OBCE BOARD MEETING PUBLIC SESSION	**September 21-22, 2022 8:00 AM** **Meeting location:** Eagle Crest Resort 1522 Cline Falls Rd, Board Rm A Redmond, OR 97756 **Zoom conference will also be available:** https://us06web.zoom.us/j/87587955221?pwd=K2g0WEVqL2QwOVlicGFZdkRhN1krUT09 Meeting ID: 875 8795 5221 Password: 598765

Board President: Franchesca Vermillion, DC Phone 503-378-5816 info@obce.oregon.gov

September 21-22, 2022

8:00 AM Meet and Greet

8:30 AM Convene Public Session

1. PUBLIC COMMENTS
(Comments must be limited to 3-5 minutes. Notify the Board office in advance if you wish to address the Board.)

2. CONSENT AGENDA Action
a. Today's agenda
b. July 21, 2022, Public Board Minutes

3. EXECUTIVE DIRECTOR REPORT Inform/Action

4. OCA Update Inform

5. UWS Update Inform

6. 9:00 AM RULE HEARINGS
a. **OAR 811-015-0025 Continuing Chiropractic Education** – Updating existing language surrounding BLS/AED/CPR

7. ADMINISTRATIVE RULES REVIEW and DISCUSSION Action
a. **OAR 811-010-0093 Guide to Policy and Practice Questions –** Version reference update

8. DISCUSSION AND ACTION ITEMS
a. Spinal Screening Requirements - Kawaoka Inform/Action
b. 2023 Board Meeting Schedule Action
c. November Introduction to the Board Action
d. CA Process updates/issues - Purnell Inform/Action
e. ETSDP Application Review – Wet Cupping Inform/Action
f. Use of NCRME acronym in signature/title - McGehee Inform/Action

g. Minor Consent to Treat – Legislative Concept 591 (2023) Inform
h. Board Best Practices Questionnaire Inform/Action

9. CORRESPONDENCE

a. None

11:30 AM Working Lunch included

10. WORK SESSION

a. InLumon Board Portal Review and Training Inform
b. Education Manual for the Evidence-Based Practice Manual Inform/Action

11. EXECUTIVE SESSION

The Board of Chiropractic Examiners will now go into Executive Session pursuant to ORS 192.660(2)(f), ORS 192.660(2)(l), ORS 192.660(2)(h), ORS 684.185, 676.175(1) and 684.100(10) concerning discipline, litigation, and exempt public records**.**

Representatives of the news media and designated staff will be allowed to attend the Executive Session. All other members of the audience are asked to leave the room. Representatives of the news media are specifically directed not to report on any of the deliberations during the Executive Session except to state the general subject of the session as previously announced.

No decision will be made in Executive Session. At the end of the Executive Session, we will return to open session and welcome the audience back into the room.

12. IN THE MATTERS OF (following Executive Session)

OBCE BOARD MEETING PUBLIC SESSION	**July 21, 2022 9:00 AM** **Meeting location:** OBCE office 530 Center St NE, Ste 620 Salem, OR 97301 **Zoom conference will also be available:** https://us06web.zoom.us/j/89906583151?pwd=M3hBaDkvUXEvQnBnSXBsaGRLbXZaQT09 Meeting ID: 899 0658 3151 Password: 747518
Board President: Franchesca Vermillion, DC	**Phone 503-378-5816** **info@obce.oregon.gov**

Board member Attendees:	**Staff Attendees:**
Franchesca Vermillion DC, President	Cass McLeod-Skinner JD, Executive Director
Michelle Waggoner DC, Vice President	Mackenzie Purnell, Administrative Specialist II
Seth Alley DC, Secretary	Miriam Lara, Administrative Specialist II
Karen Baranick DC - absent	Lori Lindley, Assistant Attorney General
Lori Schmidt JD, Public Member	Craig Kawaoka, DC, MeD, Healthcare Investigator
Glenn Taylor, Public Member	Heather Gilker, Office Specialist
Allen Knecht DC	
Public Attendees: Vern Saboe, DC; David Corll, DC; Sharron Fuchs, DC; Minga Guerrero, DC; Lisa Kouzes, DC; Carol Stoutland, DC; LoGiudice, DC.	

8:30 AM Convene Public Session

1. **PUBLIC COMMENTS –** No comments received.

2. **CONSENT AGENDA**

   a. **Today's agenda**

   Outcome: Approved as amended.

   b. **May 19-20, 2022 Public Board Minutes**

   Outcome: Approved as amended.

   c. **May 23, 2022 Public Board Minutes**

   Outcome: Approved as amended.

   d. **Discussion – Single day meetings**

   Outcome: November's board meeting to be held virtually.

   e. **Intro to the Board - November**

   Outcome: November's Intro to the Board meeting to be held virtually. Date TBD.

3. EXECUTIVE DIRECTOR REPORT

Report was received by the Board.

4. OCA Update – Dr. Vern Saboe

OCA update was provided by Dr. Vern Saboe and received by the Board.

5. UWS Update

UWS update was provided via email and received by the Board.

6. 9:00 AM RULE HEARINGS Action

a. None

7. ADMINSTRATIVE RULES

a. None

9. DISCUSSION AND ACTION ITEMS

a. **Spinal Screening Requirements** – Kawaoka Inform/Action

Issue: Whether postural screening is considered an examination.
Outcome: Bring topic back to September board meeting after reviewing what rules would be impacted.

b. **Trauma-Informed Investigation Training** – Report Out Inform

Outcome: Kawaoka, Taylor, and Vermillion attended and reported to the Board.

c. **OCA COVID-19 Advisory Committee Request** Inform/Action

Outcome: No Board action.
Outcome: No Board action. OBCE will not participate. OCA should forward request to OHA.

d. **BLS/CPR/AED Clarification** Inform/Action

Outcome: Notice will be sent out to the public about updates. Notice for rule hearing to update language to update using new language. Vermillion motions to enter rule making during September's board meeting as drafted; Alley, second. Taylor, aye; Schmidt, aye; Baranick, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Passed
Outcome: **OAR 811-015-0025** Notice will be sent out to the public about updates. Notice for rule hearing to update language to update using new language.

Vermillion moved to enter rule making during September's board meeting as drafted; Alley, second. Taylor, aye; Schmidt, aye; Baranick, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Motion passed.

e. **Oxygen Training, use in emergency situations** - Moreau Inform/Action

Issue: What would be required to become a trainer or CE course for emergency use oxygen.

Outcome:
Board needs further information with regard to training certificates obtained.

f. **ACA – Support Letter for H.R. 2654/S. 4042** Inform/Action

Outcome:
Will include information within next eblast as informational only.

g. **FCLB District I meeting** Inform/Action

Outcome:
Meeting will occur Sept. 29-Oct. 2, 2022.
McLeod-Skinner, Vermillion, Taylor will attend.

10. CORRESPONDENCE

a. **Public comments** – BLS/CPR/AED CE update Inform

Outcome: No Board action.

b. **Public comments** – Anonymous Inform

Outcome: No Board action.

c. **Public comments** – Eblast Inform

Outcome: No Board action.

12:00 PM Working Lunch included

11. WORK SESSION

a. **OCPUG Final Review** Inform/Action

Outcome:
Vermillion moves to adopt the OCPUG as amended; Knecht, second. Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passes.

12. EXECUTIVE SESSION

13. IN THE MATTERS OF (following Executive Session)

Case # 2020-2002
Proposal: Issue Notice of Proposed Discipline for revocation and to no longer teach any classes on billing/charting.

Motion: Knecht moved to accept the proposal; Vermillion, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2020-5011
Proposal: Board accepts the findings of the psychiatric evaluation.
Motion: Vermillion moved to accept the proposal; Alley, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2020-5017
Proposal: Issue Notice of Proposed Discipline for Suspension - failure to cooperate.
Motion: Schmidt moved to accept the proposal; Knecht, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2020-3026
Proposal: Refer to Peer Review Committee.
Motion: Alley moved to accept the proposal; Waggoner, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2019-5023
Proposal: Insufficient Evidence.
Motion: Vermillion moved to accept the proposal; Taylor, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2021-3009
Proposal: Insufficient Evidence.
Motion: Waggoner moved to accept the proposal; Knecht, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Case # 2021-1016
Proposal: Issue Notice of Proposed Discipline with $5,000 fine to be paid within 90 days, with 3 file pulls of 2 files each within 6 months. Continuing education requirements are 2 hours of record keeping, 2 hours in billing, 2 hours in ethics for a total of 6 hours to be completed in addition to the required 20 hours for renewal, to be completed within 90 days.
Motion: Vermillion moved to accept the proposal; Waggoner, second.
Vote: Taylor, aye; Schmidt, aye; Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Baranick not in attendance. Motion passed.

Agenda Item #2a.
Proposal: License with Stipulation.
Motion: Vermillion moved to accept the proposal; Knecht, second.
Vote: Alley, aye; Knecht, aye; Waggoner, aye; Vermillion, aye. Motion passed.

4:30 PM Adjourn for the Day

Prepared by Mackenzie Purnell, Administrative Specialist 2; 7/27/2022

Board and Commission Meeting Minutes Series documents the official proceedings of the board or commission meetings. Records may include agendas; minutes; meeting notices; items for board action; contested case hearings schedules; committee reports; exhibits; and related correspondence and documentation. Records may also include audio recordings of meetings used to prepare summaries. Retention: (a) Minutes: Permanent, transfer to State Archives after 10 years; (b) Audio recordings: 1 year after transcribed, destroy; (c) Other records: 5 years, destroy.

Executive Staff Report
September 21-22, 2022 Board meeting

To: Board of Chiropractic Examiners
From: Cass McLeod-Skinner, Executive Director

Board Meeting details: **September 21-22, 2022**
Eagle Crest Resort
Tumalo, OR

2021-23 Budget
As of the close of June, we have an estimated ending cash balance of $564,943.42 which translates to 6.65 months of expenditure reserve.

Customer Satisfaction Survey/Annual Progress Performance Report
Our customer satisfaction survey is open for input through the month of September to obtain data pertinent to our Annual Progress Performance Report and Key Performance Measures. Board members will also be filling out the Board Best Practices questionnaire and returning those to me for the same purpose.

inLumon Update and Board Training
Mackenzie will provide us an update on the overall roll out and introduction to the Board Portal within the inLumon platform to get members accustomed to the program's capabilities.

2023 Board Meeting Dates and Locations
Proposed dates and locations are as follows:

Jan. 18-19 or 19-20 – Retreat – somewhere in upper Willamette Valley or at Salem office: Oregon Garden/Silverton, McMinnville, Albany, The Grand Hotel/Salem

March 30 – virtual

May 24-25 or 25-26 – Salem, Joseph, Enterprise, La Grande, Baker, Klamath Falls, Ashland

July 27 - virtual

Sept. 27-28 or 28-29 - TBD

Nov. 16 or 30 - virtual

November's Introduction to the Board
This meeting will be held virtually on either Nov. 9 or 16, 4-7pm, depending on the availability of board member attendance.

Executive Staff Report
September 21-22, 2022 Board meeting

Current Licensee Statistics

Licensee Types	10/21	11/21	12/21	01/22	02/22	03/22	04/22	05/22	06/22	07/22	08/22	09/22
DC - Active	1235	1234	1229	1222	1221	1217	1206	1224	1233	1240	1231	1227
DC - Inactive	205	224	219	222	248	252	256	248	255	259	251	252
DC - Senior	416	418	412	413	411	414	423	445	443	442	442	439
DC - Initial	75	79	74	76	78	77	75	71	72	66	62	63
DC Total	**1931**	**1955**	**1934**	**1933**	**1958**	**1960**	**1960**	**1988**	**2003**	**2007**	**1986**	**1981**
CA - Initial	352	360	376	377	395	407	419	434	461	379	397	394
CA - Renewing	985	966	966	973	971	978	982	986	998	917	858	863
CA Total	**1337**	**1326**	**1342**	**1350**	**1366**	**1385**	**1401**	**1420**	**1459**	**1296**	**1255**	**1257**
TOTAL	**3268**	**3281**	**3276**	**3283**	**3324**	**3345**	**3361**	**3408**	**3462**	**3303**	**3241**	**3238**

***** Includes Senior and Initial DCs.

2022 Board Meeting Dates and Locations

November 17, 2022 (Thursday) – virtual

AGENCY 811 - Board of Chiropractic Examiners

2021-23 Budget to Actuals Summary Report

OPERATING OTHER FUNDS $ 2,146,466.00	Legislatively Adopted Budget (LAB)	2021-23 Revenue & Expenditures Actuals as of Month End	 % Earned/Spent	Projections	Difference between LAB Budget and Projections
Beginning Balance:					
AY Beginning Balance	$ 395,755	$ 600,248	N/A		N/A
Revenue:					
Revenue less Transfers out	$ 2,006,536	$ 1,232,747	61%	$ 2,812,629	$ (806,093)
Expenditures:					
Personal Services	$ 1,226,396	$ 461,940	38%	$ 1,131,089	$ 95,307
Services and Supplies	$ 947,114	$ 398,720	42%	$ 908,867	$ 38,247
Special Payments	$ -	$ -	0%	$ -	$ -
Total Expenditures	**$ 2,173,510**	**$ 860,660**	**40%**	**$ 2,039,956**	**$ 133,554**
Adjust for Accrued Accounts Receivable		$ (207,729)		$ (207,729)	
Net Ending Cash	$ 228,781	$ 764,605		**Net Position** (Projected AY Ending Cash)	**$ 772,673** Within Budget

Outstanding AR owed to agy		(207,729.28)
Projected ending cash	$	564,943.42
Working Cap		6.65 Months

BOARD OF CHIROPRACTIC EXAMINERS

Actuals High ighted

2021-23 CASH FLOW

	2021 JUL Actuals	2021 AUG Actuals	2021 SEP Actuals	2021 OCT Actuals	2021 NOV Actuals	2021 DEC Actuals	2022 JAN Actuals	2022 FEB Actuals	2022 MAR Actuals	2022 APR Actuals	2022 MAY Actuals	2022 JUN Actuals	2022 Mo. 13 Projections	2022 JUL Projections	2022 AUG Projections	2022 SEP Projections	2022 OCT Projections	2022 NOV Projections	2022 DEC Projections	2023 JAN Projections	2023 FEB Projections	2023 MAR Projections	2023 APR Projections	2023 MAY Projections	2023 JUN Projections	2023 Mo. 13 Projections	ACTUALS BIENNIUM TO DATE	ACTUALS + PROJECTIONS	AY23 LAB	PROJECTION TO FIN PLAN (over)/under
Beginning Cash Balance	600,247.54	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	955,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	963,289.60	938,085.43	834,292.20	817,152.93	806,161.82	796,832.22	779,925.56	767,333.16	766,985.97	771,065.20	779,024.98	789,541.27	784,713.65	794,980.08	772,672.70	972,334.14	772,672.70	228,781.00	
REVENUE																				20% Fee Increase										
0205 OTHER BUSINESS LICENSES	2,400.00	975.00	450.00	3,292.00	700.00	1,250.00	3,275.00	1,500.00	1,075.00	1,025.00	1,450.00	2,950.00		1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17	1,695.17		20,342.00	40,684.00	42,775.00	2,091.00
0210 OTHER NONBUSINESS LIC & FEES	57,907.50	75,140.25	65,396.25	70,866.50	60,801.25	61,050.75	79,021.25	55,448.75	75,887.50	66,109.50	72,142.50	76,535.00		72,000.00	72,000.00	72,000.00	72,000.00	72,000.00	72,000.00	86,400.00	86,400.00	86,400.00	86,400.00	86,400.00	86,400.00		816,307.00	1,766,707.00	1,887,274.00	120,567.00
0410 CHARGES FOR SERVICES	10.00	10.00	325.00	5.00	120.00	20.00	200.01	10.00		35.00	15.00	10.00		69.09	69.09	69.09	69.09	69.09	69.09	69.09	69.09	69.09	69.09	69.09	69.09		760.01	1,589.11	2,060.00	470.89
0505 FINES AND FORFEITS	600.00	850.00	100.00	100.00	1,600.00	391,812.50	(3,000.00)	400.00	2,600.00	175.00	100.00	100.00		725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00	725.00		395,437.50	404,137.50	86,000.00	(318,137.50)
0705 OTHER SALES INCOME																											-		27.00	27.00
0975 OTHER REVENUE	404.00	466.00	430.00	418.00	366.00	368.00	502.00	358.00	486.00	438.00	452.00	476.00		430.33	430.33	430.33	430.33	430.33	430.33	430.33	430.33	430.33	430.33	430.33	430.33		5,164.00	10,328.00		(10,328.00)
TOTAL REVENUE	61,321.50	77,441.25	66,701.25	74,681.50	63,587.25	454,501.25	79,998.26	57,716.75	80,048.50	67,782.50	74,159.50	80,071.00		74,919.59	74,919.59	74,919.59	74,919.59	74,919.59	74,919.59	89,319.59	89,319.59	89,319.59	89,319.59	89,319.59	89,319.59		1,238,010.51	2,225,445.61	2,018,136.00	(205,309.61)
REVENUE TRANSFER OUT																														
2443 TRANSFER OUT TO OHA										(5,264.00)														(5,800.00)	-	-	(5,264.00)	(11,064.00)	(11,600.00)	(536.00)
TOTAL TRANSFERS										(5,264.00)														(5,800.00)			(5,264.00)	(11,064.00)	(11,600.00)	(536.00)
AVAILABLE REVENUE	61,321.50	77,441.25	66,701.25	74,681.50	63,587.25	454,501.25	79,998.26	57,716.75	80,048.50	73,046.50	74,159.50	80,071.00		74,919.59	74,919.59	74,919.59	74,919.59	74,919.59	74,919.59	89,319.59	89,319.59	89,319.59	89,319.59	95,119.59	89,319.59		1,232,746.51	2,812,629.15	2,402,291.00	(410,338.15)
										Job Rotation Jan, Feb, Mar		Job Rotation Apr, May	Job Rotation June														from PS Projections unless highlighted		
PERSONAL SERVICES																														
3110 CLASS/UNCLASS SALARY	26,533.60	17,139.54	17,449.77	19,857.51	24,623.77	28,197.24	16,613.46	28,148.28	25,564.90	15,057.23	30,639.48	28,137.08	(4,188.58)	31,578.64	35,957.58	36,124.60	33,924.60	34,324.60	35,924.60	36,506.34	30,094.58	32,294.58	30,094.58	32,894.58	30,094.58		277,961.96	573,587.27	778,438.00	104,850.73
3160 TEMPORARY APPOINTMENTS			723.93	2,004.10	2,291.60	2,022.00	2,182.08	2,367.43		2,022.00	2,481.24	2,373.36		2,373.36	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00	2,437.00		18,467.74	47,648.10		(47,648.10)
3170 OVERTIME PAYMENTS	2,003.67													-	-	-	-	-	-	-	-	-	-	-	-		2,003.67	2,003.67		(2,003.67)
3180 SHIFT DIFFERENTIAL																													463.00	
3190 ALL OTHER DIFFERENTIAL	980.10	980.10	235.08	889.19	1,323.55	1,354.22	534.76	7,165.95	1,108.96	346.24	859.57	1,053.40		1,285.48	1,325.33	1,343.68	1,343.68	1,343.68	1,343.68	1,362.77	1,202.18	1,202.18	1,202.18	1,202.18	1,202.18		16,831.12	32,190.35	22,333.00	(9,857.35)
3210 ERB ASSESSMENT	7.20	4.80	7.20	9.60	9.60	9.60	9.60	9.60	9.60	9.60	12.00	12.00		12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00		110.40	254.40	296.00	41.60
3220 PUBLIC EMPLOYES' RETIREMT	5,561.71	3,132.89	1,620.69	2,340.09	3,170.11	3,252.18	1,321.30	4,287.13	3,302.21	2,421.21	4,699.46	5,246.11		6,054.38	6,240.35	6,306.98	6,306.98	6,306.98	6,306.98	6,374.40	5,791.32	5,791.32	5,791.32	5,791.32	5,791.32		40,355.09	113,208.78	133,262.00	20,053.22
3221 PENSION BOND CONTRIBUTION	1,652.96	1,014.69	524.91	757.92	1,026.75	1,053.33	427.93	1,388.54	1,069.54	784.21	1,522.09	1,700.37		1,960.93	2,021.17	2,042.75	2,042.75	2,042.75	2,042.75	2,064.58	1,875.73	1,875.73	1,875.73	1,875.73	1,875.73		12,923.24	36,519.58	42,824.00	6,304.42
3230 SOCIAL SECURITY TAX	2,249.36	1,369.79	1,337.68	1,626.58	2,118.26	2,416.50	1,453.10	2,845.15	2,198.34	1,321.03	2,588.67	2,393.54		2,678.78	3,021.16	3,035.34	2,867.04	2,897.64	3,020.04	3,065.17	2,562.38	2,562.38	2,562.38	2,776.58	2,562.38		23,918.00	57,697.58	61,294.00	3,596.42
3240 UNEMPLOYMENT ASSESSMENT																											-	-		0.00
3250 WORKERS' COMPENSATION	4.99	5.22	4.06	6.43	7.87	8.83	6.15	7.65	8.59	5.88	8.47	8.21		11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46	11.46		82.35	219.87	235.00	15.13
3260 MASS TRANSIT	177.09	108.71	66.80	131.42	165.28	170.64	108.02	208.12	174.22	100.76	164.63	183.56	(25.13)	211.42	238.32	239.43	226.23	228.63	238.23	241.84	202.40	215.60	202.40	219.20	202.40		1,759.25	4,400.24	4,808.00	407.76
3270 FLEXIBLE BENEFITS	5,246.30	5,246.30	4,159.71	4,965.21	5,897.69	6,155.89	4,744.58	6,987.91	6,987.91	4,402.70	5,881.86	6,851.18		7,836.23	7,836.23	7,836.23	7,836.23	7,836.23	8,093.03	8,093.03	8,093.03	8,093.03	8,093.03	8,093.03	8,093.03		67,527.24	163,359.57	195,939.00	32,579.43
3455 VACANCY SAVINGS																													(13,496.00)	
3465 RECONCILIATION ADJUST																														
TOTAL PERSONAL SERVICES	44,416.98	29,002.04	25,405.90	31,307.98	40,346.58	44,910.03	27,240.90	53,230.41	42,751.70	26,470.86	48,857.47	47,958.81	(4,213.71)	54,002.69	59,100.60	59,389.48	57,007.98	57,440.38	59,429.78	60,168.58	52,282.09	54,663.59	52,282.09	55,313.09	52,282.09		461,540.06	1,131,089.41	1,226,396.00	95,306.59
SERVICES AND SUPPLIES																														
4100 INSTATE TRAVEL		145.65	123.29								227.93	8,547.67		-	200.00	-	-	200.00	-	-	200.00	-	-	200.00	-	-		9,844.54	24,854.00	15,009.46
4125 OUT-OF-STATE TRAVEL			776.16	165.56					801.17	748.24	617.20	1,071.12		-	-	-	-	-	-	-	-	-	-	-	-	-	4,179.45	4,179.45	9,215.00	5,035.55
4150 EMPLOYEE TRAINING		660.00	2,190.59	(590.00)			2,027.00	600.00	371.40	1,044.00	751.75			-	-	-	-	1,427.00	-	427.00	-	-	-	-	-	-	7,054.74	8,908.74	5,504.00	(3,404.74)
4175 OFFICE EXPENSES		44.00	403.86	435.28	669.00	1,151.94	503.43	867.88	866.74	808.39	599.54	212.00	687.56	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	646.39	6,562.00	15,652.64	28,033.00	12,380.36
4200 TELECOMM/TECH SVC & SUPP	408.10	348.75	1,128.08	1,195.97	688.65	809.70	669.83	1,087.45	722.21	1,103.93	778.79	968.74	2,205.99	812.17	1,063.53	812.17	812.17	1,063.53	812.17	812.17	1,063.53	812.17	812.17	1,063.53	812.17	812.17	9,910.20	23,679.84	16,729.00	(6,950.84)
4225 STATE GOVERNMT SRVC CHRGS	0.10	166.45	45,835.98	0.10	866.23		0.10	863.55	0.10	18,384.23	0.10			42,759.00	932.13	66.00	66.00	932.13	66.00	66.00	932.13	66.00	66.00	932.13	66.00	66.00	66,116.94	113,132.46	96,342.00	(16,790.46)
4250 DATA PROCESSING	398.00	54.98	545.97	862.12	647.86	1,985.36	168.04	449.49	74.95	2,000.27	268.59	724.38	1,191.00	479.00	479.00	479.00	1,199.00	479.00	1,325.00	989.00	479.00	479.00	479.00	479.00	653.00	479.00	8,180.01	17,848.01	4,505.00	(13,343.01)
4275 PUBLICITY & PUBLICATIONS				30.00			78.83	565.00	33.00		528.12	686.00	100.83	-	408.24	-	-	408.24	-	200.00	408.24	-	-	408.24	-	-	1,920.95	3,854.73	3,647.00	(207.73)
4300 PROFESSIONAL SERVICES	92.41	6,117.50	20.60	714.90	319.00	4,459.80			2,769.35	53.70	20.60	264.79	5,490.67	956.43	4,257.68	956.43	956.43	4,257.68	956.43	956.43	4,257.68	956.43	956.43	4,257.68	956.43	956.43	14,832.65	45,961.90	67,187.00	21,225.10
4315 IT PROFESSIONAL SERVICES	2,573.13		536.00	487.00	457.00	7,444.50	399.00	434.00	366.00	380.00	450.00	466.00	6,340.14	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	5,446.71	13,992.63	91,140.06	62,955.00	(28,185.06)
4325 ATTORNEY GENERAL LEGAL FEES		7,330.40	7,647.20	12,314.49	6,277.69		25,696.00	7,367.80		12,049.40	3,152.60	10,122.60			9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	9,519.08	91,958.18	206,187.17	266,997.00	60,809.83
4375 EMPLOYEE RECRUITMENT & DEV														-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,072.00	1,072.00
4400 DUES AND SUBSCRIPTIONS			117.20			678.00	1,800.00		65.00	175.00				357.69	357.69	357.69	357.69	357.69	1,057.69	2,157.69	357.69	532.69	357.69	357.69	357.69	357.69	2,835.20	10,160.15	5,499.00	(4,661.15)
4425 FACILITIES RENT & TAXES	12,567.96	4,189.32		4,189.32	4,705.30		4,189.32	8,453.15	5,789.35	4,213.83	4,213.83	4,213.83		4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,213.83	4,289.68	4,289.68		56,725.21	107,442.87	110,602.00	3,159.13
4575 AGY PROG RELATED SVCS & SUPP			3,466.50	2,517.25	2,854.25		3,429.00	2,504.00		3,270.50	2,464.25	3,394.80	4,220.29	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	2,110.14	23,900.55	55,552.70	21,003.00	(34,549.70)
4650 OTHER SERVICES AND SUPPLIES		1,354.04	66,044.67	1,701.13	1,754.04	1,651.32	1,619.33	2,583.88	1,052.12	2,027.76	5,672.04	1,573.11	9,181.40	66,310.22	2,705.30	1,295.22	1,295.22	2,705.30	1,310.22	1,295.22	2,705.30	1,295.22	1,295.22	2,705.30	1,295.22	1,295.22	87,033.44	183,723.02	212,666.00	28,942.98
4700 EXPENDABLE PROPERTY							90.74							-	-	-	-	-	-	-	-	-	-	-	-	-	90.74	90.74	4,835.00	4,744.26
4715 IT EXPENDABLE PROPERTY		627.88				65.98	610.31	435.60			1,187.98	499.21		618.55	618.55	618.55	618.55	618.55	618.55	658.54	618.55	618.55	618.55	618.55	618.55	618.55	3,426.96	11,508.04	5,469.00	(6,039.04)
TOTAL SERVICES & SUPPLIES	16,039.70	21,038.97	128,836.04	24,023.12	19,239.02	18,246.60	41,280.93	26,211.80	12,511.39	46,259.25	20,933.32	32,744.25	29,417.88	124,710.13	32,958.27	26,521.21	27,241.21	34,385.27	28,082.21	29,458.20	32,958.27	26,696.21	26,521.21	33,034.12	26,771.06	22,307.38	358,719.85	908,867.04	947,114.00	38,246.96
SPECIAL PAYMENTS																														
6055 DIST TO CONTRACT SVC PROVIDER													-													-	-	-	-	-
TOTAL SPECIAL PAYMENTS																														
TOTAL EXPENDITURES	60,456.68	50,041.01	154,241.94	55,331.10	59,586.00	63,156.63	68,521.83	79,442.21	55,703.09	72,730.11	69,790.79	80,703.06	25,204.17	178,712.82	92,058.87	85,910.69	84,249.19	91,826.25	87,511.99	89,666.78	85,240.36	81,359.81	78,803.31	88,347.21	79,053.16	22,307.38	800,659.91	2,039,956.45	2,173,510.00	133,553.55
Ending Balance	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	955,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	963,289.60	938,085.43	834,292.20	817,152.93	806,161.82	796,832.22	779,925.56	767,333.16	766,985.97	771,065.20	779,024.98	789,541.27	784,713.65	794,980.08	772,672.70	972,334.14	772,672.70	228,781.00	
Unpaid Invoices B lled (89s Controller GL0501 F4150)	Waiting for AY21 Invoices to roll into AY23					(382,812.50)	(381,244.12)	(359,333.28)	(358,531.28)	(227,062.55)	(207,729.28)	(215,104.57)															(207,729.28)	(207,729.28)		
Cash Available for Expenditure	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	572,855.68	585,900.49	586,085.87	611,233.28	732,490.40	756,192.38	748,185.03	938,085.43	834,292.20	817,152.93	806,161.82	796,832.22	779,925.56	767,333.16	766,985.97	771,065.20	779,024.98	789,541.27	784,713.65	794,980.08	772,672.70		564,943.42	228,781.00	

62s																												92,543.57	Average Monthly Revenue	
APPN #: 30000																												84,998.19	Average Monthly Expend tures	
Beginning Cash Balance	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54		254,994.56	Working Capital (3 months)	
Cash Revenue + Transfer In	61,321.50	138,762.75	205,464.00	280,145.50	343,732.75	415,421.50	514,165.70	576,615.73	657,466.23	876,050.73	950,210.23	1,030,281.23																6.65	Ending Cash Balance -	
Accrued Revenue					-	382,812.50	364,066.56	359,333.28	358,531.28	207,729.28	207,729.28	207,729.28																		# of Months of Expenditures to cover for AY:
Cash Expenditures (-) + Transfer Out	(53,062.13)	(100,012.02)	(264,205.53)	(320,070.73)	(378,727.83)	(428,891.29)	(527,936.60)	(590,160.67)	(640,652.60)	(743,375.87)	(801,513.79)	(887,303.41)																		
Accrued Expenditures (-)	(7,394.55)	(10,485.67)	(534.10)		(928.90)	(13,922.07)	(576.15)	(616.73)	(5,827.89)	(432.00)	(1,028.57)	(547.36)																		
Red of exp							17,177.56	-		19,333.27	8,276.97	7,375.29																		
	601,112.36	628,512.60	540,971.91	560,322.31	564,323.56	955,668.18	967,144.61	945,419.15	969,764.56	959,552.95	963,921.66	957,782.57	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54	600,247.54			
Cash Flow Ending Cash Balance	601 112.36	628 512.60	540 971.91	560 322.31	564 323.56	955 668.18	967 144.61	945 419.15	969 764.56	959 552.95	963 921.66	963 289.60	938 085.43	834 292.20	817 152.93	806 161.82	796 832.22	779 925.56	767 333.16	766 985.97	771 065.20	779 024.98	789 541.27	784 713.65	794 980.08	772 672.70				
Difference												(5,507.03)	(337,837.89)	(234,044.66)	(216,905.39)	(205,914.28)	(196,584.68)	(179,678.02)	(167,085.62)	(166,738.43)	(170,817.66)	(178,777.44)	(189,293.73)	(184,466.11)	(194,732.54)	(172,425.16)				
	Q1			Q2			QTR 3			QTR 4				QTR 5			QTR 6			QTR 7			QTR 8							

811-015-0025
Continuing Chiropractic Education

(1) Continuing chiropractic education (CE) is to improve the competence and skills of Oregon chiropractic licensees, and to help assure the Oregon public of the continued competence of these licensees within the statutory scope of practice.

(2) In order to renew a license or certificate, each licensee shall complete an affidavit attesting to successful completion of education per their license or certificate status.

(a) Chiropractic physician first year initial status – 8 hours which must include the following:

(A) Over-the-counter, non-prescriptive substances – 4 hours;

(B) Evidence-based medicine – 2 hours;

(C) Cultural competency – 1 hour;

(D) Suicide intervention training – 1 hour;

(b) Chiropractic physician second year active status – 20 hours which must include the following:

(A) Pain Management Education – 7 hours (6 accredited hours in pain management, palliative care, and end of life care or a combination of both, and 1 hour of pain management module through the Pain Management Commission);

(B) Cultural competency – 2 hours;

(C) Suicide intervention training – 1 hour;

(D) ~~General continuing education,~~ Maintenance of ~~which must include maintenance of~~ Basic Life Support (BLS) for Healthcare Providers or its equivalent as determined by the Board – up to 6 hours accepted towards general continuing education requirement~~/Cardiopulmonary Resuscitation (CPR)/Automated External Defibrillator (AED) certification – 10 hours~~;

(E) General continuing education – 10 hours;

(c) Chiropractic physician active status - 20 hours which must include the following:

(A) Cultural competency – 2 hours;

(B) Suicide intervention training – 1 hour;

(C) Maintenance of Basic Life Support (BLS) for Healthcare Providers or its equivalent as determined by the Board – up to 6 hours accepted towards general continuing education requirement;

(D) General continuing education – 17 hours;~~General continuing education, which must include maintenance of BLS/CPR/AED certification – 17 hours;~~

(d) Chiropractic physician senior active status – 6 hours which must include the following;

(A) Cultural competency – 1 hour;

(B) Suicide intervention training – 1 hour;

(C) Maintenance of Basic Life Support (BLS) for Healthcare Providers or its equivalent as determined by the Board – up to 6 hours accepted towards general continuing education requirement;

(D) General continuing education – 4 hours;~~General continuing education, which must include maintenance of BLS/CPR/AED certification – 4 hours;~~

(e) Chiropractic assistant – 6 hours which must include the following:

(A) Cultural competency – 1 hour;

(B) ~~General continuing education, which must include maintenance of BLS/CPR/AED certification – 5 hours.~~Maintenance of Basic Life Support (BLS) for Healthcare Providers or its equivalent as determined by the Board – up to 6 hours accepted towards general continuing education requirement;

(C) General continuing education – 5 hours.

(f) The Board may require additional specific courses as part of a licensee's annual renewal hours for an upcoming license or certificate period.

(3) Continuing education course or activity hours must be completed during the preceding license or certification period. A licensee may not claim more than 20 hours of continuing education completed in one 24-hour period. Courses shall not be taken simultaneously. Each licensee shall maintain records to support the attestation of completed hours.

(4) Courses or activities determined by licensees to meet the criteria herein are presumed to be approved until or unless specifically disapproved by the Board. Licensees will be informed of any disapproved courses in a timely manner. The Board will maintain a list of disapproved courses available for review by licensees.

(5) Any chiropractic physician who is also actively licensed in a healthcare profession with prescriptive rights is exempt from the over-the-counter, non-prescriptive substances requirements.

(6) Any chiropractic physician changing license status from inactive to active or senior active shall take the required hours referenced in section (2). It shall be within the Board’s discretion to determine, on a case-by-case basis, the required continuing education based on the time away from active status.

(7) Approved continuing chiropractic education shall be obtained from courses or activities which meet the following criteria:

(a) They do not misrepresent or mislead;

(b) They are presented by a chiropractic physician, licensed here or in another state, other appropriate health care provider, or other qualified person;

(c) They exclude practice-building subjects and the primary purpose of the program may not be to sell or promote a commercial product. However, the mere mention of practice-building concepts shall not disqualify a program’s eligibility for CE credit.

(d) The material covered shall pertain to the practice of chiropractic in Oregon or be related to the licensee's specific practice;

(e) Continuing education hours for Board activities must assist in assuring the competence and skills of the licensee; and

(f) Shall be quality courses or activities adequately supported by evidence or rationale as determined by the Board.

(8) The Board may accept a maximum of 6 credit hours from each of the following categories:

(a) Being an original author of an article, published in a peer reviewed journal, given in the year of publication;

(b) Participation in a formal protocol writing process associated with an accredited health care institution or state or government health care agency;

(c) Participation as an OBCE board member or on an OBCE committee;

(d) Participation on a National Board of Chiropractic Examiners' (NBCE) examination or test writing committee;

(e) Participation in a research project, approved by the Board, related to chiropractic health care directed by an educational institution or other qualified chiropractic organization;

(f) Teaching courses at an accredited health care institution;

(g) Teaching chiropractic continuing education courses;

(h) Professionally licensed staff of the OBCE; and

(i) Professionally licensed non-board member attending public OBCE board meetings. Each meeting, the attendee will be given a maximum of 2 hours.

(9) The Board may accept credit hours from courses, seminars, or other activities. Completion of other activities as chiropractic continuing education is defined as follows:

(a) Continuing medical education (CME);

(b) Video or pre-recorded continuing education courses or seminars, unless specifically required by the Board to be taken in person;

(c) Successful completion of online or in-person college courses related to chiropractic health care taught at an educational institution; and

(d) BLS/CPR/AED courses.

(10) All licensees are required to keep full, accurate, and complete records:

(a) A verification of attendance for all CE courses or activities showing hours claimed for renewal credit, and or proof of completion signed by the sponsor and licensee.

(b) Video or pre-recorded courses shall be supported through record-keeping with a letter, memo, or on a form provided by the Board, that includes the dates and times, vendor’s or presenter’s name/s, total hours claimed for each course, location, and includes the following statement: “I swear or affirm that I

viewed or listened to these continuing education courses in their entirety on the dates and times specified in this report."

(c) A copy of a published article including the date of publication;

(d) A written record of hours in clinical protocol development and research projects. The record shall include the names and addresses of the institutions involved, name of supervisors, and their signatures verifying hours.

(e) For licensees claiming CE hours under the provisions of (8)(d), for participation on a Board committee, or assisting with a National Board of Chiropractic Examiners' (NBCE) examination or NBCE test writing committee, certification from the Board or NBCE.

(f) For licensees claiming CE hours under the provisions of (8)(f), a record of employment by health care institutions, signed by their supervisor, a copy of the course syllabus if applicable, and verification of hours.

(g) For licensees claiming CE hours under the provisions of (8)(g), licensee shall obtain and keep verification of the course taught including, the dates of the course, a syllabus and the sponsoring organization.

(11) The Board will generate a random computer list of a minimum of 10% or up to 100% of renewing licensees, who will have their CE records audited and reviewed to ensure compliance with this rule. Licensees shall respond to this request within 30 days by supplying the Board with verification of their CE courses or activities.

(12) Any licensee who has submitted inadequate, insufficient, or deficient CE records or who otherwise appears to be in noncompliance with the requirements of this rule will be given written notice by the Board and will have 30 days from the date of notice to submit additional documentation, information or written explanation to the Board establishing the licensee's compliance with this rule. The Board may issue civil citations for noncompliance of this rule.

(13) At its discretion, the Board may audit, by attendance, the content of any program in order to verify the content thereof. Denial of an audit is grounds for disapproval.

(14) Any licensee seeking a hardship waiver from their continuing education requirements shall apply to the Board, in writing, as soon as possible after the hardship is identified and prior to the close of licensure for that year. Specific details of the hardship must be included. In order to approve an application for a hardship waiver, the Board, within its discretion, must find that such hardship exists.

(15) The Board shall maintain and make available, through its web page and electronic communications to licensees, a list of disapproved courses, if any. The Board may disapprove a course or CE activity after giving the sponsor and/or licensees the opportunity to provide additional information of compliance with the criteria contained in this rule, and opportunity for contested case hearing under the provisions of ORS 183.341, if requested. Any CE sponsor or licensee may request the Board to review any previously disapproved course at any time.

Statutory/Other Authority: ORS 684.155
Statutes/Other Implemented: ORS 684.092

811-010-0093
Guide to Policy and Practice Questions

The Board's Guide to Policy and Practice Questions, originally dated January 14, 1998, and last revised ~~September~~ February 22~~17~~, 202~~1~~1, is hereby adopted.

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.150 & 684.155

PURNELL Mackenzie G * BCE

From: PURNELL Mackenzie G * BCE
Sent: Thursday, June 16, 2022 6:27 AM
To: PURNELL Mackenzie G * BCE
Subject: FW: Spinal screening

From: KAWAOKA Craig * BCE <craig.kawaoka@obce.oregon.gov>
Sent: Wednesday, June 15, 2022 3:57 PM
To: MCLEOD-SKINNER Cass * BCE <Cass.MCLEOD-SKINNER@obce.oregon.gov>
Subject: Spinal screening

Cass,

I had a question about spinal screening at a yoga studio (volunteer) and what consent/paperwork is needed. I just looked at our P&P and it states spinal screening is a non-diagnostic exam. Does this mean the DC does not need a progress note or informed consent and can just provide opinion and recommend further workup in the office? I know that's what was done in CA for marketing purposes.

Thanks,
c

Craig Kawaoka, DC, MEd
Healthcare Investigator
Oregon Board of Chiropractic Examiners
530 Center St NE, Suite 620
Salem, OR 97301
O: 503-373-1848
C: 971-301-0745
craig.kawaoka@obce.oregon.gov

Spinal Screening Affecting Rules & Statutes

811-015-0066: Telehealth

Oregon Secretary of State Administrative Rules

OBCE_Telehealth_Policy-n-Procedures_03-29-2020.pdf (oregon.gov)

811-015-0070 (2), (a): Scope of Practice Regarding Examinations, Tests, Substances, Devices and Procedures

Oregon Secretary of State Administrative Rules

OCPUG: Examination and diagnostic procedure (C), (6) Postural Analysis

OCPUG Full doc_05-19-20-22.pdf (oregon.gov)

P & P: Page 17 Spinal (Postural) Screening

Guide_to_Policy_Practice.pdf (oregon.gov)

Chart Note Template: Page 2 Postural and Ambulation assessment

OBCE_Chart_Note_Guide_and_Templates.pdf (oregon.gov)

811-010-0110
Chiropractic Assistants

(1) The certification period for chiropractic assistants in Oregon is a period equal to 12 months, expiring on the last day of the chiropractic assistant's birth month/renewal date.

(2) Chiropractic assistants may be certified upon compliance with the following:

(a) The chiropractic assistant applicant shall successfully complete a Board approved training course. The initial training course shall be at least twelve hours in length, of which eight hours shall be didactic training and four hours shall be practical training.

(A) The practical training must be in physiotherapy, electrotherapy and hydrotherapy administered by a health care provider licensed to independently provide those therapies.

(B) A chiropractic physician may perform the initial practical training provided this is direct contact time.

(C) The initial training must have been completed within 60 days preceding the application submission date.

(b) The applicant shall complete an application packet, and an open book examination administered by a national testing agency.

(c) If an applicant has a certificate or license from another state and adequate documentation of training, the Board may waive the requirement for the initial training course.

(3) Prior to initial certification, the training course verification form, completed application packet, passing examination results, and fees shall be submitted to the Board:

(a) A non-refundable application fee;

(b) A non-refundable examination fee; and

(c) An initial certification fee. A refund of the certification fee will only be allowed when requested within 60 days of the initial application.

(d) In circumstances beyond the applicant’s control the Board may determine to refund the fees or portion thereof.

(e) In the event the Board requires the NBCE chiropractic assistant examination in lieu of the Board's examination, the fee in subsection (b) will be waived.

(4) The Board shall maintain an incomplete application file for six months from the date the application was received; afterward, applicants will need to re-apply.

(5) The applicant shall be at least 18 years of age.

(6) The chiropractic assistant shall not perform electrotherapy, hydrotherapy, or physiotherapy until they receive a certificate from the Board.

(7) A chiropractic assistant shall be directly supervised by the licensed chiropractic physician at all times. The supervising licensed chiropractic physician must be on the premises.

(8) Only under the direct supervision of the licensed chiropractic physician the chiropractic assistant;

(a) may perform or provide physiotherapy, electrotherapy and hydrotherapy, the taking of vitals such as height, weight, blood pressure, temperature, pulse, respiration and/or body fat percentages, and other duties as described by the Board; and

(b) may not perform or provide physical examinations, taking initial histories, taking X-rays (unless properly licensed), interpretation of postural screening, performing manual muscle testing, or osseous adjustments or manipulations, or other tasks as prohibited by the Board.

(9) Chiropractic assistants shall report to the Board, in writing, their mailing address and place of employment. Notification of a change of mailing address or place of employment must be made within 10 days of the change.

(10) At least 30 days prior to the renewal date, the Board shall send the renewal notice to the chiropractic assistant at the last known mailing address, and/or email address.

(11) On or before the last day of the birth month, the chiropractic assistant shall submit to the Board the following:

(a) A completed renewal application and renewal fee;

(A) The renewal application may include a request for fingerprinting and a criminal background check with fees to be paid by the chiropractic assistant.

(B) Frequency of fingerprinting and criminal background checks will be determined by the Board.

(b) An attestation that the six hours of continuing education has been completed within the immediate 12 months prior to renewal date; and

(c) A completed OHA Healthcare Workforce Questionnaire; and

(d) As part of the annual registration, all licensees must complete the required health care workforce data survey and pay the fee established by the Oregon Health Authority pursuant to ORS 676.410.

(12) During the 30 day grace period immediately following the renewal date, the chiropractic assistant may continue to perform assigned duties, but must submit a completed renewal application, proof of continuing education, and payment of the renewal fee plus a delinquent fee.

(13) After the 30 day grace period, the chiropractic assistant shall not perform assigned duties until the renewal application, proof of continuing education, payment to the Board of the renewal fee and a delinquent fee are all submitted to the Board and approved.

(14) A chiropractic assistant has up to one year following their renewal date to renew and reinstate their certificate upon meeting the provisions of (12) and (13) above. After 12 months, a person must restart the application process.

(15) Continuing education programs may be comprised of subjects that are pertinent to clinical practices of chiropractic. Continuing education must meet the criteria outlined in OAR 811-015-0025 sections (8), (9) and (10). No continuing education hours may be carried over into the next renewal year. Evidence of

successful completion of six hours of continuing education during the 12 months preceding the renewal must be submitted upon request by the Board.

(16) The chiropractic assistant's certificate may be displayed in the chiropractic physician's office during the chiropractic assistant's employment, but is not required so long as the certificate is on file with the chiropractic physician’s office.

(17) The Board may refuse to grant a certificate to any applicant, may suspend or revoke a certificate, or may impose upon an applicant for certification or chiropractic assistant a civil penalty not to exceed $1,000 upon finding of any of the following:

(a) Cause, which is defined as, but not limited to, failure to follow directions, unprofessional or dishonorable conduct, injuring a patient, or unlawful disclosure of patient information. The supervising chiropractic physician is required to notify the Board, in writing, of any dismissal of a chiropractic assistant for cause within ten days. The Board shall determine if there is cause for action and shall be governed by the rules of the Board adopted pursuant to ORS Chapter 183;

(b) Conviction of a misdemeanor involving moral turpitude or a felony;

(c) Non-disclosure of misdemeanor or felony convictions; or

(d) Failure to notify the Board of a change of location of employment as required by these rules.

(18) Unprofessional or dishonorable conduct is defined as: any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic assistant performance; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a chiropractic assistant:

(a) Conduct that is prohibited as described in OAR 811-035-0019 Sexual Unprofessional or Dishonorable Conduct.

(b) Use of protected or privileged information obtained from the patient to the detriment of the patient.

(c) Violating section (8) of this rule;

(d) Charging a patient for services not rendered;

(e) Intentionally causing physical or emotional injury to a patient;

(f) Directly or indirectly engaging in threatening, dishonest, or misleading fee collection techniques;

(g) Soliciting or borrowing money from patients;

(h) Receiving a conviction of a crime for possessing, obtaining, attempting to obtain, furnishing, or prescribing controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs; illegally using or dispensing controlled drugs;

(i) Aiding, abetting, or assisting an individual to violate any law, rule or regulation intended to guide the conduct of chiropractic assistants or other health care providers;

(j) Violating the rights of privacy or confidentiality of the patient unless required by law to disclose such information;

(k) Perpetrating fraud upon patients or third party payors, relating to the practice of chiropractic;

(l) Using any controlled or illegal substance or intoxicating liquor to the extent that such use impacts the ability to safely conduct the assigned duties of a chiropractic assistant;

(m) Acting as a chiropractic assistant without a current Oregon certificate;

(n) Allowing another person to use one's chiropractic assistant certification for any purpose;

(o) Resorting to fraud, misrepresentation, or deceit in applying for or taking the certificate examination or obtaining a certificate or renewal thereof;

(p) Impersonating any applicant or acting as a proxy for the applicant in any chiropractic assistant certificate examination;

(q) Disclosing the contents of the certificate examination or soliciting, accepting, or compiling information regarding the contents of the examination before, during, or after its administration;

(r) Failing to provide the Board with any documents requested by the Board;

(s) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except attorney-client privilege;

(t) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or certification, or during the course of an investigation, or any other questions asked by the Board;

(u) Claiming any academic degree, or certification, not actually conferred or awarded;

(v) Disobeying a final order of the Board;

(w) Splitting fees or giving or receiving a commission in the referral of patients for services;

(x) Receiving a suspension or revocation of a certificate for a chiropractic assistant, or other license or certificate by any state based upon acts by the chiropractic assistant or applicant that describes acts similar to this section. A certified copy of the record of suspension or revocation of the state making that is conclusive evidence thereof.

(y) During a declared emergency, unprofessional conduct includes failing to comply with any applicable provision of a Governor’s Executive Order or any provision of this rule.

(A) Failing to comply as described in subsection (y) includes, but is not limited to:

(i) Operating a chiropractic entity required to be closed by a current Executive Order;

(ii) Providing chiropractic services at a business required to be closed by a current Executive Order;

(iii) Failing to comply with applicable Oregon Health Authority (OHA) guidance implementing a current Executive Order; and

(iv) Failing to comply with any OBCE guidance or rule implementing an Executive Order.

(B) No disciplinary action or penalty action shall be taken under this rule if the Executive Order alleged to have been violated is not in effect at the time of the alleged violation.

(19) Violations may be grounds for disciplinary action against the supervising chiropractic physician under ORS 684.100(9)

Statutory/Other Authority: ORS 684.155
Statutes/Other Implemented: ORS 684.054 & 684.155(c)(A)

811-015-0010
Clinical Justification and Standard of Care

An Oregon licensed chiropractic physician provides care for many conditions using a variety of therapeutic procedures, including but not limited to chiropractic adjustment and manipulation. There is one standard of care for all patients, irrespective of the condition, service, or advice provided. All chiropractic physicians licensed under ORS chapter 684 are subject to the following:

(1) Clinical justification, within accepted standards and understood by a group of peers, must be shown for all opinions, diagnostic, and therapeutic procedures. The singular accepted standard of care includes obtaining a history that informs the examination, conducting an examination that informs the diagnosis, and using the diagnosis to inform the management plan which includes relevant outcome markers.

(2) "Accepted standards" means skills and treatment which are recognized as being reasonable, prudent, and acceptable under similar conditions and circumstances.

(3) For neuro-musculoskeletal conditions, all initial and subsequent examinations performed by a chiropractic physician to determine the need for treatment shall include a functional chiropractic analysis. Some combination of at least two of the following PARTS exam constitutes a functional chiropractic analysis:

P — Location, quality, and intensity of pain or tenderness produced by palpation and pressure over specific structures and soft tissues;

A — Asymmetry of sectional or segmental components identified by static palpation;

R — The decrease or loss of specific movements (active, passive, and accessory);

T — Tone, texture, and temperature change in specific soft tissues identified through palpation;

S — Use of special tests or procedures.

(4) Chiropractic physicians shall treat their patients as often as necessary to allow for favorable progress. Evidence-based outcomes management shall determine whether the frequency and duration of curative chiropractic treatment is, has been, or continues to be necessary. Outcomes management shall include both subjective, or patient-driven, information as well as objective, provider-driven, information. In addition, treatment of neuro-musculoskeletal conditions outside of the Oregon Practices and Utilization Guidelines may be considered contrary to accepted standards. Chiropractic physicians treating outside of the Practices and Utilization Guidelines bear the burden of proof to show that the treatment, or lack thereof, is clinically justified.

(5) Copies of any independent examination report must be made available to the patient, the patient's attorney, the treating doctor, and the attending physician at the time the report is made available to the initial requesting party.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155

811-015-0066
Telehealth

(1) As used in this section, “telehealth” means a variety of methods, through the use of electronic and telecommunications technologies, for the distance delivery of health care services, including chiropractic services, excluding in-person services, and clinical information designed to improve the health status of a patient, and to enhance delivery of the health care services and clinical information.

(2) A chiropractic physician who is licensed by, and is in active status with, the Oregon Board of Chiropractic Examiners to practice chiropractic may use telehealth if:

(a) The use of telehealth is an appropriate manner in which to provide a chiropractic service;

(b) The chiropractic physician is providing a chiropractic service that is within the scope of practice of the chiropractic physician; and

(3) The use of telehealth as described in subsection (2) of this section is not an expansion of the scope of practice of chiropractic physicians. The use of telehealth establishes a doctor-patient relationship.

(4) The board shall treat a chiropractic service that is delivered by a chiropractic physician through telehealth as described in subsection (2) of this section the same as the board treats the chiropractic service when delivered in person. The board shall apply identical quality and practice standards to a particular chiropractic service regardless of the method of delivery of the chiropractic service.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155

811-015-0070
Scope of Practice Regarding Examinations, Tests, Substances, Devices and Procedures

(1) The Board may examine any diagnostic and/or therapeutic examination, test, substance, device or procedure (ETSDP) to determine its acceptability for patient care. The Board may require a chiropractic physician to provide information on any ETSDP for determination of its status, taking into account all relevant factors and practices, including, but not limited to: the practices generally and currently followed and accepted by persons licensed to practice chiropractic in the state, the teachings at chiropractic schools accredited by the Council on Chiropractic Education or its successor, relevant technical reports published in recognized journals, and the desirability of reasonable experimentation in the furtherance of the chiropractic arts and sciences.

(2) A chiropractic physician may use any diagnostic and/or therapeutic ETSDP which is considered standard. A standard diagnostic and/or therapeutic ETSDP is one in which one or more of the following criteria have been satisfied:

(a) Is taught or has been taught by a chiropractic school accredited by the Council on Chiropractic Education or its successor, or health professions' courses taught by regionally accredited colleges with subject matter that is within the scope of chiropractic practice and has not been disapproved by the Board; or

(b) Has been approved by the Board through the petition process:

(A) The petition requires a formalized agreement of 10% or more of the chiropractic physicians, holding an active chiropractic license in Oregon, attesting to the safety and efficacy of a particular ETSDP. The petition shall be submitted in writing to the Board by any party wishing to establish any ETSDP as standard. It is the responsibility of the petitioner to gather the required evidence and supporting statements. It is the sole responsibility and discretion of the Board to review the sufficiency of the evidence in the petition and to make a determination whether to concur and affirm the ETSDP as standard or to deny the petition. The Board may, but is not required to, hold a public hearing on any petition. The Board shall make its determination and reply to the petitioner within 180 days of receipt of the petition unless the Board and the petitioner mutually agree to extend the deadline.

(B) The petition shall specifically address the following issues:

(i) The kind of ETSDP that is the subject of the petition, i.e., whether it is an examination, a test, a substance, a device, a procedure, or a combination thereof;

(ii) A detailed description of the proposed ETSDP;

(iii) The clinical justification for the ETSDP;

(iv) A method for determining appropriate termination of care and/or consultation with other providers with special skills/knowledge for the welfare of the patient;

(v) Whether the proposed ETSDP is to be used by itself or used in addition to any other generally accepted or standard ETSDP;

(vi) A description of known or anticipated contraindications, risks, and benefits;

(vii) A description of any subpopulations for which greater risk or benefit is expected;

(viii) A description of any standard ETSDP for the equivalent condition together with its relative risks and benefits; and

(ix) An assessment of the expected consequences of withholding the proposed ETSDP.

(c) Is supported by adequate evidence of clinical efficacy as determined by the Board. In determining adequacy, the Board may consider whether the ETSDP:

(A) Has clinical justification;

(B) Has valid outcome assessment measures;

(C) Is supported in peer reviewed literature;

(D) Is consistent with generally recognized contraindications to chiropractic procedures; and

(E) The potential benefit outweighs the potential risk to the patient.

(3) A chiropractic physician may use any diagnostic and/or therapeutic ETSDP that has not met the criteria of subsections (2)(a) - (c) of this rule as investigational. It must show potential merit for effectiveness and be of acceptable risk. Documentation requirements are based on potential risk to the patient. All investigational diagnostic ETSDPs must include or be accompanied by standard diagnostic procedures until full Board approval is attained under the criteria cited in subsections (2)(a) - (c) of this rule. Nothing in this section is intended to interfere with the right of any patient to refuse standard or investigational ETSDPs. In determining risk, the Board may use the following criteria:

(a) For minimal risk procedures, defined as those which, when properly or improperly performed on the general population, would have a slight chance of a slight injury and, when properly performed on select populations, have an extremely remote chance of serious injury:

(A) Informed consent is suggested but not required; and

(B) The chiropractic physician is recommended, but not required, to participate in or conduct a formal investigation of the procedure.

(b) For low risk procedures, defined as those which, when properly performed on the general population have a slight chance of mild injury; when improperly performed on the general population have a mild chance of mild to moderate injury, and when properly performed on select populations have a remote chance of serious injury:

(A) Informed consent is required; and

(B) The chiropractic physician is recommended, but not required, to participate or conduct a formal investigation of the procedure.

(c) For moderate risk procedures, defined as those which, when properly performed on the general public have a significant chance of mild injury and a slight chance of moderate injury; when improperly performed on the general population have a slight chance of severe injury; and when properly performed on select populations have a slight chance of serious injury:

(A) Written informed consent is required; and

(B) The chiropractic physician is recommended, but not required, to participate or conduct a formal investigation of the procedure.

(d) For high risk procedures, those which, when properly performed on the general population have a significant chance of moderate injury and a slight chance of serious injury; when improperly performed on the general population have a significant chance of serious injury; and when properly performed on select populations have a significant chance of serious injury:

(A) Written informed consent is required; and

(B) The chiropractic physician is required to participate in or conduct a formal investigation of the procedure under the auspices of, or in conjunction with, any other health care professionals knowledgeable and competent in the care and treatment of potential serious injuries.

(e) Board approval is required of all moderate or high risk procedures.

(4) The Board shall maintain a list of ETSDPs which have been reviewed and have been determined to be unacceptable or approved as investigational.

(5) A chiropractic physician may not use any diagnostic and/or therapeutic ETSDPs which have been determined by the Board to be unacceptable.

Statutory/Other Authority: ORS 684
Statutes/Other Implemented: ORS 684.155

Oregon Board of Chiropractic Examiners	Effective Date: March 29, 2020 Date approved/ratified: March 29, 2020
Telehealth Policy and Procedure	

POLICY

OAR 811-015-0066, Telehealth Rule, allows Oregon licensed chiropractic physicians to utilize telehealth (electronic and telecommunication technologies) for the distance delivery of health care services and clinical information designed to improve the health status of a patient, and to enhance delivery of the health care services and clinical information.

The Board has determined that this rule applies to both existing and new patients. Chiropractic physicians can utilize telehealth for initial consultations and examinations provided that the following criteria and procedures are met, pursuant to all relevant administrative rules and statutes. Practitioners may want to seek guidance from their medical malpractice carriers and various coding authorities as to billing and other requirements.

PROCEDURES

1. Document telehealth visit start time.
2. Establish and document the reason for visit.
3. Establish and document primary complaint(s).
4. Ascertain if, after #2 and #3 above, a telehealth visit is possible. If so, go to #5.
5. Take and document personal, family, and medical histories.
6. Perform visual evaluations and document:
    a. patients self-report height, weight, blood pressure, and pulse, if possible;
    b. nutritional/dietary assessment;
    c. postural analysis;
    d. range of motion; and
    e. any contraindications to providing services via telehealth.
7. Document and provide patient a provisional diagnosis.
8. Document and provide patient a report of findings.
9. Document and provide patient a PARQ and obtain consent to provide care/treatment.
10. Document and provide patient clinical recommendations.
11. Document telehealth visit end time.

OREGON BOARD OF CHIROPRACTIC EXAMINERS

GUIDE TO POLICY & PRACTICE QUESTIONS

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Updated/Adopted: 2/22/2022

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SECTION I
Devices, Procedures, and Substances

DEVICES

BAX 3000 AND SIMILAR DEVICES

The BAX 3000 is marketed as device to diagnose and treat allergies and food sensitivities. The device was reviewed by the OBCE's ETSDP Committee and on January 17, 2013, this policy was adopted by the OBCE in accordance with the ETSDP rule.

The BAX 3000 and similar devices are disapproved (outside the scope) as a diagnostic procedure.

As a treatment modality, the BAX 3000 and similar devices are considered Investigational with Moderate Risk for use with chiropractic patients. This rating requires a written Informed Consent statement signed by the patient. This rating also recommends the chiropractic physician participate in or conduct a formal investigation of the procedure.

The written informed consent must at a minimum address or include:

- The risks of ingesting food or substances which may provoke an anaphylaxis reaction.
- A statement that the use of this treatment could cause an exacerbation.
- An acknowledgement that there is currently a lack of peer reviewed evidence and other evidence such as case studies.
- If the patient is to be part of a research or case study, consents to that participation.
- An understanding that this treatment is considered 'Investigational with Moderate Risk" by the Oregon Board of Chiropractic Examiners.
- This device/procedure is not used to diagnose allergies or other conditions and that other procedures are used for that purpose.

Chiropractic physicians using the BAX 3000 or similar devices must adhere to the OBCE's advertising rules and policies. They must refrain from making advertising claims which cannot be supported. (3/21/13)

BIOPTRON LIGHT THERAPY

The Bioptron Light Therapy Unit is approved by the FDA and the Board as a standard device. (3/16/95)

CPAP MACHINE, ORDERING

The Board determined that ordering a **CPAP** machine and/or a sleep study is within the DC's scope of practice; however, whether insurance will pay or not is another question.

