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STRENGTH IN DIVERSITY: PROFESSIONAL AND LEGISLATIVE OPPORTUNITIES IN PRIMARY CARE BY THE RECOGNITION, DEFINING AND PROMOTION OF THE LICENSURE OF CHIROPRACTIC MEDICAL EDUCATION, COMPETENCIES AND SKILLS

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INTRODUCTION

The Birth of a Broad Scope Profession

In 1886, the founder of chiropractic, D. D. Palmer, was a magnetic healer and student of spiritualism. He was an avid reader and open to new ideas and practices. He had “taken lessons and studied Christian Science, Faith Cure, Mind Cure, Metaphysics, Magnetic and Osteopathy” (1, p. 94). As he developed his skills, and as magnetic healing became chiropractic in its infancy, he recognized that his methods had limitations, but the range of conditions he felt he could successfully treat was broad:

“I treat successfully the following diseases: Rheumatism of any kind, neuralgia, the various kinds of stomach ailments, diseases of the liver, kidneys, bowels, bladder, spleen, heart, throat, and head, male and female diseases, periodical headaches, inflammation of the bowels or bladder, brain fever, lung fever, bronchitis, nervous diseases, shaking palsy, quinsy, running sores, abscesses of the lungs, liver or stomach, catarrh, pleurisy, sprains, lameness caused by injuries, asthma, malaria, dyspepsia, female weakness, diabetes, chronic diarrhea, constipation, loss of strength and vitality, eczema, indigestion, erysipelas, dropsy, diphtheria, some diseases of the eye and ear, painful menstruation, piles, incontinence of urine or bed-wetting, consumption, lupus, cancers and tumors when not too far gone, and some cases of paralysis. I give no medicines; you do not have to wait months to see a change. Three to five treatments usu-

ally show you what I can do. I treat causes, not effects. This Vital Magnetic Power of curing disease is sufficient to heal any disease when we know how.

I do not claim to cure all diseases, but I now treat and cure many diseases, which I had not thought of doing five years ago” (1, p. 94).

With regard to the traditional medical practices and physicians of the day, he opined: “Medicine and medical doctors are necessary: we cannot get along without them. But they cannot cure everybody. Neither can I. I especially invite those who have tried all other remedies and have failed to find relief” (1, p. 95).

He marketed himself as “D. D. Palmer-Cures Without Medicine” (1, p. 69). He believed that drugs did not cure disease. The medicine of the day was at best worthless, sometimes poisonous, generally without scientific merit, prescribed primarily on the basis of anecdotes and testimonials. Most all would agree that treating without the medicines and procedures available in the late 1890’s and early 1900’s gave D. D. Palmer the clinical edge. Almost 2000 years earlier Hippocrates had said “Physician Do No Harm.” He wisely heeded these words by not incorporating the drugs of the late 19th century into chiropractic practice.

D. D. Palmer was a generalist, a family care provider, and first chiropractor to practice “primary care,” albeit within his limited training and understanding. He was not opposed to medical interventions, including the use of the medicines that were available in his day.

D. D. Palmer believed that the cause of disease should be treated primarily with the use of one’s hands. His

father wrote: "His cures are made by the use of his hands only. He treats the cause of disease and not the effects. In finding the cause of disease, or as a physician would say in diagnosing, he often tells patients of their disease or ailments instead of the sick telling him. By this gift of knowing and being able to tell the sick how and where they are diseased better than they can themselves, he often finds causes which other doctors have failed to discover . . . He wants cases which other doctors cannot cure, and judging by the ones I saw there, he certainly gets them" (1, p. 74).

DISCUSSION

Early Chiropractic Education

"When D. D. Palmer founded chiropractic and began to practice and teach the fledgling art, he became embroiled in 2 major philosophical shifts, both of which originated in Germany. The Teutonic nation was determined to become the leader in all-scientific pursuits, including medicine. The other area was in education; a rationale by which young people were taught to become more productive and useful citizens. These massive changes transpired in the latter half of the nineteenth century, and they were aggravating obstacles to Palmer's infant profession. The vigor of the Germans efficiently established them as leaders in science. In the ebb and flow between the schools of vitalistic and scientific thought, there was investigation into the sciences, as the world had never seen before. Findings were promptly reported, and a scientific era was born at the very time D. D. Palmer could least afford it in terms of acceptance of his chiropractic profession.

