanced by its assignment to a centralized oversight agency).

Other Data Collection. In addition to the research literature, documents of record from the following sources were analyzed: American Chiropractic Association, Virginia Chiropractic Association, Federation of Chiropractic Licensing Boards, U.S. Census Bureau, Virginia Board of Medicine, Department of Health Professions (Investigations Division, Finance Division), Virginia State Archives, Office of the Inspector General of the U.S. Department of Health and Human Services.

A bibliography of all publications examined is appended.

Together, these information sources led to the identification of a number of issues which were subsequently explored in depth:

- issues related to the regulatory structure and its effects;
- issues related to disciplinary effectiveness and the equitable treatment of licensees; and
- issues related to cost.

The findings of the Board of Health Professions are highlighted at the conclusion of the discussion of each issue. The Board's recommendations are provided in the Executive Summary.

III. ISSUES RELATED TO REGULATORY STRUCTURE

The following issues related to the structure for chiropractic licensure in Virginia and the effects of this structure were raised with sufficient frequences to warrant analysis.

- Equity. The majority of Virginia licensed chiropractors expressed the view that licensure and regulation by the Board of Medicine was

inappropriate and inequitable, given the autonomy of the chiropractic profession, its numbers, and the domination of the Board of Medicine by medical doctors and other non-chiropractors.

Other chiropractors, including the current and past chiropractic members of the Board of Medicine favor continuation of the current arrangement, citing the benefits of interdisciplinary collegiality and opportunities to educate physicians about chiropractic efficacy. These authorities, however, support an increased number of chiropractic members on the Board, and the formation of a chiropractic advisory board to assist the Board of Medicine in the regulation of chiropractors.

The assignment of chiropractic to the Board of Medicine and the allocation of the single position on that Board to chiropractors is the prerogative solely of the Virginia General Assembly. A review of other professions regulated by that Board (See Figure 4, page 8) shows an analogous structure for the licensure of other autonomous professions (osteopathic physicians, podiatrists, and clinical psychologists).

By contrast, allied health professions (physical therapy, physician's assistants, occupational therapists, etc.) are typically provided no seats on the Board. Among these professions, advisory boards may or may not have been created by the General Assembly to assist the Board in rulemaking or discipline, or both.

Restrictiveness. The majority of chiropractors submitting comments felt that regulation by the Board of Medicine unduly restricts the scope of practice and prevents chiropractors from offering services for which they are trained and competent.

Others commented that despite the **perception** of restrictiveness, the Board of Medicine has not interpreted the statutory scope to unduly restrict practice. Opinions regarding this matter may reflect the therapeutic orientation and education of the practitioner (i.e., "straights" v. "mixers").

Examination of the relationship between the regulatory structure and scope of practice discloses this relationship to be at best indirect and complex. Two jurisdictions in which chiropractic is regulated by a non-chiropractic

board (Virginia and the District of Columbia) have "restrictive" scopes; another (Kansas) has a "moderate" scope, and the fourth (Illinois) has a "liberal" scope of practice. (See Figure 2, page 3).

Discriminatory Effects. Most chiropractors believe that the perception and reality of regulatory restrictiveness in the Commonwealth causes chiropractors to prefer other practice locations. As a result, Virginia has the lowest ratio of chiropractors to population in the nation. (See Figure 3, page 5).

Analysis discloses that board structure is associated with chiropractor/population ratios at a statistically significant level: chiropractic boards and boards with strong representation of chiropractors are correlated with higher numbers of chiropractors per capita, and, by inference, with greater access to chiropractic services. This association is even stronger when chiropractic boards, a broad scope of practice, and a school of chiropractic coexist in a state. Specifically the presence of a school of chiropractic, a chiropractic board, and a broad scope of practice lead to higher per capita rates of chiropractors.

No state in which chiropractic is regulated by a non-chiropractic board is in the top twenty percent in terms of the ratio; two jurisdictions (Virginia and the District of Columbia) are in the bottom ten percent, and Virginia has the lowest ratio.

Effects on Professionalization. The majority of chiropractors who submitted comments believe that the "generic" regulation by the Board of Medicine inhibits the further professionalization of chiropractic. Specifically, they cite the absence in Virginia of requirements for internships, continuing education, and opportunities for temporary licensing.

It is notable that, in Virginia, the same body of statutes and regulations govern the autonomous professions (MDs, osteopaths, chiropractors, podiatrists, and clinical psychologists) licensed by the Board of Medicine. No differentiation is made relative to standards of practice, unprofessional conduct (advertising, marketing, etc.), or grounds for discipline between or among these autonomous groups, although internships and

residencies are regulated in medicine, osteopathy, and clinical psychology.

By contrast, in the regulation of allied health professions (physical therapy, occupational therapy, etc.), separate statutes and regulations provide for differentiation based on the practices of the professions and relative needs for public protection. This differentiation has been fostered in some instances through the statutory creation of advisory boards or committees which consult with the Board of Medicine on profession-specific issues. These bodies are consulted when rulemaking occurs, as well as when a need exists to interpret standards of care, conduct, appropriate sanctions, etc., related to professional discipline.

A point frequently made is that unlike physicians, few chiropractors have hospital staff privileges, or participate in other institutionally-based care in which peer review mechanisms ensure appropriate oversight of the professions.

Analysis shows that variation in continuing education requirements is not associated with board structure. Among chiropractic boards, an average of twelve continuing education units are required, ranging from none to twenty-five hours. Among the four states with non-chiropractic boards, the requirement ranged from none to fifty CEUs per year. Kansas requires 50 CEUs; the District of Columbia twelve, Illinois requires only one CEU; Virginia has no requirement.

By contrast internships are strongly and directly associated with the regulation of chiropractors by chiropractic boards. The proportion of these boards with provisions for internships grew from one-quarter to more than one-third from 1988 to 1991.

Finally, only one of the four non-chiropractic board states provided for temporary license at anytime during the past four years. Among chiropractic board states the proportion rose from one in five to 30 percent during this timeframe.

If there is a need to differentiate regulations and standards appropriate for the chiropractic profession, evidence from the Virginia experience shows that this could be accomplished through a chiropractic advisory board without creating a separate board of chiropractic.

While the Board of Health Professions presents these findings without recommendations, it should be noted that there is little consensus as to the public protection value of requirements for continuing education or internships, or provision for temporary licensure, absent documentation of the relevance to these requirements to public protection in the specific profession under scrutiny.

In the instance of chiropractic, the lack of an effective peer review system does create concern for public protection. This concern can be addressed directly through greater oversight of the practice of licensed chiropractors and need not involve a separate board of chiropractic.

Issues Related to Disciplinary Effectiveness and Equity.

The majority of chiropractors presenting comments argued that disciplinary processes and decisions made by the Board of Medicine related to chiropractic licensees are inappropriate or unjust. They asserted that these unjust or inappropriate processes and actions result from a lack of understanding of the unique qualities of chiropractic and from an inclination or predisposition to harass chiropractors.