CTD MARK I MULTI-TORSION TRACTION DEVICE

The CTD Mark I Multi-torsion Traction Device (used as part of the non-surgical **t**reatment for carpal tunnel syndrome) is approved. (4/20/95)

DYNATRON 2000
The Dynatron 2000 computerized muscle-testing device is a standard device for use by chiropractors in Oregon. The Board makes no assertion of its validity. The standard designation does not imply that use of the device is per se medically necessary. (5/15/97)

ELLMAN SS PELLEVE
This is a high frequency low temperature radio wave unit (or similar units), "utilized to tighten collagen within the skin non-invasively." Although this is not a laser procedure, it may be similar to the laser treatments for cosmetic purposes. On March 18, 2010, the OBCE referred this issue to the ETSDP committee for review. Previously in September 2009, the OBCE determined a similar device, Lam Probe 4000, was not to be used. (3/18/10)

ENERGY MEDICINE DEVICES
The OBCE receives periodic inquiries regarding so-called "energy" medicine devices which purport to use: "quantum mechanics" or "quantum biofeedback" or "nano-technology" or claims in any way to have thousands of "preprogrammed scenarios and library references organized into defined groups, which create quick and manageable patient assessments."

These are presumed to be outside the Oregon chiropractic scope of practice until such time the specific device is reviewed by the OBCE under the provisions of OAR 811-015-0070 (ETSDP rule) and determined to be either standard or investigational.

This includes the "Zyto" device, Quantum QXCI Bio-Resonance Device, and any other devices which are similar in operation to the EPFX-SCIO device (which was previously evaluated and found to be unacceptable). (5/27/10)

EPIPEN
Chiropractors are allowed to administer an Epi-pen to a person who is suffering from anaphylactic shock and unable to inject the Epi-pen by him/herself. In 2007, OBCE sponsored legislation which clarified in ORS 684.025 that chiropractic physicians may provide emergency first aid.

EPFX/SCIO DEVICE
The OBCE determined the EPFX/SCIO device is unacceptable for use by chiropractic physicians in Oregon. They also voted to consider this device again if there is a new USA-FDA, or new USA- FDA-IRB (investigational review board) clearance. *(UPDATE: Dec 2007 Seattle Times article, "FDA Bans Import of Unproven Machine.")*

The Board is concerned about this device's biofeedback features, which appear to be more passive than active. (active biofeedback being standard for chiropractic in Oregon). There is also real concern with the device's purported ability to recognize if not diagnose a huge number of conditions based on the body's response to micro current stimulation.

Following review by the ETSDP Committee, the OBCE spent numerous hours over the course of three meetings to review this device. This is the first time since the ETSDP rule was adopted in 1995 that an "unacceptable" determination has been the result of this review. For more information concerning this decision see the OBCE's public meeting minutes for February, March and May of 2007 on the Board's Web page.

EPI TOUCH ALEX HAIR REMOVAL DEVICE
EPI Touch Alex hair removal device is approved as a minimal risk investigational minor surgery procedure. (9/24/99)

INFRATONIC QGM DEVICE
This device is approved as investigational for treating neuro-musculoskeletal conditions only. (5/12/17)

MAGNETS
A review of magnets revealed a lack of quality clinical evidence either supporting or opposing the use of magnets for pain relief. Magnets are not prohibited for use by chiropractors. However, it would be inaccurate for anyone to represent that the Board has "approved" the use of magnets. (7/27/00)

MD PEEL MICRO-ABRASION DEVICE
The MD Peel Micro-abrasion device is approved as a minimal risk investigational minor surgery procedure. (9/24/99)

MICROCURRENT DEVICES
Chiropractors may prescribe micro-current devices to their patients. (9/19/94)

MICROLIGHT 830/COLD LASER THERAPY
The use of the Microlight 830 is taught at some chiropractic colleges, and is therefore considered "standard" in Oregon, and determined to be within the scope of chiropractic. (7/17/03) (Also see "Laser Light Therapy" under Section I – Procedures.)

PETROMETER
The instrument called the Petrometer, used to measure range of motion, is considered standard instrumentation already in use. (12/15/94)

TENS DEVICES
Chiropractors may prescribe TENS devices to their patients. (9/19/94)

TOFTNESS DEVICE
The Toftness device, banned by the FDA, may not be used. (6/22/95)

In January 1982, the United States District Court in Wisconsin issued a permanent nationwide injunction against the manufacturing, promoting, selling, leasing, distributing, shipping, delivering, or using in any way any Toftness Radiation Detector or any article or device that is substantially the same as, or employs the same basic principles as, the Toftness Radiation Detector. The United States Court of Appeals for the Seventh Circuit upheld this decision in 1984.

The basis of the United States Government's case was that these devices were misbranded under the Food, Drug and Cosmetic Act, because they could not be used safely or effectively for their intended purposes. Consequently, Oregon licensees should cease and desist using a Toftness or Toftness-like device. (1/17/91)

TRACTION DEVICES

The Board frequently receives questions from a variety of sources regarding traction, devices that accomplish traction, and billing.

The American Chiropractic Association (ACA) notes that for the purpose of billing 97012 mechanical traction is defined as:

> "…the force used to create a degree of tension of soft tissues and/or to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds) allowed, duration (time), and angle of pull (degrees) using mechanical means."[1]

There are a variety of devices on the market that potentially provide traction. Chiropractors should investigate the device, the intent of the manufacturer, and any FDA approvals for its use. If the device is capable of providing traction, the chiropractor should ensure that the device is properly used to affect the desired goal.
The Board does not issue opinions or rulings regarding coding or billing questions. The Board encourages all Oregon Chiropractors to analyze whether the methods they employ meet the above ACA definition, and whether the specific device and that manner in which it is utilized provides traction.
The Board always reminds doctors to ensure that their notes with regard to this and all treatments should be maintained in compliance with Oregon Administrative Rule 811-015-0005(1)(C). (9/17/15)

PROCEDURES

ACUPUNCTURE
The Board has determined that needle acupuncture is outside the Oregon chiropractic scope of practice. (ORS 684.035, Chapter not applicable to other methods of healing)

ACUPUNCTURE USED AS ANESTHESIA FOR MANIPULATION
(See Also Manipulation Under Anesthesia)
MUA is specific to hospital setting. There are no specific statutes or rules concerning the use of acupuncture as the anesthetic. The Board suggests writing the Board of Medical Examiners to get their views on this subject. (4/16/92)

ALLERGIES
The scope of practice for a Doctor of Chiropractic allows for the treatment of allergies.

APPLIED SPINAL BIOMECHANICAL ENGINEERING (ASBE)
The Board determined that ASBE is investigational and must comply with the investigational rule and the rule on informed consent. Chiropractors using ASBE must register their use of this technique with the Board of Chiropractic Examiners. Patients must be informed that the technique is considered investigational and consent must be in writing to its use in their case.

AURICULOTHERAPY
After review by the ETSDP Committee and a recommendation to the Board, the Board has determined that auriculotherapy, the device used and the therapy, is standard. The therapy is performed without needles; it is a form of electro acupuncture. The procedure has been taught in CCE colleges. (11/16/06) This topic was revisited by the board and it confirmed that this therapy is part of the scope of chiropractic practice. (12/17/12)

AUTOMATED MUSCLE TESTING
The Board determined that automated muscle testing is within the scope of practice and is

[1] American Chiropractic Association, Coding Clarification 97012, Mechanical Traction/Spinalator

accepted in the P & U Vol. I Guidelines. A chiropractor needs to show rationale for using automated muscle testing. (9/21/95)

BIOFEEDBACK
Chiropractors may order or perform biofeedback. (4/15/96)

BLOOD PRESSURE (SUPINE AND STANDING)
Supine and standing blood pressure are within the scope of chiropractic practice. (11/21/91)

BLOOD WITHDRAWAL
See VENIPUNCTURE

BLOODBORNE PATHOGENS - STANDARDS, PROCEDURES
Effective July 1992, Oregon Occupational Safety and Health Division (OR-OSHA) adopted the Federal standard on Bloodborne Pathogens. Oregon Chiropractors are required to implement the standards in their clinics.

Oregon OSHA has adopted the Federal OSHA Final Standard on Bloodborne Pathogens. The purpose of the standard is to limit and control occupational exposure to blood and other potentially infectious materials. This law covers all employees who could reasonably be expected to come in contact with human blood or other potentially infectious materials in the course of their work. Therefore, if you employ people in your clinic that may be subject to exposure to blood or other bodily fluids, this law may have a direct effect on you. IT IS YOUR RESPONSIBILITY TO DETERMINE IF THIS LAW APPLIES TO YOU. The staff of the Oregon Board of Chiropractic Examiners does not have the expertise to advise you in matters related to this law.

Call or write OR-OSHA (Salem Central Office, 350 Winter St. NE, Rm. 430, Salem, OR 97310 (503) 378-3272 or 1-800-922-2689. Request Oregon Administrative Rule 437-Division 2, Bloodborne Pathogens (1910.1030) and/or Questions & Answers About Bloodborne Pathogens.

BREAST THERMOGRAPHY
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.

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.

Any chiropractic clinic providing breast thermography imaging must use the informed consent form (Appendix C). 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.

COLONICS OR COLONIC THERAPY
The board restated its previous policy in that they determine colonic therapy is hydrotherapy, and is allowed within the scope of chiropractic practice, but CCAs are not allowed to perform it due to the higher risk of the procedure. There are inherent risks, such as causing septic shock by rupturing the bowels. (9/28/07) (9/15/14)

CONTACT REFLEX ANALYSIS
Contact reflex analysis is within the scope of chiropractic practice. (4/21/94) CRA was reviewed in 2009 and its current position as standard was not changed. (05/21/09)

CRANIOSACRAL MANIPULATION
As part of Craniosacral Therapy, Craniosacral Manipulation is a standard chiropractic procedure. (1/21/93)

CUPPING
Cupping is a type of myofascial release; it is taught in accredited chiropractic colleges. The Board determined that cupping is allowed within the DC scope of practice. No determination was made on the types of cup used. (9/22/16)

DARK FIELD MICROSCOPY
Although the general use of dark field microscopy is allowed within the scope of chiropractic, Licensees may not use dark field microscopy for the purposes of conducting live cell analysis. (1/23/14)

EKGS
Chiropractors may order or perform EKG's. (4/15/93)

ELECTRODIAGNOSTIC TESTING (SSEP)
Performing an SSEP electrodiagnostic test is within the scope of chiropractic practice. (1/18/96)

ELECTROLYSIS
This procedure was reconsidered by the Board. "A person uses an electrical device that is not used for physical therapy. The tissue is destroyed so the hair does not grow back. It is a surgical intervention where you are changing the tissue type." The Board determined that electrolysis (i.e. removal of hair) is a minor surgical procedure and requires specialty certification by the Board to perform. (11/20/03)

ELECTROTHERAPY
Chiropractic Physicians may treat hemorrhoids with electrotherapy, specifically, the application of negative low voltage galvanic current (known as the Keesey technique) to the hemorrhoid. ORS Chapter 684.010(2)(a) and (5).

This therapy is approved and is considered as standard in the above-described manner and shall not be considered investigational by the Board. The Board recognizes that undergraduate and postgraduate courses at Western States Chiropractic College, a Council on Chiropractic Education accredited school, have included the teaching of this therapy for more than thirty years. (3/25/91)

EMG AND SURFACE EMG TESTING
Any trained individual, including certified chiropractic assistants, may apply electrodes and conduct surface EMG testing, but the doctor has to interpret the results. (11/16/95**,** 7/18/96)

EPLEY MANEUVER
The Oregon Board of Chiropractic Examiners confirms that the Epley Maneuver as a Canalith repositioning procedure for treatment of benign paroxysmal positional vertigo (BPPV) is well within the Oregon chiropractic scope of practice.

These procedures are taught in chiropractic colleges and addressed in the EENT (eye, ear, nose, and throat) courses required in chiropractic colleges.

Further coding for this procedure is addressed the American Chiropractic Association's *Chiropractic Coding Solutions Manual.* See http://www.acatoday.org/content_css.cfm?CID=3204 for more information on this subject. (05/22/12)

FISSURECTOMY
This procedure is within the scope of practice for chiropractic physicians in Oregon. (1/28/92)

GALVANIC ELECTRICITY
See ELECTROTHERAPY

HEMORRHOIDS (TREATMENT OF)
See ELECTROTHERAPY

INJECTIONS
Can a licensee refer a patient to an MD for an injection (e.g. to a facet joint for pain relief) without the MD having to evaluate the patient him or herself?

The Board determined that a licensee may refer to the MD for the examination, but it is up to the MD to determine whether he/she needs to perform an additional examination and how to proceed. (11/9/00)

IMMEDIATE RELEASE TECHNIQUE (IRT) / RAPID EYE TECHNIQUE
Recently the ETSDP committee recommended, and the OBCE accepted that IRT (Immediate Release Technique) may be used by Chiropractors under the investigational rule (reference below). IRT involves eye exercises combined with forms of acupressure and chiropractic adjusting. The eye exercises are shown to affect brain activity that can alter pain states. There is a growing amount of clinical correlation showing that the brain function changes can/may change endocrine function associated with stress states. The military is investigating use of similar treatment procedures with veterans suffering with PTSD (post-traumatic stress disorder).

However, RET (Rapid Eye Technique), a technique that extends the treatment time and complexity to involve psychological counseling, is counseling/psychology and is NOT a chiropractic procedure. The OBCE will allow RET courses as continuing education similar to other adjunct treatment education, such as OHSU programs on surgical procedures. (May 2008)

KEESEY TECHNIQUE
See ELECTROTHERAPY

KINESIOTAPING METHOD
May a certified Chiropractic Assistant perform "kinesiotaping"? The kinesiotaping Method involves taping over and around muscles in order to assist and give support to, or prevent, over-contraction. The Board determined if the supervising DC is trained in the taping method, that he or she may also train the certified CA also to perform the method in the clinic, and only while the

DC is on premise. The Board considers this a physiotherapy. (3/15/07)

LASER LIGHT THERAPY

A variety of low-level laser and light therapy (LLLT a.k.a. phototherapy) is available to Oregon chiropractic physicians as a standard treatment for NMS conditions. University of Western States (UWS) and other chiropractic colleges have current core curriculum on this subject. In addition, UWS is continuing work on future curriculum to cover advances and new applications in technology of this field. LLLT has been used to speed wound healing, stimulate tissue repair, reduce swelling and edema, and reduce acute and chronic pain. LLLT has been popular in Europe and Asia. More recently, in 2002, the United States FDA granted 510 (k) clearances allowing for healing and pain relief with various soft tissue disorders including carpal tunnel, rheumatoid arthritis, bursitis, tendonitis and more.

The OBCE approves and affirms, as standard use, Class I through IV lasers/phototherapy for use by chiropractors as well as certified chiropractic assistants who have been properly trained for their use.

The OBCE also approved use of Class IIIb & IV "hot" lasers for use by chiropractic physicians to treat NMS conditions. Expect requirements for DCs to obtain certification limited to treatment of benign superficial lesions, lacerations/abrasions, and removal of superficial foreign bodies.

Chiropractors and chiropractic assistants must be properly trained for use of all LLLT. Training is usually available from the vendors of these devices. Class IIIb for NMS conditions does not require detailed special training other than provided by vendors, however use of Class IV devices requires strict adherence to safety protocols. Minor surgery training should be more extensive.

Phototherapy involves the application of specific wavelengths of light energy capable of penetrating into tissue and being absorbed by cells. Light energy can be produced by low level laser and/or super luminous diodes (SLDs). Sufficient energy must be delivered to target tissue to trigger a response. Light is absorbed by irradiated tissue where the light energy is transformed into biochemical energy, which is then available for photochemical cell activities.

The FDA has classified lasers into six categories based on their potential damage to the eye. They are:

- Class 1: Safe to human eye or contained within device, no labeling required.
- Class 2: Low power lasers with output less than 1 mW. Labeled, "CAUTION – Laser Radiation: Do not stare into beam"
- Class 2a: Eye damage can occur if laser enters eye more than 1,000 seconds. Labeled: "CAUTON- Laser Radiation: Do not stare into beam"
- Class 3a: Power output up to 5 mW. Direct eye contact for short periods is not hazardous, but viewing laser through magnifying optics such as eyeglasses can present a hazard. Labeled: "CAUTON- Laser Radiation: Do not stare into beam or view directly with optical instruments."
- Class 3b: Involves certain risk. Laser output 5mW to 500 mW. Labeled "DANGER – Visible and/or invisible laser radiation – avoid direct exposure to beam."
- Class 4: High power lasers with output greater than 500 mW. Involves definite risk. Labeled "DANGER – Visible and/or invisible laser radiation – avoid eye or skin exposure to direct or scattered beam."

According to UWS instructor Joel Agresta PT, DC, a patient treated with Class IV must wear goggles. "Class IV lasers have great benefits if handled properly and can deliver more energy in less time, but proper training and understanding of the contraindications is imperative. As far as I understand, the manufacturers (i.e., K-Lasers and Avicenna) issue specific protocols that keep these lasers safe for NMS conditions. These protocols have some degree of safety built into them. By their nature they do require a higher level of safety precaution, but when following the programmed protocols it appears that they are safe."

He also said by law, Class III and above must be stored in a locked cabinet. Dr. Agresta says that "photo-biostimulation" stimulates or speeds up the inflammatory process and resultant healing when lower doses are used. However, he says that at higher doses starting around 100 to 200 Joules/cm^2 (Joules/cm^2 = power/beam area x time) inhibitory or negative effects may occur.

The ETSDP Committee and the OBCE reviewed a wealth of published clinical literature which documents many therapeutic applications of LLLT

The Board has received legal advice that LLLT for *purely cosmetic conditions*, such as hair removal, which do not address a skin condition or pathology, is not within the current scope of chiropractic practice. To the board's knowledge, this is not currently taught in any chiropractic college course. (If this changes, the OBCE can revisit this issue.)

In 2012 the Board asked whether it is "…within the scope of practice for a Doctor of Chiropractic in the state of Oregon to treat toenail fungus with laser therapy?" The Board confirmed this would be allowed, "as this is for treatment of a condition. Previous legal advice has advised the OBCE that use of lasers by chiropractic physicians for strictly cosmetic purposes is not within the chiropractic scope of practice, an example of this would be hair removal." (12/20/06; 9/28/07; 9/21/17)

LINGUAL ASCORBIC ACID TEST
Lingual ascorbic acid test is within the scope of chiropractic practice. (11/21/91)

MANIPULATION OF THE CERVICAL SPINE
Classic, diversified, and Gonstead-type manipulation of the cervical spine are standard procedures. Chiropractors may contact National Chiropractic Mutual Insurance Company for information on the risk factors of these procedures. (5/16/96)

MANIPULATION UNDER ANESTHESIA
Manipulation under Anesthesia <u>is</u> within the scope of practice for Chiropractic Physicians in Oregon. (1/28/92)

In review of this procedure, the Board found that Texas Chiropractic College teaches a continuing education course in Manipulation Under Anesthesia and offers a preceptorship program. The Board expects that hospitals involved with MUA will require proper training of Doctors of Chiropractic before allowing them to perform this procedure.

N.A.E.T. NAMBUDRIPAD ALLERGY ELIMINATION TECHNIQUE
After reviewing the details of this technique, the Board determined that, as described, it is allowable within the scope of chiropractic practice in Oregon, excepting the application of needle acupuncture. (12/19/00)

NASAL SPECIFICS
Chiropractors may not use local anesthesia for performing nasal specifics. (5/16/96)

NCV - NERVE CONDUCTION VELOCITY
(performed by a technician)
Chiropractors in Oregon may order or perform nerve conduction velocity testing. Recently the Board was asked if there is any licensure requirements for a technician who performs this test on behalf of the chiropractor and/or testing service. They determined that no special certification is required by chiropractors or any other trained person to perform NCV testing in Oregon (technical component only).

That said, the Board does have serious concerns due to persistent reports of testing services that charge excessive fees. The Board also has concerns with reports it has received regarding the billing practices associated with NCV and other kinds of diagnostic testing. The Board advises that these tests should meet basic criteria of medical necessity. (04/01)

OUTPATIENT AND RADIOLOGICAL TESTS
Chiropractors may order outpatient laboratory and radiological tests from hospitals. A chiropractor may order any test a hospital has available. (5/16/96)

PARASPINAL SURFACE EMG
Paraspinal surface EMG is within the scope of practice. (8/20/92)

POSTURAL SCREENING
See SPINAL (POSTURAL) SCREENING

PULMONARY STUDIES
Ordering pulmonary studies is within the scope of chiropractic practice. (9/21/95)

QUANTITATIVE FUNCTIONAL CAPACITY EVALUATIONS (QFCE).
QFCEs are not within the chiropractic assistant scope of practice. The QFCE requires the doctor's clinical judgment for evaluation and performance. CAs do not have the required training for this. The board also determined that QFCEs may not be performed by a Certified Strength and Conditioning Specialist (CSCS) under the OBCE's "Any Trained Person" policy, thus a CSCS may not perform this as part of the chiropractic clinic's services in or out of the clinic. The QFCE has to be performed by the chiropractic physician (or other licensed health provider within their scope of practice). (3/21/13)

RANGE OF MOTION REPORTING
When reporting range of motion (ROM) measurements, the method of measurement should be noted, e.g. visual, goniometer, or inclinometer (single or double). The preferred method of measurement is with the goniometer in the extremities and the double inclinometer in the spine. Effort should be made to obtain reproducible measurements. (1/16/97)

RAPID EYE TECHNIQUE (RET)
See Immediate Release Technique in this section above (May 2008)

RAST TESTING
RAST Testing is within the scope of practice. (6/18/92)

REIKI (Also see Reiki under Chiropractic Assistants)
A Doctor of Chiropractic asked if his certified Chiropractic Assistant may practice Reiki, a form of massage therapy, in his office without his supervision. The Board determined that the certified CA may perform this type of massage ONLY if the supervising DC is also Reiki trained, and on

premise to supervise. If the certified CA, trained in Reiki, is also an Oregon licensed massage therapist, then that is already allowed with the LMT scope of practice. (3/15/07)

SOLKOWICH CALCIUM ABSORPTION AND UTILIZATION
Solkowich calcium absorption and utilization are within the scope of chiropractic practice. (11/21/91)

SOMATIC TECHNIQUE
The Board approved the somatic technique as a standard technique. Somatic technique is a neuromuscular reeducation or active muscle relaxation technique. It is taught at Palmer College West. (10/17/96)

SPINAL (POSTURAL) SCREENING
Any properly trained person may do postural screening under the onsite supervision of a chiropractic physician, but only a chiropractic physician may interpret the information. A postural screening is a non-diagnostic exam, which does not include any treatment. (9/18/97)

SPUTUM ALCOHOL TESTING
Chiropractors may perform sputum alcohol testing. (5/15/97)

STRESS TESTS
Stress tests (e.g. Koningsberg) are within the scope of chiropractic practice. (11/21/91)

TMJ (TEMPOROMANDIBULAR JOINT)
Chiropractors may treat TMJ. (12/14/95)

TRIGGER POINT INJECTIONS (MYOFASCIAL)
Are Oregon licensees who have completed the postgraduate certification in minor surgery able to perform myofascial trigger point injections?

The Board determined that injection of myofascial trigger points is a therapy, and as such is not within the Oregon chiropractic scope of practice. In addition, the injection is more than "superficial" and thus is not covered by the minor surgery provisions. (12/11/02)

ULTRASOUND, DIAGNOSTIC
Appropriately trained Doctors of Chiropractic may provide musculoskeletal diagnostic ultrasound.
(9/17/15)

ULTRASOUND, THERAPEUTIC
Therapeutic ultrasound is within the scope of chiropractic practice. (8/19/93)

URINALYSIS
Urinalysis is allowed within the scope of chiropractic practice. (11/21/91)

VENIPUNCTURE
Chiropractors are allowed to draw blood (venipuncture) for diagnostic testing purposes. This diagnostic testing procedure is taught in approved chiropractic colleges all over the United States. (10/24/96)

> ORS 684.010(2)(b) defines "Chiropractic" as "The chiropractic diagnosis, treatment and prevention of body dysfunction; correction, maintenance of the structural and functional integrity of the neuromusculoskeletal system and the effects thereof or interferences

therewith by the utilization of all recognized and accepted chiropractic diagnostic procedures and the employment of all rational therapeutic measures as taught in approved chiropractic colleges."

ORS 684.025(2) states: "Nothing in this section or ORS 684.010 shall be interpreted as authorizing the administration of any substance by the penetration of the skin or mucous membrane of the human body for a therapeutic purpose."

Further legal advice from the Oregon Attorney General confirms that "Chiropractic physicians are accordingly authorized by law to withdraw blood or other fluid samples for diagnostic purposes in connection with the practice of chiropractic." (9/9/70)

SUBSTANCES

ALOE VERA GEL (FOR ORAL CONSUMPTION AND/OR TOPICAL USE)
Chiropractors may recommend aloe vera gel. (1/21/93)

AQUA-SOOTHE
This product is within the scope of practice, but the Board does have concerns about proper billing. (1/21/93)

BOTANICALS
Non-prescription botanicals are within the scope of chiropractic practice. (5/18/95)

CLINICAL NUTRITION
Applied clinical nutrition is within the scope of practice. See ORS 684.010. (4/21/94; 9/18/97)

COLLOIDAL SILVER; SILVER
Previous OBCE policy stated, "Licensed chiropractors may create their own colloidal silver and sell it to their patients…(3/19/98)" As of January 17, 2013, this is revised due to concerns that the oral ingestion of silver runs the risk of causing argyria, a serious skin condition, and other less common health problems.

New Policy: Chiropractic physicians may not create their own colloidal silver for ingestion purposes and/or retail this to their patients from this point forward. (i.e. outside scope as per the ETSDP rule). Chiropractic physicians creating their own solutions may only use these for topical use.

Both the National Center for Complementary and Alternative Medicine and the Food and Drug Administration have issued strong warnings and alerts that focus on oral ingestion of silver compounds.

Topical uses of silver as taught and utilized in chiropractic colleges is within the Oregon chiropractic scope of practice. Even given the potential for absorption of silver across the mucous membranes, the occasional use of intranasal Argyrol applications for sinusitis would not result in a dose that remotely approximates the chronic oral Reference Dose (RfD – 5 mg/kg of body weight/day) of silver established by the EPA as a risk for developing argyria.

Also allowed is multi-mineral formulations which include small doses of colloidal silver below the allowable EPA limits. (01/17/13)

ETHYL CHLORIDE
This product may not be used or purchased by chiropractors in Oregon. (7/16/92)

FLUORI-METHANE
Fluori-methane is not in the Physician's Desk Reference (PDR); however, according to the Oregon Board of Pharmacy it is a prescription legend drug. This product may be used as a topical anesthetic in minor surgery ONLY, within the chiropractic profession in Oregon. (7/16/92)

FORMULA 303
Chiropractors may recommend Formula 303 to patients, because it is an herbal. (8/20/92)

HCG POLICY
Use of HCG (Human chorionic gonadotropin) - "homeopathic" or otherwise - is outside the Oregon chiropractic scope of practice. The U.S Food and Drug Administration (FDA) and Federal Trade Commission (FTC) have taken action to remove "homeopathic" HCG weight loss products from the market. Their advisory issued December 11, 2011 states,

> "The labeling for the "homeopathic" HCG products states that each product should be taken in conjunction with a very low calorie diet. There is no substantial evidence HCG increases weight loss beyond that resulting from the recommended caloric restriction. Consumers on a very low calorie diet are at increased risk for side effects including gallstone formation, electrolyte imbalance, and heart arrhythmias.
>
> "These HCG products marketed over-the-counter are unproven to help with weight loss and are potentially dangerous even if taken as directed," said Ilisa Bernstein, acting director of the Office of Compliance in FDA's Center for Drug Evaluation and Research. "And a very low calorie diet should only be used under proper medical supervision."

03/27/12

HOMEOPATHICS, OVER-THE-COUNTER
The Board addressed a series of questions regarding Over-the-Counter (OTC) homeopathic products (prepackaged for use by the consumer).
Question: May the DC give the patient a dose from that vial? Answer: Yes.
Question: Send the patient home with a dose from that vial? Answer: Yes.
Question: Place a pellet of the over-the-counter remedy in a vial with water to be administered to an infant? Answer: Yes.
Question: - Or, must I sell them the entire vial of the remedy? Answer: No.

INTRADERMALS
Intradermals for allergy testing are within the scope of practice. (5/19/94)

04/11/1996
INJECTIONS
This may be used in minor surgery only.

MATOL AND FIBER SONIC (FIBER SUPPLEMENT)
This supplement is OK to recommend. (1/21/93)

MYOCIDE
The use of myocide is within the scope of chiropractic practice (OTC).

NUTRITIONAL SUPPLEMENTS
Question: May a chiropractic clinic obtain nutritional supplements from a multilevel marketing company?
Answer: DCs may obtain their nutritional supplements from any retail or wholesale source. However, engaging in multi-level marketing to patients is a different matter. If a chiropractic physician were to recruit patients to sell product and thus earn a commission, that could be in violation of the Board's rule on fee-splitting (OAR 811-0035-1015 (24). If the DC merely obtains and retails the product to patients, that is not multi-level marketing or fee-splitting.

ORIENTAL HERBS
The use of herbs is allowed within the scope of practice in Oregon. (5/19/94)

OVER-THE-COUNTER NON-PRESCRIPTION DRUGS
"Over-the-counter substances" means the same thing as "nonprescription drugs." The Board has adopted the Board of Pharmacy's definition of nonprescription (over-the-counter) drugs which is:

> ORS 689.005(22) "Nonprescription drugs" means drugs which may be sold without a prescription and which are prepackaged for use by the consumer and labeled in accordance with requirements of the statutes and regulations of this state and the Federal Government. (9/18/97)

OVER-THE-COUNTER SUBSTANCES, DOSAGES
In response to a question regarding whether the statutes or rules allow chiropractors to prescribe or recommend over-the-counter substances in higher doses to achieve a more therapeutic or beneficial dosage, the Board's response is: Chiropractors must follow the statute. The statute is based on substances, not dosages. Chiropractors must use their best clinical judgment. (1/18/96; 7/9/98)

Additional "dose-related questions were posed to the Board: 1) May a licensee give the patient a dose from an OTC/homeopathic preparation? Yes. 2) Send the patient home with a dose from that vial? Yes. 3) Place a pellet of the over-the-counter remedy in a vial with water to be administered to an infant? Yes 4) Or must I sell them the entire vial of the remedy? No. (10/5/10)

OXYGEN (NOT allowed for therapeutic purposes)
Medical oxygen is outside the chiropractic scope of practice, and chiropractic physicians may not prescribe oxygen for therapeutic purposes. (4/27/00) (3/16/06)

Concentration, oxygen
The Oregon Board of Pharmacy considers USP (medical) Oxygen (100%) a prescription drug. However oxygen concentrated at a lower percentage (90 to 95%) does not require a prescription. With that understanding, the OBCE does not prohibit oxygen concentration or the devices which produce this by chiropractic physicians. However, it would be inaccurate for anyone to represent that the Board has "approved" the use of oxygen concentration. Similar precautions as indicated for emergency medical oxygen must be observed. (11/20/2008)

USE IN Emergencies, oxygen
Chiropractic physicians and Certified Chiropractic Assistants may provide emergency first aid,

including administering emergency oxygen. A person may not administer emergency oxygen unless the person has received training in the administration of oxygen. *The OBCE is beginning the rulemaking process to establish training requirements.* (HB 2242, 2007)

Chiropractic physicians may obtain oxygen units on an over-the-counter non-prescription basis provided a few basic requirements are met. Use of portable oxygen units for clinic emergencies is currently taught at Western States Chiropractic College. Access to emergency oxygen could be useful in the event of a cardiac arrest or other incident in which a patient may stop or have difficulty breathing. These OTC oxygen units are readily available over the Web from a variety of distributors.

According to the FDA, any oxygen inhaled by a human or animal is considered a drug as per section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (the Act), and is required to be dispensed by prescription. However, the agency allows medical oxygen to be dispensed without a prescription to properly trained individuals for oxygen deficiency and resuscitation, as long as the following conditions are met:

1) A high-pressure cylinder filled with medical oxygen and used for oxygen deficiency and resuscitation must have the following statement present on the drug label: "For emergency use only when administered by properly trained personnel for oxygen deficiency and resuscitation. For all other medical applications, Rx Only."
2) The equipment intended for such use must deliver a minimum flow rate of 6 liters of oxygen per minute for a minimum of 15 minutes, and include a content gauge and an appropriate mask or administration device, and
3) Proper training is documentation that an individual has received training within the past twenty-four months or other appropriate interval, in the use of emergency oxygen including providing oxygen to both breathing and non-breathing patients, and safe use and handing of emergency oxygen equipment. Training may be obtained from any nationally recognized professional organization, such as the National Safety Council, the American Heart Association, the American Red Cross, etc. Under no circumstances can emergency oxygen be used to fill high-pressure cylinders or be used in a mixture or blend.

Once all of these conditions are met, an individual may have access to medical oxygen without a prescription. (11/16/06)

Hyperbaric Oxygen Therapy
Question: (from an insurance claims rep.) Are chiropractors allowed to bill/perform CPT 99183 in the state of Oregon (physician attendance of hyperbaric oxygen therapy)? In other words, is hyperbaric oxygen therapy within the Oregon chiropractic scope of practice?
Answer: Yes, as long as this utilizes concentrated oxygen, which is what we understand hyperbaric oxygen therapy to be.

The Oregon Board of Pharmacy considers USP (medical) Oxygen (100%) a prescription drug. However oxygen concentrated at a lower percentage (90 to 95%) does not require a prescription. With that understanding, the OBCE does not prohibit oxygen concentration or the devices which produce this by chiropractic physicians. However, it would be inaccurate for anyone to represent that the Board has “approved” the use of oxygen concentration. Similar precautions as indicated for emergency medical oxygen must be observed. (11/20/2008)

PRESCRIPTIONS, RECOMMENDATION TO STOP USE
Question: May a chiropractor tell a patient with diffuse muscular pain to stop taking Lipitor?

Answer: It could be interpreted to be out of scope to do that bluntly as it could be considered the practice of medicine. It would be appropriate to share information and concerns with the patient (which the DC did). And/or the DC should share his concerns with the prescribing doctor since they are co-treating this patient.

ORS 684.015 specifically proscribes DCs from administering or writing prescriptions for medications. ORS 684.035 (This) Chapter not applicable to other methods of healing, says, "Nothing in this chapter shall be construed to interfere with any other method or science of healing in this state."

SALICYLATES AND LIDOCAINE
See LIDOCAINE AND SALICYLATES

VITACEL
Vitacel is not considered a nutritional supplement because the main carrier is a drug. (9/16/93)

VITAMIN C WITH ECHINACEA
This supplement is acceptable for chiropractors to recommend. (1/21/93)

VITAMINS WITH BOTANICALS
These supplements are acceptable for chiropractors to recommend. (1/21/93)

SECTION II
Practice Policies Regarding Chiropractors, Applicants, and Certified Chiropractic Assistants

CHIROPRACTORS

ABANDONMENT
The Board determined that a licensee is not abandoning a patient in the case when the patient's insurance coverage reaches its limit, and the patient does not have private insurance nor can the patient afford to pay for further services. "….this is not abandonment (since) the patient is being given choices per the doctor's office policy. The decision is the patient's to continue care in that office or elsewhere with a policy that might better fit their need." (05/15/02)

ADVERTISING REVIEW POLICY: (UPDATED APRIL 27, 2010)
The OBCE does not review or pre-approve advertising by chiropractic physicians. Instead the Board is issuing this advisory:

Chiropractic physicians or any other person under the jurisdiction of the OBCE must be able to support statements, whatever the statements are, with credible evidence. This is necessary to be in compliance with:

> OAR 811-015-0045 (1) (a): "A Chiropractic physician shall not use or participate in the use of improper advertising which: States any fact which would result in the communication being untruthful, misleading or deceptive. (b) Contains statistical or other assertions of predicted rates of success of treatment..." (also provisions 2 through 4)
>
> ORS 684.100 Grounds for discipline. Section (1)(i): "The use of any advertising making untruthful, improper, misleading or deceptive statements. (j) The advertising of techniques or modalities to infer or imply superiority of treatment or diagnosis by the use thereof that cannot be conclusively proven to the satisfaction of the board.

The OBCE may not impinge upon legitimate commercial free speech rights. However, advertising statements must be supported by credible evidence. The OBCE recommends that this evidence be available for review upon request.

Doctors should review their own advertising in light of OAR 811-015-0045 and this policy. The Board will make a final determination of the credibility of evidence supporting advertising statements on a case by case basis when presented with a complaint concerning advertising.

To assist in understanding what the OBCE considers to be violations of the advertising rule, final orders or excerpts regarding advertising violations will be provided upon request. (9/22/98)

The Oregon Board of Chiropractic Examiners adopted five additional policy statements regarding advertising by chiropractic physicians at their May 17, 2007 meeting. These policies are an update to the existing OBCE policy advisory on advertising issues.

1) Any advertising claims that spinal decompression/traction devices or any other medical device are a "medical breakthrough" must be supported by credible evidence.
2) Claims of superiority for medical devices such as "Non-surgical spinal decompression is the most promising disc pain treatment today" must meet the standard articulated in ORS 684.100 Section (1) (k): "The advertising of techniques or modalities to infer or imply superiority of treatment or diagnosis by the use thereof that cannot be conclusively proven to the satisfaction of the board.

3) Statements contrasting spinal decompression favorably with drugs or surgery without mentioning other kinds of chiropractic treatment are misleading to the public.
4) Use of the term "FDA approved" in reference to the FDA 510 (k) clearance process is misbranding and misleading advertising. The FDA's regulations make clear that *"Submission of a premarket notification in accordance with this subpart, and a subsequent determination by the Commissioner that the device intended for introduction into commercial distribution is substantially equivalent to a device in commercial distribution before May 28, 1976, or is substantially equivalent to a device introduced into commercial distribution after May 28, 1976, that has subsequently been reclassified into class I or II, does not in any way denote official approval of the device. Any representation that creates an impression of official approval of a device because of complying with the premarket notification regulations is misleading and constitutes misbranding."*
5) When a statement is literally false, the (OBCE) presumes that it will cause injury to a competitor. (Cf. Energy Four, Inc. v. Dornier Medical Sys., Inc., 765 F. Supp. 724, 734 (N.D. Ga. 1991))
6) (New question) The question was asked, "May a chiropractor place their names in the medical and osteopathic doctor section in the Yellow Pages (in addition to the chiropractic section)? The salesman said that's one way to obtain additional advertising." The Board's answer is, "That is likely misleading advertising in violation of the OBCE advertising rule, OAR 811-015-0005."

Advertising

OAR 811-015-0045 (1) A Chiropractic physician shall not use or participate in the use of improper advertising. Improper advertising is any advertising which:

(a) States any fact which would result in the communication being untruthful, misleading or deceptive;

(b) Contains statistical or other assertions of predicted rates of success of treatment; or

(c) Claims a specialty, degree or diplomate not possessed or that does not exist;

(2) A chiropractor shall not practice under a name that is misleading as to the identity of the chiropractor or chiropractors practicing under such name or under a firm name which is misleading.

(3) A Chiropractic physician shall adhere to the Doctors' Title Act, ORS 676.110(2).

(4) A Chiropractic physician may use a professional card and/or letterhead identifying the Chiropractic physician's name, profession, address, telephone number, name of the chiropractic office and educational degrees. It may also include names of licensed associates.

ORS 684.100 Grounds for discipline of licensee or refusal to license; restoration; suspension; competency examinations; confidential information. (1) The State Board of Chiropractic Examiners may refuse to grant a license to any applicant or may discipline a person upon any of the following grounds:

(a) Fraud or misrepresentation.

(b) The practice of chiropractic under a false or assumed name.

(c) The impersonation of another practitioner of like or different name.

(i) The use of any advertising making untruthful, improper, misleading or deceptive statements.

(j) The advertising of techniques or modalities to infer or imply superiority of treatment or diagnosis by the use thereof that cannot be conclusively proven to the satisfaction of the board.

(L) Advertising either in the name of the person or under the name of another person, clinic, or concern, actual or pretended, in any newspaper, pamphlet, circular or other written or printed paper or document, professing superiority to or a greater skill than that possessed by other chiropractic physicians that cannot be conclusively proven to the satisfaction of the board.

(o) The advertising or holding oneself out to treat diseases or other abnormal conditions of the human body by any secret formula, method, treatment or procedure.
(04/27/10)

ANCILLARY SERVICES
A clarification of OAR 811-010-0130 Other Health Professionals.
If the licensed "ancillary" person is offsite (i.e. Radiologist, LMT, PT, etc.), may the chiropractor contract with them to provide services to the patients outside of the chiropractic clinic? The Board determined if an established relationship with the provider as either an independent contractor or employee exists, you may refer the patient out. (11/16/06)

ANIMALS, TREATMENT OF
Chiropractic physicians are permitted to treat animals provided they have a written referral from a licensed veterinarian. The care rendered as a result of the referral must be in writing and in accordance with the standards of practice outlined in ORS 686; and only as prescribed and diagnosed by the veterinarian. (10/4/97)

ATHLETIC TRAINERS, SUPERVISION
Chiropractors may supervise athletic trainers. (11/16/95)

BIRTH CERTIFICATES
ORS 432.206 (3) states that the attending physicians shall prepare and file the birth certificate within five days of the birth. ORS 432.005 defines "physician" as including DCs so the signing of birth certificates is within a chiropractic physician's scope of practice.

CHIROPRACTORS AND OTHER HEALTH LICENSES
The Board considered a series of questions concerning Chiropractors hiring and/or working with other health professional licensees. The specific example dealt with the relationship between Chiropractors and Licensed Massage Technicians.

As long as the licensee is working within the scope of the licensee's practice and is regulated by the licensee's own licensing Board, the licensee does not need to have a chiropractor present when working on the chiropractor's patient. The licensee is responsible for implementing and utilizing clinical judgment within the licensee's own scope of practice.

The Board of Nursing has specific administrative rules allowing Licensed Practical Nurses and Registered Nurses "to accept and implement orders for client care from licensed health care professionals who are authorized to independently diagnose and treat." Nurses are charged with the authority and responsibility to question any order which is not clear, perceived as unsafe, contraindicated for the client, or not within the health care professional's scope of practice.

Nurses must have knowledge of the professional's scope of practice. Please review OAR Chapter

851 Division 45 for more specific information regarding nursing scope of practice.

If the person is acting in the capacity of a Chiropractic Assistant or Ancillary Personnel, OAR 811-010-0110 will apply, and the chiropractor must be present when required.

The OBCE recommends that you thoroughly review the scope of practice for all personnel with whom you are working and/or choose to hire. (3/20/97)

CLINIC OWNERSHIP RESPONSIBILITY RULE, POLICY AND INTENT STATEMENT:

The purpose of OAR 811-035-0015 (25) is to hold chiropractic clinic owners broadly responsible for the overall conduct of their clinic or clinics. This responsibility is already inherent in ORS 684.100 1) f) A) & B), but more explicitly defined with this rule and policy. For example if the licensee owner's clinics have engaged in a consistent pattern of excessive treatment, that licensee would be in violation of this and other rules. Clinics that have only 'on the job' training, no written policies or procedures, and no process for ensuring patient safety and continuity of care when multiple doctors treat the same patient would be indicators of inadequate supervision. To the extent the licensee owner has fulfilled his/her fiduciary responsibilities for supervising and training a multi clinic practice or an individual clinic, that is an affirmative defense in the event an individual employee commits a violation of law or rule. This rule does not apply to chiropractic colleges as they are not described in OAR 811-010-0120. The Board can address specific questions as they come up: (such as)

> **Question**: Owner doctor advises and orders the employee doctor to follow the OBCE rules and guides per OAR 811-010-0120, and the employee doctor fails due to "poor judgment" or other "human errors", what criteria does the owner doctor need to follow in order to prove that appropriate training has been implemented, and the owner doctor's burden has been met in order to comply with ORS: 811-010-0125?
>
> **Answer**: Specific actions such as memos, emails, personnel file entries, continuing education, other training, clinic policies communicated; remedial actions, would all be indications that the owner doctor is providing adequate supervision. Whether the owner doctor has met the requirements of the rule would be a situation specific determination.
>
> **Question**: Are owner doctors not held responsible for independent contractors working in their office but not operating under the owner's license?
>
> **Answer**: Yes, but only to the extent that they are "…part of their chiropractic practice for the purpose of providing care to patients…" as per OAR 811-010-0130 Other Licensed Health Care Providers

New Section (25) to OAR 811-035-0015 Unprofessional Conduct Chiropractic physicians holding an ownership interest as described in OAR 811-010-0120 may be held responsible, entirely or in part, for supervised staff (listed below) who provide patient services. This includes a responsibility to render adequate supervision, management and training of ancillary staff or other persons including, but not limited to, chiropractic physicians, student interns, chiropractic assistants and/or others practicing under the licensee's supervision. Chiropractors with supervised staff may be held responsible, entirely or in part, for undue influence on staff or a restriction of a supervised chiropractic physician from using their own clinical judgment. (01/23/14)

CLINICAL JUSTIFICATION RULE POLICY

The following policy declarations further describe and explain the intent of OAR 811-015-0010(4).

The requirement in OAR 811-015-0010 (4) for evidence based outcomes management for "curative chiropractic treatment" does not include maintenance or wellness care. OCPUG defines maintenance care as inclusive of both preventive care and supportive care. While preventive may be considered similar to wellness care, supportive care "is appropriate for a patient who has reached maximum therapeutic benefit" and/or "is appropriate in patients who display persistent and/or recurrent signs of illness or impairment."

Nothing in OAR 811-015-0010 should be interpreted as requiring or implementing a "very restrictive cook book approach."

The term "evidence-based" as it relates to outcomes measures is not a specific reference to the Educational Manual (EMEBC) or to "evidence-based medicine," nor "evidence-based best practice."

There should be clinical literature and evidence supporting the outcome assessments utilized. "Evidence" means the whole body of professional knowledge. This includes the spectrum of evidence from randomized, controlled clinical trials to less rigorous forms of evidence. Examples of less rigorous forms of evidence includes one or more well designed controlled observational clinical studies, clinically relevant basic science studies, descriptive studies, case reports, or expert opinions published in refereed journals. Where such evidence is lacking professional field consensus is considered.

Lastly, the Board understands that some practitioners employ investigational or other varied (or non-traditional) chiropractic approaches addressing certain types of curative chiropractic care. It is not the Board's intent to discourage these approaches with the evidence based outcomes measures language of Section (4). Should an issue or complaint arise concerning treatment of this general type, the Board will first look to Section (1) language which states, "Clinical rationale, within accepted standards and understood by a group of peers, must be shown for all opinions, diagnostic and therapeutic procedures." (5/18/06)

COLONIC THERAPY

(See also "Colonic Therapy; colonics" under Chiropractic Assistants

The board restated its previous policy in that they determined colonic therapy is hydrotherapy, and is allowed within the scope of chiropractic practice, but CCAs are not allowed to perform it due to the higher risk of the procedure. There are inherent risks, such as causing septic shock by rupturing the bowels. (9/28/07) (9/15/14)

COMPUTERIZED SOAP NOTES

Computerized SOAP notes are acceptable as long as they are used in conjunction with the Oregon Practices & Utilization Guidelines. (4/16/92)

CONTINUING EDUCATION

Approval of Courses or Activities "not specifically listed" in the OAR

Regarding Continuing Education issues that fall under OAR 811-015-0025(9)(L) "and any other course or activity specifically authorized by the OBCE."

Continuing education requests are submitted to the administrative office for possible approval "by the Board" per OAR 811-015-0025(9)(L). If the criteria of the course or activity is, in large part, similar to other described criteria in this rule (sections 8 and 9), but the activity or course is not specifically listed, the Executive Director is delegated authority by the Board to approve the course or activity.

Other courses or activities that do not, "in large part," compare to given criteria of this rule are to be presented to the board for its approval at the next regularly scheduled board meeting.

The term "in large part" may refer to courses or activities which are related to:

- Other institutions not specifically listed, but not excluded intentionally
- Other health-related "studies," but not necessarily "research"
- Teaching "chiropractic" courses at other institutions (hospitals, gyms, nursing homes, etc.), and
- Teaching "chiropractic" courses not necessarily as continuing education

(02/20/03)

Board Member CE Allowance
A CE allowance for board members falls within the requirement of the CE rule. Members are improving and increasing their knowledge and proficiency in chiropractic practice by study and review of cases and policy issues. In addition it is already standard for OBCE subcommittees to receive CE credit for their services, so it would not be out of line for board members to receive credit.

Board members agreed that a maximum of six hours CE will be allowed annually for any of the following - board member participation at regular bi-monthly meetings, subcommittee meetings, national conferences, or other board member represented event. (1/22/09)

The Board determined that a maximum of six (6) CE credit will be allowed annually for professional staff, committee members, and board-appointed mentors. In addition, any non-board member attending the Public Session of a board meeting will be credited up to two hours CE with a maximum of 6 hours per year. Hours will be credited based on sign-in/sign-out. (7/16/2015)

Concussion CE, Mandatory
New licensees are required to complete one hour of concussion training as found at the Centers for Disease Control's website by their first renewal. The training is titled, "HEADS UP to Clinicians: Addressing Concussion in Sports Among Kids and Teens." (1/25/18)

Credit Taken 13 Months Prior to Renewal
If CE hours were taken 13 months preceding the current licensing renewal period, and the hours were submitted but NOT used toward last year's renewal, they may be used for the current license renewal period. (8/27/96)

Educational Manual for Evidenced Based Chiropractic Chapters
The OBCE approved 2 hours CE credit for the complete reading of each chapter of the Educational Manual for Evidence-Based Chiropractic. CAs or DCs may acquire credit for reading the Manual. (9/21/06; 12/1/11)

Federation of Chiropractic Licensing Boards' (FCLB) PACE approved programs
The OBCE accepts all continuing education courses approved by the Federation of Chiropractic Licensing Boards' PACE (Providers of Approved Continuing Education) program. The OBCE also accepts all continuing education courses or activities that meet the criteria and requirements of OAR 811-015-0025. (11/18/04)

National Board of Chiropractic Examiners Part IV Exam Assistants
The Board considered the number of hours possible to contribute to the Part IV process and determined that the exam assistants will be allowed up to 19.5 hours continuing education credit. The OBCE will determine the means to establish how many credit hours should be approved per exam. (9/21/00)

Teaching at a Health-Care Institution or Teaching Post-Graduate Education
The purpose of this policy is to clarify the continuing education allowance in OAR 811-015-0025 (h) teaching courses at an accredited health care institution; and (i) teaching chiropractic continuing education courses. The Board has determined that a licensee may report a maximum eight (8) credit hours per year for teaching, if he or she is the person who develops the course outline, researches the course material and then teaches the class.

Because of this determination, the administrative rule citation 811-015-0025(9)(h) "teaching courses at an accredited health care institution" does not include teaching aides, clinic or class assistants, etc.

In relation to both 811-015-0025(9)(h) "teaching courses at an accredited health care institution" and (i) "teaching chiropractic continuing education courses"; a licensee may receive credit hours for the actual time teaching the class, not for the research and development of the program. (5/19/05; Eff. 8/1/05)

COUNSELING PATIENTS
A Chiropractor may only counsel within the area of chiropractic. Example: Counseling regarding sleep habits, eating habits, exercise, stress levels as it affects the musculoskeletal system. (3/17/93)

Chiropractors must stay within the guidelines as taught in chiropractic colleges. Counseling should relate to diagnosis and treatment. (1/21/93)

CPAP MACHINE, ORDERING
Ordering a **CPAP** machine and/or a sleep study is considered to be within the DC's scope of practice in Oregon.
Whether insurance will pay or not is another question.

DEATH CERTIFICATES
According to the Office of Vital Records, a DC can sign a death certificate. ORS 432.307, states, "physicians" sign death certificates. In ORS 432.005, the definition of "physician" includes DCs; so yes they can sign a death certificate.

DIABETIC EDUCATION
An Oregon chiropractic physician may provide diabetic education within chiropractic care. This education may include lifestyle counseling, nutritional support, and diagnostic testing for blood sugar levels. (03/06/02)

DIPLOMATE STATUS
Chiropractors in Oregon my claim a diplomate status if, in fact, they have earned that credential, otherwise they would be in violation of the Board's advertising rule. (10/25/00)

DMV'S MEDICALLY AT-RISK DRIVER PROGRAM
The Oregon Department of Motor Vehicles (DMV) requires medical doctors and other health care providers (such as chiropractic, naturopathic doctors, physical therapists etc.) to report drivers with severe and uncontrollable functional or cognitive impairments that impact their ability to safely operate a motor vehicle. This could result in suspension of driving privileges.

Chiropractic physicians are required to contact DMV to report a severe and uncontrollable impairment only if they are a patient's primary care provider. Otherwise, the chiropractic physician must submit a report to the patient's medical doctor or other primary care provider who then will determine whether to report. A chiropractic physician may still report to DMV on a voluntary basis, if needed.

In the rare case where this may be an issue, a chiropractic physician should review the actual administrative rules, detailed information, and reporting forms found on the DMV's Web page which can be found at http://www.oregon.gov/ODOT/DMV/pages/driverid/medical.aspx

Severe and uncontrollable impairments are defined as:

- Severe means the impairment substantially limits a person's ability to perform many daily activities, including driving.
- Uncontrollable means that the impairment cannot be corrected or compensated for by surgery, medication, therapy or adaptive devices.

Once someone is reported to DMV, the driver may receive a Notice of Suspension in the mail informing the driver his/her license will be suspended 5 days from the date on the notice. At that point, the driver has several options. The driver can contact DMV and:

- Request the opportunity to demonstrate that he/she can still safely drive. Based on the information contained in the medical referral, the driver may also be required to provide DMV with additional medical information. The person will have to take the vision, knowledge and drive tests. The driver's license will be reinstated upon passing the required tests.
- Request an administrative hearing to appeal DMV's decision to suspend their driving privileges.
- Voluntarily give up their driving privileges by turning in their driver's license.

For additional information, call the DMV Medical Program Coordinator in Salem at (503) 945-5295. (11/18/04)

DOCTORS' TITLE ACT, ORS 676 (2011)
676.110 Use of Title Doctor (1) An individual practicing a health care profession may not use the title "doctor" in connection with the profession, unless the individual:
(a) Has earned a doctoral degree in the individual's field of practice; and
(b)(A) Is licensed by a health professional regulatory board as defined in ORS 676.160 to practice the particular health care profession in which the individual's doctoral degree was earned; or
(B) Is working under a board-approved residency contract and is practicing under the license of a supervisor who is licensed by a health professional regulatory board as defined in ORS

676.160 to practice the particular health care profession in which the individual's doctoral degree was earned.

(2) If an individual uses the title "doctor" in connection with a health care profession at any time, the individual must designate the health care profession in which the individual's doctoral degree was earned on all written or printed matter, advertising, billboards, signs or professional notices used in connection with the health care profession, regardless of whether the individual's name or the title "doctor" appears on the written or printed matter, advertising, billboard, sign or professional notice. The designation must be in letters or print at least one-fourth the size of the largest letters used on the written or printed matter, advertising, billboard, sign or professional notice, and in material, color, type or illumination to give display and legibility of at least one-fourth that of the largest letters used on the written or printed matter, advertising, billboard, sign or professional notice.

(3) Subsection (1) of this section does not prohibit:

(a) A chiropractic physician licensed under ORS chapter 684 from using the title "chiropractic physician";

(b) A naturopathic physician licensed under ORS chapter 685 from using the title "naturopathic physician";

(c) A person licensed to practice optometry under ORS chapter 683 from using the title "doctor of optometry" or "optometric physician"; or Enrolled House Bill 2395 (HB 2395-A)

(d) A podiatric physician licensed under ORS 677.805 to 677.840 from using the title "podiatric physician."

676.120 Use of deceased licensee's name. Notwithstanding ORS 676.110, upon the death of any person duly licensed by a health professional regulatory board as defined in ORS 676.160, the executors of the estate or the heirs, assigns, associates or partners may retain the use of the decedent's name, where it appears other than as a part of an assumed name, for no more than one year after the death of such person or until the estate is settled, whichever is sooner.

676.130 Enforcement of ORS 676.110 and 676.120. Each health professional regulatory board as defined in ORS 676.160 shall notify the appropriate district attorney of any violation of ORS 676.110 and 676.120 which may be brought to the attention of such board. The district attorney of the county in which any violation of those sections takes place shall prosecute the violation upon being informed of the violation by any person or by one of such boards.

ELECTRONIC SIGNATURES

A chiropractic clinic keeps daily charts electronically which indicate the provider of the services, and asks, "Is it necessary for a chiropractic physician to print out and personally sign each daily chart note?" No, it is sufficient to keep that information electronically as along as the provisions of OAR 811-015-0005 (1) (b) are met, "Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record."

On a related point, regarding electronic chart notes, a digital signature satisfies the requirement to sign each chart note entry.

EMERGENCY FIRST AID

Chiropractic physicians and Certified Chiropractic Assistants may provide emergency first aid. The following language was adopted into 684.025 new subsection (4):

(a)"This chapter does not prevent a person licensed under ORS 684.054 from providing emergency first aid, including administering emergency oxygen.
(b) A person may not administer emergency oxygen unless the person has received training in the administration of oxygen. The State Board of Chiropractic Examiners shall adopt rules that establish training requirements.

(c) As used in this subsection, 'emergency oxygen' means oxygen delivered at a minimum flow rate for a specified period of time as determined and regulated by the United States Food and Drug Administration." (HB 2242, 2007)

EMPLOYEE STATUS

(See also, Multidiscipline Clinics)

In response to the question, "Can a DC be an employee of a hospital or clinic that is multi-disciplinary with no majority interest?" the Board replied, "First, you must determine if the employer is "a business entity organized for the purpose of practicing chiropractic." It would be hard to argue that a hospital is organized for this purpose. The OBCE sees no problem from a business organization standpoint for a chiropractor or be employed by a hospital as long as the chiropractic physician is allowed to meet his/her responsibilities as outlined in ORS 684, OAR 811, and the Oregon Chiropractic Practice and Utilization Guidelines. The same logic may hold true for some other employing entity, however it must not be a subterfuge to skirt the requirements of OAR 811-010-0120. See also OAR 811-010-0120 (8) multidisciplinary provisions." (5/28/03)

In a follow-up question (from an acupuncturist clinic owner) the Board was asked, "May we change the status of our independent contracting DCs to employee status? And, if so, could the business also hire a CA, and have the DC supervise?

The Board determined that DCs may be hired as employees just the same as they may also employ other health professionals. As the independent contractor situation is fraught with issues, having employees is probably a safer way to operate. We do have a requirement that chiropractic clinics must be majority owned and controlled by licensed Oregon chiropractors, but that same rule allows for multi-disciplinary (Oregon health licensee) clinics as well. What we don't want is non-health care or corporate controlled practice of chiropractic health care. However, it is the DC's responsibility to be part of a clinic that is compliant with our laws and rules, including the Oregon Doctor's Title Act, which applies to L.Ac.'s as well. The clinic can hire a chiropractic assistant as long as the DC is on site to supervise any practice as a CA. A complete explanation of our chiropractic assistant rules and policies can be found on the OBCE web page. Refer to OAR 811-010-0130

FAMILY/RELATIVES, TREATMENT OF

Oregon chiropractors may treat family members and employees. However, chart notes and files must be kept as with any other patient.

OAR 811-010-0005 defines "patient" as "any person who is examined, treated, or otherwise provided chiropractic services whether or not the person has entered into a physician/patient relationship or has agreed to pay a fee for services."

FEE SPLITTING AND COMMISSIONS

ABS Health Center, Inc. Marketing Plan

The Oregon Board of Chiropractic Examiners advises that a chiropractic physician who participates in a marketing plan recently offered by ABS Health Center, Inc. based in Cincinnati, Ohio would be in violation of Administrative Rule 811-035-0015, prohibition on fee-splitting in the referral of patients for services.

ABS Health Center, Inc. attempted to enlist an Oregon chiropractic physician whereby they proposed to "..bill back a marketing fee of $1,000 for every $3,500 cash patient closed (29% if the amount collected is less than $3,500)" in return for an agreement whereby ABS leases a

spinal decompression device for the doctor's office and conducts direct mail & broadcast media to recruit patients to use this device.

Any Oregon chiropractic physician who agreed to this would be in violation of the Oregon Board of Chiropractic Examiner's Administrative Rule 811-035-0015 which states,

> "Unprofessional conduct means any unethical, deceptive, or deleterious conduct or practice harmful to the public; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a Chiropractic physician:…
>
> (24) Splitting fees or giving or receiving a commission in the referral of patients for services."

In a letter to ABS, Executive Director Dave McTeague also said, "We note that you have attempted to draw a distinction between Insurance/Medicare/Medicaid and cash pay patients, stating that fee splitting is OK if it involves cash pay patients. This letter is to inform you that the Oregon Board of Chiropractic Examiner's administrative rule does not make this distinction and that fee splitting for chiropractic patients of the magnitude proposed is illegal in Oregon." (5/18/06)

Adjustments or Other Minor Gifts for Patient Referrals
The practice of extending a free adjustment or other minor gift to patients referring a new patient for services is not a violation of the Board's administrative rule, unless in the Board's opinion the practice grows to be deceptive, unethical, deleterious or harmful to the public.

OAR 811-035-0015 states: "Unprofessional conduct means any *unethical, deceptive, or deleterious conduct or practice harmful to the public*; any departure from, or failure to conform to, the minimal standards of acceptable chiropractic practice; or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a Chiropractic physician: ....(24) ***splitting fees or giving or receiving a commission*** in the referral of patients for services. (emphasis added).

Commissions and Fees
Webster's Ninth New Collegiate Dictionary's definition of "commission," which speaks specifically to money, was considered.

The Board noted that any gratuity between professionals and any business entity for patient referrals is unethical and harmful to the public. Any practitioner offering anything to another practitioner in exchange for a patient referral is subject to possible sanctions for unprofessional conduct.

The Board suggests that chiropractors needing further advice or legal opinion in regard to this policy, should contact their own attorney. (3/20/97)

Recently a licensee asked the Board about solicitations from a company in New York (ChiroAppointment.com). They claim to have names of patients who are interested in Chiropractic care. ChiroAppointment.com charges $40 per referral. The Board determined this is definitely a violation of the fee splitting rule, OAR 811-035-0015 (24). See the article in the Summer 2009 BackTalk.

