



Oregon

Theodore R. Kulongoski, Governor

Oregon Board of Chiropractic Examiners

3218 Pringle Road SE, Suite 150

Salem, Oregon 97302-6311

(503) 378-5816

FAX (503) 362-1260

E-mail: Oregon.obce@state.or.us

Web: www.oregon.gov/OBCE

PUBLIC SESSION MINUTES

Eugene Hilton Hotel
66 E. 6th St, Eugene, OR
March 18, 2010

Members Present

Joyce McClure DC, President
Michael Vissers DC, Vice-President
Cookie Parker-Kent, Secretary
Ann Goldeen DC
Douglas Dick Public Member
Daniel Cote DC
Huma Pierce DC

Staff Present

Dave McTeague, Executive Director
Kelly Beringer, Admin Assistant
Donna Dougan, Admin Assistant
Tom Rozinski, Investigator
Lori Lindley, Assistant AG

Others Present: Drs. Adam Drapkin, Matt Freedman, Sharron Fuchs, Megan Wagner, Sharell Tracy, Tobias Joyce, Richard McCarthy, Chris Osterlitz, Carol Stoutland, (*and two other DCs' names illegible on sign-in sheet??*) and Mona Searles L.Ac, Malvin Finkelstein L.Ac., Chris Gorawski, L.Ac., and OR Medical Board staff, Michelle Provinsal.

8:00 AM Chiropractic Forum & meeting with area doctors & others

Issues discussed include delivery of the BackTalk newsletter (most preferred paper), any improvement to access of information is appreciated, how the board is doing (those present agreed, "good"), and informed consent.

9:15 AM CONVENE Public Meeting

ADOPTION OF THE AGENDA Adopted as presented.

PUBLIC COMMENTS Re: Dry needling - Sharon Fuchs DC and multiple licensed acupuncturists

DISCUSSION ITEMS

1. ETSDP: Breast Thermography, draft guidelines

The subcommittee, with Dave McTeague and Ann Goldeen's help, and after multiple drafts, presented **Version 4b** to the Board. Submitted with the guidelines is a recommended Informed Consent form (which the committee feels makes it clear that breast thermography is adjunctive). Dr. Joyce McClure added for the public's benefit that this discussion began when it was reported that breast thermography is performed in Oregon by a few DCs, and some non-DCs. A friend of the profession brought this forward, and we went through the ETSDP committee to determine whether breast thermography is within the scope of practice of chiropractic, whether it is fully understood or clearly defined. So we try to decide what level risk there is to allowing or disallowing the procedure. The Board determined the procedure moderate risk/investigative. The risk is that a patient might believe that the thermography is all they need to have done; that a mammogram would not be necessary. There is not enough literature to

substantiate that breast thermography can be used alone. In order to use an investigative procedure, a DC must inform the patient of the risks.

Dr. Sharron Fuchs commented that she is still concerned about the Meditherm device; it is FDA approved for heat detection and for use under obstetrics and gynecology for breast issues, but only as an adjunctive tool. There are only certain devices that are approved for breast thermography, specifically. Meditherm posts their guidelines on the internet; one of them that mammograms be performed at age 40. She presented (to the ETSDP?) a document that is a collaborative paper by the American College of Radiology and Breast Imaging Society. She is not sure if the document should be part of the standards or how it should be used.

Dr. McClure asked for any additional comments. No other was given. Dr. McClure proposed that a brief statement be added to the draft guidelines similar to, "The American Radiology Association advises an initial mammogram be done at age 40; high risk individuals may require more frequent screenings" (and then reference the document).

Dr. Vissers added that some clarification is needed. He referred to a comment on page 2, and recommends a minor change to "mammogram" to "mammogram or breast MRI." Also, on the last page, there was a question of proper terminology regarding "FDA approved" versus "cleared." Which will we require? Dave McTeague commented that we have not seen any documentation on any of these devices, so some confusion remains. Does the FDA require "approval" because of the type of machine? The Board determined to accept FDA "cleared," but will revisit the matter if "approval" is mandatory.

Add to the Informed Consent form, "I understand that breast thermography may be used as an adjunctive screen, and take out "has been approved by the FDA."