In addition, critics of the current system cite the fact that the under-representation of chiropractors may result in serious problems when informal fact-finding conferences do not resolve disciplinary issues, leading to the subsequent conduct of formal hearings. Virginia statutes require that participants in informal conferences refrain from participation in formal hearings related to the same disciplinary case. The single chiropractor on the Board cannot participate in both processes.

Finally, a number of chiropractors argue that case resolution time in Virginia was too long, and that a separate board of chiropractic could resolve disciplinary issues more expeditiously.

Disciplinary effectiveness is the hallmark of professional regulation in the public interest. For that reason, the Board of Health Professions has carefully and thoroughly analyzed information on disciplinary performance among "chiropractic," and "non-chiropractic" boards, including the Virginia Board of Medicine.

According to Dolan and Urban, (1983), board effectiveness may be measured by the annual number of revocations, probations, suspensions, reprimands, censures, and voluntary surrenders of licenses. These enforcement measures can be subsumed under three topical headings: complaints made, investigations conducted, and sanctions determined during a specific time period.

A national study of chiropractic discipline was conducted by the Office of the Inspector General, U.S. Department of Health Professions in 1989. That study found that the substantial majority of national disciplinary actions from 1986 to 1989 were for excessive utilization of services and associated fees, and for advertising abuses. Complaints about services involves excessive visits, and visits incurred beyond an established period of usefulness. Relatively few cases involved overuse of x-rays.

Excessive advertising is not condoned by the American Chiropractic Association (1991-1992b). The most prominent form of advertising abuse, according to the Inspector General, was "no out-of-pocket expense" (NOOPE), a marketing device used to recruit new patients. NOOPE has been criticized as an unfair advertising practice. Some states prohibit NOOPE by statute; in Virginia, chiropractic advertising is subject to generic advertising ethics regulations applicable to physicians, osteopaths, podiatrists, clinical psychologists and chiropractors.

The research conducted for this review included surveys of all state boards regulating chiropractic, a retrospective analysis of Virginia complaints, investigations and sanctions involving chiropractors over the past five years, and the reading of a small non-random selection of chiropractic case files by members and staff of the Board of Health Professions. While the results of this last activity cannot stand alone as evidence of propriety or justice, they provide impressions which support or refute some allegations against the process and outcomes of disciplinary cases.

Certain caveats are important to comparisons of states using these data. The number of complaints, investigations and sanctions is influenced by the scope of practice and other regulatory provisions which differ among the states. Board effectiveness, as measured by enforcement activity, also depends on the availability of financial and other resources sufficient to support enforcement activity.

With these important limitations in mind, a comparative analysis of disciplinary performance in Virginia and other states follows.

- Figure 5 examines the rate of complaints, investigations and sanctions involving chiropractors in all jurisdiction for two time periods: 1988-89 and 1990-91. Chiropractic complaints increased from six percent to 6.5 percent of all chiropractors nationally during this period. Investigations showed a similar increase from 4 percent to 4.5 percent. Sanctions remained stable: one percent of all chiropractors were sanctioned by state boards in both 1988-89 and 1990-91.

- As Figure 6 demonstrates, however, the rate of complaint fluctuates even over short timeframes. In Virginia, over the past four years, the proportion of chiropractors who are subjects of complaints ranged from more than six percent in 1988 to just under three percent in 1990.

Figure 5

Complaints, Investigations, Sanctions
All Boards Regulating Chiropractic
(n=39)