Donating to a Non-Profit
The Board was asked if a non-profit organization (i.e. private school) could advertise to their members (i.e. parents) that if they utilize the services of a particular chiropractic physician, the physician will donate 10% back to the non-profit organization. The Board determined this is not "fee splitting" and does not violate the spirit of OAR 811-035-0015(24). (11/20/03)

Leasing Agreements and Professional Referrals
In May of 2003, the Board reviewed the following question regarding business practices under a multiple discipline clinic setting. The following response from the OBCE is not in any way legal opinion but only presents information about choices.

For a chiropractic physician who is leasing/renting office space, office personnel/billing services, that also leases/rents to other types of licensed professionals: Do "walk-in" patients requesting chiropractic services constitute a "referral" by the front desk person to that doctor? **No**.

> New OBCE policy: In review of this question the Board explored whether a "referral" by a parent company or other health care provider constitutes fee splitting in percentage of gross lease arrangements (or percentage of pay arrangements). The Board received legal advice that it has broad authority to interpret the meaning of the fee splitting rule (OAR 8110-035-0015 (24)).

Therefore the Board has determined that a chiropractor or health professional who enters into percentage of gross leasing arrangement, and who may refer patients or receive referrals from the other party, does not constitute "fee splitting" if the business agreement is entered into prior to any patient base and there is not a true commission or fee paid per patient back to the chiropractor or other health professional. This same logic also holds true for percentage of patient base rate of pay. (5/28/03)

Merchant Fees (Visa, MasterCard, Discover card charges)
The OBCE does not consider it a violation of the fee-splitting rule for an advertiser to charge a merchant (i.e. chiropractic clinic) for the actual costs related to "merchant fees." Typically these run in the 2 to 3% range of the purchase cost. Merchant fees specifically relate to the typical charges that vendors, such as those listed above, charge the merchant for the cost of using their credit card transaction service.

Online sales of coupons
Online sales of coupons or other services in which the prospective patient/customer pays a fee which then is shared between the advertising and the chiropractic clinic business are a violation of 811-035-0015 (24) Splitting fees or giving or receiving a commission in the referral of patients for services." Following this ruling many of these advertisers modified their program to a flat rate advertising contract which does not violate this rule."

Question: Is it fee splitting if the doctor's portion of the split is donated to a non-profit charity?
Answer: Yes, as the advertiser still receives a split on a per patient basis.

Question: A DC/L.Ac asks if she can advertise on Groupon as a L.Ac?
Answer: The OBCE would not have jurisdiction as long as chiropractic & "DC" are not referenced in the advertisement. However, caution is advised.

Question: A DC has a LMT in office; can that person advertise with a fee-splitting coupon advertiser?
Answer: If the LMT is part of the chiropractic clinic, the answer is No.

Question: A DC has a LMT in office, can that person advertise with a fee-splitting coupon advertiser, but also say that a free chiropractic exam is part of the offer, but the chiropractor gets no payment?
Answer: The answer is No. (05/02/12)

FUNCTIONAL CHIROPRACTIC NEUROLOGY
The Board recognizes functional chiropractic neurology procedures and protocols as "standard" as per the Board's ETSDP rule. All chiropractic physicians who advertise that they hold special certification or training must be able to support those advertising claims with credible evidence. (03/17/14)

HIPAA - IMMINENT DANGER EXCEPTION
The OBCE recognizes the **Imminent danger exception** as outlined in HIPAA regulations. This policy communicates to chiropractic physicians that they may take appropriate action when faced with an imminent danger situation. See below an example of a recent situation.

> A chiropractic physician may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the chiropractic physician in good faith, believes the use or disclosure:
>
> (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
> (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
> (ii) Is necessary for law enforcement authorities to identify or apprehend an individual:
> (A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or
> (B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in Sec. 164.501.

This policy is based on current HIPAA regulations. Any chiropractic physician, who in good faith discloses protected health information under the above mentioned criteria, will not be found to be in violation of any other patient confidentiality laws or rules. (9/20/05)

HYPNOTHERAPY
Hypnotherapy is defined as a type of psychological therapy and is not allowed within the scope of chiropractic practice. Hypnotherapy continuing education courses will not be accepted for license renewal credit. (09/15/14)

INACTIVE LICENSE
(Changing to active after five or more years)
The following policy is an expansion of the current Oregon Administrative Rule 811-010-0086(8) which reads, "Inactive licensees who apply for reinstatement after five or more years after the date of transfer to inactive license, or who cannot demonstrate to the satisfaction of the Board they have been in active practice during the preceding five years, may be required to establish their competency in the practice of chiropractic by

(a) receiving a passing grade on all or part of an examination required by the Board; **Or**

(b) submitting a letter showing proof of active practice and any disciplinary actions from the state boards where licensure is maintained.

Any licensee who has maintained an inactive license for five or more years will be required to meet one of the following criteria before they may receive an active license in Oregon:

1. Proof that the licensee was actively practicing at least one year of the past five. Proof should include evidence of malpractice insurance, clinic address, and license verification from the state where practicing. *(A thumbprint will be required in the future once a more clear policy is established regarding that requirement.)*

Or

2. Show proof that one of the following exams was successfully passed in the past five years:
   a) National Board of Chiropractic Examiners' SPEC (Special Purposes Exam for Competency)
   b) National Board of Chiropractic Examiners' Part IV (practical) Exam
   c) Another state's licensing exam

Or

3. Petition the Oregon Board
   (DC should explain why it is not necessary to prove competence, or explain the reason(s) why it is not necessary to meet *these* requirements to prove competence.) (11/99)

INDEPENDENT MEDICAL EXAMINATION (I.M.E.)

There is one standard for all chiropractors**,** whether they be IME, examining, treating, consulting or rehabilitating chiropractors. A professional relationship exists between the patient and the chiropractor, regardless of whether the chiropractor is the examining or treating doctor.

Regardless of the role, the chiropractor is expected to perform an appropriate chiropractic examination based on the patient's current and past complaints, the manner of onset, and the elicited history. From this the chiropractor will make a diagnosis and determine any further procedures or tests necessary to clarify the diagnosis and/or prognosis. These may include, but not be limited to: diagnostic imaging, laboratory testing, or other specialized studies. If indicated, *the evaluating chiropractor will propose any of the following: a recommended course of further care, a timeframe for reevaluation, treatment options or referrals; or discharge from care when appropriate.*

All examinations should include a "functional chiropractic analysis." The Board has always assumed this was inherent in the P & U Guidelines, even though it was not included as specific language. The Board also stated that diagnosis should be based on pertinent history and examination findings, and reflected in the record.

The issues arising out of an OBCE action in 2002 resulted in the following agreement between the OBCE and the respondent chiropractic physician.

a. The doctor/patient relationship between examiner and the examinee is limited to the examination, the opinion, and the review of the patient history and medical records provided; and does not include ongoing treatment monitoring. The examiner shall make important health information, diagnosis and treatment recommendations available to the patient, treating doctor, and patient's legal counselor or guardian via the independent report. Upon receipt of a signed written request from the patient or patient's legal guardian, a copy of the examination report shall be made available as indicated in the request - to the patient and/or any other party designated by the patient.

b. An independent chiropractic examiner should review the dictated medical opinion of a fellow panel member of an independent or insurer examination for its accuracy and completeness, and when necessary to clarify biomechanical or chiropractic reasoning, the independent chiropractor examiner should supplement the dictated medical opinion with his or her independent chiropractic opinion.

Administrative Rule 811-015-0010 (Clinical Justification) also governs the conduct of independent examinations.

Workers' Compensation IMEs. The Oregon Workers Compensation Department (OWCD) is required to maintain a list of providers authorized to perform independent medical evaluations (IMEs) for workers' compensation claims as a result of SB 311 (2005). The OWCD director may remove a provider from the list after a finding of violation of standards of professional conduct for workers comp IME claims. Health professional licensing boards may adopt such standards or if they don't the default standards are published by the American Board of Independent Medical Examiners (ABIME). The OBCE considered this issue at their May 18, 2006 meeting and decided to accept the ABIME standards (below) and also submit to OWCD the OBCE's policy as additional applicable standards for IMEs performed by chiropractic physicians.

ABIME Guidelines of Conduct: Physicians should:

1. Be honest in all communications
2. Respect the rights of the examinees and other participants, and treat these individuals with dignity and respect;
3. At the medical examination:
    - Introduce himself/herself to the examinee as the examining physician;
    - Advise the examinee they are seeing him/her for an independent medical examination, and the information provided will be used in the assessment and presented in a report;
    - Provide the examinee with the name of the party requesting the examination, if requested;
    - Advise the examinee that no <u>treating</u> physician-patient relationship will be established;
    - Explain the examination procedure;
    - Provide adequate draping and privacy if the examinee needs to remove clothing for the examination;
    - Refrain from derogatory comments; and
    - Close the examination by telling the examinee that the examination is over and ask if there is further information the examinee would like to add.
4. Reach conclusions that are based on facts and sound medical knowledge and for which the examiner has adequate qualifications to address;
5. Be prepared to address conflict in a professional and constructive manner;
6. Never accept a fee for services which are dependent upon writing a report favorable to the referral service; and
7. Maintain confidentiality consistent with the applicable legal jurisdiction.

(7/18/06)

INSURANCE – PIP OR HEALTH?

<u>A</u> chiropractic clinic manager asked, "Is it acceptable to bill a patient's regular health insurance after being in a car accident instead of the auto PIP insurance." The Board answered, "No, ORS 742.526 states that the auto PIP insurance is primary."

LYME DISEASE

After review of the ETSDP Committee discussion notes, the OBCE adopted this statement at their November 2010 meeting:

In the treatment of patients with Lyme disease, it is standard of care for chiropractic physicians to participate adjunctively in the co-management with other appropriate health care providers having prescription writing privileges.

The November 2010 Board minutes and the ETSDP (Examinations, Tests, Substances, Devices and Procedures) Committee discussion notes can be found on the OBCE's web site www.oregon.gov/obce. (Nov 2010)

MAGNETIC RESONANCE IMAGING (MRI'S)

Chiropractic physicians in Oregon have a broad scope of practice for diagnostic testing. This includes ordering magnetic resonance imaging (MRI) when indicated. Some entities such as hospitals or third party payers have questioned whether chiropractic physicians may order MRIs.

Chiropractors need direct access in ordering magnetic resonance imaging to establish diagnosis for key conditions presenting in their patient population that directs management of care.

Chiropractic physicians receive extensive training in this area. The training of doctors of chiropractic emphasizes the role of imaging, especially conventional radiography and magnetic resonance imaging. Chiropractic students are taught the basic physics, clinical applications, the advantages and limitations of these imaging modalities. In addition, chiropractic students are taught to interpret key bone and joint conditions as well as current imaging guidelines.

In all requests for diagnostic testing, there needs to be clinical justification (OAR 811-015-0010). (2/3/2010)

MASSAGE THERAPIST, SCOPE OF PRACTICE

The Board of Massage Technicians determined on January 9, 1992, that it is the intent of licensed massage technicians to stretch soft tissues which must include the movement of the bony joints through the normal range of motion.

Adjustments and manipulations are not identified as being within the scope of practice of massage therapists since the Board understands the intent of those two activities to be toward the joint surfaces and beyond the normal range of motion rather than the surrounding soft tissues. Although the Board realizes spontaneous manipulation of the joints may occur while doing massage, the intent is directed towards the soft tissues.

MIGRAINE HEADACHES

The Board determined that treating migraine headaches is within the Oregon chiropractic scope of practice.

MILITARY SERVICE (AND RENEWAL)

408.450 Duty to pay fees during military duty states, "No person in the military or naval service of the United States, or any auxiliary corps thereof, while exercising any privilege in this state by virtue of having paid an annual license or privilege fee to any state board or commission for the right to practice a profession or engage in a trade, shall lose such privilege because of failure to pay any such fee for any subsequent year during the period the person is in such service, unless dishonorably discharged therefrom. Upon being discharged from such service under honorable conditions and upon written application within 60 days of such discharge, every such person shall be restored to

former status with respect to any such privilege without the necessity of paying the then current license fee."

When the OBCE is made aware of a licensee's relevant military service, we will apply the above mentioned law accordingly.

As regards continuing education, requests for waivers or delay in submission will be reviewed on a case by case basis as per the OBCE's hardship policy. The OBCE requests notification of this before the end of the licensee's renewal period. (July 2011)

MINOR SURGERY CERTIFICATION

The Board decided to accept procedures performed by WSCC's 12th quarter students in a (new) practical minor surgery elective course as part of their fulfillment of the rotation required for certification in Oregon. The course offered is in addition to the 36-hours (24 lecture and 12 lab) normally offered by WSCC. A maximum of 12 minor surgical cases may be acquired, and no more than two students may obtain credit for any one procedure. (11/99)

MOTOR CARRIER PHYSICALS

Chiropractors may perform physicals for D.O.T. motor carrier certification.

According to Title 49-Transportation Chapter III-FHA Dept. of Transportation Subchapter B - Federal Motor Carrier Safety Regulations, chiropractors are included in the definition of "medical examiner."

> "Medical examiner means a person who is licensed, certified, and/or registered, in accordance with applicable State laws and regulations, to perform physical examinations. The term includes, but is not limited to, doctors of medicine, doctors of osteopathy, physician assistants, advanced practice nurses, and doctors of chiropractic."

*(*Federal Motor Carrier Safety Regulations, sec. 390.5, revised 6/18/98*)*

MULTI-DISCIPLINE CLINICS

(See Doctors' Title Act) If any person (including a group or combination of individual persons) uses certain terms listed in the statute in any printed or written matter, or in any advertising, signs, or professional notices, then the particular health care profession under which the person is licensed also must be identified in print at least one-fourth as large as the title or name of the professional "person" or entity. The designation of the person's health care profession also must be displayed in such a way as to be at least one-fourth as "legible" as the title or name.

To further explain, the following examples are given:

> If a multidiscipline clinic has a sign out front that says XYZ Rehab Clinic, then each profession involved in the clinic must be identified, such as:
>
> XYZ Rehab Clinic
> Medical Doctor, Chiropractor etc. (in one-fourth size print)
>
> If a person's name is used, then one must be identified as a chiropractor, i.e. John Doe, Chiropractor, or John Doe, Chiropractic Physician.

The provisions of the "Doctor's Title Act", ORS 676.100 - 676.130 apply in the case of multidisciplinary organizations such as rehabilitation facilities in which various health-care professionals practice.

The Doctors' Title Act is essentially a consumer protection statute. If any person (including a group or combination of individual persons) uses certain terms listed in the statute in any printed or written matter, or in any advertising, signs, or professional notices, then the particular health care profession under which the person is licensed also must be identified in print at least one-fourth as large as the title or name of the professional "person" or business entity. The designation of the person's health care profession also must be displayed in such a name. The concept is to provide consumers with sufficient information to identify under which license a health care professional in Oregon is practicing.

The purpose and effect of the statute do not differ if the "person" is an individual physician or a multidisciplinary organization. A plain reading of the statutory terms demands that each health care professional working in a multidisciplinary clinic, institute, or group must identify his or her profession according to the "one-fourth" rule. (11/3/92); (11/7/11)

In May of 2003, the Board reviewed the following questions regarding business practices under a multiple discipline clinic setting. The following responses from the OBCE are not in any way legal opinions but only presents information about choices.

Employee status
Can a DC be an employee of a hospital or clinic that is multi-disciplinary with no majority interest?

> First, you must determine if the employer is "a business entity organized for the purpose of practicing chiropractic." It would be hard to argue that a hospital is organized for this purpose. The OBCE sees no problem from a business organization standpoint for a chiropractor or be employed by a hospital as long as the chiropractic physician is allowed to meet his/her responsibilities as outlined in ORS 684, OAR 811, and the Oregon Chiropractic Practice and Utilization Guidelines. The same logic may hold true for some other employing entity, however it must not be a subterfuge to skirt the requirements of OAR 811-010-0120. See also OAR 811-010-0120 (8) multidisciplinary provisions. (5/28/03)

Independent Contractor
Could an Oregon DC work as an independent contractor in the above illustration?

> The legal requirements for independent contractor status are outlined in state and federal law. The OBCE recommends chiropractors seek specific legal advice to determine their appropriate status as an independent contractor or employee. (5/28/03)

Does the OBCE have specific recommendations for clauses in independent contractor contracts?

> The OBCE holds all chiropractors to the same standards of practice as outlined in ORS 684, OAR 811, and the Oregon Chiropractic Practice and Utilization Guidelines. The OBCE also recommends review of the OBCE Guide to Policy and Practice Questions. (5/28/03)

NETWORK CHIROPRACTIC
The Oregon Board of Chiropractic Examiners (OBCE) reviewed the conclusions of the advisory committee on E.T.S.D.P.s (examinations, tests, substances, devices and procedures).

The Board determined that Network Chiropractic is standard under Board's present rule. This is solely due to the fact that this technique is taught in a post-graduate continuing education course at Sherman College of Straight Chiropractic. (Oregon Administrative Rule 811-015-0070)

In making this determination, the OBCE offers no opinion as to the clinical efficacy of Network Chiropractic.

However, the OBCE has serious concerns with the utilization recommended for this technique.

The OBCE recommends any Oregon chiropractic physician desiring to utilize Network Chiropractic protocols review OCPUG standards and administrative rules on clinical justification and excessive treatment. (10/15/98, updated May 22, 2003))

PAP SMEARS

A medical testing service asked, "May Oregon chiropractors order, collect and receive medical laboratory test results for pap smears?" Yes. DCs in Oregon have a very broad scope of practice in the area of diagnostics. They are also trained in ob-gyn and female health issues in chiropractic college.

PARENTAL CONSENT

When a patient is a child or "minor," the chiropractic physician must have the permission of the parent, custodian or legal guardian before treating the patient. There is no law which specifically defines the type of permission that must be given. Written contracts are enforceable and may be preferred to oral contracts. OAR 811-015-0006 states that the doctor shall preserve a patient's medical records, unless given written permission from the patient. However, a custodial parent or guardian of a minor patient may authorize disclosure to self or others. Disclosure must be made in situations involving court orders. OAR 811-015-0006 implies that only the custodial parent is entitled to information concerning the minor. However, laws governing domestic relations provide that the noncustodial parent shall not be deprived of the authority to consult with any person who provides treatment and that records shall be available to inspect and receive. (Attorney General opinion, July 1995 BackTalk Newsletter)

PATIENT-CHIROPRACTOR RELATIONSHIP

See Independent Medical Exams

PATIENT, DEFINITION

The definition of patient in the Oregon Administrative Rules for Chiropractors will mandate documentation of diagnosis and treatment using standard chiropractic methods.

OAR 811-010-0005(4): "Patient" means any person who is examined, treated, or otherwise provided chiropractic services whether or not the person has entered into a physician/patient relationship or has agreed to pay a fee for services. (Eff. 9/29/92)

PATIENT RECORDS

Disclosure of Deceased Patient Records

The question was asked of the Board, "May the parent of a patient who is deceased gain access to the patient's chiropractic patient record?"

Depending on the estate or probate of the deceased patient, the personal representative should be able to obtain the records. In probate and estate law, the personal representative steps into the shoes of the deceased and carries on with business on behalf of the deceased.

If the chiropractor were to obtain from the personal representative (whether it is a parent or someone else) the probate documents showing they were in fact acting for the deceased and that they requested the records, those records should be releasable to the personal representative.

The parent of a majority-aged patient would not be able to get those records unless they had an authorization, as the confidentiality of those records does not cease with the death of the patient. (04/17/03)

Electronic Records
If a chiropractic physician or clinic determines to transfer original paper patient records to an electronic medium and then destroy those paper records, the following conditions must be met:

- All relevant information must be transferred. A record or memo indicating who, what - when, where and how the transfer occurred must be made.
- The records may not be altered in any significant way.
- Color coded patient records must be captured as well.
- There must be a secure and reliable backup system for all electronic patient records.

The HIPAA law requires health care providers to "maintain reasonable and appropriate administrative, technical and physical safeguards (a) to ensure confidentiality of the information, and (b) protect against (i) threats or hazards to the security of the information; and (ii) unauthorized uses or disclosures of this information." (07/19/12)

Faxed Records Requests
It is acceptable and legal for a chiropractic physician to accept a faxed copy of a request for patient records; an original signature is not mandatory. (02/20/03)

Ownership of patient records
The Board determined that until the OBCE could rewrite OAR 811-015-0005(1) regarding ownership of the patient records, its interpretation of that rule will be that "including but not limited to" means <u>if the records are present, they must be included in the record</u>. The statement is NOT interpreted to mean that ALL parts listed in section (1) must be (created, and thereby) included. (03/01)

Release of patient records
It is recommended the chiropractic physicians review the provisions of OAR 811-015-0005, OAR 811-015-0006 and 192.553 to ORS 192.581

Transfer of Patient Files
A chiropractor is purchasing another clinic. Is it necessary for him to get a written consent for the seller to pass on the patient file and information to the buyer, from the seller's patients? In other words, do the existing patients need to give permission to transfer their health information? Not in this case. This situation is covered in the OBCE Records rule (OAR 811-015-0005 (5), which states, "The responsibility for maintaining original patient records may be transferred to another chiropractic business entity or to another chiropractic physician as part of a business ownership transfer transaction."

The OBCE reviewed the intent of OAR 811-015-0005 Records which states:

"(1) It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations."

The OBCE interprets this to mean that IF those parts exist, then they must be considered part of the record. For a more comprehensive understanding of the Board's expectations for patient record keeping, please refer to the entirety of OAR 811-015-0005 and the Oregon Chiropractic Practice and Utilization Guidelines.

Regarding the actual release of records,

OAR 811-015-0006, Disclosure Of Records *(1) A Chiropractic physician shall make available within a reasonable time to a patient or a third party upon the patient's written request, copies or summaries of medical records and originals or copies of the patient's X-rays.*

(a) The medical records do not necessarily include the personal office notes of the Chiropractic physician or personal communications between a referring and consulting physician relating to the patient

(Updated 11/18/04)

On September 18, 2008, the OBCE clarified that, *Independent Medical examiners are not required to keep records from other providers.*

On May 19, 2005, the OBCE further reviewed the records release administrative rule and policies. The following is an update to the previous policy.

A prompt response to a valid request for release of patient records from a patient or authorized representative is in the patient's and the public's interest. What is a "reasonable time" may vary depending upon the circumstances of the chiropractic physician and the request. The Board requests the records be released as soon as possible with the expectation that in most cases release would occur within 7 days. Without a valid reason, failure to release records within 30 days of a documented request may be considered to be a violation of OAR 811-015-0006(1) and ORS 684.100 (t).

OAR 811-015-0006 (2) states: "The Chiropractic physician may establish a reasonable charge to the patient for the costs incurred in providing the patient with copies of any portion of the medical records. A patient shall not be denied summaries or copies of his/her medical records or X-rays because of inability to pay or financial indebtedness to the Chiropractic physician."

However, charges for patient records must also comply with ORS 192.563 (below) passed as part of HB 2305 in 2003 and was updated in 2007.

192.563 Health care provider and state health plan charges. A health care provider or state health plan that receives an authorization to disclose protected health information may charge:

(1)(a) No more than $30 for copying 10 or fewer pages of written material, no more than 50 cents per page for pages 11 through 50 and no more than 25 cents for each additional page; and

(b) A bonus charge of $5 if the request for records is processed and the records are mailed by first class mail to the requester within seven business days after the date of the request;

(2) Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal

representative of the individual; and

(3) Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual.
(5/19/05, 10/23/08)

PHYSICAL THERAPY, BILLING
The DC may provide treatment under the physical therapy codes. CAs may provide the therapies under DC supervision pursuant to ORS 684.155. (5/12/17)

POST-DOCTORAL DIPLOMATES, USE OF INITIALS
If a chiropractor has completed a legitimate diplomate course, he/she may use the post-doctoral initials as long as they comply with the OBCE rules on advertising and the Doctor's Title Act.

PRIMARY CARE PHYSICIANS
Chiropractors in Oregon are primary care physicians. (1/19/95, 9/18/97)

PYRAMID SELLING
Pyramid schemes are illegal. (ORS Ch. 646.608(1)(r)) Pyramids are illegal because they are inherently fraudulent. In order to achieve the profits that are promised, a never-ending chain of participants must be recruited. At some point a saturation level will be reached and no more recruits will be available. When that occurs, the most recent recruits cannot receive what has been held out to them to cause them to join, and they lose all or a part of what they paid to join the scheme.

Some multi-level sales plans have the potential to run afoul of Oregon's law against pyramid schemes. A paper prepared by the Oregon Attorney General's office "Multi-level Sales Plans in Oregon" which addresses these issues is available by calling the Board office. However, a private attorney should be consulted for specific legal advice.

RECORD KEEPING
A doctor contacted the Board and asked, "Is it required that I sign every dated entry even after having been gone on vacation (the relief doctor has already signed them)?" Staff asked the board for further clarification of the rule: What is your interpretation? Does the single practitioner doctor have to initial every entry, as the rule seems to say; or is it enough to indicate elsewhere in the charts that all entries are performed by the DC?

Current administrative rule 811-015-0005 Records states, *"(1)(b) Every page of chart notes will identify the patient by name and one other unique identifier (date of birth, medical record number, etc.), and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record." (4/10/15)*

The Board's interpretation of this rule is that in a sole practitioner office, the entries are sufficiently identified by the name on the cover sheet, or at the top of every page, as long as there are not other people seeing and treating the patient. (07/19/12)

Record Keeping – Chart Notes Completion
While the best practice would be to complete the preliminary chart note within one day of the patient's visit, it is the policy of the OBCE that chart notes be completed within 72 hours of the patient's visit. The preliminary chart notes should be done within 72 hours of a patient's visit and a finalized version entered into the record no later than 30 days following the patient visit. (11/20/14)

REFLEXOLOGY (also listed under Chiropractic Assistants)
The board was asked whether an UN-licensed person (either CA or DC) may provide reflexology treatment on chiropractic patients within the Oregon chiropractor's clinic. The OBCE responded that this is unlicensed treatment of the chiropractic patients in the chiropractic clinic.

The inquiring physician is also a naturopath and this may be allowed under his naturopathic license for his ***naturopathic*** patients. Given this difference in scope, the Board reminded the chiropractor to always remember to chart under *which* license these services are being provided.

In conclusion, *ONLY* a person actively licensed in Oregon as a DC, or Chiropractic Assistant (under the direct onsite supervision of an Oregon licensed chiropractor), may perform reflexology on the chiropractic patients. (11/20/08)

REVOKED CHIROPRACTORS (WHAT THEY MAY AND MAY NOT DO)
(1) A revoked chiropractor shall not practice chiropractic. They shall not practice or attempt to practice through employees, agents, associates, corporations, partnerships or any other entity.
(2) A revoked chiropractor may not own and/or operate a chiropractic clinic. They must close the clinic and refrain from advertising or distributing any information that would likely cause the public to believe they are still licensed.
(3) A revoked chiropractor may sell the clinic business to another licensed chiropractor and/or may become a landlord for the business real estate, leasing or renting the property to another person. A revoked chiropractor must not retain any management authority and may not share in the proceeds of the business other than bona fide contract or rental payments.
(4) If a revoked chiropractor utilizes any portion of the clinic property for purposes other than practicing chiropractic, they must clearly segregate that portion from any chiropractic activity being conducted by lessors or purchasers. (6/21/91, 9/18/97)

SATELLITE OFFICES
If a chiropractor has two or more offices, they are to hang their original license (wall hanging) in the main office and hang their renewal certificate in a satellite office. A chiropractor may request a duplicate certificate ($5.00) from the OBCE. (11/29/91)

SCHOOL PHYSICALS
The Oregon Board of Chiropractic Examiners reaffirms that chiropractic physicians are qualified by "clinical training and experience to detect cardiopulmonary diseases and defects." SB 160, enacted by the 2001 Oregon Legislature, specified that chiropractic physicians may perform school physicals provided they have this training.

Chiropractic physicians have extensive training in diagnosis. This includes the ability to detect cardiopulmonary diseases and defects, as well as a range of other conditions.

Chiropractic professional education covers this subject in physiology, physical diagnosis and cardiorespiratory diagnosis classroom hours as well as internships in student clinic and outpatient clinic experience.

Further, cardiovascular diseases and defects and related diagnosis are tested on four qualifying examinations performed by the National Board of Chiropractic Examiners (NBCE). NBCE Parts I, II, and III are given to chiropractic students as they proceed through college. The NBCE Part IV practical examination is required for licensure in Oregon.

State law requires doctors to use the School Sports Pre-Participation Examination form approved by the Oregon Department of Education. This form also includes suggested exam protocols. It

can be obtained from the OR School Athletics Association web page
http://www.osaa.org/docs/forms/

Chiropractic physicians are further reminded that performing a school physical examination creates a doctor-patient relationship. The resulting records must be retained by the chiropractic physician for seven years or until the student (patient) is eighteen. These records may be stored off site (such as at the school), as long as the DC has access and confidentiality is maintained. (However HIPAA requirements should be reviewed if this is done.) (07/18/02)

TELEMARKETING

Chiropractors may engage in telemarketing to gain patients. Neither the Board nor anyone else may restrict chiropractors from using telemarketing to advertise. However, the Board does have the ability to proscribe any advertisement that is false, or that could be misleading or deceptive. See OAR 811-015-0045.

As far as telemarketing is concerned, OAR 811-035-0015(24) does not prohibit giving or receiving a commission in the referral of patients for chiropractic services. Due to Article I, section 8 of the Oregon Constitution, administrative rule 811-035-0015(24) does not apply to this situation. (7/22/96)

TESTIMONIALS

See also, "Advertising Review Policy"

Question: I have been reading your guide on testimonials and I wanted to clarify what we are considering. We would like to film our patients, without a script about their experience with their problem, our office, our treatment, and their results. We are happy to put any disclaimer that is deemed important by the board, but feel that testimonials are extremely important to marketing chiropractic. I have noticed that most chiropractic websites have testimonials. Please advise if it is ok to use honest, unscripted patient reports on our website.

Answer: You're referring to the Federal Trade Commission's guide which is found on the OBCE's website. The OBCE doesn't have any rules prohibiting testimonials. It's probably best to obtain a written permission statement from any patients who provide testimonials. There is a rule which says advertising must not be deceptive or misleading.

TRAVEL-TO-TREAT

(See ORS 684.020 And 684.107) The Board does not have a set limit on the number of times an out of state chiropractor may come into Oregon as long as it is "a single temporary assignment for a specific sporting, performing arts or educational event not to exceed 15 days" and, the doctor "is actively engaged in the practice of chiropractic in the state in which the person is licensed." The Board does not require notification that this provision of law is being utilized. (2/27/97, 9/18/97)

X-RAY SERVICES BY CHIROPRACTIC PHYSICIAN

A chiropractic clinic may take X-rays for another chiropractic physician or doctor. While this does not create a patient relationship with the doctor or other appropriately licensed person taking the films, the chiropractic clinic still has the obligation to abide by the x-ray rules found in OAR 811-030-0020 and OAR 811-030-0030 (addressing shielding, contraindications such as pregnancy, diagnostic quality etc.).

In order to request films, the ordering doctor should include the relevant diagnoses, area of clinical interest, birth date, etc. so that the clinic taking the films has a "double check" that ensures the proper films are taken. It is not necessary for the clinic taking the films to review the entire patient file to determine whether the views ordered are in fact clinically necessary.

It is highly recommended all chiropractic physicians with x-ray equipment review OAR 811-030-0020 and OAR 811-030-0030, which also includes these record keeping requirements:

- The operator shall maintain a record on each exposure of each patient containing the patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors. For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-045 requires the facility to determine the typical patient exposure for their most common radiographic examinations, i.e. technique chart.
- Each film shall be properly identified by date of exposure, location of X-ray department, patient's name or number, patient's age, right or left marker and postural position marker and indication of the position of the patient.

(3/18/10)

X-RAY (Which Views Are Necessary?)
Concerning views necessary for proper evaluation of the spine, the Board determined that it is up to the doctor's professional discretion.

However, the standard recognized by the Board is OAR Chapter 333, Division 106(15) which states, "The number of radiographs taken for any radiographic examination should be the minimum number needed to adequately diagnose the problem." Chapter 811 administrative rules and P & U Guidelines should be followed. (12/19/96)

APPLICANTS (for Chiropractic)

DISCLOSURE OF SCHOOL RECORDS
This policy is regarding disclosure of school records without permission of the student.

The Board staff may disclose:

1. name of school,
2. graduation date, and
3. transcript without grades or pass/fail information. (1991)

EXAMINATION
Appeals
Oregon law chapter 684 does not contemplate appeals. The Board does NOT allow any appeal process and it may deny a license based on failure to pass the test. (5/18/93)

Exam Schedules
The OBCE will offer at least four Oregon specific examination opportunities each year. Retakes will be given each examination. (10/16/97)

National Board of Chiropractic Examiners (NBCE) Part IV
Effective February 1, 1998, The Oregon Board of Chiropractic requires the National Board of Chiropractic Examiners' (NBCE) Part IV exam for licensure in Oregon.

All candidates taking the state boards, must show proof of a passing grade in Part IV (in addition to all other application requirements)**.** Candidates will be required to take three (Oregon specific)

exams. The three exams include Ethics/Jurisprudence/Public Health, Obstetrics/Gynecology, and Minor Surgery/Proctology.

Reciprocity candidates are not affected by the Board's decision to accept Part IV. Generally, reciprocity candidates are not required to test in any practical exams. (7/18/96; 7/9/98)

Physiotherapy Minimum Educational Requirement
The Board determined that for a chiropractic college to meet our 120-hour requirement, all their hours must be documented classroom hours. The Board said it was too hard to document clinical hours toward this requirement. (8/20/98)

Special Purposes Examination for Competency (SPEC)
Reciprocity applicants who lack the required NBCE examinations may request the OBCE's authorization to take the NBCE Special Purpose Examination for Competency (SPEC) under the provisions of ORS 684.052. The Executive Director may authorize this unless there are other reasons for OBCE review. (7/31/2003)

Waivers (from application/examination deadlines)
The Executive Director will determine a finding of fact in each request for waiver of deadlines for applicants wanting to take the Oregon specific examinations and will send the information to each Board member for them to approve or deny. (9/18/97)

FELONY RECORD
The Board may deny a chiropractic applicant licensure with a felony conviction in areas that could be harmful to patients. ORS 684.100(1) states, "The board may refuse to grant a license...upon the following grounds: ... (d) A conviction of a felony or misdemeanor involving moral turpitude."

Any applicant denied a license for this reason has a right to appeal and make his/her case in a contested case hearing. Upon review of the hearing officer's recommendations, the Board will then consider whether to approve the application, with or without conditions, or continue to deny.

PRE-PROFESSIONAL LIBERAL ARTS AND SCIENCES POLICY
At its November 2001 meeting, the OBCE reconsidered its policy on pre-professional education for license application in Oregon. The Board determined that it will accept the Council on Chiropractic Education's (CCE's) standards defined for two-year's education. (11/29/01)

WORKING UNDER A LICENSED CHIROPRACTOR
Chiropractic college interns (12th quarter students) engaged in clinical studies during the period of the students' enrollment in an institution authorized to confer a doctoral degree in chiropractic may work in a chiropractic clinic when the doctor, who must have faculty status with a chiropractic college, is teaching them adjustive technique in an actual 'hands on' situation. The student may perform chiropractic in an instruction mode under the doctor.

The doctor is to refer to the student as an intern or chiropractic student. The student is not to be called a doctor. The doctor and student must get permission from the patient before the student works on the patient. (8/15/91, 7/17/97, 7/9/98)

CERTIFIED CHIROPRACTIC ASSISTANTS

The Certified Chiropractic Assistant (CCA) may perform physiotherapy, electrotherapy, or

hydrotherapy once he or she has received the certificate from the Board. The CCA scope of practice does not include performing physical examinations, taking initial histories, taking X-rays, interpretation of postural screening, doing manual muscle testing or performing osseous adjustments or manipulations. (See OAR 811-010-0110)

ANY TRAINED PERSON (INCLUDING CERTIFIED CAS) MAY PERFORM THE FOLLOWING

1) Clarify initial patient intake history, which includes recording or performing height, weight, blood pressure, temperature, and pulse rate.
2) Record hand dynamometer readings.
3) Demonstrate, teach, check and review with patients the doctor's prescribed exercises
4) Facilitate provision of vitamins and/or supplements to patients as ordered by the doctor.
5) Relay doctor's instructions to the patient on recommendations of nutritional needs.
6) Facilitate provision of cervical pillow or support as recommended by the doctor.
7) Make follow-up phone calls to patients on their progress as instructed by the doctor.
8) Schedule return office visits for patients as instructed by the doctor.
9) Schedule referrals as instructed by the doctor.
10) Check patient's body fat percentage.
11) Perform postural screenings under the on-site supervision of a chiropractor, but only a Chiropractor may interpret the information.
12) May apply electrodes and conduct surface EMG testing, but the doctor has to interpret the results.
13) This list is not intended to be all-inclusive.

(Updated 11/16/95, 7/18/96; 11/20/08; 4/3/09)

ASSISTANT LICENSES, VALID IN OREGON

A Chiropractor who practices in Taiwan which recognizes United States Chiropractic licenses asked, "If it is possible, can the State of Oregon issue a chiropractic assistant license for the chiropractic assistants here in Taiwan? The Board responded "No. A chiropractic assistant certificate is only valid in the State of Oregon and under the supervision of an Oregon licensed chiropractor."

COLONICS OR COLONIC THERAPY

See also "Colonic Therapy" under "Chiropractors"

The board determined that colonic therapy is hydrotherapy and is allowed within the scope of chiropractic practice, but CCAs are not allowed to perform it due to the higher risk of the procedure. There are inherent risks, such as causing septic shock by rupturing the bowels. (9/28/07) (9/15/14)

COMPUTERIZED MUSCLE AND INCLINOMETER TESTING

Certified Chiropractic Assistants may not do computerized muscle or inclinometer testing. The Board considers this to be part of the physical examination. (9/21/00)

A follow up request was made asking if the inclinometer may be used by a Chiropractic Assistant. The Board maintains that this is part of the physical examination; the scope of practice does not allow it. (10/26/11)

(DIRECT) SUPERVISION OF CLINIC STAFF

The OBCE was asked if licensed chiropractic assistants could provide therapies in a business space next door to the clinic. The OBCE responded that the chiropractic assistant who is supervised needs to be in the same office space (defined as the same building or space contiguous) as the supervising doctor. OAR 811-035-0001 states, "'Direct supervision' means

that the licensed Chiropractic Physician is physically present in the clinic, is monitoring the activities of the supervisee in the clinic and is available to intervene, if necessary."

If an employee and/or independent contractor is independently licensed to perform prescribed services within their scope of practice they may do so without direct supervision of the chiropractic physician. (7/31/03) (12/1/11)

ENGLISH PROFICIENCY REQUIREMENT FOR CA APPLICANTS
The Board reviewed this matter in light of a question from a licensee - May he interpret or provide an interpreter for non-English speaking CA applicants (to successfully complete the application and exam)? The OBCE surveyed other state health regulatory boards and determined that most other boards require that licensees be English-speaking proficient. Many of the other health-related licensing boards already have a policy, rule, or statute requiring applicant's to be English-speaking.

The Board determined that ALL (CA) applicants must be proficient in English in order to complete the chiropractic assistant licensing process in Oregon. (May 2008)

FELONY RECORD
The Board may deny a certified chiropractic assistant applicant certification with a felony conviction in areas that could be harmful to patients. ORS 684.100(1) states, "The board may refuse to grant a license...upon the following grounds: … (d) A conviction of a felony or misdemeanor involving moral turpitude."

Any applicant denied certification for this reason has a right to appeal and make his/her case in a contested case hearing. Upon review of the hearing officer's recommendations, the Board will then consider whether to approve the application, with or without conditions, or continue to deny.

INITIAL TRAINING FOR CA APPLICANTS
All initial training for Chiropractic Assistants must be completed according to OAR 811-010-0110.

Chiropractic Students Training To Be Chiropractic Assistants
Seventh (7th) quarter students and above may use the completed course in Physiological Therapeutics in lieu of the OBCE's Initial Training Program to be a certified chiropractic assistant. A copy of their transcript or a letter from the course instructor on college letterhead will be accepted as proof of completion of the course. See OAR 811-010-0045 (3) for other specifics. (4/15/93)

Massage Therapists
The Board determined that a massage therapist must acquire the 12 initial training because they are not trained in the hydrotherapy or electrotherapy. (11/99) (01/11)

Physical Therapist Assistants
Question: May PTAs submit their **physical therapist assistant** education in lieu of the OBCE's required 12-hour initial training course to be licensed as a certified chiropractic assistant (CCA)?

The Board determined that PTA's will be waived from the 12-hour initial training requirement if the PTA education was completed within the past five years, *or if they have been continuously employed in the past five years.* (11/99) (01/11)

Online Initial Training (also see Webinar Training below)
The Board has determined that CA initial training courses (ITC) may be presented online for the 8-hour didactic (lecture) portion of the required 12 hours. An approved program will meet the following criteria

- Obtain OBCE approval prior to any presentation being offered
- Monitor and verify attendance (which must be no less than the 8 hours required) *
- Provide adequate testing frequently throughout the training ** and
- Provide a certificate of completion to each attendee

*** Monitoring/Verifying Attendance** - Each pre-approved course must incorporate a monitoring system, and verify the online attendance. The learner must login using a unique username and password. The system should log the amount of time the learner spends on the course and the learner cannot complete the course in less time than is assigned to the particular course.
**** Testing** - Interactive test questions must be presented throughout the course.

Current board-approved trainers (and their related courses) may be converted to an online course meeting the above criteria without additional board approval. *(The required (4-hours) hands-on portion must still only be provided live.)* (9/15/14)

Other Training or Certification
If an applicant has a current certificate or license from another state, or adequate documentation of training, the Board may waive the requirements for the initial training course. (11/99)

Supervising DC, Training by the
Due to a need for more initial training courses for chiropractic assistants, the Board determined that a supervising DC may train his applying CA. The DC must be in attendance, and directly supervising the CA during the training.

The Board determined that the DC must keep adequate documentation and submit evidence to the Board that the CA was appropriately trained according to OAR 811-010-0110. The OBCE developed a form which will meet all the points of this policy and the administrative rule. The form is available by request at the administrative office.

The Supervising DC and chiropractic assistant should understand that this does NOT preclude certification by the OBCE. This process addresses the 12-hour initial training only. Each assistant must still apply with the OBCE, take the open book exam and submit the required fees. OAR 811-010-0110 is still in effect and included in the chiropractic assistant application packet. (11/99) (01/11)

Webinar Training
It was proposed to the Board that webinars be allowed as a training tool for the eight (8) hours didactic portion of the Chiropractic Assistants initial training. After considering a draft of the proposed outline/presentation, the Board approved webinars as a viable option for the training. The Board continues to deny video presentations as they want the live person to person interaction.

Any program offered for chiropractic assistant initial training must be pre-approved by the Oregon Board of Chiropractic Examiners (Board). Note: “Pre-approval” is already required with current administrative rule. The Board will ONLY consider for pre-approval a minimum eight

(8) hour program which covers all modules of the Board's required didactic training outline. These programs may be offered either in-person or by LIVE (not pre-recorded) webinar. This policy is drafted to better implement administrative rule 811-010-0110(2)(a)(i) through (iii).

When a program for approval is a webinar, it must meet the additional following criteria:

1. The proposed program must include technology which enables participants and the instructor to ASK and ANSWER questions in real time
2. Must offer some evaluation after EACH module of OBCE's required outline; the Board requires a minimum of 4 questions be asked
3. The sponsor/program must be able to demonstrate that interaction on the part of participants is required throughout the presentation. (for example: webcams, question/answer, etc.)
4. Answers to survey questions must be recorded and made available to the Board, if requested for audit purposes.
5. The webinar software and/or vendor must be able to record the ACTUAL time each participant spends "in" the webinar.
6. All webinar sponsors/programs must provide timely evidence of attendance after each full (minimum eight hours) program is completed. This report will include: Actual time each participant spends in the webinar, each participants name and e-mail address, Evidence of participation for each attendee (questions asked, answers to poll questions, etc.)

The board reserves the right to revoke approval for any training vendor that does not comply with the guidelines listed above at any time. It also reserves the right to not accept the training of Chiropractic Assistant applicants who enroll in webinar training but there is insufficient evidence in the opinion of the Board to conclude that they attentively participated in such training by an approved vendor. (08/16/12)

KINESIOTAPING METHOD

May a certified Chiropractic Assistant perform "kinesiotaping"? The kinesiotaping Method involves taping over and around muscles in order to assist and give support to, or prevent, over-contraction. The Board determined if the supervising DC is trained in the taping method, that he or she may also train the certified CA also to perform the method in the clinic, and only while the DC is on premise. The Board considers this a physiotherapy. (3/15/07)

The Board was asked for additional clarification on the Kinesiotaping policy. "Does the board consider the two methods – 'Kinesiotaping' and 'taping' - one in the same?" Yes. The Board hasn't distinguished a difference. And, referring to the policy's second sentence, the question was asked, "If the DC is trained in the taping does this mean the DC needs to be trained to the extent that he holds a 'certification' in Kinesiotaping, or taping?" No. The training received in chiropractic college is sufficient. Other reasonable training would be acceptable also. (05/15/12)

LASER LIGHT THERAPY

Refer to Laser Light Therapy in Section 1 Procedures.

MASSAGE, OVERSIGHT REQUIREMENTS

See also, "Therapies, including Massage"

Question: Does this mean the supervising chiropractic physician should be entering the treatment room periodically or seeing the patient during the same appointment for massage therapy (performed by the CCA)?

Answer: No, the OBCE's policy doesn't say that, although it may be advisable as regards the particular patient's needs. We would presume there is other contact between the doctor and patient.

If a chiropractic clinic decides to have CCAs provide full body massages without having a meaningful patient relationship, the OBCE appreciates the concerns that would raise. That said, massage can be an important part of a chiropractic wellness program. Abuses of this privilege could lead to additional OBCE rulemaking mandating additional training for CCAs who provide full body massages or limiting their scope in this area.

Myofascial release is allowed within the CA scope of practice. (07/20/17)

QUANTITATIVE FUNCTIONAL CAPACITY EVALUATIONS (QFCE)

QFCEs are not within the chiropractic assistant scope of practice. The QFCE requires the doctor's clinical judgment for evaluation and performance. CAs do not have the required training for this. The board also determined that QFCEs may not be performed by a Certified Strength and Conditioning Specialist (CSCS) under the OBCE's "Any Trained Person" policy, thus a CSCS may not perform this as part of the chiropractic clinic's services in or out of the clinic. The QFCE has to be performed by the chiropractic physician (or other licensed health provider within their scope of practice). (3/21/13)

RANGE OF MOTION

A chiropractor submitted a letter inquiring whether chiropractic assistants or any "trained personnel" may perform range of motion tests. The Board determined that chiropractic assistants or other persons may not perform range of motion tests. According to the administrative rule 811-010-0110(7) for CAs, it is clear that "the scope of practice does not include performing physical examinations…" The performance of range of motion tests is definitely a physical examination. (12/99)

REFLEXOLOGY

The board was asked whether an UN-licensed person (either CA or DC) may provide reflexology treatment on chiropractic patients within the Oregon chiropractor's clinic. The OBCE responded that this is unlicensed treatment of the chiropractic patients in the chiropractic clinic.

The inquiring physician is also a naturopath and this may be allowed under his naturopathic license for his *naturopathic* patients. Given this difference in scope, the Board reminded the chiropractor to always remember to chart under *which* license these services are being provided.

In conclusion, *ONLY* a person actively licensed in Oregon as a DC or Chiropractic Assistant (under the direct onsite supervision of an Oregon licensed chiropractor), may perform reflexology on the chiropractic patients. (11/20/08)

REIKI

A Doctor of Chiropractic asked if his certified Chiropractic Assistant may practice Reiki, a form of massage therapy, in his office without his supervision. The Board determined that the certified CA may perform this type of massage ONLY if the supervising DC is also Reiki-trained, and on premise to supervise. If the certified CA, trained in Reiki, is also an Oregon licensed massage therapist, then that is already allowed with the LMT scope of practice. (3/15/07)

TERMINOLOGY

The use of the terms for chiropractic assistants, "massage therapist" and "therapist" are misleading and should not be used, as per the Oregon Administrative Rule 811-015-0045. The

Board also determined that the designation “CCA” or “CA” (see below) should be spelled out, since many people would not recognize the acronym.

The rule was changed so that “Certified” has now been dropped and we are now referring to them simply as “Chiropractic Assistants.” (9/16/2008)

THERAPIES, Including Massage

All CCA provided therapies must be performed under the supervision of a chiropractic physician who must always be on premise. A CCA could provide a full body massage if the chiropractic physician prescribes it, and provides instruction on how to do it.

Whatever therapy is provided by a CCA has to be justified by the results of the history, examination, and diagnosis for each chiropractic patient, as governed by the Oregon Chiropractic Practice and Utilization Guidelines and other applicable administrative rules. A CCA may not provide any therapy that is not part of chiropractic patient care. (1/25/12)

VITALS, CONTINUING EDUCATION

Newly certified chiropractic assistants must submit to the Board proof of completion of two hours in Vitals CE at their first renewal. Training is to include lecture and hands-on. For the hands-on portion, 20 documented checks of each of the following must be performed: blood pressure, pulse, respiration*; and body temperature. A minimum of 10 different people must be tested. The OBCE has a prescribed form to log the vitals.

* Measuring respiration can be done by auscultation (listening with a stethoscope) to count the breaths or observing movements of the chest. 3/17/16

WORKING FOR OTHER HEALTH-CARE PROVIDERS

A certified chiropractic assistant (CCA) is only certified to work in a chiropractic office under the direction of a licensed chiropractic physician. Other health care providers may not have their personnel take the Board’s CCA exam for certification in their office. (8/15/91)

SECTION III

NEW & UPDATED Board Policies

The following policies are either new or updated to a new format.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Animal Chiropractic Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to provide chiropractic care to animals.

Policy:

Yes, under the following conditions:

- Active Oregon chiropractic license;
- Successfully completed post-graduate animal chiropractic program; and
- Current written referral from an active licensed treating veterinarian.

As applicable to CAs:

Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Birth Certificate Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to sign birth certificates.

Policy:

Yes, for chiropractic physicians under the following conditions:

- Active Oregon license;
- Have appropriate Board approved specialty certification in Obstetrics; and
- Must have attended and managed the birth.

As applicable to CAs:

Not within the scope of certified chiropractic assistants.

ORS 432.005(26) "Physician" means a person authorized to practice medicine, chiropractic or naturopathic medicine under the laws of this state or under the laws of Washington, Idaho or California, a physician assistant licensed under ORS 677.505 to 677.525 or a nurse practitioner licensed under ORS 678.375 to 678.390.

Oregon Board of Chiropractic Examiners	Effective Date: September 17, 2020 Date approved/ratified: September 17, 2020
CHIROPRACTIC ASSISTANT CONTINUING EDUCATION COURSE INSTRUCTION	

POLICY

An individual or entity may conduct certified chiropractic assistant continuing education courses, provided they meet any of the following:

(a) A professional degree in a healthcare related field or a license from a health professional regulatory board;

(b) Three years of experience as a certified chiropractic assistant in the State of Oregon;

(c) A degree or certification for college-level courses that supports job duties of a certified chiropractic assistant; or

(d) Are a company or entity that offers continuing education to health care providers.

Oregon Board of Chiropractic Examiners	Effective Date: September 17, 2020 Date approved/ratified: September 17, 2020
CHIROPRACTIC ASSISTANT INITIAL COURSE INSTRUCTION	

POLICY

An individual or entity may conduct initial certified chiropractic assistant training, provided they meet any of the following:

(a) A professional degree in a healthcare related field or a license from a health professional regulatory board. The practical training must be in physiotherapy, electrotherapy and hydrotherapy administered by a health care provider licensed to independently provide those therapies; or

(b) Are a company or entity that offers continuing education to health care providers.

PROCEDURES

Links detailing the initial training requirements are below:

http://www.oregon.gov/obce/Documents/Guidelines_for_DC_Training_CA.pdfhttps
https://www.oregon.gov/obce/Documents/CA_InitialTrainingSyllabus.pdf

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Clinical Nutrition Counseling Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensee to provide clinical nutritional counseling.

Policy:
Yes, any active Oregon licensed chiropractic physician may provide clinical nutritional counseling.

As applicable to CAs:
Certified chiropractic assistants may assist with clinical nutrition counseling at the direction of the supervising licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Colonic Therapy Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform colonic therapy.

Policy:
Yes, any active Oregon licensed chiropractic physician may perform colonic therapy.

As applicable to CAs:
Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Compensation for Patient Referrals Policy	

Issue: Whether it is allowed for Oregon chiropractic licensees to offer or receive compensation for patient referrals.

Policy:
Compensation offered or received in excess of a token or de minimis gift over the course of a year is prohibited. Offering or receiving compensation per referral versus a one time may be considered an inappropriate inducement for patient referrals.

As applicable to CAs:
Same as above.

See 42 USC Sec. 1320a-7a(a)(5); 42 USC Sec. 1320a-7a(i)(6); 42 USC Sec. 1320a-7b(b); OAR 811-035-0015(28).

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Device-Assisted Range of Motion Measurement and Muscle Testing Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform device-assisted range of motion or muscle testing.

Policy:
Yes, any active Oregon licensed chiropractic physician may perform device-assisted range of motion or muscle testing.

As applicable to CAs:
A certified chiropractic assistant may perform device-assisted range of motion measurement but may not interpret the findings. They may not perform manual or device-assisted muscle testing.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Diagnostic Imaging Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform, order, and interpret diagnostic imaging studies.

Policy:

Perform

Any active Oregon licensed chiropractic physician may perform diagnostic imaging procedures.

Order

Any active Oregon licensed chiropractic physician may order any type of diagnostic imaging modality that is clinically indicated.

Interpret

Every diagnostic imaging procedure must be accompanied by a formal interpretation report.
Any active Oregon licensed chiropractic physician may interpret any type of diagnostic imaging modality for which they are appropriately trained.
Interpretation may be referred to another qualified licensed professional. Referral for a second opinion does not establish a doctor/patient relationship.

Integration

All available diagnostic images must be integrated into a patient's evaluation and management plan.

As applicable to CAs:

A certified chiropractic assistant may not perform, order, or interpret any diagnostic imaging solely under their CA scope. A certified chiropractic assistant may take radiographs with appropriate certification and radiographic technician license under the order of the supervising licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Disabled Person Parking Permits Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to qualify a person for a disabled person parking permit.

Policy:
Yes, any active Oregon licensed chiropractic physician may qualify an established patient for a disabled person parking permit.

As applicable to CAs:
Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Durable Medical Equipment Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to recommend, order, or provide durable medical equipment.

Policy:
Yes, it is within the scope of an Oregon licensed chiropractic physician to recommend, order, or provide durable medical equipment.

As applicable to CAs:
Certified chiropractic assistants may not recommend or order durable medical equipment. They may, however, provide instruction on use, if properly trained to do so and under the direction and supervision of a licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Electrodiagnostic Testing Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform, order, or interpret electrodiagnostic testing.

Policy:

Perform

Any active Oregon licensed chiropractic physician may perform electrodiagnostic testing which requires appropriate training and certification.

Order

Any active Oregon licensed chiropractic physician may order any type of electrodiagnostic testing that is clinically indicated.

Interpret

Every electrodiagnostic testing procedure must be accompanied by a formal interpretation report. Any active Oregon licensed chiropractic physician may interpret any type of electrodiagnostic testing procedure for which they are appropriately trained.

Interpretation may be referred to another qualified licensed professional. Referral for a second opinion does not establish a doctor/patient relationship.

Integration

All available electrodiagnostic tests must be integrated into the patient's evaluation and management plan.

As applicable to CAs:

A certified chiropractic assistant may not perform, order, or interpret any electrodiagnostic testing solely under their CA scope. A certified chiropractic assistant may perform electrodiagnostic testing procedures with appropriate certification and training under the order of the supervising licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: October 15, 2021 Date approved/ratified: September 16, 2021
Electroencephalogram (EEG) Test Policy	

ISSUE: Whether it is within the scope of practice for Oregon licensed chiropractic physicians to interpret electroencephalogram (EEG) tests.

POLICY:

For Oregon licensed chiropractic physicians who are appropriately trained in interpreting EEG techniques and testing, and provide proof of said training to the OBCE, it is within the scope of practice for that trained physician to interpret EEGs.

If the chiropractic physician is screening for a psychological or psychiatric component of an EEG, that screening and analysis is outside the scope of practice for Oregon licensed chiropractic physicians and the physician should refer the patient out for appropriate testing by another type of healthcare professional.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Electronic Health Records and Signatures Policy	

Issue: What are the timeline requirements for documentation and signatures for chart notes/SOAP, including paper and electronic health records.

Policy:

The timeline requirements are as follows:

- Documentation (dictation, handwritten notes, electronic chart entry, etc.) completed within 72 hours of a patient's visit.

- Electronic signature within 30 days.

Documentation is required for treatment of any and all patients including family members, spouses, and employees.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Electrotherapy Devices and Treatments Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to use electrotherapy devices and treatments.

Policy: Electrotherapy devices and treatments fall under the heading of "physiotherapy" which is within scope of Oregon licensed chiropractic physicians.

Rectal electrotherapy treatment by chiropractic physicians requires additional training for certification pursuant to OAR 811-015-0030.

As applicable to CAs:
Certified chiropractic assistants may not order electrotherapy devices or treatments. They may not perform intra-orificial electrotherapy. Certified chiropractic assistants, with appropriate training, may utilize electrotherapy devices and treatments under the supervision and direction of an Oregon licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Emergency First Aid/Medicine Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to administer emergency first aid/medicine.

Policy: Yes, it is within scope for Oregon licensed chiropractic physicians and certified chiropractic assistants to administer emergency first aid/medicine, including but not limited to:

- AED machine
- Basic First Aid procedures
- CPR
- Emergency use of oxygen*
- Epi-pen**
- Naloxone

This policy is addressing use only but not access or prescription rights and requires proper training for use.

* Please review "Emergency Oxygen Use" Policy
** Oregon licensed chiropractic physicians are authorized to use Epi-Pens in appropriate clinical situations but are not authorized to prescribe them.

As applicable to CAs:
Same as above.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Emergency Oxygen Use Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to administer emergency oxygen.

Policy: Yes, it is within scope to administer emergency oxygen. Please refer to ORS 684.025(4) and OAR 811-010-0090(3) for proper procedures and requirements.

As applicable to CAs:
Same as above.

Oregon Board of Chiropractic Examiners	Effective Date: September 16, 2021 Date approved/ratified: September 16, 2021
Emotional Support Animals	

ISSUE: Whether Oregon licensed chiropractic physicians can write an approval or reference letter for an emotional support animal (ESA).

POLICY:
It is outside the scope of practice for an Oregon licensed chiropractic physician to write letters in support of obtaining an emotional support animal's registration or use. Because chiropractic physicians are not licensed mental health professionals, it is outside the scope of chiropractic physicians to diagnose the conditions allowing for the registration or use of ESAs.

Please see the following sources:
Oregon Board of Licensed Professional Counselors and Therapists (Fall 2018, page 2):
https://www.oregon.gov/OBLPCT/Documents/Newsletter_Fall_18.pdf
ESA Registration of America: https://www.esaregistration.org/esa-letter/

Oregon Board of Chiropractic Examiners	Effective Date: July 25, 2019 Date approved/ratified: July 25, 2019
EXTRACORPOREAL SHOCKWAVE THERAPY (EST)	

ISSUE

Whether extracorporeal shockwave therapy (EST) is within the scope of practice for chiropractic physicians.

POLICY

EST is within the scope of practice for chiropractic physicians. The OBCE approves and affirms, as standard use, EST for use by chiropractic physicians as well as certified chiropractic assistants who have been properly trained for its use.

Oregon Board of Chiropractic Examiners	Effective Date: May 12, 2017 Date approved/ratified: January 25, 2018
FEDERAL AVIATION ADMINISTRATION (FAA) BASIC MED MEDICAL EXAMINATION	

ISSUE(S)

1. Whether Oregon Doctors of Chiropractic are considered "physicians;" and
2. Do DCs have the privilege and experience to conduct the "BasicMed" FAA Medical examination?
3. Is any additional training required in order for DCs to perform the FAA BasicMed Medical examination?

POLICY

Doctors of Chiropractic, duly licensed and active in Oregon, are considered state-licensed physicians under ORS 684.010(3). The "BasicMed" FAA Medical examination is within the training and scope of practice for Doctors of Chiropractic within Oregon.

The Board does not make a statement as to whether the FAA should allow Oregon DCs to perform these exams as the Board does not make FAA rules and does not interpret those rules.

In order to perform the FAA BasicMed Medical examination, the Board requires DCs to take and successfully pass the Certified Medical Examiner training, be certified and listed on the National Registry of Certified Medical Examiners, and take an additional 2 hours of PACE approved training.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Gynecological/Genitourinary Examination and Diagnosis Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform gynecological and/or genitourinary examinations.

Policy:
Yes, so long as the licensee has an active Oregon chiropractic physician license. The examination procedures that are allowed include, but are not limited to:

- PAP Smear
- STI testing
- Routine screening examinations
- GU examinations

This policy does not address obstetrics or proctology. Please see relevant rules and laws regarding obstetric and proctology certification.

As applicable to CAs:
Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: January 16, 2020 Date approved/ratified: January 16, 2020
HEMP AND MARIJUANA DERIVED PRODUCTS	

POLICY

The purpose of this policy is to provide licensees with guidance regarding the use and recommendation of hemp and marijuana derived products.