Dr. McClure asked for a motion. Dr. Goldeen moved to accept these guidelines (as edited) as policy. Dave McTeague added that this may need to be adopted as administrative rule; he will check with Lori Lindley, the AAG. Dr. Vissers seconded the motion. All in favor. Doug Dick, aye; Cookie Parker-Kent, aye; Dan Cote, aye; Huma Pierce, aye; Michael Vissers, aye; Ann Goldeen, aye; and Joyce McClure, aye. The policy is adopted and will be attached to these minutes.

9:40 A.M. Public Hearing on Proposed Administrative Rules

Dr. McClure opened the public hearing for the proposed administrative rules. She asked for any comments about the proposed prepay plan language.

A) Pre-Pay Plans/Escrow Accounts

Discussion: Dr. Goldeen was surprised to see the escrow account requirement removed. The majority of the committee did not see that the escrow accounts were necessary in the instances chiropractors were using the pre-pay plans. Dr. Vissers added that it seemed that the difficulty was that contracts weren't clear as far as how much care, what was the diagnosis (if it changed was it or not incorporated into that contract), or if someone discontinues care how do you figure or prorate a reimbursement. He doesn't think the New Mexico or Georgia boards really address that either.

If we adjust that issue, I think we will address most of the "complaints" we hear about.

Dr. McClure asked whether the policy can be drafted to cover wellness care also. Cookie Parker-Kent asked what if a patient's issue is resolved in 6 versus the planned 10 visits. Would we be

able to write in something to allow a refund or more visits. There needs to be provisions in the contract for those unexpected incidents (MVA, WC, fall, etc.). Board members agree to construct only the guidelines for the contract content. Joyce recommends we send this back to the Rules Advisory Committee. Dave McTeague added that the board needs to first draft a refined proposal. Dr. Vissers will work on a streamlined version of the draft. Suggested items to include begin with: diagnosis, treatment plan, account for unexpected incidents, account for completed care, or terminated care due to patient choice, moving, new injury; how are the unused portion of funds calculated or prorated (i.e. identify cost of each visit).

What about “co-pays?” Dr. Cote thought contractually, we could not change co-pays. Dr. Vissers agreed; licensees should check the patient contracts. Hold over.

B) Repeal deceased chiropractor clinic name change requirement

Joyce McClure asked for any comment on this issue. A DC recently died, and family was concerned that Oregon Administrative rule required that the clinic name be changed. Proposed language was to delete the rule citation requiring the name change; specifically delete OAR 811-010-0120 (7)(d)(B)(ii).

10:05 am Dr. McClure closed the Hearing. Discussion: Dr. Vissers moved to accept the proposed deletion of the deceased chiropractor clinic name requirement. Cookie Parker-Kent seconded the motion. All in favor. McClure, aye; Goldeen, aye; Cote, aye; Pierce, aye; Vissers, aye; Dick, aye; and Parker-Kent, aye.

2. Policy Issue: “dry needling” issue review

Malvin Finkelstein L.Ac. and chairperson of the OR Medical Board’s Acupuncture Advisory Committee presented. It is the OMB’s opinion that dry needling is acupuncture. He read a number of statutes, rules, definitions, etc. which all support his opinion that this procedure is acupuncture. Also present is Chris Debrowski L.Ac. on OUM? Or OAM? Mr. Finkelstein noted that there are nine other states which have prohibited PTs from adopting dry needling as part of their scope. Mr. Debrowski added that the states which have allowed dry needling, are not well-organized in their profession. To the OMB, it is clear that dry needling is acupuncture and therefore, no other profession should therefore be performing it. OAR 847-###-0005. Mr. Finkelstein also touched on safety precautions necessary in use of needling. Weekend courses on dry needling cannot cover the information adequately. Currently, the approximate number of hours to license as an acupuncturist is 3000. There is no defined number of hours for safety precautions taught in the school – it is all integrated with the specific classes. Mr. Debrowski will provide the full curriculum from OCOM.

Michelle, staff of the OMB cited an ORS that has definition which she will get to the OBCE. Yet, another L.Ac. (also a nurse practitioner) spoke. She admits that she took less than three hours of weekend education. She also admits that nurse practitioners and physician assistants do perform dry needling or acupuncture.

