



2009

Adjusting the Role of Chiropractors in the United States: Why Narrowing Chiropractor Scope of Practice Statutes Will Protect Patients

Peter Morrison

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Peter Morrison, *Adjusting the Role of Chiropractors in the United States: Why Narrowing Chiropractor Scope of Practice Statutes Will Protect Patients*, 19 Health Matrix 493 (2009)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol19/iss2/21>

This Note is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

NOTE

ADJUSTING THE ROLE OF
CHIROPRACTORS IN THE
UNITED STATES: WHY NARROWING
CHIROPRACTOR SCOPE OF PRACTICE
STATUTES WILL PROTECT PATIENTS

Peter Morrison[†]

INTRODUCTION

In April 2007, the Appellate Division of the New Jersey Superior Court reopened the century-old debate about the chiropractor's role in the American healthcare system.¹ What type of care may chiropractors offer? How are chiropractors permitted to treat their patients? How do chiropractors work with medical doctors? These are all questions that state legislatures, licensing boards, and courts have struggled to answer throughout the more than 100-year existence of chiropractic care.

The history of the chiropractic industry is rife with internal rivalry, external conflicts, and inconsistent methods of practice nationwide.² This checkered past has resulted in state scope of practice statutes that range from restrictive to expansive, with the majority covering the vast area in the middle.³ These inconsistencies have

[†] J.D. Candidate, 2009, Case Western Reserve University School of Law; B.A., 2004, University of Wisconsin. The author would like to thank Professor Sharona Hoffman for her editorial advice and guidance. The author would also like to thank Kristin Marsteller for her unwavering love and support throughout this process.

¹ *Bedford v. Riello*, 920 A.2d 693 (N.J. Super. Ct. App. Div. 2007), *aff'd in part and remanded*, 948 A.2d 1272, 1274 (N.J. 2008).

² See generally NAT'L CHIROPRACTIC BD. OF EXAMINERS, JOB ANALYSIS OF CHIROPRACTIC BY STATE (1994) (compiling 5,000 responses from practicing chiropractors that details, *inter alia*, which activities they perform, treatment procedures, and work environment).

³ AGENCY FOR HEALTHCARE POLICY AND RESEARCH (Now, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY), U.S. DEP'T OF HEALTH AND HUMAN SERV., CHAPTER V: LICENSURE AND LEGAL SCOPE OF PRACTICE (1997), *available at*

resulted in an industry that permits some practitioners wide latitude in their treatment and diagnostic options, such as colonic irrigation and obstetrics, while confining others to simple spinal manipulation.⁴ Many of these diagnostic and treatment procedures overlap with conventional medical care.⁵

This wide range of procedures can result in uninformed consumers who must choose between conventional medicine and chiropractic care and, in many circumstances, act as the informational conduit between their chiropractors and their medical doctors.⁶ These inconsistencies also allow for an overlap between conventional medicine and chiropractic procedures such that a chiropractor's patients might think they are receiving sufficient medical treatment when they are not. It is important that chiropractic care be as uniform as possible so it may contribute to a cooperative healthcare system, thereby protecting the patient-consumer.

States legitimately exercise their police power to protect the public's health and safety when they regulate and license any professionals, including chiropractors.⁷ Every state has a statutorily created licensing board to regulate its chiropractic industry.⁸ In the United States, chiropractic boards are generally composed of four to eight members, a quarter of whom are generally laypersons.⁹ These licens-

<http://www.chiroweb.com/archives/ahcpr/chapter5.htm> (last visited Mar. 28, 2009).

⁴ See Lester C. Lamm & Karin Pfannenschmidt, *Chiropractic Scope of Practice: What the Law Allows – Update 1999*, J. NEUROMUSCULOSKELETAL SYS., Fall 1999, at 102, 105 tbl.2.

⁵ Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 133 (1996) [hereinafter Cohen, *Holistic Health Care*].

⁶ See Arch G. Mainous III et al., *Fragmentation of Patient Care Between Chiropractors and Family Physicians*, 9 ARCHIVES FAM. MED. 446, 449 (2000).

⁷ ERWIN CHERMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 680 (3d ed. 2006) (citing *Ry. Express Agency v. New York*, 336 U.S. 106 (1949) (upholding a law on the basis of its contribution to public safety)); *Williamson v. Lee Optical of Okla.*, 348 U.S. 483 (1955) (wherein the Court upheld a law on the basis of public health “which [made] it unlawful for any person not a licensed optometrist or ophthalmologist to fit lenses to a face or to duplicate or replace into frames lenses or other optical appliances, except upon written prescriptive authority”).

⁸ Michael H. Cohen et al., *Emerging Credentialing Practices, Malpractice Liability Policies, and Guidelines Governing Complementary and Alternative Medical Practices and Dietary Supplement Recommendations: A Descriptive Study of 19 Integrative Health Care Centers in the United States*, 165 ARCHIVES INTERNAL MED. 289, 289 (2005).

⁹ David Chapman-Smith, *Legislative Approaches to the Regulation of the Chiropractic Profession*, 16 MED. LAW 437, 443 (1997). The state with the most chiropractors is California and its licensing board has seven members, five of whom are chiropractors and the two are laypersons. The entire board is appointed by the

ing boards must regulate within the bounds of their state's scope of practice act. For example, the New Jersey licensing board must follow the New Jersey scope of practice act, which provides that chiropractic care is a:

[S]ystem of adjusting the articulations of the spinal column by manipulation thereof. A licensed chiropractor shall have the right in the examination of patients to use the neurocalometer, X-ray, and other necessary instruments solely for the purpose of diagnosis or analysis. No licensed chiropractor shall use endoscopic or cutting instruments, or prescribe, administer, or dispense drugs or medicines for any purpose whatsoever, or perform surgical operations excepting adjustment of the articulations of the spinal column.¹⁰

Altering statutory definitions and scopes of practice is the most direct way for state legislatures to exercise their police power to protect uninformed consumers.

This Note posits that state legislatures should protect the public by narrowing their chiropractic scope of practice statutes to limit chiropractors to operating as musculoskeletal specialists within the conventional medical system. Part I outlines the history of chiropractic care, including its fight for legitimacy, proposals for integration, internal conflicts, and current state of the industry. Part II examines current scope of practice models and the influences that shape them. Part III discusses the importance of consumer protection with regard to the chiropractic industry and the impact that autonomy should have in the current healthcare system. Finally, Part IV presents this Note's proposal to narrow scope of practice statutes in an attempt to bring consistency to the field, thereby protecting patients from potentially harmful confusion and misrepresentations.

I. BACKGROUND

Today, chiropractic care fits within a broader definition of health modalities called Complimentary and Alternative Medicine ("CAM"). CAM encompasses chiropractic care, massage therapy, acupuncture, and naturopathy, as well as other types of alternative medicine. Researchers do not typically focus their empirical studies on chiropractic care alone, but rather examine the CAM industry as a whole. Until the mid-1970s, most did not consider chiropractic care as part of

government. *Id.*

¹⁰ N.J. STAT. ANN. § 45:9-14.5 (West Supp. 2008) (quotation omitted).

mainstream medicine.¹¹ Many saw chiropractors as outcasts, possibly because “most chiropractors viewed themselves as differing in philosophy and practice from other health care practitioners.”¹² Today, chiropractic care is a leader in the CAM industry¹³, and as of 1997, it accounted for about 30% of all patient visits to complementary and alternative care practitioners, which amounts to approximately 190 million patient visits to chiropractors each year.¹⁴ Available data from a study completed in 1997 suggest that the probability of a person visiting a CAM practitioner increased by approximately 10% in only seven years. This represents an increase in patients, not just patient visits.¹⁵ Another recent study found that approximately 68% of the adult population has used a CAM therapy at some point in their lives.¹⁶ Chiropractic care is no longer outside of the mainstream; the National Directory of Chiropractic currently has over 65,000 practicing chiropractors catalogued in its database.¹⁷ This prevalence of consumers and practitioners justifies taking chiropractic care seriously from a consumer protection perspective.

The ever-evolving field of chiropractic care began in Burlington, Iowa, in 1886 when Daniel David Palmer started his practice as a magnetic healer.¹⁸ Daniel Palmer capitalized on the painful healing

¹¹ William C. Meeker & Scott Haldeman, *Chiropractic: A Profession at the Crossroads of Mainstream and Alternative Medicine*, 136 ANNALS INTERNAL MED. 216, 216 (2002) (citation omitted).

¹² *Id.*

¹³ See Nat'l Ctr. for Health Statistics, U.S. Dep't of Health & Human Servs., *Complementary and Alternative Medicine Use Among Adults and Children: United States, 2007*, NAT'L HEALTH STAT. REP., Dec. 10, 2008, at 1, 3, available at <http://nccam.nih.gov/news/2008/nhsr12.pdf> (noting that 8.6% of adults obtained chiropractic and osteoporotic care in the last 12 months, the highest percentage of any CAM modality that requires an office visit).

¹⁴ *Id.* at 217 (explaining that, in 1997, “an estimated 190 million patient[s] visit[ed] . . . chiropractors,” which translated to “about 30% of visits to all complementary and alternative practitioners”).

¹⁵ David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-up National Survey*, 280 JAMA 1569, 1569 (1998).

¹⁶ Michael Goldstein, *The Emerging Socioeconomic and Political Support for Alternative Medicine in the United States*, 583 ANNALS AM. ACAD. POL. & SOC. SCI. 44, 45 (2002).

¹⁷ National Directory of Chiropractors, <http://www.chirodirectory.com> (last visited Feb. 16, 2009); see also Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185, 196 (1998).

¹⁸ JOSEPH KEATING, JR. ET AL., *CHIROPRACTIC HISTORY: A PRIMER* 8-10 (2004), available at www.historyofchiropractic.org/ChiroHist%20Primer/primerall72.pdf.

methods of his day, such as blood letting,¹⁹ by advertising their “horrors and abominations” in an effort to highlight his business of magnet healing, a noninvasive, painless modality.²⁰ After nine years of clinical experience in magnetic healing, Daniel Palmer decided that inflammation was the central characteristic of all diseases, and that inflammation was due to displacement of “anatomic structures.”²¹ Daniel Palmer believed that he could reposition parts of the body to reduce friction and inflammation, thereby curing and preventing disease.²² He used Greek terms to form the word “chiropractic,” meaning, “done by hand,” and in the summer of 1896, Daniel Palmer chartered his school, later known as Palmer’s School of Chiropractic (“PSC”).²³ Daniel Palmer’s son, Bartlett Joshua Palmer, ran PSC with his father. It did not take long for competition to emerge in the form of a school founded by a PSC graduate, Solon M. Langworthy. The American School of Chiropractic and Nature Cure, in Cedar Rapids, Iowa, incorporated naturopathic remedies like stretching machines and herbal remedies into its chiropractic curriculum.²⁴ Thus began the ideological rift within the chiropractic industry between those who strictly supported Palmer’s methods (“Straights”) and those who believed that chiropractors should incorporate additional modalities into their regimen of care (“Mixers”). This feud between the Straights and Mixers remains today and is one factor contributing to the inconsistencies in scope of practice statutes; chiropractors are unable to agree among themselves how they should define their practice.²⁵

A. Straights v. Mixers

There are two divergent schools of thought within the chiropractic industry. The “Straight” school espouses “focus[ing] . . . on analyzing the spinal column to detect and eliminate nervous system interferences known as ‘vertebral subluxations.’”²⁶ Conversely, the “Mixing” school “uses a variety of procedures, including the manipulation of

¹⁹ *Id.* at 6-7.

²⁰ *Id.* at 8.

²¹ *Id.* at 9.

²² *Id.* at 8-9.

²³ *Id.* at 10.

²⁴ *Id.*

²⁵ See *infra* notes 150-70 and accompanying text.

²⁶ MICHAEL H. COHEN, COMPLEMENTARY & ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES 54 (1998); see *infra* notes 157-168 and accompanying text.

the body and soft tissues, massage, physical therapy, nutrition, acupuncture, counseling, hypnotherapy and minor surgery.”²⁷

Though it runs contrary to Daniel Palmer’s theory of spinal manipulation, the Mixing school has prevailed as the dominant theory of practice in the United States. Indeed, the Council for Chiropractic Education (“CCE”) requires an accredited chiropractic college to teach a Mixing curriculum to maintain its accreditation.²⁸ Therefore, in New Jersey, a graduate of a Straight chiropractic school may not be eligible for licensure because the licensing board requires that the CCE accredit the graduating institution, which it will not do for a Straight school. James Winterstein, president of the National University of Health Sciences,²⁹ proposed a split in the industry among what he calls “chiropractic physicians” and “chiropractors,” going as far as proposing a dual-level skills exam, one for each type.³⁰ Winterstein proposes that people who “wish only to detect and correct spinal subluxations for the purposes of optimizing human health” will visit a *chiropractor*.³¹ In contrast, a person who seeks a practitioner to “look in their eyes and ears; to palpitate the abdomen; to listen to the heart and lungs; to provide breast examinations; and to perform prostate examinations or gynecologic exams based on clinical indications” will visit a *chiropractic physician*.³² To date, this proposal has gained little traction.

This division between Mixers and Straights is often bitter. Some Mixers even accuse Straight chiropractors of not living by their own code, because in public, Straights will trumpet their strict adherence to

²⁷ COHEN, LEGAL BOUNDARIES, *supra* note 26, at 54.

²⁸ *In re Sherman Coll. of Straight Chiropractic*, 397 A.2d 362, 365 (N.J. Super. Ct. App. Div. 1979); *see* discussion *infra* Part I.C.

²⁹ “National University of Health Sciences began as National School of Chiropractic, which was renamed The National College of Chiropractic in October 1920. The vision of the members of the college included a perspective in which the various members of complementary and alternative medicine would be able to study together, work together, and develop a strong sense of collegiality and integrated function. To carry out this vision, it was decided in 1993, as part of its long-range plan, that the college would begin to move toward expansion of its educational offerings. As part of this planning process, the concept of a university was born and became a reality on September 1, 2000.” National University of Health Sciences, Purpose and Goals, <http://www.nuhs.edu/show.asp?durki=882> (last visited Feb. 16, 2009).