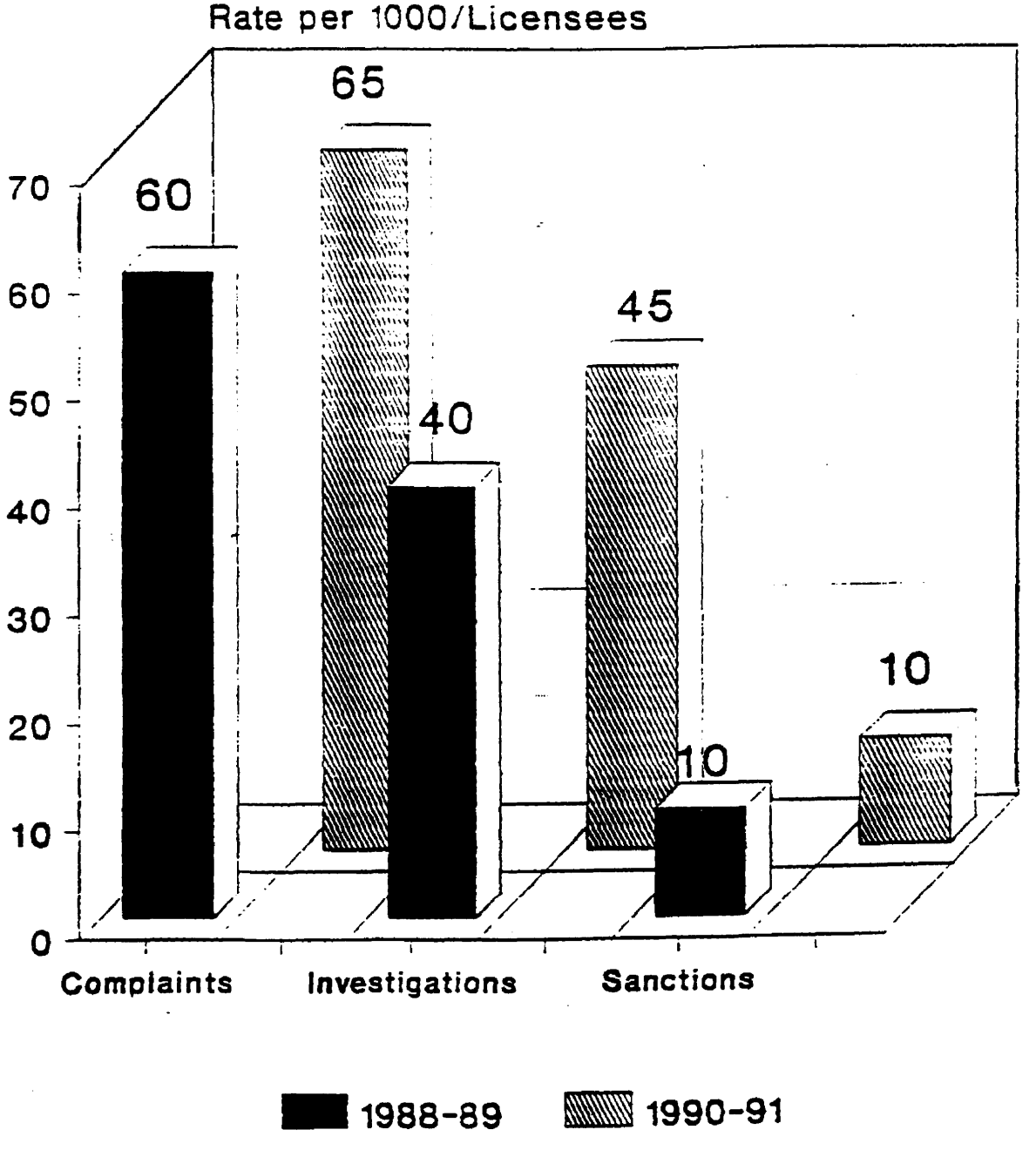
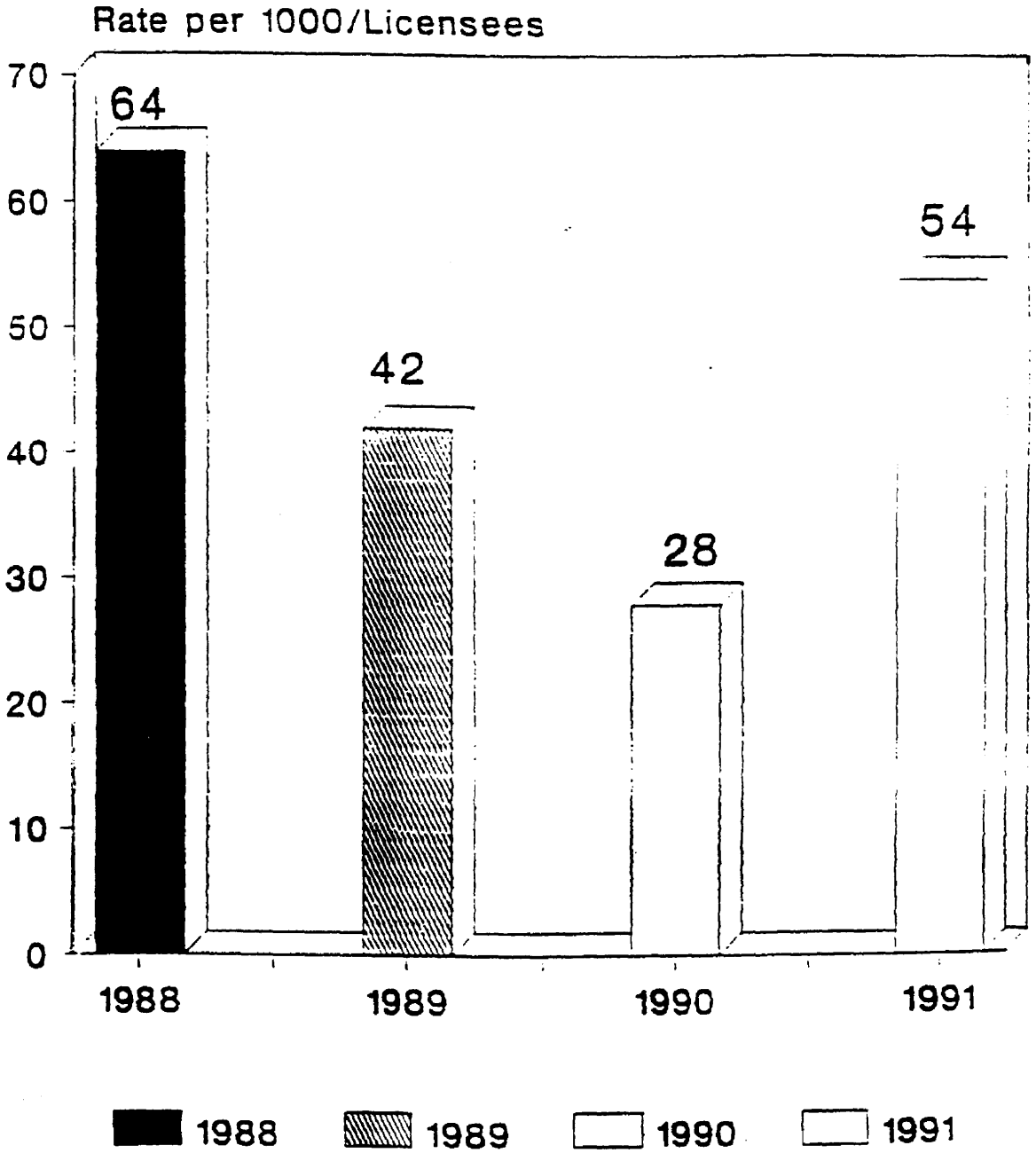


Figure 6

Virginia Chiropractic Complaints
1988-1991



- Figure 7 compares the Virginia experience with other states having either "chiropractic" or "non-chiropractic" licensing boards. While the rate of complaints and investigations in Virginia was lower over the last three years than in other states (both "chiropractic" board and "non-chiropractic" board states), the rate of sanction was identical (one percent) in the three comparison groups.

- Figure 8a compares the chiropractic disciplinary experience in Virginia with other professions regulated by other boards in the Department of Health Professions. Chiropractic complaints were equal to complaints against optometrists (5.4 percent), but higher than for dentists (3.9 percent). The rate was nearly 20 times as great for chiropractors as for nurses (.3 percent).

  Figure 8b compares complaint data among chiropractors, physicians, and physical therapists, all licensed by the Board of Medicine. The range was from more than seven percent of licensed podiatrists to less than one percent for physical therapists. Between these extremes, chiropractors were second in the grouping (five percent), MDs were third (three percent) and, osteopathic physicians were fourth (two percent).

- Figures 9a through 10b present the nature and sources of complaint in Virginia and in other states with chiropractic or non-chiropractic boards. While directly comparable data are not available, rates of complaint against Virginia chiropractors for advertising violations were substantially greater than in other states (both chiropractic board and non-chiropractic boards), but fee complaints were made at much lower rates.

  Notably, fee complaints were much more frequent in chiropractic board states (50 percent of all complaints) than in non-chiropractic board states (25 percent). Only ten percent of all Virginia complaints were about fees for service.

  One-third of Virginia complaints involved standards of care, while one-quarter of complaints in non-chiropractic states, and less than one-eighth of complaints in chiropractic board states involved standards of care.