Authority:

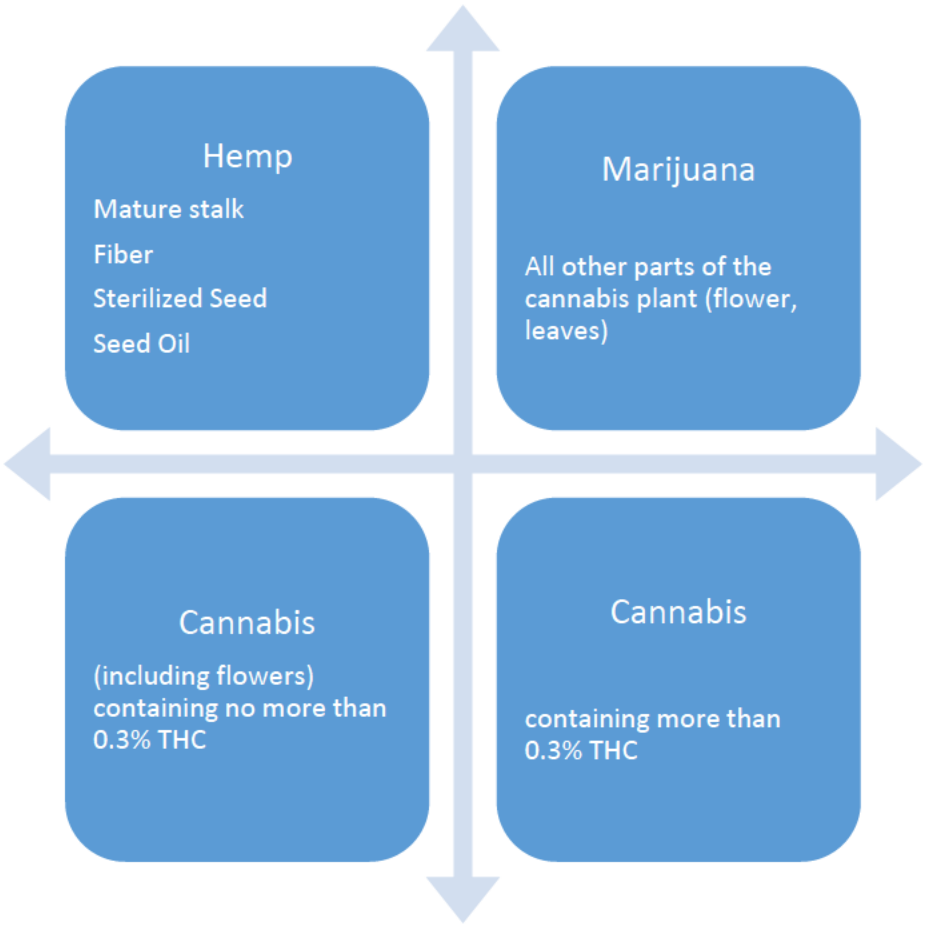
1) ORS 475B, OAR 603, and OAR 333
2) ORS 475B and OAR 845-025 regulate recreational marijuana
3) ORS 571 details the requirements for the sale and use of CBD products
4) ORS 614 details the regulations around recreational marijuana.
5) ORS 676.150 details health professionals' duty to report
6) ORS 684 details the scope of practice for chiropractic physicians
7) OAR 811-015-0010, Clinical Justification
8) OAR 811-015-0070 Scope of Practice Regarding Examinations, Test, Substances, Devices, and Procedures
9) Oregon Retail Sale of Cannabidiol (CBD) Products FAQ: https://www.oregon.gov/pharmacy/Imports/Cannabidiol_CBD_Informational_6.2019.pdf
10) FDA Regulation of Cannabis and Cannabis-Derived Products, Including Cannabidiol (CBD) https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd (last visited October 31, 2019)
11) FDA and Marijuana: Questions and Answers https://www.fda.gov/newsevents/publichealthfocus/ucm421168.htm#dietary_supplements (last visited December 26, 2018)
12) Statement from FDA Commissioner Scott Gottlieb, M.D., on signing the Agriculture Improvement Act of and the agency's regulation of products containing cannabis and cannabis-derived compounds, https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm628988.htm (last visited December 26, 2018)

Definitions:

"Industrial hemp" has the meaning as defined by ORS 571.300 (2017). By definition, such products contain an average tetrahydrocannabinol (THC) concentration that does not exceed 0.3 percent on a dry weight basis.

"Marijuana" and "cannabinoid products" have the meaning defined in ORS 475B.015 (2017).

"Cannabinoid," "cannabinoid product," "cannabinoid concentrate," "cannabinoid extract," "cannabinoid tincture," and other similar terms have the definitions specified by OAR 845-025-1015 (2019) and ORS 475B.791.



Regulatory Oversight

	Medical Marijuana	Recreational Marijuana	Industrial Hemp
Product	Marijuana	Marijuana products and CBD products derived from marijuana or industrial hemp containing ≥ 0.3% THC.	CBD products containing ≤ 0.3% THC derived from industrial hemp..
Location of Sales	Designated growers or OHA regulated medical marijuana dispensaries.	Licensed OLCC recreational marijuana dispensaries.	Any retail location.
Restriction on Sales	Must have a medical marijuana card.	Must be >21 years of age or older.	None.

	Individuals with a qualifying medical condition and a recommendation for medical marijuana from an attending physician may apply for a medical marijuana card.	Source of CBD must be labeled – hemp or marijuana.	Unless the product is used for the sale of inhalant delivery systems and their components, then must be 21 years of age or older.
Regulatory Body	Oregon Health Authority (OHA)	Oregon Liquor Control Commission (OLCC)	Oregon Department of Agriculture (ODA)

*Please note that these regulatory bodies above may have specific statutory or rule requirements for sale of products. Please contact those agencies directly for further information.

All hemp items sold at retail in Oregon must comply with the product testing required for like-marijuana items (solvents, pesticides, etc.).

PROCEDURES

1. **Medical Use of Cannabidiol (CBD)**
   As of the date of the enactment of this policy, the U.S. Food and Drug Administration (FDA) continues to ban the use of CBD in food products and restricts its use as a dietary supplement. Based "on the evidence, FDA has concluded that THC and CBD products are excluded from the dietary supplement definition under sections 201(ff)(3)(B)(i) and (ii) of the FD&C Act, respectively. Under those provisions, if a substance (such as THC or CBD) is an active ingredient in a drug product that has been approved...or has been authorized for investigation as a new drug for which substantial clinical investigations have been instituted and for which the existence of such investigations has been made public, then products containing that substance are outside the definition of a dietary supplement. FDA is not aware of any evidence that would call into question its current conclusions that THC and CBD products are excluded from the dietary supplement definition under sections 201(ff)(3)(B)(i) and (ii) of the FD&C Act."

   The FDA has also issued warning letters to companies selling CBD products claiming that they prevent/treat diseases like cancer, diabetes, psychiatric disorders, etc. Examples: "soothing tincture for chronic pain," "CBD can successfully reduce anxiety symptoms," "For many, CBD holds the answers to treating depression."

2. **Clinical Justification.**
   The Board's existing rules require that the chiropractic physician utilize clinical rationale and justification that, "within accepted standards and understood by a group of peers, must be shown for all opinions, diagnostic, and therapeutic procedures. Accepted standards mean skills and treatment which are recognized as being reasonable, prudent. and acceptable under similar conditions and circumstances."

3. **Scope of Practice.**
   In considering the inclusion of new substances in the practice of chiropractic, the Board may take into account all relevant factors and practices, including, but not limited to: the practices generally and currently followed and accepted by persons licensed to practice chiropractic in the state, the teachings at chiropractic schools accredited by the Council

on Chiropractic Education or its successor at any time since 1974, relevant technical reports published in recognized journals, and the desirability of reasonable experimentation in the furtherance of the chiropractic arts.

A chiropractic physician may utilize substances that are supported in peer reviewed literature, which has clinical rationale, valid outcome assessments measures, is consistent with generally recognized contraindications to chiropractic procedures, and where the potential benefit outweighs the potential risk to the patient.

4. **Current Conclusions**

As chiropractic physicians do not have prescription rights within Oregon statute, there is no statutory authority to allow chiropractic physicians to recommend or prescribe marijuana, CBD, hemp, or products derived from these substances.

To dispense, use, or sell topical products derived from marijuana or hemp, licensees must abide by the laws and rules established by the OHA, OLCC, and ODA, as applicable. This is an explanation of OBCE's position and licensees act at their own risk with regard to federal prohibitions/requirements.

According to the FDA, under the FD&C Act, it is illegal to market and sell CBD as a dietary supplement.
https://www.oregon.gov/pharmacy/Imports/Cannabidiol_CBD_Informational_6.2019.pdf

Additionally, chiropractic physicians cannot sell recreational marijuana unless properly licensed through the OLCC to do so.
(https://www.oregon.gov/olcc/marijuana/Pages/FAQs-Licensing-General.aspx.)

Oregon Board of Chiropractic Examiners	Effective Date: July 26, 2018 Date approved/ratified: October 4, 2018
INSTRUMENT ASSISTED SOFT TISSUE MOBILIZATION (IASTM)	

ISSUES

Whether Instrument Assisted Soft Tissue Mobilization (IASTM), including Graston technique, is within the certified chiropractic assistant scope of practice.

POLICY

Certified chiropractic assistants may perform IASTM, including Graston technique, so long as they have obtained, and can provide proof of, in-person, hands-on, training in IASTM and perform it under the direct supervision of a chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: July 26, 2018 Date approved/ratified: October 4, 2018
IONTOPHORESIS AND PHONOPHORESIS	

ISSUES

1. Whether chiropractic physicians and certified chiropractic assistants may perform iontophoresis and phonophoresis?

2. If so, whether the use of lidocaine, salicylates, and dexamethasone is within the scope of practice for both types of practitioners?

POLICY

Iontophoresis and phonophoresis – procedures where a health practitioner uses an over-the-counter (OTC) topical substance with ultrasound or low voltage galvanic current – is within the chiropractic physician's scope of practice. (04/11/1996)

Certified chiropractic assistants may perform iontophoresis and/or phonophoresis under the chiropractic physician's supervision as a form of physiotherapy. (11/20/2008)

Use of OTC salicylates and lidocaine substances in phono-or iontophoresis is allowed within the scope of chiropractic practice. (04/11/1996) (09/17/2015)

Use of dexamethasone, in prepackaged dosages, by chiropractic physicians and certified chiropractic assistants for iontophoresis purposes is within the scope of practice for each type of practitioner. Chart notes should reflect the practitioner performing iontophoresis and the use of dexamethasone and the specific plan/order regarding how it is administered. (07/26/2018)

Oregon Board of Chiropractic Examiners	Effective Date: January 20,2022 Date approved/ratified: January 20, 2022
Laboratory Studies Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform, order, and interpret laboratory studies.

Policy:

Perform

Any active Oregon licensed chiropractic physician may perform laboratory studies with a current facility certificate or waiver issued by Clinical Laboratory Improvement Amendments (CLIA).

Order

Any active Oregon licensed chiropractic physician may order any type of laboratory testing that is clinically indicated.

Interpret

Every laboratory testing procedure must be accompanied by an interpretation report.

Any active Oregon licensed chiropractic physician may interpret any type of laboratory testing procedure for which they are appropriately trained.

Interpretation may be referred to another qualified licensed professional. Referral for a second opinion does not establish a doctor/patient relationship.

Integration

All available laboratory test results must be integrated into a patient's evaluation and management plan.

As applicable to CAs:

A certified chiropractic assistant may not perform, order, or interpret any laboratory testing solely under their CA scope. A certified chiropractic assistant may perform laboratory testing procedures with appropriate certification and training under the order of the supervising licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 25, 2018 Date amended: January 23, 2019

LICENSEES ON ACTIVE MILITARY DUTY POLICY AND PROCEDURE

POLICY

Deferral of renewal fees and continuing education requirements for licensees on active military duty who are deployed for 1 month or longer. Licensees who are not deployed, yet considered on active military duty, are required to pay annual renewal fees and abide by all renewal terms, including continuing education requirements.

PROCEDURES

1. When contacted by licensee of a deployment for military service, regarding renewal and continuing education requirements, staff will inform the military member that the renewal fee and CE requirements will be deferred until licensee returns from deployment but only if deployed at a length of one month or longer.
2. Staff will request that licensee submit official documentation of deployment to the OBCE.
3. Staff will inform licensee that they must contact the OBCE prior to returning to Active practice.
4. Staff will request required CE and the appropriate fees prior to renewing licensee's license.
5. If licensee returns mid-year they will be required to renew again on their regular renewal month. The costs will be prorated for the number of months remaining in the current renewal period.
6. If not deployed but on active military duty, licensee is required to pay annual renewal fees and abide by all renewal terms, including CE requirements.
7. If deployed or non-deployed active military duty licensee fails to pay renewal fees, ORS 408.450 applies.
8. Thirteen (13) months after failure to pay, the license is moved to dormant status; the license may be restored to original status pursuant to the procedure within ORS 408.450.

Oregon Board of Chiropractic Examiners	Effective Date: February 5, 2022_ Date approved/ratified: February 5, 2022_
Local Anesthetics: Topical/Injectable (Lidocaine)	

POLICY:
It is within the scope or practice for an Oregon licensed chiropractic physician to purchase, possess, prescribe, or utilize local anesthetics per the following criteria:
Criteria:

- Topical Lidocaine in liquid, gel, or patch at 2% to 5% (over-the-counter) to be used on the epidermis and mucus membranes, for the purpose of local anesthesia.
- Injectable Lidocaine (Xylocaine) to be used in connection with minor surgery as per ORS 684.010(5) in the following concentrations:
  1% without epinephrine
  1% with 1:100,000 epinephrine (for use in highly vascular areas for the control of bleeding)
  2% without epinephrine for use in patients with higher tolerance to 1%

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Lifestyle Management Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to provide, counsel, or coach patients on lifestyle management.

Policy:

Any active licensed Oregon chiropractic physician may provide lifestyle management coaching/counseling within the chiropractic standard of care with an established patient. Utilizing lifestyle management with complex pathological conditions (*e.g.* endocrine, rheumatological, psychological, auto-immune, infectious) may necessitate communication with a patient's appropriate other healthcare provider(s). Lifestyle management is not intended to replace standard medical care.

Lifestyle management includes, but is not limited to:

- Sleep hygiene, stress management, meditation, diet, and exercise education;
- Health risk reduction;
- Drug and alcohol cessation;
- Social engagement/social drivers of health;
- Injury prevention;
- Personal safety; and
- Weight management.

Lifestyle management does not include:

- Psychological/psychiatric disorder counseling;
- Diagnosing anxiety, depression, and other psychological conditions; or
- Prescription medication management.

As applicable to CAs:

Certified chiropractic assistants may assist with lifestyle management under the direction of the supervising licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Manipulation Under Anesthesia Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform manipulation under anesthesia.

Policy:

Yes, under the following conditions:

- Active Oregon chiropractic license;
- Successfully completed post-graduate training program; and
- Privileges at an appropriate facility.

As applicable to CAs:

Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Mechanical Traction Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to use mechanical traction devices.

Policy: Mechanical traction falls under the heading of "physiotherapy" which is within scope of Oregon licensed chiropractic physicians.

As applicable to CAs:
CAs may not order mechanical traction. CAs may not perform or order manual traction. Certified chiropractic assistants, with appropriate training, may perform mechanical traction under the supervision and direction of an Oregon licensed chiropractic physician.

Oregon Board of Chiropractic Examiners	Effective Date: March 15, 2018 Date approved/ratified: March 15, 2018
MEDIA PRESS RELEASE POLICY AND PROCEDURES	

POLICY

To determine the procedures for issuing and removing media press releases on the OBCE website.

PROCEDURES

1. **Issuance.**

   At any time, the OBCE may issue media press releases regarding cases or other situations involving risks to public safety.

2. **Retention and Removal.**

   If a press release is issued pursuant to a case, the release will remain on the OBCE website for 90 days after completion of the requirements within the final and/or stipulated order but not to exceed 10 years.

   If a press release is issued pursuant to some other situation or purpose, the release will remain on the OBCE website for no longer than 10 years.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Myofascial Therapy and Massage Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to provide myofascial therapy and massage.

Policy:
Yes, it is within the scope of an Oregon licensed chiropractic physician.

As applicable to CAs:
Yes, under the following conditions:

- Active CA certification;
- CA has completed adequate training and proven competency to safely perform myofascial massage as determined by the supervising chiropractic physician; and
- It is performed at the direction and under the direct supervision of licensed chiropractic physician.

See ORS 684.010(2)(a). Physiotherapy as defined by statute encompasses myofascial therapy and massage.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Nasal Specific Procedure Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform nasal specific procedure.

Policy:
Yes, any active Oregon licensed chiropractic physician may perform nasal specific procedure.

As applicable to CAs:
Not within the scope of certified chiropractic assistants.

Oregon Board of Chiropractic Examiners	Effective Date: October 4, 2018 Date approved/ratified: October 4, 2018
NEEDLE ELECTROMYOGRAPHY (EMG)	

ISSUE

Whether performing Needle EMG is within the scope of practice for chiropractic physicians.

POLICY

Chiropractic physicians are allowed to perform diagnostic Needle EMG on an individual basis, to be reviewed by the Board, depending on undergraduate, graduate, and post-graduate studies, training, and work.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Out of Scope Policy	

Issue: In addition to limits imposed by the chiropractic scope of practice pursuant to ORS 684.010(2), are there other treatments/modalities/practices that are outside the scope of practice for Oregon licensed chiropractic physicians and certified chiropractic assistants?

Policy: The following treatments/modalities/practices are outside the scope of practice for Oregon licensed chiropractic physicians and certified chiropractic assistants:

- Acupuncture
- Acupuncture as anesthesia
- CBD/Hemp products*
- HCG products
- Hypnotherapy
- Injections – joint, trigger points, nutrition
- Oxygen except for emergency purposes
- Prescription strength Ethyl Chloride
- Psychological diagnoses/management (as found in current DSM)
- Recommending stop or alteration of use of prescription
- Toftness technique
- Vaccinations other than during a declared state of emergency or otherwise authorized by Oregon Health Authority

This list will be regularly updated.
*Please review the "Hemp and Marijuana Derived Products Policy" for deeper understanding on this topic.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Pre-Participation Physicals Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to perform and sign pre-participation physicals.

Policy:
Yes, under the following conditions:

- Active Oregon license; and
- Successfully completed clinical training in detecting cardiopulmonary diseases and defects.

As applicable to CAs:
Certified chiropractic assistants are only allowed to conduct portions of the pre-participation physical examination that are allowed within their duties as described in rule and law.

This policy does not address CDL, FAA, and "Return to Play" examinations. See separate individual policies.

See ORS 336.479(5)(e).

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Prescription Medication Modification Policy	

Issue: Whether it is within the scope of practice for Oregon chiropractic licensees to alter or discontinue prescription medications.

Policy: Recommendations to alter or discontinue a prescription medication are not within the scope of chiropractic practice.

Referring to qualified licensed healthcare professionals for consideration of starting/stopping/altering dosages of prescription medications is within chiropractic scope of practice.

As applicable to CAs:
Certified chiropractic assistants may not refer, recommend, alter, or discontinue prescription medications.

Oregon Board of Chiropractic Examiners	Effective Date: January 16, 2020 Date approved/ratified: January 16, 2020
RADIOGRAPHIC MENSURATION ANALYSIS POLICY	

ISSUE

Can a non-DACBR (Diplomate of the American Chiropractic Board of Radiology) chiropractic physician perform radiographic mensuration analysis?

POLICY

Yes, chiropractic physicians licensed in the State of Oregon can perform radiographic mensuration analysis.

Chiropractic physicians are trained to do these types of measurements, no matter whether they are DACBR certified or not. How the physician goes about determining the measurements is up to that practicing physician's best clinical skill and judgment.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Referral to Other Providers or Facilities Policy	

Issue: Whether Oregon chiropractic licensees are allowed to refer for additional diagnostic or management services.

Policy: Oregon licensed chiropractic physicians are authorized to provide a timely referral for any evaluation and/or case management to appropriate and licensed healthcare provider or facility. Referral should be based on individual patient needs and clinical justification.

As applicable to CAs:
Certified chiropractic assistants may not make referrals, unless under emergency medical circumstances.

Oregon Board of Chiropractic Examiners	Effective Date: March 18, 2021 Date approved/ratified: March 18, 2021
Topical Salicylates	

POLICY:

It is within the scope of practice for a licensed chiropractic physician in the State of Oregon to purchase, possess, or use over-the-counter Trolamine Salicylates, in liquid, gel, or patch form (in any combination or amalgamation of legal over the counter products) for the control of pain/discomfort.

Oregon Board of Chiropractic Examiners	Effective Date: March 29, 2020 Date approved/ratified: March 29, 2020
TELEHEALTH POLICY AND PROCEDURE	

POLICY

OAR 811-015-0066, Telehealth Rule, allows Oregon licensed chiropractic physicians to utilize telehealth (electronic and telecommunication technologies) for the distance delivery of health care services and clinical information designed to improve the health status of a patient, and to enhance delivery of the health care services and clinical information.

The Board has determined that this rule applies to both existing and new patients. Chiropractic physicians can utilize telehealth for initial consultations and examinations provided that the following criteria and procedures are met, pursuant to all relevant administrative rules and statutes. Practitioners may want to seek guidance from their medical malpractice carriers and various coding authorities as to billing and other requirements.

PROCEDURES

1. Document telehealth visit start time.
2. Establish and document the reason for visit.
3. Establish and document primary complaint(s).
4. Ascertain if, after #2 and #3 above, a telehealth visit is possible. If so, go to #5.
5. Take and document personal, family, and medical histories.
6. Perform visual evaluations and document:
    a. patients self-report height, weight, blood pressure, and pulse, if possible;
    b. nutritional/dietary assessment;
    c. postural analysis;
    d. range of motion; and
    e. any contraindications to providing services via telehealth.
7. Document and provide patient a provisional diagnosis.
8. Document and provide patient a report of findings.
9. Document and provide patient a PARQ and obtain consent to provide care/treatment.
10. Document and provide patient clinical recommendations.
11. Document telehealth visit end time.

Oregon Board of Chiropractic Examiners	Effective Date: February 5, 2022_ Date approved/ratified: February 5, 2022_
Topical Salicylates	

POLICY:

It is within the scope of practice for an Oregon licensed chiropractic physician to purchase, possess, prescribe, or use in their practice, over-the-counter Trolamine Salicylates, in liquid, gel, or patch form, to be used for the control of pain/discomfort and in any over-the-counter combination or amalgamation of legal over-the-counter products.

Oregon Board of Chiropractic Examiners	Effective Date: January 20, 2022 Date approved/ratified: January 20, 2022
Termination of Patient Care Policy	

Issue: What is the proper procedure for terminating patient care?

Policy:

Termination of patient care (terminating doctor/patient relationship) may occur for any reason, so long as it does not violate current state or federal law. Should the licensed chiropractic physician choose to terminate care, the following procedure must be followed:

- Patient must be notified of termination of care (verbal or written) within a reasonable time frame;
- Document the reason for termination in the patient's chart; and
- Refer patient to appropriate other providers when necessary.

The patient has the right to access or obtain a copy of their medical record when requested and regardless of any balances due.

As applicable to CAs:

Terminating patient care is within the scope of certified chiropractic assistants at the direction of the supervising licensed chiropractic physician.

APPENDIX A

EXAMINATIONS, TESTS, SUBSTANCES, DEVICES, and PROCEDURES (ETSDP)

EVALUATION FORM
Examinations, Tests, Substances, Devices, And Procedures

Please complete and return to:
Oregon Board of Chiropractic Examiners
530 Center St. NE, Suite 620
Salem, OR 97301
(503) 378-5816

NAME: _____
First MI Last

CLINIC ADDRESS: _____

PHONE: ___(___)_____

Requesting approval for ETSDP as (check appropriate box):

[ ] Standard

Please answer the attached questions completely, using another piece of paper.

When finished, return this form, signed and dated, to the OBCE administrative office (see above address).

If you have any questions, please contact the OBCE administrative office.

[ ] Investigational

Use the attached questions as a general guide to determine effectiveness and acceptable risk to the patient.

When finished, return this form, signed and dated, to the OBCE administrative office (see above address).

If you have any questions, please contact the administrative office.

_____ _____
Signature Date

OBCE USE ONLY: RISK FACTOR:

Board Approved Board Denied Need More Information

E.T.S.D.P. EVALUATION QUESTIONS

Clinical Rationale
Is this an exam, test, substance, device or procedure, herein after referred to as ETSDP?

Describe in detail your ETSDP.

Describe the clinical rationale for your ETSDP.

How do you determine appropriate termination of care and/or consultation to other providers with special skills/knowledge for the welfare of the patient?

If this is a diagnostic procedure, are you using it by itself or in addition to generally accepted diagnostic procedures?

Taught at accredited chiropractic school
Is this ETSDP taught at a chiropractic school accredited by the Council on Chiropractic Education or its successor at any time since 1974? If so, which one(s)?

Consensus
Do you have evidence of consensus on safety and/or effectiveness and/or of practices generally and currently followed and accepted by persons licensed to practice chiropractic in this state?

Outcome assessment measures
Choose from the following or list outcome assessment measures:

visual analog scale
pain drawing
Oswestry questionnaire
objective signs
general patient satisfaction
other

Literature based references
Cite any literature discussing indications, contraindications, and beneficial, adverse or unintended effects of this ETSDP.

Please indicate the current level of support for this ETSDP from the following:

1) One or more randomized controlled clinical trials or experimental studies that address reliability, validity, positive predictive value, discrimination, sensitivity and specificity.
2) One or more well designed controlled observational clinical studies such as case control or cohort studies published in referenced journals.
3) Clinically relevant basic science studies addressing reliability, validity, positive predictive value, discrimination, sensitivity and specificity published in referenced journals.
4) Expert opinion, descriptive studies, case report.

Consistent with generally recognized contraindications to chiropractic procedures
Please list any known or suspected contraindications.

Is there a subpopulation that would be at higher risk for this ETSDP? (e.g. people with osteoporosis, skin lesions, heart disease, etc.)

Potential benefit outweighs the potential risk to the patient.
Does the ETSDP affect any structure (either mechanically, chemically, thermally, or electrically, etc.) in such a way that a beneficial effect can be created?

Does this ETSDP affect any structure (either mechanically, chemically, thermally, electrically, etc.) in such a way that an adverse effect can be created?

Describe the beneficial effects your patients have experienced from this ETSDP.

Describe any adverse or unintended effects your patients have experienced from this ETSDP.

Please rate the risk factor if this ETSDP is used improperly on select populations. Choose from the following categories:

1) an extremely remote chance of serious injury
2) a remote chance of serious injury
3) a slight chance of serious injury
4) a significant chance of serious injury
5) extremely likely chance of serious injury

Please describe.

Please rate the risk factor if this ETSDP is used properly on the general population. Choose from the following categories:

1) an extremely remote chance of serious injury
2) a remote chance of serious injury
3) a slight chance of serious injury
4) a significant chance of serious injury
5) extremely likely chance of serious injury

Please describe.

Alternatives
Is there a standard ETSDP for the equivalent condition? If yes, does your ETSDP expose a patient to more risk or harm than the standard treatment for an equivalent condition?

List alternatives to this ETSDP if any.

What are the suspected effects, results or consequences of doing nothing?

General
Are you currently conducting or soon planning to conduct an organized investigation into the use of the ETSDP?

OREGON ADMINISTRATIVE RULE

811-015-0070 E.T.S.D.P.
Scope of Practice Regarding Examinations, Tests, Substances, Devices and Procedures

(1) The Board may examine any diagnostic and/or therapeutic examination, test, substance, device or procedure, herein after referred to as ETSDP, to determine its acceptability for patient care. The Board may require a Chiropractic physician to provide information on any ETSDP for determination of its status. The Board may take into account all relevant factors and practices, including but not limited to, the practices generally and currently followed and accepted by persons licensed to practice chiropractic in the state, the teachings at chiropractic schools accredited by the Council on Chiropractic Education or its successor at any time since 1974, relevant technical reports published in recognized journals and the desirability of reasonable experimentation in the furtherance of the chiropractic arts.

(2) A Chiropractic physician may use any diagnostic and/or therapeutic ETSDP, which is considered standard. A standard diagnostic and/or therapeutic ETSDP is one in which one or more of the following criteria have been satisfied:

(a) is taught or has been taught by a chiropractic school accredited by the Council on Chiropractic Education or its successor at any time since 1974, or health professions' courses taught by regionally accredited colleges with subject matter that is within the scope of chiropractic practice and has not been disapproved by the Board; or

(b) has been approved by the Board through the petition process.

(A) The petition requires a formalized agreement of ten percent (10%) or more of the Chiropractic physicians, holding an active chiropractic license in Oregon, attesting to the safety and efficacy of a particular ETSDP. The petition shall be submitted in writing to the Board by any party wishing to establish any ETSDP as standard. It is the responsibility of the petitioner to gather the required evidence and supporting statements. It is the sole responsibility and discretion of the Board to review the sufficiency of the evidence in the petition and to make a determination whether to concur and affirm the ETSDP as standard or to deny the petition. The Board may, but is not required to, hold a public hearing on any petition. The Board shall make its determination and reply to the petitioner within 180 days of receipt of the petition unless the Board and the petitioner mutually agree to extend the deadline.

(B) The petition shall specifically address the following issues:

(i) The kind of ETSDP that is the subject of the petition, i.e., whether it is an examination, a test, a substance, a device, a procedure, or a combination thereof;

(ii) A detailed description of the proposed ETSDP;

(iii) The clinical rationale for the ETSDP;

(iv) A method for determination of appropriate termination of care and/or consultation to other providers with special skills/knowledge for the welfare of the patient;

(v) Whether the proposed ETSDP is to be used by itself or used in addition to any other generally accepted or standard ETSDP;

(vi) A description of known or anticipated contraindications; risks, and benefits;

(vii) A description of any subpopulations for which greater risk or benefit is expected;

(viii) A description of any standard ETSDP for the equivalent condition together with its relative risks and benefits; and

(ix) An assessment of the expected consequences of withholding the proposed ETSDP.

(c) is supported by adequate evidence of clinical efficacy as determined by the Board. In determining adequacy the Board may consider whether the ETSDP:

(A) has clinical rationale;

(B) has valid outcome assessment measures;

(C) is supported in peer reviewed literature;

(D)is consistent with generally recognized contraindications to chiropractic procedures; and

(E) the potential benefit outweighs the potential risk to the patient.

(3) A Chiropractic physician may use any diagnostic and/or therapeutic ETSDP that has not met the criteria of subsection (2)(a) or (b) or (c) of this rule as investigational. It must show potential merit for effectiveness and

be of acceptable risk. Documentation requirements are based on potential risk to the patient. All investigational diagnostic ETSDP's must include or be accompanied by standard diagnostic procedures until full Board approval is attained under the criteria cited in subsection (2)(a) or (b) or (c) of this rule. Nothing in this section is intended to interfere with the right of any patient to refuse standard or investigational ETSDP's. In determining risk, the Board may use the following criteria:

(a) For minimal risk procedures, defined as those which when properly or improperly performed on the general population would have a slight chance of a slight injury and when properly performed on select populations have an extremely remote chance of serious injury,

(A) informed consent is suggested but not required; and

(B) the Chiropractic physician is recommended, but not required, to participate in or conduct a formal investigation of the procedure.

(b) For low risk procedures, defined as those which when properly performed on the general population have a slight chance of mild injury, when improperly performed on the general public have a mild chance of mild to moderate injury, and when properly performed in select populations have a remote chance of serious injury,

(A) informed consent is required; and

(B) the Chiropractic physician is recommended but not required to participate or conduct a formal investigation of the procedure.

(c) For moderate risk procedures, defined as those which when properly performed on the general public have a significant chance of mild injury and a mild chance of moderate injury, when improperly performed on the general population have a slight chance of severe injury, and when properly performed in select populations have a slight chance of serious injury,

(A) written informed consent is required; and

(B) the Chiropractic physician is recommended but not required to participate or conduct a formal investigation of the procedure.

(d) For high risk procedures, those which when properly performed on the general population have a significant chance of moderate injury and a slight chance of serious injury, when improperly performed on the general population have a significant chance of serious injury, and when properly performed in select populations have a significant chance of serious injury,

(A) written informed consent is required; and

(B) the Chiropractic physician is required to participate in or conduct a formal investigation of the procedure under the auspices of, or in conjunction with, any other health care professionals knowledgeable and competent in the care and treatment of potential serious injuries.

(e) Board approval is required of all moderate or high risk procedures.

(4) The Board shall maintain a list of ETSDP's which have been reviewed by the Board and have been determined to be unacceptable or approved as investigational.

(5) A Chiropractic physician may not use any diagnostic and/or therapeutic ETSDP's which have been determined by the Board to be unacceptable.

Statutory Authority: ORS 68
Statutes Implemented: ORS 684.155
Adopted Eff. 12/19/95

APPENDIX B

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

192.553 to ORS 192.581 2015

PROTECTED HEALTH INFORMATION

192.553 Policy for protected health information. (1) It is the policy of the State of Oregon that an individual has:

(a) The right to have protected health information of the individual safeguarded from unlawful use or disclosure; and

(b) The right to access and review protected health information of the individual.

(2) In addition to the rights and obligations expressed in ORS 192.553 to 192.581, the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164, establish additional rights and obligations regarding the use and disclosure of protected health information and the rights of individuals regarding the protected health information of the individual. [Formerly 192.518]

192.556 Definitions for ORS 192.553 to 192.581. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; or

(d) A health care clearinghouse.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005; and

(y) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) “Health information” means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) “Health insurer” means an insurer as defined in ORS 731.106 who offers:

(a) A health benefit plan as defined in ORS 743B.005;

(b) A short term health insurance policy, the duration of which does not exceed three months including renewals;

(c) A student health insurance policy;

(d) A Medicare supplemental policy; or

(e) A dental only policy.

(8) “Individually identifiable health information” means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) “Payment” includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) “Personal representative” includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) “Protected health information” means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) “Protected health information” does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) “State health plan” means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; or

(c) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) “Treatment” includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers. [Formerly 192.519; 2013 c.129 §24; 2013 c.681 §42; 2013 c.698 §30; 2017 c.152 §§1,2; 2017 c.206 §§12,13]

192.558 Use or disclosure by health care provider or state health plan. A health care provider or state health plan:

(1) May use or disclose protected health information of an individual in a manner that is consistent with an authorization provided by the individual or a personal representative of the individual.

(2) May use or disclose protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) For the provider’s or plan’s own treatment, payment or health care operations; or

(b) As otherwise permitted or required by state or federal law or by order of the court.

(3) May disclose protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) To another covered entity for health care operations activities of the entity that receives the information if:

(A) Each entity has or had a relationship with the individual who is the subject of the protected health information; and

(B) The protected health information pertains to the relationship and the disclosure is for the purpose of:

(i) Health care operations as listed in ORS 192.556 (4)(a) or (b); or

(ii) Health care fraud and abuse detection or compliance;

(b) To another covered entity or any other health care provider for treatment activities of a health care provider;

(c) To another covered entity or any other health care provider for the payment activities of the entity that receives that information; or

(d) In accordance with ORS 192.567 or 192.577. [Formerly 192.520; 2015 c.473 §5; 2017 c.484 §4]

192.561 Disclosure by health care provider in coordinated care organization. (1) Notwithstanding ORS 179.505, a health care provider that is a participant in a coordinated care organization, as defined in ORS 414.025, shall disclose protected health information:

(a) To other health care providers participating in the coordinated care organization for treatment purposes, and to the coordinated care organization for health care operations and payment purposes, as permitted by ORS 192.558; and

(b) To public health entities as required for health oversight purposes.

(2) The disclosures described in subsection (1) of this section may be provided without the authorization of the patient or the patient's personal representative.

(3) Subsection (1) of this section does not apply to psychotherapy notes, as defined in ORS 179.505. [2012 c.8 §16]

192.563 Health care provider and state health plan charges. A health care provider or state health plan that receives an authorization to disclose protected health information may charge:

(1)(a) No more than $30 for copying 10 or fewer pages of written material, no more than 50 cents per page for pages 11 through 50 and no more than 25 cents for each additional page; and

(b) A bonus charge of $5 if the request for records is processed and the records are mailed by first class mail to the requester within seven business days after the date of the request;

(2) Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual; and

(3) Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual. [Formerly 192.521]

192.566 Authorization form. A health care provider may use an authorization that contains the following provisions in accordance with ORS 192.558:

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____(Name of person/entity disclosing information) to use and disclose a copy of the specific health information described below regarding: _____(Name of individual) consisting of: (Describe information to be used/disclosed)

_____

_____

to: _____ (Name and address of recipient or recipients) for the purpose of: (Describe each purpose of disclosure or indicate that the disclosure is at the request of the individual)

_____

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS information

_____Mental health information

_____Genetic testing information

_____Drug/alcohol diagnosis, treatment, or referral information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information) and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires _____ (insert either applicable date or event).

By: _____ (Individual or personal representative) Date: _____

Description of personal representative's authority: _____

APPENDIX C
STANDARDS FOR USE OF BREAST THERMOGRAPHY IMAGING IN CHIROPRACTIC PRACTICE

OBCE's 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. _____
me
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 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. _____

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_____

TABLE OF CONTENTS

INTRODUCTION

The Oregon Chiropractic Practice and Utilization Guidelines (OCPUG)

This document was first published in 1991 by the Oregon Board of Chiropractic Examiners (OBCE or Board) with the goal of outlining a healthcare resource for Oregon chiropractic physicians. This document has undergone several iterations to reflect emerging research and clinical experience in the hopes that it would continue to become a more useful tool for practitioners. The OBCE will continue to review and update this document for this purpose. This resource is not designed to cover the complete scope of chiropractic practice in Oregon, nor is it directed at any other individual or group besides Oregon licensed chiropractic physicians and those who practice under their supervision.

ACKNOWLEDGMENTS

The OBCE expresses sincere gratitude to the following individuals who have been instrumental over the years in helping to author and revise this document through cooperation, research, and debate:

Scott Abrahamson, DC	Larry Hanberg, DC	William McIlvaine, DC	Michael Vissers, DC
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CHAPTER I

GOALS AND OBJECTIVES FOR CLINICAL PRACTICE

As a primary health care provider and as a portal of entry to the health delivery system, an Oregon chiropractic physician is led by these goals to accomplish their associated objectives.

I. Therapeutic Relationship

A. GOAL: Establish a professional doctor-patient relationship with the individual seeking care and appropriately triage their health issue(s) as well as their complaint(s) being presented.

B. OBJECTIVES:

1. Establish rapport in an atmosphere of physical comfort conducive to information gathering.

2. Provide for the presence of a third party, as required, to assist or observe in recording information, allaying apprehension, or other circumstances.

3. Elicit a thorough case history through written and/or oral means and provide a permanent record of findings with due regard for a patient's ethnic, cultural, or linguistic background.

4. Include within each case history, chief complaint, present health and relevant past health, including history of injury, disability, and cognitive assessment.

5. Assess the reliability of information presented.

II. Examination

A. GOAL: Provide such examination and diagnostic procedures and/or refer for additional diagnosis and management, as indicated by clinical relevance.

B. OBJECTIVES:

1. Specify which examination and diagnostic procedures are pertinent to the patient's complaint and present condition of health or past health issue.

2. Perform such examination and diagnostic procedures within statutory scope of practice and clinic capabilities, consistent with efficient exploration of the condition presented.

3. Assess the sensitivity, specificity, and predictive value of examination procedures selected.

4. Conduct examination and diagnostic procedures in an objective manner, remaining impartial with respect to etiology and extent of condition.

5. If referring for outside examination or diagnostic procedures, explain the clinical relevance and justification for additional testing to the patient.

6. Assess historical and physical data to identify relative or absolute contraindications for chiropractic care.

7. If referring to another health care provider, include relevant information pertaining to the referral and document such referral made.

8. Accurately record examination findings in the patient's case file consistent with universal health standards, administrative rules, and statutes.

III. Diagnosis

A. GOAL: Arrive at provisional diagnoses or clinical impressions consistent with the presenting complaint(s) and the results of examination and diagnostic procedures conducted.

B. OBJECTIVES:

1. Gather and interpret the results of all examination and diagnostic procedures, differentiating between normal and abnormal findings, and determine the relevance of the presenting complaint(s).

2. Determine subsequent evaluation procedures appropriate to the continued investigation of the patient's condition and establish a clinical impression or diagnosis.

3. Rule in or rule out the pathophysiological processes responsible for the patient's presenting complaint(s).

4. Record objectively supported differential diagnoses or clinical impressions, complicating factors and/or concomitant conditions using scientifically and/or clinically sound diagnostic procedures and language.

IV. Prognosis and Decision to Treat and/or Refer

A. GOAL:

1. Provide patient with PARQ.

2. Arrive at an initial prognosis and determine whether to accept the patient for chiropractic care and/or refer to another health care provider.

B. OBJECTIVES:

1. Determine the patient's initial prognosis.

2. Determine whether the condition is amenable to chiropractic care and is within the scope of chiropractic practice. Provide patient with report of findings.

3. If any portion of the patient's condition is not treatable within the scope of chiropractic practice, refer to the appropriate health care provider, forwarding any diagnostic tests or relevant information in an expedient manner. Document the referral.

V. Treatment Plan

A. GOAL: Generate an appropriate treatment plan with recommended re-evaluation dates.

B. OBJECTIVES:

1. Provide a treatment plan including procedures and modalities consistent with accepted standards of practice.

2. Record and date the treatment plan, including expected length and intensity of treatment, and projected re-evaluation dates.

3. If there are any general or specific considerations or contraindications for care, note them in the case file, modify the plan appropriately, and/or refer the patient to another provider.

4. Provide the patient with report of findings and with a PARQ. Obtain and record informed consent from the patient.

5. Records should be in a format that permits interpretation by other health care providers.

VI. Monitoring

A. GOAL: Assess the effectiveness of the treatment and make appropriate amendments to the treatment plan to provide efficacious care for the presenting complaint(s).

B. OBJECTIVES:

1. Perform ongoing assessment of both subjective and objective findings, documenting them in the patient record.

2. Initiate an appropriate re-evaluation to account for exacerbations, aggravations, waxing or waning of a chronic condition, or re-injury.

3. Evaluate new objective findings, integrating them with historical data, modify diagnoses and treatment appropriately, including a potential referral to a different discipline to provide timely, efficacious, and continuous care.

4. Generate reports of the patient's current condition that include information in a format a third-party representative will be able to clearly understand. Include clinical impression and treatment or modified treatment plan so that decision-making on authorization of services will be appropriate and timely.

VII. Discharge

A. GOAL: Decide on the appropriate discontinuation of care either at the endpoint of treatment or when no further improvement in the patient's condition can reasonably be expected. This responsibility includes the determination of follow-up care when necessary.

B. OBJECTIVES:

1. Release the patient from curative care:

   a. At the request of the patient;
   b. Patient non-compliance;
   c. When the objectives of the treatment plan have been achieved; or

d. When patient has achieved maximum medical improvement.

2. Document the necessity of follow-up care and inform the patient and any necessary ancillary personnel.

CHAPTER II

CHIROPRACTIC CLINICAL APPLICATION, DIAGNOSIS, AND TREATMENT PROCEDURES

SEQUENCE OF CLINICAL APPLICATION

The methods for appropriate clinical decision-making must be consistent with primary health care provisions and portal of entry procedures and standards. Each step taken in reaching a clinical impression provides an opportunity for the chiropractic physician to decide to continue further, refer the patient to another provider, or obtain a second opinion. The following is a general sequence of procedures that is commonly followed by the chiropractic physician. It is intended as a guideline, not as an exhaustive list.

I. Intake Interview of Patient

- A. History of presenting illness
- B. Past medical history
- C. Family medical history
- D. Personal, social, and socio-economic history

II. Examination and Diagnostic Procedures

- A. Physical examination
  1. General
  2. Specific to the presenting complaint(s)
  3. Chiropractic examination of spine and extremities
- B. Psycho-social assessment
- C. Laboratory examination (ordered or performed when clinically indicated)
- D. Diagnostic imaging (ordered or performed when clinically indicated)
- E. Special examinations (ordered or performed when clinically indicated)
  1. Gynecological examination
  2. Proctological examination
  3. Obstetrical examination
  4. Minor surgical examination
  5. Electrodiagnostic evaluation
  6. Vascular evaluation

III. Diagnostic and/or Clinical Impression

IV. Prognosis and Decision to Treat and/or Refer

V. Chiropractic Therapeutic Care and Patient Management

VI. Re-evaluation and Appropriate Modification of the Diagnostic Impression and Treatment Plan (if indicated)

VII. Conclusion of Treatment

CHIROPRACTIC DIAGNOSTIC PROCEDURES

I. History

A necessary component of clinical fact-finding through subjective offerings by the patient. The history may include, but is not limited to, the following:

A. Presenting condition
   1. Location
   2. Chronology
   3. Quality
   4. Severity
   5. Setting (circumstances)
   6. Modifying factors
   7. Associated symptoms (review of systems)
   8. Prior treatment(s)

B. Past medical history
   1. Accidents and injuries
   2. Previous illnesses
   3. Surgeries
   4. Medications

C. Family medical history
   1. Parents
   2. Grandparents
   3. Siblings

D. Personal, social, and socio-economic history
   1. Description of job
   2. Exercise
   3. Diet
   4. Habits/hobbies

II. Examination and Diagnostic Procedures

A. Psycho-social assessment

B. Physical examination shall include:
   1. Vitals, including but not limited to height, weight, blood pressure, and pulse
   2. Examination specific to presenting complaint(s)

C. Physical examination, when clinically indicated, may also include, but not be limited to:
   1. Heart, lungs, and abdomen
   2. EENT
   3. Integumentary examination
   4. Orthopedic and neurological tests
   5. Static and motion palpation of the spine and/or extremities
   6. Postural analysis
   7. Muscle testing including dynamic, isokinetic, static, and/or manual analysis

D. Laboratory examination

   1. Clinical laboratory testing may be necessary when the history and/or other examination findings indicate, including but not limited to blood, urine, saliva, hair, mucus, or stool.

   2. Biopsies of superficial structures may also be performed with additional Oregon minor surgery certification.

E. Diagnostic imaging

While diagnostic imaging procedures may be vital to diagnosis and case management, the decision to use any diagnostic imaging procedure should be based on clinical necessity following an adequate case history and physical examination.

F. Special examinations/evaluations

1. Gynecological examination
2. Proctological examination
3. Obstetrical examination
4. Minor surgical evaluation
5. Electrodiagnostic evaluation
6. Vascular evaluation
7. Laboratory evaluation
8. Diagnostic imaging evaluation

G. Other clinically indicated examination/evaluation procedures that comply with the OBCE rules.

III. Diagnosis and/or clinical impression

A. Severity
B. Acute vs. chronic
C. Location of lesion and/or disease
D. Etiology
E. Complicating factors
F. Concomitant conditions

IV. Prognosis and decision to treat and/or refer

The decision to treat and/or refer is made after appropriate examination and a differential diagnosis has been established. Consideration of the contraindications to the proposed treatment should be taken at this time as well as consideration of consultation and/or acquiring a second opinion.

When possible and/or appropriate, a prognosis should be given at the time that a diagnosis is made. The prognosis may change as the condition of the patient and the response to treatment changes. A referral to a different healthcare provider or discipline is appropriate when clinically indicated.

CHIROPRACTIC THERAPEUTIC CARE AND PATIENT MANAGEMENT

A. Manual therapy
   1. Adjustment
   2. Manipulation
   3. Mobilization
   4. Soft tissue manipulation

B. Physiological therapeutics
   1. Heat and/or cold
   2. Hydrotherapy
   3. Electrotherapy
   4. Phototherapy
   5. Mechanotherapy

6. Therapeutic and/or rehabilitation exercise
7. Orthotics
8. Bracing and taping

C. Nutritional supplementation, recommendations, and/or over the counter medications

D. Counseling within chiropractic scope of practice

E. Treatment in special areas
1. Gynecology
2. Obstetrics
3. Proctology
4. Minor surgery

V. Re-evaluation and assessment

VI. Conclusion of Treatment

CHAPTER III

RECORD KEEPING AND REPORT WRITING

The quality of a physician's ability to provide efficacious health care is dependent on their ability to gather, organize, analyze, and make decisions on clinical data. Good decisions are the result of accurate and complete facts being retrievable from a patient's records.

Therefore, documentation of the patient's medical history, presenting complaint(s), progression of care, diagnosis, prognosis, and treatment plan should be reflected in the record keeping and written reports of the patient file. Some aspects of this file have been included in Chapter I. Components of this file should include:

I. Patient History and Examination Records

There is considerable variation in how physicians develop and record a clinical history and examination findings. The reader is referred to Chapter I, Sections I and II for a summary of the suggested guidelines.

II. Chart Notes

Chart notes should be recorded at each visit in a form which may be understood by any medical/healthcare provider. While the patient's history indicates their status at the time of the initial visit or at the onset of a new condition, the progress record (often called chart notes) reflects the patient's state of health at subsequent points of time.

The minimum acceptable records should create a story of the patient's response to the physician's management of their case. This story should be legible and clear enough to allow another medical/healthcare provider to assume management of the case after an initial review of the chart notes. Full SOAP charting at each visit, while recommended, is not required, but components of the file should include:

A. Subjective complaints

The patient's complaints should be recorded at each visit (in the patient's own words when possible) indicating improvement, worsening or no change, or any significant event since the last visit with provider.

B. Objective findings

Changes in the objective signs of a condition should be noted at each visit in the doctor's own words.

C. Assessment or diagnosis

It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed and these results included in the daily entries with any amendments in the diagnosis.

D. Plan of management

A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient’s condition changes and treatment is altered accordingly. Changes in procedures should be noted.

E. Procedures

Daily recording of procedures performed should include descriptions of therapeutic procedures performed, soft tissue techniques, modalities used, exercises prescribed, nutritional supplementation, over the counter medications, or prescribed diet and activity instructions. Patient response to therapies, and who provided those therapies, should be noted.

III. Written Reports

A. History
   1. Presenting complaints
   2. Past medical history
   3. Family health history
   4. Patient's personal, social, and socio-economic history

B. Examination findings
C. Assessment, diagnosis, or clinical impression
D. Plan of management and/or response to treatment
E. Prognosis and/or outcome expectations

IV. Ancillary Documentation

A. Correspondence (sent and received)
B. Specialty reports (diagnostic imaging, lab nerve conduction studies, etc.)
C. Communications (telephone log, dialogue with specialists and/or providers co-managing case or concomitant conditions that may have effect on presenting complaint, and family or friends of the patient, etc.)

CHAPTER IV

CHIROPRACTIC CARE AND MANAGEMENT

Based upon clinical circumstances and other considerations, patient individuality may influence frequency and duration of care. Clinical judgment and decision-making may require peer review and further consultation.

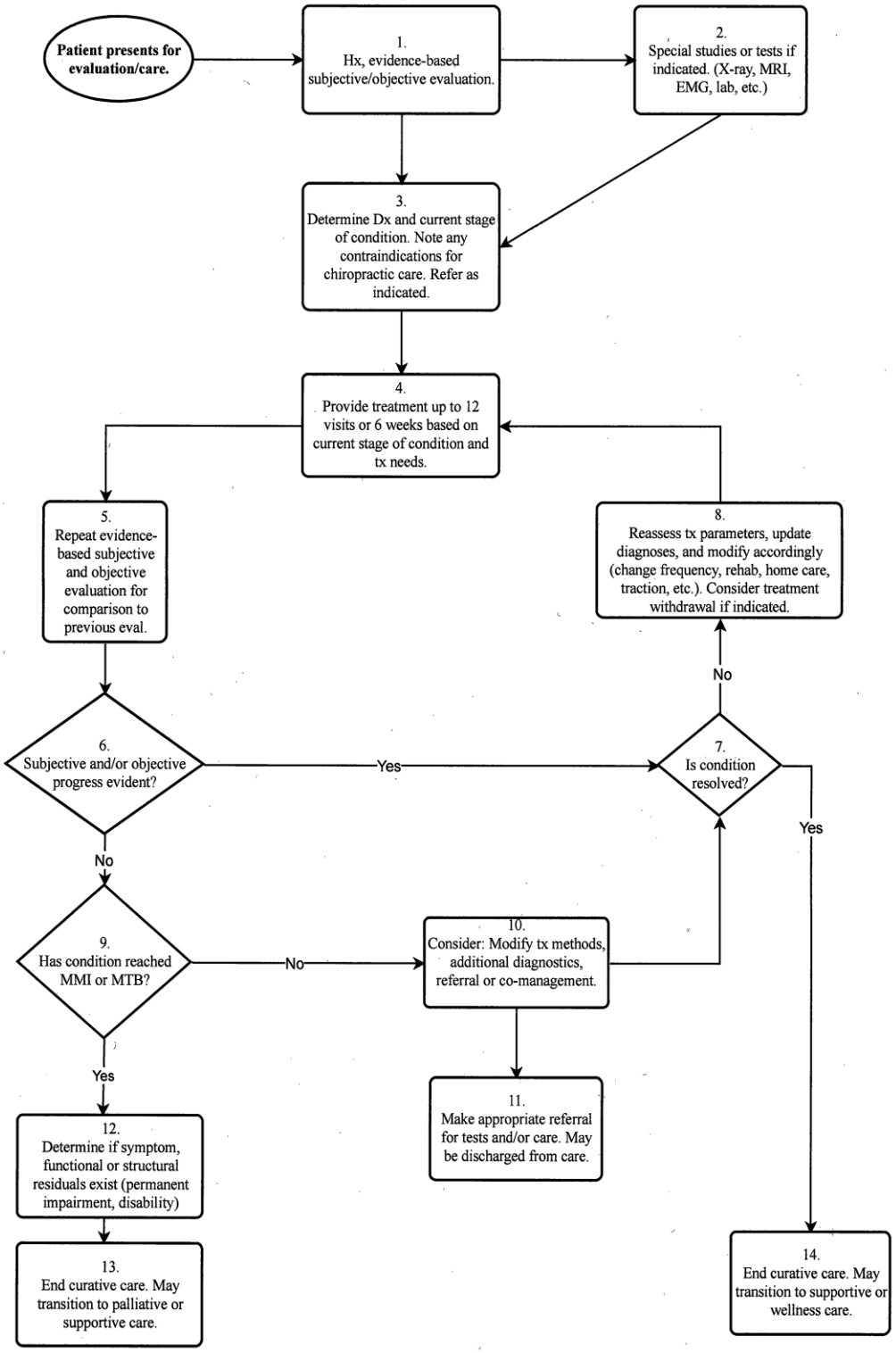
The following curative care algorithm presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

Rehabilitation

Rehabilitation is treatment designed to facilitate the process of recovery from injury, illness, or disease. The goal of rehabilitation is to promote recovery, improve function, and to help the patient become self-reliant in management of their health. This generally involves transitioning the patient from passive to active care to achieve efficient patient recovery.

Pediatric patients

Pediatric evaluations require age-appropriate inquiry and examination to determine treatment plans; this management may need to be modified.


Patient presents for evaluation/care.
1. Hx, evidence-based subjective/objective evaluation.
2. Special studies or tests if indicated. (X-ray, MRI, EMG, lab, etc.)
3. Determine Dx and current stage of condition. Note any contraindications for chiropractic care. Refer as indicated.
4. Provide treatment up to 12 visits or 6 weeks based on current stage of condition and tx needs.
5. Repeat evidence-based subjective and objective evaluation for comparison to previous eval.
6. Subjective and/or objective progress evident?
Yes
No
7. Is condition resolved?
No
Yes
8. Reassess tx parameters, update diagnoses, and modify accordingly (change frequency, rehab, home care, traction, etc.). Consider treatment withdrawal if indicated.
9. Has condition reached MMI or MTB?
No
Yes
10. Consider: Modify tx methods, additional diagnostics, referral or co-management.
11. Make appropriate referral for tests and/or care. May be discharged from care.
12. Determine if symptom, functional or structural residuals exist (permanent impairment, disability)
13. End curative care. May transition to palliative or supportive care.
14. End curative care. May transition to supportive or wellness care.

The following recommendations correlate and refer to the steps in the algorithm:

Box 1: History, Subjective/Objective Evaluation	Chiropractors should conduct a medical history of the presenting condition and a past medical history including illnesses, hospitalizations, surgeries, and prior musculoskeletal conditions. The history should consider red flags and psychosocial risk factors. Subjective-based outcome assessment tools (OATS) of good reliability and validity should be used at this time to establish a baseline for pain, function, and/or disability. Chiropractors should perform a physical examination appropriate to the presenting complaint(s). Procedures should be chosen according to specificity and sensitivity and have a relatively high likelihood for ruling in or out a specific condition. A physical examination should be neither more nor less than the presenting condition(s) require(s).
Box 2: Imaging and Special Studies	Chiropractors should determine the clinical necessity of additional testing that would improve their ability to accurately diagnose and/or provide treatment for the presenting condition(s). This testing can include, but is not limited to: diagnostic imaging, radiographs, laboratory, EMG, functional capacity, etc. Clinical necessity should be reflected in the records including the concerns warranting the study and how the results will influence management.
Box 3: Determine Diagnosis, Stage of Condition, and any Contraindications to Care	Based on history and examination, chiropractors should determine and document a diagnostic impression expressed in generally accepted terminology. The diagnostic impression clarifies the details of the diagnosis, including stage of condition (acute, sub-acute, repair, remodeling, chronic), and contributing and complicating factors. If any of the patient's conditions are outside the scope of practice or clinical capacity of the specific chiropractor, or if treatment is contraindicated, then a referral to a different provider should be made and documented.
Box 4: Treatment Plan	Chiropractors should formulate a treatment plan appropriate to the diagnostic impression and the patient's presentation. This should include the frequency and duration of treatment, specific therapies, and goals for each. The treatment plan should not exceed 12 visits or 6 weeks before an updated evaluation for curative care (example: 3x/week for 4 weeks acute, or 2x/week for 6 weeks subacute). Proposed treatment plan(s) and prognosis should be discussed in the context of the report of findings and PARQ conference. Informed consent shall be documented.
Box 5: Re-Evaluation	An updated evaluation of the subjective OATS and objective/functional examination should be performed at regular intervals, or whenever clinically relevant, to determine patient progress, efficacy of care, and necessity of additional treatment. Intervals between re-evaluations

	should not exceed 12 visits or 6 weeks, depending on the patient's current condition and treatment goals. See above examples.
Box 6: Determine if Progress is Shown	A comparison of the new evaluation findings (from Box 5) to the previous evaluation findings should be performed to determine progress (OATS, functional, etc.). Patient progress should be determined by comparing previous to current findings and assessed by the physician for clinically meaningful change. (OATS specific, ICA and ACA guidelines, etc.) **If progress is shown, go to box #7. If no improvement, go to box # 9.**

Box 7: Is Condition Resolved?	The chiropractor should determine if the condition has resolved (subjectively, functionally, structurally, etc.). This should be goal specific. Possible endpoints of care should be when patient is at pre-injury status or maximum medical improvement (MMI). **If resolved, go to box #14. If not resolved, go to box #8.**
Box 8: Modify Treatment if Indicated	As treatment continues, the diagnoses should be amended based on the patient's clinical presentation. If indicated, the chiropractor should modify treatment, including but not limited to: changing the frequency of visits, modifying modalities, updating home care instruction, etc. If appropriate, treatment frequency may be proportionately decreased to determine the patient response to daily living without care prior to the next evaluation.
Box 9: Has Condition Reached Maximum Medical Improvement or Therapeutic Benefit?	If the patient is not showing progress with care, then the chiropractor should determine whether the patient has reached MMI or maximum therapeutic benefit (MTB). MMI refers to a date from which further recovery or deterioration is not anticipated. MTB refers to when provided care no longer provides benefit, but other options may still exist for improvements. **If MMI/MTB, then go to box #12. If not, go to box #10.**
Box 10: Modify Case Management	If the patient is not progressing and is not considered MMI or MTB, the chiropractor should consider psychosocial factors and other treatment options. Examples of other or additional treatment options include, but are not limited to: referral to another provider, referral for additional testing, adding or removing therapeutic modalities from the treatment plan, etc. **If referral is indicated, go to box #11. To continue care, go to box #7 (may do both).**
Box 11: Referral and/or Discharge	See box #2 and #3 to determine appropriate referral needs. Chiropractic care may be suspended or terminated at this time, while the patient's condition may benefit from transfer of care to a different care provider. Referrals should be documented in the patient records.
Box 12: Residual Findings/ Permanent Impairment	When a patient's condition has reached MMI or MTB, if any residuals are still evident (subjective, functional, objective, structural, etc.), the chiropractor should determine if a permanent impairment evaluation and/or disability rating is indicated. All residuals should be documented and discussed with the patient.
Box 13: End Curative Care with Residuals.	Curative care should be terminated after MMI or MTB has been determined and residuals (if any) are documented. The patient may be transitioned into supportive or palliative care if indicated.

Box 14: End Curative Care.	When terminating curative care, the patient may be transitioned to supportive or wellness care, if indicated.

Nothing in the existing laws or rules of the Board defines a separate standard of care for "curative care," "maintenance care," "palliative care," "supportive care," or "wellness care." All require that the patient is entitled to an appropriate physical examination, a report of findings following the examination, including a clinical impression, and recommendations for care, followed by a PARQ, to obtain informed consent from the patient prior to rendering therapeutics.

Curative Care:

The term "curative care" refers to treatment with an intent to resolve the presenting complaint(s) without a guaranteed curative outcome.

Maintenance Care:

The term "maintenance care" is not well-defined at this time in scientific literature and is inherently vague. For purposes of this document, the OBCE will forego its use.

Palliative Care:

Palliative care is treatment to temporarily improve a patient's quality of life without anticipation of overall improvement. Palliative care may be inappropriate when it interferes with other therapeutic protocols.

Supportive Care:

Supportive care is ongoing treatment/care for patients who have reached MTB but who may fail to sustain these benefits and may progressively deteriorate without treatment. In addition, it is intended to minimize exacerbations and degenerative sequelae. Supportive care sometimes includes the return to curative care for the waxing and waning of chronic conditions. Supportive care may be inappropriate when it interferes with other therapeutic protocols.

Wellness Care:

Wellness care is intended to enhance and optimize a patient's physical well-being and potentially prevent the future onset of symptoms. It is not limited to spinal manipulation but could include any element of the chiropractor's scope of practice.

CHAPTER V

GLOSSARY OF CHIROPRACTIC MEDICAL TERMS

Acute - a condition of sudden onset; any condition with a short (<4 weeks) clinical course.

Algorithm - a step-by-step method of solving a problem.

Asymmetry - lack or absence of symmetry of position or motion. Dissimilarity in corresponding parts or organs of opposite sides of the body which are normally alike.

Chiropractic - is defined pursuant to ORS 684.010.

Chronic - long standing (>12 weeks).

Diagnosis - the act of distinguishing one disease from another.

Clinical diagnosis - based on signs, symptoms, and/or history and clinical presentation, in the absence of objective findings.