D. D. Palmer was of the old school of teaching. During his year as a schoolmaster, it was his responsibility to teach children regardless of their ability to learn. His pupils, whether dullards or geniuses, were given the information with the expectation that information taught was education gained.

It was also customary of D.D.'s time that if a craft were taught, it would be offered without additional background or peripheral education. If a pupil studies to become a magnetic healer, for example, this is what was taught. Nothing else was offered. A behavioral psychologist from Germany, Wilhelm Maximilian Wundt, changed his philosophy. Wundt believed that people are only what their experiences or stimuli allow them to be. His theories influenced John Dewey, a prominent American specialist in education. Dewey placed into practice 3 of the beliefs he culled from the new psychology: to put children in possession of their fullest talents,

education should be active rather than passive; to prepare children for a democratic society, schools should be social rather than individualistic; and to enable children to think creatively, experimentation rather than imitation should be encouraged.

Dewey's approach was in direct opposition to D. D. Palmer's background. No longer was it enough to just teach chiropractic. Now it became necessary to teach the subject with the support of other relevant topics" (1, p. 75).

Modern and Scientific Chiropractic Education was Born

The debate continued to escalate as to what constituted rational, reasonable and scientific chiropractic education that prepares the graduate DC for primary care. The profession wanted the respect; was it willing to accept the responsibility? Healthcare system parity was being fought for. As new schools were created would chiropractic education meet the concerns and needs of the public, regulators and legislative bodies?

What is Chiropractic Healing Anyway?

In its infancy, D. D. Palmer described it as: "a scientific method of treating diseases. It is a new and radical departure from all other known methods. Chiropractic healing uses no drugs or chemicals, no surgical operations . . . Chiropractic healers need knowledge of the anatomical construction of the human body and the physiological laws governing the distributing of its vital fluids and forces.

Chiropractic healing simplifies the treatment of the most painful and prostrating forms of diseases. The human body is a very sensitive and delicately constructed piece of machinery. As the good book says: 'We are fearfully and wonderfully made.' There are numerous accidents, which are liable to injure and misplace the various parts of this highly sensitive, nervous system.

A pressure upon any one of the nerves causes such diseases as paralysis, rheumatism, neuralgia, asthma, female diseases and the numerous diseases of the stomach, liver and kidneys. All motor and sensory powers are derived through the nerves. How necessary then it is that they should be perfectly free to act. Strange but true, all the nerves of the body may be reached and acted upon by they hands" (1, p. 77).

D. D. Palmer's explanation and understanding of the science and art of chiropractic is a part of the foundation

of the profession today. The profession has grown in many areas, including its science, art, definition and purpose.

The Birth and Development of Rational Chiropractic

Shortly after D. D. Palmer was arrested and jailed for practicing medicine without a license, a fallout occurred between father D. D. and son B. J. Palmer. B. J. purchased the Palmer School from his father, and went on to develop his own system of healing. Meanwhile, D. D. Palmer supported J. F. Alan Howard, a graduate of the Palmer School, in the creation of the eclectic, scientific and broad scope National College of Chiropractic in Chicago, Illinois in 1907. For decades, this eclectic school offered both DC and ND education and training (2). The early years were an important and critical time, as this early divergence became the source for the irreparable separation that exists within the chiropractic profession today. Rational chiropractic, supported by D. D. Palmer and J. F. Alan Howard, sought to develop the philosophy, science and art of chiropractic, and legal and legislative standing that would be required for the chiropractic profession to emerge as acceptable to the academic, scientific and legal sectors of society. The opposition to rational chiropractic was led by B. J. Palmer, who sought to "protect" chiropractic by using evasive terminology in order to avoid the "chill of the law," such as 'analysis' for diagnosis, 'adjustment' for treatment and 'pressure on the nerve' for reflex stimulation or inhibition. It is unfortunate that altogether too many of the pioneers in chiropractic began to believe this 'evasive terminology' to be the gospel, promulgated by B. J. Palmer for more than a half a century (2).

