Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

Historical Aspects

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In the early part of the century, mobility was influenced by two primary factors: interest and capacity. In terms of interest, we must consider society from the perspective of the early 1900s when people were less mobile and remained closer to family and their roots. However, as technology improved, these considerations became less of a barrier. The advent of faster and more accessible transportation and better quality communication technology has made the thought of moving away from family less unappealing. After all, now you can "reach out and touch someone" for "a dime a minute." However, doctors were not the only ones who had access to better transportation and communication. The general population were also participants in migratory demographic patterns, and doctors had to move with the populations to have sufficient population to support a practice.

The capacity to move also played a significant role in interjurisdictional mobility (although the author recognizes that there is substantial overlap with the previous discussion of "interest" here). We must look at capacity from the perspective of the favorability (or unfavorability) of laws which had substantial to another state. In general, these laws and the practice environment could be seen in one of four basic combinations:

1. No direct regulation, but no aggressive pursuit of DCs. Essentially, DCs were not really given much thought and did not appear to provoke enough of the ire of other professionals to incur much aggressive behavior. (Some would consider being ignored the most severe form of criticism.)

2. No direct regulation, and aggressive pursuit of DCs. In this case, there was no clear regulation, and DCs were targets for a relatively new medical profession trying to establish an unopposed foothold in the "legitimate" health care arena. This, of course, was accomplished largely by defining legitimate health care, often at the expense of those who opposed medicine. Public "professional floggings" were the order of the day, when medicine could take the moral high ground of protecting the endangered public from dangerous adjustments in favor of more acceptable methods, such as use of leaches. (OK, there is no need to confuse the subject with the fact that leaches are becoming an accepted medical procedure again. Who says history doesn't repeat itself?)

3. Direct regulation with a somewhat "hands-off" approach to DCs. There were those who flinched (or perhaps fainted) at the thought of regulating DCs, after all, this was a de facto statement of legitimacy. However, regulation also set guidelines by which both sides could live. If a DC stayed on "their side of the line," there would be no need for a fight; moreover, the line was more clearly drawn as a result of the regulatory legislation.

4. Direct regulation with still aggressive pursuit of DCs. Unfortunately, it was not uncommon to see regulation as an erosion of professional territory, and there were those that continued to rail against a slow but persistent advance on this territory. This was the subject of the now-famous

> Wilk et al. antitrust suit, which many thought would finally put the issues to rest. However, the encroachment of managed care has heated the issues up again as the competition for market share increases, and all professionals are fighting harder for a continually shrinking health care dollar and their professional esteem.

As chiropractors in all states became regulated, they also became more isolationist/protectionist of their ways of doing things. This was fueled by changes in technology, improvements in knowledge (research), different practice standards, different scopes of practice, fluctuating educational programs, different approaches to competency assessment, and the professions own philosophical divisiveness. These issues are woven into the fabric of chiropractic care, and are difficult to view as separate, unrelated entities. In essence, this becomes a cyclical "chicken and egg" question that continues today, since it is difficult to draw a clear "cause and effect" algorithm to determine which of these factors "causes" the other factors to evolve. ï for increased interstate mobility. For example, the climate for increased interstate mobility is further supported by an increasing homogeneity in the previously mentioned factors (such as scopes and standards of practice, education, assessment, and improved tolerance for differing philosophical viewpoints). The profession has moved toward more similarities than differences over the years. Research and improved dissemination of information are beginning to impact practice standards and outcomes. The profession is attempting to refine its discrimination between valid and clearly invalid procedures. This may be a very murky area, but at least the clearly invalid procedures and therapies are more likely to be identified and discarded in favor of the valid or not yet disproved procedures. We see such improvements having an impact on educational standards, which influence assessment, which influences societal thinking, which influence standards of practice, which influence scopes of practice ... well, you get the idea.

However, and more importantly, this protectionism has continued to exist until very recently, most notably in the form of state board examinations. Historically, states believed a person was not qualified to enter a state unless they took that state's practical exam. Many boards believed that their state's practical exam was so much better than their neighbor states that a practitioner would be required to go through a "spanking line" for each state they wanted a license in. Even now, with the availability of the NBCE Part IV practical examination, it's astonishing to hear a regulator from any state verbally protect their exam as matching or exceeding the quality of the NBCE Part IV practical exam. In my personal view, this is at best naivete, and at worst regulatory arrogance. However, it is the increasing acceptance of the NBCE Part IV practical exam that provokes the question underlying this article.