³⁰ James Winterstein, *Chiropractors and Chiropractic Physicians*, DYNAMIC CHIROPRACTIC, MAY 29, 2000, http://www.dynamicchiropractic.com/pdf_out/DynamicChiropractic.com-Chiropractors-and-Chiropractic-Physicians-1235381931.pdf, at 3.

³¹ *Id.*

³² *Id.*

Daniel Palmer's teachings, while in practice they will employ diagnostic devices such as blood testing.³³ This ongoing feud is one of the reasons that the definition of chiropractic care is so fluid and ambiguous. If chiropractors cannot settle on a definition for their field of practice, surely states and their licensing boards are going to have trouble doing so as well.

B. Licensure

Langworthy—in an attempt to legitimize the industry—led the movement for licensure, a campaign that Daniel Palmer vehemently opposed.³⁴ In 1905, Langworthy succeeded in lobbying for a licensing bill that passed both houses of the Minnesota legislature. Daniel Palmer, with the help of the medical community, convinced the Minnesota governor to veto the legislation.³⁵ Daniel Palmer was concerned that licensing would change the definition of chiropractic care and would obstruct his attempts to expand chiropractic field, especially the Straight school.³⁶ During the progressive era, the laws and regulations assumed that consumers were capable of making their own informed decisions and choosing their own course of care.³⁷ These laws were necessary to “serve . . . the ideals of medical freedom and . . . public interest.”³⁸ Palmer was concerned that licensing would ultimately interfere with this freedom, while at the same time steering consumers toward the Mixing School.

Those chiropractors who operated in states without licensure statutes were often subject to prosecution for practicing medicine without a license, the primary punishment for which was incarceration or fine.³⁹ Bartlett Palmer spent much of his time developing a legal apparatus to defend the thousands of chiropractors arrested each year.⁴⁰ By 1931, an estimated 12,000 practicing chiropractors had undergone some 15,000 prosecutions for unlawful practice. Ultimately, it became apparent to chiropractors that they could not rely on judicial leniency to “escape the strictures of the law. . . .”⁴¹

³³ Peter J. Modde, *Malpractice is an Inevitable Result of Chiropractic Philosophy and Training*, LEGAL ASPECTS MED. PRAC., Feb. 1979, at 20, 21.

³⁴ See KEATING ET AL., *supra* note 18, at 10.

³⁵ *Id.*

³⁶ J. STUART MOORE, *CHIROPRACTIC IN AMERICA: THE HISTORY OF A MEDICAL ALTERNATIVE* 89 (1993).

³⁷ *Id.* at 90.

³⁸ *Id.*

³⁹ See KEATING ET AL., *supra* note 18 at 20.

⁴⁰ *Id.* at 12.

⁴¹ MOORE, *supra* note 36, at 81.

Though licensure renders a group more susceptible to government regulation, it also conveys a status of societal acceptance and legitimacy.⁴² Chiropractors began to push for “friendly” licensing laws that would create autonomous licensing boards under which the real regulations would arise.⁴³ The movement for chiropractor licensing became part of a nationwide movement for occupational licensing, “which finally institutionalized medical regulation in America after more than two centuries of sporadic and largely ineffective efforts.”⁴⁴ For chiropractors, licensing was an important step toward legitimacy. Despite intra-industry disagreements, “chiropractors were able to join loosely in pushing legislation through most of the states.”⁴⁵ Today, chiropractors have successfully lobbied for licensing statutes in many countries and now enjoy the protections and legitimacy that licensure provides.⁴⁶ Along with licensure came the restrictions that Daniel Palmer feared—scope of practice statutes.

C. Chiropractor Education

Chiropractic education was entrenched in the feud between the Mixers and the Straights. Schools were divided based on philosophy and ultimately, the Mixers emerged victorious. In the United States, the U.S. Department of Education (formerly the U.S. Office of Education) must approve all education accreditation agencies. The CCE is the approved accrediting body for chiropractic colleges,⁴⁷ and it abides by the Mixing philosophy. Competitive accreditation organizations have emerged, but they have not managed to obtain or maintain government approval.⁴⁸ As a result, the industry is moving toward the Mixing school, because that is the only training most school offer.⁴⁹ While education standards in chiropractic colleges were once minimal,⁵⁰ the standards have now increased to a point where all chiropractic colleges typically require four years of training, and most include physical therapy education along with a variety of

⁴² Goldstein, *supra* note 16, at 57.

⁴³ MOORE, *supra* note 36, at 90.

⁴⁴ *Id.* at 81-82.

⁴⁵ *Id.* at 89.

⁴⁶ See Meeker & Haldeman, *supra* note 11, at 217.

⁴⁷ For the story of the founding of the organization and how it advanced the legitimacy of chiropractic, see *infra* notes 224-27 and accompanying text.

⁴⁸ SAMUEL HOMOLA, *INSIDE CHIROPRACTIC: A PATIENT'S GUIDE* 51 (Stephen Barrett ed., Prometheus Books 1999).

⁴⁹ Stephen Barrett, *The Spine Salesmen*, in *THE HEALTH ROBBERS: A CLOSE LOOK AT QUACKERY IN AMERICA* 161, 167 (Stephen Barrett & William T. Jarvis eds., 1993).

⁵⁰ KEATING ET AL., *supra* note 18, at 14.

science and anatomy courses.⁵¹ “Most states [also] require chiropractors to earn continuing education credits to maintain their licenses.”⁵²

Chiropractors commonly argue that their education is as good as, or better than, physicians’ education.⁵³ Often the basis for this argument is that they, too, take classes in anatomy, physiology, pediatrics, obstetrics, and gynecology, to name a few. However, very few physicians teach in chiropractic colleges, so, although they have the classes, the education might be insufficient because the instructors are other chiropractors.⁵⁴ Indeed, chiropractic schools confine most of their training to the classroom, where there is very little patient contact with the exception of chiropractic adjustments.⁵⁵ In contrast, during medical school and residency, medical students spend much more time training with patients who present with a full range of diseases and injuries.⁵⁶ Moreover, chiropractic colleges have lower admissions standards, and a lot of time is spent learning chiropractic theory, adjustment, and marketing techniques.⁵⁷ Chiropractic education has come a long way since Daniel Palmer first opened his school;⁵⁸

⁵¹ HOMOLA, *supra* note 48, at 8. The CCE now requires the following standards be met for graduates: (1) Two years of college with a C average; (2) 4200 hours of instruction over four years; (3) “[P]erform and interpret, order and interpret, or interpret at least twenty-five . . . area radiographic (diagnostic imaging) examinations with written reports of findings”; (4) “[I]nterpreted clinical laboratory tests to include at least twenty-five . . . urinalyses, twenty . . . hematology procedures such as complete blood counts, and ten . . . clinical chemistry, microbiology or immunology procedures or profiles on human blood and/or other body fluids”; (5) “[P]erformed a minimum of 80% chiropractic spinal adjustments and/or manipulations during at least 250 separate patient care visits”; (6) “[I]ntegrated the elements of the basic, chiropractic, clinical sciences and clinical instruction into clinical decisions”; (7) “No more than [20%] of [the] appropriate services may be administered to students and/or student’s families”; (8) “The degree candidate must have ordered, performed, and integrated the data for case management and follow-up from appropriate services of those listed above on a minimum of ten . . . different outpatients as a requirement for graduation.” *Id.* at 51, 53.

⁵² NAT’L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., ABOUT CHIROPRACTIC AND ITS USE IN TREATING LOW-BACK PAIN 5 (2005) [hereinafter NCCAM, ABOUT CHIROPRACTIC].

⁵³ HOMOLA, *supra* note 48, at 52 (citing STEPHEN BARRETT ET AL., CONSUMER HEALTH: A GUIDE TO INTELLIGENT DECISIONS (7th ed. 2002)).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ KURT BUTLER, A CONSUMER’S GUIDE TO “ALTERNATIVE MEDICINE”: A CLOSE LOOK AT HOMEOPATHY, ACUPUNCTURE, FAITH-HEALING, AND OTHER UNCONVENTIONAL TREATMENTS 74 (1992).

⁵⁸ “[E]arly chiropractic schools were almost all proprietary, that is, operated for profit by their owners. There was strong incentive to emphasize quantity (of students) over quality (of instruction). High school graduation was not usually re-

however, critics contend that chiropractors still must accept the shortcomings of their training when compared to medical school.⁵⁹

D. Relationship between Chiropractors and the Medical Community

Understanding the relationship between chiropractors and physicians is important because their organizational entities have had a major impact on the shape of legislation and regulation.⁶⁰ Chiropractors and their supporters believe that conventional medicine's treatment of chiropractors epitomizes the recent history of alternative medicine, "because, although chiropractic may represent the most utilized alternative therapy in the United States, organized medicine has spared no expense or energy in attempting to eliminate it."⁶¹ In contrast, many doctors regard chiropractors as a societal problem because chiropractors are so well entrenched and in their opinion, few of them practice responsibly.⁶² This rift between doctors and chiropractors dates back to Daniel Palmer's printed assaults on the "political physicians" of his time.⁶³ The poor relationship exposes patients to less than adequate care, and stems from the historical animosity between chiropractors and physicians, poor inter-industry communication, and the inability of doctors and chiropractors to cooperate and integrate care.

1. Inevitable Conflict

The contradicting theories that underlie conventional medicine and chiropractic care are seemingly irreconcilable. Chiropractors posit a whole body theory that focuses on an "individual [as] an organic whole, rather than a collection of accidents put together like an artificial patchwork. . . ."⁶⁴ Under the whole body theory, lifestyle, dietary, and emotional issues all play a role in the treatment of the patient.⁶⁵ Many chiropractors believe that doctors merely aim to fix the symptoms and cure disease, while their own practice aims to cure

quired, and laboratory facilities were few and far between." KEATING ET AL., *supra* note 18, at 14.

⁵⁹ BUTLER, *supra* note 57, at 85.

⁶⁰ See generally *infra* notes 213-23 and accompanying text.

⁶¹ Boozang, *supra* note 17, at 196.

⁶² William T. Jarvis, *Chiropractic: A Skeptical View*, CHIROBASE, <http://chirobase.org/01General/skeptic.html> (last visited Apr. 8, 2009).

⁶³ KEATING ET AL., *supra* note 18, at 7-8.

⁶⁴ Cohen, *Holistic Health Care*, *supra* note 5, at 134 (citation omitted).

⁶⁵ See Cohen, *Holistic Health Care*, *supra* note 5, at 133-34.

the entire body.⁶⁶ Surely, doctors do aim to cure the entire body; chiropractors simply view their methods as superior.

In many states, the current statutory scheme for doctors and chiropractors embodies traditional notions of professional hierarchy, wherein only physicians may diagnose and treat patients, while non-physician health professionals may only focus on pinpoint ailments and parts of the body.⁶⁷ Accordingly, states license a doctor to diagnose and treat a disease, while a chiropractor must operate under a scope of practice statute that defines the manner in which she may diagnose and treat. Michael Cohen⁶⁸ believes that “[w]ith chiropractic, the conflict over scope of practice may be inevitable: chiropractors address spinal and nervous system issues in patients with a variety of conditions, whereas biomedicine claims the exclusive authority to diagnose and treat, and many physicians would either limit chiropractors to spinal problems or, ideally, eliminate them.”⁶⁹ He further posits that non-traditional health care providers have fundamentally different views, and that is why the relationship between chiropractors and physicians is so unstable and characterized by conflict.⁷⁰

2. The Cooperative Relationship between Doctors and Chiropractors

Some chiropractors claim that the medical community has been working to defeat them from the beginning. Cohen contends that Nathan Smith Davis founded the American Medical Association (“AMA”) primarily to eliminate homeopathic medicine.⁷¹ Since the formation of its Committee on Quackery in 1963, the AMA has continually taken up arms against CAM providers.⁷² As recently as

⁶⁶ *Id.* at 139.

⁶⁷ James W. Hilliard & Marjorie E. Johnson, *State Practice Acts of Licensed Health Professions: Scope of Practice*, 8 DEPAUL J. HEALTH CARE L. 237, 251 (2004).

⁶⁸ Michael Cohen is one of the leading researchers of complementary medicine and the law. He is the author of www.camlaw.com, a complementary and alternative medicine law blog. For complete biographical information, see <http://www.camlawblog.com/cat-about-michael.html> (last visited Feb. 16, 2009).

⁶⁹ COHEN, *LEGAL BOUNDARIES*, *supra* note 26, at 47.

⁷⁰ Cohen, *Holistic Health Care*, *supra* note 5, at 91.

⁷¹ MICHAEL H. COHEN, *LEGAL ISSUES IN ALTERNATIVE MEDICINE: A GUIDE FOR CLINICIANS, HOSPITALS, AND PATIENTS* 66 (2003). Officially, the AMA contends that its original mission was to elevate the standards of medical education and licensure in the United States. American Medical Association, *AMA’s Founder*, <http://www.ama-assn.org/ama/pub/about-ama/our-mission.shtm> (last visited Feb. 22, 2009).

⁷² *Wilk v. Am. Med. Ass’n*, 671 F. Supp. 1465, 1473 (N.D. Ill. 1987); see *infra* notes 247-63 and accompanying text.