There was discussion back and forth how much education is recommended/required for DCs to be able to 1) safely perform dry needling and 2) for acupuncturists to perform chiropractic manipulation.

Dr. McClure summarized – there is a lot of cross-over in many of our professions; however, it does not seem like we have all the information to adopt anything today. (Attending acupuncturists left at 11:05)

Sharon Fuchs asked for 15 minutes to talk yet more dry needling. She hesitantly agreed. She first spoke about Dr. Irving's attempts to reach (OMB and PT) boards to avoid "turf war" perceptions, however, those attempts were thwarted. She discusses the use of "class 2" acupuncture needles, she mentioned her email exchanges about fascia on the Oregon DCs listserv to expand the idea that DCs are "neuro, musculo-, fascial, skeletal specialists." She continues to maintain that the use of dry needling is a diagnostic tool. She maintains that dry needling is separate from acupuncture. ORS 677.757 defines acupuncture (she read it). Doug Dick interrupted Dr. Fuchs and told her that he wants to hear about "endorsements" – some substantiations – not just individual articles.

Dr. Fuchs continued – "As physicians though, we have to understand that there's more to it than acupuncture in that idea; that we're trying to affect musculo, fascial, neurologic, skeletal issues and that dry needling isn't acupuncture. I'm trying to lay the foundation for the thinking of it." Fuchs went on. We need to evolve; it's within our specialty, we're able to use needles, we know sterile technique, we can do EMGs into the muscle.

Dr. Fishkin offered to come and teach the course. Dr. Vissers interjected though that the Board's legal advice was that it is not clear cut (allowed). Lori Lindley answered that it (dry needling) fell under the definition of acupuncture, and unless it was taught in schools as part of the accepted curriculum in Oregon that we wouldn't be able to accept it. Dr. Fuchs indicated that WSCC is willing to do a post-graduate program; the foundations are already being laid by Dr. Irving, who is currently teaching the didactic portion of dry needling.

Dr. McClure again stated that we do not have enough information about the adequate and necessary education to perform this technique. We're not ready to go forward on this. Dr. Cote agreed.

In closing, the Board members agreed that if WSCC should incorporate the training as part of its core curriculum, it would be easier to say whether dry needling was allowed within the scope of practice. Post-grad training isn't enough. After still more comment, Dr. Fuchs left.

12:00 PM Working Lunch (continue Public Agenda Discussions)

3. Policy Issue: Legislative Concepts for 2011, budget review

The Board briefly reviewed the budget issues and proposals during Dave McTeague's Staff Report.

4. 2009 Key Performance Measures results (moved to the May 27, 2010 agenda)

5. Policy Issue: Draft policy on X-ray services provided by chiropractic physicians

Dave received this inquiry. If a DC provides radiology services for another DC clinic, what is his obligation, liability and/or responsibility? Dave had answered the DC, but was concerned about some of the Board of Radiologic Technology rules; specifically, is there any responsibility on the part of the DC taking the x-rays to determine clinical justification? After some email conversations with Drs. McClure, Freedland, Corll and Vissers, a policy was drafted for the full board's consideration. Dr. Dan Cote moved to adopt the policy; Huma Pierce DC seconded the motion. All in favor. Vissers, aye; Dick, aye; Cote, aye; McClure, aye; Parker-Kent, aye; Pierce, aye; and Goldeen, aye.

6. Rules Advisory Committee report on CA initial training

Dave presented the February 16, 2010 RAC committee recommendation; they proposed to change the CA initial training hours from six to 12 - broken down as 8 hrs didactic and four hours practical

(performed by a licensee that is independent to train the practical). The board may prescribe a specific training manual for the minimum training standard.

Some other suggestions for change to the rule were presented, but those may/may not be considered in the rulemaking process (*rule hearing*).

Dr. Vissers moved to propose the initial training language for permanent rulemaking; Cookie Parker-Kent seconded the matter. All in favor. Goldeen, aye; Dick, aye; McClure, aye; Parker-Kent, aye; Vissers, aye; Pierce, aye; and Cote, aye. The hearing will be scheduled for the May 27 meeting.