There have been and continue to remain, 2 separate and distinct forces within the profession, the rational and the evasive. The fact and truth of the matter is that the profession has been split almost since its inception. In recognizing this diversity, ONE discovers the profession's strength.

Primary Care, Demand for Parity and Equal Privileges: Facing Reality

The profession has made great strides since its birth in 1895. However, the frank and stark reality remains that the profession cannot and will not sit at the same table with the current make-up of primary-care providers, unless fundamental realities are acknowledged and changes take place within the profession. Primary care must change to accept chiropractic in its current state, or chiropractic must change to embrace primary care.

The rational group must be allowed to compete, develop their diversity and practice chiropractic medicine. If we are going to be race-car drivers, and participate in the healthcare race, we must learn to drive faster than 50 miles per hour.

The Institute of Medicine has developed a definition of primary care in its study assessing primary care:

"Primary care is the provision of integrated, accessible health care services by physicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (3).

Chiropractic has not been asked to participate in the Institute of Medicine study process. Why not? Because it is the understanding of health-care policy makers outside of the profession that chiropractors don't practice primary care and/or medicine. Why has this medical mainstreaming not been made a priority by chiropractic national leadership? Why has this unfortunate bias that keeps trained chiropractic physicians at the back of the health-care train been allowed to continue? Do we as a profession practice primary care or medicine in the context of the above referenced definition? The reality: few can and do; others don't know how and can't due to legislative and managed care/third party payer restrictions accepted by the medical mainstreams. The profession has created an illusion that doesn't line up with reality. They have created a mirage of primary care that seems to be defined and understood only from within. An insider, questioning this reality, is often treated as an agnostic or infidel. Rational scientific discussions regarding primary care are avoided, lest discussions lead to "forbidden ground," the practice of chiropractic medicine that incorporates selectively medical treatments and procedures.

Chiropractic education and clinical training is in crisis, suffering from a deficiency in primary-care exposures, gaps in didactic and clinical training and inadequate clinical tools available to effectively manage conditions commonly seen in the primary care setting.

The educational clinical deficiencies of many limit and discredit the competent training of others, fostering confusion and division. This educational disunity is then naturally promulgated at the federal, state and local levels.

A chiropractor practicing chiropractic is a chiropractor practicing chiropractic until those concerned within the profession determine otherwise. *We are defined by the lowest COMMON function performed and training received by all chiropractors. This is the reality.*

Its absolutely necessary that the profession identify and define their primary-care skill sets and competencies, to facilitate mainstreaming into primary health-care delivery.

Reimbursement Often Dictates Scope of Practice

The insurance movement in the 1960's, 70's and 80's, has stagnated and crippled the profession. Universally, the profession has very few Current Procedural Terminology (CPT) codes for which they can seek reimbursement and contractually provide. Insurance contracts have fueled the limiting and dictate the scope of practice. Too often, insurance equality mandates and the "having" to provide a chiropractic benefit, has resulted in an extremely limited benefit of chiropractic services.

The 2-edged sword of insurance equality has boxed the profession by defining the doctor of chiropractic as primarily a neuromusculoskeletal provider, treating "subluxations" and "vertebral dysfunctions." The lowest common denominator found in clinical training has been identified, that of performing adjustments for vertebral subluxations. For reimbursement purposes we primarily perform a technical component, and in the grand scheme of the health-care team we exist somewhere between a massage therapist and a physical therapist. Rational chiropractic must accept the challenge to advocate legislatively and politically for its practitioners, creating opportunities and growth, collaborating with other rational medical disciplines, and not waste its time attempting to reconcile the differences with the "evasive." Two can't walk together except that they are agreed.