1990, a federal court held that the AMA had engaged in a conspiracy to eliminate the chiropractic profession.⁷³ A New England Journal of Medicine editorial "lambasted alternative care, claiming that these therapies are insufficiently tested, 'rely . . . on anecdotes and theories', are possibly dangerous, and are 'a reversion to irrational approaches to medical practice.'"⁷⁴

Historically, doctors have taken protectionist measures against chiropractors, including, among others, the formation of the Committee on Quackery.⁷⁵ Critics focus on the fact that chiropractors cannot support the efficacy of their methods through double blind, placebo-controlled, randomized studies,⁷⁶ while conventional medicine has a greater amount of hard empirical data to support its efforts. Despite this, the conventional sentiment among chiropractors is that,

Physicians convince legislatures to restrict the scopes of practice of other providers and pressure prosecutors to bring criminal actions against nonphysician providers. . . . In addition, since physicians are the main breadwinners for hospitals, health maintenance organizations, and other health care institutions, they exert a large amount of power over the fashioning of policies to govern these institutions. Physician groups have bullied hospitals into adopting policies that favor physicians and disadvantage or even eliminate alternative health care providers, even when there is no evidence that such policies are necessary to protect patients.⁷⁷

Many doctors' negative reactions to the proliferation of alternative medicine has been so pronounced that they have established organizations and journals that speak out against this phenomenon, which some say exist solely to discredit alternative therapies such as chiro-

⁷³ COHEN, LEGAL ISSUES, *supra* note 71, at 66 (quoting *Wilk v. AMA*, 895 F.2d 352 (7th Cir. 1990)).

⁷⁴ Kristen J. Josefek, *Alternative Medicine's Roadmap to Mainstream*, 26 AM. J.L. & MED. 295, 296-97 (2000) (citing Richard Saltus, *Medical Journal Rips Alternative Remedies*, BOSTON GLOBE, Sept. 17, 1998, at A1).

⁷⁵ *Wilk*, 671 F. Supp. at 1473-74.

⁷⁶ See Cohen, *Holistic Health Care*, *supra* note 5, at 97. Critics contend that the chiropractic industry's ability to thrive despite any scientific validity is a testament to "the reality that healthcare delivery involves much more than science. Politics, business considerations, and the clinical art often take precedence." Jarvis, *supra* note 62.

⁷⁷ Boozang, *supra* note 17, at 186 (quoting Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1288-89 (1996)).

practic care.⁷⁸ Some proponents of chiropractic care contend that conventional medicine's organizational efforts merely preceded theirs, and if chiropractors had been able to consolidate their leadership, reduce internal conflicts, and increase cohesion, they might have earned autonomy from the state, via licensure, prior to doctors and would now hold the more prominent position.⁷⁹

There will always be competition between service providers within the same industry. Newcomers will always try to maximize their status while those who are established will resist those efforts.⁸⁰ While intra-industry conflict in most other industries does not put people's health at risk, in the conflict between chiropractors and physicians, it can. Doctors' and chiropractors' general disdain for one another has a detrimental impact on patients because it leads to a breakdown in communication, both between doctors and chiropractors and between patients and their health care providers. Legislatures can reduce this problem by narrowing the chiropractor scope of practice, thereby giving the consumer a clearer understanding of whether to visit a chiropractor or a physician for a given ailment.

3. Failure in Communication

The divergence between chiropractic philosophy and conventional medical philosophy, coupled with the historical disdain these two groups have for one another, results in disjointed health care for the patient because a communication breakdown occurs between the patients and their healthcare providers, as well as between the chiropractor and the family doctor. A failure in communication between chiropractors and physicians can compromise patient care as significantly as a breach in technical competence.⁸¹ The uninformed patient is often the reason for communication failure. Patients do not understand that their alternative medicine therapies might be very relevant to their medical course of treatment, and that, to avoid potential risks, they should communicate all methods of treatment to all care providers.⁸² A recent survey conducted by leading researchers in chiropractic care suggests, "when patients choose not to tell their physicians that they use CAM therapies, they appear to be less concerned about their physician's disapproval than their physician's perceived inability

⁷⁸ *Id.* at 189 (citations omitted).

⁷⁹ Goldstein, *supra* note 16, at 56.

⁸⁰ *Id.*

⁸¹ Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 343 (2000).

⁸² See Mainous et al., *supra* note 6, at 449; Mainous, *supra* note 6, at 449.

to understand or incorporate CAM therapy into their overall medical management.”⁸³

This same study revealed that 63-72% of patients are not disclosing CAM therapy to their medical doctor.⁸⁴ Reporting rates for chiropractic care are likely higher than for the rest of the CAM industry, because society has accepted chiropractic care as more mainstream than other forms of CAM.⁸⁵ The AMA substantiates these other studies, finding that, for all uses of CAM, up to 70% of patients may not reveal their use of unconventional treatment to their physician.⁸⁶ However, the AMA stresses the importance of communicating all treatments to physicians.⁸⁷ Despite these AMA recommendations, it is apparent, through their lack of communication, that patients are aware of this disconnect between conventional and alternative medical providers.⁸⁸ Practitioners report that they seldom receive adequate information about the health status of their patients and courses of treatment that the other providers are administering. Relying on patients to be the information conduit between these practitioners is problematic because of the patient’s reluctance to disclose relevant information.⁸⁹

But patients are not entirely at fault here; they are more likely responding to their perception that their doctor does not approve of CAM therapies.⁹⁰ Even when presented with information by the

⁸³ David M. Eisenberg et al., *Perceptions about Complementary Therapies Relative to Conventional Therapies Among Adults Who Use Both: Results from a National Survey*, 135 ANNALS INTERNAL MED. 344, 350-51 (2001).

⁸⁴ *Id.* at 348.

⁸⁵ The following are the stated reasons for patient non-disclosure of CAM therapies to their medical doctors: it was not for the doctor to know (61%); the doctor never asked (60%); it was none of the doctor’s business (31%); the doctor would not understand (20%); the doctor would disapprove or discourage (14%); the doctor would not continue as their provider (2%). *Id.* at 349 (multiple responses permitted).

⁸⁶ COUNCIL ON SCIENCE AND PUBLIC HEALTH, AMERICAN MEDICAL ASSOCIATION, ALTERNATIVE MEDICINE REPORT (1997), available at <http://www.ama-assn.org/ama/pub/category/print/13638.html> [hereinafter AMA REPORT].

⁸⁷ *Id.*

⁸⁸ Eisenberg et al., *supra* note 83, at 350.

⁸⁹ Mainous et al., *supra* note 6, at 449; see also David M. Eisenberg et al., *Unconventional Medicine in the United States – Prevalence, Costs, and Patterns of Use*, 328 NEW ENG. J. MED. 246, 246 (1993) (finding that, “[a]mong those who used unconventional therapy for serious medical conditions, the vast majority (83 percent) also sought treatment for the same condition from a medical doctor; however, 72 percent of the respondents who used unconventional therapy did not inform their medical doctor that they had done so”).

⁹⁰ Mark Sanders, a chiropractor and industry whistle blower, maintains that, despite doctors’ mistrust of chiropractors, it is important for a doctor to maintain a good relationship with at least one reputable chiropractor. Mark Sanders, *Take It*

patient, both doctors and chiropractors admit to poor communication between one another concerning shared patients.⁹¹ Generally, chiropractors are more likely to communicate and are more positive toward sharing care with physicians because they are outside of the mainstream medical establishment, looking for acceptance within.⁹² Chiropractors are actually liable for malpractice if they fail to refer their patients to a doctor whenever a "patient's condition exceeds the scope of their training, education, and competence."⁹³ In cases of referral, family physicians and chiropractors share information with one another at a staggeringly low rate, approximately 25% of the time.⁹⁴ This discontinuity in care is not good for patients, as it allows for gaps in the flow of information, which can lead to gaps in patient care. A clearly defined scope of practice statute can resolve this by reducing overlap between chiropractic care and conventional medical care, which should reduce animosity and encourage a more cooperative environment.

Discontinuity is nothing new in patient care, and it exists internally within conventional medicine, as well. There is typically poor communication between specialists and general physicians.⁹⁵ Although there are advantages to continuity in patient care, given the current model of health care delivery, it is unrealistic to envision a purely continuous model that seamlessly integrates chiropractic care with conventional medical care. This Note argues that if scope of practice statutes define roles and reduce overlap, there will be a reduction in the animosity that doctors feel toward chiropractors. Any reduction in animosity should lead to greater communication between patients and their health care providers, as well as among the providers themselves.

from a D.C.: A Lot of Chiropractic is a Sham, 67 *Medical Economics* 31, 39, (1990). This will encourage the chiropractor to refer patients with serious medical conditions to the doctor, and the doctor will be able to refer interested patients to a chiropractor who the doctor knows will not interfere with her prescribed course of care. *Id.*

⁹¹ Mainous et al., *supra* note 6, at 449.

⁹² *See id.*

⁹³ *See* Ford v. Peters, No. A1-04-076, 2005 U.S. Dist. LEXIS 9262, at *19 (D. Wyo. May 5, 2005); Enslin v. Kennedy, 26 Cal. Rptr. 3d 274, 279 (Cal. Ct. App. 2005); Robertson v. Counselman, 686 P. 2d 149, 152 (Kan. 1984); *see also* 55 AM. JUR. POF 3d 1, *Proof of Malpractice by Chiropractor* § 55; COHEN, LEGAL ISSUES, *supra* note 71, at 37.

⁹⁴ Mainous et al., *supra* note 6, at 446 (noting that "family physicians received information from chiropractors on 26.5% of referred patients while chiropractors received information from family physicians in 25.0% of cases.")

⁹⁵ Mainous et al., *supra* note 6, 446.

4. Conventional Notions about Patient Care

Chiropractors and other CAM practitioners generally consider their profession more patient-friendly, because many incorporate and emphasize the whole body theory in their practice. The whole body theory is concerned with the emotional health of the patient, not simply treating the disease.⁹⁶ By some accounts, this theory leads to increased patient counseling, improved explanation of illnesses, a willingness to discuss emotional factors, better understanding of problems, more personal attention, and greater expenditure of time.⁹⁷ Chiropractors generally consider themselves much better at managing this patient relationship.

Chiropractors generally exercise greater interpersonal competence and are more likely to consider personal preferences and attend to the more intimate and emotional aspects of medical care.⁹⁸ Chiropractors and their proponents often credit this with lowering the rate of chiropractor malpractice suits.⁹⁹ Some chiropractors use malpractice statistics as evidence that they are practicing in a field that is friendlier to patients.¹⁰⁰ However, even though data suggest that, relative to physicians, patients do not sue alternative medicine providers very often,¹⁰¹ the most plausible explanation for this is the severity of illnesses that alternative medicine providers commonly treat. Generally, the rates of medical injury increase proportionately with the invasiveness of therapy. It follows that, because chiropractors employ largely non-invasive methods, there will be fewer injuries and fewer bases for suit.¹⁰² Another explanation may be that the law in the area of alternative medical malpractice is immature and largely undefined.¹⁰³

Some consider the impersonal state of conventional medical practice to be the reason for the increase in chiropractor visits.¹⁰⁴ Some

⁹⁶ See Cohen, *Holistic Health Care*, *supra* note 5, at 160.

⁹⁷ Eisenberg et al., *supra* note 83, at 350.

⁹⁸ Kinney, *supra* note 81, at 344.

⁹⁹ E.g., David M. Studdert et al., *Medical Malpractice Implications of Alternative Medicine*, 280 JAMA 1610, 1612 (1998).

¹⁰⁰ Stephen M. Foreman & Michael J. Stahl, *Chiropractors Disciplined by a State Chiropractic Board and a Comparison with Disciplined Medical Physicians*, 27 J. MANIPULATIVE PHYSIOLOGICAL THERAPEUTICS 472, 476 (2004) (stating that allegations of incompetence or negligence rates for doctors is 34% compared to 6.4% for chiropractors).

¹⁰¹ COHEN, LEGAL ISSUES, *supra* note 71, at 37.

¹⁰² Studdert et al., *supra* note 99, at 1612.

¹⁰³ *Id.*

¹⁰⁴ See Boozang, *supra* note 17, at 212.

chiropractors maintain that one of the primary reasons patients seek out chiropractic care is that they are looking for a compassionate caregiver who will attend to their emotional needs, because physicians are especially inattentive.¹⁰⁵ CAM supporters maintain that many people are unhappy with conventional medicine in general, a result of the natural suspicion of “authoritarian, insular sections of society.”¹⁰⁶ They credit technology with dehumanizing the patient¹⁰⁷ and further “reducing the problem of human illness—with all its intricate physical, social, emotional, and cultural aspects—to the biological problem of disease.”¹⁰⁸ They do not contend that doctors are lazy, but merely that doctors rely on test results without enough consideration for the people that they are testing, and that has led to a decline in patient satisfaction.¹⁰⁹

Many doctors challenge the argument that their field drives patients to alternative medicine. Though “overall levels of trust and confidence in medical care have declined since the 1960s,”¹¹⁰ and there are studies noting specific complaints regarding certain aspects of care for the seriously ill,¹¹¹ a national study of CAM use found that there is no relationship between CAM use and dissatisfaction with conventional medical care.¹¹² Furthermore, claims that CAM usage is on the rise because it allows patients to have more control over their care are unsubstantiated given that, today, almost all patients express a desire for this control.¹¹³

¹⁰⁵ *Id.*

¹⁰⁶ AMA REPORT, *supra* note 86.

¹⁰⁷ Michael H. Cohen & Mary C. Ruggie, *Integrating Complementary and Alternative Medical Therapies in Conventional Medical Settings: Legal Quandaries and Potential Policy Models*, 72 U. CIN. L. REV. 671, 676 (2003).

¹⁰⁸ *Cf.*, Eric J. Cassell, *The Sorcerer's Broom: Medicine's Rampant Technology*, 23 HASTINGS CENTER REP. 32, 33 (1993).

¹⁰⁹ *Id.* at 34-35.

¹¹⁰ Goldstein, *supra* note 16, at 45-46 (citing John Astin, *The Characteristics of CAM Users: A Complex Picture*, in COMPLEMENTARY AND ALTERNATIVE MEDICINE: CHALLENGE AND CHANGE, 101-114 (Merrijoy Kelner, et al. eds. 2000); Peter T. Kilborn, *Trend Towards Managed Care is Unpopular, Surveys Find*, N.Y. TIMES, Sept. 28, 1997, at A25.