Differential diagnosis - generating a list of possible disorders that could be causing symptoms.

Physical diagnosis - determination of disease by inspection, palpation, percussion, and auscultation.

Functional - affecting the function but not the structure; said of disturbances with no detectable organic cause; idiopathic.

Health - a state of optimal physical, mental, and social well-being and not merely the absence of disease and infirmity.

Manual Therapy - therapeutic application of manual force including such procedures as massage, active relaxation, passive stretch, exercises, joint mobilization, thrust manipulation, immobilization, and stabilization.

Manipulation - passive maneuver in which specifically directed manual forces are applied to spinal and extra-spinal articulations of the body, with the object of restoring mobility to restricted areas.

Massage - the therapeutic application of friction, stroking, and kneading of the muscles and tissues of the body.

Mobilization - a form of manual therapy applied within the physiological passive range of joint motion, characterized by non-thrust passive joint manipulation.

Neurophysiological effects - a general term denoting functional or aberrant disturbances of the peripheral or autonomic nervous systems. The term is used to designate nonspecific effects related to: a) motor and sensory functions of the peripheral nervous system; b) vasomotor activity, secretomotor activity and motor activity of smooth muscle from the autonomic nervous system; c) trophic activity of both the peripheral and autonomic nervous system.

Objective - relating to or being an indicator of disease such as a physical sign, lab test, or x-ray, that can be observed or verified by someone other than the person being evaluated.

Palpation - the application of clinical touch during a physical exam.

Motion palpation - palpatory diagnosis of passive and active segmental joint range of motion.

Static palpation - palpatory diagnosis of somatic structures in a neutral static position.

Prognosis - the likely outcome or course of a disease; the chance of recovery or reoccurrence.

Restriction - limitation to movement.

Sign - any objective evidence of a disease, as opposed to a symptom.

Subacute - between the acute and chronic phases of a condition (4-12 weeks).

Subjective - pertaining to or perceived only by the affected individual, not observable by others.

Symptom - any subjective evidence of a disease, as opposed to a sign.

Technique - physical or mechanical procedures used in the treatment of patients.

Proposed 2023 Board Meeting Schedule and Locations

- January 18-19 or 19-20

Retreat

Upper Willamette Valley: Salem office, Oregon Garden/Silverton, McMinnville, Albany, The Grand Hotel/Salem

- March 30 Virtual
- May 24-25 or 25-26

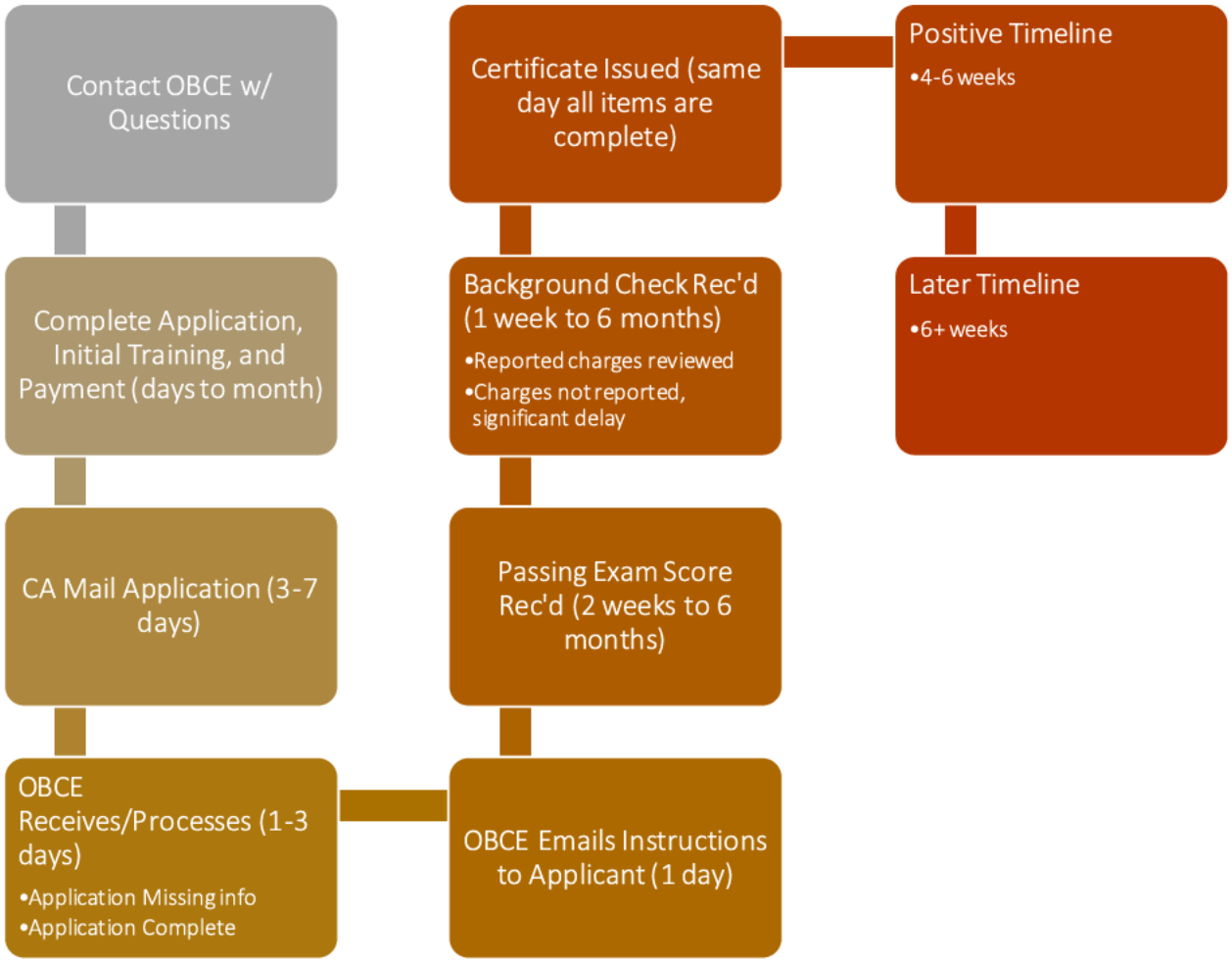
Salem, Joseph, Enterprise, La Grande, Baker, Klamath Falls, Ashland

- July 27 Virtual
- September 27-28 or 28-29 TBD
- November 16 or 30 Virtual

November 2022 Introduction to the Board meeting date

- November 9 or 16, 4-7pm

CA Process



Significant delay
- Incomplete Applications
- Unreported Charges

InLumon
- Simplify app processing timeline

DC Student Applicants
- Remove REQ of exam due to transcript

JUDITH BOOTHBY MS DC PC

CHIROPRACTIC PHYSICIAN

Oregon Board of Chiropractic Examiners
530 Center St NE, Suite 620
Salem, OR 97301
503-373-1573

6-16-2022

Dear Oregon Board of Chiropractic Examiners:

I am interested in becoming a member of the ETSDP (Examinations, Tests, Substances, Devices, and Procedures) ad hoc committee with the purpose of analyzing and investigating the practice of wet cupping and to make recommendations to the Board.
I have attached my CV.

I have participated to advance chiropractic in the State of Oregon in the following ways:
Previous member of the ETDSP committee from 1996 thru 2016,
Headed the committee which wrote the ETDSP rule and got it passed by the OBCE 12/19/95
Participated in creating petition to the OBCE which established chiropractic functional neurology as standard 1/14/14
Helped to establish the functional council of chiropractic with the OCA
Help establish chiropractors presenting case studies at the OCA convention 2012-2019

Please let me know you received my CV

Sincerely,

Judith Boothby, MS DC PC

110 SE 16TH Ave. • Portland, OR • 97214
Phone 503-233-0943

Curriculum Vitae for Judith Boothby MS DC PC

Work Address:
Judith Boothby MS DC PC
110 SE 16th Ave.
Portland, OR 97214

Work Phone:
Home Phone:

Personal Information:
Date of Birth:
Place of Birth:

Employment History:

- Oregon Chiropractic from 1986 through 2019, 2021 thru present
- Iowa Chiropractic, 2020
- Somerville, Massachusetts, Chiropractic from 5/1988 thru 6/1989
- Massachusetts General Hospital, Department of Radiology from 5/88 thru 6/89 Also worked at MGH for MIT thesis 9/79 thru 12/80. Wrote computer programs to upgrade radiation treatment planning from two to three dimensions thus preserving function and reducing morbidity.
- Lawrence Berkeley National Laboratory, Berkeley, CA consulting for 1 week 1986
- UCSF Long Hospital, San Francisco, CA, consulting for 2 weeks 1986
- Mt, Hood Community College, Gresham, OR Taught a class in in the drafting department on auto-cad and design 1983 and 1984
- Thermal Dynamics, West Lebanon, NH Employed as a mechanical engineer. Designed Plasma Welding Equipment 1981-82
- General Electric, Somersworth, NH Apprentice machinist 1976-78

License: Oregon Board of Chiropractic Examiners, license #27 2207

Education:
Western States Chiropractic College, Graduated 1986 DC Doctor of Chiropractic
Massachusetts Institute of Technology, Graduated 1981 MS in Mechanical Engineering
University of New Hampshire, Graduated 1979 BS in Mechanical Engineering
Hamburg High School, Graduated 1975

Additional training:
Functional Neurology with the Carrick Institute 2010-12
Pediatric Functional Neurology with Robert Melillo DC PhD, 9/2012-4/13

Awards:

- Voted Top Doc in Portland Monthly's Top Doctors Magazine January 2014 and 2015. Was the featured chiropractor January 2013 which was the first time chiropractic was mentioned in the Top Doctors publication.
- Chiropractor of the Year, Oregon Doctors of Chiropractic 2005 for standing up for the right of patients to receive low risk nurturing health care.
- Young Chiropractor of the Year, Chiropractic Association of Oregon 1996 for leading committee of the CAO instrumental in writing proposal to OBCE for OAR 811-015-0070 Scope of Practice Regarding Examinations, Tests, Substances, Devices and Procedures

Volunteer activities:
Current:

- Returning Veterans Project
- Camp Victory. Empowering girls who have been sexually assaulted.

Past:

- Created Functional Chiropractic Council of the OCA
- Helped to establish presenting Case Studies at the OCA convention
- Participated in creating petition to OBCE which established chiropractic functional neurology as standard on January 14, 2014
- Member OBCE -ETDSP committee from 1996 thru 2016
- Mentor for Chick Tech. Opportunities for high school girls to pursue STEM
- Children's Relief Nursery
- Council for Prostitution Alternatives
- Taught English as a second language, Rockwood library

Publications:
Judith Boothby MS DC PC, Shelly Coffman, PT DPT OCS FAAOMPT CSCS, Todd Turnbull DC. Successful Interprofessional Treatment of Juvenile Rheumatoid Arthritis: A Case Report, IMCJ Integrative Medicine: A Clinician's Journal, April/May 2017, Vol 16, No 2
http://www.imjournal.com/index.cfm/fuseaction/Content.Main/id/92/OA-SuccessfulInterprofessionalTreatmentofJuvenileRheumatoidArthritis:ACaseReport

Survivor Stories, Speaking Out About Cancer, Edited by Rod Schecter and Jessica Lynn Myers. Rivanna Health Publications, Charlottesville, VA 2003. Calm Down, Little Cells by Judith Boothby

Hobbies: Racing Dragon Boats, walking

CARRIE EBLING DC
4234 SE Henderson Street, Portland, OR 97206

August 3, 2022

Oregon Board of Chiropractic Examiners

RE: ETSDP (Examinations, Tests, Substances, Devices, and Procedures) ad hoc committee for the exploration of wet cupping

To whom it may concern:

In response to the recent emails regarding committee participation to explore the applications of and safety surrounding wet cupping, please find my curriculum vitae attached for review.

I have over 20 years of experience with teaching and utilizing manual therapies in the massage therapy and chiropractic fields and have studied and practiced (dry) cupping therapy since 2016. As an educator, predominantly for the University of Western States, I am very adept at looking to the research literature for best practices and evidence informed decision making. I also respect that clinician experience is a branch of the evidence informed tree, as many therapies commonly utilized by manual providers lack valid research for a plethora of reasons. That said, considering the biomechanical, neurological, and physiological effects of various treatments to aid in clinical decision-making skills is paramount to techniques I personally relied on in private practice as well as currently teach.

I have recently closed my private practice and while I'm enjoying the free time, I would look forward to the opportunity to contribute to the Oregon Board to provide licensees with guidance for best practices.

Thank you for your consideration,

Dr. Carrie Ebling

Chiropractic Physician

CARRIE EBLING DC

4234 SE Henderson Street, Portland, OR 97206

PERSONAL STATEMENT:

An intensely motivated practitioner of manual therapies committed to furthering education. Capable of effective communication with students and patients of all abilities to ensure clear understanding of classroom and treatment goals. Reliable instructor that is well organized and adept with current technologies to maximize student engagement. Skilled at hands on demonstrations as well as compiling germane lecture material that highlights developments in the field. Highly qualified independent thinker with demonstrated collaboration on global curriculum synchronicity. Gifted learner and distributor of detailed information that is ready for the next stage in a successful career.

EXPERIENCE:

Elemental Medicine — ***Private Practice Doctor of Chiropractic*** — 2009 - 2022
Portland, OR

- Utilizing diversified, instrument assisted and drop table manipulations to the spine and extremities in an urban wellness-based practice
- Proficient with joint mobilizations, muscle energy, cupping therapy, and other treatment-based soft tissue techniques as an adjunct to manipulative corrections
- Frequent application of rehabilitative and corrective exercises

Licensed Massage Therapist — ***Private Practice*** — 1999 - 2020

- Focused on medical / orthopedic massage therapy

University of Western States — ***Educator*** — 2006 - Present
Portland, OR

Instruction:

- *Adjustive Psychomotor Skills, Rehabilitation Principles, Spinal Rehabilitation, Upper Extremity Orthopedic Assessment, Extremity Muscle Testing* Course lead for the Department of Chiropractic Sciences (2018-Present)
- *Advanced Rehabilitation, Neuroorthopedic Assessment of the Spine, Clinical Phase II* Co-teacher (2019-Present)
- *Wellness and Relaxation Massage, Fundamental of Treatment Based Massage, Treatment Massage for Specific Conditions, Medical Massage, Treatment-Based Massage* series*, Kinesiology 1 and 2, Anatomy and Physiology 1-3, Pathology,* and *Medical Terminology* for the Massage Therapy program (2006 - 2018)
- *Soft Tissue and Rehabilitation 1* Lecture and Lab components for the Department of Chiropractic Sciences division of the Doctor of Chiropractic program (2010 - 2014)
- *Physiological Therapeutics* Lecture and Lab components for the Department of Chiropractic Sciences division of the Doctor of Chiropractic program (2015-2016)
- *Certified Chiropractic Assistant* course for the Continuing Education department (2010 – Present)
- *First Aid / AED / CPR* for campus clinicians, massage students, and the Continuing Education department (2006 - 2013)

Supervision:

- Student club supervisor: *R2P, Soft Tissue, Adjusting* (2020-Present)
- Providence ElderPlace Massage Internship – Organize quarterly schedule, oversee students providing supportive and nurturing massage to residents (2010 - 2018)
- Compass Oncology Cancer Massage Internship - Oversee students and provide palliative massage to chemotherapy and radiation patients. (2007 - 2018)
- East Portland Clinic of UWS and Campus Health Clinic Massage Internship - Oversee all student clinician activities including documentation with adherence to HIPAA, health intake, assessment, treatment planning, therapeutic massage, patient self-care and referrals. Perform quarterly evaluation and one-on-one student training. (2006 - 2018)
- Coordinate activities and duties of Teaching Assistants. (2006 - 2018)

CARRIE EBLING DC

4234 SE Henderson Street, Portland, OR 97206

Curriculum Development:

- Created and taught a 2-term technique lab and lecture course, *Fundamentals of Treatment-Based Massage* and *Treatment-Based Massage for Specific Conditions*, to replace the existing *Deep Tissue Massage 1 and 2* courses (2015 - Present)
- Assisted in the revision of *Wellness and Relaxation Massage* (2014-2015)
- Co-developed the *Capstone* course to prepare students for the Massage State Board licensing exam (2012 - 2013)
- Revised clinical standards and course outcome measures based on the Council of Massage Therapy Accreditation (2011 - 2015)
- Revamped *Soft Tissue and Rehabilitation 1* and *Physiological* Therapeutics for the Department of Chiropractic Sciences to provide a strong and practical foundation to DC students that follows CSPE Protocols and CSA guidelines. (2010 - 2016)
- Developed Continuing Education courses that incorporate time in the Gross Anatomy Lab with assessment and treatment of musculoskeletal pathologies targeted for Manual Therapists (Fall 2010 - Present)
- Followed Oregon's Model Curriculum to assist in the development of the Massage Therapy Certification program (2005 - 2006)

Committee Participation

- Team Lead for Department of Chiropractic Sciences (2021-Present)
- Faculty Development Committee (February 2013 - Present)
- Massage Curriculum Committee (June 2014-2018)
- Massage Program Advisory Committee (August 2012 - 2018)

Ashmead College — ***Educator*** — 2002 - 2006, Tigard, OR

- Instructed: *Kinesiology, Anatomy and Physiology, Student Clinic*
- Coordinated teaching schedule for 24 instructors on a quarterly basis
- Team lead for a five-campus curriculum revision
- Interim Director of Education in 2004
- Hired and mentored incoming instructors

Oregon Trail Red Cross — ***Educator*** — 2002 - 2013

- Authorized to teach *Lay Responder CPR, First Aid and AED*

MANUAL THERAPY RELATED CONTINUING EDUCATION:

Myofascial Decompression Therapy/Cup Therapy	2022
Neurocentric Approach – Justin Dean, Phil Snell DCs	2021
McKenzie Method of Diagnosis and Management, Parts A and B	2019
Contemporary Cupping Methods	2016
Cox Technic – Drs. Cox and Greenwood, DC	2015
Fascial Manipulation III – Luigi Stecco, PT	2014
Instrument Assisted Soft Tissue Mobilization – Tom Hyde, DC	2013
Breast Cancer Rehabilitation – Klose Training	2013
Diaphragm/Pelvic Floor Piston for Rehab – Julie Wiebe, PT	2012
Kinesiotaping KT1,2,3 – Kenso Kase, DC	2012
Low Force Mobilization – Marc Heller, DC	2012
Fascial Manipulation Ia, Ib, IIa, IIb – Luigi Stecco, PT	2011
Spine Adjusting – Kenneth Stillwell, DC	2010
Pelvic Floor Fitness – Brianne Grogan, PT	2010
Trigger Points for the Pelvic Floor – Brian Baisinger, DC	2009
Activator Methods	2008

CARRIE EBLING DC

4234 SE Henderson Street, Portland, OR 97206

PROFESSIONAL EDUCATION

Western States Chiropractic College	2005 - 2008
Doctor of Chiropractic, Cum Laude	Portland, OR
Florida School of Massage	1999
Certification in Hydrotherapy and Massage	Gainesville, FL
Florida State University	1993 - 1997
Bachelor of Science in Anthropology, Cum Laude	Tallahassee, FL

DR. MICHAEL T. LOGIUDICE

1819 Watson Butte Ave SE | Salem, Oregon 97306 |

OBJECTIVE: To serve our dynamic chiropractic community, while also protecting the rights of patients.

• CAREER CHRONOLOGY

AMERICAN PROACTIVE CHIROPRACTIC REHABILITATION
Clinic Director

November 2018-Present 36-45 hours per week

Clinic Director for a busy start-up. Managing the chiropractic side of the business, responsible for all aspects of building a successful patient-centered wellness, sports, auto and work injury clinic.

DR. DONALD LEARY, D.C., CHIROPRACTIC
July 2018 - Sept 2018; 32-36 hours per week

Locum Tenens Chiropractor

Covering Clinician for a busy Oregon Health Plan (OHP) Practice. Provided chiropractic care using instrument and manual methods, treating spinal conditions for the Medicaid population of Marion County and Salem, Oregon. Patient-base is young, disabled, unemployed an/or unemployable, and many had mental health comorbidities.

LINN CITY CHIROPRACTIC, MICHAEL T. LOGIUDICE, DC, LLC
April 2008 to June 2018; 40-50 hours per week

Clinic Owner

Responsible for all aspects of starting, promoting, marketing, and building a successful patient centered wellness, sports, auto and work injury clinic.

Responsibilities include but are not limited to:

- Evaluate spine-related (axial) neuromusculoskeletal and non-axial (extremity) conditions.
- Ordered diagnostic imaging using clinical judgment and standards of care, for spine and extremity musculoskeletal conditions.
- Diagnose chiropractic conditions and use a multi-disciplinary approach to integrate care for better outcomes.
- Implement chiropractic manipulation/adjustment to restore joint function and related soft tissue function in patients experiencing conditions such as radiculopathy, degenerative diseases, disc disorders, facet syndrome.
- Counsel on nutrition, exercise, sleeping habits, stress management, and psychosocial matters related to management of chiropractic cases.
- Prescribe orthotic braces, harnesses, belts, shoe orthotics, and supports commonly used in the chiropractic industry.
- Share chiropractic care plans with ancillary and primary care providers, integrating care when possible.

- Identify pathological, non-chiropractic conditions that present as neuromusculoskeletal conditions, and refer to the appropriate specialist for evaluation and management.
- Examination, diagnosis, treatment and management of neuromuscular and musculoskeletal conditions using non-pharmacologic and non-operative methods in an outpatient setting.
- Utilization of standard medical evaluation procedures along with biomechanical assessment to establish a diagnosis and formulate a management plan.
- Consult with other providers and refer patients as needed, for other accepted medical conditions.
- Patient education, prescribe therapeutic exercise, lifestyle recommendations, and other interventions such as joint manipulation and mobilization, soft tissue therapies, and physical modalities.
- Conduct weekly/monthly meetings with support staff to hone our trade, sharpen our in-office systems, boost morale, and improve technical proficiency.
- Oversee daily operations in an integrative setting; membership spa; prescribe therapeutic massage; and implement strategies for practice growth.
- Complete medical narratives for personal injury and workers' comp cases.
- Independent Medical Examiner; rendering second opinions on auto injury cases.
- Currently enrolled in becoming ODOT examiner certified.
- Modeled private practice style as a Primary Spine Practitioner for my patients, co-managing many other comorbidities in the process.
- Additional responsibilities included: marketing to MD's, writing a standard operating procedures (SOP) manual for support personnel within the confines of the chiropractic clinic, to include treatment protocols for common and uncommon conditions amenable to chiropractic care.
- Completed over 1,000 hours of continuing education focusing on: clinical decision-making, evaluation & management.
- Utilized Activator, Arthrostim, Manual, Gonstead, Thompson Drop, and Non-surgical Spinal Decompression therapies to improve outcomes.
- Evaluating spine-related (axial) neuromusculoskeletal and non-axial (extremity) conditions brought on by excessive individual combat loads.

DR. KEITH OVERLAND, NORWALK CHIROPRACTIC, NORWALK, CT

Dec 2006 - Jun 2007 32 hours per week

Chiropractic Assistant

- Lead Chiropractic Assistant (CA) for a busy sports chiropractic and rehab clinic

- Used hands-on Instrument Assisted Soft Tissue Mobilization and other manipulative techniques to strip and release taut muscle fibers and painful chronic scar tissue
- Helped design and implement a physical therapy suite inside of clinic focusing on functional medicine
- Utilized Class IV LASER, e-stim, hot & cold modalities as well as ultrasound physio therapeutics to aide the doctor with his chiropractic treatment protocols
- Learned front office procedures; scheduling, canceling, re-scheduling, as well as patient education procedures to improve patient outcomes and patient retention
- Used Muscle Energy Techniques; such as Active Release Technique (ART) Pin and Stretch, Strain/Counterstrain, PNF, PFS, as well as static and dynamic stretching techniques for athletes and patients wanting to take your performance to the next level
- Designed and implemented a Home Exercise Room for current patient base

ARMY NATIONAL GUARD - REGIMENTAL TRAINING INSTITUTE (RTI) OREGON

August 2010 to Oct 2018 (retired) 48 hours per month

Instructor

- Serves as an Instructor; provides technical training for Military Occupation Specialty (MOS) reclassification of Soldiers annually;
- develops, maintains, and updates course material; conducts remedial training, examinations, and evaluations of Soldiers for the purpose of awarding the Military Occupational Specialty (MOS)
- ensures accountability and positive control of test materials protecting the integrity of examinations; maintains accountability of computers and related equipment valued in excess of $1,000,000; responsible for the health, welfare, and supervision of all student and guest instructors.

Education and Additional Highlights:

- Doctor of Chiropractic (Clinical Excellence Award) Univ Bridgeport, College of Chiropractic
- Masters of Science (cand) Human Clinical Nutrition, Univ Bridgeport, CT
- Bachelor of Science (Mathematics & Science) Univ Bridgeport, CT
- Medical Specialist Course, MOS 91B ARMY Ft. Dix, NJ 1999
- Combat LifeSaver Course (7), ARMY NATIONAL GUARD HQ 249th RTI Monmouth/Umatilla, OR
- NBCE Examiner Part IV UWS 2022

National Board of Chiropractic Examiners:

- Parts I, II, III, IV, and Physiotherapy

Oregon Board of Chiropractic Examiners:

- Ethics, Minor Surgery, Proctology, Obstetrics , Jurisprudence, Pain Management Sexual Boundaries, Cultural Awareness

Military Service:

US MARINE CORPS 1990-1997 (Active duty)

- 8654 Reconnaissance Marine, Airborne, SCUBA qualified
- 0151 Administrative Clerk
- 0311 Infantryman

CO ARMY National Guard (Reserves) 1997-1998

- 63B Light Wheeled Mechanic
- 42L30 Administrative Specialist
- 11B30V Infantryman Airborne, Ranger qual

NJ ARMY National Guard 1997-2004

- 68W30 Medical Specialist
- 11B30V Infantryman Ranger qual
- 42L30 Administrative Specialist

OR ARMY National Guard 2010-2018

- 91B38 Combat Medic, Instructor
- 11B38V Infantry Instructor, Ranger qual

Certifications/Licenses:

Active Release Technique (Soft Tissue Management) Neck and upper extremity
GRASTON IASTM Mod I & II certified
Acupuncture Certification for Physicians, AcCP
Personal Injury Certification, Personal Injury Institute
Healthcare Provider CPR Certification, AAOS 2017
Triton DTS Non-Surgical Spinal Decompression Specialist
GRASTON Instrument Soft Tissue Myofascial Release, Mod I & II
Certified SOLE SUPPORTS Gait - referenced Casting
Certified First Responder, AAOS
Oregon Workers Compensation Certification 2008

Research (non-published):

Injuries to Chiropractors in a Clinical Setting, Presented as Senior Thesis at
University of Bridgeport, College of Chiropractic, LoGiudice, Mawla,Finley, Dec 2006

Special Interests:

Activator & Arthrostim Adjusting Techniques - not rated
Active Release Techniques (ART) - Cervical, Lumbar, Upper/Lower Extremity
GRASTON - Instrument Assisted Soft Tissue Mobilization Mod I & II
Treatment of Cervical and Lumbar Radiculopathy (w/ Spinal Decompression)

Human Clinical Nutrition , Gut disorders, Health & Wellness, Whiplash injuries Repetitive Stress Injuries, Occupational injuries, Prehab/rehab, Micronutrient Supplementation

Awards and Recognitions:
Clinical Excellence Award, UBCC, Dec 2006

Military Recognition:
DD-214 Honorable Discharge NGB Form 22 (2)
Honorable Discharge (3)
Army Service Ribbon National Defense Service Ribbon
Sea Service Ribbon (1/star) Combat Action Ribbon
Navy Unit Commendation Ribbon
Humanitarian Service Medal
Joint Meritorious Unit Ribbon Good Conduct Medal (2/stars)
SW Asia Service Medal/Ribbon (3/stars)
Armed Forces Expeditionary Medal
Kuwait Liberation Medal (Kuwait)
Kuwait Liberation Medal
(Saudi Arabia)
Meritorious Unit Commendation Ribbon
Army Achievement Medal/Ribbon
USN/USMC Overseas Svc Ribbon
Meritorious Service Medal
Gulf War Era (Service) Medal Expeditionary, Medal, Ribbon
United Nation Medal (Somalia) NJ Meritorious Service Medal
NJ Homeland Defense Medal NJ Good Conduct Ribbon (2)
NJ Merit Award (7th) NJ Unit Strength Award
NJ State Service Award Veterans of Oregon Service Medal
CT Veterans Wartime Svc Medal
Cold War Medal
Warriors Medal of Honor Rifle Expert Badge (4th)
Pistol Expert Badge (3rd) RANGER Tab
Recon Tab SCUBA Diver Badge
Special Operations Diver Badge ARMY Parachutist Badge
Air, Sea, and Rescue Qualified Enlisted Promotions (6)
Land Navigation Certificate Certificate of Commendation (2nd)
Certificate of Appreciation (3rd) Ocean Crossing Acknowledgement
Cold War Certificate of Recognition
Service Stripe / Hash Mark (7th)
Meritorious Promotion to Cpl USMC/ARNG Honorable Discharge
ARMY Reserve Component Commendation Achievement Medal (2)
Retired from Military 2018

Continuing Medical Education:

Dan Dock DC Seminars, Cervical/Lumbar Differential Assessment; Whiplash Series
Parker Seminars, Las Vegas, NV 2017, 2018, 2019, 18 hrs CEUs Clinical Skills Tract
Chirofest, Vancouver WA 16 hrs CEUs, Vancouver, WA '18, '19, '21
Oregon Chiropractic Convention, 20 hrs CMEs, '15, '16, '18
Minor Surgery / Clinical Proctology UWS, Portland, OR
Gait Analysis, NUHS, Kim Ross DC, PhD
Record Keeping
Diagnostic Imaging, Educational Manual for Evidence-based Chiropractic
Patient-Doctor Relationship
Whiplash Soft Tissue Injuries, Gregg Jones DC
Introduction to Nutritional Response Testing, Roger Popp DC
Graston Technique Certified, Mod. I - II
Upper/Lower Quadrant Graston Technique Module II, WSCC
Kinetics, Kinematics, Kinesiology, and Kinesthesia Institute (4KI)
Sole Supports, Bottom Block, Certification Seminar
The Crash Course, Injury Mechanisms in Low Velocity Collisions
The Orthotics Group Seminar, Custom Orthotics Therapy
Five Star Practice Management Series, Seattle, WA
Tax planning, Corporate Structure
Evidence Based Outcome, WSCC
Pain Management, WSCC
Fundamentals of Musculoskeletal MRI
Documentation and Chart Noting
Advanced Pain Strategies
Mock Trial: Going to Court Series
Treatment Goals, Treatment Plan, Care Plan, What is the difference?
Managing your Medicare Patient, ACOM
Critical Elements of Medical Narrative
Clinical indications for MRI, correlation with x-ray findings
Personal Injury Certification, Personal Injury Institute
Insurance Coding, Billing, & Documentation: Reimbursement Strategies
Personal Injury Training, Trauma patient care & Advanced Documentation Protocols
Personal Injury Institute, Certification 100 + hours
Colossus Training for Assessing General Damages for Bodily Injury
Evaluation and Diagnosis
Sexual Boundary Training
Advanced Upper Extremity & Spinal Adjusting (12 CEU)
Clinical Indications for MRI in Chiropractic Practice
National Registry Certified Medical Examiners, ODOT (currently enrolled)

Pro-bono work:
Provided pro-bono care for 10 veterans annually referred by the Returning Veterans Project, Portland, Oregon. 2010 - 2018

Civic:

President and Vice-President West Linn Chamber of Commerce 2017-2018
West Linn Rotary Club Member 2008-2009

Military Deployments:

Desert Storm/Shield (Combat)	Kuwait, UAE, Dubai, Saudi Arabia
Somalia	
Bangladesh	Philippines
Somalia	Honduras x2
Italy	

Internships:
Gary Ierna DC

Keith Overland DC

References:
Mathew Funk

Bryan Barry DC

Jon Pritchard

Alex Todd

Todd Smallenburg

Harvey 'Lenn' Bell

Gonzzo Watson DC

David Milroy DC, ND

Bassam Mawla DC

Raymond Santa DC

Michael Chambers

Michael Thompson

Affiliations:
American Chiropractic Assoc.
Christian Chiropractic Assoc.
Oregon Chiropractic Assoc. Veterans of Foreign Wars
1st Marine Division Assoc. 1st Reconnaissance Bn Assoc American Legion
University of Bridgeport Alumni Assoc
Woodburn High School Alumni Fellowship Companies for Christ Int'l

PURNELL Mackenzie G * BCE

From: Dr. LoGiudice
Sent: Wednesday, June 15, 2022 12:16 PM
To: OBCE Oregon * BCE
Subject: Cover letter for ETSDP committee

Follow Up Flag: Follow up
Flag Status: Completed

To OBCE,

My name is Dr. Michael LoGiudice. I am in privated practice and use many tools in my office, and have frequently called the Board in the past about therapies I want to add to my practice. I have my AcCP certification that I paid over $12k for, yet, I cannot dry needle. I am a doctor that is personally, professionally, and financially impacted by the Board's decisions. I would not only like to provide my input on wet cupping, but on other new procedures and technologies as well.

I live and work in the Salem area, so it will be easier for me to attend required meetings regarding this matter at hand.

I would like my name thrown into the hat for the adhoc committee for ETSDP, as I recently became a NBCE Chiropractic Examiner, and this is right in-line with analyzing and investigating the practice of dry cupping, which I use in private practice almost weekly, but am certainly curious as the therapeutic benefit of wet cupping, which sounds similar to bloodletting from the days of old.

I have been a Oregon Licensed Chiropractor in FT practice since I opened my doors in 2007. I think my experience and expertise will provide great insight to revealing new technologies, techniques and procedures as they constantly pop up in private practice, especially with PEMF, Shock Wave, Class IV LASER, as well as Piezoelectric therapy devices, and Softwave. This committee should be formed to investigate all new technologies that we may encounter in private practice.

Dr. Michael LoGiudice
NPI 1972785921
American Proactive Chiropractic
Clinic NPI 170765056
1640 Lancaster Dr. NE
Salem, OR 97301
O:

Shelly J. Patterson, D.C.
PO Box 1235 Lincoln City, Oregon 97367

2022

Oregon Chiropractic Board, RE: Wet Cupping

Dear Healthcare Providers,

I am writing to express my interest in particing in the committee to evaluate wet cupping as an approved services for your Chiroprqctic patients Oregon. I have been a massage therapist for over 15 years. Since then, I have accumulated a broad set of skills and a love for this very personal kind of work. After being introduced to chiropractic therapies, I decided to pursue my doctorate degree in that field. And then, there came a quite unexpected pause.

I have been using therapeutic dry cupping on my patients with great results. I believe that performing wet cupping would further enhance the efficacy of healing in certain cases of musculoskeletal problems. I have pursued cupping education for many years for my massage therapy practice. I have attended most of the available course from the International Cupping Society. They do not currently offer any guidance on wet cupping. I was introduced to wet cupping as a part of an overall training in Thai Medicine practices.

It would be my privilege to be a part of developing a course of action to include wet cupping among the list of approved practices for Oreon Chiropractors. Thank you for your time and consideration,

Best of Health,

Shelly J. Patterson, D.C.

Shelly J. Patterson, DC
PO Box 1235
Careful Chiropractic, LLC
Lincoln City, OR 97367
Mobile Phone:
EMAIL: s

EDUCATION, Vocational Studies, and Certificates

University of Western States, **Doctor of Chiropractic** Portland, OR 2018; OR Lic. #6006
The Naga Center School of **Traditional Thai Medicine and Thai Massage** Clinic Core Certification, Portland, Oregon. 2010
Hawaii Healing Arts College and Massage Professionals, **Massage Therapy Program**, Kailua, Hawaii 2006
University of Hawaii at Manoa, **Masters of Science in Botany**, May 2005. *Member, Honors Program Ecology, Evolution, and Conservation Biology.*
University of Hawaii at Manoa, **Bachelors of Science** in Biology, May 1998. *With Distinction*
University of Hawaii at Manoa, **Minor Degree is Music**, May 1998.
Clark College **Associate of Arts and Sciences**, Vancouver, Washington 1993. *With Honors.*
Columbia Academy, Battle Ground, Washington 1989. *Cum Laude.*

PUBLICATIONS

Patterson, Shelly, LeGrande, M., and Morden, C.W. Genetic Variation Among Metrosideros polymorpha Populations Along an Altitudinal Gradient in Hawaii. Hawaiian Journal of Systematic Biology (1999) 4:8-11

CURRENT AND PREVIOUS PROFESSIONAL MEMBERSHIPS

State of Oregon Licensed Chiropractic Physician #6006
State of Washington Massage Practitioner Credential # MA00025196
State of Oregon Licensed Massage Therapist #17267

PROFESSIONAL EXPERIENCE

Owner, Operator, Chiropractor, Massage Therapist, Careful Chiropractic, LLC. From October 2019 **to present**
Massage Therapist, Swedish and Thai Massage Practitioner 01/2008 to present. Comma Vino Spa (Portland Oregon), Within the Wild Adventure Lodges (Homer, AK), Talon Lodge (Sitka, AK), Careful Chiropractic, The Coho Oceanside Lodge (Lincoln City, OR).
Adjunct Instructor, Pioneer Pacific College Massage Therapy Program 07/2008 to 12/2010. Included course design and instruction in the topics of anatomy, kinesiology, pathology, spa, and massage technique.
Account Manager Ascent Healthcare Solutions 04/2005 to 08/2007. Managed reprocessing programs for multiple hospitals in Hawaii, Oregon, Washington, and Idaho. Included creation and delivery of presentations for physicians, nurses, and health care management teams.
Medical Sales Representative, Caris Medical, Inc. 04/2005 to 07/2006 for Wilson-Cook Medical GI endoscopy products, Hawaii.

PERSONAL INTERESTS AND ACTIVITIES

: Gardening, fishing, hiking, camping, reading, music. Native Plants and Mycology of Washington and Oregon and Hawaii.

Dr. Timothy W. Ray

LinkedIn dr-tim-ray-a757f936/ • Portland, OR

June 23, 2022

RE: ETSDP ad hoc committee.

To Whom This May Concern:

I am interested in participating in committee membership in the ETSDP ad hoc committee. I have enclosed my resume for your review.

As my career profile illustrates, I am well-prepared to meet and exceed your expectations. Having served as a Director of Sports Medicine, I am accustomed to the rigors of fast-paced, highly-regulated environments requiring sharp diligence, consummate accuracy, and outstanding communication skills. If given the opportunity,

Further, I would bring the following strengths to your committee:

- Oversight all facets of program administration, from development to execution, directing cross-functional leaders to ensure adherence to overarching strategies, milestones, and objectives; evaluate existing operations to identify inefficiencies and redundancies, innovating process improvements to optimize workflow and delivery.
- Instrumental in administration of national and international sports chiropractic organizations.
- An active member in the Sports Medicine community as an independent consultant, board member for multiple prominent organizations and global athlete medical services provider.

I would welcome the opportunity to meet and discuss this opening in detail.

Thank you for your consideration. I look forward to hearing from you!

Sincerely,

Dr. Timothy Ray, DC, MSc, DABCO, CCSP, ICSC, DIANM, FICC

Dr. Timothy W. Ray, DC

Chiropractic Clinician

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An entrepreneurial Manual Medicine Specialist with extensive experience in Sports Medicine, Orthopedics, and graduate Sports Medicine education. Highly skilled in delivering comprehensive, effective care to patients. Experience with multi-disciplinary sports medicine teams in sports and athletic environments. Recognized for being instrumental in cultivating and expanding national and international sports chiropractic organizations. Proven knowledge of industry trends, best practices in the provision of innovative evidence-based strategies and solutions in care.

Areas of Expertise

- Strength and Conditioning
- Neuromusculoskeletal Medicine
- Somatic Dysfunction Assessment
- Strategic Planning & Analysis
- International Sports Federation Collaboration
- Corrective Exercise
- Orthopedics
- Dry Needling Intramuscular Therapy
- Documentation & Publication
- Program Development
- Performance Enhancement
- Team Leadership & Development
- Program Management
- Regulatory Compliance

Professional Experience

University of Western States, Portland, OR **2017 – 2022**
Director of Sports Medicine Master's Program and Associate Professor

Direction of all facets of program development, administration, and execution, managing interdisciplinary teams to ensure adherence to overarching strategies, milestones, and requirements. Delivery of on-going care and treatment innovation for patients in need of chiropractic and sports medicine services.

- Improved program ranking to first in the nation for best online sports medicine programs by Intelligent.com, BestColleges.com and CollegeChoice.com from 2017- 2022.
- Realigned program curriculum to improve student success.
- Exceeded objectives for Institutional Learning Outcomes: Target: 85-99%, Actual: 98%.
- Accomplished objectives of Program Learning Outcomes: Target: 85-99%, Actual: 100%.
- Achieved objectives for Course Learning Outcomes Direct Assessments: Target 80%, Actual: 91.95%.
- Exceeded objectives for Summative Assessment of Graduation Rates: Target: 80-89%, Actual: 91.6%.
- Designed and taught Advanced Sports Medicine, Practicum and Performance Enhancement courses.

Power Advanced Athlete Healthcare, PC, Longmont, CO, President, 1980 – 2017

- 3-time Olympic Doctor
- Spine and Sports Medicine Internship, Steadman-Hawkins Sports Medicine Center, Vail, CO, 2013
- Sports Chiropractor of the Year, Colorado Chiropractic Association, 2006 & 2013

Additional Experience

- PCI A Colorado Independent Physicians Association: President (former) Developed and managed capital and management resources in the pursuit of cooperative business ventures, capitated payment plans, and the development of innovative specialty health care delivery.
- Consultant, Colorado Board of Examiners, Department of Labor, Department of Regulatory Agencies
- Research Editorial Staff: Integrated Medical Association

Education

Master of Science in Sports Science and Rehabilitation
Logan University, St. Louis, MO

Doctor of Chiropractic
Logan College of Chiropractic, St. Louis, MO

Bachelor of Science in Human Life Science
Logan College of Chiropractic, St. Louis, MO

Professional Affiliations

Federation Internationale de Chiropratique du Sport (FICS: International Federation of Sports Chiropractic), Chairman of the International Games Commission, International Federations Commission, Education Commission (Present), Board of Directors (Former),
American Chiropractic Association, (Present)
Council on Sports Injuries and Physical Fitness, Board Chairman/President / 2nd, 1st Vice President/ Oregon State Sports Council Coordinator, Colorado State Sports Council VP, Pres/Vice President (Former).
Council on Chiropractic Orthopedics (Present)
International Academy of Neuromuscular Medicine: (Present), Examination committee
United States Sports Chiropractic Federation: (Former) President/Vice President/Secretary General/Chairman of the Board/Founding Board Member,
Colorado Chiropractic Association (Former) Board of Directors, Boulder County Representative & Insurance Relations Committee,
Colorado Chiropractic Sports Council (Former), Co-Founder, Executive Board
Preferred Chiropractic Incorporated, a Colorado IPA, (Former) President

Honors & Awards

President's Award **Federation Internationale de Chiropratique du Sport (FICS)**, 2021
FICS Service Award, 2018
Fellow, **International College of Chiropractic (FICC)**, 2014
Presidential Service Award, **Colorado Chiropractic Association,** 2014
Sports Chiropractor of the Year, **Colorado Chiropractic Association,** 2006 & 2013

Licenses & Certifications

Doctor of Chiropractic: Missouri, Colorado, New Mexico, Oregon
Certified Human Movement Specialist
Fellow of the International Academy of Neuromusculoskeletal Medicine
International Certificate in Sports Chiropractic
Certified Dry Needling Intramuscular Therapy, National University
Certified Functional Movement Analysis (FMS) Levels I and II
Certified Performance Movement Taping
Corrective Exercise Specialist (CES) #1505980, National Academy of Sports Medicine
Certified Selective Functional Movement Analysis (SFMA)
Graston Instrument Assisted Soft Tissue Manipulation
Certified Functional Movement Taping
Performance Enhancement Specialist (PES) #1333893, National Academy of Sports Medicine
Emergency Medical Technician (EMT) #21273
International Chiropractic Sports Diplomate (ICSSD) #1246
Certified Strength and Conditioning Specialist (CSCS) (Inactive) #911626, NSCA
Certified Chiropractic Sports Physician (CCSP) #713
Fellow, Academy of Chiropractic Orthopedists (FACO) #1176
Diplomate, American Board of Chiropractic Orthopedists (DABCO) #1859

Diplomate, National Board of Chiropractic Examiners #8857

Community Involvement

Oregon State Senate Subcommittee: Concussion Return to Play Legislation
Colorado State Board of Chiropractic Examiners: Chiropractic Practice Review
Colorado Department of Labor and Employment: Chiropractic Review
Colorado Chiropractic Association: Board of Directors
World Federation of Chiropractic 7th Biennial Congress Sports Medicine Educational Subcommittee
Research Editorial Staff: The Original Internist. American Integrated Medical Association
Colorado Spine Physicians Association Founding Board Member, Secretary/Treasurer
United States Sports Chiropractic Federation: Founding Board Member President, Vice President, Secretary General, Chairman of the Board.

Voluntary Sports Chiropractic Care Services.
International
Olympic Games: Atlanta 1996, Sydney 2000, Salt Lake City 2002
Continental Games: Pan American Games: 2003, 2011 All Africa Games: 1999
World Games: 2005, 2009, 2013, 2017, 2022
World Sport Games: 2015, 2017, 2019
World Championships: Speed Skating 2000, Sport Aerobics 2001, Tug of War 2010, Powerlifting 2014

National
U.S. Pro Strongman Championship, Prineville, OR - 2019
U. S. National Synchronized Figure Skating Championships, Portland, OR - 2018
U. S. National Colligate Taekwondo Championships, Boulder Colorado - 2016
U.S. Olympic Track and Field Trials - 2000, 2004, 2008, 2012, 2016, 2022
U. S. Track and Field National Finals - 2001, 2003, 2007, 2015
Dew Action/Right Guard Open Sports Tour Denver, CO - 2006
US National Colligate Team Trials, Taekwondo, Denver - 2006
US Figure Skating Championships, Portland Oregon - 2005
Gravity Games, Copper Mountain, Colorado - 2005
USARFU Western Division Rugby Championships, Ft. Worth TX - 2005
USARFU National Rugby Championships, Boston, MA for the Boulder Rugby Club - 2005
US Taekwondo National Championships, Colorado Springs, CO - 2004
US Junior Olympic Taekwondo Championships, Atlanta, GA - 2004
USA Rugby Football Union, College All Star Championships, Boulder, CO -2004

Regional
Seaside Invitational Volleyball Tournament, Seaside, Oregon - 2019, 2021
Director of sports chiropractic services for UWS at 3 high schools, one college and 17athletic organizations in the Portland metropolitan region - 2017 to 2022
Chiropractor: Longmont, and Lyons High School Track and Basketball Teams - 2006 - 2013
Chiropractor, Buffalo Bandits, Pro Lacrosse vs Colorado Mammoth, 2005, 2007, 2013
Boulder Lions High School Rugby Team 2011 – 2013 AAU Regional Taekwondo Qualifier, Denver - 2009

PURNELL Mackenzie G * BCE

From: PURNELL Mackenzie G * BCE
Sent: Wednesday, September 07, 2022 12:34 PM
To: PURNELL Mackenzie G * BCE
Subject: Use of NRCME

From: Michael Megehee <
Sent: Wednesday, September 07, 2022 10:55 AM
To: GILKER Heather * BCE <Heather.GILKER@obce.oregon.gov>
Subject: Re: P&P Workgroup Information and Times

Hi Heather,

In preparation for my lead regarding the Motor Carrier Medical Examinations, I was looking under the P&P regarding the use of Initials after the Dr's Name.

The P&P states that initials can be added to the Dr's name if they have completed a **diplomate** program.

Many DCs are listing NRCME after their name to indicate that they are Certified Medical Examiners in the Federal Motor Carrier Safety Administration's National Registry of Certified Medical Examiners (NRCME). I have been doing that myself and want to always follow the Oregon regulation's for DC.

Given this is a Federal Program that requires FMCSA regulated training provided by FMCSA Accredited Training Organizations and passing the NRCME test, may a DC in Oregon add "NRCME" to their name such as Michael Megehee, DC, NRCME?

If not, would it be possible to begin an effort to allow this Federal Designation to a DC's name? Also, should I immediately remove NRCME from my name.

Thank you,

MIke

LC 591
2023 Regular Session
81100-001
7/19/22 (LAS/ps)

D R A F T

SUMMARY

Permits minor 15 years of age or older to consent, without parental consent, to chiropractic treatment.

A BILL FOR AN ACT

Relating to consent of minors to chiropractic services; amending ORS 109.640 and 109.650.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 109.640, as amended by section 14, chapter 349, Oregon Laws 2021, is amended to read:

109.640. (1) A physician, physician assistant licensed under ORS 677.505 to 677.525, nurse practitioner licensed under ORS 678.375 to 678.390 or naturopathic physician licensed under ORS chapter 685 may provide birth control information and services to any person without regard to the age of the person.

(2) A minor 15 years of age or older may give consent, without the consent of a parent or guardian of the minor, to:

(a) Hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Oregon Medical Board [*or*]**,** a naturopathic physician licensed under ORS chapter 685 **or a chiropractic physician licensed under ORS chapter 684**, and dental or surgical diagnosis or treatment by a dentist licensed by the Oregon Board of Dentistry, except as provided by ORS 109.660.

(b) Diagnosis or treatment by a physician assistant who is licensed under

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

ORS 677.505 to 677.525 and who is acting pursuant to a collaboration agreement as defined in ORS 677.495.

(c) Diagnosis and treatment by a nurse practitioner who is licensed by the Oregon State Board of Nursing under ORS 678.375 and who is acting within the scope of practice for a nurse practitioner.

(d) Treatment by a chiropractic assistant who is certified by the State Board of Chiropractic Examiners and who is acting within the scope of practice for a certified chiropractic assistant.

[*(d)*] **(e)** Except when the minor is obtaining contact lenses for the first time, diagnosis and treatment by an optometrist who is licensed by the Oregon Board of Optometry under ORS 683.010 to 683.340 and who is acting within the scope of practice for an optometrist.

SECTION 2. ORS 109.650 is amended to read:

109.650. A hospital or a physician, physician assistant, nurse practitioner, naturopathic physician, **chiropractic physician, chiropractic assistant,** dentist or optometrist **providing information, services, care, diagnosis or treatment to a minor as** described in ORS 109.640 may advise [*a*] **the minor's** parent or legal guardian [*of a minor*] of the care, diagnosis or treatment [*of*] **provided to** the minor or the need for any treatment of the minor, without the consent of the minor, and is not liable for advising the parent or legal guardian without the consent of the minor.

Board member name_____

Calendar Year 2021-2022 Best Practices Self-Assessment Guidance

Annually, board members are to self-evaluate their adherence to a set of best practices and report the percent of total best practices met by the board (percent of yes responses in the table below) in the *Annual Performance Progress Report* as specified in the agency Budget Instructions.

Recommended Assessment Process

1. Select a neutral party to facilitate the self-evaluation (recommended, not required).
2. Individual board members complete the score card shown below.
3. Tabulate the results for all board members (can be done by neutral party in advance).
4. Discuss the results—particularly the results for those areas where there are disparate responses or where the group agrees that they are not adhering to a best practice.
5. Record the group's joint response to each best practice on a new score card. If consensus is not achieved, the board or commission should record the response as "no."

Best Practices Assessment Score Card

Best Practices Criteria	**Yes**	**No**
1. Executive Director's performance expectations are current.		
2. Executive Director's receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The board reviews the *Annual Performance Progress Report*.		
5. The board is appropriately involved in review of agency's key communications.		
6. The board is appropriately involved in policy-making activities.		
7. The agency's policy option packages are aligned with their mission and goals.		
8. The board reviews all proposed budgets.		
9. The board periodically reviews key financial information and audit findings.		
10. The board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The board coordinates with others where responsibilities and interests overlap.		
14. The board members identify and attend appropriate training sessions.		
15. The board reviews its management practices to ensure best practices are utilized.		
16. Others *[The board may add additional best practices; however, they are not to be counted when calculating the percentage adherence to best practices.]*		
Total Number		
Percentage of Total		

Analyzing Assessment Results and Defining Next Steps

Once the above table has been completed, the board will want to prepare responses to the following questions. Responses should be integrated into the *Annual Performance Progress Report*, which is due from agencies on September 30th of each year.

- How are we doing?
- How do we compare to others and/or to our target? (Once this data is available.)
- What factors are affecting our results?
- What needs to be done to improve future performance?

Educational Manual

for

Evidence-Based

Chiropractic

FORWARD

Objective

The primary objective of this patient-centered, evidence-based document is to provide an educational tool to assist chiropractic physicians and their patients in making decisions about appropriate chiropractic health care for better patient outcomes. The strength of this document is that it is patient-centered, supported by the best available evidence and not solely condition based.

Further this document is profession-initiated with broad representation by Oregon licentiates in the development process. Extensive grassroots support facilitates the educational process and promotes implementation. Patient-centered, evidence-based objectives put the interest of the patient first, based on the best available evidence. Individual differences mandate that what may be good for a typical patient may not be good for the individual patient requiring flexibility in interpretation. Consensus based standards of quality derived from high level evidence, provides a basis for peer review criteria, to assist the profession in decision making based on predetermined elements of care against which aspects of individual chiropractic care can be compared. Perfect decisions about optimum care are not possible since the process of analyzing evidence and opinion is imperfect. Nevertheless the potential benefits from patient-centered, evidence-based objectives are protection of patients, reduction in practice variation, quality assurance, and improved risk management.

The Status of Chiropractic Practice Guidelines in North America

Interest in chiropractic practice and utilization guidelines gained momentum in the latter part of the 1980's. Prior to 1990 several states, including Ohio, Oregon and Washington, had begun guideline development. With the publication of Vear's book: *Chiropractic Standards of Practice and Quality of Care* in 1992[1], some issues surrounding guidelines for chiropractic practice became formalized as standards. Beginning with the Mercy Conference Guidelines, published in 1993[2] practice guidelines for the chiropractic profession came into the national arena. Following directly on this publication, the politically driven Wyndham guidelines[3] were published by a group of straight chiropractors dissatisfied the Mercy proceedings. The process for both sets of guidelines that were based on consensus relied heavily on the use of authoritative theory and opinion, lacking a systematic evaluation of supporting evidence.

Procedure based guidelines significantly impacting the chiropractic profession have also been developed on a national level by the RAND Corporation[4-5] and the Agency for Health Care Policy and Research[6]. Both groups evaluated supporting evidence for the use of manipulation in the treatment of acute low back pain, concluding that it is both safe and effective. These studies have been embraced enthusiastically by some chiropractors, which has gained more mainstream recognition for a limited role in which the chiropractor treats only back pain, and possibly neck pain and some forms of headache.

Such a limited role, however, is not consistent with the broad scope of practice in the State of Oregon.

Guidelines continue to be put forth both nationally by the International Chiropractic Association (ICA)[7] and the Council on Chiropractic Practice (CCP)[8]and at the state level[9] (Florida). These documents are still largely based on consensus opinion, without the panel members reviewing the best available evidence, and far from meeting the Institute of Medicine[10] criteria for guideline development. The ICA, CCP and Florida Guidelines have conflicts with the accepted practice of chiropractic in Oregon relative to diagnosis, assessment and informed consent. The CCP guidelines are designed specifically for vertebral subluxation practice, which is not inclusive or representative of the practice of chiropractic in the State Oregon. In addition some contributors and panel members listed in these guidelines did not participate directly in the consensus process. Of serious concern is the significant number of misleading references. Although found to be more acceptable, the Mercy guidelines are based primarily on consensus and have not been updated, necessitating development of a current document to guide chiropractic practice in the State of Oregon. [11]

Current Status of Practice and Utilization Guidelines in Oregon

The Oregon Chiropractic Practice and Utilization Guidelines were published in 1991[12] by the Oregon Board of Chiropractic Examiners (OBCE) in response to public demand for more accountability. Developed through consensus, these guidelines were recognized in the Northwest as one of the most advanced documents at the time. Given the more than ten years that have elapsed since these guidelines were initiated, serious questions regarding their adequacy have been raised. In response to these questions, the OBCE implementing the strategic planning process, appointed a steering committee comprised of doctors of chiropractic, representative of the various constituencies in the State of Oregon, including: Chairman Charles Simpson (OBCE representative), members John Cafferty (subluxation based chiropractor), Thomas Dobson (initiator of the current guideline process), Janet Steward, and Jack Pederson (broad scope practitioners) with Meridel Gatterman as process consultant. Dr. Gatterman has 11 years of guideline development experience including: the Oregon Practice and Utilization Guidelines,[12] the Mercy Guidelines [2] and the Canadian Guidelines[13] . Published works that employed a facilitated consensus process include development of chiropractic nomenclature [14], and a patient centered paradigm for both chiropractic[15], and complementary medicine.[16]

The steering committee utilized the following four approaches to assess the status of the Oregon Chiropractic Practice and Utilization Guidelines, Volume I:

- survey of stakeholders;
- focus groups and key person interviews;
- expert reviews;
- application of the Institute of Medicine (IOM) of the National Academy of Sciences "provisional assessment instrument".[10]

The survey and focus groups responses, key person interviews, and expert reviews all identified deficiencies in the 1991 guidelines. The steering committee concluded that the

1991 guidelines (derived primarily through consensus of expert opinion with little documentation of evidence) are in need of revision. Inclusion of current scientific evidence coupled with broad professional consensus was designed to make the revision more accountable, credible, as well as patient centered and evidence-based.

Patient Centered, Evidence-based Care

Patient centered care puts the patient first, before cost cutting by managed care, doctor's egos, or financial gain. Patient centered practice evaluates the individual patient's clinical state, predicament, and preferences, and applies the most efficacious interventions to maximize the quality and quantity of life for that person[17.] Chiropractic practice has traditionally been patient centered with anthropological and sociological studies providing evidence and seed material for a patient centered paradigm[18-20]. Following evaluation of these studies combined with the philosophical first principles of chiropractic, a patient centered paradigm emerged.[15]. Subsequent to identification using qualitative methodology, a nominal panel comprised of chiropractic educators, researchers and practitioners validated a patient centered paradigm through a nominal consensus process. Based on this model the following characteristics of a patient centered paradigm were refined and agreed upon by the nominal consensus panel charged to assist in the development of the Oregon Practice Guidelines:

1. Recognition and facilitation of the innate organization and adaptation of the person;
2. Recognition that care should ideally focus on the total person;
3. Acknowledgment and respect for the patient's values, beliefs, expectations and health care needs;
4. Promotion of the patient's health through a preference for drugless, minimally invasive, and conservative care;
5. A proactive approach that encourages patients to takes responsibility for their health;
6. The patient and patient centered practitioner act as partners in decision making, emphasizing clinically effective and economically appropriate care, based on various levels of evidence.

Evidence-based Care

Evidence-based practice has been defined as:

> **"the conscientious explicit, and judicious use of the current best evidence in making decisions about the care of individual patient's** "[17]

Evidence-based practice means:

> **"integrating individual clinical expertise with the best available external evidence from systematic research"**[17.]

Sackett emphasizes that "Good doctors use both individual clinical expertise, and the best available external evidence, and neither alone is enough. He notes that without clinical expertise, practice risks becoming tyrannized by evidence, because even excellent external evidence may be inapplicable or inappropriate for an individual patient. Without

current best evidence, practice risks rapidly becoming out of date, also to the detriment of the patient. Evidence-based practice is not "cookbook practice." It is also recognized that the best available evidence is not just limited to external evidence from randomized controlled trials but also involves the individual clinicians' expertise along with the consensus of leading chiropractic clinicians and researchers based on varying degrees of patient-centered clinical research. A thorough literature review is crucial to successful evidence based practice[17].

The Epistemology of Scientific Knowledge

Consideration of how we know what we know is based on a hierarchy of ways of knowing. This hierarchy gives us the degree of certainty that can be attributed to evidence.

1. Laws or Principles of Science

Theories that have been scientifically demonstrated and are now accepted as scientific fact based on a sequence of events occurring with unvarying uniformity under the same conditions. Laws and principles explain natural actions.

2. Theories of Science

A set of related ideas that have the potential to explain or predict human experience in an orderly fashion and that are based on data. Theories follow a hypothesis that has been investigated and is now in an advanced data gathering mode. Although there are many questions that still need to be answered, this category of scientific knowledge is frequently used clinically as if it were a demonstrated fact.

3. Hypothesis

Hypotheses are testable statements referred to as the working tools of science. A question or conjecture is presented and tested through observation and data gathering and processing.

4. Conjecture

An opinion of an expert person in a given field of science based on slight evidence.

Guidelines for Grading Evidence

The strength of both scientific and legal evidence is graded according to three levels. Standards of practice require higher levels of supporting evidence on which to judge competency. Due to resource limitations, evidence ratings in this document are limited to Standards. References following statements clearly indicate what evidence supports this document.

Scientific Evidence

The convention for grading scientific evidence is based on a hierarchy of levels that provide degrees of predictability.

Type I

Evidence provided by one or more well designed* randomized controlled clinical trial(s) (RCT) for therapeutic interventions or by one or more well designed descriptive studies that address sensitivity, specificity, and predictive value (for diagnostic procedures/devices).

Type II
Evidence provided by one or more well designed observational studies, such as a case control or cohort study, or a well designed prospective case series, or clinically relevant basic science studies that address sensitivity, specificity, and predictive value**.**

Type III
Evidence provided by studies not meeting the criteria of Type I or II, that may include expert opinion, field practitioner consensus, or other sources, as judged by an Expert Panel.

* For the purpose of this document, "well designed" refers to a study that has, at a minimum, relatively high internal validity (low systematic error) and sufficient precision for statistical significance (adequate study numbers)

Legal Evidence
Legal evidence is also based on a hierarchy of supporting evidence ranging from statutes which are mandatory to legal opinion that is discretionary.

Legal Type I
This administrative aspect of practice is mandated by ORS or OAR, or is found to be essential and is necessary (A standard of practice).

Legal Type II
This administrative aspect of practice is supported by uncontrolled studies and/or published legal opinion and is recommended, and in some cases mandatory. (Official AG opinion vs., "legal opinion" written in a legal peer review journal vs. "case law" opinion)

Legal Type III

This administrative aspect of practice is supported by a consensus of practitioners as determined by the Expert Panel or by expert legal opinion and is discretionary.