Diversity in Educational Philosophies: Portal-Of-Entry Trained vs. Primary Care Trained

The profession has had difficulty recognizing and tolerating the differences in the didactic and clinical training diversity. The "evasive" have held back the "rational" by using national organizations to road block and limit the recognition of educational diversity within chiropractic's educational institutions. This effort has, in my opinion, severely limited those desiring to be primary care trained chiropractic physicians from receiving the access to competent training necessary to function in a primary care role.

The profession has been and continues to be embroiled in intra-professional subversion and bias against those who wish to practice primary care. The commonly accepted reality is the existence of 2 distinct groups of chiropractors: those that are trained as portal-of-entry providers (the majority), and those that are trained as primary care providers (minority).

Recognizing educational and competency diversities within the profession should be the first step in the process of reconciling a profession that has been educationally and philosophically divided for over 100 years. This effort must take place prior to seeking any legislative considerations.

The majority of the profession has failed to accept the educational challenges and requirements of primary care. There has been a lack of tolerating didactic and clinical diversity, allowing a wide variety of scientific and rational skills to develop.

The Council on Chiropractic Education and other interested parties must allow the chiropractic didactic and clinical training to develop rationally and scientifically, and include therapies common to and appropriate for primary care interventions. The training of the doctor of chiropractic as a primary-care physician should follow accepted primary-care models and algorithms, being consistent, equivalent or exceeding that of other primary health-care providers.

Council on Chiropractic Education: Is It Confused?

"A doctor of chiropractic is a primary care physician and clinician whose purpose, as a practitioner of the healing arts, is to help meet the health needs of individual patients and of the public, giving particular attention to the structural and neurological aspects of the body.

The application of science in chiropractic concerns itself with the relationship between structure, primarily the spine, and function, primarily coordinated by the nervous system of the human body, as that relationship may affect the restoration and preservation of health. Further, this application of science in chiropractic focuses on the inherent ability of the body to heal without the use of drugs or surgery.

The purpose of chiropractic professional education is to provide the student with a core of knowledge in the basic and clinical sciences and related health subjects sufficient to perform the professional obligations of a doctor of chiropractic.

As a gatekeeper for direct access to the health care delivery system, the doctor of chiropractic's responsibilities as a primary care physician include wellness promotion, health assessment, diagnosis and the chiropractic management of the patients' health care needs. When indicated, the doctor of chiropractic consults with, co-manages, or refers to other health care providers" (4).

Portal of Entry: The opportunity for the doctor of chiropractic to be the first contact a patient may make with a provider to seek health-care information and/or services.

Primary Care Chiropractic Physician and Clinician: An individual who serves as a point for direct access to health-care delivery, the doctor of chiropractic's responsibilities include (1) patient's history; (2) completion and/or interpretation of physical examination and specialized diagnostic procedures; (3) assessment of the patient's general health status and resulting diagnosis; (4) provision of chiropractic care and/or consultation with continuity in the co-management, or referral to other health care providers; and (5) development of sustained health care partnership with patients (4, p. 76).

Facing the Stark Reality

To practice in a primary-care setting or role, the primary-care chiropractic physician must be similar to other primary-care providers, and therefore must have common skill sets to prescriptive medications, either directly or indirectly. Given the public health-care issues, rising health-care costs, national insurance reform, cost-benefit issues and the powers that control education and the market place the profession has placed itself in an awkward position. They are on the outside looking in. They have not been invited to the primary care table. Many policymakers perceive the "drugless, without the use of drugs or surgery" chiropractic position as naïve, unreal, anti-medicine, anti-government, anti-cost containment, irrational and unscientific. Therefore, in my opinion, the profession is not used in primary care.

The consumer wants one-stop shopping, ideally one primary-care physician who is "drugless" philosophically, but has access to prescriptive medications when medically necessary and reasonable.