¹¹¹ Goldstein, *supra* note 16, at 45-46 (citing Raymond Murray & Arthur Rubel, *Physicians and Healers—Unwitting Partners in Healthcare*, 326 NEW ENG. J. MED, 61, 61-64 (1992)).

¹¹² *Id.* (citing John A. Astin, *Why Patients Use Alternative Medicine*, 279 JAMA, 1548, 1548-53 (1998)).

¹¹³ *Id.* (citing John A. Astin, *The Characteristics of CAM Users: A Complex Picture*, in COMPLEMENTARY AND ALTERNATIVE MEDICINE: CHALLENGE AND CHANGE, 101-114 (Merrijoy Kelner et al. eds., 2000)).

Even if patients are unhappy with conventional medical care, 70% of patients still see a medical doctor before or at the same time as their CAM provider, and only 15% of people typically see a CAM provider before seeing a medical doctor.¹¹⁴ In a recent study, of all respondents who saw a physician and used CAM therapies over a 12 month period, 79% considered a combination of the two to be superior to either one individually.¹¹⁵ This is evidence that people still trust their doctors; however, if physicians and chiropractors are not going to facilitate communication between one another, they will compromise the care of their patients.

Patients likely prefer concurrent physician and chiropractor care because each employ very different diagnostic and treatment methods in their respective practices. A narrowly defined scope of practice statute should enable patients to recognize these differences and understand that there are different reasons to see different care providers. There is a small minority of patients who only visit CAM providers for their medical care because conventional medicine has alienated them in some way,¹¹⁶ but this small percentage actually represents a large number of people.¹¹⁷ These people must realize that there are services that chiropractors do not, and should not, offer. A strict scope of practice statute should help to clarify this and ensure that these patients do not exclusively rely on chiropractors for their medical needs.

E. Chiropractic Integration into the Conventional Medicine Model

Though it might seem that the differences between physicians and chiropractors are irreconcilable, some within the health care industry are moving toward integrating CAM with conventional medicine.¹¹⁸ This integration will require narrowing chiropractors' scope of practice so that they know their role within an integrated system. In fact, many of the integrating institutions have internally narrowed chiropractors' scope of practice to enable integration.¹¹⁹

One of the reasons that integration is moving forward in some areas is because of the health industry's increasing acceptance of

¹¹⁴ Eisenberg et al., *supra* note 83, at 347.

¹¹⁵ *Id.* at 346.

¹¹⁶ *See infra* note 141-43 and accompanying text.

¹¹⁷ *Id.*

¹¹⁸ J. Michael Menke, *Overcoming Barriers to the Integration of Chiropractic*, in *INTEGRATING COMPLEMENTARY MEDICINE INTO HEALTH SYSTEMS* 596 (Nancy Faass, ed., 2001).

¹¹⁹ Cohen & Ruggie, *supra* note 107, at 693.

chiropractic care and CAM in general.¹²⁰ Managed care organizations and workers' compensation programs that include alternative therapies as covered benefits often pressure physicians into making use of chiropractors.¹²¹ Some chiropractors are unsure if this integration could ever work in light of the historical antipathy expressed by doctors.¹²² Still, there is hope. Many in the chiropractic profession "ha[ve] matured to recognize the value of medical care in cases that are beyond the benefits of chiropractic treatment."¹²³ Additionally, integrated medical institutions are having little trouble, finding that the few doctors who approach integration with arrogance and self-righteousness are able to overcome their misconceptions relatively quickly.¹²⁴

A definite challenge to integration is the variety of techniques and training methods chiropractors employ,¹²⁵ as well as the decision of whether coordination is even necessary in certain situations. Currently, both doctors and chiropractors work as "gatekeepers" within their respective practices, because both are often the first caregiver with whom a patient consults.¹²⁶ Proponents of chiropractic care contend that the doctor is merely one of many health professionals from which patients solicit advice on health-related matters.¹²⁷ An estimated 90% of patients using alternative medicine providers are self-referred, not physician-referred.¹²⁸ To integrate successfully into the medical profession, chiropractors will have to accept doctors treating them as specialists like cardiologists or dermatologists¹²⁹ and not as primary care physicians.

In addition, the current ambiguity in scope of practice makes it impossible to incorporate chiropractors' care into the current medical

¹²⁰ See Avery Comarow, *Embracing Alternative Care: Top Hospitals Put Unorthodox Therapies into Practice*, U.S. NEWS & WORLD REP., Jan. 21, 2008, at 31, 32. Curiously, the article does not mention chiropractors as a type of complementary and alternative care. See *id.* at 31-40. This is likely an indication of chiropractors' general acceptance in comparison to modalities such as homeopathy and magnetic therapy.

¹²¹ Boozang, *supra* note 17, at 203; see *infra* notes 243-45 and accompanying text (discussing managed care's acceptance of chiropractors).

¹²² Cohen & Ruggie, *supra* note 107, at 682-83.

¹²³ Menke, *supra* note 118, at 596.

¹²⁴ Cohen & Ruggie, *supra* note 107, at 712.

¹²⁵ Mainous et al., *supra* note 6, at 450.

¹²⁶ See Cohen, *Holistic Health Care*, *supra* note 5, at 134.

¹²⁷ Eisenberg et al., *supra* note 83, at 350.

¹²⁸ Studdert et al., *supra* note 99, at 1610 (citing David M. Eisenberg et al., *Unconventional Medicine in the United States – Prevalence, Costs, and Patterns of Use*, 328 NEW ENG. J. MED. 246, 246-52 (1993)).

¹²⁹ Mainous et al., *supra* note 6, at 449.

malpractice scheme.¹³⁰ Based on current precedent, a court could find a physician's referral to a chiropractor as negligent if it delays or inhibits the patient's opportunity to obtain necessary medical care.¹³¹ Many doctors are concerned about the "malpractice implications of coordinating care with [chiropractors]";¹³² however, some believe that malpractice concerns should not prevent physicians from referring patients to chiropractors, because they are state-approved licensed professionals.¹³³

If states narrow their scope of practice statutes to allow for a consistent definition of chiropractic care, doctors will then have an idea of what type of care their patients would receive if referred. Currently, many chiropractors practice within a very broad scope, and a doctor is not likely to know the care her patient is going to receive when she is treated. Today, physicians are beginning to recognize that to advise their patients about chiropractic care, they need to be knowledgeable about the chiropractic modes of therapy.¹³⁴ Doctors cannot effectively accomplish this unless they are sure of the chiropractors' scope of practice.

Patients will certainly benefit from an integrative healthcare system characterized by open communication and cooperation; however, the industry must overcome inconsistencies in chiropractic practice by narrowly defining the legal scope of practice. Recent attempts at integration are largely untested beyond the single hospital level, and the integration of chiropractic care into the conventional healthcare model remains controversial.¹³⁵

F. Chiropractors as Primary Care Providers

While some within the chiropractic industry may be advocating for integration with conventional medicine, others consider themselves primary care providers¹³⁶ and are working to position chiropractic care alongside conventional medicine as a primary care

¹³⁰ See discussion *infra* Part II.B.

¹³¹ Michael H. Cohen and David M. Eisenberg, *Potential Physician Malpractice Liability Associated with Complementary and Integrative Medical Therapies*, 139 ANNALS OF INTERNAL MED. 596, 600 (2002).

¹³² Mainous et al., *supra* note 6, at 447.

¹³³ Studdert et al., *supra* note 99, at 1610.

¹³⁴ Cohen & Ruggie, *supra* note 107, at 677 n. 21 (citing Stephen Straus, *Complementary and Alternative Medicine: Challenges and Opportunities for American Medicine*, 75 ACAD. MED. 527, 573 (2000)).

¹³⁵ See Meeker & Haldeman, *supra* note 11, at 216.

¹³⁶ See Mainous et al., *supra* note 6, at 447-48.

profession.¹³⁷ According to the Institute of Medicine, primary care is the “provision of integrated, accessible health care 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.”¹³⁸ A 1993 study showed that 63.3% of chiropractors believed that they should be general care, portal-of-entry practitioners,¹³⁹ while 90.4% considered themselves primary care practitioners.¹⁴⁰

While some studies suggest that as few as 5% of adults who use alternative forms of health care rely on these forms as the sole means of care,¹⁴¹ this figure represents approximately one million people, annually, who are placing themselves at a substantial risk.¹⁴² There is concern because “[p]atients who use chiropractors as primary care physicians, either because they don’t know any better or because they have been turned off by orthodox medical care, run the greatest risk.”¹⁴³

Doctors typically have a negative reaction to chiropractors acting as primary care practitioners. They are concerned that chiropractors might present themselves as primary care providers even though chiropractic schools do not adequately train them in diagnosis and they are not able to prescribe medication.¹⁴⁴ Chiropractors’ self-perception as primary care providers can also further deteriorate communication with a patient’s medical doctor because chiropractors

¹³⁷ Cheryl Hawk & Marie E. Dusio, *A Survey of 492 U.S. Chiropractors on Primary Care and Prevention-Related Issues*, 18 J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS 57, 64 (1995).

¹³⁸ COMM. ON THE FUTURE OF PRIMARY CARE, INST. OF MED., PRIMARY CARE: AMERICA’S HEALTH IN A NEW ERA I (Molla S. Donaldson et al. eds., 1996).

¹³⁹ Hawk & Dusio, *supra* note 137, at 60 (“Respondents were asked to mark the statement about scope of practice that best reflected their opinion on [the chiropractor’s] position in the health care system.” 25.7% felt that they should be portal-of-entry for musculoskeletal conditions but not general primary care, and 4.1% felt that they should be musculoskeletal spinal specialists only.)

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 446.

¹⁴² This number is calculated by taking the approximate number of people in the United States, ~300,000,000 (U.S. Census Bureau, <http://www.census.gov> (last visited Feb. 16, 2009)) and multiplying by the approximate percentage of the population who visit a chiropractor each year, 7.4% (American Chiropractic Association, General Information about Chiropractic Care, http://www.acatoday.org/pdf/Gen_Chiro_Info.pdf (last visited Feb. 16, 2009)), then multiplying that number by the 5% who only see chiropractors for their healthcare.

¹⁴³ Modde, *supra* note 33, at 21.

¹⁴⁴ Mainous et al., *supra* note 6, at 449. For a discussion on the nuances of primary care medical practice see JEROME GROOPMAN, HOW DOCTORS THINK 90-91 (2007).

may not feel like they need to communicate with other primary care providers.¹⁴⁵ Likewise, if family physicians feel that chiropractors should not act as primary care providers, they are going to be less likely to co-manage care.¹⁴⁶

The competition for primary care status is another reason that chiropractors' scope of practice should be limited. The primary care physician should act as a "gatekeeper," one who "determines the patients' medical needs and directs them to specialists and other providers accordingly."¹⁴⁷ Chiropractors generally do not have the training required to complete this task competently, while still providing satisfactory care to their patients.¹⁴⁸

II. CURRENT SCOPE OF PRACTICE MODELS IN THE U.S.

The state legislature, under its police power, has the ultimate authority to determine the scope of practice for any health care provider.¹⁴⁹ Every state has a different statute to control its licensing board. Scope of practice statutes can vary greatly from state to state based on a number of variables, the most important of which are the accepted definition of chiropractic care and the politics surrounding the statute's creation. This section will explore the fluid definition of chiropractic care, the differences among the states in the allowable practices of chiropractors, the current industry proposals to bring uniformity to the field of chiropractic care, and the politics surrounding legislating and regulating the industry. Such awareness of the current environment is necessary to understand the potential dangers to the chiropractic consumer.

A. The Definition of Chiropractor

Defining chiropractic care is difficult because it varies from state to state, and from practitioner to practitioner. A Straight chiropractor might say that chiropractic care is a drug-free, subluxation-based healthcare modality that provides lifetime medical and preventative care for the entire family.¹⁵⁰ A Mixer might define chiropractic as "a

¹⁴⁵ Mainous et al., *supra* note 6, at 449.

¹⁴⁶ *Id.*

¹⁴⁷ Josefek, *supra* note 74, at 309 (citation omitted).

¹⁴⁸ See discussion *supra* Part I.C.

¹⁴⁹ See *supra* notes 7-9 and accompanying text.

¹⁵⁰ World Chiropractic Alliance, Purpose and Overview, <http://www.worldchiropracticalliance.org/about/wca.htm#issues> (last visited Feb. 23, 2009); see also Chapman-Smith, *Legislative Approaches*, *supra* note 9, at 440-41.

health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health.”¹⁵¹ A commonly used statutory definition is “a health-care field dedicated to the detection and correction of vertebral subluxation in order to eliminate spinal nerve interference which can adversely affect health.”¹⁵² Ultimately, however, the scope of practice statute is the legal dictate defining the modalities a chiropractor can use on a specific area of the body, thus effectively defining chiropractic care at a statutory level.¹⁵³

While these definitions may not seem overly divergent, they actually embody very different, inconsistent views of chiropractic care. These inconsistencies can be confusing to consumers, as they might not be aware of the type of care they will receive from office to office, and from state to state. It is important for the consumer and the chiropractor to have a clear understanding of what the chiropractor can and cannot do.¹⁵⁴ These irregularities in the perceived definition of chiropractic care have led to a fractured chiropractic industry that some say is bound by no more than its opposition to external critics.¹⁵⁵ In the interest of securing insurance coverage, new clients, and research funding, chiropractors have called for the chiropractic industry to unify and clearly define who they are and what they do;¹⁵⁶ however, that has yet to happen.

A primary reason for modern-day factionalism in the chiropractic industry is the illusory subluxation.¹⁵⁷ Subluxations are the historical and theoretical basis for chiropractic care, and many laws even describe and define chiropractic care as the location and removal of subluxations.¹⁵⁸ Doctors define a subluxation as an “incomplete or partial dislocation – a condition, visible on x-ray films, in which the

¹⁵¹ American Chiropractic Association, What is Chiropractic?, http://www.amerchiro.org/level2_css.cfm?T1ID=13&T2ID=61 (last visited Feb. 22, 2009).