Figure 7

Complaints, Investigations, Sanctions By Board Type

(n=39)

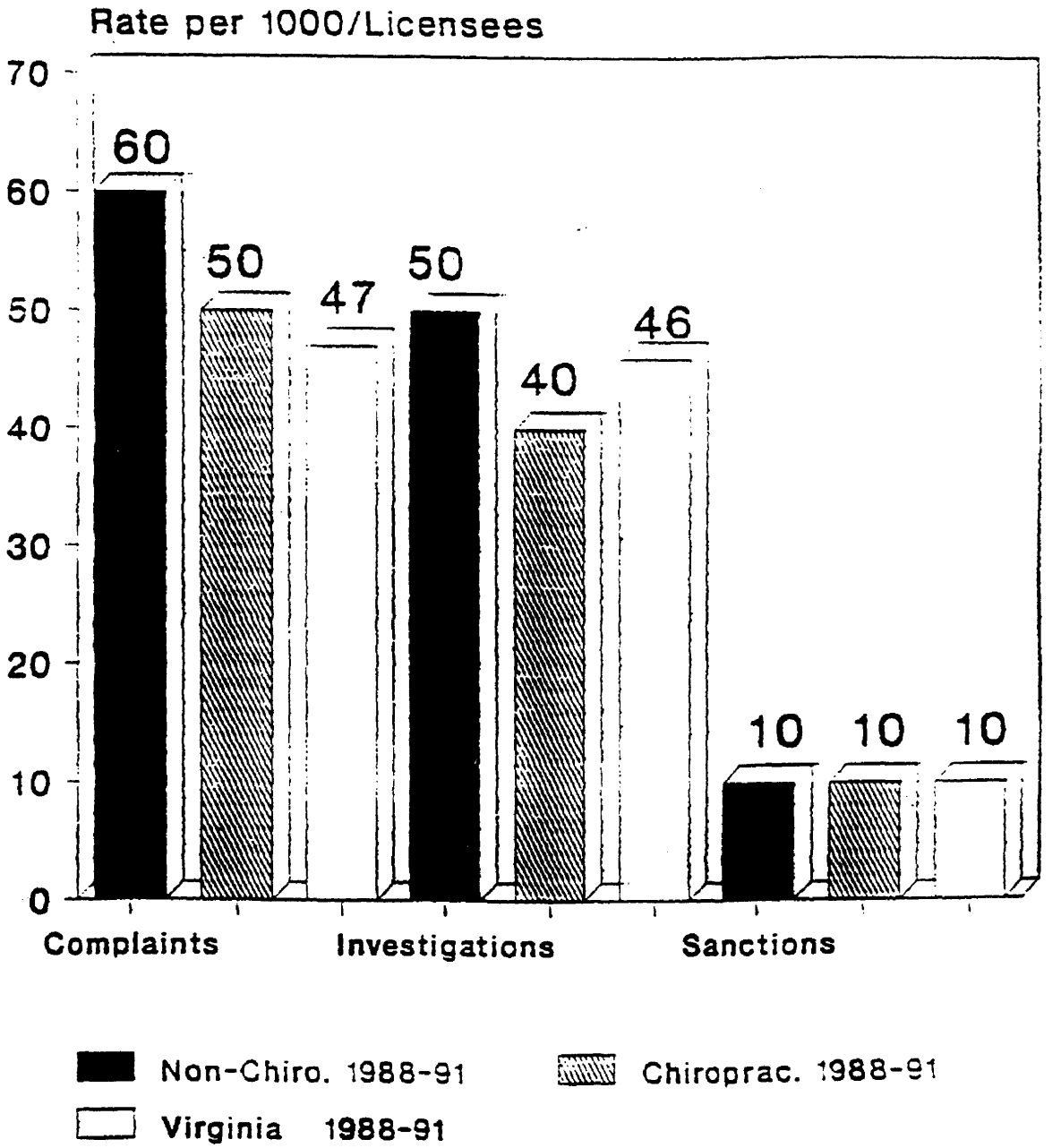


Figure 8A

Virginia Complaints
By Licensee:1991

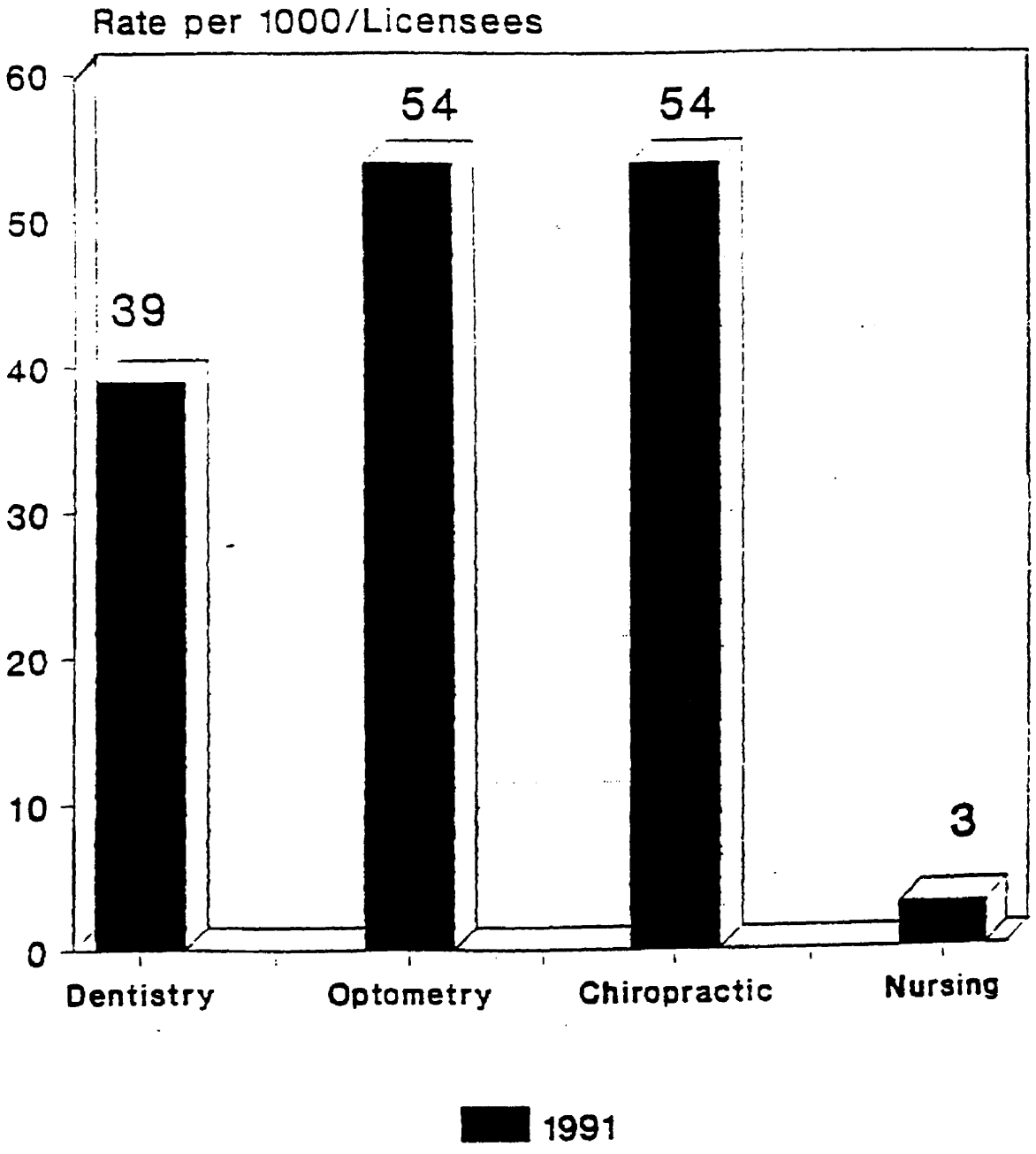


Figure 8B