The Quality of Care and Accountability to the Public

"Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Focusing on outcomes requires clinicians to take their patient's preferences and values into account as together they make health care decisions. The phrase *current professional knowledge* in the above definition underscores the need for health professionals to stay abreast of the biomedical knowledge within their pro-

fessions within their professions and to take responsibility for explaining to their patients the processes and expected outcomes of care. It includes the need to maintain high standards for licensure, certification, and recertifications for all individuals and institutions that provide health care.

Use of unnecessary or inappropriate care. This makes patients vulnerable to harmful side effects. It also wastes money and resources that could be put to more productive use.

Under use of needed, effective, and appropriate care. This is related to accessibility—that is, whether people get the proper preventive, diagnostic, or therapeutic services; whether they delay seeking care; and whether they receive appropriate recommendations and referrals for care. People may face geographic, administrative, cultural, attitudinal, or other barriers that limit their abilities to seek or receive such care. Within managed care environments, efforts to restrict access to some services may result in underused of care.

Shortcomings in technical and interpersonal aspects of care. Technical quality refers to the ways health care is delivered, eg, skill and knowledge in making correct diagnoses, and prescribing appropriate medications. Professional competence is critical to high-quality care, and inferior care results when health-care professionals are not competent in their clinical areas. Interpersonal aspects of care are of particular importance in primary care. They include listening, answering questions, giving information, and eliciting and including patient (and family) preferences in decision making. Interpersonal skills are also essential to primary care clinicians in their roles as coordinators—as members of a collaborative team and with other health professionals. The performance of systems must also be measured and improved. Indeed, greater attention will need to be focused on the failures of systems of care in which well-trained and well-meaning clinicians work" (4).

The 2 Healthcare Umbrellas

Traditional Medicine

- Allopathic Medicine (MD)
- Osteopathic Medicine (DO)
- Naturopathic Medicine (ND/NMD)
- Oriental Medicine (OMD)
- Specialists (DDS, DPM)

In this diversity, all practice MEDICINE to a greater or lesser degree, and have or are striving to have, at least some degree of prescriptive authority and/or

access to, or use of prescriptive medications to be able to effectively manage conditions seen in a primary care setting/ direct access role.

- Chiropractic Medicine (Advanced DC)—comparable didactic and clinical training in primary care with other like practitioners. Overlap and separate and distinct training from that of a traditional DC.

Can chiropractic (medical) schools competently teach primary care with access to prescriptive medications? hospital training? Given the movement in medical training to de-emphasize hospital rotations as being necessary for non-hospitalists, such as primary care providers, there are opportunities for chiropractic medical schools to provide competent primary care training.

Alternative and Complementary Medicine

- Chiropractors (DC)—limited scope license, NMS and monocausal practitioners
- Acupuncturists (LAc)
- Biofeedback
- Nutritionists
- Massage therapists (LMT)
- Herbalists
- Energy practitioners
- Mind-body therapies
- Physical therapy (RPT)
- Naturopathy (ND)
- Movement therapies
- Musculoskeletal therapies: Applied Kinesiology, naprapathy, rolfing, chiropractic, cranio-sacral therapy

Removing Barriers to the Full Use of Competent Chiropractic Physicians: Vision of Upcoming Changes

“Chiropractic has survived, and it has begun to embrace the values and behaviors of a mainstream health profession. . . . Chiropractic still maintains some vestiges of an alternative health care profession in image, attitude, and practice. The profession has not resolved questions of professional and social identity, and it has not come to a consensus on the implications of integration into mainstream health care delivery systems and processes. In today’s dynamic health care milieu, chiropractic stands at the crossroads of mainstream and alternative medicine. **Its future role will probably be determined by its commitment to interdisciplinary co-operation and science-based practice**” (5).

I believe that the future of chiropractic in primary care will be directly related to its commitment to the science-based education and practice of chiropractic medicine

and the addition of selective medicalization in both the clinical and didactic training of the chiropractic physician who practices chiropractic medicine.