¹⁵² Hilliard & Johnson, *supra* note 67, at 253; *see e.g.*, FLA. STAT. ANN. § 460.403(9)(a) (West 2009).

¹⁵³ Michael Kohler, *Chiropractic's Standard of Care*, DYNAMIC CHIROPRACTIC, Sep. 27, 2005, available at http://www.dynamicchiropractic.com/pdf_out/DynamicChiropractic.com-Chiropractics-Standard-of-Care-1235387829.pdf.

¹⁵⁴ PAUL BENEDETTI & WAYNE MACPHAIL, SPIN DOCTORS: THE CHIROPRACTIC INDUSTRY UNDER EXAMINATION 238 (2002).

¹⁵⁵ Jarvis, *supra* note 62.

¹⁵⁶ Hawk & Dusio, *supra* note 137, at .57.

¹⁵⁷ Jarvis, *supra* note 62.

¹⁵⁸ *Id.*; *see also* ALASKA STAT. § 08.20.900 (2008); COLO. REV. STAT. § 12-33-102(2) (2008) (“Chiropractic adjustment means the application . . . of adjustive force to correct subluxations. . . .”); CONN. GEN. STAT. § 20-24 (2007); DEL. CODE ANN. tit. 24, § 701 (2007); MASS. GEN. LAWS ANN. ch. 112, § 89 (West 2008); NEV. REV. STAT. ANN. §634.014 (LexisNexis 2008).

bony surfaces of a joint no longer face each other exactly but remain partially aligned.”¹⁵⁹ Chiropractors, on the other hand, are not able to agree on the definition of subluxation—some say you can see it on an X-ray, some say you cannot.¹⁶⁰ One chiropractor has publically suggested that a subluxation could be as small as one millionth of a millimeter.¹⁶¹ This, however, would make the subluxation smaller than the diameter of most protein molecules, and it would be absurd to think that anyone would be able to detect such a miniscule anomaly.¹⁶² Chiropractors cannot agree on how subluxations should be diagnosed, treated, or even what they should be called.¹⁶³ This is because there is virtually no scientific basis for the subluxation theory, and, for over one hundred years, chiropractors have failed to establish a scientific definition.¹⁶⁴ Most chiropractors claim to no longer make use of the subluxation theory, yet the government still requires their identification in order to be eligible for any sort of Medicare reimbursement.¹⁶⁵ Subluxation theory tends to substitute chiropractic theory and philosophy for traditional science,¹⁶⁶ and this has left the industry in its current fractured state.¹⁶⁷

The conflict within the chiropractic industry concerning the scope of practice is likely inevitable given the nature of the field. Different chiropractors have come to practice on very different types of patients, claiming to treat a broad array of conditions, or at least spinal and nervous system conditions that are purportedly the cause of other

¹⁵⁹ HOMOLA, *supra* note 48, at 31. For an alternate definition, see STEDMAN’S MEDICAL DICTIONARY 1716 (27th ed. 2000), which defines “subluxation” as “[a]n incomplete luxation or dislocation; though a relationship is altered, contact between joint surfaces remains.”

¹⁶⁰ BUTLER, *supra* note 57, at 68.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ HOMOLA, *supra* note 48, at 31 (pointing out that nearly 300 names for subluxations have been proposed).

¹⁶⁴ Jarvis, *supra* note 62.

¹⁶⁵ See discussion *infra* Part II.C.4.

¹⁶⁶ Jarvis, *supra* note 62.

¹⁶⁷ The confusion within the chiropractic industry over scope or practice and the role of the subluxation in chiropractic care was described as follows by the Department of Health and Human Services:

[H]eated controversy regarding chiropractic theory and practice continues to exist. . . . On-site and telephone discussions with chiropractors, and their schools and associations, coupled with a review of background materials . . . result in a picture of a profession in transition and containing a number of contradictions.

DEPT’ OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GEN., CHIROPRACTIC SERVICES UNDER MEDICARE 5 (1986), available at <http://oig.hhs.gov/oei/reports/oi-05-86-00002.pdf> [hereinafter INSPECTOR GENERAL REPORT].

bodily ailments.¹⁶⁸ In light of the confusion over what chiropractors generally do, “interpretation of regulatory language may be the only reliable and relevant resource for defining the chiropractic profession.”¹⁶⁹ Therefore, it is imperative that scope of practice statutes be consistent and clear in providing a legal definition of chiropractic care that the consumers can stand by and safely rely upon.

B. Current Chiropractor Scope of Practice in the United States

Around the time the United States was founded, any person could present himself as a medical healer and offer his services and concoctions as the newest breakthrough in medicine, regardless of efficacy or potential danger to the patients.¹⁷⁰ In the mid eighteenth-century, authorities used medical licensing as a “means to separate those with training from practitioners whose ignorance posed a danger to patients.”¹⁷¹ Thus, unlicensed practitioners became liable for the unlawful practice of medicine,¹⁷² while licensed professionals gained an affirmative defense against lawsuits to the extent that their actions fell within the scope of practice permitted under their licenses.¹⁷³

Legislatures created licensing boards to regulate the chiropractic industry,¹⁷⁴ and each board is comprised of a majority of chiropractors¹⁷⁵ who, like the members of most licensing boards, generally work to restrict access to the field of practice.¹⁷⁶ Furthermore, courts have found that chiropractor-licensing boards can rely on their own expertise when determining if a practitioner has acted outside his scope of practice.¹⁷⁷ This provides an opportunity for favoritism,

¹⁶⁸ Cohen, *Holistic Health Care*, *supra* note 5, at 123.

¹⁶⁹ Lamm & Pfannenschmidt, *supra* note 4, at 102.

¹⁷⁰ COHEN, LEGAL ISSUES, *supra* note 71, at 66.

¹⁷¹ *Id.*

¹⁷² Cohen et al., *Emerging Credentialing Practices*, *supra* note 8, at 289.

¹⁷³ Hilliard & Johnson, *supra* note 67, at 252; *see also* COHEN, LEGAL ISSUES, *supra* note 71, at 48 (discussing the benefits of strong credentialing criteria—a method of managing liability in the practice of CAM).

¹⁷⁴ *See supra* Part I.B.

¹⁷⁵ *See supra* note 9 and accompanying text.

¹⁷⁶ *See* Cohen, *Holistic Health Care*, *supra* note 5, at 145; Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 11 (1976). For a discussion on the power of licensure from a racial monopolization and suppression perspective, *see* David E. Bernstein, *Licensing Laws: A Historical Example of the Use of Government Regulatory Power Against African-Americans*, 31 SAN DIEGO L. REV. 89 (1994).

¹⁷⁷ *Zabrecky v. Conn. Bd. of Chiropractors*, No. 0702118, 1991 Conn. Super. Ct. LEXIS 2682, *5 (Nov. 15, 1991) (holding that a chiropractor was acting outside his scope of practice when he used an injection on a patient because a statute that permitted the chiropractor to ““treat the human body...by the oral administration of

which creates an impression of impropriety. Therefore, it is important for the legislatures to control these licensing boards "from the inside out, rather than from the outside in."¹⁷⁸ Legislatures are able to accomplish this via scope of practice language within licensing statutes.

A licensing statute's scope of practice section protects the public from an overreliance on chiropractors who might perform procedures or attempt to treat conditions without adequate training.¹⁷⁹ It also provides the licensing boards with the guidelines necessary to regulate and discipline their own members.¹⁸⁰ A chiropractor's scope of practice can vary greatly from state to state, not just in allowable procedures, but also in the power the legislature delegates to the licensing board. Some states simply give a general definition of professional practice, while others specify certain acts within the scope of practice or delegate further discretion to define the scope to the licensing boards.¹⁸¹ The regulatory language may appear in the statute, regulations, or practice standards determined by the licensing board.¹⁸² Though the location of the regulations may vary, inconsistencies between scope of practice statutes are the likely result of chiropractors' inability to clearly define their own practice.¹⁸³

foods, food concentrates, food extracts or vitamins' did not authorize the defendant chiropractor to inject a substance or to inform the patient about injecting a substance into the body"), *cited in* COHEN, *LEGAL BOUNDARIES*, *supra* note 26, at 52.

¹⁷⁸ Josefek, *supra* note 74, at 305 (citing David G. Warren, *Book Review*, 18 J. LEGAL MED. 257, 260 (1997)).

¹⁷⁹ BENEDETTI & MACPHAIL, *supra* note 154, at 237; COHEN, *LEGAL BOUNDARIES*, *supra* note 26, at 46; COHEN, *LEGAL ISSUES*, *supra* note 71, at 39.

¹⁸⁰ BENEDETTI & MACPHAIL, *supra* note 154, at 237.

¹⁸¹ STEFANO MADDALENA, *ALTERNATIVE MEDICINE: ON THE WAY TOWARDS INTEGRATION? A COMPARATIVE LEGAL ANALYSIS IN WESTERN COUNTRIES* 229 (2005).

¹⁸² DAVID CHAPMAN-SMITH, *THE CHIROPRACTIC PROFESSION: ITS EDUCATION, PRACTICE, RESEARCH AND FUTURE DIRECTIONS* 65 (2000).

¹⁸³ BENEDETTI & MACPHAIL, *supra* note 154, at 239 (arguing that, "[b]ecause chiropractors cannot agree on what they are treating, how they treat it, or what works, they find it impossible to describe their scope of practice or to enforce consistent standards of practice"). The following are two very different examples of text from scope of practice statutes:

Delaware

(a) "Chiropractic" means a drugless system of health care based on the principle that interference with the transmission of nerve impulses may cause disease.

(b) The practice of chiropractic includes, but is not limited to, the diagnosing and locating of misaligned or displaced vertebrae (subluxation complex), using x-rays and other diagnostic test procedures. Practice of chiropractic includes the treatment through manipulation/adjustment of the spine and other skeletal structures and the use of

The vast differences between states' scope of practice statutes are bewildering.¹⁸⁴ The trouble is that, whether they intended to or not, many state legislatures have drafted language that allows for a broad interpretation of how chiropractors are permitted to practice.¹⁸⁵ Scope of practice statutes generally address both a chiropractor's diagnostic and treatment capabilities.¹⁸⁶ The more liberal statutes allow chiropractors to use any diagnostic tool the CCE has approved for teaching at chiropractic colleges, while the more conservative statutes may limit a chiropractor's use of certain procedures, such as blood and urine testing.¹⁸⁷ With regard to treatment, the more liberal statutes

adjunctive procedures not otherwise prohibited by this chapter. DEL. CODE ANN. tit. 24, § 701 (2007).

West Virginia

The practices and procedures which may be employed by doctors of chiropractic are based on the academic and clinical training received in and through chiropractic colleges accredited by the Council of Chiropractic Education or its successors and as determined by the board. These include the use of diagnostic, analytical and therapeutic procedures specifically including the adjustment and manipulation of the articulations and adjacent tissues of the human body, particularly of the spinal column, including the treatment of intersegmental disorders. Patient care and management is conducted with due regard for environmental and nutritional factors, as well as first aid, hygiene, sanitation, rehabilitation and physiological therapeutic procedures designed to assist in the restoration and maintenance of neurological integrity and homeostatic balance. W.VA. CODE ANN. § 30-16-3 (LexisNexis 2007).

¹⁸⁴ BENEDETTI & MACPHAIL, *supra* note 154, at 238.

¹⁸⁵ *Id.* at 237; *see, e.g.*, COLO. REV. STAT. § 12-33-102(1) (2008) (defining "[c]hiropractic" as, "that branch of the healing arts which is based on the premise that disease is attributable to the abnormal functioning of the human nervous system. It includes the diagnosing and analyzing of human ailments and seeks the elimination of the abnormal functioning of the human nervous system by the adjustment or manipulation, by hand, of the articulations and adjacent tissue of the human body, particularly the spinal column, and the usage as indicated of procedures which facilitate and make the adjustment or manipulation more effective, and the use of sanitary, hygienic, nutritional, and physical remedial measures necessary to such practice. 'Chiropractic' includes the use of venipuncture for diagnostic purposes. 'Chiropractic' does not include colonic irrigation therapy. 'Chiropractic' includes treatment by acupuncture when performed by an appropriately trained chiropractor as determined by the Colorado state board of chiropractic examiners.").

¹⁸⁶ Robert L. Hirtle, Jr., *Chiropractic Jurisprudence and Malpractice Considerations*, in *CHIROPRACTIC STANDARDS OF PRACTICE AND QUALITY OF CARE*, 239, 245 (Herbert J. Vear, ed., 1992).

¹⁸⁷ *Id.* One of the principle differences between chiropractic care and conventional medical care is that chiropractic care is "guided by a doctrine that permits an unlimited practice with a limited treatment method, [while] science-based medicine is unlimited both in scope of practice and treatment methods and is free to adopt any treatment method of value." HOMOLA, *supra* note 48, at 54. Statutory definitions

will, again, permit any therapy taught in chiropractic colleges, such as physical therapy and nutritional counseling, while the conservative statutes may restrict approved modes of therapy or “limit the modalities that may be used in support of chiropractic adjustment.”¹⁸⁸

The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality¹⁸⁹ has divided the types of scope of practice statutes into three categories: (1) Restrictive; (2) Expansive; and (3) Intermediate.¹⁹⁰ Restrictive statutes are limiting in scope if “they explicitly prohibit chiropractors from performing two or more of the following: venipuncture [(phlebotomy)] for diagnostic purposes, use of physiotherapy modalities, dispensing of vitamin supplements, or provision of nutrition advice to patients.”¹⁹¹ A statute is expansive if it “allows three or more of the following practices: specialty diagnostic procedures, pelvic and rectal examination, venipuncture for laboratory diagnosis, signing of birth and death certificates, and acupuncture using needles.”¹⁹² A statute is intermediate if it falls somewhere within this spectrum.¹⁹³

Common features among all state practice statutes include: categorizing chiropractors as primary contact professionals, so no referral from a physician is required; the right and duty to diagnose, including the right to take X-rays; the right to use spinal manipulation; and the prohibition from performing surgery¹⁹⁴ and prescribing drugs.¹⁹⁵

“suggest use of licensing laws to contain competitors and preserve conventional medicine’s professional turf.” Cohen, *Holistic Health Care supra* note 5, at 90; *see also* Cohen & Ruggie, *supra* note 107, at 709 (discussing the inequities between medical licensing and other CAM treatments other than chiropractic care).