Virginia Complaints
MD's, DO's, DPM's, DC's, PT's:1991

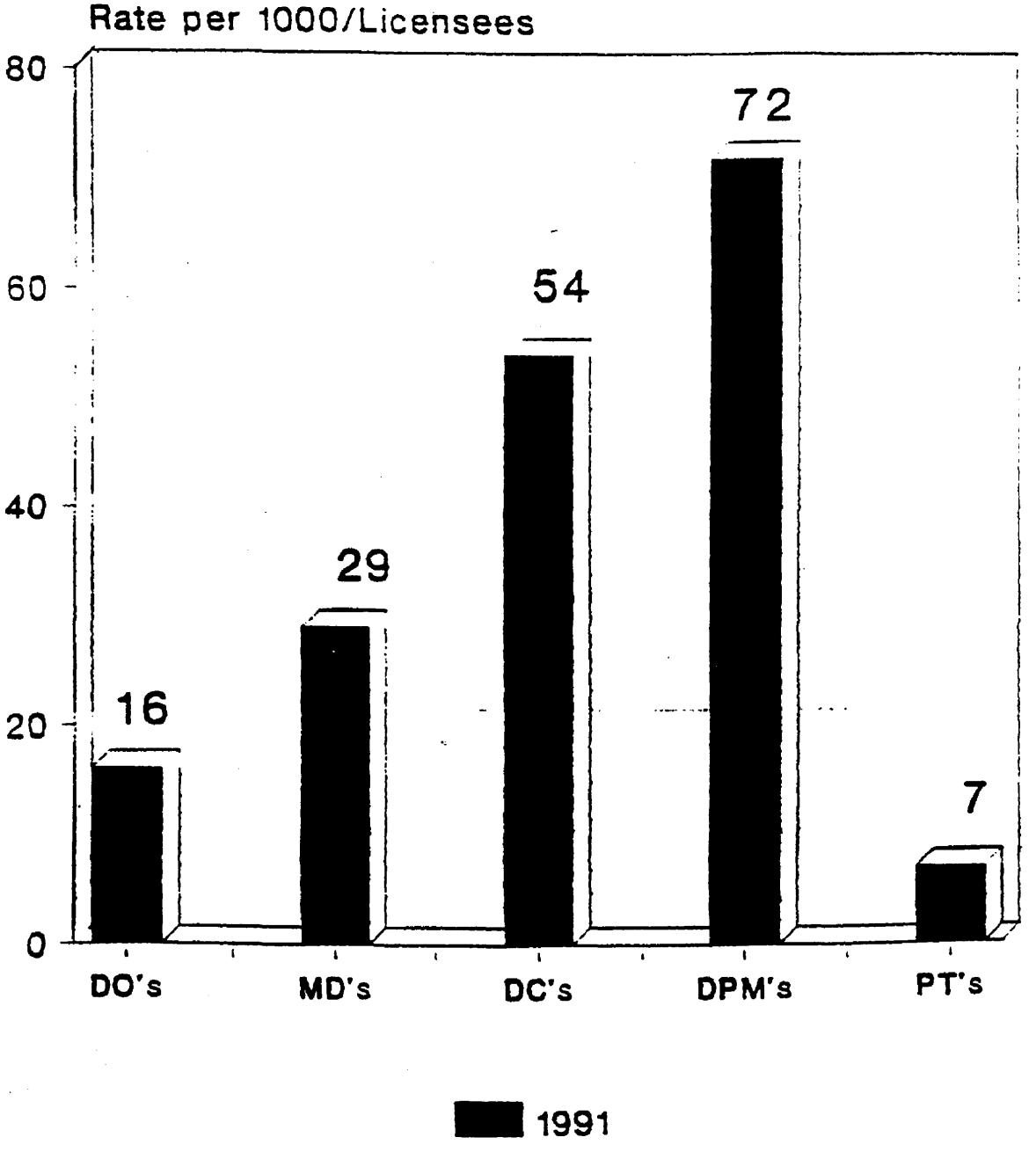
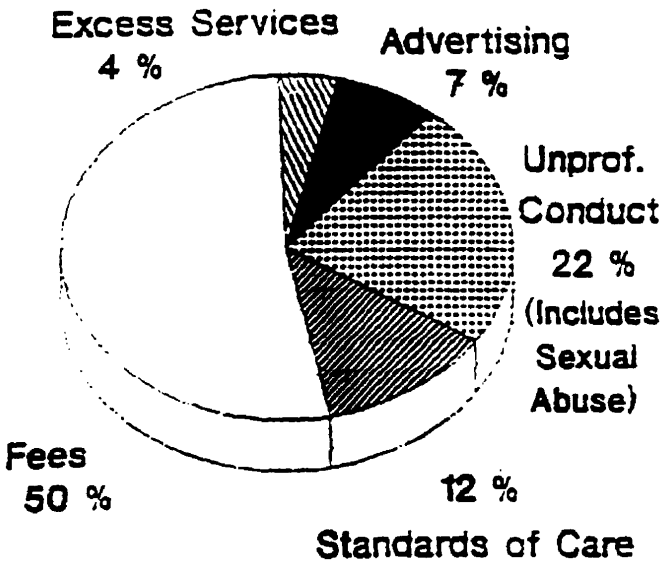


Figure 9A

Types of Complaints
By Board
1988-91

Chiropractic
(n=35)



Non-Chiropractic
(n=4)