The Legislative and Regulatory Process

Legislatures have not allowed or required regulatory boards to play a role in requiring continuing competence demonstrations of their licensees throughout their careers. The private sector has been far more active in this arena. Voluntary professional associations and private certification and credentialing boards have established and continue to perfect standards, goals and evaluation measurements to meet the demands for competence throughout one’s professional practice. These models are good starting points but will need additional development. In addition, the role of the private sector can only go so far. Practitioners whose credentials are not routinely reviewed by private systems may fall through the cracks without attention by the states. It is being proposed that a national board examination in primary care be developed.

A Future Vision of Health Care Workforce Regulation: National Standards

The Pew Health Professions Commission envisions a future regulatory system for the health professions that will undergo the following transformations to better serve the public interest:

A move towards national standards: Health care workforce regulation, along with education and credentialing, is moving in the direction of national standards. The federal government may lead this national uniformity, agreements among the states or national professional associations. For regulation, the most dramatic effect will be standard scopes of practice authority and continuing competence requirements for each profession across the country.

Significant overlap of practice authority among the health professions—driven by the professions, new information and technologies, and innovation in the workplace, traditional boundaries—in the form of legal scopes of practice—between the professions have blurred.

This trend will continue to pressure the regulatory system to accommodate the demand for flexibility while ensuring that the public’s safety is protected. Decisions regarding scopes of practice and continuing competence requirements therefore must be based on comprehensive evidence regarding the accessibility, quality and cost-effectiveness of care provided to the consumer.

New venues and participants for regulatory policy-making—The representation of various parties at health-care decision-making tables is changing. Legislatures may not be the best venue to decide technical professional matters as lobbying, campaign contributions and allegiance to constituents often distort rational policy development. A more impartial venue with increased representation of interested parties, particularly consumers of health-care services, will better support regulatory policy-making that is accountable, balanced and based on empirical evidence (6).

There Is Strength in Professional Diversity: Recommendations

- Chiropractic medical education must not compromise consumer protection, public welfare and safety.
- Schools of chiropractic medicine must provide comparable primary-care training with access to therapeutic interventions that are commonly found in primary-care.
- Schools of chiropractic medicine must fall into line with national and state public health-care goals, strategies and policies. (e.g. a rational approach to immunizations, etc.)
- Encourage competition. Foster that scopes of chiropractic medical practice be determined by competent training, not philosophy or tradition. Chiropractic medical schools must be proactive with appropriate regulatory entities and provide for primary-care training that is comparable to traditional medical training.
- Develop a national examination for the advanced-practice DC who has obtained the necessary competencies for primary health-care delivery.

Recognize, Allow, Tolerate and Legislate Diversity Within the Profession

Promote to state boards and other appropriate entities, the “Advanced Trained DC/DCM” that has access to prescriptive medications, either directly or indirectly.

Promote That There Exist 2 Distinct Groups of Doctors of Chiropractic:

Doctor of Chiropractic (DC): “basic” trained DC who is an NMS/VSC specialist, who has direct access to patients and is considered a “Portal of Entry” provider. They are “drugless” (non-pharmaceutically based) and have specialties that are related primarily to neuromusculoskeletal conditions.

Doctor of Chiropractic (Advanced DC): “advanced” trained doctor of chiropractic in the field of general health-care delivery, with advanced training (diploma/certification/degree) in primary care, and has direct or indirect access (with or without collaborative agreements) to prescriptive medications to manage commonly seen primary-care conditions.

State Licensing Boards and the profession to allow the adopting of legislative language that recognizes the educational and skills diversity within the profession, and implement 2 groups of DC’s, one with basic training (DC), the other with advanced training (Advanced DC Practice).

Develop a national model for scopes of practice of the DC and the advanced DC practice.

Establish relationship with the ACA, AOA, AMA and other appropriate national and regional entities to discuss and develop a timetable for integration.

The Evolving of Existing Scopes of Practice. Until national models for scopes for practice can be developed and adopted, states should explore and develop mechanism for existing professions to evolve their existing scopes of practice and for new professions (or previously unregulated professions) to emerge. In developing such mechanisms, states should be proactive and systematic about collecting data on health-care practice.