¹⁸⁸ Hirtle, *supra* note 186, at 245; *see, e.g.*, W.VA. CODE ANN. §30-16-3 (LexisNexis 2007).

¹⁸⁹ Formerly the Agency for Healthcare Policy and Research.

¹⁹⁰ AGENCY FOR HEALTHCARE POLICY AND RESEARCH, *supra* note 3.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.* (finding that 40 states have statutes that match the intermediate description leaving very few fully restrictive or expansive states).

¹⁹⁴ *E.g.*, NCCAM, ABOUT CHIROPRACTIC, *supra* note 52, at 5 n.†. (“In Oregon, chiropractors can become certified to perform minor surgery (such as stitching cuts) and to deliver children by natural childbirth.”)

¹⁹⁵ CHAPMAN-SMITH, THE CHIROPRACTIC PROFESSION, *supra* note 182, at 65; Josefek, *supra* note 74, at 298; NCCAM, ABOUT CHIROPRACTIC, *supra* note 52, at 5; AGENCY FOR HEALTHCARE POLICY AND RESEARCH, *supra* note 3. More than 50% of states permit clinical lab procedures, routine physicals, female pelvic exams, and rectal exams. Lamm & Pfannenschmidt, *supra* note 4, at 104 tbl.1. More than 80% allow X-rays, the use of thermography, and the use of a vascularizer. *Id.* “More than 90% of the responding regulatory boards allow chiropractors to perform routine physical examinations, draw or order clinical lab procedures, perform some aspect of physiological therapeutics, supplement with vitamins, adjust extremities, and provide

Some states, like Iowa, have statutes that focus on spinal manipulation and adjustment, and contain broad language such as that permitting the treatment of “human ailments,”¹⁹⁶ while others, such as Delaware, focus on “ambiguous concepts such as the location and removal of interference with ‘transition of nerve energy.’”¹⁹⁷ Still others, such as New Jersey, have seen their chiropractic scope of practice severely narrowed.

The New Jersey statute permits the chiropractor to manipulate the spine and related structures,¹⁹⁸ and the New Jersey Supreme Court, in *Bedford v. Riello* held that, “[a]n extremity is neither never nor always a related structure. Under the laws governing chiropractic practice, the issue in every case is whether a condition of the extremity manipulated is logically connected, by cause or effect, to a spinal condition”.¹⁹⁹ The Court goes on to note that a case-by-case analysis is necessary to determine whether the structure is related.²⁰⁰ The New Jersey Supreme Court clarified and amended the Appellate Division’s narrower holding that “‘related structures’ may permit a chiropractor to maneuver other structures...but only as the movement impacts on the spine.”²⁰¹

The federal determination of the scope of a chiropractor’s practice is relevant under two circumstances: (1) if the matter concerns federal workers’ compensation insurance, and (2) if the matter concerns Medicare.²⁰² Both situations operate under the Medicare definition of chiropractor, which states that a chiropractor must be licensed by a state and is permitted to “perform the services of a chiropractor in the jurisdiction” in which she is licensed “only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation).”²⁰³ Until recently, the Medicare law required chiropractors to

rehabilitative services.” *Id.* at 102.

¹⁹⁶ IOWA CODE ANN. § 151.1 (West 2008).

¹⁹⁷ COHEN, LEGAL BOUNDARIES, *supra* note 26, at 40; DEL. CODE ANN. tit. 24, § 701 (2007).

¹⁹⁸ N.J. ADMIN. CODE § 13:44E-1.1 (2007).

¹⁹⁹ 948 A.2d 1272, 1274 (N.J. 2008).

²⁰⁰ *Id.*

²⁰¹ 920 A.2d 693, 698 (N.J. Super. Ct. App. Div. 2007) (holding that the adjustment of a patient’s knee for the purposes of healing knee pain and not spinal pain is considered outside a chiropractor’s scope of practice in New Jersey and therefore a jury should be instructed that this can be considered evidence of deviation from the standard of care for purposes of a malpractice suit).

²⁰² Hirtle, *supra* note 186, at 245-46.

²⁰³ See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICARE CLAIMS PROCESSING MANUAL § 10.4 (2008), available at <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> (including chiropractors in the definition of “physician” but only “with respect to treatment by means of

prove subluxations via X-ray, but that resulted in excess reliance on unnecessary X-rays.²⁰⁴

The current system of chiropractic legislation, especially in states with broad statutes, can fool consumers in state into thinking that a chiropractor will conduct a diagnostic test with the same care and training as a physician. This is a real danger in states like Colorado, where chiropractors are performing female pelvic examinations, male genital examinations, rectal examinations, and female breast examinations.²⁰⁵ States can eliminate this danger by legislatively restricting and unifying chiropractors' scope of practice.

It is not important to note every discrepancy between all the different chiropractic scope of practice statutes; it is enough to know that there is great diversity, as well as overlap with conventional medicine,²⁰⁶ such that consumers can be confused and possibly placed in harm's way.²⁰⁷ Chiropractors maintain that this overlap is evidence of a flawed system that defines scope of practice in "terms of function (e.g., the notion that only medical doctors 'diagnose' and 'treat' patients whereas chiropractors deal solely with spinal alignment)."²⁰⁸ Chiropractors further claim that this overlap means they are technically capable of practicing medicine in the particular specialty with which their scope of practice overlaps because they have been doing so for some time.²⁰⁹ Chiropractors, their licensing boards, and their professional organizations continually fail to limit practitioners "whose diagnostic abilities and treatment methods [as well as education standards] are not adequate for the scope of practice they claim."²¹⁰ As a result, reform is necessary, but efforts to reform must withstand the political and legal pressures that chiropractors exert.

C. Legitimacy and the Political Machine – The Chiropractor's Ally

Many chiropractic industry successes have come on the heels of aggressive lobbying campaigns or crafty political strategizing. Most of the greatest legitimizing achievements for chiropractors are para-

manual manipulation of the spine (to correct a subluxation)").

²⁰⁴ See discussion *infra* notes 237–42 and accompanying text.

²⁰⁵ See Lamm & Pfannenschmidt, *supra* note 4, at 104 tbl.1. Though rectal examinations are permitted in Colorado, colon irrigation therapy is not. COLO. REV. STAT. § 12-33-102(1) (2008).

²⁰⁶ MADDALENA, *supra* note 181, at 436.

²⁰⁷ For a detailed analysis of chiropractic modalities by state, see Lamm & Pfannenschmidt, *supra* note 4, at 102-06.

²⁰⁸ COHEN, LEGAL BOUNDARIES, *supra* note 26, at 46.

²⁰⁹ MADDALENA, *supra* note 181 at 437.

²¹⁰ HOMOLA, *supra* note 48, at 54; see *supra* Part I.C.

digm examples of how alternative medical providers have been able to maneuver through the political system and the courts.²¹¹ Chiropractors have been adept at transcending political parties²¹² to achieve success for their initiatives. Such successes are an indicator of political and institutional strength and will affect any efforts to narrow scope of practice statutes. Any plans for restructuring scope of practice statutes must account for the “political and economic relations between the medical profession and its challengers.”²¹³

1. Licensure and Professional Organizations

Not surprisingly, elected officials on the federal and state level respond to pressure from special interest groups when deciding on legislative matters.²¹⁴ Chiropractic organizations spend considerable resources on lobbying elected officials.²¹⁵ Chiropractors trumpet their licensing achievement as a legislative grant of legitimacy,²¹⁶ when in fact it is likely that legislators do not understand what it means to identify and remove subluxations, given that chiropractors themselves cannot agree on it.²¹⁷ The licensing achievement likely has more to do with concerted lobbying efforts than any legislative acknowledgment. A well-organized special interest group is “likely to prevail over an amorphous ‘public’ whose members are dispersed and, as individuals, are not in sharp conflict with the organized interest.”²¹⁸ Chiropractors admit this, yet still consider the licensing statutes to be “some measure of legislative acceptance that spinal manipulation has a statutory impact on health.”²¹⁹

Generally, the mission of a chiropractic association, as for most professional associations, is to advance the interests of its respective practitioners and, among other things, promote public recognition of

²¹¹ BUTLER, *supra* note 57, at 63.

²¹² Goldstein, *supra* note 16, at 58.

²¹³ Cohen, *Holistic Health Care*, *supra* note 5, at 91.

²¹⁴ Saul Green, *Science, Politics, and Alternative Medicine: What Physicians Should Know*, in SCIENCE MEETS ALTERNATIVE MEDICINE: WHAT THE EVIDENCE SAYS ABOUT UNCONVENTIONAL TREATMENTS 33, 38-39 (2000).

²¹⁵ In the 2004 election cycle, the American Chiropractic Association’s political action committee (ACA-PAC) received over \$400,000 in donations from its members and distributed over \$390,000 to political candidates. The Center for Responsive Politics, <http://www.opensecrets.org/pacs/lookup2.asp?strid=C00102764&cycle=2004> (last visited Feb. 16, 2009).

²¹⁶ See Gellhorn, *supra* note 176, at 11 n.18.

²¹⁷ See discussion *supra* Part II.A.

²¹⁸ Gellhorn, *supra* note 176, at 16; see also *id.* at 12.

²¹⁹ Cohen, *Holistic Health Care*, *supra* note 5, at 93; Goldstein, *supra* note 16, at 57.

its member's services, while attempting to influence public policy.²²⁰ There are two dominating chiropractic associations operating today. The largest is the American Chiropractic Association ("ACA"), which has approximately 22,000 members and adheres mainly to a Mixer philosophy.²²¹ The second largest is the International Chiropractors Association ("ICA"), whose approximately 6,000 members adhere to a Straight philosophy.²²² In 1984, chiropractic reformists formed the National Association for Chiropractic Medicine ("NACM"), which has remained small in comparison to the other professional organizations.²²³ To be admitted to the NACM, applicants must sign a pledge to "[d]isavow the pseudoscientific subluxation theory and stop claiming that chiropractors can treat or prevent systemic disorders," and they must restrict their scope of practice to "neuromusculoskeletal problems" of a nonsurgical nature.²²⁴

2. Educational Accreditation

The ability to boast an educational accreditation council is due, in part, to both the political prowess of chiropractors and to the bureaucratic nature of government agencies.²²⁵ In 1968, the U.S. Department of Health, Education, and Welfare ("HEW") concluded that chiropractors did not base their care on principles accepted by the scientific community and chiropractic education did not prepare the student to properly diagnose or treat. The report recommended that the Medicare program not cover chiropractic care.²²⁶

Despite this report, in 1974 HEW approved the Council on Chiropractic Education ("CCE"), primarily because the Commissioner of Education determined that the agency was not responsible for valuing the legitimacy of the field of training that is seeking recognition from the HEW.²²⁷ At the time, chiropractors claimed this as major success because societal recognition of its educational methods lends legitimacy to the entire industry. Yet, critics today contend that the CCE

²²⁰ Hilliard & Johnson, *supra* note 67, at 245-46.

²²¹ Barrett, *The Spine Salesmen*, *supra* note 49, at 167.

²²² *Id.*

²²³ Jarvis, *supra* note 62.

²²⁴ Barrett, *The Spine Salesmen*, *supra* note 49, at 167; BUTLER, *supra* note 57, at 88-89; Jarvis, *supra* note 62, at 72.

²²⁵ See Barrett, *The Spine Salesmen*, *supra* note 49, at 168.

²²⁶ *Id.* at 167-68 (citing U.S. DEP'T OF HEALTH, EDUC. & WELFARE (now, U.S. DEP'T OF HEALTH AND HUMAN SERVS.), INDEPENDENT PRACTITIONERS UNDER MEDICARE: A REPORT TO CONGRESS (1968), available at <http://www.chirobase.org/05RB/HEW/hew03.html>).

²²⁷ *Id.* at 168.

has tainted the accreditation process by permitting schools to teach subluxation dogma.²²⁸ Regardless of criticism, the CCE is another success for chiropractors in their effort to become mainstream providers, and a demonstration of their ability to navigate the political system.

3. The National Center for Complementary and Alternative Medicine

Yet another political success, this time for proponents of all CAM therapies, came in 1991 with the founding of the Office of Alternative Medicine, later known as the National Center for Complementary and Alternative Medicine (“NCCAM”).²²⁹ The founding of the NCCAM purportedly began with a specific U.S. Senator and his personal acceptance of CAM. Iowa Representative Berkley Bedell introduced his friend, Senator Tom Harkin, to Royden Brown, the owner of a company that manufactured bee pollen capsules.²³⁰ Brown advocated taking 250 bee pollen capsules over five days to cure all allergies.²³¹ Harkin became convinced of the efficacy of CAM therapy, and, as chairperson of the Senate Appropriations subcommittee in charge of the National Institutes of Health (“NIH”) funding, encouraged the founding of the NIH’s Office of Alternative Medicine.²³²

In 1998, the NIH elevated the Office of Alternative Medicine to the NCCAM and promoted it from a NIH office to one of the twenty-eight principle NIH Centers/Institutes²³³ that comprise the NIH itself.²³⁴ Chiropractors rely on the NCCAM and its continued growth as a mark of legitimacy,²³⁵ while their critics wonder why the NIH is allowing those with questionable techniques to “cloak themselves in

²²⁸ HOMOLA, *supra* note 48, at 52; *see supra* Part I.C.

²²⁹ NATIONAL INSTITUTES OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NIH ALMANAC 2008-2009 365 (2008), http://www.nih.gov/about/almanac/Almanac_2008_2009.pdf.

²³⁰ Green, *supra* note 214, at 39-40.