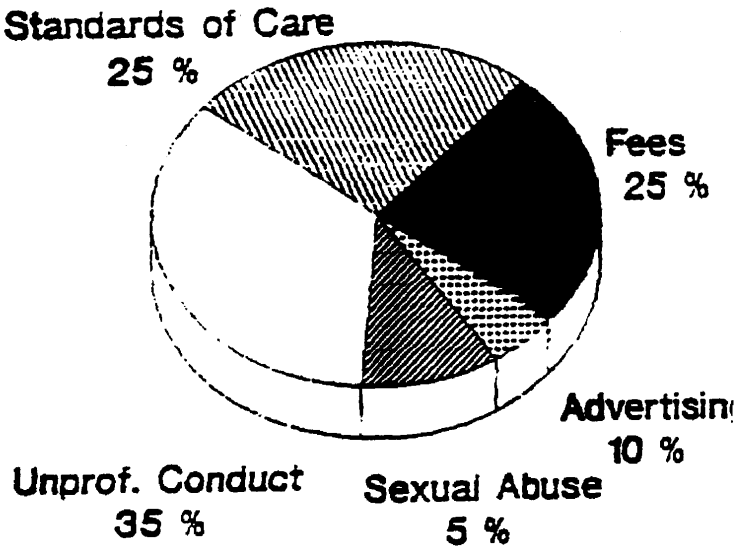
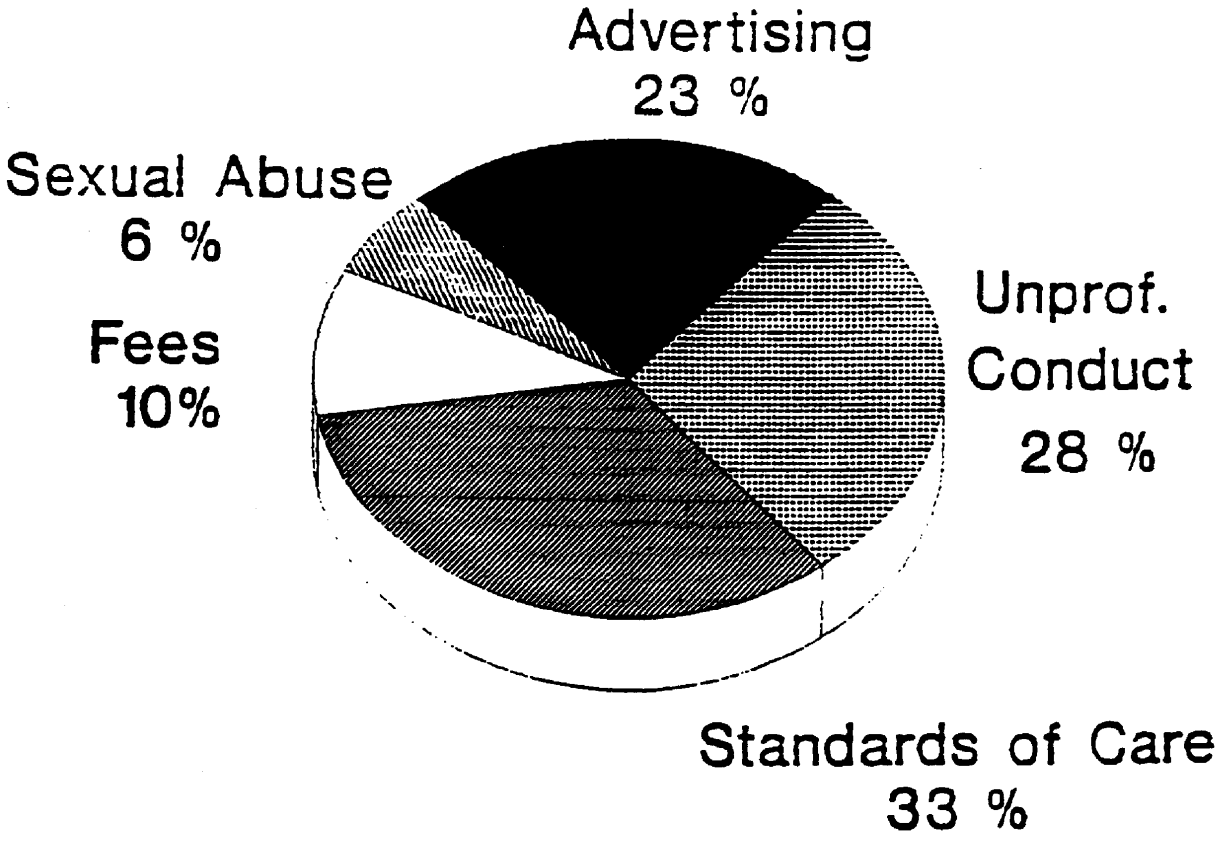


Figure 9B

Types of Complaints
Virginia

1988-91



Chiropractic

Figure 10A

Source of Complaints
By Board
1988-91

Chiropractic	Non-Chiropractic
(n=35)	(n=4)

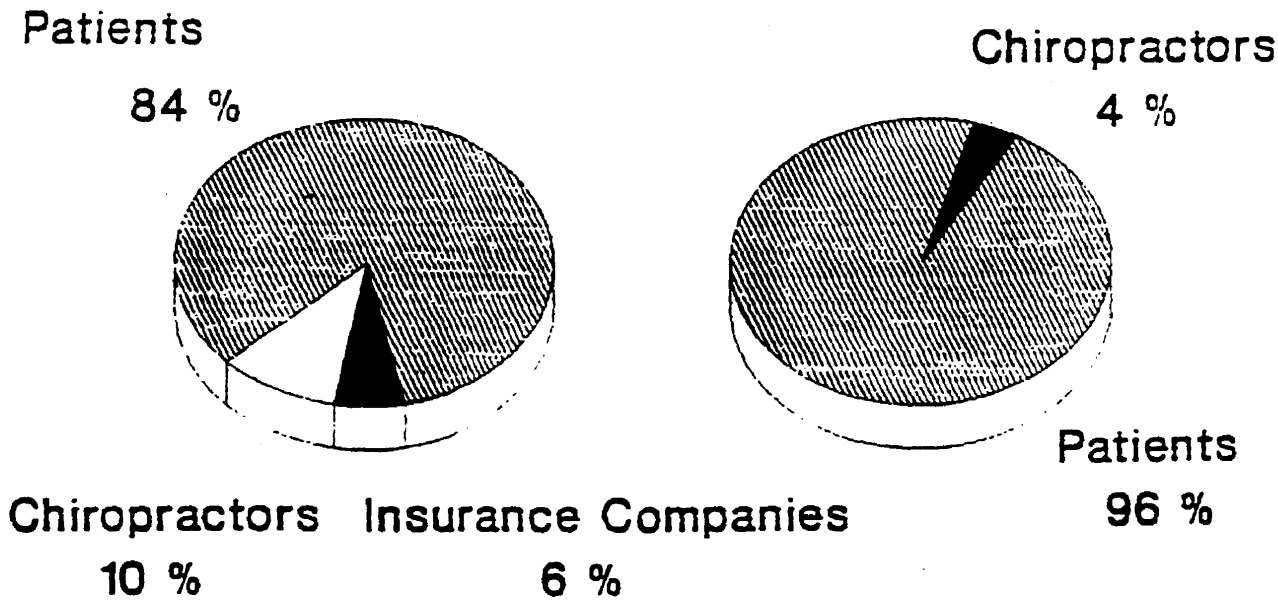
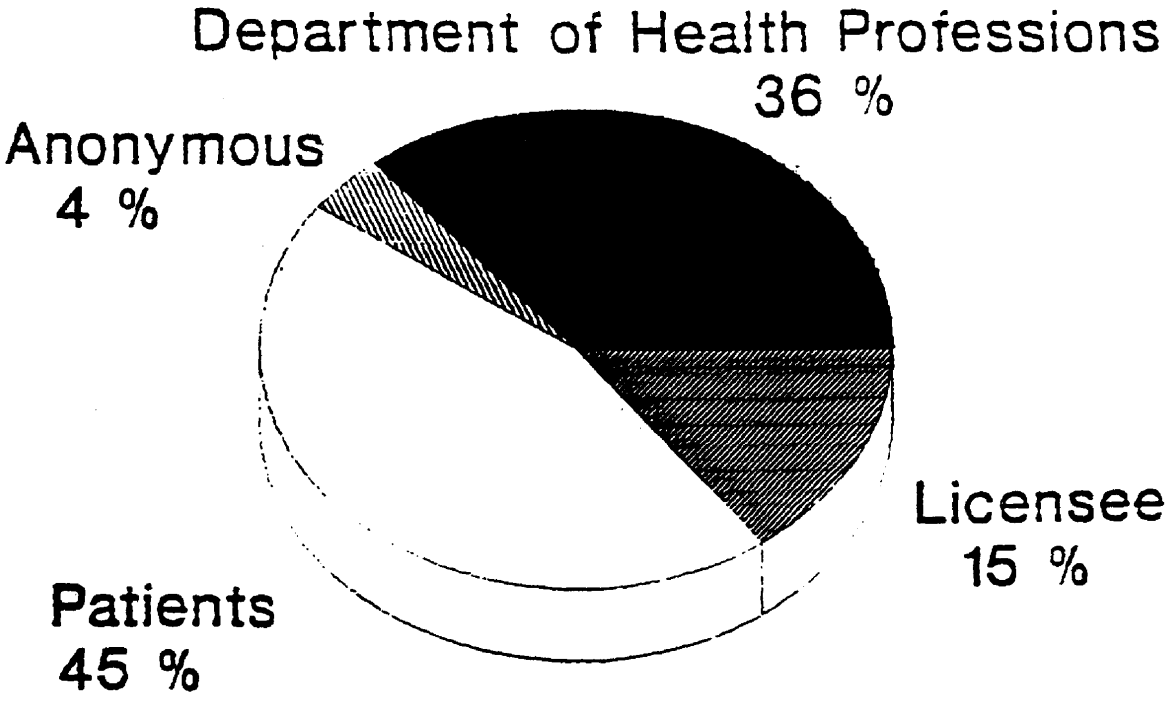