One of the major selling points of the NBCE Part IV practical exam was increased mobility for those practitioners who had successfully completed this exam. Specifically, any state adopting the NBCE Part IV practical exam would allow relatively unfettered access to their state for any person who had passed the exam, regardless of where it was taken, state of residence, or other considerations. (Note: most states still require some form of jurisprudence exam, but these are easy to administer and are much more readily accessible than a full state board exam may have been prior to this.)

Currently, there are about 30 states accepting or requiring the NBCE Part IV practical exam, with more signing on all the time. As a practical matter, this means that any person successfully completing this exam has fairly quick access to licensure in any of those 30 states without having to take additional state boards. However, what about seasoned practitioners who have been in practice for many years, provided good service, have no deleterious actions against their licenses, and who want to enter semi-retirement in Sun Town, USA? This practitioner is likely to have to take a state board in that state before being allowed to more, so the practitioners may have to take the NBCE Part IV

practical, even though they have been out of school for many years. Although there is another exam given by the NBCE for this purpose (known as the SPEC exam), the question is not which exam should a moving practitioner have to take, but should they have to take one at all when newer, less experienced practitioners can move freely and without such barriers.

Some may be reading this thinking, "This really doesn't have anything to do with me. I don't have any intention of moving." There are many elements which may have an impact on a decision to relocate. Such things as migrating populations, changes in practice environment (including the impact of managed care), semi-retirement, health (the practitioners or member of practitioner's family), a change in a spouse's job opportunities, or just looking for a different environment may have an impact. In previous years, professionals would focus their attention on the population and migrate accordingly. Today, however, the consumer is not the primary purchaser of health care: the employer is. Therefore, it is not unreasonable to relocate according to employment demographics rather than simple population demographics. In any event, to believe you may never be interested in moving across state lines may simply be an exercise in engaging in naivete.

In general, there are several mobility models available to look at:

Endorsement

This is essentially a unilateral model where a state grants a license to practice based solely on the merits of the practitioner's education, experience, previous examination in another jurisdiction, and other qualifications. Once endorsement is granted in another state, the doctor receives a license in that state and must keep the requirements up to maintain the license.

Reciprocity

This process is similar to endorsement, but as the term implies, it relies on a reciprocal partnership agreement between states that they will each maintain certain standards of examination and qualification review, and that each state will grant a license to a professional based on their licensure in the other state. (Of course, the other state must reciprocally grant a license in the same manner.) Again, however, a separate license is granted, and must be maintained by compliance with the requirements of the granting state.

National Licensure

This approach is to vest the responsibility for licensure of health care professionals in the federal government. However, proponents of the 10th Amendment to the Constitution would find this Amendment states, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Commonly known as the "states rights" amendment, it may seem an efficient resolution to the question. However, critics may see this as a further erosion of state sovereignty by incursion of the federal government into the business of the state.

Interstate Compact

This is an old idea being given a new application in health care, and is still in the thinking stages. A similar compact has just been approved in the nursing profession, but this is very new and there is little experience available to assess its long-term chances for success.

In short, it is a contract between states that a professional will be granted a single license (presumably in the state of residence), but can practice in any state which is a signatory to the compact. Some have discussed the possibility of a separate "interjurisdictional license" in addition to the regular license, but these are details to be solved if this plan continues to evolve.) When practicing in another state, the practitioner is subject to the laws of the state where the service is provided. In the event a complaint is lodged, it is likely to be handled in one or both states according to the compact. Proponents of this approach compare it with a driver's license, in which fines may have to be paid in the state where the infractions occurred, but continued egregious offenses may cause the suspension or revocation of the actual resident license to drive. (In this case, both the resident license and the "interjurisdictional license" may be at risk for action against the practitioner.) In the case of a practitioner who moves from one jurisdiction to another, they merely exchange one resident license for another, much as we do with our driver's licenses.

The interstate compact idea is beginning to gain some steam in the regulatory circles. Critics of the idea are most concerned about controls over a practitioner having a resident license to practice in one jurisdiction, but practicing in and violating the laws of another jurisdiction. At the recent meeting of the Federation of Association of Regulatory Boards (FARB) the comparison to a driver's license was criticized. It was brought up that when a driver violates the law in another state, the police officer writes a ticket and gains some assurance that the driver will address the infraction appropriately. Any suggestion of their intent not to do so could cause their arrest and impounding of their car. However, if a Minnesota practitioner violates a law in South Dakota, it may be difficult for the South Dakota board to compel the practitioner to respond, or provide records, etc.

As you can see, the idea of improved interjurisdictional mobility is gaining some popularity, but there are still some "bugs" to be prevails, it is clear there is significant interest in improved mobility with reduced obstacles for practitioners.

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