The proposed language of OAR 811-010-0110(2)(a) reads,

The initial training course shall be at least twelve hours in length, eight hours may be didactic training and four hours practical training which must be in physiotherapy, electrotherapy, and hydrotherapy, and administered by a health care provider licensed to independently provide those therapies. A chiropractic physician may perform this initial training provided this is direct contact time. The initial training must have been completed within the 12 months preceding the application submission date.

7. Policy Issue: Laser & other “cosmetic” treatment issues

The following issues were presented to the board for consideration:

- Regarding the **Cryoprobe**, a device which uses compressed nitrous oxide gas to freeze to a depth of 5 mm on human skin, the board determined that its use is allowed as a minor surgery procedure.
- **Ellman SS Pelleve** uses a high frequency, low temp radiowave to tighten collagen within the skin non-invasively. Dr. Goldeen moved to accept the Ellman SS Pelleve as allowed within the scope of minor surgery. Motion died for no second.

Dr. Vissers made a second motion to send this request for approval to the ETSDP committee; Dr. Pierce seconded the motion. All in favor. Cote, aye; Dick, aye; Vissers, aye; McClure, aye; Goldeen, aye; Parker-Kent, aye; and Pierce, aye.

- **Zerona laser** – Drs. Corll, Nelson, Quinn and Herrin presented this request. Dr. Goldeen moved to send the Zerona laser issue to the ETSDP committee as well; Cookie Parker-Kent seconded. All in favor. McClure, aye; Vissers, aye; Cote, aye; Parker-Kent, aye; Pierce, aye; Dick, aye; Goldeen, aye.

Send notice to DCs currently using the Zerona and Ellman SS Pelleve lasers that we are referring these devices to the ETSDP committee. They may fall under the jurisdiction of minor surgery certification; so stop using either device until there is a determination (unless certified in minor surgery). Dr. Vissers proposed “Complete your treatment plans, but no more advertising.” Send to ETSDP and direct them to investigate efficacy, research. Ask the committee, “Do they work and do either or both fall under minor surgery?” The involved parties need to provide the research, and appropriate application for approval.

8. Staff Report

Dave summarized current projects at hand including the online license renewals, and the beta-testing of the Ethics exam. Dave was contacted by the LFO office and they want justification for our avoiding the

“sweep” of ending balances. In the process, we got the attention of the Legislative Fiscal office, and they requested copies of our financial information by next Thursday. Dave reviewed our budget as well. The ALJ rate increased from \$80 to \$124 for this biennium. Plus we need to remove the caps on our fees in rule (adds a legislative concept). Doug Dick moved to have this as a Legislative Concept; Dr. Goldeen seconded the motion. Michael Vissers opposed the proposal. Cote, aye; Pierce, aye; McClure, aye; Goldeen, aye; Dick, aye; and Parker-Kent, aye.

CORRESPONDENCE

Suzanne Lady DC, CA initial licensing issues

Dr. McClure summarized this issue. Dr. Lady is trying to open a referral business for licensed chiropractic assistants to work for multiple contracting DC clinics. There are a number of issues which make this unfeasible. The board discussed that the CA license has to be posted in each office; malpractice ramifications are huge for Dr. Lady if she were to be the employing, supervising DC and she is not willing to take that on. The board’s database has no tracking mechanism to follow the “hired” CA. Concluded: It is a bad business model. The board took no action.

1:00 PM **ADJOURN** to Executive Session

3:30 PM **RECONVENE** Public Session

IN THE MATTERs OF

Case # 2010-5001 Jennifer Molinar, CA applicant

The Board proposed to issue the CA license with stipulations to disclose her arrest and conviction history. Doug Dick moved to accept the board’s determination; Cookie Parker Kent seconded the motion. Michael Vissers was recused. Ann Goldeen, aye; Doug Dick, aye; Joyce McClure, aye; Cookie Parker-Kent, aye; Huma Pierce, aye and Dan Cote, aye.

New Case # Christian Schuster DC – The Board proposed to issue a demand letter (with a stayed suspension) that licensee comply with his probation. If he fails to comply within 30 days the suspension becomes immediately effective. Michael Vissers moved to accept the board’s determination; Joyce McClure seconded the motion. All in favor. Cote, aye; Pierce, aye; McClure, aye; Parker-Kent, aye; Dick, aye; Vissers, aye; and Goldeen, aye.