Figure 10B

Source of Complaints
Virginia
1988-91



Chiropractic

The sources of complaint vary among board types as well, but inconsistent classifications make valid comparisons difficult. Patients were the source of 96 percent of all complaints in non-chiropractic boards, and accounted for 84 percent of complaints in chiropractic board states. In Virginia, patient complaints accounted for less than one-half of all complaints against chiropractors.

- Figure 11 compares case resolution times in Virginia and among board types. Virginia's average case resolution time was slightly lower (94 days) than in chiropractic board (98 days) and non-chiropractic board states (95 days). These differences are not statistically significant.

Dolan and Urban offer a useful typology for examining disciplinary performance. They argue that boards spend too much time and resources investigating and sanctioning offenses that do not place the public at true risk (advertising, marketing, etc.), and too little time and resources pursuing complaints that present a high risk for harm to the public (for example, standards of care). They call the former "false positive" cases, and the latter "false negative" cases.

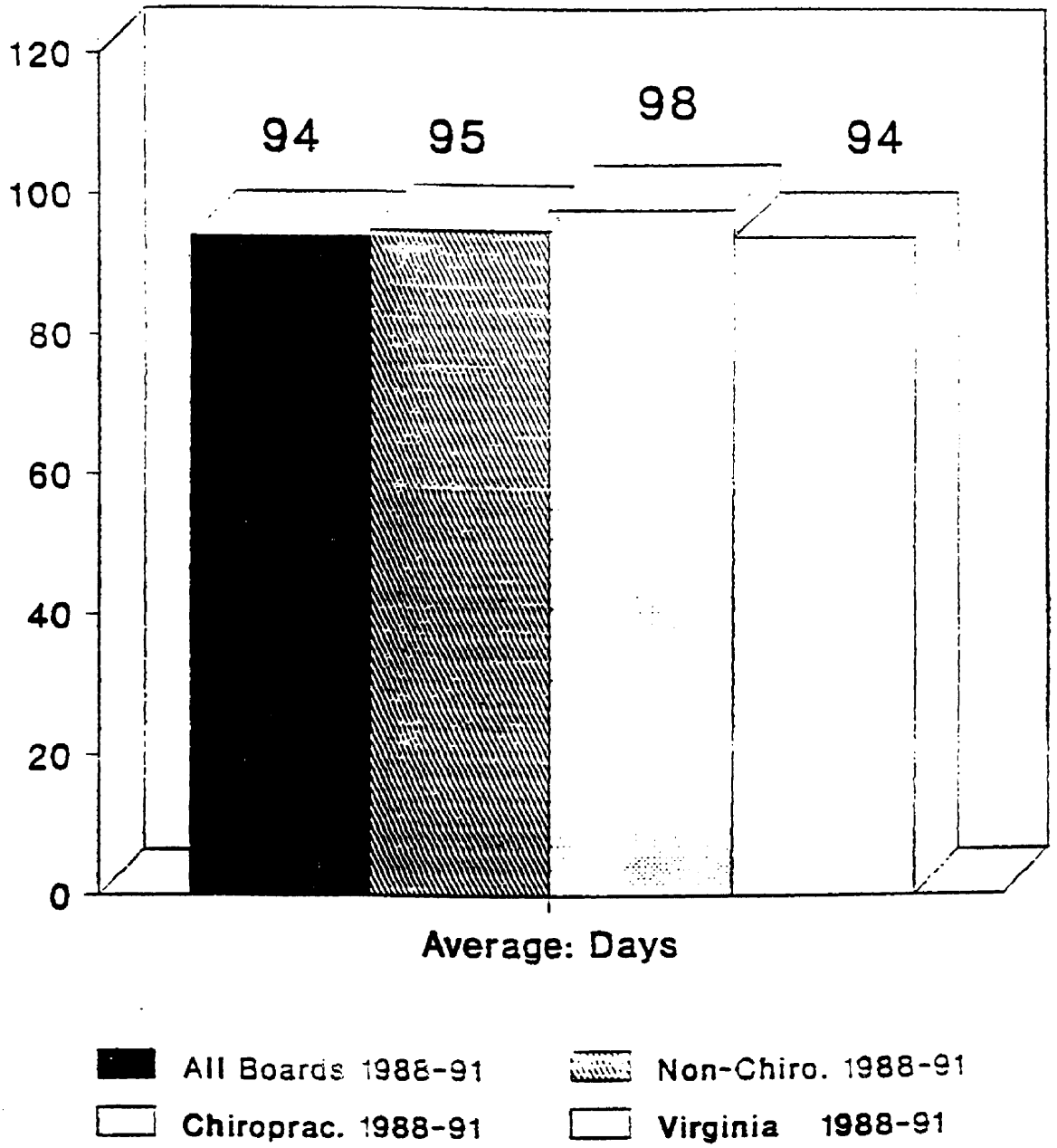
In Virginia, while it appears that advertising cases do comprise nearly one-quarter of the docket, the Commonwealth leads other states in addressing cases involving standards of care.