A Three Tiered Evidence-based Consensus Process
The process used to develop the following chapters involves three levels of consensus. Each chapter is developed first through a seed statement from a seed panel composed of 5-7 panel members that review the best available evidence. Seed statements are then reviewed by a 9-15 member nominal panel that reviews all chapters for consistency, continuity and to minimize redundancy. The final review is by a 100-member Delphi panel that reviews one or all chapters and participates in the consensus process by mail.

Panel Selection
Selection of panel members is made by the Steering Committee based on the following criteria:

A. Geographical representation

B. Philosophical representation
C. Gender representation
D. Practice experience representation

Where possible a balance of each population identified will be included. To facilitate frequent meetings balanced geographical representation is not always possible at the seed panel level.

Challenges to the Consensus Process

Challenges to the consensus process have included lack of differentiation between guidelines and standards, political opposition to guideline development, limited resources, and a scarcity of quality evidence.

Standards versus Guidelines

Despite peer reviewed publication of a paper by two steering committee members and one nominal panel member that differentiated between guidelines and standards[21], there remains the perception by many that guidelines are synonymous with standards. This in part is due to the inappropriate use of guidelines as absolute standards by third party payers and attorneys. While this utilization of guidelines is not consistent with the defined use of these terms in the literature, the process has been hampered by the fear that development of guidelines will lead to misuse.

Guidelines are considered to be recommendations that allow for flexibility and individual patient differences. Standards are more binding and require a high level of supporting evidence. While guidelines serve as educational tools to improve the quality of practice, standards that outline minimum competency are used more as administrative tools on which to base policy. Confusion generated by poor differentiation of guidelines from standards therefore contributes to mistrust of the guideline process. Because of this challenge the updated Oregon Practice and Utilization Guidelines document is referred to as a Manual for Evidence Based Chiropractic Practice. Where applicable, standards are clearly stated.

Political Opposition

Opposition to updating the Oregon practice and utilization guidelines by representatives of one political organization is an ongoing challenge to the process. A concerted attempt by members of the steering committee, the OBCE and members of the profession to engage these individuals in continued participation in the process has been made, emphasizing that the way to ensure that the process is inclusive is to participate. Various claims regarding lack of inclusion of evidence or changes in seed statements as they proceeded through the process could have been easily addressed and resolved if these individuals would have communicated their concerns in a timely manner and continued their participation. At all times the process has worked to improve seed statements as they achieved consensus through the seed panel, nominal panel and Delphi process.

Resources

A challenge to the current process is the lack of adequate resources to fully support an ambitious effort. A grant application for outside funding was not successful and a request for additional funding from the OBCE was not approved by the 2001 Legislative Session. This prevented contracting with a project manager as planned, contributing to slower progress.

However, the process has proceeded with strong support from numerous Oregon chiropractors who have contributed their time and energy to review evidence, draft seed statements, and attend meetings or review drafts sent to them by mail. The OBCE has supported this effort by providing meeting space, mailings, and printing services within its current budget.

Lack and Quality of Evidence

The greatest challenge to evidence-based practice is the lack of evidence. This is true of all health care professions.[22] This has been especially acute for the chiropractic profession that has long been denied external funding. It is only in the recent past that significant federal funding has been applied to the study of chiropractic. This has created a problem of legitimization in which the science of chiropractic has been evaluated through the lens of the medical paradigm.

Paradigm

A paradigm is a socially constructed disciplinary matrix, grounded on habits of mind and webs of belief.[23] It is characterized by symbolic generalizations, shared models and shared values. It includes concepts, perceptions, and techniques shared by a scientific community and used by that community to define legitimate problems and legitimate solutions.[23] A paradigm is useful as both a plan of action and a lens through which the chiropractor views the patient. The chiropractor is thus provided with a worldview through which the science of chiropractic can advance, in the patient's interest.[15]

The Chiropractic Paradigm

The Association of Chiropractic Colleges (ACC)[24] agreed to the following chiropractic paradigm that has subsequently been adopted by the World Federation of Chiropractic:

The purpose of chiropractic is to optimize the patient's health. This is based on the principle that the body's innate recuperative power is affected by and integrated through the nervous system. The practice of chiropractic within the chiropractic paradigm includes:

- establishing a diagnosis;
- facilitating the body's homeostasis through emphasis on neurological and biomechanical integrity, and
- promoting health.

The Chiropractic Foundation

The foundation of chiropractic includes philosophy, science, art, knowledge, and clinical experience. The chiropractic paradigm directly influences the following:

- patient health through quality care;
- education;
- research;
- health care policy and leadership;
- relationships with other health care providers;
- professional stature; public awareness and perceptions

The Subluxation

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on subluxation. A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

Chiropractic Scope of Practice

Members of the Association of Chiropractic Colleges educate students for the competent practice of chiropractic. These accredited academic institutions have defined the scope of chiropractic practice within the chiropractic paradigm.

Since human function is neurologically integrated Doctors of Chiropractic evaluate and facilitate biomechanical and neuro-biological functions and integrity through the use of appropriate conservative, and diagnostic and chiropractic care procedures. Therefore, direct access to chiropractic care is integral to everyone's health care regimen.

Chiropractic Practice

A. Diagnosis

Doctors of Chiropractic, as primary contact health care providers, employ the education, knowledge, diagnostic skill and clinical judgment necessary to determine appropriate chiropractic care and case management. Doctors of Chiropractic have access to diagnostic procedures and/or referral resources as required.

B. Case Management

Doctors of chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and when appropriate, collaborate with and/ or refer to other health care providers.

C. Health Promotion

Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices[24].

Chiropractic Nomenclature Developed through Consensus

Chiropractic nomenclature has been developed through agreement obtained by a rigorous process using both nominal and Delphi consensus methods[14]. Moving through increasingly complex stages agreement was reached on the following ten terms used to discuss chiropractic science.:

Articular functional units.

- Motion segment-A functional unit made up of the two adjacent articulating surfaces and the connecting tissues binding then to each other.
- Spinal motion segment- Two adjacent vertebrae, and the connecting tissues binding then to each other.

The lesion treated by chiropractors.

- Subluxation-A motion segment, in which alignment, movement integrity and/or physiological function are altered although contact between joint surfaces remains intact.
- Manipulable (chiropractic) subluxation-A subluxation in which alignment, movement integrity and/or function can be improved by manual thrust procedures.
- Subluxation complex-A theoretical model of motion segment dysfunction (subluxation) which incorporates the complex interaction of pathological changes in nerve, muscle, ligamentous, vascular and connective tissues.
- Subluxation syndrome-An aggregate of signs and symptoms that relate to pathophysiology or dysfunction of motion segments.

Treatment procedures utilized by chiropractors.

- Adjustment-Any chiropractic therapeutic procedure that utilizes controlled force, leverage, direction, amplitude, and velocity which is directed at specific joints or anatomical regions. Chiropractors commonly use such procedures to influence joint and neurophysiological function.
- Manual therapy-Procedures by which the hands directly contact the body to treat the articulations and/or soft tissues.
- Manipulation-A manual procedure that involves a directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit
- Mobilization-Movement applied singularly or repetitively within or at the physiological range of joint movement, without imparting a thrust or impulse, with the goal of restoring joint mobility.

Introduction to the Philosophy, Science and Art of Chiropractic

The Traditional Philosophy of Chiropractic

The traditional vitalistic philosophy of chiropractic is based on the scientific philosophy of biology that features the functional organization of living beings.[25] Living beings are capable of maintaining their overall organization in the face of extensive variations in their environment.[25] Similar organization does not occur in the non-living world[25].

According to D.D. Palmer, the founder of chiropractic, the vital functioning of each individual is directed by the body's innate intelligence, and expression of universal intelligence.[26] Universal intelligence accounts for the universal regularities and laws of nature that are the concern of physics and chemistry, and the particular regularities and laws of physiology [27].

That those processes of bodily functioning whereby the body is regulated through electrophysiological, biochemical , immunological, and other mechanisms, forms the basis of the science of physiology. Palmer's concept of "innate intelligence", the ability of the body to regulate and repair itself, is also referred to as homeostasis.[28] The philosophy of chiropractic is based on the belief that the true locus of health comes from within through modulation by the nervous system. Recognition of the role of the nervous system in health and disease has increased in the last decade. Recent evidence that supports Palmer's traditional concept is exemplified by the emerging focus on neuroimmunology which provides evidence in support of a strong relationship between nervous system and immunological function[29].

The philosophy of chiropractic is both vitalistic and holistic[30]. Chiropractic holistic philosophy views the patient as an whole person, not as a disease bearing organism. The body is seen as an integral unit capable of maintaining health. The systems of the body are viewed as complex, interactive, and have a powerful ability to self-correct provided functional integrity is maintained. The holistic philosophy of chiropractic promotes health, prevents illness, and encourages healing through care that focuses on the total individual in the context of personal, familial, social, and environmental factors.

Holism with respect to humans recognizes that the whole has properties that its parts lack and the properties of the parts interact to form the whole[25] Perceiving the whole is more difficult than the parts. It often requires subdividing the whole looking for connections and the interaction of the parts in the context of the whole. In the historical perspective of chiropractic philosophy there is an important interrelationship between optimal nerve function, the integrity of the musculosketetal system, and health.

The Science of Chiropractic

Traditionally, the science of chiropractic has focused on the modulating function of the nervous system in the self healing of the human organism, and the role that interference with the nervous system has on the loss of optimal health. While this is fundamental to chiropractic principles the most compelling scientific evidence to date supports chiropractic treatment of neuromusculoskeletal conditions.

In the more than one hundred years that chiropractic has been in existence, much of the significant and reproducible research has been compressed within the past two decades. The past five years has been particularly significant with the evidence supporting the primary chiropractic intervention (manipulation) as one of the first-line means of health care intervention in the treatment of acute low back pain in adults. The science of

chiropractic comes from basic science evidence, case studies, clinical trials, and other outcome studies.

In 1975 the NINCDS (National Institute of Neurological, Circulatory, Disorders and Stroke) conference [31] found that "specific conclusions cannot be derived from the scientific literature for or against either the efficacy of spinal manipulative therapy or the pathophysiological functions from which it is derived". Given the impetus of this conference, considerable research has been conducted demonstrating the safety and efficacy of this procedure. In spite of the paucity of funds, (up to 1994 coming solely from the profession itself), chiropractic researchers have made steady gains. With external funding, future gains promise to add significant data to support the uniqueness of chiropractic theories and to sustain evidence-based practice.

Basic science studies have been primarily been designed to test theories related to one piece of the core of chiropractic practice, the chiropractic spinal subluxation. Where the spinal subluxation seen by allopathic (medical) practitioners is viewed radiographically and frequently demonstrates hypermobility , the chiropractic subluxation typically exhibits restricted motion, along with misalignment and altered neurological function[5].

Anatomical studies related to subluxation have primarily investigated the components of the spinal motion segments including the zygapophyseal joints[32-33]structures surrounding the intervertebral foramen[34-39], and the sacro-iliac joints[40]. Basic scientific evidence for chiropractic subluxation has also been demonstrated in 16 studies of animal models[41].

Studies in the field of neuroscience have included investigation of the innervation of components of the spinal motion segment[42,43], spinal nerve roots[44] peripheral nerves[45] and the autonomic nervous system[46-49]. Studies of systemic effects of spinal manipulation through nervous system modulation include changes in immune function[50,51.]. Neurophysiological investigations into pain modulation include, spinal cord mechanisms of referred pain and neurologically linked physiological aberrations[52-54].

Numerous biomechanical studies related to subluxation and manipulation have been conducted advancing the science of chiropractic. A major area of chiropractic research has focused on the characterization of the forces applied to the surface of the patient during various adjustive procedures[55-60], others investigators have evaluated loads and displacements used to measure the mechanics of spinal segments[61-68]. The mechanical effects of cavitation and the audible release accompanying high velocity low amplitude thrust procedures have also been studied[69-73.]

These investigations, primarily conducted by chiropractors are but a small part of basic science research that validates chiropractic theories. Studies conducted by basic scientists in other related fields have provided considerable support beyond the studies mentioned here. Knowledge gained by basic science models has yielded information on subluxation not available by measurements on living humans.

The most compelling evidence for chiropractic care comes from clinical trials that evaluate the effectiveness spinal manipulation for neuromusculoskeletal conditions. Over 40 clinical trials of spinal manipulation for the treatment of low back pain have been conducted. These have been subjected to evaluation of methodological quality[74] and meta-analysis[75]. This has led to acceptance of manipulation as a viable alternative to allopathic care in the treatment of acute low back pain. Chronic low back pain while subjected to less scrutiny, has also demonstrated significant response to chiropractic manipulation[76,77]. Evidence from clinical trials also supports the treatment of neck pain with manipulation[78-80]. Benefit from cervical manipulation has also been demonstrated from headache trials studying tension[81-83], migraine[84,856] and cervicogenic types[86-88].

Non musculoskeletal conditions for which clinical trials of varying rigor supporting chiropractic intervention include obstetric and gynecologic disorders (such as dysmenorrhea and premenstrual syndrome)[89-94], and pediatric conditions, (such as: colic[95], otitis media[96,97], and hyperactivity[98)] . Trails of chiropractic care of other conditions have demonstrated mixed results. Hypertension studies involving adults demonstrated both short-lived reductions [99,100] and no significant alteration[101] in blood pressure readings. Studies of children with eneuresis have demonstrated both the effectiveness of chiropractic treatment[102] and no efficacy beyond the natural history of the condition[103]. Asthma trials studying both children and adults have shown positive results[104-,106], no significant improvement[107], and both no benefit[108], and a significant decrease in nighttime symptoms[109] , in the same study.

In addition to the clinical trials previously mentioned, a variety of methods have been used for outcomes research including community based trials, observational studies and cross sectional surveys all of which provide supporting data. Among the community based trials the Meade studies reported greater effectiveness of chiropractic care for low back pain compared to hospital-based physical therapy[110,111]. Observational studies of chiropractic care designed to assess patient outcomes for low back pain have been reported[112-118]. Cross-sectional studies of chiropractic have evaluated care-seeking for acute and chronic low back pain[110,111] . Physicians' beliefs and behaviors regarding management of low back pain[119]and patient's satisfaction with the care provided have also been studied[120,121.] A preliminary study suggests that geriatric patients under chiropractic care are more apt to report better health status, more likely to exercise vigorously, and more likely to be mobile in the community[122].
This discussion has not included many of the cohort studies, case series or case reports that document the effectiveness of chiropractic care. There is evidence from these types of studies also contributes to chiropractic science. In addition these studies provide clues as to the direction of future chiropractic research. Agendas for prioritizing future research related to chiropractic theories and practice are conducted nationally on an annual basis[123,] and internationally on a biannual basis [124.] Regular research conferences that present the results of chiropractic are held world wide including those sponsored by the Foundation for Chiropractic Education and Research (The International Conference on Spinal Manipulation), and the World Federation of Chiropractic.

There is little doubt that evidence from clinical trials clearly supports the treatment of low back pain by chiropractors[125]. Evidence for the treatment of neck pain[126] and headaches[81-88] is also convincing. Although both clinical experience and expert opinion in the chiropractic, osteopathic, and medical literature [127-131] suggest an observable link between manipulation and improvement in at least some non-musculoskeletal conditions clinical trails lag far behind actual practice. To date at least 73 randomized clinical trials of a broadly defined spinal manipulative procedure have been reported in the English language literature. No trial to date has found manipulation to be statistically or clinically less effective than the comparison treatment.[132] Causation related to subluxation remains to be demonstrated. It is imperative to remember that lack of evidence does not constitute evidence against, while further research accumulates in the field of chiropractic science.

The Clinical Art of Chiropractic

Chiropractic practice is fundamentally patient centered and pragmatic, based on empirical results. This patient centered orientation as opposed to an illness orientation has traditionally been central to the clinical art of chiropractic[133]. Coulehan[134] states that chiropractors do not subtract the patient to get to the disease as if peering through a translucent screen to find a disease entity within. He also states that the application of this clinical art is a matrix of acceptance, validation, explanation and treatment**.**

The sense of acceptance or positive regard for a patient is considered one of the core qualities necessary for patient-doctor interaction[134]. Validation includes acknowledging the patient's perceptions, values, health care preferences and expectations. Genuineness both as the ability to be oneself in a relationship without hiding behind a role or facade[134], and genuine caring [135] have also been noted as prominent in chiropractic care.

Chiropractic art includes a clear and understandable explanation of the patients condition[134]. This explanatory model is mechanistic, holistic and based on science. Additionally, it is based on a logical set of beliefs presented in scientific terminology, promoting a natural noninvasive approach to healing[135]. It includes stressing influences on health, "drugless" treatment and a positive, dynamic view of the healthy state[135]. Patients are encouraged to take responsibility for their health and enter into a partnership in decision making [15]. Chiropractors strive to develop a positive image of patients' personal control over their health that requires commitment and cooperation[135].

Primary to the chiropractic explanatory model is the emphasis that the chiropractic adjustment facilitates a change in physiology which can translate into improved health. Traditional chiropractic thought explains this phenomenon as the body's innate capacity for healing. Additionally chiropractic art includes enhancing patients' focus on their health. Current understanding of biopsychosocial factors explains how the chiropractor strengthens patients' belief that they will recover and is considered to be included in the chiropractic clinical art [135]. Chiropractors seek to create conditions in their patients that

are conducive to the liberation of patient's innate recuperative capacities, thus enabling them to return to their optimal state of health[15].

Chiropractic treatment is characterized by advanced skill in manual procedures. The level of skill necessary to perform a successful adjustment requires years of training in the art of palpation and adjusting. Both the chiropractic examination and treatment involves extensive "laying on of the hands"[135]. Mastery of chiropractic technique procedures utilizes the healing power of touch, adding comfort to the clinical action of the treatment.

Beyond the skills of patient evaluation and diagnostic testing germane to portal of entry providers, much of the art of chiropractic involves the location and correction of subluxation. This includes the skill at analysis used to locate the subluxation, the specific adjustive technique used to reduce or correct the subluxation, and the assessment used to determine the type of future care. Chiropractic adjustive procedures are specific and include high velocity low amplitude thrust techniques (manipulation), mechanically assisted techniques, light touch techniques, soft tissue techniques and reflex procedures [136].

REFERENCES

1. Vear HJ: Chiropractic Standards of Practice and Quality of Care. Aspen Pub Gaithersburg MD. 1992.
2. Haldeman S, Chapman-Smith D Peterson DM: Guidelines for Chiropractic Quality Assurance and Practice Parameters. Proceedings of the Mercy Center Consensus Conference Gaithersburg MD. Aspen Pub . 1993.
3. Practice Guidelines for Straight Chiropractic (Proceedings of the International Straight Chiropractic Consensus Conference), Chandler AZ. World Chiropractic Alliance 1983.
4. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE. Phillips RB, Brook RH: The Appropriateness of Spinal Manipulation for Low Back Pain. Indications and Ratings by a Multidisciplinary Panel. 1991 RAND Santa Monica, CA. Pub No. R-4025/2CCR/FCER.
5. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE, Phillips RB, Brook RH: Spinal Manipulation for Low-Back Pain. Indications and Ratings by an All-Chiropractic Panel. 1992 RAND Santa Monica CA. R-4035/3-CCR/FCER.
6. Bigos S, Bower O, Braen G et al. Acute Low Back Problems in Adults Clinical Practice Guideline No. 14. 1994 AHCPR Publication No. 95-0642. Rockville, MD; Agency for health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.
7. Recommended Protocols and Guidelines for the Practice of Chiropractic. International Chiropractic Association Arlington VA 1999.
8. Kent C, Boone WR, Rondberg TA: Clinical Practice Guideline: Vertebral Subluxation in Chiropractic Practice. No 1 1998 Council on Chiropractic Practice. Chandler AZ.
9. Rubenstein HM: Wellikoff RJ: Practice Guidelines and Parameters for the State of Florida. 1996 Florida Board of Chiropractic
10. IOM Committee on Clinical Practice Guidelines provisional assessment instrument
11. Cates JR, Young DN, Guerriero DJ, Et al: Evaluating the quality of clinical practice guidelines. J Manipulative Physiol Ther 2001; 24170-75.
12. Oregon Chiropractic Practice and Utilization Guidelines. 1991 Oregon Board of Chiropractic Examiners. Salem OR.
13. Henderson D, Chapman-Smith D, Mior, Vernon H: Clinical Guidelines for Chiropractic Practice in Canada. Canadian Chiropractic Association. Toronto Ont. 1993.
14. Gatterman MI, Hansen DT. Development of chiropractic nomenclature through consensus. J Manipulative and Physiol Ther 1994 17; 302-309.
15. Gatterman MI: A patient centered paradigm: A model for chiropractic education and research. J Alter Complement Med: Research on Paradigm, Practice and Policy. 1995 1:415-432.
16. Gatterman MI: A patient centered paradigm: A shared model for complementary care. Proceedings of World Med 96. Washington. The World Congress of Complementary Therapies in Medicine. 1996 .
17. Sackett DL: Evidence-based medicine. Spine 1998; (23) 10: 1085-1086.
18. Coulehan JL: Chiropractic and the clinical art. Soc. Sci. Med. 1985;21:383-390.
19. Kelner M, Hall O, Coulter I: Chiropractors, Do They Help? A study of their education and practice. Toronto: Fitzhenry and Whitehead, 1980.
20. Jamison JR: Clinical Communication: the essence of chiropractic: J Chiro Human 1994; 4:26-35.
21. Smith R: Where is the wisdom: The poverty of medical evidence. BMJ 1991; 303:798-789.
22. Gatterman MI, Dobson TP, LeFevbre R. Chiropractic quality assurance: standards and guidelines. J CCA 2001; 45;11-17.
23. Kuhn TS: The Essential Tension. University of Chicago Press. Chicago IL. 1977.
24. President's consensus statement: Association of Chiropractic Colleges 1997.
25. Audi R: The Cambridge Dictionary of Philosophy. Cambridge MA. Cambridge University Press. 581-582. 1995.
26. Palmer DD. The Chiropractor's Adjuster: The Science, Art and Philosophy of Chiropractic. Portland Printing House. Portland OR 1910.
27. Toulmin S: Concepts of function and mechanism in medicine and medical science. In Englehardt HT, Spicker S ed. Evaluation and Explanation in the biomedical Sciences.

28. Cannon WB: The Wisdom of the Body, 2nd ed. New York, Norton 1939.
29. Blalock JE, Smith EM: A complete regulatory loop between the immune system and neuroendocrine systems. Fed Proc 1985 44: 108-11
30. Coulter ID. An institutional philosophy for chiropractic. Chiro J Aust 1991; 21:136-41.
31. Goldstein M The research status of spinal manipulative therapy. Bethesda, MD: US Public Health Service, National Institute of Neurological and Communicative Disorders and Stroke. 1975. Publication No. NIH76-998.
32. Giles LGF, Taylor JR, Cockson A: Human zygapophyseal joint synovial folds. Acta Anat. 1986 126;110-114.
33. Giles LGF: Pathoanatomic studies and clinical significance of lumbosacral zygapophyseal (facet) joints. J Manipulative Physiol Ther 1992 15:36-40.
34. Bachop W, Janse. The corporotransverse ligament at the L5 intervertebral foramen (abstract). Anat Tec 1983 205.
35. Bachop WE, RO CS: A ligament separating the nerve from the blood vessels at the L5 intervertebral foramen. J Bone and Joint Surg 1984 8:437.
36. Giles LGF, Kaveri MJP: Some osseous and soft tissue causes of human intervertebral canal (foramen) stenosis. J Rheumatology 1990 17:1474-81
37. Giles LGF ligaments traversing the intervertebral canals of the human lower lumbosacral spine. Neuro-Orthopedics. 1992 13:25-38
38. Giles LGF: A histological investigation of human lower lumbar intervertebral canal (foramen) dimensions. J Manipulative Physiol Ther 1993 15 551-555.
39. Cramer GD, Howe J, Glenn WV, Greenstein J, Potvin W: Morphometric comparison of computed tomography to magnetic resonance imaging in the evaluation of the lumbar intervertebral foramina. Clin Anat 1994 7:173-180.
40. Bowen v, Cassidy JD: Macroscopic and microscopic anatomy of the sacroiliac joints from embryonic life until the eighth decade. Spine 1981 6:620-628.
41. Vernon H: Basic scientific evidence for chiropractic subluxation. In Gatterman MI ed Foundations of Chiropractic Subluxation. St. Louis, Mosby . 1995 36-55.
42. Giles GF, Taylor JR: Innervation of human zygapophyseal joint synovial folds. Acta Orthop Scand 1987 58:43-46.
43. Giles LGF: The relationship between the medial branch of the lumbar posterior primary ramus and the mammillo-accesory ligament. J Manipulative Physiol Ther. 1991 14:189-192.
44. Olmarker K, Kiuchi S, Rydevik: anatomy and physiology of spinal nerve roots and the results of compression and irritation. In Giles LGF, Singer KP eds: Clinical Anatomy and the Management of Low Back Pain. Oxford Butterworth-Heinemann 1997 243-253.
45. Triano JJ, Lutges M. Subacute intermittent mechanical irritation of the sciatic nerve of mice. J Manipulative Physiol Ther 1980 3:75-80.
46. Sato A, Swenson R: Sympathetic nervous system responses to mechanical stress of the spinal column in rats. J Manipulative Physiol Ther 1984 7: 144-147.
47. Giles LGF: Paraspinal Ganglion distortion due to vertebral body osteophytosis: a cause of vertebrogenic autonomic syndromes? J Manipulative Physiol Ther 1992 15: 551-555.
48. Cauwenbergs P: Vertebral subluxation and the anatomic relationship of the autonomic nervous system. In Gatterman MI ed: Foundations of Chiropractic: Subluxation St Louis, Mosby 1995 235-266.
49. Jinkins JF: The pathoanatomic basis of somatic. Autonomic and neurogenic syndromes originating in the lumbosacral spine. In Giles LGF, Singer KP eds. Clinical Anatomy and Management of Low Back Pain. Oxford Butterworth -Heinmann 1991 243-253.
50. Brennan PC, Kokjohn K Kaltinger CJ et al Enhanced phagocytic cell respiratory burst induce by spinal manipulation: potential role of substance P. J Manipulative Physiol Ther 1919 14; 399-408.
51. Brennan P C Review of the systemic effects of spinal manipulation. In Gatterman MI ed: Foundations of Chiropractic: Subluxation. St. Louis, Mosby 1995 268-278.
52. Gillette RG: Spinal cord mechanisms of referred pain and related neuroplasticity. In Gatterman MI ed.: Foundations of Chiropractic: Subluxation. St. Louis, Mosby 1995 280-301.

53. Christiansen J, Meyer J altered metabolic enzyme activities in fast and slow twitch muscles due to induced sciatic neuropathy in the rat. J Manipulative Physiol Ther 1987 10:227-231.
54. Hu JW, Yu X-M Vernon H Sessle BJ: Excitatory effects on neck and jaw muscle activity of inflammatory irritant injections into cervical paraspinal tissues. Pain 1993 55:243-250.
55. Adams AA, Wood J: Forces used in selected chiropractic adjustments of the low back: a preliminary study. Research Forum 1984 1:5-9.
56. Adams AA, Wood J Changes in force parameters with practice experience for selected low back adjustments. Research Forum 1985 1;40-48.
57. Cohen E, Triano JJ, McGregor M Papakyriakou M: Biomechanical performance of spinal manipulation therapy by newly trained vs. practicing providers: does experience transfer to unfamiliar procedures? J Manipulative Physiol Ther 1995 18:347-352.
58. Hessell BW, Herzog W Hasler EM: Experimental measurement of the force exerted during spinal manipulation using the Thompson technique. J Manipulative Physiol Ther 1990 13:448-453.
59. Kawchuck GN, Herzog W, Hasler EM: Forces generated during spinal manipulative therapy of the cervical spine: a pilot study . J Manipulative Physiol Ther 1992 15;275-278.
60. Herzog W, Conway PJ, Kawchuk GN, Zhang Y, Hasler EM: Forces exerted during spinal manipulative therapy. Spine 1993 18: 1206-1212.
61. Triano JJ, Shultz AB: Transmitted loads during lumbosacral SMT. Proceedings of the International Conference on Spinal Manipulation 1994:53-54.
62. Gudavalli MR, Cox JM, Cramer GD, Baker JA, Patwardhan AG: Intervertebral disc pressure changes during low back treatment procedures. International Conference on Spinal Manipulation 1998 111-113.
63. Kirstukas SJ, Backman JA: Meaurement of loads during unilateral throacic manipulation. International Conference on Spinal Manipulation 1998 121-123.
64. Gudavalli MR, Triano JJ, Patwardhan AG, Havey R, Mcgregor M: Biomechanics of the atlanto-axial joint during vertebral artery provocation test. Adv Bioeng 1995 29:321-322.
65. Herzog W, Kawchuck GN, Conway PJ, Zhang YT: Biomechanical studies of spinal manipulative therapy (SMT): quantifying the movements of vertebral bodies during SMT. JCCA 1995 38:11-24.
66. Gal JM, Herzog W, KawchuckGN, Coneay PJ, Zhang YT: Forces and relative vertebral movements during SMT to unembalmed post-rigor human cadavers: Peculiarities associated with joint cavitation. J Manipulative Physiol Ther 1995 18:4-9.
67. Breen AC, Alllen R, Morris A. Spine kinematics: a digital videofluoroscopic technique. J Biomed Eng 198911:224-228
68. Triano JJ Schultz AB: Motions of the head and thorax during neck manipulations. J Manipulative Physiol Ther 1994 17: 573-583.
69. Sandoz R: The significance of the manipulative crack and of other articular noises. Ann Swiss Chirop Assoc 1969 4-47.
70. Herzog W Zhang YT Conway PJ, Kawchuck GN: Cavitation sounds during spinal manipulative treatments. J Manipulative Physiol Ther 1993 16; 523-526.
71. Conway PJ, Herzog W, Zhang Y, Hasler EM, Ladly K: Forces required to cause cavitation during spinal manipulation of the thoracic spine. Clin Biomech 1993 16:210-214
72. Brodeur R: The audible release associated with joint manipulation. J Manipulative Physiol Ther 1995 18;155-64.
73. Conway PJ Herzog W, Suter E: The frequency response of cavitation caused by spinal manipulation. Proceedings International Conference on the Spine 1998 102-104.
74. Koes B W, Bouter LM, VanMameren H, Essers et al: Methodological quality of randomized clinical trials of treatment efficacy in low back pain. Spine 1995 20:228-235.
75. Anderson R, Meeker WC, Wirick BE et al: A meta-analysis of clinical trials of spinal manipulation. J Manipulative Physiol Ther. 1992 15: 181-194.
76. Cassidy JD, Kirkaldy-Willis WH: Manipulation. In Kirkaldy Willis WH: Managing Low Back Pain 2nd ed. New York, Churchill Livingstone 1988 287-296.

77. Triano JJ, McGregor M Hondras MA, Brennan PC: Manipulative therapy vs. education programs in chronic low back pain. Spine 1995 20: 948-955.
78. Sloop PR, Smith Ds, Goldenburg E, Dore C: Manipulation for chronic neck pain. A double blind controlled study. Spine 1982; 7: 532-535.
79. Cassidy JD, Lopes AA, Yong-Hing: The immediate effect of manipulation versus mobilization of pain and range of motion in the Ther. 15: 570-575.
80. Koes BW: Bouter LM, Van Mameren H: et al A randomized clinical trial of manual therapy and physiotherapy for persistent back and neck complaints: sub group analysis and relationship between outcome measures. J Manipulative Physiol Ther 1993 16:211-219.
81. 81.Boline P, Kassak K, Bronfort G, Anderson AV: Spinal manipulation vs amyltryptoline for the treatment of chronic tension type headaches: a randomized clinical trial. J Manipulative Physiol Ther 1995 18: 148-154.
82. Hoyt W et al Osteopathic manipulation in the treatment of muscle-contraction headache. J Am Osteopath Assoc. !979 322-325.
83. 83.Mootz RD, Dhami MSI, Hess JA et al: Chiropractic treatment of chronic episodes of tension type headache in male subjects: a case series analysis JCCA 1994 38:152-159.
84. 84.Tuchin PJ: A case series of migraine changes following a manipulative therapy trial. Australasian Chiropractic and Osteoppathy 1997 6:85-91.
85. 85.Nelson CF, Boline P: The efficacy of spinal manipulation, amitripyline and the combination of both therapies for the prophylaxis of migraine headaches. J Manipulative Physiol Ther. 1998 21:511-519.
86. 86.Vernon H: Spinal manipulation and headaches of cervical origin. J Manipulative Physiol Ther 1989 12:455-468.
87. 87.Whitingham W Ellis WB, Milyneux TP: the effect of manipulation (toggle recoil) for headaches with upper cervical joint dysfunction: a pilot study. J Manipulative Physiol Ther 1994 17: 369-375.
88. 88.Nilsson N, Christensen HW, Hartvigsen J: The effect of spinal manipulation in treatment of cervicogenic headache. J Manipulative Physiol Ther 1997 20:326-330.
89. Liebl NA, Butler LM: A chiropractic approach to the treatment of dysmenorrhea. J Manipulative Physiol Ther 1990 13:101-106.
90. Stude DE: The management of symptoms associated with premenstrual syndrome. J Manipulative Physiol Ther 1991 14: 209-216.
91. 91.Kokjohn K: Schmidt DM, Triano JJ, Brennan PC: The effect of spinal manipulation on pain and prostaglandin levels in women with primary dysmenorrhea. J Manipulative Physiol Ther 1992 15: 279-285.
92. 92.Boesler D, WarnerM, Alpers Finnerty EP, Kilmore MA: Efficacy of high-velocity low amplitude manipulative technique in subjects with low back pain during menstrual cramping. J Am Osteop Assoc 1993 93:203-214.
93. Walsh MJ: Polus B Chandraraj S: The efficacy of chiropractic therapy on premenstrual syndrome: A case series study. Chiro J Aust.1994 24:122-124.
94. Wittler M: Chiropractic approach to premenstrual syndrome (PMS). J Chiro Research Clin Investigation. 1992 8:26-29.
95. .Klougart N, Nilsson N Jacobsen I: Infantile colic treated by chiropractors: a prospective study of 316 cases. J Manipulative Physiol Ther 1989 12: 281-288.
96. Deganhardt B F, Kuchera MI: Efficacy of oseopathic evaluation and manipulative treatment in reducing the morbidity of otitis media in children. J Am Osteop Assoc 1994 4: 673
97. Froehle RM: Ear infection: A retrospective study examining improvement from chiropractic care and analyzing for influencing factors. J Manipulative Physiol Ther 1996 19: 160-177.
98. Gliesen J M, Center DB, Leach RA: An evaluation of chiropractic manipulation as a treatment for hyperactivity in children. J Manipulative Physiol Ther 1989 12; 353-363.
99. Yates RG, Lamping DL, Abram NL , Wright C: Effects of chiropractic treatment on Blood pressure and anxiety: a randomized controlled trial. J Manipulative Physiol Ther 1989 12 484-488.
100. Goertz C, Mootz R: A review of conservative management strategies in the care of patients with essentia l hypertension J NMS system. 1993 1;91-108.
101. Wagnon R, Sandefur R Ratliff C: Serum aldosterone changes after specific chiropractic manipulation. Am j Chiro Med 1988 1;66-69.

102. Reed WR, Beavers S, Reddy SK, Kern G: Chiropractic management of primary nocturnal eneuresis . J Manipulative Physiol Ther 1994 17: 596-600.
103. Kreitz BG, Aker: Nocturnal enuresis: treatment for the chiropractor. J Manipulative Physiol Ther 1994 17:465-73.
104. Killinger L Chiropractic care in the treament of asthma Palmer j research 1995 2:74-77.
105. Bronfort G, Evans R, Kubic, P et at: The role of chiropractic treatment in chronic childhood asthma: a pilot and feasibility study for a randomized clinical trial. Proceedings of the International Conference on Spinal Manipulation. 1998 59-61.
106. Hayek R: Asthma and chiropractic. An Australian trial. (single blind cross over study) Proceedings of the International Conference on Spinal Manipulation..
107. Nielsen NH et al: Chronic asthma and chiropractic spinal manipulation: a randomized clinical trial. Clinical Experim Allergy. 1995 25:80-88.
108. Balon J, Aker PD, Crowther E, et al: A comparison of active and simulated chiropractic manipulation as adjunctive treatment for childhood asthma. N Engl J Med. 1998 339: 1013-1020.
109. Balon J, Aker PD Crowther E, et al A randomized controlled trial of chiropractic spinal manipulation in children with chronic asthma. American Thoracic Society Convention, San Francisco 1997 : poster presentation.
110. Meade TW, Dyer S, Browne W et al: Low back pain of mechanical origin: randomized comparison of chiropractic and hospital outpatient treatment. BMJ 1990 300: 349-37
111. Meade TW, Dyer S, Browne W et al: Randomized comparison of chiropractic and hospital outpatient management for low back pain: results from extended follow up. BMJ 1995 311:349-51.
112. Bronfort G: Chriopractic treatment of low back pain: a prospective survey. J Manipulative Physiol Ther 1986 9:99-113.
113. Cox J, Feller JA: Chiropractic treatment of low back pain: a multicenter descriptive analysis of presentation and outcome in 424 consecutive cases. JNMS 1994 2:178-90.
114. Chiropractic Services Pilot Program Evaluation : Washington DC: United States Department of Veterans Affairs1990. SDR no 86-09 (Final Report).
115. Triano JJ, Hondras MA, McGrgor M: Differences in treatment history with manipulation for acute, subacute, chronic and recurrent spine pain. J Manipulative Physiol Ther 1992 15:24-30.
116. Waalen DP: Demographic and clinical characteristics of chiropractic patients: a five year study of patients treated at the Canadian Memorial Chiropractic Col. JCCA 1994 38: 75-82.
117. Carey TS, Evans A, Hadler N et al: Care seeking among individuals with chronic low back pain. Spine 1995 20:312-317.
118. Carey TS, Evans, A, Hadler N et al: Acute severe low back pain. Spine 1996 21:339-44.
119. Cherkin DC, MacCornack FA, Berg OA: Managing low back pain: a comparison of the beliefs and vehaviors of family physicians and chiropractors. Wet j Med 1988 149:475-480.
120. Cherkin DC, MacCornack FA: Patient evaluation of low back pain care from family physicians and chiropractors. West j Med 1989 150: 351-355.
121. Sawyer CE, Kassak K: Patient satisfaction with chiropractic care. J Manipulative Physiol Ther 1993 16:25-32.
122. Coulteer I, Hurwitz EL, Arnonow HU, Cassata DM, Beck JC: Chiropractic patients in a comprehensive home-based geriatric assessment, follow-up and health promotion program. Top Clin Chiro 1996 3;46-55.
123. Hawk C, Meeker W, Hansen D: The National Workshop to Develop the Chiropractic Research Agenda. J Manipulative Physiol Ther 1997 20: 147-149.
124. Chiropractic Research Agenda, International Conference on Spinal Manipulation Vancouver British Columbia. 1998.
125. The Royal College of General Practitioners, Clinical Guidelines for the Management of Acute Low Back Pain, 1997.
126. Hurwitz EL, Aker PD, et. Al.: Manipulation and mobilization of the cervical spine: a systematic review of the literature. Spine 1996 21:1746-1759.
127. Leach RA: The Chiropractic Theories 3rd ed, Williams and Wilkins, Baltimore. 1994
128. Lewit K: Manipulative Therapy in the Rehabilitation of the Motor System, London, Butterworths. 1987
129. Kunert W: Functional disorders of internal disorders due to vertebral lesions. Ciba Symposium 1965 13;85-96.

130. Grieve GP Common Vertebral Joint Problems 2nd ed. Churchill Livingstone , Edinburgh 1988.
131. Stoddard A: Manual of Osteopathic Practice 2nd ed Hutchinson, London. 1983.
132. Meeker WC, Haldeman S. Chiropractic: A Profession at the crossroads of mainstream and alternative medicine. Am Col Physic-A Soc Int Med 2002; 136:216-27.
133. Firman GJ: Goldstein MS: The Future of chiropractic: A psychosocial view. N Eng J Med. 1975; 293:639-642.
134. Coulehan JL: Chiropractic and the clinical art. Soc. Sci. Med. 1985; 21: 383-390.
135. Coulehan JL: The treatment act: An analysis of the clinical art of chiropractic. J Manipulative Physiol Ther. 1991 ;14: 5-13.
136. Lee HK, Gatterman MI: Chiropractic adjusting techniques: The rock that anchors chiropractic. In Peterson D, Wiese G: Chiropractic: An Illustrated History. St Louis MO. Mosby 1995 240-261.

Standards of Quality

1. The patient centered chiropractor acts first and foremost in the patient's interest.
2. The patient centered chiropractor approaches the patient as a whole being.
3. The patient and patient-centered chiropractor act as partners in decision making that encourages the patient to take responsibility for his/or her health.

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CHAPTER 1

PATIENT-DOCTOR RELATIONSHIP

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Section 1

INTRODUCTION

Relationships are the bedrock of all interchanges between two people, and in general, involve caring, feeling, trust, power, and a sense of purpose.[1] In a patient centered relationship the purpose is to help the patient. The helping relationship is founded on: empathy, congruence, genuineness, respect, positive regard, caring and concern for the other.[1] Chiropractors offer a patient centered form of clinical care that exhibits these characteristics.[2-4] The partnership arrangement, also characteristic of patient centered care, demands a sharing of power and control between the patient and doctor.[1] The resulting alliance enhances patients' sense of control over themselves. Tools for refining patient centered care in the chiropractic consultation can influence the locus of control in the patient-chiropractor relationship and enhance the patient's sense of congruency.[5]

The shift to patient centered care is reflected in the current trend in terminology, referring to the patient–doctor relationship instead of the doctor-patient relationship.[1, 6-9] Studies have found significantly greater patient satisfaction with chiropractic care over other practitioners treating similar conditions.[2, 10, 11] The patient-doctor relationship plays an important part in patient satisfaction.[1]

Section 2

PATIENT'S RIGHTS AND RESPONSIBILITIES

Awareness of patients' rights has been heightened with the rise in health care consumerism.[1, 12] An increase in patient participation in the patient-doctor encounter has evened the power relationship with patients demanding the right to become more involved in their own health care decisions.[1, 12] This has led to more patient autonomy, a more egalitarian relationship, and active participation by patients in making decisions about their health care. The conventional model where the doctor "always knows best" no longer goes unchallenged.[1] Relinquishing power to patients includes acknowledging a patient's bill of rights.

Patient's Bill of Rights

A patient and/or his/her legal representative has the right to:

- receive informed consent regarding procedures, risks and alternatives, and receive answers to questions with respect to treatment; [13-15]
- refuse treatment and accept the potential consequences of that choice after thorough explanation; [13,15]
- expect reasonable safety insofar as the health care environment is concerned; [15]
- be interviewed and examined in surroundings that permit reasonable visual and auditory privacy; [13-15]
- have another person present during examination and/or treatment; [15]
- expect that all communications and records pertaining to their care should be treated as confidential; [13-15]
- receive complete, current information concerning diagnosis, treatment, and prognosis in terms reasonably understood; [13-15]
- know the identity and professional status of the individual providing service to them and know who has the primary responsibility for coordinating their care; [13-15]
- expect reasonable continuity of care; [13,15]
- be fully advised of and accept or refuse to participate in any research project and/or O.B.C.E. approved investigational procedure(s); [13,15]
- receive and examine an explanation of charges for services rendered; [13,15]
- receive considerate and respectful care; [13,14]
- expect <u>not</u> to be denied treatment solely on the basis of race, color, religion or sexual preference. [15]

Patient's Responsibilities

A patient and/or his/her legal representative has the responsibility to:

- be honest and forthright with the doctor and office staff and to provide accurate and complete information about present complaints, past illnesses, accidents, hospitalizations, medications and any other information related to his/her health; [14,15]
- report to the doctor in a timely manner any new incident, trauma or changes in his/her health condition; [15*]
- acknowledge and consider instructions provided by the doctor and/or office staff; [14*]
- request clarification about any aspect of his/her care not fully comprehended; [14,15*]
- keep scheduled appointments or give adequate notice of delay or cancellation; [14*]
- treat doctors and office staff with respect and courtesy.[14]

* Considering the above items, lack of cooperation may cause endangerment to the patient's health and/or impaired results of care. Chiropractors have the right to select their cases and patients. It is permissible for the doctor to discontinue treatment of a patient when the patient fails to cooperate in an agreed upon plan of management. [16]

Section 3

INFORMED CONSENT

Informed consent is the issue pertaining to a patient's right to make a decision about treatment based on adequate foreknowledge or understanding of that treatment and its anticipated outcome.[17-24] It is the process of giving patients information needed to make educated decisions concerning their treatment.[17,19, 25,26] Informed consent serves as an opening for dialogue with the patients and involves them in their care.[27] It is the process of effectively communicating with patients in terms they understand, allowing them the opportunity to ask questions.

One of the goals of these guidelines is to inform practitioners about the ethical issues and legal precedents within which they must work. The basic principle of consent is that competent persons have the right to choose what will be done to them. It is the responsibility of the physician to inform the patient, in non-technical terms, of anticipated practices and procedures and to receive the patient's informed consent prior to examination and therapy procedures.[19] When applicable, the physician should also explain reasonable alternative treatments.[19, 26]

Informed consent can be viewed as an opportunity to establish trust and rapport and to collaborate with patients in the decision-making process. Through informed consent, the chiropractor can strengthen a person's commitment to treatment by promoting understanding of what can be accomplished.[25]

Informed consent is an important risk management tool.[23] By adding the element of trust and respect for the patient, an atmosphere of joint decision making is created. It gives the practitioner a chance to educate patients about the value of chiropractic and how it may benefit them.

To gain informed consent, Oregon health care practitioners are required to utilize a Procedures, Alternatives, Risks and Questions (PARQ) Conference.[28] In this PARQ conference the physician shall explain the following:

(a) in general terms the procedure or treatment to be undertaken;
(b) that there may be alternative procedures or methods of treatment; and
(c) that there are risks, if any, to the procedure or treatment.

After giving the explanation specified above, the physician shall ask the patient if the patient wants a more detailed explanation. If the patient requests further explanation, the physician shall disclose to the patient in substantial detail the procedure, the viable alternatives, and the material risks, unless to do so would be materially detrimental. In determining that further explanation would be materially detrimental, the physician shall give due consideration to the standards of practice of reasonable chiropractic practitioners in the same or a similar community under the same or similar circumstances.[28]

The essence of informed consent is communication between the patient and doctor, whether written or oral.[29] This responsibility should be seen as an ethical, as well as a legal, obligation.[26] Therefore, **patient-doctor discussion is the key**. [12,19-21, 30,31-33] The doctor must be prepared to expand the explanation, if necessary, and the information should be tailored to the patient and the procedure or treatment.

Suggestions for Documenting Informed Consent

Most authorities recommend that informed consent be documented.[20, 22, 23,34,35] The following methods are offered as options for charting informed consent. However, the practitioner is not limited to these specific suggestions.

1. Patients can be given standardized forms[17,26,36] which they sign. However, practitioners should not rely exclusively on those forms and must communicate directly with the patients.[29, 34] The use of a written consent form is at the discretion of the individual practitioner in the State of Oregon. [16,28] If a written form is used, it must be signed by the patients and included in their record.[34]

2. The acronym PARQ can be written in the patient's chart indicating that the physician has explained the procedures (**P**), viable alternatives (**A**), material risks (**R**), if any, and asked if the patient has any questions (**Q**). If the patient requests further information, the physician can underline the **PARQ** chart notation to reflect the patient's request and that the physician provided more detailed information.[37]

It is important to note that consent to have one physician perform a procedure is not consent for any other physician unless the patient agrees to substitute care. The practitioner may make a written entry into the patient's record, or, if a written form is used, the practitioner may wish to include a sentence to address this issue.

There are situations in which the method for obtaining informed consent may need to be modified. For example, each parent of minor children (under 18) has the authority and responsibility to consent to health care for his/her minor children unable to consent for themselves. If the parents are divorced, the noncustodial parent may authorize the physician's treatment in the absence of the custodial parent. In the case of minor parents who cannot consent for either their own care or that of their children, *consent must come from a third party such as a parent, grandparent or legal guardian.*

Section 4

DISCLOSURE AND CONFIDENTIALITY OF RECORDS

"The chiropractic physician shall preserve a patient's medical records from disclosure and will release them only on a patient's written consent stating to whom the records are being released or as required by State or Federal law".[38]

Confidentiality is an ethical and legal responsibility and is also necessary if practitioners expect individuals to be straightforward and honest. Patients must be confident that information will remain private and secure from public scrutiny. This confidence forms the basis for the principle that all patient-doctor communications are privileged and confidential.[19,39-43] Practitioners must not disclose whether an individual is, or has been, a patient. This includes disclosing information to the immediate family of the patient, with the exception of a parent or guardian of a minor or person legally declared incompetent.[19] The practitioner is responsible for observing professional and legal requirements of confidentiality, as well as ensuring these requirements are met by any employee involved in the preparation, organization, filing or other handling of patient records.[39]

Ultimately, patients have the right to have any information pertaining to their health kept confidential and not made available to others without authorization.[19,38-45] This information remains privileged even after the patient dies.[19, 41, 43] Even though an individual pays for professional services, they do not own the resulting records.[19] With few exceptions, e.g. federally assisted drug or alcohol abuse programs, patients have the right to copy,41,42 inspect,[41,42] correct, amend, authorize or restrict access,[19,40-42] be notified of intended disclosures [19,40-42] and pursue breach of duty remedies with respect to their personal health records.[42]

There are few exceptions to the rules of disclosure. However, the following situations allow disclosure without permission of the patient:

- response to certain court orders;
- conformity with statutory reporting law, e.g. child,[45] elderly abuse;
- communicable disease reporting, e.g. TB;
- injuries allegedly resulting from a criminal act, e.g. knife or gunshot wounds;
- cases where an individual threatens harm to themselves and/or others with a reasonable probability they will carry out the threat.[40-43]

In the cases of communicable disease where the patient refuses to inform or allow someone else to inform an endangered third party, or when there is a threat of physical violence where a third party may be in danger, the duty for disclosure to both public officials and the third party may exist.[41, 42]

The State of Oregon has developed a statute encouraging health care providers to adopt voluntary guidelines that will give health care recipients access to their medical records in addition to preserving them from unnecessary disclosure. This statute recommends utilizing a written release authorization form. (See Appendix A)

If, in the professional judgement of a physician, disclosure of a medical record or part of a record would be injurious to a patient, the provider may withhold that record or provide an accurate and representative summary of the information contained in the record. In addition, a health care provider may withhold another provider's record in their possession even after receiving a written release authorization. In either of these situations, the health care provider must disclose

the author and date of the withheld record(s) and/or summary(s), or declare the record provided to be a summary. "A patient may not maintain an action for damages against a health care provider for disclosures made by the health care provider in good faith reliance on a properly executed written release authorization…" [44]

With respect to workers' compensation claims, signed forms 801, 827, 829, and 2837 (Release of Information) give medical providers the authority and responsibility to release relevant medical records to the insurer, the insurer's representative, or the Director of the Department of Consumer and Business Services.[46]

In order to protect the patient's right to privacy, the health care provider must have further specific consent for admitting a non-essential person (e.g. student intern) where privacy may be compromised or when taking pictures for clinical or professional purposes. Like other forms of consent, this should be documented. [19]

If information is going to be electronically transferred, a confidentiality statement should be utilized as a cover sheet to preserve confidentiality. [40, 41, 45] For example,

> *PLEASE NOTE: The information contained in this transmission is confidential in nature. The information is to be used for its intended purpose only and is to be destroyed after the stated need has been fulfilled. Please deliver IMMEDIATELY to the individual indicated above. If you have received the transmission in error, please notify us immediately by telephone and destroy the transmitted documents.*

The health care provider may even want to include in their release of record document a check box that gives the patient the choice to not have their records transmitted electronically as the confidentiality of these systems is somewhat less reliable. The healthcare provider should maintain records of any electronic transmissions and request the receiver to sign and return attached receipts when the data has been received. [40, 45] The increasing reliance on electronic storage and transmission of health record data requires that the provider take all reasonable precautions to ensure that confidentiality is maintained. [41- 43]

It is the patients' responsibility to be aware of their insurance company's policy with respect to releasing medical records; i.e. who is allowed access to their private health records. In order for the healthcare provider to submit a standard health insurance claim form to an insurance carrier, the patient must "…authorize the release of any medical or other information necessary to process this claim." [47]

Other areas may compromise confidentiality including sign-in sheets, patient files, door/wall hanging file holders, “thank you for referral” cards, etc. Health care providers should establish policies and procedures that ensure reasonable protection of the patients' right to confidentiality in addition to acting as role models by demonstrating their commitment to patient privacy and confidentiality. [40, 41, 43,45]

Section 5

DOMESTIC VIOLENCE

Domestic violence is one of the major, serious public health problems affecting families in America and globally.[48-51] Domestic violence, child abuse and elder abuse are all included in the broader category of family violence.[49] Most definitions of domestic violence (a.k.a. intimate partner abuse (IPA), intimate partner violence (IPV)) include the following components:

1. ongoing pattern of intentional violent or assaultive or coercive behaviors or tactics. [48, 51-58]
2. purposeful tactics or behaviors directed at achieving and maintaining power, compliance or control over the victim, [51,52,57] thereby denying their individual and civil rights.[56]
3. may include any or all of the following:

   Physical abuse: [48-57]
   - injuries of a non-accidental or unexplained nature including shaking, slapping, hitting, kicking, punching, choking, biting, throwing, use of conventional and household objects as weapons;[52]
   - injuries commonly targeted to proximal areas so they remain concealed; [52]
   - denial of medical attention, physical needs (food, water, shelter, sleep), access or use of contraceptives or other safe sex techniques; [52]
   - restraint or not allowing victim to leave their room or home; [52]
   - murder. [52,54-57]

   Sexual abuse: [48-53,56,57]
   - rape; [52]
   - making sexual jokes or comments intended to humiliate or demean; [52]
   - forcing any person to watch pornography or others having sexual contact, or participating in prostitution or pornography. [52]

   Emotional or psychological abuse: [48,50-54,57]
   - social isolation or deprivation; [48, 52, 53, 57]
   - verbal abuse or intimidation and threats; [48,52,53,56,57]
   - control by isolation from family and friends; [52-54,57]
   - techniques of coercion or brainwashing designed to use children against a partner; e.g. threatening to take or hurt the children, using children to continue contact through custody or visitation. [52]

   Economic coercion or control: [48,51,52,54,57]
   - in any type of relationship: adult, adolescent, current heterosexual, homosexual including former dating, marriage, and cohabitating. [48,52,53,58]

Domestic violence is a gender-neutral term and universal problem, which cuts across all racial, socioeconomic, national, religious and ethnic boundaries.[48,49, 54,57] The overwhelming majority of victims, 90-95%, are women; [48,49,57] however, expert opinion and initial studies suggest domestic violence among lesbians gay, bisexual and transgender individuals may be comparable to domestic violence perpetrated against heterosexual women.[53] There is no standardization of what constitutes a violent act. This results in conflicting estimates of the number of women and men affected by "violence[54]." There is paucity of data about domestic violence against men.

Statistics

The following statistics help to illustrate the pervasiveness of violence against women:

- estimates of incidents of violence to women range from 1-12 million/year[48] but the most commonly reported incidence rate is 2-4 million/year; [48,51, 54,57]
- prevalence ranges from 20-54% of women experiencing violence in a relationship or lifetime; [48,52-54,56,57]
- battering is the single greatest cause of injury to women; [48]
- 30-75% of women killed in the U.S. are murdered by a domestic partner; [48,55]
- 1 in 10 women are in a violent relationship at any given time; [48]
- 75% of spousal assaults occur at the time of separation or divorce; [55]
- violence tends to be repetitive and averages six violent episodes/year; [49]
- 4-24% of pregnant women are physically assaulted; [48, 51, 53, 57]
- abuse of women and children occurs concurrently an estimated 30-70% of the time; [54,57]

While these statistics are useful to illustrate the magnitude of the problem, they are only estimates. Many cases of domestic violence are unreported or undetected so the true incidence is unknown. [48-50,54]

The toll of domestic violence is enormous.[49,51] It is estimated that 1.8 billion dollars per year are spent directly on health care for victims.[51] In addition to the healthcare cost, there is a high societal cost.[49] Boys who are reared in violent homes have an increased risk of becoming abusers[51] and girls who witness or experience violence have an increased risk of becoming victims.[48,51] Children who live in violent homes have higher rates of learning difficulties, decreased academic performance, increased behavioral problems and are more likely to be violent adults.[57]

Chiropractors have the opportunity to play an important role in shaping societal values by naming the disease, domestic violence.[56] This is a primary responsibility and may allow the survivor to begin seeing his/her situation differently, giving them the opportunity to start taking control of their lives.[56] The public may come to understand that domestic violence is unacceptable behavior when physicians make it clear that it's important to ask whether an intimate or formerly intimate partner caused injuries.[56] If the root cause of an incomplete diagnosis, prescription for medication, recurrence of injury, or stress related injuries is domestic violence, the practitioner has the opportunity to protect the patient from escalating risk by addressing this issue.[56] If the practitioner recognizes and helps a victim with "minor" signs or symptoms of domestic violence, a serious or even fatal episode could be prevented.[56]

For practice tips for identifying and treating the abused patient see Appendix B

Section 6

CHILD AND ELDER ABUSE

Child Abuse

Child abuse and neglect is a problem[59-61] of "epidemic proportions"[62] that affected approximately 20,000 Oregon children in 1997 and 1998.[62] The victim of child abuse is an unmarried person, under the age of 18, who has been non-accidentally physically or mentally injured, negligently treated or maltreated, sexually abused or exploited, or who dies as a result of abuse or neglect.[62]

Chiropractors observe and treat children on a regular basis. A chiropractor, having reasonable cause to believe any child with whom the chiropractor comes in contact has suffered abuse or any person with whom the chiropractor comes in contact has abused a child, is required by Oregon Law[63] to report[64] orally "by telephone or otherwise to the local office of the State Office for Services to Children and Families (SCF), to the designee of the State Office for Services to Children and Families or to a law enforcement agency within the county where the person making the report is located at the time of the contact." Any report made is subject to confidentiality[65] and the person making the report may not be sued for making a report in good faith[66].

Abuse can be classified into four basic categories: [62]

- physical abuse;
- neglect;
- mental injury or emotional maltreatment;
- sexual abuse.

ORS 419B.005 defines child abuse as:
"Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury." This does not include reasonable discipline unless the discipline results in assault or any of the following conditions:

- "Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child;
- "Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are defined in ORS chapter 163;
- "Sexual abuse, as defined by ORS chapter 163;
- "Sexual exploitation;[67]
- "Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child;
- "Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare;
- "Buying or selling a person under 18 years of age as described in ORS 163.537."

Elder Abuse (persons 65-years of age or older)

Abuse in its various forms affects our society from children to the elderly. It is estimated that approximately 2.5 million older people are abused each year; however, only about 10% of the cases are reported. Elderly victims of abuse "often have low self-esteem, blame themselves for the abuse, and do not want to admit their vulnerabilities or betray their families," and are usually abused by those with whom they live.[68] Neglect of, or ridicule toward, an elderly person can frequently be an indicator of elder abuse.

Comparatively, the definitions of abuse for older people are very similar to those for children. As with child abuse, chiropractors have a legal and ethical obligation to report any suspected elder abuse[69] with confidentiality "to the local office of the Senior and Disabled Services Division or to a law enforcement agency within the county where the person making the report is located at the time of contact."[70] They may not be sued for such reporting.[71]

Section 7

BOUNDARY ISSUES IN THE PATIENT-DOCTOR RELATIONSHIP

Across time and culture there has been recognition of the exceptional power given to physicians by patients and the potential for misuse of that power. A chiropractor, as a fiduciary, provides help and care for the patient.[72] The patient is protected from abuses of power by the ethics and character of the chiropractor and the prescribed boundaries and roles that define professional behavior.

Boundaries define the expected psychological, physical and social distance between patients and practitioners. They are derived from ethical treatise, cultural morality and jurisprudence.[73] Boundaries form protection for the patient so that professional care occurs safely within the unique form of social intimacy of the patient-doctor relationship. Specific to this relationship, "The health and welfare of the patient shall always be the first priority of Chiropractic physicians."[16]

Unprofessional conduct by a chiropractic physician, includes, but is not limited to: "Engaging in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning;"[74] proof of actual injury need not be established."[74]

Patients who are in pain or who are ill are vulnerable to psychological regression. Transferential dynamics are common in clinical encounters where patients are dependent and physically and emotionally more vulnerable. It is common for patients to be emotionally and/or physically attracted to professionals who care for them. When alerted, physicians should take extra steps to define or clarify the professional relationship. "The chiropractor is the one who must recognize and set the boundaries between the care and compassion appropriate to the chiropractic treatment and the emotional responses that may lead to sexual misconduct." [75] The power differential inherent in the patient–doctor relationship makes true consent to sexual contact by the patient impossible.[72,76]

With the exception of pre-existing consensual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship.[70,76-91] There is a range of opinions with respect to the ability of the patient-doctor relationship to change after care has ended. Some suggest a sexual relationship may never be appropriate[70], while others indicate an interim period ranging from three months to one year between termination and initiation of a personal intimate relationship.[77,81]

Even those authorities who indicate that sexual or romantic relationships with former patients may be ethical, prohibit the physician from the following:

- using or exploiting trust, knowledge, or influence of emotions derived from the previous professional relationship;
- using privileged information to meet their personal or sexual needs; and
- abusing authority or power derived from the previous professional relationship.[74,86]

Where there may be a question as to the status of the patient, i.e. current or former, some licensing boards have chosen to adopt more subjective criteria to determine if sexual misconduct

has occurred. Following are some of the areas of consideration likely to be evaluated by a licensing board to determine the current status of the patient:

- evidence of termination procedures;[73,74]
- circumstances of cessation or termination;[74,92]
- time passage since therapy termination; [74,92]
- nature and duration of therapy; [73,74,92]
- former client's personal history and/or current mental status; [92]
- statements and/or actions made by the physician during the course of care suggesting or inviting the possibility of a post termination relationship; [92]
- likelihood of adverse impact on the person and/or others; [92]
- transfer of patient's care to another physician; [74]
- the nature of the patient's chiropractic problem; [74]
- extent to which the patient has confided personal and/or private information to the chiropractor; [74]
- degree of emotional dependence on the chiropractor; [74]
- extent of chiropractor's knowledge about the patient; [74]
- any other relevant information.[73]

Consequences of sexual misconduct for patients of health care professionals have been documented to include:

- distrust and anger toward physicians;
- delays in seeking health care;
- increased depression, shame, guilt;
- psychosomatic symptoms;
- post-traumatic stress disorder (panic attacks, flashbacks, extreme guilt and self-destructive feelings). [81,93]

Consequences of sexual misconduct extend beyond the patient to potentially affect the patient's family, the doctor's family, the doctor's staff, other patients, the community and the profession.[81] Consequences of sexual misconduct for the chiropractor may include Board sanctions such as license suspension or revocation, probation, chaperone requirements and mandated counseling. Additionally, civil suits or criminal prosecution, extortion or retaliation are possible consequences of unprofessional conduct.