Case #08-1028 Nicholas Brown DC

The Board proposed a 180 day suspension, three year probation, \$5000 civil penalty and completion of NBCE’s PROBE ethics class for violations of the sexual misconduct rule. Doug Dick moved to accept the board’s determination; Cookie Parker-Kent seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 09-1009 Brent Warner DC

The Board proposed to deny licensee/respondent’s exceptions request. Cookie Parker-Kent moved to accept the board’s determination. Ann Goldeen seconded the motion. All in favor. Pierce, aye; Dick, aye; Vissers, aye; Goldeen, aye; Cote, aye; McClure, aye; and Parker-Kent, aye.

Also the Board moved to issue the Final Order including responses to exceptions and adopts the recommendations of the administrative law judge. Michael Vissers moved to accept the board’s determination. Ann Goldeen seconded the motion. All in favor. Pierce, aye; Dick, aye; Vissers, aye; Goldeen, aye; Cote, aye; McClure, aye; and Parker-Kent, aye.

Case # 09-5007 Gregory Moll DC *(The hearing began 3-1-10)*

The Board moved to deny licensee's request for deposition for discovery as requested by the licensee's attorney. Michael Vissers moved to accept the board's determination. Cookie Parker-Kent seconded the motion. Daniel Cote was recused. Pierce, aye; McClure, aye; Vissers, aye; Dick, aye; Parker-Kent, aye; and Goldeen, aye.

Case # 09-1030

The Board proposed no statutory violation. Michael Vissers moved to accept the board's determination. Doug Dick seconded the motion. All in favor. Pierce, aye; Dick, aye; Vissers, aye; Goldeen, aye; Cote, aye; McClure, aye; and Parker-Kent, aye.

Case # 10-1000

The Board proposed insufficient evidence to find a violation, with a letter of concern. Doug Dick moved to accept the board's determination. Joyce McClure seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 10-1001

The Board proposed no statutory violation. Ann Goldeen moved to accept the board's determination; Michael Vissers seconded the motion. All in favor. Cote, aye; Pierce, aye; Dick, aye; Parker-Kent, aye; Vissers, aye; McClure, aye; and Goldeen, aye.

Case # 10-1002 Susan Gray DC

The Board proposed to issue a Notice to Revoke the license. Joyce McClure moved to accept the board's determination; Michael Vissers seconded the motion. All in favor. Cote, aye; Pierce, aye; Dick, aye; Parker-Kent, aye; Vissers, aye; McClure, aye; and Goldeen, aye.

Case # 10-1004

The Board determined insufficient evidence to find a violation. Cookie Parker-Kent moved to accept the board's determination. Huma Pierce seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 10-1003

The Board determined no statutory violation. Michael Vissers moved to accept the board's determination; Cookie Parker-Kent seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case #10-3000

The Board determined no statutory violation. Ann Goldeen moved to accept the board's determination. Cookie Parker-Kent seconded the motion. All in favor. Cote, aye; Pierce, aye; Dick, aye; Parker-Kent, aye; Vissers, aye; McClure, aye; and Goldeen, aye.

Case # 10-3003

The Board determined case closed with a letter of concern. Daniel Cote moved to accept the determination; Ann Goldeen seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 10-3002 Timothy Goulart DC

The Board proposed to issue a \$500 Civil Penalty for violations of the Doctors Title Act. Huma Pierce moved to accept the Board's determination. Cookie Parker-Kent seconded the motion. All in favor. Cote, aye; Pierce, aye; Dick, aye; Parker-Kent, aye; Vissers, aye; McClure, aye; and Goldeen, aye.

Case # 07-5011

The Board determined case closed. Joyce McClure moved to accept the board's determination. Doug Dick seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 08-3005

The Board determined case closed. Joyce McClure moved to accept the board's determination. Huma Pierce seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

Case # 08-3009

The Board determined case closed. Joyce McClure moved to accept the board's determination; Ann Goldeen seconded the motion. All in favor. Vissers, aye; Pierce, aye; Cote, aye; Goldeen, aye; McClure, aye; Parker-Kent, aye; and Dick, aye.