²³¹ Consequently, in 1992, Brown and his business partners agreed to pay \$200,000 to settle charges of false representation. Press Release, Federal Trade Commission, Arizona Company Agrees to Pay \$200,000 to Settle FTC Charges it Made False Health Claims about Bee-Pollen Products (Dec. 30, 1992), *available at* <http://www.ftc.gov/opa/predawn/F93/ccpollen.6.htm>; STEPHEN BARRETT, BEE POLLEN, ROYAL JELLY, AND PROPOLIS, <http://www.quackwatch.com/01QuackeryRelatedTopics/DSH/bee.html> (last visited Mar. 28, 2009).

²³² Green, *supra* note 214, at 39-40; *see also* *The Man Bee-hind the Pollen Allergy ‘Cure’*, USA TODAY, July 22, 1993, at D6.

²³³ For a structural explanation of the National Institutes of Health, *see* <http://www.nih.gov/about/organization.htm>. (last visited Feb. 16, 2009).

²³⁴ NIH ALMANAC, *supra* note 229.

²³⁵ *See* Cohen & Ruggié, *supra* note 107, at 677.

legitimacy” by association with the NIH.²³⁶ Chiropractors have been more successful than any other CAM practitioners in lobbying corporations and government officials to ensure their legitimacy and staying power; as such, they reaped the reward in the form of insurance and Medicare reimbursements.

4. Medicare and Insurance

In 1972, chiropractors realized another great success when President Nixon signed the Social Security Amendments into law, expanding the definition of physician under the Medicare and Medicaid laws to include chiropractors.²³⁷ The original Medicaid law called for chiropractic reimbursement only for treatment of “subluxations demonstrated by x-rays.”²³⁸ This led to a major increase in chiropractors’ unnecessary use of X-rays²³⁹ to identify misalignments, which chiropractors arguably cannot even detect on X-rays.²⁴⁰ Recognizing chiropractors’ frequent use of unnecessary X-rays, Congress amended the law in 2000, striking the requirement that chiropractors demonstrate subluxations via X-ray and requiring only a claim that one exists.²⁴¹ In 1990, Medicare reimbursed chiropractors approximately \$181 million for their services,²⁴² and, as of 2003, chiropractors could also bill Medicaid in more than 24 states.²⁴³

Acceptance by Medicaid and Medicare led to increased acceptance by managed care organizations and private insurance. As of 2002, more than 50% of HMOs, more than 75% of private insurance plans, and all state workers’ compensation systems offered chiropractic services.²⁴⁴ Some of the HMOs even permit chiropractic care without requiring a physician’s referral.²⁴⁵ Many private plans permit chiropractic coverage of musculoskeletal problems because, as of 1999, “forty-six states [had] ‘insurance equality’ laws” mandating that insurers cover chiropractic services.²⁴⁶ Medicare and insurance

²³⁶ AMA REPORT, *supra* note 86.

²³⁷ Stephen J. Barrett, *The Selling of the Spine: Chiropractors Wangle \$100 Million Windfall*, 21 NEW PHYSICIAN 721, 721 (1972).

²³⁸ Barrett, *The Spine Salesmen*, *supra* note 49, at 169.

²³⁹ BUTLER, *supra* note 57, at 71.

²⁴⁰ See *supra* notes 157–68.

²⁴¹ HOMOLA, *supra* note 48, at 27.

²⁴² Barrett, *The Spine Salesmen*, *supra* note 49, at 169.

²⁴³ NCCAM, ABOUT CHIROPRACTIC, *supra* note 52, at 5.

²⁴⁴ Meeker & Haldeman, *supra* note 11, at 217; NCCAM, ABOUT CHIROPRACTIC, *supra* note 52, at 5.

²⁴⁵ AMA REPORT, *supra* note 86.

²⁴⁶ HOMOLA, *supra* note 48, at 27; accord Studdert et al., *supra* note 99, at 1614.

coverage helped the chiropractic industry grow to new heights²⁴⁷ and is perhaps the greatest evidence of chiropractors' ability to lobby for acceptance within the American healthcare model. In addition to their political shrewdness and power, chiropractors have become adept at fighting back against their opposition.

5. *Wilk v. The American Medical Association*²⁴⁸

During the 1960s and 1970s, the AMA's Committee on Quackery²⁴⁹ was engaged in a variety of anti-chiropractic activities with a mission to protect the public from what it thought were "unscientific and unethical practices."²⁵⁰ The AMA's official ethical principal was that "a physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate with anyone who violates this principle."²⁵¹ They saw this as protecting patients, while chiropractors saw it as an unfair trade practice. Chiropractors began to sue the AMA and other similar organizations, but most of the defendant-groups settled their cases out-of-court, rather than face the prospect of an uncertain outcome and potentially significant legal expenses.²⁵² The AMA has since changed its policy to allow its members to decide the merits of chiropractic care for themselves.²⁵³ The AMA did choose to fight one case that Chester Wilk and other chiropractors filed in 1976, requesting injunctive relief and damages

²⁴⁷ Eisenberg et al., *supra* note 15, at 1574.

²⁴⁸ 671 F. Supp. 1465 (N.D. Ill. 1987), *aff'd*, 895 F.2d 352 (7th Cir. 1990), *rehearing en banc denied*, No. 87-2672 (7th Cir. Apr. 25, 1990).

²⁴⁹ *Wilk*, 671 F. Supp. at 1473-77.

²⁵⁰ Barrett, *The Spine Salesmen*, *supra* note 49, at 188.

²⁵¹ *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 355 n.1 (7th Cir. 1990) (quoting former Principle 3 of the AMA's Principles of Medical Ethics).

²⁵² Barrett, *The Spine Salesmen*, *supra* note 49, at 188-89.

²⁵³ *Id.* The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Annual Meeting: "(1) There is little evidence to confirm the safety or efficacy of most alternative therapies. Much of the information currently known about these therapies makes it clear that many have not been shown to be efficacious. Well-designed, stringently controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. (4) Courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities." AMA REPORT, *supra* note 86.

for the Committee on Quackery's anti-trust practices in violation of §§ 1 and 2 of the Sherman Act.²⁵⁴

The AMA won a jury verdict in *Wilk v. AMA*, however, the 7th Circuit Court of Appeals reversed the judgment and ordered a new trial because the jury was permitted to consider inappropriate factors.²⁵⁵ On remand, following a bench trial, the District Court "concluded that the AMA, through former Principle 3, had unreasonably restrained trade in violation of . . . the Sherman Act,"²⁵⁶ and that before resorting to an all-out boycott, the Committee had to attempt to use less drastic means.²⁵⁷ The Seventh Circuit Court of Appeals affirmed the holding because the District Court had not abused its discretion; however, the panel noted that it may have found differently had it been the original trier of fact²⁵⁸ and that neither it nor the District Court was properly equipped to determine the scientific validity of chiropractic care.²⁵⁹

The fallout from *Wilk* has caused groups like the AMA to retreat and essentially abandon their assaults on the chiropractic industry for fear of boycotts or lawsuits.²⁶⁰ As a result, the media does not often criticize chiropractors, because there are so few doctors and associations speaking on the topic.²⁶¹ Though they have been successful in quieting their opposition, chiropractors should not necessarily use *Wilk* as an endorsement of their methods because it is an anti-trust case and, as previously mentioned, the Court of Appeals did not consider itself qualified to rule on the validity of chiropractic care.²⁶² In light of the AMA's jury verdict win, some chiropractic opponents hold hope that juries might be able to reel in the "chiropractic monster."²⁶³ However, it seems unlikely that legislators are beyond reach; rather, in light of the AMA's defeat in *Wilk*, it is more likely that the medical lobby is taking on other issues.

Clearly the chiropractic industry is well entrenched in society and the majority of chiropractic organizations will actively work against any widespread attempt to narrow the nation's scope of practice statutes. However, despite chiropractors' success at limiting any

²⁵⁴ *Wilk*, 895 F.2d at 355. Plaintiffs later dropped the damages claim but continued to pursue injunctive relief. *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.*

²⁵⁷ Barrett, *The Spine Salesmen*, *supra* note 49, at 188-89.

²⁵⁸ *Wilk*, 895 F.2d at 370.

²⁵⁹ BUTLER, *supra* note 57, at 73 (citing *Wilk*, 895 F.2d at 365).

²⁶⁰ HOMOLA, *supra* note 48, at 29; see BUTLER, *supra* note 57, at 88.

²⁶¹ Barrett, *The Spine Salesmen*, *supra* note 49, at 163.

²⁶² BUTLER, *supra* note 57, at 73 (citing *Wilk*, 895 F.2d at 365).

²⁶³ BUTLER, *supra* note 57, at 77.

perceived threat to their industry,²⁶⁴ with the proper initiative, a well-organized lobby could achieve legislation limiting the scope of chiropractic practice.

D. Current Scope of Practice Reform Proposals

It is not surprising that chiropractors and their critics have very different views on how scope of practice statutes should evolve in the future. These opinions embody the different points of view regarding chiropractors as members of the medical community. The proposals range from an abolishment of the scope of practice laws, to a complete integration of chiropractic care into the conventional health care model.

Many chiropractors believe that states should expand their scope of practice statutes to include emerging treatment modalities such as nutritional guidance and vitamin sales.²⁶⁵ They contend that if there is going to be a statutory definition of chiropractic care, it should be brief, inclusive,²⁶⁶ and broad enough to allow for innovation within the field, while keeping chiropractors within the bounds of their specified skill-set.²⁶⁷ They further maintain that a broader scope of practice statute would alleviate the problem of requiring statutory authorization for new chiropractic developments as they become available, a consequence that might accompany a narrow statute. Proponents of a broad statute contend that malpractice standards, tort law, and the duty to refer patients to physicians are sufficient to keep chiropractors operating within their prescribed domain of experience and training.²⁶⁸

Another option is for legislatures to eliminate a statutory definition of chiropractic care, because determining the scope of practice is

²⁶⁴ A more recent, smaller scale lobbying effort that demonstrates chiropractors skillful mastery of the legislative system is their recent achievement of title protection in Michigan. See MICH. COMP. LAWS ANN. § 333.16401(1)(b) (West 2008) (excluding animal “chiropractors”). See also Chapman-Smith, *Legislative Approaches*, *supra* note 9, at 446 (“A major reason for legislation to regulate the health profession is to prevent unqualified practitioners from passing themselves off as member of that profession. . . .”). Until 2002, there were massage therapists and physical therapists who were advertising chiropractic adjustments and the new legislation prohibits non-chiropractors from claiming they can perform chiropractic adjustments. Editorial, *Landmark Michigan Law Protects Chiropractors, Patients*, 21 DYNAMIC CHIROPRACTIC 1 (2003), available at <http://www.chiroweb.com/archives/21/06/08.html>.

²⁶⁵ See Cohen, *Holistic Health Care*, *supra* note 5, at 136-37.

²⁶⁶ Chapman-Smith, *Legislative Approaches*, *supra* note 9, at 441.

²⁶⁷ COHEN, *LEGAL BOUNDARIES*, *supra* note 26, at 54.

²⁶⁸ Cohen, *Holistic Health Care*, *supra* note 5, at 140.

a task best left to the licensing board.²⁶⁹ Australia currently employs this model.²⁷⁰ This approach is problematic because an inevitable perception of favoritism accompanies most self-regulated industries wherein those who are regulating stand to benefit from their own decisions. In fact, many correctly argue that legislatures should “re-capture the public power now delegated to multiple licensing boards whose members are drawn from and owe allegiance to the occupations they supposedly regulate in the public interest.”²⁷¹

Opponents of chiropractic care often call for a narrow scope of practice statute that will eliminate encroachment into conventional medicine. Though some want to eliminate the profession, moderates suggest developing policies designed to encourage chiropractors to act as musculoskeletal specialists instead of primary care physicians.²⁷² Proponents offer this proposal partially in light of data suggesting that family physicians are beginning to see chiropractors as specialists, much like dermatologists and cardiologists.²⁷³ Others propose restrictive statutes that define the profession and then further define the restrictive activities that could be potentially harmful.²⁷⁴ Chiropractors suggest that a narrower scope of practice that only allows physicians to treat and diagnose acts is essentially nothing more than a protectionist measure, preventing them from incorporating successful modalities into their treatment scheme,²⁷⁵ while allowing physicians to maintain their dominant role in the healthcare industry.

It is important to note that many of the suggestions for altering chiropractor scope of practice statutes come from those in a position to gain from those alterations. Doctors and chiropractors historically do not cooperate with one another,²⁷⁶ and often it is difficult to grasp the true impetus for an expert's suggestion. Does the doctor really want to protect patients, or does he want to protect himself? Does the chiropractor really believe in his espoused philosophy, or does he simply want to make more money? Legislators are in the best position to ignore professional and institutional biases and conclude that a strict scope of practice statute is necessary to protect patients from the

²⁶⁹ Chapman-Smith, *Legislative Approaches*, *supra* note 9, at 441.

²⁷⁰ *Id.*

²⁷¹ Gellhorn, *supra* note 176, at 27; *see also* Milton Heumann et al., *Prescribing Justice: The Law and Politics of Discipline for Physician Felony Offenders*, 17 B.U. PUB. INT. L.J. 1, 9 (2007) (discussing similar protectionism, monopolization, and bias that is present in physician licensing boards).

²⁷² *See* Mainous et al., *supra* note 6, at 449.

²⁷³ *See id.*

²⁷⁴ MADDALENA, *supra* note 181, at 439.

²⁷⁵ *See* Cohen, *Holistic Health Care*, *supra* note 5, at 97.

²⁷⁶ *See supra* Parts I.D.1-2.

uncertainty, confusion, and harm that could result from chiropractic care.

III. CONSUMER PROTECTION AND PATIENT AUTONOMY

A common theme throughout this Note is that patients are not capable of determining on their own the adequacy of healthcare providers, and therefore, it is necessary to limit the field of available healthcare services to those that are going to be most effective. Oliver Wendell Holmes, Sr. wrote of the medical consumer in his day, and little has changed.