See Appendix C for strategies that may prevent boundary violations and/or allegations of sexual misconduct.

Section 8

THE PATIENT-DOCTOR RELATIONSHIP AND INDEPENDENT EXAMINATIONS

Independent and second opinion examinations are isolated chiropractic evaluations of an individual's health performed by a physician not involved in that person's care.[94,95] When performed by a chiropractic physician, these may be referred to as IMEs (independent medical examinations) or ICEs (independent chiropractic examinations). All independent examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis.[96] Some combination of the following of the PARTS exam constitutes a functional chiropractic analysis:

- **P** Location, quality, and intensity of pain or tenderness produced by palpation and pressure over specific structures and soft tissues;
- **A** Asymmetry of sectional or segmental components identified by static palpation;
- **R** The decrease or loss of specific movements (active, passive, and accessory);
- **T** Tone, texture, and temperature change in specific soft tissues identified through palpation;
- **S** Use of special tests or procedures.[97]

In the context of independent examinations the use of an investigational procedure is considered inappropriate.

These types of evaluations may be ordered by treating physicians, employers, patients and their attorneys, insurers, disability management companies and managed care organizations, workers compensation boards, and other entities that make determinations about disability and impairment.[95] An independent examination may be performed at various stages of an injury or illness and is generally utilized to clarify health and/or job issues.[95]

At the outset of the examination, prior to gathering health information, the examining physician should ensure to the extent possible that the patient understands the ethical obligations of the physician to perform an impartial evaluation. The examiner also explains the differences between the role of independent examiner and the traditional fiduciary role of the physician. The examiner should explain who has requested the examination.

In an independent examination, the patient-doctor relationship is limited because the examiner does not monitor the patient's health over time, provide treatment or fulfill many duties traditionally performed by physicians.[94] Despite the limited relationship, important health information, diagnosis and treatment recommendations shall be made available to the patient, treating doctor, and patient’s legal counsel or guardian via the independent report.[98,99] Upon request, a copy of the independent report shall be made available to the patient, the treating doctor, and/or the patient’s legal guardian. [98,99]

Section 9

TERMINATION OF THE PATIENT-DOCTOR RELATIONSHIP

Once the patient-doctor relationship has been established, it may be terminated by either party.

Patient Termination

The most common way for patients to end the relationship is their recovery from the condition for which they were receiving chiropractic care.[100] Another way the patient may terminate the relationship is to discharge the physician at any time.[100] If at the time of termination by the patient, it is the opinion of the treating physician that the condition requires further care, it is suggested that the physician notify the patient. This should be documented by the physician.

Physician Termination

Physicians may terminate the patient-doctor relationship at their discretion, but must not abandon the patient. The patient must be given reasonable notice,[16] preferably in writing. By sending the notice "return receipt requested" the physician will have the assurance that the patient was notified. The patient must also be given reasonable time to locate another physician. The courts have held that once a physician has agreed to treat a patient a physician cannot cease his treatment except, first with the consent of the patient, or secondly upon giving the patient time and notice so that he may employ another doctor or thirdly when the condition of the patient is such that medical treatment is no longer required.[100]

Abandonment

Abandonment has been defined as "the unilateral severance by the physician of the physician-patient relationship" without reasonable notice, at a time when there is still the necessity of continuing medical attention.[100] Abandonment involves intent on the part of the physician to improperly terminate the patient-doctor relationship.[100] Examples of abandonment include:

- the physician fails to provide adequate withdrawal notice to the patient;
- the physician fails to see a patient within a clinically indicated timeframe;
- the physician withdraws from a patient case without making arrangements for continued care for lack of payment or any other reason.

Physician Substitution/Referral

Physicians are entitled to reasonable time away from their practices as long as arrangements are made for a competent, licensed substitute. Notice must be given to the patient of the substitution, as the patient may prefer to consult with a doctor other than the substitute.[100] If notice is not given and the patient's condition suffers an adverse effect the physician may be held to have abandoned the patient.[100] If the substitute is an "employee" of the physician, standard rules of vicarious liability may apply. If the substitute is unqualified or incompetent the physician may also be liable for the substitute's negligence. In multi-physician practices where each physician sees the others' patients on a rotating basis, none of the physicians can be held to have abandoned a patient if another member of the group or partnership has seen that patient.[100] When a physician refers a patient to a second physician, the referring physician cannot be held liable for abandonment as long as due care is used in selecting the second physician.[100] This referral should be documented by the referring physician

Physicians have the right to make reasonable limitations on their practice.[100] Physicians are not legally obligated to treat any patient beyond the chosen limitations of their practice. In such circumstances, referral to another physician does not constitute abandonment. [100]

Section 10

PATIENT-DOCTOR RELATIONSHIP STANDARDS

1. Informed Consent

The patient has the right to informed consent regarding procedures, risks and alternatives, and answers to questions with respect to treatment, in terms that they can be reasonably expected to understand. In order to obtain the informed consent of a patient, the chiropractic physician shall explain the following:

(a) In general terms the procedure or treatment to be undertaken;
(b) That there may be alternative procedures or methods of treatment, if any; and
(c) That there are risks, if any, to the procedure or treatment. [28] (Legal Type 1)

2. Patient Confidentiality

The patient has the right to expect that all communications and records pertaining to their care will be treated as confidential. [19,39,40-43,45] The chiropractor shall preserve a patient's medical records from disclosure and will release specific records only on a patient's written consent stating to whom the records are being released or as required by State or Federal law.[38] (Legal Type 1)

3. Abandonment

The patient has the right to continuity of care once the doctor has agreed to treat the patient. The chiropractor may terminate the patient-doctor relationship only when the patient has been given reasonable notice.[16] (Legal Type 1)

4. Patient-Doctor Boundaries

With the exception of pre-existing consensual sexual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship. Chiropractors shall not engage in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning. [72,73,77-90] (Legal Type 1)

5. Independent Medical Examinations

All independent and second opinion examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis.[96] A copy of the independent report shall be made available, upon request, to the patient, the patient's attorney and the treating doctor.[99] All independent and second opinion examiners have an ethical obligation to perform an impartial examination. (Legal Type 1)

6. Child and Elder Abuse Reporting

Chiropractors must report child abuse and elder abuse to the appropriate officials.[63,69] (Legal Type 1)

REFERENCES

1. Stewart M, Brown JB, Weston WW, McWhinney I, McWilliam CL, Freeman TR. Patient-centered medicine: transforming the clinical method. London: Sage Publications, 1995.
2. Coulehan JL. Chiropractic and the clinical art. Soc Sci Med 1985;21(4):383-90.
3. Phillips RB, Mootz RD. Contemporary chiropractic philosophy. In: Haldeman S, ed. Principles and practice of chiropractic. 2nd ed. Norwalk, CT: Appleton and Lange, 1992:45.
4. Gatterman MI. A patient-centered paradigm: a model for chiropractic education and research. J Altern Complement Med 1995;1(4):371-86.
5. Jamison JR. Tools for refining patient-centered care: a consideration of LOC and SOC in the chiropractic consultation. Chiro J Aust 1996;26:118-24.
6. Boon H, Stewart M. Patient-physician communication assessment instruments: 1986 to 1996 in review. Patient Educ Couns 1998;35(3):161-76.
7. Virshup BB, Oppenberg AA, Coleman MM. Strategic risk management: reducing malpractice claims through more effective patient-doctor communication. Am J Med Qual 1999;14(4):153-9.
8. Wee CC, McCarthy EP, Davis RB, Phillips RS. The patient-physician relationship: physician counseling about exercise. JAMA 1999;282(16):1583-8.
9. Petersen DM. Report of my findings: your password to the future (Editorial). Dynamic Chiropractic 1999;17(22):3.
10. Cherkin DC, MacCornack FA. Patient evaluations of low back pain care from family physicians and chiropractors. West J Med 1989;150(3):351-5.
11. Carey TS, Garrett J, Jackman A, et al. The outcomes and costs of care for acute low back pain among patients seen by primary care practitioners, chiropractors, and orthopedic surgeons. N Engl J Med 1995;333(14):913-7.
12. Beisecker AE. Patient power in doctor-patient communication: what do we know? Health Commun 1990;2(2):105-22.
13. The American Hospital Association. A patient's bill of rights 1992.
14. ChiroNet policy statement. "Patient rights" and "Patient responsibilities." Portland Oregon. 2002.
15. ICA code of ethics: principle 1E: patient's bill of rights within the health care setting International Chiropractic Association, 1985.
16. Oregon Administrative Rule 811-035-0005 Duties and obligations of Chiropractic physicians to their patients.
17. Grant KD. Informed consent: Medical-legal update for the practitioner on recent judicial opinions applying state laws. Am Surg l992;58(2):146-52.
18. Kent C, Boone WR, Rondberg TA. Clinical practice guideline number 1: vertebral subluxation in chiropractic practice. Chandler, AZ: Council on Chiropractic Practice 1998:95-8.
19. Schafer RC. Chiropractic physician's guide: clinical malpractice. West Des Moines, IA: National Chiropractic Mutual Insurance Company l983;4-7.
20. Chapman-Smith D, ed. Cervical adjustment. The chiropractic report 1999;13(4).
21. Theisler CW. Informed consent: an Australian case study (letter to the editor). J Manipulative Physiol Ther 1999;22(2):119.
22. Jamison JR. Informed consent: an Australian case study. J Manipulative Physiol Ther 1998;21(5):348-55.
23. Campbell L, Ladenheim CJ, Sherman R, Sportelli L. Informed consent: a search for protection. Topics in Clinical Chiropractic 1994;1(3):55-63.
24. Audi R, ed. The Cambridge dictionary of philosophy: informed consent. Cambridge: Cambridge University Press, l995:378.
25. Jensen PS, Josephson AM, Frey J. Informed consent as a framework for treatment: ethical and therapeutic considerations. Am J Psychother 1989;43(3):378-86.
26. Vear HJ, ed. Chiropractic standards of practice and quality of care. Gaithersburg, MD: Aspen Publishers, l992:134-5.
27. Epstein RM, Campbell TL, Cohen-Cole SA, McWhinney IR, Smilkstein G. Perspectives on patient-doctor communication. J Fam Pract 1993;37(4):377-88.
28. Oregon Revised Statute 677.097 Procedure to obtain informed consent of patient.
29. Col☂n W. Informed consent: what your patients don't know can hurt you. The Psychiatric Resident. Jan/Feb 1994:23-8.
30. Roter DL, Hall JA. Physicians' interviewing styles and medical information obtained from patients. J Gen Intern Med 1987;2(5):325-9.
31. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. Ann Intern Med 1996;125(9):763-9.
32. Cherkin D, Deyo RA, Berg AO, Bergman JJ, Lishner DM. Evaluation of a physician education intervention to improve primary care for low-back pain I. Impact on physicians. Spine 1991;16(10):1168-72.
33. Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to

interviewing. Ann Intern Med 1991;115(6):470-7.
34. OUM Progress Report. Informed consent: your patient's rights. Bellevue, WA: OUM and Associates 1998;11(3):1-8.
35. Hartley MA. The law and patient consent: its relevance to chiropractors and osteopaths. J Aust Chiro Org 1996;5(1):8-11.
36. Steinecke R. Informed consent. J Can Chiro Assoc 1996;40(1):43-6.
37. Kailin DC. Acupuncture risk management: the essential practice standards and regulatory compliance. Corvallis OR: CMS Press, 1997:107.
38. Oregon Administrative Rule 811-015-0006 Disclosure of records.
39. Haldeman S, Chapman-Smith D, Petersen DM, eds. Guidelines for chiropractic quality assurance and practice parameters: Proceedings of the Mercy Center Consensus Conference. Gaithersburg, MD: Aspen Publishers, 1993:89-90.
40. American Academy of Pediatrics. Safeguards needed in transfer of patient data: American Academy of Pediatrics Task Force on Medical Informatics, Section on Computers and Other Technologies, Committee on Practice and Ambulatory Medicine. Pediatrics 1996;98(5):984-6.
41. Knopp RK, Satterlee PA. Ethical issues in emergency medicine: confidentiality in the emergency department. Emerg Med Clin North Am 1999;17(2):385-96.
42. Cassidy SO, Sepulveda MJ. Health information privacy reform. J Occup Environ Med 1995;37(5):605-14.
43. Rutberg MP. Medical-legal issues facing neurologists: medical records confidentiality. Neurol Clin 1999;17(2):307-13.
44. Oregon Revised Statute 192.525, 1997. State policy concerning medical records; disclosure following written release.
45. Chilton L, Berger JE, Melinkovich P, et al. American Academy of Pediatrics. Pediatric Practice Action Group and Task Force on Medical Informatics: Privacy protection of health information: patient rights and pediatrician responsibilities. Pediatrics 1999;104(4):973-7.
46. Oregon Department of Consumer and Business Services: Bulletin No. 281 (Rev.), Apr 1999.
47. Health Insurance Claim Form, HCFA-1500.
48. Olsen EA. Identifying and responding to the battered woman. JNMS 1996;4(2):45-51.
49. U.S. Preventive Services Task Force. Guidelines from guide to clinical preventive services. Section I. Screening. Part I. Mental disorders and substance abuse. Screening for family violence. 2nd ed. Williams & Wilkins, 1996.
50. Haile-Mariam T, Smith J. Domestic violence against women in the international community. Emerg Med Clin North Am 1999;17(3):617-30.
51. Salber PR, Taliaferro E. Domestic violence. In: Rosen, ed. Emergency medicine: concepts and clinical practice. 4th ed. Mosby-Year Book, Inc.1998: 2908-21.
52. Armatta J, Erde K, Frisch P, et al. Recognizing abuse: health care provider's guide to identifying and treating domestic violence. Oregon Medical Association, Oregon Association of Hospitals and Health Systems, Professionals in Partnership, Mar 1996.
53. Alpert E, Bleiberg MS, Campbell JC, et al, advisory committee. Preventing domestic violence: clinical guidelines on routine screening. The Family Violence Prevention Fund, Oct 1999.
54. Haywood YC, Haile-Mariam T. Violence against women. Emerg Med Clin North Am 1999;17(3):603-15.
55. Resnick PJ, Scott CL. Legal issues in treating perpetrators and victims of violence. Psychiatr Clin North Am 1997;20(2):473-87.
56. Abbott J. Injuries and illnesses of domestic violence. Ann Emerg Med 1997;29(6):781-5.
57. El-Bayoumi G, Borum ML, Haywood Y. Domestic violence in women. Med Clin North Am 1998;82(2):391-401.
58. Stringham P. Domestic violence. Primary Care 1999;26(2):373-84.
59. Freitag R, Lazoritz S, Kini N. Psychosocial aspects of child abuse for primary care pediatricians. Pediat Clin North Am 1998;45(2):391-402.
60. Kocher MS, Kasser JR. Orthopaedic aspects of child abuse. J AM Acad Orthop Surg 2000;8(1):10-20.
61. Bethea, L. Primary prevention of child abuse. AM Fam Physician 1999;56(6):1577-1585, 1591-92.
62. State Office for Services to Children and Families, Child Protective Services Section. Recognizing and reporting child abuse and neglect: an explanation of Oregon's mandatory reporting law. Salem, OR: Oregon Department of Human Resources, rev. 10/99.
63. Oregon Revised Statute 419B.010 Duty of officials to report child abuse; exceptions; penalty.
64. Oregon Revised Statute 419B.015 Report form and content; notice to law enforcement agencies and local office of State Office for Services to Children and Families.
65. Oregon Revised Statute 419B035 Confidentiality of records; when available to others.
66. Oregon Revised Statute 419B.025 Immunity of person making report in good faith.
67. Oregon Revised Statute 419B.005 Definitions.
68. Kleinschmidt KC. Elder abuse: a review. Ann Emerg Med 1997;30(4):463-72.
69. Oregon Revised Statute 124.060 Duty of officials to report.

70. Oregon Revised Statute 124.065 Method of reporting; content; notice to law enforcement agency and to division.
71. Oregon Revised Statute 124.075 Immunity of person making report in good faith; identity confidentiality.
72. Stahl MJ, Foreman SM. Sexual misconduct: ethical, clinical and legal ramifications and the chiropractic profession. National Chiropractic Mutual Insurance Company 1997.
73. Linklater D, MacDougall S. Boundary issues: what do they mean for family physicians? Can Fam Physician 1993;39:2569-73.
74. Oregon Administrative Rule 811-035-0015 Unprofessional conduct in the chiropractic profession
75. State of Washington, Department of Health. Sexual misconduct statement and policy of the chiropractic disciplinary board, 1993.
76. Shiel RC. Promoting effective boundaries in doctor-patient relationships. Chiropractic Technique 1996;8(2):88-92.
77. Colorado Revised Statute 12-33-117(1)(z),(aa).
78. Australian Medical Association 1995; Sexual conduct between doctors and their patients.
79. Arkansas State Board of Chiropractic Examiners. Rules and Regulations. C.2.(p)(i).
80. College of Chiropractors of Alberta. Policy on sexual abuse/impropriety; Mar/Apr 1993.
81. Robinson GE, Stewart DE. A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment. Part 1: content Can Med Assoc J 1996;154(5):643-9.
82. McCullough LB, Chervenak FA, Coverdale JH. Ethically justified guidelines for defining sexual boundaries between obstetrician-gynecologists and their patients. Am J Obstet Gynecol 1996;175(2):496-500.
83. Twemlow SW. Exploitation of patients: themes in the psychopathology of their therapists. Am J Psychother 1997;51(3):357-75.
84. Kagle JD, Giebelhausen PN. Dual relationships and professional boundaries. Soc Work 1994;39(2):213-20.
85. Blackshaw SL, Patterson PGR. The prevention of sexual exploitation of patients: educational issues. Can J Psychiatry 1992;37:350-3.
86. Overlock ME, Gonzales RJ. Crossing a patient's sexual boundaries. Tenn Med 1996;89(11):403-4.
87. Foote W, Rovics C. Licensing boards and sexual misconduct. Oregon Attorney General's Public Law Conference, 1999.
88. Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners, 1991 to 1995. Am J Obstet Gynecol 1997;176(6):1340-8.
89. Cullen RM, Northwood BR. Medical discipline and sexual activity between doctors and patients. N Z Med J 1995;108:481-3.
90. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. JAMA 1991;266(19):2741-5.
91. Redleaf A, Baird SA. Behind closed doors: gender, sexuality, and touch in the doctor/patient relationship. Westport, CT: Auburn House, 1998:131-5.
92. Washington Assurance Commission 246-807-311 Sexual misconduct
93. Kluft RP. The physician as perpetrator of abuse. Primary Care 1993;20(2):459-80.
94. AMA policy statement 5-10.03: Patient-physician relationships in the context of work related and independent medical examinations. Dec, 1999
95. Peterson KW, Babitsky S, Beller TA, et al. The American Board of Independent Medical Examiners. J Occup Environ Med 1997;39(6):509-14.
96. Bergmann TF, Peterson DH, Lawrence DJ. Chiropractic technique New York, NY. Churchill Livingstone, 1993:211.
97. Oregon Administrative Rule 811-010-0093 Guide to policy and practice questions: independent medical examinations.
98. Oregon Administrative Rule 811-010-0005 Definitions.
99. Oregon Administrative Rule 811-015-0006 Disclosure of records.
100. Holder AR. Engle v. Clarke, 346 SW 2d 13, KY 1961.100.The action of abandonment in medical malpractice litigation, 36 Tulane Law Rev, 1962.
101. Epstein RS, Simon RI. The exploitation index: An early warning indicator of boundary violations in psychotherapy. Bulletin of the Menninger Clinic 1990;54:450-65.

APPENDIX A

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Oregon Revised Statute 192.525, 1997

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____(name of hospital/health care provider) to release a copy of the medical information for _____ (name of patient) to _____(name and address of recipient).

The information will be used on my behalf for the following purpose(s):

_____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

___ All hospital records (including nursing records and progress notes)
___ Transcribed hospital reports
___ Medical records needed for continuity of care
___ Most recent five year history
___ Laboratory reports
___ Pathology reports
___ Diagnostic imaging reports
___ Clinician office chart notes
___ Dental records
___ Physical therapy records
___ Emergency and urgency care records
___ Billing statements
___ Other

___ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

___*HIV/AIDS-related records
___*Mental health information
___*Genetic testing information
*Must be initialed to be included in other documents.
___**Drug/alcohol diagnosis, treatment or referral information:
**Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

___ This authorization is limited to the following treatment:

_____

___ This authorization is limited to the following time period:

_____

___ This authorization is limited to a worker's compensation claim for injuries of _____(date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of patient)

_____ _____
(Date) (Signature of person authorized by law)

APPENDIX B

PRACTICE TIPS FOR IDENTIFYING AND TREATING THE ABUSED PATIENT

DOMESTIC VIOLENCE

Victim Barriers to Terminating or Disclosing Abusive Relationships

There are many reasons why victims don't report and/or terminate abusive relationships. Such barriers may include the following:

- shame, humiliation, embarrassment; [48-51]
- psychological repression, poor self-esteem/self-image; [48,50,52]
- fear of reprisal, retribution, repercussions, e.g. threats to kill or harm children, family, friends, etc.;[48, 49, 51-54]
- fear of abandonment,[49] poverty/economic concerns,[48,50,52,54] loneliness,[52] the unknown;[52]
- fear of not being believed; [52]
- legal consequences; [49,50,52]
- religious traditions;[48,50,52]
- cultural: social, family, marital expectations; [48,50-52]
- feel protective of partner; [51]
- thinks the doctor does not know or care about or can help with domestic violence; [51]
- thinks the doctor is too busy; [51]
- alcohol or drug problems; [49]
- language barriers;[50]

Physician Barriers To Screening For/Identifying Domestic Violence

Health care providers identify several reasons why they are reluctant to ask patients about domestic violence. Such barriers to screening/identifying domestic violence may include the following:

- lack of knowledge and training,[48,51,54,] unprepared to respond; [48,51]
- because of the clinical presentation, patients may appear to be neurotic or hypochondriacs; [48]
- discomfort due to own feelings and reactions to a disclosure of abuse; [48]
- misconceptions such as abuse is rare,[48] private,[48,51] the battered victim's fault,[48,51]
- opening up a "can of worms" or "Pandora's box;" [48,51,54]
- fear of offending the patient; [49,51,54,57]
- inability to "fix" abusive relationships; [49,51]
- time constraints/lack of time to deal with the problem; [49,51,54,57].
- personal bias against women in international community,[50] racial prejudice; [50,54]
- sexism; [50,54]
- frustration with outcome, don't think it will help and "she'll just go back to him;" [51,57]
- physicians' beliefs or values about abuse; [54]
- loss of control or feelings of powerlessness; [54]
- belief that a victim can leave if he/she just wants to; [51]
- knowing the assailant and not believing he is capable of abuse. [51]

Patterns of Abuse

There is no single model which can describe all domestic violence patterns.[48] However, it is useful to consider the following models to conceptualize the abuse process in women.

One model describes a cycle of violence in phases where phase one begins with a minor battering/assault which gradually increases tension in the relationship. The victim may try to decrease the tension but is largely unsuccessful.[48] Phase two involves a discharge of building tension resulting in an acute battering incident which may be met with disbelief or denial and is dismissed by the victim as an isolated incident. Subsequent episodes are met with shock, rationalization, self blame, denial and repression.[48] Phase three is often referred to as the "honeymoon phase"[48] where the abuser expresses remorse, exhibits attentiveness, reaffirms love and promises it will never happen again.[48,57] This is done mostly out of fear of being caught.[48] There is not always a honeymoon phase.[48]

Another model highlights the roles of violence and withdrawal where some lesser degree of violence creates emotional withdrawal in the attacked partner. The abuser may be met with withdrawal the next time upset, needy or in want of support. This in turn provokes a more violent attack, which is followed by further withdrawal and/or fear. The escalating cycle of neediness is met with increasing withdrawal until the violence becomes severe.[58]

In addition to the physical violence, emotional abuse always accompanies and typically precedes physical violence.[48] This cycle of violence is repetitive, escalates in severity and frequency [48,49,57,58] and is used to gain compliance or control over the victim.[51]

Profile of the Abuser
Battering and abuse are learned behaviors that result from being personally abused or witnessing abuse.[48,51] Abusers may be characterized by any or all of the following:

- extreme jealousy and possessiveness; [48]
- inefficient coping skills; [48]
- thinking they are unique and don't have to follow rules; [48]
- justifying behavior with excuses blaming others for causing their behavior; [48]
- viewing others as holding them back from being successful; [48]
- minimizing abuse as part of avoiding responsibility for violent actions; [48]
- having trouble experiencing close, satisfying relationships with others; [48]
- substituting drama and excitement for closeness; [48]
- being secretive, closed minded, self righteous;[48]
- seeking to gain power and control; [48,54,57]
- fragmentation (Dr. Jekyl and Mr. Hyde) using a public face that is childlike, dependent, insecure, charming, affectionate, seductive or manipulative; [48]
- alcohol use or abuse involved [48,49,52,54-57] but not established as causal. [48,52]

Women at Increased Risk for Domestic Violence
There is no specific highly predictive profile of women at increased risk for domestic violence; however, following are some generalizations about vulnerabilities:

- witness or experience family violence as a child or adolescent; [48,49,51,57] however, the majority did not grow up in abusive homes; [48]
- under 35 years of age; [49,54,57]
- refugee, migrant[50,54] living in rural or remote areas, [50] homebound; [50]
- conflicting evidence about minorities being more vulnerable; [50,57]
- lower socioeconomic status [50,54,57] or education; [49]
- pregnancy; [57]
- mental illness, physical disabilities; [54]
- unmarried; [49]
- unmarried couple living together; [58]
- wives in marriages where their education or occupation level is higher than their spouse; [51]
- mixed marriages (religion or race); [51]
- history of alcohol abuse by male partner; [54]
- recently separated or divorced. [57]

Presentation
The majority of domestic violence presentations are not "injuries," but are seen for non-traumatic diagnoses.[48,51,54] Chiropractors should be aware that chronic pain [51,52,56,57] or back pain itself [48] may be the result of domestic violence. Other clinical findings that may suggest need for further investigation include the following:

1. Injuries
   - explanation for injuries does not fit injuries observed; [48,49,51,56]
   - multiple injuries in various stages of repair; [48,51,52]
   - assaultive trauma, most commonly head, face, neck and areas covered by clothing; mandibular fractures; facial fractures; trunk trauma; blows to abdomen or other areas; other blunt trauma or injuries suggestive of defensive posturing like forearm fractures; [49,51,52,56,58]
   - "accident prone" history. [51,52]

2. Pain
   - chronic pain; [51,52,56,57]
   - back pain; [48]
   - chest pain; [48,51,52,57]
   - pain from diffuse trauma without visible evidence.[52]

3. Somatic Complaints
   - headaches; [48,51,52,57]
   - choking sensation; [48]
   - hyperventilation; [48,57]
   - gastrointestinal symptoms; [48,51,52,57]
   - sexual dysfunction; [52]
   - neurologic concerns, syncope,[57] paresthesias,[51] dizziness; [51,52]
   - palpitations; [51,52,57]
   - chronic non-specific medical complaints often presumed to be psychosomatic; [48,51,57]
   - sleep disturbance, e.g. insomnia; [48,51,52,57]
   - fatigue, decreased energy, difficulty concentrating; [51,52]
   - dyspnea; [51,52]
   - upper respiratory tract infections, bronchitis; [54,56]
   - poor control of diabetes, hypertension, heart disease. [51]

4. Obstetric, Gynecologic Problems
   - miscarriages; [48,49,52,57]
   - injured pregnant woman[49,51,52,57] or fetus; [51,57]
   - register late [49,52,57] or no prenatal care; [51]
   - pre-term labor; [49,51,52]
   - low birth weight infants; [49,57]
   - spontaneous abortions; [51,52]
   - frequent urinary tract infections or vaginitis; [52]
   - dyspareunia; [52]
   - pelvic pain; [48,51,52]
   - injuries to breasts, abdomen or genitals; [52]
   - substance abuse, poor nutrition and/or inadequate weight gain during pregnancy. [52]

5. Emotional and Behavioral or Psychological Sequelae of Violence
   - depression; [48,49,51-53,57]
   - suicide attempts; [48,49,51,52,56,58]
   - anxiety; [48,51,52,57]
   - mental illness; [48]
   - inability to cope; [52]
   - nervous behavior, lack of eye contact, worrying about staying too long in office, frequent comments that she has to check with her partner, comments that partner is jealous, financial dependence, shy, frightened, embarrassed, noncompliant, evasive, passive, cries; [48]
   - poor self-esteem, social isolation; [48,52]
   - hovering (batterer accompanies victim to monitor what is said); [48]
   - post-traumatic stress reactions/disorder; [49,52,57,58]
   - panic disorders; [51,52]
   - eating disorders; [51,52,57]
   - drugs and alcohol abuse. [48,49,51-53,56-58]

6. Other
   - more likely to be prescribed analgesics, minor tranquilizers[48,52,57] and antidepressants; [48]
   - multiple visits [56] or frequent visits without physiologic abnormality; [52]
   - long term disability from injuries; [58]
   - homelessness or welfare.[58]

Screening and Identification
Physicians routinely screen for problems less prevalent than domestic violence, and yet routine screening for domestic violence is rarely practiced.[48,49,53] This is especially true in the primary care setting where it is estimated that less than 10% of primary care physicians routinely screen for domestic violence during a regular office visit.[53] Battery is so prevalent that physicians in an entry-level health care system have an ethical obligation to consider abuse as a possibility in their evaluation of female patients.[48,52] Screening is simply asking the patient a few direct questions. The goal of screening is not for the physician to "fix" the problem but to identify the abuse and provide appropriate education, support, and referrals, and to acknowledge and validate the situation as real and dangerous.[48,52] Before initiating any discussions about domestic violence, the physician must put the patient in a position to disclose this information safely and confidentially (without partner and/or children present).[48,51,54-57] The FAMILY VIOLENCE PREVENTION FUND recommends screening begin as early as age 14.[53] It is recommended that all female patients are screened whether signs or symptoms are present or not and whether abuse is suspected or not.

Battered women/victims favor routine questions about domestic violence and expect their physicians to initiate discussions about it.[48,49] While many find it difficult to volunteer the information, most women are willing to discuss issues about violence if specifically asked. Questions should be direct, sensitive, empathetic, nonjudgmental and asked in a confidential setting.[48-50,52,57] It is recommended that direct questions about abuse be included in the routine history[49,52,57] as no one can be excluded from screening.[56] This is because the prevalence is so high,[49,54,56] the prevalence of undetected cases is high, [48,49,57] and there is no, or low, positive predictive presentations for the presence of domestic violence.[48,52,54,57] In addition, screening for abuse should be considered for each new complaint or when the patient has a new intimate partner. [53]

Phrasing Questions
An easy way to introduce the topic is a statement such as "Because violence is so common, I've begun to ask about it routinely" or "I've begun to ask all my patients about it." [52,53] This may then be followed by one of the following or similar questions:

- "Are you in a relationship with a person who physically hurts or threatens you?"[53]
- "Have you been hit, kicked, punched or otherwise hurt by someone in the past year? [52,53,58] If so, by whom?" [54]
- "At anytime has your partner or anyone at home hit, hurt or frightened you?"[53]

Patient Denies Abuse or Does Not Want To Discuss The Topic
When patients' deny abuse or are reluctant to discuss the topic, they should not be badgered. [48,54] Providing a list of local programs presents a less threatening resource than face to face confrontation while still providing support for the patient.[52,54] It is appropriate, however, to make further inquiries with more specific questions when the patient answers "no" or will not discuss the topic if there are signs and/or symptoms strongly indicating abuse.[52] Some examples of this follow:

- "It looks as though someone may have hurt you. Could you tell me what happened?"[52]
- "Sometimes when people come for healthcare with physical symptoms like yours, we find that there may be trouble at home. We are concerned that someone is hurting or abusing you. Is this happening?"[52]
- "Sometimes when people feel the way you do, it's because they may have been hurt or abused at home. Is this happening to you?"[52]

Patient Acknowledges Abuse or Wants To Discuss the Topic
When the patient acknowledges abuse or wants to discuss the topic, it is important to listen non-judgmentally[51,52,54] and assure the patient that the disclosure is confidential.[48,53] In addition, validation[48,52,54,57] of their position with any of the following statements provides further support:

- "No one deserves to be hurt or threatened with violence." (The most important and easily provided intervention is this simple message.)[48,54]
- "You are not to blame for the behavior of the perpetrator."[54]
- "You are not alone."[52]
- "You aren't crazy." [52]
- "What happened to you is wrong."[52]
- "Help is available."[52]
- "I have treated others with this problem and am comfortable dealing with it."[52]

It is important to educate the patient[48,49,54,57] about the escalating cycle of abuse (nature and course)[48,49,57] which not only produces serious medical problems[48,57] but is also a criminal act [48,54] for which there are protective service agencies and legal assistance, e.g. civil protection orders/restraining orders, criminal prosecution, civil litigation, etc.[49-52,54,55,57]

Legible, accurate, detailed and complete documentation by the physician is invaluable for legal purposes.[51,52,54] This may provide the only evidence that abuse has taken place[51] and improves the likelihood of successful prosecution.[54] Good records also frequently substitute for personal appearance by the physician in a legal setting.[57] It may be reasonable to establish a "confidential" file set for domestic violence cases in order to further limit access and protect the confidentiality of the patient. Along with the medical information, the file should include the arrival date and time, name, address, phone number of anyone with the victim and the address where the incident occurred.[52] It is appropriate to begin with an all inclusive medical, trauma and relevant social history,[52] in addition to a history of the incident using the patient's own words[48,51,52,54] with modifiers such as "the patient states..." [48,51] when possible. A list of complaints and symptoms[52,55] should be obtained and a complete physical examination including neurological examination, radiographic evaluation, and rape assessment, if appropriate,[52] should be performed. If any special services aren't available in the physician's office, referral to an appropriate facility for documentation is indicated. (See Appendix D) Body diagrams/maps[48,49,54] may be useful for documenting a detailed description of the injuries including extent,[48] resolution/acuity,[48,52] measurements/size,[48,52] type, number, and location. [52] Results of laboratory testing, diagnostic imaging or other diagnostic procedures should be included in the chart. The physician should document whether the injuries are consistent with the patient's explanation.[52]

If possible, photographs should also be included because they are particularly valuable as evidence.[54] Prior to taking photographs, written informed consent should be obtained[48,52,58] in addition to having a female chaperone present.[48] If available, a digital camera has the greatest versatility for documenting visible injuries. Two views of each injury should be taken, including a measuring device[51,52] and at least one picture with the patient's face for identification.[51,52] The photographs should be marked with the following information: name of patient, photographer, witnesses,[51,52] time,[48,52] place,[48] chart/record number,[51] and date and signature of the photographer.[48,58] The photographs should be placed in a sealed envelope with the patient's name and social security number and put in a safe place.[48] If a standard camera is used, label the films and keep secure until developed[51] at which time 2-3 copies should be made.

If the police are involved, the investigating officer and any action taken should be documented if possible.[52] The police should only be called with the patient's documented consent; however, there are some exceptions where reporting is mandatory, which include the following:

- If there is evidence of injury by gunshot, knife or other deadly weapon. [51,55,57,58]
- Child abuse, elder abuse or neglect. [62,69]
- Where there is a duty to protect a potential third party victim from danger.[48,51,52,55] According to the *Tarasoff* case of 1976, if it is determined the patient presents a serious danger of violence to another, the health care provider is obliged to use reasonable care to protect the intended victim against such danger via notification of the intended victim, notification of the police or taking whatever steps reasonably necessary under the circumstances. Sixteen states have adopted Tarasoff limiting statutes, which only require reporting when there is an explicit threat made.[55] "In Oregon, the duty to warn is **not** clear. In the case of possible domestic violence, the physician, **upon advice of legal counsel,** should err on the side of caution and warn the at-risk spouse or partner."[52]

It is very important to include an assessment of the patient's danger and fear. [48,51,52,54,57,58] To evaluate the patient's level and immediacy of danger, it may be helpful to ask some further questions,[48] as the most critical components of assessment are the patient's level of fear and appraisal of immediate and future safety.[52] Following are some questions that may provide further insight to the patient's position:

- "Are you in immediate danger?" "What do you think will happen when you go home?" [48,54] (This is one of the most important questions: "Is it safe to go home?"[51])
- "Is another violent attack imminent?"[48]
- "How frequent and severe are the attacks?" [48,51] "Are they escalating?"[51,52]
- "Do they have a firearm or deadly weapon?"[48,51,52,54]
- "Is there a history of violent behavior outside the home[51] or history of violent acts or threats using a weapon?"[51,58]
- "Have they threatened to kill you[48,51,52] or you them?"[48,51]
- "Is there drug or alcohol use?"[48,51,58] as this makes behavior less predictable.[48]

- "Have there been threats to children?"[48,52,54,58]
- "Are you, or a partner, threatening suicide and if so, is there a suicide plan?" If so, the situation is urgent.[48,51,52]
- "Are there forced unwanted types of sex or refusing to use birth control?"[53]
- "Is there humiliation, swearing, name calling, mental instability, obsession with victim,[51,58] drug/alcohol use or abuse?" [58]
- "Are there threats to injure self or patient,[52] reporting to immigration or stalking?"[58]
- "Is there isolation which includes controlling access to friends and family and limiting outside involvement?"[51,53,58]
- "Has there been destructive behavior such as destroying patient's property, injuring pets of patient or child?"[58]
- "Does the abusive partner control all the money?"[51,58]

Appropriate treatment for the patient's injuries should be provided[52] as well as appropriate referrals for support. (See Appendix D) In addition, it is important to discuss alternatives in a safe place, [51,56,57] giving the patient an opportunity to decrease the sense of isolation and lack of power.[57] The patient may or may not be in immediate danger and may or may not want access to a shelter. Based on these criteria, additional decision-making and appropriate action may proceed.

If the patient is in immediate danger, it should be determined if there are family or friends to stay with[50-52] or if immediate access to a shelter[51,52,57] or police contact is wanted.[52,54] An opportunity should also be given to use a private phone to assist with any/all of the above.[52]

If there is no immediate danger or the patient doesn't want immediate access to a shelter, the chiropractor may offer written information about shelters and other community resources [48-52,54,55,57] or instructions how to find this information in the phone book.[48] Shelters and affiliated agency referrals should be made carefully and only to those dedicated to assisting battered women.[48] Affiliated agencies and community resources may include the following: children's services, counseling, legal and employment services[54] and law enforcement.[50,51] With respect to legal needs, possibilities are criminal prosecution, civil litigation,[52,57] civil protection/restraining orders,[51,52, 57] temporary custody, and mandatory payment of rent or mortgage.[54] It is important to remember that written information may be dangerous for the patient to possess.[48,52] The patient should not be forced to take written information. The number of a local hotline or other information may be most safely given on a prescription blank or appointment card.[52]

The victim should be assisted in developing a safety plan[48,50-52,54,57,58] with which they can prepare for future situations as well as make judgments about the safety of their current situation. This should be an ongoing process where questions such as "Is it safe to go home?"[48,51,54] can help the victim to regularly assess their safety status. Identification of potentially dangerous situations and appropriate responses increase the preparation and safety when or if the risk of violence increases.[48,50] Options should include planning for immediate relocation to a shelter[57] and/or seeking shelter and financial help from family and friends.[50-52] If possible, three options should be included for emergencies where shelters may be full, family and friends are out of town, etc. Victims should be given information directly and/or made aware of how to access available resource numbers for assistance.[48-52,54,55,57] A packed overnight bag[57] or "flight kit" which may be an unused suitcase placed in a well-hidden area[52] should include as many of the following items as possible: enough money to get started, clothing, medicine, address book, car/house keys, valuables, books, children's toys, papers (social security card, health insurance information, birth certificates, driver's license, restraining order, etc.).[58]

In the case where no apparent emergent situation exists and the patient is returning home, a follow up appointment should be scheduled.[48]

Despite the limited and imperfect options for detecting and intervening in domestic violence situations, the benefits are substantial for families in which the cycle of abuse is interrupted.[49] Patients should not leave the health care facility without knowing that battering is a crime and there is help in the judicial system.[54] It would be useful for the physician to be familiar with, or help develop, a network with physicians, and community referral resources (shelters, legal services, law enforcement, district attorney's office, etc.) as this can be extremely effective in developing a coordinated response to meet the complex needs of battered women.[51]

Educational Materials for the Health Care Providers

Chiropractors can increase public awareness about domestic violence,[48,57] show willingness to discuss the topic,[48] and help women understand the problem[50] by having pamphlets, posters, etc. in the office. This is an important form of intervention and prevention.[57] There should be materials from community resources relating to domestic violence in the waiting room, examination room, female restrooms and other strategic locations.[49,51 57] It is also

important to support culturally sensitive publications in different languages for women in the international community as it is more difficult for them due to cultural, religious, social, family, legal and immigration reasons.[50]

Child Abuse

The various forms of abuse have potential physical and behavioral indicators. [62]

(A) Physical abuse, possible physical indicators;

- bruises and welts on the body;
- bruises and welts reflecting the shape of an object used (electrical chord, belt buckle);
- various types of burns (cigarette, rope, etc.);
- laceration;
- fractures.

Physical abuse, possible behavioral indicators:

- wary of adult contacts;
- apprehensive when other children cry;
- behavioral extremes;
- frightened of parents;
- afraid to go home.

(B) Neglect, possible physical indicators:

- consistent hunger, poor hygiene, inappropriate dress;
- consistent lack of supervision;
- unattended physical and/or emotional problems or medical needs.

Neglect, possible behavioral indicators:

- begging, stealing food;
- extended stays at school;
- poor school performance;
- fatigue;
- alcohol or drug abuse;
- delinquency.

(C) Mental injury or emotional maltreatment, possible physical indicators:

- failure to grow;
- speech or sleep disorders;
- forced to dress in "opposite sex" clothing.

Mental injury or emotional maltreatment, possible behavioral indicators:

- behavior extremes: aggression or withdrawal;
- habit disorders (sucking, biting, rocking);
- attempted suicide;
- conduct disorders (antisocial, runaway, destructive behavior);
- emotionally needy.

(D) Sexual abuse, possible physical indicators:

- difficulty in walking or sitting;
- pain or itching in the genital area;
- bruises, bleeding or infection in external genital area;
- venereal disease;
- pregnancy.

Sexual abuse, possible behavioral indicators:

- withdrawal, fantasy or infantile behavior;
- poor peer relationships;
- delinquent or runaway;
- reports sexual assault (children seldom lie about sexual abuse);
- refer also to behavioral indicators of mental injury or emotional maltreatment.

Elder Abuse

Observations suggestive of elder maltreatment include: [68]

(A) General

- absence of caregiver or abandonment;
- poor supervision;
- recent conflicts or crises;
- medication problems (duplications or unusual dosages);
- recurrent healthcare admissions or visits;
- delay in seeking care;
- unexplained injuries;
- inconsistent histories between patient and caregiver.

(B) Patient

- fearful of caregiver.

(C) Patient or caregiver

- depressed;
- reluctant to answer questions.

Physical indicators of elder abuse:[68]

(A) Physical abuse

- unexplained bruises, wounds, burns, or other injuries;
- rope or restraint marks on wrists and/or ankles.

(B) Psychological abuse

- habit disorder (sucking, rocking);
- neurotic disorders (antisocial, borderline).

(C) Neglect

- dehydration or malnutrition;
- poor hygiene;
- inappropriate dress;
- unattended physical or medical needs.

APPENDIX C

STRATEGIES THAT MAY PREVENT BOUNDARY VIOLATIONS AND/OR ALLEGATIONS OF SEXUAL MISCONDUCT

A. Office Procedures
- provisions for chaperones as needed;
- provisions for patient modesty (privacy when disrobing, draping, etc);
- patient bill of rights;
- staff communication;
- staff availability near treatment rooms;
- consent to treat minors;
- documentation of incidents;
- follow-up/response to complaints;
- termination or referral of patients.

B. Staff Education
- sexual harassment policy;
- expectations regarding communication and behavior in the office;
- not discussing intimate subjects, personal problems or lives with patients;
- confidentiality;
- socializing with patients.

C. Self Assessment Tools to Analyze Risk
- Risk factor analysis (See Appendix E) [91]
- The Exploitation Index: An early warning indicator of boundary violations in psychotherapy. (See Appendix F) [101]

D. Access to Mentors or Second Opinions

Doctors are often isolated in practice. An experienced colleague or counselor can provide insight, and help with difficult and/or sensitive issues that arise in practice.

E. Patient Education/Orientation
- chaperone option offered to patient;
- query patients regarding their concerns;
- pamphlets, videotapes, report of findings, PARQ conference (see Section 3);
- clinic procedure regarding disrobing, gowning, and draping.

F. Identification of High Risk Situations for the Chiropractor
- attraction to a patient;
- personal relationship problems;
- times of emotional distress;
- substance abuse;
- burn-out.

G. Recognition of High Risk Patient Behaviors
- inappropriate gifts, cards or correspondence;
- inappropriate “personal” comments and questions;
- sexual innuendo and humor;
- seductive clothing or behavior;
- seeking inappropriate extended visits and/or care.

APPENDIX D

DOMESTIC VIOLENCE RESOURCES

NATIONWIDE DOMESTIC VIOLENCE 24-HOUR TOLL-FREE HOTLINE: 800-799-SAFE
TDD number for the hearing impaired: 800-787-3224 (non-English translators available)

ASHLAND
- Dunn House — 541-779-4357

ASTORIA
- Clatsop County Women's Crisis Service — 503-325-5735

BAKER CITY
- May Day, Inc. — 541-523-4134

BEND
- Central Oregon Battering and Rape Alliance — 541-389-7021 / 800-356-2369

BURNS
- Harney Helping Organization (HHOPE) — 541-573-7176

COOS BAY
- Coos County Women's Crisis Center — 800-448-8125

CORVALLIS
- Center Against Rape & Domestic Violence — 800-927-0197

ENTERPRISE
- Safe Harbors — 541-426-6565

EUGENE
- Family Shelter Network — 541-689-7156
- Sexual Assault Support Services — 541-343-7277 / 800-788-4727
- Womenspace — 800-281-2800

FLORENCE
- Siuslaw Area Women's Center — 541-997-2816

GRANTS PASS
- Women's Crisis Support Team — 541-474-1400 / 800-750-9278

GRESHAM
- Gresham Police Domestic Violence Unit — 503-618-2394

HILLSBORO
- Domestic Violence Resource Center — 503-469-8620

HOOD RIVER
- Project Helping Hands Against Violence — 541-386-6603

KLAMATH FALLS
- Klamath Crisis Center — 800-452-3669

LAGRANDE
- Shelter from the Storm — 541-963-9261

LAKEVIEW
- Crisis Intervention Center — 800-338-7590

LINCOLN CITY
- Women's Violence Intervention Project 541-994-5959

MILL CITY
- Canyon Crisis Service 503-897-2327

MILWAUKIE
- Clackamas Women's Services 503-654-2288

MCMINNVILLE
- Henderson House 503-472-1503

ONTARIO
- Project Dove 541-889-2000

PENDLETON
- Domestic Violence Services 800-833-1161

PORTLAND
- La Linea de Crisis Para La Mujer 503-232-4448 / 800-556-2834
- Men's Resource Center and Women's Agenda Counseling 503-235-3433
- Multnomah County Mental Health Crisis Line 503-215-7082
- Portland Police Domestic Violence Reduction Unit 503-823-0961
- Portland Women's Crisis Line 503-235-5333
- Raphael House Of Portland 503-222-6222
- Salvation Army West Women's and Children's Shelter 503-224-7718
- Volunteers Of America Family Center 503-232-6562
- Yolanda House 503-977-7930
- Bradley-Angle House 503-281-2442
- Council For Prostitution Alternatives 503-282-1082

ROSEBURG
- Battered Person's Advocacy 800-464-6543

SALEM
- Mid-Valley Women's Crisis Service 503-399-7722

ST. HELENS
- Columbia County Women's Resource Center 503-397-6161

THE DALLES
- Haven From Domestic Violence 541-298-4789

TILLAMOOK
- Women's Crisis Center 800-992-1679

UMPQUA
- Lower Umpqua Victims' Services Day: 541-271-0261
  Eve: 541-271-2109

VANCOUVER:
- YWCA Safechoice 360-695-0501

UPDATED 12/02

APPENDIX E

An Excerpt of Behind Closed Doors
Gender, Sexuality, and Touch in the Doctor/Patient Relationship
Angelica Redleaf
with Susan A Baird

SEXUAL MISCONDUCT RISK FACTOR ANALYSIS

PURPOSE: The Risk Factor Analysis (RFA) is a tool that can be used to quickly evaluate your current risk level for sexual misconduct.

This questionnaire was created by Ben Benjamin, Ph.D., and Angelica Redleaf, D.C.; some portions are adapted from the article "Are You In Trouble With A Client?" by Estelle Disch, Ph.D., which appeared in *Massage Therapy Journal*, Summer 1992. Ben Benjamin is the director of the Muscular Therapy Institute in Cambridge, Mass. Estelle Disch has practiced for more than 20 years as a clinical sociologist and psychotherapist in Boston, Mass., and is the co-director of BASTA! (Boston Associates to Stop Therapy Abuse).

What is the Risk Factor Analysis?

The RFA asks very specific questions. Some are about stress you may be experiencing in your life or in your practice. Others are about attractions to patients, interactions with patients, and attitudes towards patients. The questions are based on typical kinds of doctor behaviors and attitudes.

The RFA is meant for you to keep to yourself. It can be taken again from time to time – for example, every six months – to give you a quick idea of your risk level. It can be used independently of the Practice Analysis, which includes more general questions about doctor and staff behavior and attitudes.

How does the RFA Differ from the Doctor Self-Analysis?

The RFA and the Doctor Self-Evaluation Questionnaire (DSE) both ask the practitioner to self-evaluate his or her level of risk. The DSE asks general questions about your behaviors, attitudes, skills, and attributes, and about your staff's behaviors, skills, and attitudes. The RFA asks very specific questions that are designed to give you a quick idea of the level of risk you are incurring by practicing the way that you do.

By comparing your responses to both questionnaires, (see page 158) you will be able to gain a very clear picture of what *you think* about yourself as a practitioner, and of what *you think* about your staff. This information is a good start, but neither of these self-evaluations can see past your own blind spots.

The rest of the Practice Analysis will either confirm, challenge, or illuminate your ideas about yourself as a practitioner, and about your practice as a whole.

Instructions

Place a check-mark next to the number (1, 2, or 3) of each statement that applies to you. When you have completed the questionnaire, add up all of the numbers that are the same – i.e. add up all the number 1s on a page and write that number at the bottom of each sheet, then do the same for all the 2s and 3s on each sheet. Add up the totals for each number on the last page in the space provided. Directions for assessing your RFA numbers are on the next page.

At the end of the self-scoring section, there are guidelines for comparing your RFA results with the results of the Doctor Self-Evaluation and the rest of the Practice Analysis.

RISK FACTOR ANALYSIS QUESTIONNAIRE

1	I want this patient to like me.
1	I like it when my patients find me attractive. I keep this to myself.
2	Sometimes I schedule the patients that I really like last so that I can spend more time with them.
2	I am surprised by how much I anticipate this patient's visit.
2	I think about this patient frequently.
1	I have not been in a relationship in a long time.
1	I feel lonely much of the time, unless I'm working.
2	With certain patients I have trouble asking to be paid.
1	I talk about my personal life to my patients.
2	I find myself working weekends to accommodate a few patients I like.
1	Some of my patients rely on me a lot.
2	I feel as if I am under tremendous pressure.
1	I like it when my patients look up to me.
2	I feel like I have very little to give lately.
2	My relationship with my significant other(s) isn't meeting my needs.
3	I've sometimes touched patients in inappropriate ways.
3	I've had sex with patients.
3	I've had sex with patients in the office.
2	I dress particularly well when I know one or more of my patients has an appointment that day.
1	I fantasize about what it would be like to have sex with some of my patients.
2	I'm not charging one or more of the patients to whom I'm attracted.
2	I have some of my patients take off more of their clothes than they really need to remove.
2	I sometimes sneak looks as patients are undressing.
2	I believe it's okay to date my patients.
2	I sometimes tell dirty jokes to my patients.
2	I like doing treatments in those areas of patient's bodies that are close to their erogenous zones.
2	I compliment patients when I think they look nice.
1	This patient feels more like a friend.
2	I often tell my personal problems to one or more of my patients.
2	I feel sexually aroused by one or more of my patients.
3	I'm waiting to dismiss this patient so that we can become romantically involved.
2	To be honest, I think that good-by hugs last too long with one or more of my patients.
2	Appointments with one or more of my patients last longer than with others.
2	I tend to accept gifts or favors from this patient without examining why a gift was given.

Totals for this page:

1 _____ 2 _____ 3 _____

1	I feel totally comfortable socializing with patients.
1	I have a barter arrangement with one or more of my patients that is sometimes a source of tension.
3	I have had sexual contact with one or more of my patients.
2	I have attended professional or social events at which I knew that this patient would be present.
2	This patient often invites me to social events and I don't feel comfortable saying either yes or no.
2	Sometimes when I'm working on this patient, I feel like the contact is sexualized for myself and maybe for the patient.
2	There's something I like about being alone in the office with this patient when no one else is around.
2	I am tempted to lock the door when working with this patient.
3	This patient is very seductive and I don't always know how to handle it.
2	I have invited this patient to public or social events.
1	I find myself cajoling, teasing, joking a lot with this patient.
3	I allow this patient to comfort me.
3	Sometimes I feel like I'm in over my head with this patient.
2	I feel overly protective of this patient.
3	I sometimes have a drink or use some recreational drug with this patient.
3	I am doing more for this patient than I would for any other patient.
2	I find it difficult to keep from talking about this patient with other people who are close to me.
2	I find myself saying a lot about myself with this patient – telling stories, engaging in peer-like conversation.
3	If I were to list patients with whom I could envision myself in a sexual relationship, this patient would be on the list.
3	I call this patient a lot and go out of my way to meet with him/her in locations convenient to him/her.
2	This patient has spent time at my home.
3	I often tell my personal problems to this patient.
3	I enjoy exercising my power over some of my patients.
3	I'm going through a crisis at this point in my life.
2	Sometimes I'm afraid I might burn out.
3	I need someone to take care of *me*.
3	If a patient consents to sex, it's okay.

Totals for this page:

1 _____ 2 _____ 3 _____

Totals for both pages:

1 _____ 2 _____ 3 _____

If you have checked off even one number 3: You are at risk. Know that you are a ticking time bomb who could potentially hurt yourself, your patient(s) and your profession! You would be very wise to get help from a therapist, consultant or significant other. You also should consider getting training in this area. Ignoring your high risk or attempting to get through this by yourself might be very unwise.

If you have checked off more than three number 2s: You have the potential for problems. The more number 2s you check off, the more your risk factor increases. You could use some help in getting yourself on track concerning professional boundaries.

If you checked off more than five number 1s: You may be overstepping your professional boundaries. You might not be in danger of overstepping them sexually, but you still could find yourself losing your effectiveness as a health provider. Be aware of your attitudes about patients, yourself, and your practice.

During times of stress and personal loss, we are more likely to overstep our professional boundaries. There are training sessions available that address the questions of boundaries and sexual misconduct, and there are therapists, mentors, friends, and colleagues who could help you at such times. Your risk is greatest when you attempt to go through such a transition all by yourself.

Redleaf A, Baird SA. Behind closed doors: gender, sexuality, and touch in the doctor/patient relationship. Westport, CT: Auburn House, 1998: 131-135.

APPENDIX F

THE EXPLOITATION INDEX

The Exploitation Index: Rate yourself according to the frequency that the following statements reflect your behavior, thoughts, or feelings with regard to any particular patients you have seen in psychotherapy within the past 2 years, by placing a check in the appropriate box. Approximate frequency as follows:

Rarely = about once a year or less Sometimes = about once every 3 months Often = once a month or more

Please give your immediate, "off the cuff" responses:	Never	Rarely (Yearly)	Sometimes (Quarterly)	Often (Monthly)
1. Do you do any of the following for your family members or social acquaintances: prescribing medication, making diagnoses, offering psychodynamic explanation for their behaviors?				
2. Are you gratified by a sense of power when you are able to control a patient's activity through advice, medication, or behavioral restraint? (e.g. hospitalization, seclusion)				
3. Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing nothing?				
4. Do you accept gifts or bequests from patients?				
5. Have you engaged in a personal relationship with patients after treatment was terminated?				
6. Do you touch your patients (exclude handshake)?				
7. Do you ever use information learned from patients, such as business tips or political information, for you own financial or career gain?				
8. Do you feel that you can obtain personal gratification by helping to develop your patient's great potential for fame or unusual achievement?				
9. Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?				
10. Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing or impressive?				
11. Do you ask your patient to do personal favors for you? (e.g. get you lunch, mail a letter)				
12. Do you and your patients address each other on a first-name basis?				
13. Do you undertake business deals with patients?				
14. Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?				
15. Have you accepted for treatment a person with whom you have had social involvement or whom you know to be in your social or family sphere?				
16. When your patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?				

The Exploitation Index questionnaire is used with direct permission of R. S. Epstein, MD

Please give your immediate, "off the cuff" responses:	Never	Rarely (Yearly)	Sometimes (Quarterly)	Often (Monthly)
17. Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity)				
18. Do you accept a medium of exchange other than money for your services? (e.g. work on your office or home, trading of professional services)				
19. Do you find yourself comparing the gratifying qualities you observe in a patient with the less gratifying qualities in you spouse or significant other? (e.g. thinking: "Where have you been all my life?")				
20. Do you feel that your patient's problems would be immeasurably helped if only he/she had a positive romantic involvement with you?				
21. Do you make exceptions in the conduct of treatment because you feel sorry for your patient, or because you believe that he/she is in such distress or so disturbed that you have no other choice?				
22. Do you recommend treatment procedures or referrals that you do not believe to be necessarily in your patient's best interest, but that may instead be to your direct or indirect financial benefit?				
23. Have you accepted for treatment individuals known to be referred by a current or former patient?				
24. Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?				
25. Do you take pleasure in romantic daydreams about a patient?				
26. Do you fail to deal with the following patient behavior(s): paying the fee late, missing appointments on short notice and refusing to pay for the time (as agreed), seeking to extend the length of sessions?				
27. Do you tell patients personal things about yourself in order to impress them?				
28. Do you find yourself trying to influence your patients to support political causes or positions in which you have a personal interest?				
29. Do you seek social contact with patients outside of clinically scheduled visits?				
30. Do you find it painfully difficult to agree to a patient's desire to cut down on the frequency of therapy, or to work on termination?				
31. Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?				
32. Do you join in any activity with a patient that may serve to deceive a third party? (e.g. insurance company)				

Scoring Key: Never = 0, Rarely = 1, Sometimes = 2, Often = 3.

A total of 27 or greater, scores in the highest 10% of a sample of 532 psychiatrists.

* Epstein, R.S. and Simon, R.I. "The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy"
* Epstein, R.S. Simon, R.I., and Kay, G.G. "Assessing Boundary Violations in Psychotherapy: Survey Results with The Exploitation Index." Bulletin of the Menninger Clinic 56:150-166, 1992.

Educational Manual for Evidence-Based Chiropractic

Chapter 2

Diagnostic Imaging

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DIAGNOSTIC IMAGING

INTRODUCTION

The fundamental purpose of diagnostic imaging is to provide information to assist in the development of a diagnosis or otherwise impact the treatment plan. It is the responsibility of the chiropractic physician to keep abreast of advancements in diagnostic imaging. The chiropractic physician must make imaging decisions based on what is best for the patient.[1] This chapter presents current knowledge regarding the utilization of diagnostic imaging in the assessment of chiropractic patients.

APPROPRIATE UTILIZATION OF RADIOGRAPHIC STUDIES

While diagnostic-imaging procedures may be vital to diagnosis and case management, the decision to utilize any diagnostic imaging procedure should be based on a demonstrated need (i.e. clinical necessity) following an adequate case history and physical examination.[2]

Once radiographs have been obtained, it is required[3] that a report of the findings be recorded and placed in the patient's permanent record. It is the responsibility of the clinician to ensure that all radiographs are evaluated for pathologic and biomechanical information. All radiographic reports will include the patient's name, age, sex, date of examination and report, and area of study and views. A narrative of radiographic findings, and impressions should be included.