These Mechanisms Include

Alternative dispute resolution processes to resolve scope of practice disputes between 2 or more professions; procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and comprehensive legislative “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority, and regulating currently unregulated healing disciplines.

Definitions and Action Steps

Portal of Entry: patient has direct access to patients with neuromusculoskeletal complaints. Chiropractors skills limited to neuromusculoskeletal conditions, and diagnosis and treatment of subluxations of the spine.

Primary Care: is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community (4, p. 15).

Advanced Practice DC Certification in Primary Care: Statutory requirements in addition to current licensure requirements to include certification, training and competency testing in primary care as defined by the Institute of Medicine and/or with or without a collaborative agreement with a licensed medical practitioner (MD, DO) for the practice of primary care and the prescription of drugs.

Action Steps

- National chiropractic organizations (CCE, ACA, et al) must tolerate chiropractic medical expansion and the Advanced Practice DC.
- Develop professional relationships with primary care programs and groups, seeking advice and resources (AAFP, IOM, AMA, et al).
- Develop bona fide and comparable educational and clinical programs that teach primary care and have access to necessary therapeutic interventions.
- Adopt national guidelines and standards that can be promulgated to state licensing boards and legislatures.
- Define the diversity between the DC (NMS) and the Advanced Practice DC.
- The AACCP establishes a task force that oversees that these action steps are completed.

CONCLUSION

Recommended Changes to Scopes of Practice and Professional Practice Authority: *'Determining which health care practitioners are permitted to provide what services; from the Pew Taskforce on Health-care Workforce Regulation.'*

Current Issues

The recommendation regarding practice authority in the 1995 report, *Reforming Health Care Workforce Regulation* generated considerable controversy. Based on the formal responses submitted regarding the report, this recommendation received one of the highest scores for level of concern and was also one of the most challenged (6).

Despite the 1995 recommendation, the processes by which professional practice authority acts are determined have not changed. Legislative calendars across the country continue to be flooded with bills that would regulate emerging health professions or change the practice authority of currently regulated professions. In 1995, over 800 such bills were considered and approximately 300 laws passed. Two years later, 1600 bills were introduced and about 300 laws enacted.

This legislative activity is just one component of "turf battles," the apparently inevitable fights between the professions over who can provide what services. Often lost in the battles between professions is consumer protection, regulation's ostensible primary purpose. The potential benefits and dangers to the public from any proposed change are difficult to determine as each party brings to the dispute arguments that embrace the "public's interest."

State legislators seeking to answer the health-care consumers' concerns may begin by asking 2 questions before addressing the merits of any proposed change: First, *who* should determine professional practice authority? Second, *how* should the decision-making be accomplished? In other words, are state legislators the most appropriate experts and are state legislatures the best setting for resolving such technical questions as whether optometrists should be allowed to treat glaucoma, or whether nurse practitioners are qualified to prescribe pharmaceuticals?

An inherent clash of values frames these questions. State legislation values local representation and accountability to constituents, public debate and political compromise. In contrast, today's consumers and providers are operating in regional or national health-care markets that increasingly value customer access and choice, collaboration among practitioners, cost-effectiveness and quality grounded in evidence. The challenge to state legislators is to incorporate—or at least acknowledge—these contemporary values and standards into their decision-making about practice acts.

Consumer access and choice—At a minimum, consumers want access to competent health-care practitioners and the ability to choose among many types of health-care practitioners. Consumers also want to be assured that their choices are at least safe, and preferably effective as well. The public has a reasonable expectation that their health-care practitioners, whether selected by the consumer or assigned by the health-care provider or plan, are competent to provide the care that they are providing. Finally, consumers are purchasers are increasingly aware of health-care costs and demanding value for their dollars, while at the same time wary of health-care systems that substitute less expensive workers for their higher paid counterparts.

