The Chiropractic Scope of Practice in the United States: A Cross-Sectional Survey

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Abstract

Objective: The purpose of this study was to assess the current status of chiropractic practice laws in the United States. This survey is an update and expansion of 3 original surveys conducted in 1987, 1992, and 1998.

Methods: A cross-sectional survey of licensure officials from the Federation of Chiropractic Licensing Boards e-mail list was conducted in 2011 requesting information about chiropractic practice laws and 97 diagnostic, evaluation, and management procedures. To evaluate content validity, the survey was distributed in draft form at the fall 2010 Federation of Chiropractic Licensing Boards regional meeting to regulatory board members and feedback was requested. Comments were reviewed and incorporated into the final survey. A duplicate question was imbedded in the survey to test reliability.

Results: Partial or complete responses were received from 96% (n = 51) of the jurisdictions in the United States. The states with the highest number of services that could be performed were Missouri (n = 92), New Mexico (n = 91), Kansas (n = 89), Utah (n = 89), Oklahoma (n = 88), Illinois (n = 87), and Alabama (n = 86). The states with the highest number of services that cannot be performed are New Hampshire (n = 49), Hawaii (n = 47), Michigan (n = 42), New Jersey (n = 39), Mississippi (n = 39), and Texas (n = 30).

Conclusion: The scope of chiropractic practice in the United States has a high degree of variability. Scope of practice is dynamic, and gray areas are subject to interpretation by ever-changing board members. Although statutes may not address specific procedures, upon challenge, there may be a possibility of sanctions depending on interpretation. (J Manipulative Physiol Ther 2014;37:363-376)

Key Indexing Terms: *Health Resources; Health Services; Legislation; Licensure; Chiropractic*

Chiropractic is the third largest health profession in the United States and the largest and most recognized of the complementary and alternative professions.[1] Chiropractors in all 50 states, the District of Columbia, Puerto Rico, and the United States Virgin Islands provide direct access care to patients.[1]

Scope of practice is the regulation of professionals in a specific jurisdiction and is used to legally create boundaries by restricting the allowed activities for a specified profession.[2] Its purpose is to protect the public by setting legal limits for what a provider can do, and it can be used as a means to define a profession in a particular locale.[3–5] Some scholars counter that practice laws have failed to protect the public but have been used as a tool to limit competition.[6–12]

Practice laws are the responsibility of each state, and this has caused variations in scopes of practice for a wide variety of health professionals.[3,13–17] The United States does not have a unified scope of practice for most health care professionals. This has contributed to fragmentation of health care across jurisdictions. The only health care professionals that have a unified scope of practice across state lines are medical doctors and doctors of osteopathy.[2] The medical profession was the first to have licensure standards, and because they were the first to become licensed, their scope of practice is uniform and broad.[4,5,18] As each health care profession sought licensure, the *American Medical Association* aggressively defended their practice rights and ensured that limitations were put on other professions.[7,18–21] It should be noted that all health professional organizations have followed the same tactics in defending their practice rights.[22,23]

In addition to the prior 3 surveys, there have been several surveys that were located in the gray literature performed by state associations, student research projects, and the World Federation of Chiropractic. The state surveys explore local attitudes of their members on issues of chiropractic unity, drugs, and scope expansion.[24,25] "The Legal Status of Chiropractic Practice Internationally" is a survey of association members from 85 countries. Data from 49

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countries were collected pertaining to legal status, direct access to patients, protection of titles, presence of regulations for licensure, imaging rights, prescription rights, laboratory tests, ability to authorize sick leave, and reimbursement climate. The report was completed in June 2011.[26] The student research project surveyed alumni practicing in the states of Alabama and Florida.[27] None of the respondents to these surveys were members of regulatory boards.