Analysis of quantitative information related to the discipline of chiropractors does not disclose factors that would lead to strong recommendations in favor or in opposition to the formation of a separate Board of Chiropractic in the Commonwealth.

More important to the question of the appropriateness of the current structure for regulation are questions of equity and fairness in disciplinary decisions. Such qualitative judgments cannot be made from a review of aggregate data, and any attempt to "second-guess" the Board of Medicine by a review of individual cases would be vulnerable to attacks alleging bias or prejudice on the part of reviewers.

Figure 11

Resolution Time for Complaints
By Board Type



The majority of chiropractors hold that disciplinary decisions of the Board of Medicine related to licensed chiropractors could be improved by closer consultation with the chiropractic profession. While this is accomplished informally in the instance of chiropractic, formal arrangements for consultation exist in the regulation of allied health professions. In the absence of evidence to the contrary, the Board of Health Professions must consider this to be a valid suggestion, i.e. the formation of an advisory board on chiropractic to supplement the representation of chiropractic among the members of the Board should be seriously considered.

Moreover, the problems which occur because of the inability of the single chiropractor on the Board of Medicine to participate in informal conferences and formal hearings in some cases implies that the number of chiropractors on the Board should be reconsidered. It is noted that two chiropractors previously served on the Board, and that no reason has been provided for eliminating one of these positions in the recent past.

Issues Related to Cost

The Department of Health Professions does not separately account for the cost of regulating chiropractors. Revenues received from chiropractic licensees are approximately $81,125 per year (including 120 initial exams per year at $250 and 818 renewals at $125 per biennium). Because Board of Medicine overall revenues have been greater and expenditures have been much less than projected in the current biennium, it is expected that licensure fees for all professions regulated by that Board will be reduced in the near future, as required by Virginia law.

The national average for initial licensure is $225 for non-chiropractic board states and $220 for chiropractic board states with a range of $50-$300 in non-chiropractic board states and $50-$525 in chiropractic board states. Average renewals are $190 per biennium in non-chiropractic board states (with a range of $120-$300) and $200 per biennium in chiropractic board states (with a range of $25 - $322).

Estimates of the comparative costs of (a) maintaining the current system, (b) increasing the number of chiropractors seated on the board, (c) creating an advisory board on chiropractic to the Board of Medicine (with or without adding additional chiropractors to the Board), and (d) creating a separate Board of Chiropractic have been made by staff. Expenses for options (a), (b), and (c) are well within revenues projected from the existing chiropractic licensure base.

The highest expenses would occur should option (d), a separate Board of Chiropractic be exercised. The costs of operating boards for professions of similar numbers within the Department are $126,000 (Board of Psychology), and $122,000 (Board of Nursing Home Administrators). Funding for an increase of this order over current revenues generated from chiropractic licensing would require only small increases in chiropractic fees. These increased costs would ultimately be passed on to the consumer, but their effects on cost per chiropractic visit or procedure would be insignificant.

The cost of adding an additional chiropractor to the Board of Medicine, or of creating an advisory board to the Board of Medicine (with or without increasing chiropractic members on the Board), or of creating a separate Board of Chiropractic are not factors which should inhibit recommendation of any of these alternatives should they be warranted by any systematic evidence that the public would be better protected by these alternative arrangements or regulatory structures.

SUMMARY

The greatest obstacle to a recommendation of any alternative structure for the regulation of chiropractic in the Commonwealth at this time is the division of opinion within and outside the chiropractic profession regarding the merits of these alternatives.

The Virginia Chiropractic Association sees no merit in either expanding the number of chiropractors on the Board of Medicine or in creating an advisory board or committee on

chiropractic to the Board of Medicine. That association believes that only a full Board of Chiropractic can adequately protect the public and serve the needs of the profession.

Other chiropractic leaders, including current and past chiropractors seated on the Board of Medicine oppose the creation of a separate Board of Chiropractic. They believe that adding one or more chiropractors to the Board or the creation of an advisory board on chiropractic may facilitate the better management of rulemaking and discipline related to chiropractic.

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APPENDIX - A: SURVEY of STATES

COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Health Professions

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Study of The Need for Board of Chiropractic

In Virginia, chiropractors and the practice of chiropractic are regulated by the Board of Medicine, a 17 member board which includes one chiropractor member. The Virginia Legislature has requested the Board of Health Professions to study the need for and efficacy of a separate licensing board of chiropractic within the Department of Health Professions. We would appreciate your providing the following information concerning the licensure of chiropractors within your state. Please return by August 12, 1992. Thank you.

	1988	1989	1990	1991
1. a. What board licensed chiropractors in your state in? (e.g. Chiropractic Board: CB, Medical Board : MB, Other Board : OB)	____	____	____	____
b. What board disciplined chiropractors in your state in?	____	____	____	____
2. How many licensed chiropractors were there in?	____	____	____	____
3. How many complaints against chiropractors were received in?	____	____	____	____
4. How many of these complaints were investigated in?	____	____	____	____
5. How many investigations resulted in a sanction?	____	____	____	____
6. What was the average number of days for resolving these complaints in?	____	____	____	____
7. What source accounted for the greatest number of complaints in? (e.g. patients, physicians, other chiropractors)	____	____	____	____

Study of The Need for Board of Chiropractic
(continued)

8. What type of complaint was received most in? (e.g. excessive service/fee abuse; alcohol or drug abuse; standards of care; unprofessional conduct (including advertising); etc.)

   1988: _____

   1989: _____

   1990: _____

   1991: _____

9. What was the total cost in dollars of the regulatory program for chiropractors in?

   1988: _____

   1989: _____

   1990: _____

   1991: _____

	1988	1989	1990	1991
10. a. What was the initial licensure fee in? (in dollars)	____	____	____	____
b. What was the annual renewal fee in? (in dollars)	____	____	____	____
11. What percentage of all licensure and other fees were allocated for the costs of chiropractic regulation in? (i.e. was some portion of fees collected used for general funds or other purposes?)	____	____	____	____
12. If continuing education was required for licensure renewal, how many units were required in? (please indicate "clock hours" or "CEU's")	____	____	____	____

Study of The Need for Board of Chiropractic
(continued)

	1988	1989	1990	1991
13. a. Did your state issue a temporary chiropractic license in?	____	____	____	____
b. If yes, what was the maximum time limit of the license?	____	____	____	____
14. Was there a chiropractic internship available in?	____	____	____	____
15. a. Was there a Scope of Practice change from the previous year? (yes or no)	____	____	____	____
b. If yes, was there an increase or decrease in allowable procedures or interventions? (dec or inc)	____	____	____	____

16. What was the composition of the licensure board for chiropractors in?
(e.g. 4 D.C.'s, 1 M.D., 1 Ph.D., 1 D.O., 2 Public)

1988: _____

1989: _____

1990: _____

1991: _____

COMMENTS: _____

_____

_____

STATE: _____ **BOARD:** _____

NAME and POSITION: _____

DAYTIME TELEPHONE: _____