3:40 PM ADJOURN for the day

Oregon Board of Chiropractic Examiners

Standards for Use of Breast Thermography Imaging in Chiropractic Practice

- Definition of Clinical Thermography
- Breast Thermography Education
- Equipment Guidelines
- Informed Consent

The Oregon Board of Chiropractic Examiners has determined that breast thermography is investigational. Investigational means further study is warranted, evidence is equivocal or insufficient, the patient has to evaluate their own risk and it is not standard. Standard means that it is taught in a chiropractic college or otherwise accepted in the chiropractic profession.

Definition of Clinical Thermography

Thermography, when used in a clinical setting, is an imaging procedure that detects, records, and produces an image (thermogram) of a patient's skin surface temperatures and/or thermal patterns. The procedure uses equipment that can provide both qualitative and quantitative representations of these temperature patterns.

Thermography does not entail the use of ionizing radiation, venous access, or other invasive procedures; therefore, the examination poses no harm to the patient. Clinical thermography is appropriate and germane to chiropractic practice whenever a clinician feels a physiologic imaging test is needed for differential diagnostic purposes. Clinical thermography is a physiologic imaging technology that provides information on the normal and abnormal functioning of the sensory and sympathetic nervous systems, vascular system, musculoskeletal system, and local inflammatory processes. The procedure also provides valuable diagnostic information with regard to dermatologic, endocrine, and breast conditions.

Clinical thermography may contribute to the diagnosis and management of the patient by assisting in determining the location and degree of irritation, the type of functional disorder, and perhaps the treatment prognosis. The procedure may also aid the clinician in the evaluation of the case and in determining the most effective treatment.

Clinical breast thermography is an investigational procedure that may be performed by a doctor or technician who has been adequately trained and certified by a recognized organization. However, the interpretation of the thermal images will only be made by health care providers who are licensed to diagnose and hold credentials as board certified clinical thermographers or diplomates from a recognized organization. This is meant to insure that directed care and proper follow-up recommendations will be made available to the patient if warranted by the interpretation of the images.

Breast Thermography Education

Adequate training in thermographic imaging is a necessity to insure quality image acquisition, accurate interpretation, and public safety. Minimum training as a technician (proven with core curriculum or post graduate training from the ACA, ACCT, ITS, IACT, AAT, or AAMII only) is required before breast thermography may be used in chiropractic practice. If a chiropractor is to engage in interpreting images from outside offices, the chiropractor needs to be board certified or a diplomate in thermology from the ACA, ITS, IACT, AAT, or AAMII.

A chiropractor may also image the breast as long as the images are sent out for interpretation by an appropriately trained health care provider who is licensed to diagnose and is board certified; or a chiropractic physician who holds a diplomate in thermology from the ACA, ACCT, ITS, IACT, AAT, or AAMII. This same health care provider must have obtained training in breast thermography as part of their core curriculum in board certification or diplomate thermology courses, or obtained post-graduate training under the tutelage of a recognized expert in the field (that can be demonstrated to the satisfaction of the OBCE).

Certified Clinical Thermographic Technicians: (DCs or other trained persons obtaining the images) Training courses leading to certification are comprised of both formal classroom hours and practical imaging experience. Courses typically cover basic thermal imaging principles, patient management, laboratory and imaging protocols. Candidates that complete a recognized course of study, and successfully pass the required examination(s), hold credentials as certified clinical thermographic technicians.

Certified Clinical Thermologist and Diplomates: (DCs doing interpretation) Educational courses at this level are comprised of both formal classroom hours and practical imaging experience. The course material typically covered includes: a review of relevant anatomy and physiology, pathophysiologic processes and their relation to thermographic presentations, laboratory and imaging protocols, patient management, thermal imaging principles, image analysis and interpretation, thermographic correlation to a mammogram or MRI and a time period of practical field experience. Candidates that complete a recognized course of study, and successfully pass the required examinations, hold credentials as board certified clinical Infrared Imagers or thermologists. A typical course of study includes: a review of breast anatomy and physiology, pathophysiologic breast processes and their relation to thermographic presentations, laboratory and imaging protocols, patient management, thermal imaging principles, image analysis and interpretation, and a time period of practical field experience.