Balancing these tensions between free choice and protection from harm forms the core of the legislator's charge. State legislators try to achieve this balance by establishing and revising practice acts through normal legislative processes. Practice act decisions benefit from

the strengths of state legislative activity and suffer under the shadows of partisan politics, campaign contributions and professional lobbying. Critics charge that the outcomes may not always be in the public's best interest:

Narrow scope of practice, restrictive reimbursement standards, and other legal barriers may limit access to care for large numbers of Americans. In the absence of a national commitment to universal health insurance, the potential for non-physician practitioners to supply much-needed, general health services at reasonable costs should not be ignored.

Sharing practice authority among the health professions—It is not only the interests of the public that the state legislator must consider when facing a bill to establish or change a practice act. Health-care professionals themselves have additional and conflicting interests. While the professions have an interest in minimal restrictions, they also benefit from the anti-competitive aspects of regulation. It is always the professions—never the public or consumer advocates—who request regulatory changes to practice acts.

However, the health professions do not act in concert in this arena. Partly because of the current regulatory scheme itself, with its separate and often exclusive scopes of practice, each profession sees itself as proprietary owner or manager of a given territory. Some of the grants of authority have been extremely liberal, resulting in expansive practice acts such as that for physicians; others are extremely restrictive. Requests for changes by one profession are viewed as expansions, encroachments, and infringements by another. Every proposal must end in a win for one side and a corresponding loss for the other. In recent years, increased competition, driven by workforce oversupply and by new employment models within managed-care systems, has exacerbated these inter-professional practice battles.

Due to different educational and regulatory histories, the various professions are uniquely situated and view regulation and potential changes differently. Medicine is the only profession with state practice acts that cover *all* of health-care services. With this exclusivity, little or nothing exists that can be added to the medical act and medicine has no incentive to delete anything. From this position, medicine can see every request for regulatory change from any other profession or occupation as a challenge or confrontation. With all-inclusive practice authority, the profession also has the credentials, expertise and political influence to comment on potential impacts of changed laws on patients, clients and consumers.

A number of professions that provide some or many of the same services as physicians (for example, nurse

practitioners, physician assistants, certified nurse midwives, certified nurse specialists, certified registered nurse anesthetists and optometrists) have spent considerable amounts of time and money in recent years bolstering requests to change their practice acts to permit them to provide care that is consistent with their education and training. Virtually every request has been opposed by organized medicine, often by state medical licensing boards, and sometimes by other professions as well. The outcomes of these requests vary by profession, by year, and by state.

Some of the allied-health professions and occupations, and some of the previously unregulated "alternative" and "complementary" professions, have pursued regulation and accompanying subsets of the medical practice acts. Virtually every pursuit has been opposed by at least one other profession. The outcomes of these pursuits vary by profession, by year and by state. Other professions and occupations have declined to pursue regulation.

This fragmented, competitive and adversarial regulatory activity ignores the fact that clinical practice is no longer based on exclusive professional or occupational domains. Collaborative teams of health-care practitioners who often share some elements of practice authority are more the rule than the exception in today's health-care systems.

Today's practitioners, administrators and consumers are increasingly comfortable with the principle that if someone is competent to provide a health service safely, and has met established standards, then he or she should be allowed to provide that care and be reimbursed for it, even if that care was historically delivered by members of another profession. Nurse practitioners, physician assistants, pharmacists and midwives for example are providing health care that was in the exclusive domain of physicians a few years ago.

The adversarial system for determining practice authority also ignores the natural evolution of professions, and individuals within the professions, as they develop their education, training and accreditation standards to meet the changing needs of patients and clients.

Uniformity among the states—Individual state legislators in separate state legislatures are at a disadvantage in a world increasingly driven by regional, national and global economies and information systems. This is no less true for decisions regarding health-care practitioners than for decisions regarding tele-communication, commerce and aviation industries. With recent develop-

ments in telepractice and widespread use of the internet, the contrast between technological evolution and the relative stagnation in health professions regulation has been sharpened.

The successful integration of the neuromusculoskeletal portal-of-entry DC has, and continues, to take place. The integration of the primary-care-trained (advanced practice) chiropractic physician into mainstream primary-health-care delivery has many opportunities and faces many challenges, none of which are deemed unsurmountable.

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