Data from the Congressional Budget Office indicates that the Patient Protection and Affordable Care Act will expand health care coverage to 33 million nonelderly Americans.[28] Twenty-seven million people are expected to gain health insurance by 2017.[29] In addition to the increase in the number of insured, the senior population has been growing at an exponential rate. One of 5 in the US population will be older than 65 years by 2030.[30] The fastest growing segment of this group is the oldest of the old—those 85 years and older.[31] With society's longevity comes the associated increase in chronic diseases. Those with chronic disease require more health care resources.[32]

Full-scope physicians have not been able to address the needs of our population's growing health care demands. They are working fewer hours,[33] restricting their practices by opting out of Medicare,[34] and setting up boutique practices to provide better quality care to fewer patients.[35–37] In addition, a substantial number of these providers will be retiring soon.[38,39] This has caused public officials to worry about stretching an already thin workforce.[40–43] States are looking for ways to accommodate the demands for health care, especially in states that are already experiencing health care workforce shortages.[41] Using all health care providers to the fullest extent of their training is one solution that will provide timely relief to these problems.

In addition to the workforce shortage, the Patient Protection and Affordable Care Act is encouraging the formation of Accountable Care Organizations and the Patient Centered Medical Home in an effort to improve health outcomes through integration and cross-communication between providers.[44] Clarification of the chiropractic scope of practice will help to facilitate referrals and participation in these organizations.

Legislation relating to the scope of practice of health professionals is increasing in the United States because of these factors. There were 1795 scope of practice-related bills proposed in 54 states, territories, and the District of Columbia between January 2011 and December 2012, but only 349 have been adopted or enacted into law.[40,45] The purpose of this study is to clarify regulations that guide chiropractic practice by updating and expanding the 3 original surveys conducted in 1987,[46] 1992,[47] and 1998.[48] The original 3 studies surveyed 78 services, whereas this study surveys 97 services.[46–48] To the author's knowledge, this update offers the most comprehensive survey of regulatory officials on specific services allowed in their jurisdictions.

Methods

The institutional review board at the National University of Health Sciences reviewed this study and exemption was granted.

Following the procedures of the 3 previous surveys, spinal manipulation and regional spine plain film radiography were not included in the survey.[46–48] The current survey was updated in consultation with the original investigator, the American Chiropractic Association, and the Federation of Chiropractic Licensing Boards (FCLB) to include the following items: diagnostic ultrasound imaging, surface electromyography (EMG), National Department of Transportation Driver Physicals, orthopedic and neurologic examinations, hernia examinations, magnetic therapy, traction, oxygen therapy, dry needling of trigger points, hyperbaric chamber, manipulation under anesthesia, and veterinary chiropractic. Electrotherapy was broken down to specific therapies. Applied kinesiology and intervaginal uterine manipulation were removed from the survey. Ninety-seven services were evaluated compared with 78 services in the prior surveys. A comment section was added to the survey to allow for commentary after each set of questions.

To evaluate content validity, the survey was distributed in draft form at the fall 2010 FCLB regional meeting to regulatory board members, and feedback was requested. Comments were reviewed and incorporated into the final survey. In addition to surveying Canada, the United States, and the District of Columbia, the survey was expanded to include Puerto Rico, and the Virgin Islands, Australia, and New Zealand. Results from Australia, Canada, and New Zealand will be reported in a separate article. The sample frame used included regulatory officials who were a part of the FCLB e-mail list. Officials were asked to respond with their name, contact information, and position on the board. If the official was no longer a member of the board, he/she was asked to contact the investigator and provide contact information for an alternate official. The officials were asked to choose a single response indicating the extent that a health care service was within the chiropractic scope of practice in their jurisdiction. Structured answers included the following: (1) can perform (includes can order), (2) can perform with additional training/certification, (3) can order (or refer), and (4) cannot order/perform. After each section of the survey, officials were given an opportunity to clarify their responses in an essay box. If a jurisdiction left an item blank, it was not counted in the percentage totals. Reminders were sent each month to those who had not completed the survey. Portable document format of the survey was made available to the board members as well.

In late January 2011, the study began data collection using the Form Creation Module for the DotNetNuke Content Management System (v 1.6.4 Code 5 Systems; LLC, Aberdeen, SD). Because of the magnitude of the