Supervised Instruction: In the event that the core curriculum of a board certified or diplomate course did not cover breast thermography, post-graduate training under the tutelage of a recognized expert in the field (expert in the field that can be demonstrated to the satisfaction of the OBCE) would provide the training needed for breast thermography interpretation. All the standards and practical study listed above apply.

Certifying Organizations: Educational courses in clinical thermography are provided through recognized organizations. Due to the many non-clinical uses of thermographic imaging, only organizations specifically founded to serve the educational needs in clinical thermography are recognized. The currently recognized training organizations are the: American Chiropractic Association, American College of Clinical Thermology, International Academy of Clinical Thermology, American Academy of Thermology, and past graduates of the American Academy of Medical Infrared Imaging (no longer in existence).

Equipment Guidelines

In order to provide quality image production and accurate clinical interpretations, certain minimum equipment standards should be maintained, only FDA cleared equipment for thermography of the breast shall be used. (Note: No evidence has been presented that this equipment is actually “FDA approved”.)

Informed Consent

Any chiropractic clinic providing breast thermography imaging must use the attached informed consent form. This is in addition to verbal communication with the patient to ensure their understanding of these informed consent provisions, the investigational status and that this is adjunctive to other standard diagnostic imaging or examination.

Clinic or Entity Name: _____
Address: _____
City/State/Zip: _____
Phone Number: _____ (____) _____

Informed Consent ***Breast Thermal Imaging

Please **read carefully and initial your name** on the line at the end of each section.

The Oregon Board of Chiropractic Examiners has determined that breast thermography is investigational. Investigational means further study is warranted, evidence is equivocal or insufficient, the patient has to evaluate their own risk and this is not considered standard by the Chiropractic profession. Standard means taught in a chiropractic college or otherwise accepted in the chiropractic profession.

I understand that thermography of the breast is a procedure utilizing a digital thermal imaging camera to visualize and obtain an image of the infrared radiation (heat) coming from the surface of the skin. _____

I understand that Infrared Imaging of the breast is not intended as a replacement of breast mammography and that according to the current recommended protocol, clinical examination and mammogram are considered the standard breast cancer screen for women. Thermography is not a stand-alone diagnostic tool, meaning it is not approved to be used by itself for screening. _____

I understand that Thermal breast scans and mammography do not provide the same information on breast tissues and therefore provide different values on breast tissue assessment (thermography looking for physiological changes and mammography looking for anatomical changes) _____

I understand that breast thermography may be used as an adjunctive screen in addition to mammography, MRI and clinical exam to detect early stages of breast abnormalities. _____

I understand that the imaging physician and/or technician providing the Thermal Breast Scans at (clinic name) are not diagnosing or treating breast abnormalities. Follow up care relating to treatment must be done with properly trained and licensed breast specialists. _____

I understand that if by any chance, an abnormal finding is discovered on my breast scan, I will comply with any diagnostic or referral recommendation made by Dr. (name) such as following up with a breast ultrasound/mammogram and/or with a breast specialist to ensure I receive proper care. _____

I understand that I will disrobe from the waist up during the exam. My breasts will then be imaged with an electronic thermographic camera. I understand that the procedure does not use radiation or compression and does not pose any harmful effects to my body. A clinical breast examination could be necessary at the end of my imaging session and will be performed by Dr. (name) to verify any abnormal findings. _____

I understand that the results of my thermograms will be made available to my physicians and others as I so designate for further diagnosis and analysis in the overall evaluation of my breast health. _____

I have been given a Pre-Imaging instruction form to follow and I agree that I have complied with the preparation protocol prior to the procedure. _____

I also understand that this procedure is not covered by insurance and the office fee is due and payable at the time of service unless special provisions have been made with the office in advance. _____

I understand that the American College of Radiology advises that for women at average risk for cancer that annual mammograms be performed from age 40 and from age 30 if other risk factors are present (BRCA mutations, family history of breast cancer, etc.) See Journal American College of Radiology 2010;7:18-27) _____

Having understood the above and having received satisfactory answers to all questions that I may have had concerning the purpose, outcome, benefits, and risk factors of thermographic evaluation, I consent to examination by Infrared Imaging of my breasts by (clinic). _____

Signature _____ Date _____
Print Name _____