There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives. They have submitted to be half-drowned in water, and half-choked with gases, to be buried up to their chins in earth, to be seared with hot irons like galley-slaves, to be crimped with knives, like cod-fish, to have needles thrust into their flesh, and bon-fires kindled on their skin, to swallow all sorts of abominations and to pay for all of this, as if to be singed and scalded were a costly privilege, as if blisters were a blessing, and leeches were a luxury. What more can be asked to prove their honesty and sincerity?²⁷⁷

Prior to the industrial revolution and trade globalization, the doctrine of *caveat emptor*, "let the buyer beware," was considered sufficient to protect consumers.²⁷⁸ At the time, the theory was adequate, because for the most part, buyers and sellers had equal bargaining positions. For example, in a simple sales relationship, the buyer of fruit could inspect the product before making a decision.²⁷⁹ However, with the proliferation of trade and the expansion in technology, "[e]ven highly intelligent individuals may go astray in situations where they lack expert knowledge or are emotionally vulnerable."²⁸⁰ Therefore, it is important for government to limit the market to protect the consumer where she is unable to protect herself.

²⁷⁷ OLIVER WENDELL HOLMES, *MEDICAL ESSAYS 1842-1882* 378-79 (1891). This is Oliver Wendell Holmes, Sr. the physician and poet, not his son the Supreme Court Justice.

²⁷⁸ STEPHEN BARRETT ET AL., *CONSUMER HEALTH: A GUIDE TO INTELLIGENT DECISIONS* 11 (8th ed. 2007).

²⁷⁹ *Id.*

²⁸⁰ *Id.*

A. Consumer Protection

Patients are in need of protection from chiropractors who offer services that overlap with conventional medicine, and which might lead consumers to believe that they are receiving comparable medical care. Consumers' concerns about health care come down to three general issues: quality, cost, and access.²⁸¹ Chiropractors are easily accessible and their treatments generally cost far less than medical treatment,²⁸² so there is a danger that patients might overlook the differences between chiropractors and physicians in favor of accessibility and cost.²⁸³ Though there are chiropractors who practice responsibly, every sector in the healthcare industry has its quacks and frauds and the government should protect those who are exposed and impressionable from the dangers of this quackery.²⁸⁴

Opponents of consumer protection measures argue that consumers of alternative medicine are able to educate themselves by simply going on the Internet or visiting a bookstore.²⁸⁵ This argument lacks merit because the validity of available sources is unknown, and some are largely biased and untested.²⁸⁶ While it may be true that the sophisticated patient might be able to navigate these sources to connect with the best doctors and obtain the best care,²⁸⁷ those who are desperate and vulnerable might not be so fortunate.²⁸⁸

In addition to overlap with physician care and patient misinformation, the general field of chiropractic care has other elements from which consumers need protection. Though there is evidence that chiropractors today are placing a greater emphasis on science, professionalism,²⁸⁹ and education,²⁹⁰ there also exist patterns of activity and practice which at best appear as overly aggressive marketing²⁹¹ and, in

²⁸¹ Kinney, *supra* note 81, at 339.

²⁸² Eisenberg et al., *Unconventional Medicine*, *supra* note 89, at 246.

²⁸³ BARRETT ET AL., *supra* note 278, at 11.

²⁸⁴ Boozang, *supra* note 17, at 190-91 (citation omitted).

²⁸⁵ *Id.* at 200.

²⁸⁶ For example, the first ten search results returned on *Google.com* for "chiropractor" include 1 department of labor site, 1 online encyclopedia, 6 sales/advocacy sites, 1 employment site, and 1 site taking a physician's perspective on choosing a chiropractor. (Mar. 18, 2008).

²⁸⁷ Josefek, *supra* note 74, at 308.

²⁸⁸ See also Gellhorn, *supra* note 176, at 25 (arguing that "some kind of quality control may be needed to protect the uninformed against blatant incompetents, wily charlatans, and persons whose past delinquencies suggest the probability of future corrupt conduct").

²⁸⁹ INSPECTOR GENERAL REPORT, *supra* note 167, at 6-7.

²⁹⁰ See *supra* note 50.

²⁹¹ BUTLER, *supra* note 57, at 76.

some cases, seem deliberately aimed at misleading patients and the public regarding the efficacy of chiropractic care.²⁹² Those who continue to offer unproven and questionable treatment are able to thrive by directing their focus to misleading the patient into believing that there is hope.²⁹³ Those operating on the fringe of the chiropractic industry are “[p]romoters of quackery [who] tend to disparage accepted scientific methods as well as consumer protection laws.”²⁹⁴ Unfortunately, there are some scope of practice statutes that allow these people to operate on the fringe. These irresponsible practitioners are the reason why it is necessary to narrow scope of practice statutes. Opponents of such regulatory action argue that patients should be able to choose any therapy they believe will help them feel healthy and in control of their bodies.²⁹⁵ However, such regulation is necessary to protect unsophisticated and vulnerable consumers.

B. Autonomy in the Healthcare Industry

Some chiropractors maintain that the end of the era that allowed freedom of access to any type of healthcare, regardless of efficacy or safety, does not correspond to a desire to protect patients, but rather that it coincides with the expansion and growth of the AMA.²⁹⁶ They contend that this resulted in the dominant view that the layperson is vulnerable and in need of protection, even with regard to which profession to consult.²⁹⁷ These critics further posit that legislatures have based the current regulatory scheme on the assumption that patients lack the sophistication to make the proper decision of which healthcare provider to choose.²⁹⁸ However, it is not that patients lack sophistication or intelligence, but rather that, when they are ill, they are vulnerable, and history shows that there are chiropractors who are willing to attempt to capitalize on these vulnerabilities.²⁹⁹

“[T]he current regulatory scheme . . . aim[s] to protect patients from their own ill-advised choices.”³⁰⁰ To argue that this is a paternalistic approach to regulation is true, however, it is also necessary. Arguably, most government regulations come with a certain dose of

²⁹² INSPECTOR GENERAL REPORT, *supra* note 167, at 7; Jarvis, *supra* note 62.

²⁹³ BARRETT ET AL., *supra* note 278, at 45.

²⁹⁴ *Id.*

²⁹⁵ *Id.*; AMA REPORT, *supra* note 86.

²⁹⁶ See Cohen, *Holistic Health Care*, *supra* note 5, at 145.

²⁹⁷ *Id.* (citing Walter J. Wardwell, *Chiropractors: Challengers of Medical Domination*, 2 RES. SOC. HEALTH CARE 207, 208 (1981)).

²⁹⁸ See *id.*

²⁹⁹ See *supra* note 290-93 and accompanying text.

³⁰⁰ Cohen, *Holistic Health Care*, *supra* note 5, at 133.

paternalism, but that is better than requiring sick and vulnerable people to sift through a myriad of treatment options that differ in both safety and efficacy.³⁰¹ An open market can be a good thing, but consumers are only going to benefit from that market “to the extent that the marketplace is trustworthy.”³⁰² Ultimately, the initial impetus for medical consumer protection regulations is irrelevant; currently, legislators use the regulations to protect consumers from unskilled practitioners and unsound treatment or advice.³⁰³ Any chilling effect these regulations might have on the continuation of current practices or the development of new chiropractic modalities³⁰⁴ is necessary to protect the consumer.

IV. PROPOSAL FOR A NARROWED SCOPE OF PRACTICE STATUTE

Throughout this Note, I have argued that it is necessary to restrict chiropractors’ scope of practice to protect consumers. The restrictions I propose are inspired by the Appellate Division of the New Jersey Superior Court in *Bedford v. Riello*, before the New Jersey Supreme Court amended the ruling.³⁰⁵ However, in *Riello* the court still permitted reliance on the subluxation theory that exists in New Jersey’s definition of chiropractor, which states, “[n]othing in this act shall be deemed to prohibit a chiropractor from caring for chiropractic subluxation as determined by chiropractic analytical procedures. Chiropractic analysis which identifies the existence of a subluxation may be the only basis for chiropractic care.”³⁰⁶ Part of my goal is to remove as much ambiguity as possible so that patients and doctors might be able to rely on a standard definition of chiropractic care. Any reliance on subluxation theory frustrates this purpose by automatically muddying the waters and making it impossible for the relevant bodies to agree upon a definition. Therefore, I do not recommend relying on subluxation theory in any scope of practice statute.

The *Riello* court held that a chiropractor may care for these subluxations by maneuvering other structures, such as the knee, but only insofar as that movement will affect the spine.³⁰⁷ I agree with

³⁰¹ BARRETT ET AL., *supra* note 278, at 45.

³⁰² *Id.* at 46.

³⁰³ Cohen, *Holistic Health Care*, *supra* note 5, at 85-86.

³⁰⁴ *Id.* at 137.

³⁰⁵ 920 A.2d 693 (N.J. Super. Ct. App. Div. 2007), *aff’d in part and remanded*, 948 A.2d 1272, 1274 (N.J. 2008).

³⁰⁶ N.J. STAT. ANN. § 45:9-41.27 (West 2004) (emphasis added).

³⁰⁷ *Bedford*, 920 A.2d at 698 (N.J. Super. Ct. App. Div. 2007) (holding that the adjustment of a patient’s knee for the purposes of healing knee pain and not spinal

this limitation, but rather than rely on the subluxation, the section should refer to musculoskeletal conditions such as lower back, shoulder, or neck pain.³⁰⁸ Critics will argue that “definitions that attempt to allocate particular functions to particular professions, while excluding others, fail because they ignore the essentially overlapping nature of many of those functions.”³⁰⁹ While it is true that there will always be an overlap between conventional medicine and chiropractic care, the goal should be to reduce that overlap as much as possible. Legislatures can accomplish this by requiring that chiropractors operate as musculoskeletal specialists, while still abiding by their duty to refer patients to a physician.

While limiting the definition of a chiropractor to musculoskeletal specialist or a derivation thereof, legislatures should also be sure to limit the diagnostic tools chiropractors are able to use. The only test that I would recommend permitting is the responsible use of X-ray examination to rule out more serious medical problems.³¹⁰ Beyond that, chiropractors should be prohibited from using any diagnostic tool that a patient could misconstrue as qualified physician care (e.g. rectal and breast exams).

Critics of this plan will likely argue that if a chiropractor limits treating musculoskeletal ailments with a conservative use of X-rays, properly refers his patients to physicians, and does not rely on subluxation theory, then he might not be able to make a living.³¹¹ This is not necessarily true. Once chiropractors stop encroaching on conventional medicine with unproven techniques and focus on musculoskeletal pain, where they have shown the most success,³¹² doctors are likely to be much more willing to open lines of communication and begin referring new patients to chiropractors. This could ultimately lead to

pain is considered outside a chiropractor’s scope of practice in New Jersey and therefore a jury should be instructed that this can be considered evidence of deviation from the standard of care for purposes of a malpractice suit.

³⁰⁸ Many patients visit chiropractors to cure tension headaches, however a 1999 JAMA study found that “[a]n isolated intervention, spinal manipulation does not seem to have a positive effect on episodic tension-type headache.” Geoffrey Bove & Niels Nilsson, *Spinal Manipulation in the Treatment of Episodic Tension-Type Headache: A Randomized Controlled Trial*, 280 JAMA 1576, 1576 (1998).

³⁰⁹ Hilliard & Johnson, *supra* note 67, at 252.

³¹⁰ While New Jersey permits the use of a neurocalometer, it is a device which is only relied upon by subluxation-based chiropractors and therefore has no place in this suggested model. Stephen Barrett, *How the Nervo-Scope and Similar Heat-Detection Devices Are Used to Sell Unnecessary Chiropractic Treatment*, <http://www.chirobase.org/06DD/nervoscope.html> (last visited Feb. 11, 2009).

³¹¹ Barrett, *The Spine Salesmen*, *supra* note 49, at 175.

³¹² See Sanders, *supra* note 90, at 35-36.

an integrated healthcare system that includes, rather than excludes, chiropractors.³¹³

Another argument that opponents to this plan will make is that millions of people visit chiropractors each year to treat symptoms that range far beyond simple back pain, and these people are very happy with their selected course of treatment. However, the potential health risks to a patient receiving a diagnostic test such as a breast and rectal exam from a chiropractor who is not able to conduct the exam with the same care and read it with the same skill as a physician are simply too high.

I have suggested a goal legislators should strive towards and offered New Jersey's statute as a model. However, I stopped short of giving actual suggested language, because, in many states, the definition of chiropractors, their scopes of practice, and their licensing regulations exist in a variety of different formats, often spread across multiple statutes, interpreted through specific case law, and directed by individual licensing boards. I simply suggest that, however it is accomplished, the legislatures should limit chiropractors to diagnosing and treating musculoskeletal conditions by employing a limited array of diagnostic techniques.

After a state has sufficiently limited chiropractors' ability to practice, the next step should be to conduct an information campaign aimed at educating the public on the definition of chiropractic care, informing them of when they might have cause to visit a chiropractor. This should help to unravel existing webs of misinformation, while laying out the vision of a healthcare model that includes chiropractors employing modalities in a way that is safe for their consumers.

V. CONCLUSION

The chiropractic industry has evolved into a field that bears the imprimatur of its tumultuous history, resulting in inconsistent methods, and, in some cases, a deceiving overlap with conventional medicine. The great majority of the millions of American who visit a chiropractor every year will not misconstrue their chiropractor's care as analogous to a physician's care. However, overly broad scope of practice statutes permit some chiropractors to offer services that patients may regard as sufficient to satisfy their diagnostic and general medical needs, creating a need for the state to protect unsophisticated

³¹³ Some integrated healthcare systems have successfully limited chiropractors' scope of practice within their institutions as a means of facilitating this integration. Cohen & Ruggie, *supra* note 107, at 700.

consumers. The most direct remedy is for state legislatures to narrow their chiropractors' scope of practice to address only musculoskeletal conditions as they affect the spine. This limitation will enable chiropractors to clearly identify their role within the medical community, thereby minimizing the risk to patients.