The following discussion is designed to assist in the plain film radiographic decision-making process. The guidelines are divided into categories as shown in Table 1. These categories include: clinical indicators, structural and functional abnormalities, other indicators, and inappropriate use of x-rays. All relevant clinical and historical information needs to be considered.[4-39] The practitioner's clinical judgment will be the basis for determining whether to take radiographs or not. [40]

CLINICAL INDICATIONS

Table 1: Guidelines for Chiropractic Utilization of Radiographic Studies

- History of malignancy (with unexplained new symptoms) [4,5,6,7,11,12, 17, 19, 29]
- Significant trauma, recent trauma, repetitive trauma with significant clinical findings[4,5,6,7,12,13,14,15,16,17,18, 19]
- Old trauma in the area of complaint [3]
- Suspected fractures[5,10,18]
- Clinically significant neurologic signs and symptoms [4,5,6,7,13,14,15,16,19,29]
- Unexplained weight loss [4,5,6,7,14,17,19, 29]
- Unrelenting night pain [6, 17, 35]
- Pain unrelieved by recumbency [6,7,29, 38]
- Suspicion or history of inflammatory arthritis with change in symptoms [4,5,11,13,14,31]
- Known or suspected bone density loss [6,7,12]
- Palpable mass [5]

- Substance abuse [4,5,7,14]
- Prolonged corticosteroid use [4,5,7,14,17]
- Fever of unknown origin (>100° F) [4,5,7,14,17]
- Suspected infection [5,6,7,11,29]
- Abnormal laboratory finding (Erythrocyte Sedimentation Rate [ESR], White Blood Cell Count [WBC], etc.) [5,6,7,11,17]
- Recent surgery or invasive procedure related to chief complaint [5, 17]
- Failure to improve without prior radiography [4,5,6,14,17]
- Patients over 50 years of age are at greater risk of having significant pathologies[4,5,7,12,14,17,19,29,32]

Identification of Structural or Functional Abnormalities

- Scoliosis or deformity [5,17,20,21,30]
- Congenital anomaly [5,13,27]
- Surgical history at area of chief complaint [5,6,17,22]
- Postural abnormalities [17,]
- Hyper/hypomobility [23,24,36]
- Aberrant motion[32]

Other Indicators

- Suspected physical abuse [28]
- Environmental exposure to toxic or infectious agents [17]
- Recent immigration or foreign travel [17]
- Medicolegal implications when combined with clinical indicators[4,17,25]

Inappropriate use of x-rays

- Pregnancy - unless the patient's symptoms are of such significance that failure to x-ray would result in a substantial health risk to the mother [8,9]
- Financial gain [4, 17, 33]
- Patient education [4, 17]
- Routine (habitual) screening procedure [4, 17, 26, 33]
- Research without sanctioned review-board approval [34]
- Unnecessary duplication of services
- Routine pre-employment screening [17]
- Inadequate equipment to produce a diagnostic radiograph [3,5,10,17]
- Routine discharge radiographs [17,33]
- Non-licensed operator [3, 17]

IMAGING MODALITIES

There are a number of imaging modalities available to the chiropractic physician to utilize in the diagnostic work-up and treatment of patients. The following will be a discussion of those modalities including plain film radiography, tomography, fluoroscopy, videofluoroscopy, computed tomography (CT), magnetic resonance (MR) imaging, radionuclide imaging (bone scan), myelography, DEXA, PET, and ultrasound.

Plain Film Radiography

The use of plain film radiography in the chiropractic profession began in 1910.[36] It was initially used as a research tool and later as the imaging modality of choice for diagnosis of pathology as well as evaluation of postural and biomechanical integrities of the spinal column and pelvis. Use has expanded to include the appendicular skeleton.

Plain films offer the doctor insight into pathology, indications and contraindications for chiropractic adjustment, as well as postural and biomechanical alterations.[5] The risk of exposure to ionizing radiation mandates that a thorough history and examination be performed prior to the decision to utilize these procedures.

AP and lateral radiographs of the skeleton are the most common imaging procedure used in the chiropractic office. Additional views to the minimum diagnostic series include oblique views, angulated spot views, and dynamic stress studies. Oblique projections are essential in evaluating the facet joints of the cervical and lumbar spine as well as the intervertebral foramina (IVF) in the cervical spine. In the appendicular skeleton, oblique projections more fully demonstrate complex anatomy. Angulated projections are helpful in confirming or denying the presence of osseous versus soft tissue lesions. The sacroiliac joints are more clearly demonstrated on the angulated projection than on any other study.[37] Dynamic stress views include flexion/extension and lateral bending of the cervical and lumbar spine. These studies reveal information related to the end range of motion.[38] Stress radiography is also utilized to evaluate injured joints of the appendicular skeleton.

Soft Tissue Radiography

Soft tissue radiographs, chest and abdomen, are also utilized by the chiropractic physician. These types of studies may require specialized equipment i.e. film, screens, and grids to produce high quality radiographs. As with all radiographic procedures it is essential to obtain the highest quality radiographs when performing these procedures. Radiographs of soft tissues are strictly taken to evaluate for pathology. Poor quality radiographs reduce the likelihood that abnormalities will be identified.

In addition to plain film radiography of the abdomen, contrast studies of the digestive tract, barium swallow and enema, may be utilized by the chiropractic physician. Specialized equipment, i.e. fluoroscope, is needed to insure proper exposure and to produce superior quality radiographs. The images of the procedure must be videotaped. Initial evaluation of these procedures should be done in real time. Special training and experience are required to perform and interpret contrast studies.

Minimal Diagnostic Radiographic Series

It is accepted within the healthcare community that a minimum series of diagnostic radiographs are needed to evaluate each region of interest. As a general rule two views 90° to each other should be obtained. Some areas require additional views as an essential part of the minimal diagnostic series. The following tables represent the accepted standards.

Table 2: Minimum Standard Views for the Axial Skeleton, Chest, and Abdomen

AREA	AP	LATERAL	OBLIQUE	APOM	PA	ANGULATED
CERVICAL[39]	X	X		X		
THORACIC[40]	X	X				
*LUMBAR[41]	X	X				
PELVIS	X					
SACRUM/COCCYX	X	X				
STERNUM		X	X			
CLAVICLE	X					X
RIBS	X		X			
†SKULL	PA Caldwell	X				
CHEST (Full Inspiration)[42]		LEFT			UPRIGHT	
ABDOMEN	X					

*Lumbar spots may be needed, dependent upon the ability to visualize the L5-S1 region. Lateral spot or AP angulated spot radiographs should be considered after evaluation of the AP and lateral.

†To rule out pathology plain radiographs of the skull should only be taken as part of a study that includes computed tomography or MRI.[43]

Table 3: Minimum Standard Views for the Extremities**

AREA	VIEWS
ACROMIOCLAVICULAR JOINT[44]	Bilateral AP
SHOULDER	Internal and external rotation
ELBOW	AP and Lateral
WRIST	Dorsopalmar, dorsal oblique, and lateral
HAND	Dorsopalmar, dorsal oblique, and lateral
FINGERS	Dorsopalmar, dorsal oblique, and lateral
HIP	AP and frog leg lateral
KNEE	AP and lateral
PATELLA	AP, lateral, and sunrise
ANKLE	AP, medial oblique, and lateral
CALCANEUS	Axial and lateral
FOOT	AP, medial oblique, and lateral
TOES	AP, medial oblique, and lateral
LONG BONES	AP and lateral
TEMPOROMANDIBULAR JOINT	Lateral (TM joint is better evaluated with advanced imaging – MRI)

**Complete extremity series are dependent upon patient presentation and findings on initial radiographs.

NEUROMUSCULOSKELTAL SPECIAL IMAGING PROCEDURES

The choice of an appropriate imaging modality is a case specific process. A given patient may have specific needs or limitations that affect choices. The exact nature and degree of the pathology suspected affects imaging choices. These factors and the continuing development of imaging protocols make consultation with a radiologist valuable. The information provided here is intended as a general guide.[15,46-58]

Magnetic Resonance Imaging

Magnetic resonance imaging (MRI) is a valuable diagnostic tool in neuromusculoskeletal imaging. Sectional images can be obtained through all body areas in axial (transverse), sagittal and coronal planes, or at oblique angles for smaller anatomical areas. No ionizing radiation is produced with MRI and risks to appropriately chosen patients have not been identified. Patients with pacemakers, some aneurysm clips, metallic foreign bodies, and other ferromagnetic artifacts are not appropriate candidates for MRI.

In general, MRI images tissues based on their hydrogen atom content, reflecting total quantity and molecular bonds. Therefore, both free and intracellular water, and fat produce the majority of the MRI "signal" which creates the image. MRI is an excellent procedure for imaging soft tissues of the body including the brain, spinal cord and cerebrospinal fluid, intervertebral discs, articular cartilage, muscles, tendons, ligaments, menisci, and most organs. MRI does not image cortical and trabecular bone though changes in the surrounding marrow can be diagnostic for many osseous pathologies.[51]

MRI is rarely used as the initial imaging procedure. In many cases, MRI will provide additional information after evaluation of plain film radiographs. MRI may be used as the initial study in cases of significant or rapidly progressing neurologic changes, especially those that indicate central nervous system **(**CNS**)** pathology. MRI is also useful as a follow-up imaging procedure after surgical treatment for IVD herniation and neoplasm. [51]

Computed Tomography

Computed tomography (CT) combines the imaging physics of plain film x-ray with the advantages of sectional imaging**.** Like plain film, CT produces its images through the interaction of x-ray photons with the tissues of the body, and is quite valuable in imaging osseous structures .[15] CT also carries the same consideration of the potential harmful effects of ionizing radiation. The radiation dose should be kept as low as possible without losing diagnostic information and the risk-benefit ratio carefully weighed. Pathologies containing calcium densities may also be evaluated with CT. Some soft tissues, particularly of the chest and abdomen are best imaged with CT due to limitations of MRI in those areas.

Previously known as the CAT (computed axial tomography) scan, it is important to remember that primary or direct images are obtained in the axial plane. Sagittal and coronal reconstructions can be formed with the data obtained in the axial plane, but some extrapolation is done by the computer with a resultant loss of detail. Three-dimensional CT offers limited diagnostic information and is used primarily as a surgical planning tool.

Computed tomography is used extensively, with and without intravenous contrast agents, for chest and abdomen examinations. It is superior to MRI in most scenarios for the chest and abdomen since the motion artifacts produced by heart contractions and bowel peristalsis may interfere with the acquisition of MR images. Plain film radiographs, as scout films, will often be used for preliminary examination of the chest and abdomen before CT imaging.

CT provides detailed evaluation of fractures. This is particularly useful in unusually shaped bones or areas difficult to image with plain film such as the pelvis, craniovertebral junction, posterior elements of the spine, and ankle. Computed tomography may be combined with arthrography when the differential list includes cartilaginous and bony abnormalities or when MRI is inconclusive, such as some cases of glenoid labrum tear. CT evaluation in the musculoskeletal system typically follows radiographic examination.

Computed tomography is also used extensively, though less than MRI, in evaluation of the spine, spinal canal, and intervertebral discs. CT is superior to MRI in detailing significant osseous changes, but MRI is usually more valuable in evaluating the impact on neurologic structures. Myelography can improve the ability of CT to evaluate neurologic structures, especially the thecal sac. In some cases, both procedures will be used to reach an accurate diagnosis and provide information for surgical planning. In cases where MRI is not available or not appropriate, CT, with or without myelography, is typically the imaging procedure of choice.[51]

CT is also used to evaluate head trauma injuries where fracture and acute intracranial bleed are suspected

Radionuclide Imaging

Radionuclide imaging of bone (bone scan) involves the intravenous administration of a radionuclide tagged to a phosphate analog, which is incorporated in the hydroxyapatite crystal of bone. Gamma rays emitted by the radionuclide are then detected quantitatively to produce an image. The image produced reflects blood flow and areas of increased bone production. Bone scan is much more sensitive than plain film for detecting osseous abnormalities but is distinctly nonspecific and would not be used as the only imaging procedure. A bone scan is typically used when the presence or the location of osseous pathology is questioned. Since almost all pathologies of bone lead to some reactive bone growth, bone scan may be applicable in a wide variety of suspected pathologies. It is most commonly used in the detection of radiographically occult stress fractures, neoplasms, and infection. It is used extensively in the evaluation of skeletal metastasis since the entire skeleton can be imaged at once.[15,51]

Single photon emission computerized tomography (SPECT) is a very useful method for displaying multiple planes of radionuclide activity. SPECT is especially useful to identify small areas of osseous pathology, particularly in the spine.

Radionuclide scans are also available for many organs. These scans may allow some degree of visualization to evaluate the size and location of organs. They are most useful in their ability to indicate the functional quality of the tissue in question.

Diagnostic Ultrasound

Diagnostic ultrasound (US) is an imaging procedure that relies on the reflection or transmission of sound waves by body tissues for producing images. The added capabilities of Doppler ultrasound allows for the quantification of flow rates in given structures, like arteries. Among the most significant advantages of US are availability, low cost, noninvasiveness, and lack of known harmful effects. This procedure is used frequently in abdominal imaging where it is capable of determining organ size, organ masses, and in distinguishing between cystic, solid, and complex masses. It is typically the first imaging procedure chosen for thyroid abnormalities and can provide useful information in breast imaging. Diagnostic ultrasound is also increasing in use for musculoskeletal imaging and it is capable of detecting tears or hypertrophy in some of the commonly injured and more superficial soft tissue structures. Superficial masses may also be initially evaluated by ultrasound.

The large quantity of cartilage relative to bone in the pediatric skeleton, especially the very young, lends itself to evaluation by ultrasound. Diagnostic ultrasound of the adult spine is controversial due to a lack of consensus on normal versus abnormal findings. [51]

Videofluoroscopy

Videofluoroscopy (VF) is a modality that enables clinicians to view dynamic, real-time imaging of anatomy and function. VF is also a diagnostic test that can reliably record dynamic function of joints and their range of motion. [1], [2], [3], [4], [5] The role of VF has been well established in interventional radiology and in the evaluation of neuromusculoskeletal, gastrointestinal, myelographic, and other studies requiring the injection of contrast material.

VF like other advanced imaging modalities is not typically utilized as an initial imaging procedure. It may be used as a follow-up to demonstrate abnormal joint mobility that is suspected clinically but not adequately substantiated by other diagnostic studies. [6], [7], [8] The value of VF, by comparison to static imaging modalities, is its ability to visualize the entire range and character of joint motion. [3], [4], [6], [9], [10], [11] The ability of VF to absolutely define segmental range of motion and the therapeutic significance of direct visualization of spinal dynamic function needs further investigation. [5]

Practitioners utilizing VF must document clinical justification and be cognizant of its contraindications, and limitations. [12], [13], [14], [15], [16] Specialized training is needed to adequately interpret the images acquired. Operators of this equipment must be knowledgeable in the basic concepts of radiobiology and fluoroscopy systems. [4]

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS

Table 4: Comparison of Imaging Procedures

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Muscle or tendon injury of extremities	Minimal use: May identify secondary effects, such as subluxation, gross disruption of Achilles' and quadriceps tendons.	No routine use; may add info regarding associated osseous structures	Ideal imaging in most cases	No routine use	Best imaging choice in some cases, particularly where structure is superficial (rotator cuff, Achilles' tendon, quadriceps tendon, many muscles)	Imaging often not required; most useful in evaluating for suspected instability and the need for surgery
Ligamentous injury of extremities	May identify secondary effects such as subluxation stress studies may be diagnostic	No routine use; may add info regarding associated osseous structures	Ideal imaging in most cases	No routine use	Limited, specific applications	Imaging often not required; most useful in evaluating for instability and need for surgery
Fibrocartilage injury	Offers little or no diagnostic information	Offers little or no diagnostic information	Imaging of choice in most cases	No routine use	No routine use	Arthroscopy may be the most appropriate procedure
Muscle, tendon or ligament injury of spine [15]	May identify secondary effects such as subluxation, especially on stress studies.	No routine use; May add info regarding associated osseous structures	No routine use; gross soft tissue disruptions may be appreciated	No routine use	Limited specific applications	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
IVD pathology (excluding routine degenerative change) [15,46-48]	Limited information; may be used to rule out other diagnoses	Provides some imaging of disc , herniations; addition of myelography provides some information of effect on adjacent neural structures	Best imaging choice, provides anatomical and physiological information and the effect on adjacent neural structures without added contrast	No routine use	No routine use	Incidental bulges and herniations may have no clinical significance. Discogram may be useful to identify symptomatic anular tears.
Stenosis: central canal, lateral recess, intervertebral foramen [59,50]	Limited value in evaluating presence or extent of stenosis; often first imaging choice to evaluate gross osseous changes	Excellent for determining and quantifying osseous and some soft tissue causes of stenosis; addition of myelography allows evaluation of effect on neural structures	Often imaging of choice due to less invasive nature, lower risks. Excellent for determining soft tissue causes of stenosis and for determining effect on neural structures; less useful in evaluating osseous impact	No routine use	No routine use	
Post-surgical spine, new or increased symptoms [15]	Appropriate for initial evaluation; stress views may be useful in evaluating fusion	May be useful in evaluating osseous abnormalities; surgical changes may make interpretation difficult	Appropriate for evaluating effect on neurologic structures; with contrast can identify scar tissue	May be useful in detecting pseudoarthrosis	No routine use	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Fracture, acute, extremity (1)	Initial imaging of choice; often only imaging required	Useful for complex fractures, areas of complex anatomy (elbow, ankle, etc.); appropriate for evaluation of intra-articular extent of fracture	Excellent for identifying bone contusions and subtle fractures may be used following CT to determine effect on neurologic structures	Useful when clinical suspicion of fracture is high and radiographs are negative or inconclusive	No routine use	
Fracture, acute, spine [7,51]	Initial imaging of choice; may require follow-up with CT or MRI	Excellent for evaluating spinal fracture; appropriate when suspicion of spinal fracture is high and radiographs are negative or inconclusive; sagittal and coronal reconstructions may be helpful; useful in areas of complex anatomy (crabiovertebral and pelvis, etc.)	Appropriate for spinal injury with positive neurologic findings; Excellent for evaluating effect on neural structures; offers little fracture detail; can differentiate simple compression fracture from pathologic fracture	May be used when clinical suspicion of fracture is high and radiographs are negative; SPECT imaging may be required	No routine use	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Fracture, stress [49]	Initial imaging of choice; many will be radiographically occult, especially in early stages	May be used to determine extent; not usually required; may be useful for pars interarticularis	Sensitive to early changes; may be difficult to differentiate stress fracture from other pathologies	Appropriate for detection of radiographically occult, clinically suspected stress fracture; may require SPECT imaging, especially in the spine and other areas of complex osseous anatomy	No routine use	
Dislocation	Most appropriate initial imaging	Useful if radiographic findings questionable; may be used for additional detail, especially to detect associated fracture	May be useful in detailing associated soft tissue injuries and/or effect on adjacent neurovascular structures	No routine use	No routine use	
Articular cartilage pathology [52]	Depicts general cartilage loss; may show calcinosis secondary to crystal deposition; not effective for focal defects	No routine use	Diagnostic in most cases; intra-articular contrast (MRI-arthrogram) may improve sensitivity	No routine use	No routine use	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Suspected intra-articular body	Most appropriate initial imaging; may not provide information with uncalcified, unossified cartilagenous bodies	With arthrography, can provide diagnostic information	Can provide diagnostic information; excellent for osteochondritis dessicans [15]	No routine use	No routine use	Arthroscopy preferred if clinical suspicion is high
Congenital malformation [15]	Initial imaging of choice	May provide detail in complex osseous malformation	May provide valuable information regarding associated soft tissue or neural abnormalities	No routine use	No routine use	
Biomechanical aberration	Appropriate for initial imaging; stress views may be required; fluoroscopy may add information	May be useful as follow-up to radiographically identified abnormalities	May be useful; stress studies may be useful	No routine use	No routine use	
Degenerative joint disease [53,54]	Imaging of choice	Rarely provides additional information; some complex or surgical cases may benefit	May be useful in evaluating some complications, such as stenosis	Can identify sites of involvement, but very non-specific	No routine use	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Inflammatory arthritis [55,56]	Imaging of choice	Rarely provides additional information	Can detect some changes earlier than plain film	No routine use	No routine use	
Crystal deposition disease [57,58]	Imaging of choice	More sensitive to calcium deposition, but rarely provides additional information	Can detect articular cartilage involvement	No routine use	No routine use	
Infection [7,15]	Initial imaging of choice; radiographic latent period from several days to several weeks	May be useful as follow-up to radiographically identified abnormalities	Very sensitive; no significant latent period; useful in radiographically occult cases and to determine extent of involvement	Much more sensitive than plain film; non-specific; useful in cases of high clinical suspicion and negative radiographs	No routine use	
Neoplasm, osseous [7]	Initial imaging of choice	May be useful as follow-up to radiographically identified abnormalities or in areas of complex anatomy	Very sensitive; may provide useful histologic information; useful in radiographically occult cases and to determine extent of involvement. Procedure of choice for multiple myeloma	Much more sensitive than plain film; non-specific; useful in cases of high clinical suspicion and negative radiographs, and to determine the extent of skeletal metastasis		Metastasis evaluation requires very specific Metastasis evaluation requires very specific protocols based on a number of patient variables

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Neoplasm, soft tissue [59]	Initial imaging of choice, but frequently non-diagnostic; use soft-tissue technique	Useful in evaluating tumors containing fat, calcium or bone; useful in determining osseous involvement	Most appropriate imaging	No routine use	May be useful in determining some tumor characteristics and effect on adjacent structures	P.E.T. useful for detecting breast, colon and brain neoplasms
Avascular necrosis	Initial imaging of choice; significant radiographic latent period	No routine use	Most appropriate in cases of high clinical suspicion and negative radiographs; demonstrates extent of involvement [15]	Sensitive, but not specific; appropriate in cases of high clinical suspicion and negative radiographs	No routine use	
Metabolic disease	Secondary skeletal changes may be identified and monitored	Not likely to add significant information	Some complications, changes may be identified	May provide information regarding sites of skeletal involvement	No routine use	
Head injury	Not likely to provide significant information	Imaging of choice in suspected skull fracture; provides significant information regarding acute brain trauma	Provides significant information regarding brain trauma; CT may be more appropriate in early stages	No routine use	No routine use	

PATHOLOGY	PLAIN FILM	COMPUTED TOMOGRAPHY	MRI	RADIONUCLIDE STUDY	ULTRASOUND	CLINICAL CONSIDERATIONS
Chronic sinus disease	Appropriate for initial evaluation; not as sensitive or specific as CT	Most appropriate imaging; initial imaging in most cases	May be used as follow-up to CT findings in unusual cases	No routine use	No routine use	
GI disease	Abdomen plain film does not provide adequate information in most scenarios; used as initial evaluation for suspected acute obstruction or perforation; barium studies may be diagnostic	Provides best imaging of many organs; frequently used with addition of barium	Useful for evaluation of some organs; presence of gas and intestinal motility often provides for poor imaging	Scans for specific organs can be useful	Frequently used in evaluation of abdominal disease; especially useful for solid organs and cystic abnormalities	
GU disease	Frequently used as initial study, but usually requires additional imaging; addition of contrast often required	Often provides best imaging; usually includes contrast agent	Frequently useful; may not provide adequate imaging of some areas	No routine use	Frequently used for evaluation of kidney and bladder disease	

IMAGING OF BIOMECHANICAL ABNORMALITIES

Chiropractic radiographic analysis that includes appropriate views, when combined with clinical findings, is intended to provide a better understanding of the patient's condition[60]. High quality radiographic images are essential to rule out pathology and evaluate structural alignment[61]. When radiographs are part of a biomechanical analysis it is paramount to evaluate images for pathologies that may weaken bony architecture, requiring modification of therapy[62,63]. Biomechanical analysis is used to determine misalignment, postural and motion abnormalities, and to guide manipulation.

Many radiographic lines, angles, and measurements have been demonstrated to be reliable indicators of postural and biomechanical abnormalities. [32,37]

Spinal Radiographic Analysis

Most chiropractic methods of radiographic analysis have stressed the importance of assessing the patient in the upright, weight-bearing position. This allows for both full spine and regional postural evaluation. Specific consideration is given to the identification of abnormal spinal curves, that may compromise efficient biomechanical function. Studies that evaluate the reliability, validity and clinical relevance of radiographic line drawing have produced conflicting evidence.[32,37]

Reliability

Reliability is the repeatability of a measurement and indicates consistency and precision when a procedure is done by different examiners and at multiple times.[14] Factors that influence the reliability of spinal radiographic analysis include: anatomic variants, positioning of patient and x-ray equipment. In addition to these and other potential sources of systematic error, random measurement error adversely affects the reliability of measurement methods. While inter-examiner reliability of the actual marking of x-rays has been demonstrated [64-68], the reliability of the entire procedure has not been established. [14] Reliability does not establish the clinical relevance or validity of measurement procedures.

Validity and Clinical Efficacy

Validity refers to how accurately an assessment procedure measures, identifies or predicts the true state of the patient.[69] While construct validity (a measure of the theoretical concept of x-ray line marking) has been evaluated,[68] the predictive validity (the clinical relevance of x-ray line marking, i.e. can it identify current spine problems, predict future occurrences, or measure resolution) has not been established through well-designed clinical trials.[70] Predictive validity is crucial; it is far more relevant than construct validity or reliability tests in establishing the clinical efficacy of assessment procedures

Functional Radiographic Analysis

Functional radiographs are practical tools for the evaluation of spinal segmental motion. Since Hviid[71] in 1963, chiropractors including Sandoz,[72] Anderson,[73] Conley,[74] West,[73] Grice[75] and Henderson [76] have advocated cervical templating techniques to determine hypomobility, hypermobility and instability of spinal motion segments. Functional radiographs may be used to evaluate the segmental range of motion by comparing the neutral position to the end range of movement in either the sagittal or coronal planes. Medical investigators, including Penning[77] and Dvorak,[38] have established normative values for gross segmental flexion and extension without reference to the neutral lateral view. However, clinical information may be lost when the information from the neutral position is not included in the assessment.

The key to accurately evaluating motion on functional spinal radiographs is precise standards of patient positioning.[60] Meticulous attention to the details of positioning cannot be overemphasized if the information obtained from the resultant radiographs is to be considered a reliable assessment of that particular patient's function.[78] Functional radiographic studies have traditionally been performed with active movement by the patient. Dvorak et al[38] emphasized the value of obtaining functional radiographic studies of the cervical spine both actively and passively. While they claim that many more hypermobile segments are discovered on the passive stress studies[38] the application of force at the end of active range of motion risks injury to the patient. These systems of functional radiographic analysis may be of clinical value to the doctor of chiropractic who provides spinal manipulation/adjustments to specific levels of segmental dysfunction.[32] The reliability[38] and clinical validation[79] of cervical flexion extension studies have been demonstrated.

Full Spine Radiography

Depending on history and clinical findings, the need for full spine radiography is based on the clinical judgment of the doctor. The choice of sectional or full spine views is dependent on clinical necessity and the ability to produce diagnostic quality radiographs. AP/PA full spine radiographs are used for evaluation of pathology and biomechanical analysis. Single exposure, lateral full spine radiographs are not recommended.[63]

The use of full spine radiographs is of value when clinical findings indicate the involvement of multiple spinal levels .[63] Taylor[32] has noted the following circumstances in which the PA full spine radiograph may be preferred over sectional radiographs:

- cases in which clinical examination disclosed the need for radiography of several spinal sections;
- cases in which severe postural distortions are evident, scoliosis evaluation after clinical assessment;
- cases in which a mechanical problem in one spinal area adversely affects other regions;
- to specifically evaluate complex biomechanical or postural disorders of the spine and pelvis under weight bearing conditions.[32]

Full spine radiographs can be considered to be of diagnostic quality[80] with less radiation exposure to the patient compared to sectionals of the multiple levels involved This requires appropriate technology and technique with careful attention to exposure factors, film speed, and shielding.[78,81,82] The evaluation of suspected pathology may require sectional or spot views to attain better detail.[63]Analysis of full spine radiographs has been used to identify biomechanical faults, chiropractic subluxations and joint dysfunction.. There is a variety of line marking systems used to evaluate radiographs. The validity and reliability of the full spine analytical systems has been studied with mixed results.[63,83,84,85]

PATIENT SAFETY

Patient safety in diagnostic imaging encompasses a range of activities performed before, during and after the actual imaging exam. The primary goal of these efforts is to provide the most clinically significant information with the lowest possible risk and cost to the patient. [86,87,88] The following key areas should be addressed: patient education and informed consent (PARQ), patient comfort, selection criteria, radiation safety, image quality control, facilities maintenance and record keeping.

Patient Education and Informed Consent (PARQ)

The chiropractic physician should explain the diagnostic imaging procedures and follow up, the time and cost involved, risks and contraindications, and patient preparatory procedures. This should be done regardless of whether the treating physician will perform the imaging or order it from another facility. (See patient/doctor relationship chapter)

Patient Comfort

A clean, safe, comfortable environment should be provided for waiting, changing garments, securing personal items, and performing the imaging procedure. The privacy of the patient should be guarded during preparation for and execution of the exam, as well as with the storage of radiographs and reports.

Radiation Safety

The most important aspect of patient safety is to minimize the radiation dose to the patient. There is no known safe dose of ionizing radiation. Even the smallest dose can produce genetic damage. Diagnostic imaging doses do not typically produce clinical manifestations. The benefit to the patient must outweigh the risk.[88-92]As Low As Reasonably Achievable (ALARA): Efforts should be made in all areas of the imaging procedure to provide the lowest possible dose to the patient without compromising image quality. [90]

Patient Selection Criteria

The planned diagnostic imaging procedures must supply significant clinical information that cannot be otherwise determined. If the diagnosis, treatment or prognosis will not likely change based on imaging findings, the imaging is not appropriate. Every exposure, including post-treatment exposures and scanograms, must have clinical justification with adequate documentation consistent with the patient's case history. [93]

Chiropractic physicians are responsible for ordering necessary and appropriate imaging studies. More than one study may be indicated to fully evaluate a patient. Pre-existing x-ray studies should be accessed if possible. These may be repeated if timely access is not feasible, they are of poor quality or are not clinically relevant. Consultation with a radiologist may be helpful in determining which studies are most appropriate for a case.

Image Quality Control

Assurance of image quality and low patient dose is dependent on many equipment and procedure factors. Attention is required in the setup and maintenance of equipment as well as during the imaging procedures. [86,87,89,94]

The following factors are listed as a guide for evaluating and monitoring plain film quality as it relates to patient safety. These should be considered to assure the highest possible film quality and lowest possible patient dose.

Equipment

- Tables and film holders: stable, level, and plumb
- Control arm / tube holder: stable, locking mechanism for maintaining appropriate angle, markings for consistent and reproducible source image distance (SID)
- Collimation: accurate, centered, apparent on three sides
- X-ray tube and exposure controls: calibrated, current exposure charts
- Film/screen combinations: as fast as possible while maintaining adequate detail, screens clean and without defects, cassettes marked and without defects
- Markers: adequate to identify patient, anatomy, special procedures, proper placement
- Filters and shields: devices for reducing dose to sensitive tissues such as eye, thyroid gland, breast, and gonads should be available for frequently performed studies
- Processor: chemicals should be changed at prescribed intervals, processing temperature and speed consistently monitored

- Darkroom: film storage and handling should be safe from fogging factors

Technique

- Technique charts: current and appropriate to the equipment; charts used consistently, factors recorded
- Positioning: standard and consistent positioning; options in positioning that may reduce dose employed (PA for full-spine; anode-heel effect).[95,96] minimum diagnostic series to assure complete evaluation
- Patient prep: gown as appropriate, remove jewelry, dentures, other artifacts as appropriate
- Repeat films rates: monitored to identify problems

Facilities Maintenance

Equipment such as a floating tabletop, movable wall bucky, and the locking tube arm mechanism should be stable. Storage of chemicals should not pose a hazard to patients.

Facilities should allow for adequate performance of chosen procedures. Room size should accommodate the longer source-image distance (SID) required of projections such as the lateral cervical spine and PA and lateral chest. A horizontal surface should be available to accommodate certain extremity studies, lumbar imaging on larger patients, and patients with difficulty remaining immobile.[2] Referral may be necessary when facilities will not accommodate for special patient needs. Appropriate shielding should be utilized. Extremity and chest radiographs require specific film/screen combinations. Additional materials such as supports, weights and compression bands should be available. The patient should be referred to an appropriate facility if available equipment is not adequate to perform a chosen study.

Test and evaluation procedures are recommended at given intervals. [93,96] (See Appendix A.)

Record Keeping

Following production and processing of radiographs, films should be checked for proper identification. (See Appendix B.) A written report should be generated that includes identifying information, the study performed, pertinent findings and a clinical impression. Optimally one copy of this should be kept with the films in addition to a copy that should be placed in the patient's file. Films should be stored in an area that provides for patient privacy and has physically appropriate conditions to protect film quality.[86]

References

1. Haldeman S, Chapman-Smith, Peterson D. Guidelines for Chiropractic Quality Assurance and Practice Parameters: Proceedings of the Mercy Center Consensus Conference. Gaithersburg MD: Aspen; 1993: 13.

2. Oregon Chiropractic Practices and Utilization Guidelines Vol. 1 Common neuromusculoskeletal conditions. OBCE 1991.

3. Oregon Administrative Rules Chapter 811-030-0030-2-C-k.

4. Taylor JAM, Resnick D: Imaging decisions in the management of low back pain. In: Advances in Chiropractic. Mosby; 1994;1: 1-28.

5. Mootz RD, Hoffman LE, Hansen DT. Optimizing clinical use of radiography and minimizing radiation exposure in chiropractic practice. Topics in Clinical Chiropractic 1997; 4(1): 34-44.

6. Simmons ED, Guyer RD, Graham-Smith A, Herzog R. Contemporary concepts in spine care radiographic assessment for patients with low back pain. Spine 1995; 20(16): 1839-1841.

7. Staiger TO, Paauw DS, Deyo RA, Jarvik JG. Imaging studies for acute low back pain when and when not to order. Postgraduate Medicine 1999; 105(4): 161-172.

8. Curry TS, Dowdey JE, Murry RC. Christensen's Physics of Diagnostic Imaging. 4th ed. Lea & Febiger; 1990.

9. Guebert GM, Pirtle OL, Yochum TR. Essentials of Diagnostic Imaging. Mosby; 1995.

10. Oregon Administrative Rules. 1995; OAR 333-106-010 through 130.

11. Roland M, van Tulder M. Should radiologists change the way they report plain radiography of the spine? The Lancet July 18, 1998; 352: 229-230.

12. Scavone, JG, Latshaw RF, Rohrer GV. Use of Lumbar Spine Films. JAMA 1981; 246(10): 1105-8.

13. Miller JS, Craw MM. Diagnostic imaging of the cervical spine following whiplash-induced injury. Topics in Clinical Chiropractic. 1997; 4(1): 26-33.

14. Haas M, Taylor AM, Gillette RG. The routine use of radiographic displacement analysis: A dissent. JMPT. May 1999; 22(4): 258.

15. McLean ID. Choices in diagnostic imaging: A quick reference. Topics in Diagnostic Radiology and Advanced Imaging. Fall 1999; 8-9.

16. Kewalramani LS, Orth MS, Krauss JF. Cervical spine injuries resulting from collision sports. Paraplegia. 1981; 19: 303-312.

17. Rowe L. Imaging of mechanical and degenerative syndromes of the lumbar spine. Clinical Anatomy Management of Low Back Pain; P.276.

18. Mann, DC. Spine fractures in children and adolescents. Spine. 1990; 4(1): 25.

19. Deyo RA, Diehl AK. Lumbar spine films in primary care: current use and effects of selective ordering criteria. Journal General Internal Medicine. 1:20-25, 1986.

20. El-Sayyad MM. Comparison of roentgenography and Moire topography for qualifying spinal curvature. Physical Therapy. 1985; 66(7): 1078-1082.

21. Aaron A, Weinstein D, Thickman D, Eilert R. Comparison of orthoroentgenography and computed tomography in the measurement of limb-length discrepancy. The Journal of Bone and Joint Surgery, 1986; 74A(6): 897-901.

22. Kirkaldy-Willis WH, Farfan HF. Instability of the lumbar spine. Clinical Orthopaedics and Related Research. 1981; 165: 110-123.

23. Fisk JD. Imaging of the VSC. The Chiropractic Journal. 1995.

24. Wood J, Wagner NO. A review of methods for radiographic analysis of cervical sagittal motion. Chiropractic Technique. 1992; 4(3): 83-86.

25. Schultz GD, Bassano JM. Is radiography appropriate for detecting subluxations? Top Clinical Chiropractic. 1997; 4(1): 1-8.

26. Shaw A, Vigano-Omini M, Houlgrave R, Garent T. Critical analysis of four articles on the clinical usefulness of flexion-extension radiographs of the cervical spine. WSCC Roentgenometrics Class. 1999.

27. Pueschel SM, Scola FH. Atlanoaxial instability in individuals with down syndrome: Epidemiologic, radiographic and clinical studies. Pediatrics. 1987; 80(4): 555-559.

28. Cullen JC. Spinal lesions in battered babies. Journal of Bone and Joint Surgery. 1975; 57-B(3): 454-456.

29. Perillo M, Hannan M, Lemberg D. Advanced diagnostic imaging of adults with neck or low back pain: A seed algorithm. Top Clinical Chiropractic. 1997; 4(1): 9-14.

30. Calliet, R. Scoliosis diagnosis and management. FA Davis. 1975; p. 53-4. Back Letter. 15((9): 97, 100, 2000.

31. Sandman TD, Sandman KB. Rheumatoid arthritis of the cervical spine: Examination prior to chiropractic manipulative therapy. Journal of Manipulative and Physiological Therapeutics. March 1981; 4(1): 19-20.

32. Taylor, JAM. The role of radiography in evaluating subluxation. In: Gatterman, MI, Foundations for Chiropractic: Subluxation. St. Louis: Mosby; 1995. p. 68-86.

33. Sherman, R. Chiropractic x-ray rationale. Journal of the CCA. 1986, 30(1): 33-35.

34. Thomas M. Chiropractic research and the IRB. J Chirop 1987; 6:60-63.

35. Woll PJ, Rankin EM. Persistent back pain due to malignant lymphadenopathy. Ann Rheum Dis 1987; 46:681-683.

36. Peterson C, Gatterman MI, Wei T. Chiropractic radiography. In. Gatterman MI, Chiropractic Management of Spine Related Disorders. Baltimore: Williams & Wilkins; 1990. p. 90-110.

37. Yochum TR, Rowe LJ. Essentials of Skeletal Radiology. 2nd ed. Baltimore: Williams & Wilkins; 1996.

38. Dvorak J, Froehlich D, Penning L, Baumgartner H, Panjabi MM. Functional radiographic diagnosis of the cervical spine: flexion/extension. Spine 1988; 13:748-755.

39. American College of Radiology Standards, Diagnostic Radiology. ACR standard for the performance of radiography of the cervical spine in children and adults. 1999.

40. American College of Radiology Standards, Diagnostic Radiology. ACR standard for the performance of radiography of the thoracic spine. 2000.

41. American College of Radiology Standards, Diagnostic Radiology. ACR standard for the performance of radiography of the lumbosacral spine. 2000.

42. American College of Radiology Standards, Diagnostic Radiology. ACR standard for the performance of pediatric and adult chest radiography. 1997.

43. Resnick D. Diagnosis of bone and joint disorders. 3rd ed. Philadelphia: W.B. Saunders Company; 1995. p. 2562-63.

44. Bossart PJ, Joyce SM, Manste BJ, Packer SM. Lack of efficacy of 'weighted' radiographs in diagnosing acute acromioclavicular separation. Annals of Emergency Medicine 17(1):20-24, 1988

45. 45.Yap JJL, Curl LA, Kvitne RS, McFarland EG. The value of weighted views of the acromioclavicular joint. Results of a survey. American Journal of Sports Medicine 27(6):806-809, 1999.

46. Albeck MJ, Hilden J, Kjaer L, Holtas S, Praestholm J, Henriksen O, Gjerris F. A controlled comparison of myelography, computed tomography, and magnetic resonance imaging in clinically suspected lumbar disc herniation. Spine 1995;20(4):443-48.

47. Herzog RJ. The radiologic assessment for a lumbar disc herniation. Spine 1996;21(24S):19S-38S.

48. Van de Kelft E, van Vyve M. Diagnostic imaging algorythm for cervical soft disc herniation. Acta chir belg 1995; 95:152-156.

49. Kaiser JA, Holland BA. Using imaging studies in the diagnosis of low back pain. Journal of Musculoskeletal Medicine 1995; July:20-35.

50. Postacchini F. Surgical management of lumbar spinal stenosis. Spine 1999; 24(10):1043-51.

51. Taylor JAM, Resnick D. Imaging decisions in the management of low back pain. Mosby-Year Book, Inc.; Advances in Chiropractic 1994; Vol. 1:1-28.

52. Bohndorf K. Imaging of acute injuries of the articular surfaces (chondral, osteochondral and subchondral fractures). Skeletal Radiology 1999; 28:545-560.

53. Fumiere E, Sintzoff S, Baleriaux D, Matos C. Facet joints disease. 1997; 80:192-195.

54. Preidler KW, Brossmann J, Resnick D. Osteoarthritis. Seminars in Roentgenology 1996; 31(3):208-219.

55. Keat A. Spondyloarthropathies. British Medical Journal 1995; 310 (May):1321-1324.

56. Rubin DA. The radiology of early arthritis. Seminars in Roentgenology 1996; 31(3):185-197.

57. Calcium pyrophosphate dihydrate crystal deposition disease: imaging perspectives. Current Problems in Diagnostic Radiology 2000; November/December:210-229.

58. Rui DS, Martel W. Radiologic manifestations of the crystal-related arthropathies. Seminars in Roentgenology 1996; 31(3):229-238.

59. Randall RL, Mann JA, Johnston JO. Orthopedic soft-tissue tumors: Concepts for the primary care physician. Primary Care 1996; 23(2):241-261.

60. Howe JW: Facts and fallacies, myths and misconceptions in spinography. J Clin Chiro Archives, ed. 2. Winter, 34-35, 1972.

61. Peterson CK. The Nonmanipulable Subluxation. In: Gatterman MI, ed. Foundations of Chiropractic Subluxation. St. Louis: Mosby; 1995.

62. Gatterman MI, Standards of practice relative to complications of and contraindications to spinal manipulative therapy. J Can Chir Assoc 1991: 35:232-6.

63. Taylor JAM. Full-spine radiography: a review. J Manipulative Physiol Ther 1993; 16:460-74.

64. Plaugher G, Cremata EE, Phillips RB. A Retrospective Consecutive Case Analysis of Pretreatment and Comparative Static Radiological Parameters following Chiropractic Adjustments. JMPT 1990; 13:498-506.

65. Owen EF. Line Drawing Analyses of Static Cervical X-ray used in Chiropractic. JMPT 1992; 15:442-9.

66. Plaugher G, Hendricks AH, Doble RW, et al. The Reliability of Patient Positioning for Evaluating Static Radiologic Parameters of the Human Pelvis. JMPT 1993; 16:517-22.

67. Harrison DE, Harrison DD, Cailliett R, et al. Cobb Method or Harrison Posterior Tangent Method: Which is Better for Lateral Cervical Analysis? Spine 2000; 25:2072-8.

68. Harrison DE, Holland B, Harrison DD, et al. Further Reliability Analysis of the Harrison Radiographic Line-Drawing Methods: Crossed ICCs for Lateral Posterior Tangents and

Modified Risser-Ferguson Method on AP Views. JMPT 2002; 25:93-8.

69. Hulley SB, Cummings SR, Browner WS, et al. Designing Clinical Research: An Epidemiologic Approach. 2nd ed. 2001 Philadelphia: Lippincott Williams & Wilkins. p. 43.

70. Gore DR. Roentgenographic Findings in the Cervical Spine in Asymptomatic Persons: A Ten-Year Follow-up. Spine 2001; 26:2463-6 and Spine 2002; 27:1249-50.

71. Hviid H. Functional radiography of the cervical spine. Ann Swiss Chiro Assoc 3:37-65, 1963

72. Sandoz R. Newer trends in the pathogenesis of spinal disorders. Ann Swiss Chiro Assoc. 5:112, 1971.

73. Swartz JB. Cervical templating. Digest of Chiro Economics March/April 1984.

74. Conley RW. Stress evaluation of cervical mechanics. J Clin Chiro 3:46-62, 1974

75. Grice AS. Preliminary evaluation of fifty sagittal motion radiographic examinations J CCA 21(1):33, 1977.

76. Henderson DJ Dorman TM. Functional roentgenometric evaluation of the cervical spine in the sagittal plane. J Manipulative Physiol Ther 8:219-27 1985.

77. Penning L. Normative movements of the cervical spine. AJR 130:317-26 1978.

78. Peterson C. Chiropractic Radiography. In. Gatterman MI: Chiropractic Management of Spine Related Disorders, Williams & Wilkins, Baltimore 1990.

79. Dvorak J, Panjabi MM, Grob D, Novotny JE, Antinnes JA. Clinical validation of functional flexion/extension radiographs of the cervical spine. Spine 1993; 18:120-7.

80. Phillips RB. An evaluation of chiropractic x-rays by the diplomate members of the American Chiropractic Board of Roentenology. ACA J Chiro 1980: 14:S80-S88

81. Hardman LA, Henderson DJ. Comparative dosimetric evaluation of current techniques in chiropractic full-spine and sectional radiography. Manipulative Physiol Ther 1981; 25:141-145

82. Hildebrant RW. Chiropractic spinography. 2nd ed. Baltimore; Williams & Wilkins, 1985.

83. Plaugher G, Hendricks AH. The inter- and intraexaminer reliability of the Gonstead pelvic marking system. J Manipulative Physiol Ther 1991; 14:503-508.

84. Plaugher G, Hendricks AH, Doble RW, Araghi HJ, Bachman TR, Hoffart VM. The effects of patient positioning on radiographically evaluated static configurations of the pelvis. Proceedings of the 1991 Conference on Spinal Manipulation, VA 1991.

85. Harrison DD, Harrison DE, Troyanovich SJ, Hansen DJ. The anterior-posterior full-spine view : the worst radiographic view for determination of mechanics of the spine.

86. Guebert GM, Pirtle OC, Yochum TR: Essentials of Diagnostic Imaging, Mosby, St. Louis 1995.

87. Cullinan AM, Cullinan JE: Producing Quality Radiographs, J.B. Lippincott Company, Philadelphia 1994.

88. Williams JR, Catling MK: An investigation of x-ray equipment factors influencing patient dose in radiography. The British Journal of Radiology 71(1998), 1192-1198.

89. Quality Assurance for Diagnostic Imaging, NCRP Report #99; National Council on Radiation Protection and Measurements, Bethesda, MD; 1990.

90. Johnston DA, Brennan PC: Reference dose levels for patients undergoing common diagnostic x-ray examinations in Irish hospitals. British Journal of Radiology 73(2000): 396-402.

91. Rommens C, Rinegeard C, Hubert P: Exposure of red bone marrow to ionising radiation from natural and medical sources in France. J Radiol. Prot 21 (2001) 209-219.

92. Clarke RH: Conflicting scientific views on the health risks of low-level ionising radiation. J Radiol Prot 18 (September 1998) 159-160.

93. Oregon Administrative Rule 811-030-0030(2)(d) X-ray Departments, Equipment and Procedures.

94. Guidelines for Establishing Radiographic Quality Assurance and Quality Control Programs, State of California, Department of Health Services, Radiologic Health Branch; Sacramento, CA; 1st revision 1994.

95. Fung KKL, Gilboy WB: "Anode heel effect" on patient dose in lumbar spine radiography. British Journal of Radiology 73(2000): 531-536.

96. Nicholson RA, Thornton A, Sukumar VP: Awareness by radiology staff of the difference in radiation risk from two opposing lateral lumbar spine examinations. (correspondence), The British Journal of Radiology, 72(1999),221.

97. Continuous Quality Assurance and Quality Control Program Radiology Department, Western States Chiropractic College, Portland, OR,(in development)

98. Oregon Administrative Rule 811-030-0030(2)(f) X-ray Departments, Equipment and Procedures

Videofluoroscopy Bibliography

1. Reistman CA, et al., Changes in segmental intervertebral motion adjacent to cervical arthrodesis: A prospective study. Spine, 2004. 29(11): p. E221-E226.
2. Lee S, et al., Development and validation of a new technique for assessing lumbar spine motion. Spine, 2002. 27(8): p. E215-E220.
3. Takayanagia K, et al., Using cineradiography for continuous dynamic-motion analysis of the lumbar spine. Spine, 2001. 26(17): p. 1858-65.
4. Humphreys K, Breen A, and S. D, Incremental lumbar spine motion in the coronal plane: An observer variation study using digital videofluoroscopy. Euro J Chiropractic, 1990. 238: p. 56-62.
5. Croft AC, et al., Videofluoroscopy in cervical spine trauma: an interpreter reliability study. J Manipulative Physiol Ther, 1994. 17(1): p. 20-24.
6. Hino, H., et al., Dynamic motion analysis of normal and unstable cervical spines using cineradiography. An in vivo study. Spine, 1999. 24(2): p. 163-8.
7. Jones MD, Cineradiographic studies of abnormalities of the higher cervical spine. Arch Surg, 1967(94): p. 206-13.
8. Woesner ME and M. MG, The evaluation of cervical spine motion below C2: A comparison of cineroentgenographic methods. Amer J Roentg, Rad Ther, and Nuclear Med, 1972. 115(1): p. 148-154.
9. Yoshimoto H, et al., Kinematic evaluation of atlantoaxial joint instability: An in vivo cineradiographic investigation. Spine, 2001. 14(1): p. 21-31.
10. van Mameren, H., et al., Cervical spine motion in the sagittal plane. II. Position of segmental averaged instantaneous centers of rotation--a cineradiographic study. Spine, 1992. 17(5): p. 467-74.
11. Dvorak J, et al., In vivo flexion/extension of the normal cervical spine. J Orthopaedic Research, 1991. 9(6): p. 828-34.
12. Bell GD, Skeletal applications of videofluoroscopy. J Manipulative Physiol Ther, 1990. 13(7): p. 396-405.
13. OBCE, OAR Clinical Justification, in 811-015-0010. 2005.
14. OBCE, OAR Scope of Radiography in the Chiropractic Practice, in 811-030-0020. 2005.
15. OBCE, OAR X-ray Departments, Equipment and Procedures, in 811-030-0030. 2005.
16. Protocol for the use of Spinal Videofluoroscopy, American Chiropractic Association, American Chiropractic College of Radiology and Council on Diagnostic Imaging, 2003

APPENDIX A

Imaging Test/Evaluation Procedures[97]

The following test/evaluation procedures are recommended at the given intervals:

Daily (before use)

- Warm up processor (prescribed time)
- Check developer temperature
- Fill rinse tank
- Clean cross-over rollers
- Run and check "clean-up" film
- Warm up x-ray tube
- Visually inspect darkroom

Daily (end of use)

- Turn off processor
- Offset processor cover
- Drain rinse tank

Monthly

- Inspect film and chemical storage areas
- Inspect darkroom
- Check accuracy of built-in processor thermometer

Quarterly

- Evaluate retake rate, reasons
- Clean intensifying screens
- Inspect screens and cassettes

Semi-annually

- Test darkroom for light leaks
- Evaluate film fog from safelight
- Check film fixer retention
- Check collimator light field to radiation field
- Evaluate intensifying screen/film contact

- Sensitometry-densitometry

Annually (Most performed by service engineer)

- Check/calibrate kVp accuracy
- Check mAs reproducibility
- Check radiation dose reproducibility
- Evaluate filtration
- Check SID accuracy
- Check x-ray beam perpendicularity, bucky centering
- Evaluate focal spot size
- Check grid uniformity and alignment
- Check phototimer reproducibility
- Check exposure timer accuracy

Modified from: Guidelines for Establishing Radiographic Quality Assurance and Quality Control Programs," State of California; Continuous Quality Assurance and Quality Control Program.

APPENDIX B

Legal Requirements for taking X-rays in the State of Oregon[98]

The following changes were made to Chapter 811 administrative rules in November 2004 by the Oregon Board of Chiropractic Examiners. (New language is underlined, deleted language is struck through.)

Supervision

811-030-0011 Staff employees of a Doctor of Chiropractic may be directed to take X-rays of a patient if they are in possession of a permit issued by the State Board of Radiologic Technology, but this permit is limited only to the taking of X-rays. (ORS 684.155)

Scope of Radiography in the Chiropractic Practice

811-030-0020 (1) The radiographic diagnostic aspect of Chiropractic practice shall include all standard radiographic procedures that do not conflict with ORS 684.025.

(2) All radiographs shall be of diagnostic quality. Radiographic films are subject to review by the Board to determine quality. Poor quality radiographs may result in disciplinary action.

(3) X-ray is not to be used for therapeutic purposes.

(4) Fluoroscopy shall not be used as a substitute for an initial radiographic study and shall be used only with documented clinical justification. In order for anyone to operate a fluoroscopy unit they must be properly trained and they must have written documentation that shows that these requirements are met. (OAR 333-106-045)

(5) Use of radio-opaque substances for diagnostic X-ray, other than by mouth or rectum, is not permitted.

(6) Pregnant females shall not be radiographed unless the patient's symptoms are of such significance that the proper treatment of the patient might be jeopardized without the use of such radiographs.

(7) All critical parts, i.e. fetus, eyes, thyroid gland, breasts and gonads, beyond the area of primary examination shall be shielded. (684.155)

X-ray Departments, Equipment and Procedures

811-030-0030 (1) All X-ray departments, equipment and **procedures including fluoroscopy** shall be in compliance with the current rules and regulations of the Oregon State Health Division Radiation Control Section, including but not limited to, the physical design of the department, occupational exposure, collimation, shielding and exposure charts ~~and fluoroscopy~~.

(2) In addition:

(a) The patient shall be an adequate candidate for the radiographic or fluoroscopic procedure employed;

(b) The radiographic field shall be restricted to the area of clinical interest;

(c) Specialized views shall be used any time the area of clinical interest is not clearly visualized on a standard film;

(d) Every exposure, including post-treatment exposures, and scanograms, shall have clinical justification with adequate documentation consistent with the patient's case history;

(e) The operator shall maintain a record on each exposure of each patient containing the

patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors. **For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-045 requires the facility to determine the typical patient exposure for their most common radiographic examinations, i.e. technique chart.**

(f) Each film shall be properly identified by date of exposure, location of X-ray department, patient's name and number, patient's age, right or left marker and postural position marker; and **indication of the position of the patient**;

(g) The patient with tremors must be immobilized;

(h) The radiographs of a patient with an antalgic posture may be taken in an upright position only if the patient is adequately supported and immobilized to insure diagnostic quality. Otherwise, the recumbent position shall be used;

(i) Upright or postural views shall not be used for any patient whose size exceeds the capacity of the X-ray equipment. Penetration must be adequate on all films;

(j) ~~Full Spine (14 x 36 inch) radiographs~~: **~~(A)~~** Sectional views shall be taken in preference to a single 14 x 36 inch film if the patient's size or height prevents diagnostic qualify on a single 14 x 36 inch film;

~~(B)~~ **(k)** If two exposures are made on a single film, the area of exposure shall be critically collimated to avoid double exposure of the overlapping area;

~~(C)~~ **(l)** All views shall employ graduated filtration or adequate devices to attenuate the primary beam for the purpose of reducing unnecessary radiation and to improve film quality. Split screens, gradient or graded screens, paper light barriers inside the cassette, or any other attenuating device in the beam between the patient and the film shall not be permitted, other than the grid controlling scattered radiation.

~~(k)~~ **(m)** A record of radiographic findings on every set of radiographs reviewed shall be included in the patient's permanent file;

~~(l)~~ **(n)** Radiographs shall be kept and available for review for a minimum of seven years or until a minor becomes 18 years of age, whichever is longer. (ORS 441.059, 684.025, 684.150)

STANDARDS

In addition to the legal requirements for taking x-rays in the State of Oregon, the following standards shall apply:

1. The chiropractic physician must make imaging decisions based on a demonstrated need (clinical necessity) and what is best for the patient.

2. Efforts should be made in all areas of the imaging procedure to provide the least possible dose to the patient without compromising image quality. [90]

3. Standard views for a minimum series of diagnostic radiographs are needed to evaluate each region of interest. As a general rule two views 90° to each other should be obtained. Some areas require additional views as an essential part of the minimal diagnostic series.

4. When radiographs are part of a biomechanical analysis it is paramount to evaluate images for pathologies that may weaken bony architecture, requiring modification of therapy

5. The choice of sectional or full spine views is dependant on clinical necessity and the ability to produce diagnostic quality radiographs.

6. Chiropractic Physicians are responsible for ordering necessary and appropriate imaging studies. Relevant pre-existing x-ray studies should be accessed, if possible.

EMEBC – Chapter 3

RECORD KEEPING

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Section 1

INTRODUCTION

The importance of keeping complete and accurate records cannot be overemphasized. Documentation of patient care is often as important as the rendition of care itself" [1] Proper record keeping is the documentation of the patient-doctor interaction. This record should be constructed so that it may be understood by others necessary to support a patient's health and reimbursement needs.

As a critical component of our health care delivery system, the accumulation of essential information, known as a patient record, serves many purposes, including:

- It provides a historical accounting of the patient's health concerns and treatments. While the actual record belongs to the provider, the information contained within the record belongs to the patient.[1] [3]

- Record keeping should facilitate and maintain communication between health care professionals. "…clinicians must ensure that their documentation of a patient's health status is understood by others on the health care team." [4] Each health care provider having access to that record has the same duty to record patient information and ensure that it is safeguarded.[1, 2, 4, 5]

- Quality record keeping allows a physician or reader to follow the conditions presented by the patient through the evolution of a diagnosis and treatment plan and the patient's response to the treatment.[5] The quality of the patient record may be considered a reflection of the quality of patient care. [1, 5]

- In the context of medico-legal concerns the record serves as the legal instrument to provide *"substantive evidence on whether care rendered met the legal standard of care."*[1] "… the courts side with whatever the patient has said ... 'If it's not in the chart, from a legal standpoint, either the procedure didn't happen or the comment wasn't made'."[6]

- The patient record documents the services provided allowing the physician to be properly reimbursed.[1, 2, 4, 5] "It is often the quality of the documentation, rather than the condition of the patient, that determines the amount of care deemed medically necessary by the insurance company or auditors." [7]

- The record should include documentation of informed consent. Any limitations as requested by the patient should also be noted.[1]

- Patient records have also been used to evaluate physicians for the purposes of teaching, research, and to provide data for public health needs.[4, 5]

- The information in the record constitutes the foundation for writing accurate reports to health care providers, 3rd-party-payors, attorneys or any other interested parties. [1, 4]

As many health care systems grow, mature, and interrelate on an ever-increasing basis, the health care record becomes more and more important. "Ultimately, good record keeping is a necessity. It is important to everyone: patient, doctor and staff."[2] Each physician has an ethical, as well as legal, duty [1] to construct these records in such a manner as to be accurate, legible, complete and organized. [1, 3, 4, 6] Finding ways and methods that allow for the most complete compilation of this essential data in a simple and easy manner is a frequent challenge.

There are numerous forms and methods of record keeping available, including standard formats and other organizational systems used throughout healthcare fields.[1] Each doctor may standardize files in the way best suited to each particular practice. SOAP format is recommended.[7] "Good decisions are often the result of accurate and complete facts being retrievable from a patient record." [7, 8]

Section 2

RECORD KEEPING

"Each patient shall have exclusive records which shall be sufficiently detailed and legible as to allow any other chiropractic physician to understand the nature of that patient's case and to be able to follow up with the care of that patient if necessary."

"It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations." Oregon Administrative Rule 811-015-0005(1)

INTERNAL DOCUMENTATION

Patient record

Information contained in the patient file is the foundation of the patient's permanent record. Each page in the patient file shall contain the patient's name and/or ID number [1] The following additional information shall also be included in the patient file/s:

- Patient identification/pertinent demographic information [4, 9-11]
- Patient/case history [4, 9-11]
- Examination findings [4, 9, 10]
- Imaging, laboratory and special study findings [4, 9-11]
- Diagnoses [4, 9-11]
- Treatment plan[4, 9, 10]
- Chart notes [4, 9-11]
- Insurance and billing information [4, 9, 10]
- Consent documentation [4, 9, 10]
- Reports and other correspondence[4, 9, 10]
- Referring physicians [4, 9, 10, 12]

Often, the patient record is stored in a folder. The folder itself may also become part of the record if the practitioner writes patient data on the folder, such as personal information, treatment plan, diagnoses, etc.;[4] however, care should be taken to comply with patient privacy laws (e.g. HIPAA). Outdated portions of the patient record may be removed and stored in an archive file. If this is done, a note should be kept in the active file identifying the location of those records. [4, 9, 10]

Doctor/clinic identification

Basic information identifying the practitioner and/or clinic should appear on each page of documentation. [4, 9, 10] This information should include:

- Practitioner's name and professional degree [4, 10]
- Facility name (if different) [4, 10]
- Street address and mailing address (if different) [4, 10]

- Telephone numbers [4, 10]

Patient identification
The record shall clearly identify each patient. [1, 5, 6] This information is often obtained by using preprinted forms that are completed by the patient and ***may*** include the following:

- Name (prior/other names) [4, 10]
- Date of birth, age [4, 10]
- Gender [4, 10]
- Occupation/employer [4, 10]
- Marital status/spouse's name, occupation [4, 10]
- Name(s) of dependents [4, 10]
- Race [4, 10]
- Address, telephone numbers (home and work) [4, 10]
- Social security number [4, 10]
- Case/file number (when applicable) [4, 10]
- Name of consenting parent or guardian (when applicable) [4, 10]
- Letter of guardianship (when applicable) [4, 10]
- Radiograph/lab identification [4, 10]
- Emergency contact name/number [4, 10]
- Photographs

Patient case history
A detailed case history is an important part of the patient record as it is the foundation of the clinical database for that patient. [4, 10] This information should include an adequate description of the patient's perception of their history. [4, 10] History questionnaires, drawings and other information completed by the patient should be included in the patient record. [4, 10]

Elements of the patient history may include the following:

- Presenting or chief complaint [4, 9, 10]
- Date or time of onset of symptoms [4, 9, 10]
- Description of accident or injury (if applicable) [4, 9]
- Past and present health history [4, 9, 10]
- Family and social history [4, 9, 10]
- Systems review (as appropriate) [4, 9, 10]
- Past and present therapeutic and diagnostic procedures [4, 9, 10]
- Signature of person eliciting history [4, 10]

Examination findings
The results of all examination procedures performed, ordered or requisitioned must be recorded and will become part of the permanent patient record. [4, 9, 10] Objective information is obtained by a physical examination/assessment of the area of complaint and related areas and/or systems. Preprinted and formatted examination forms may be used to facilitate the gathering and recording of this information.[4, 10]

Documentation should include the date of the examination and the name or initials of the examining practitioner. [4, 10] If abbreviations are used, a legend should be available. [4, 10]

The examination and diagnostic procedures may include the following:

A. Physical examination

- Vital signs [4, 8, 10]
- Heart, lung and abdomen [8]
- EENT [8]
- Integumentary examination [8]
- Chiropractic, orthopedic and neurological tests [4, 8, 10]
- Static and motion palpation of spine and extremities [8]
- Postural analysis [8]
- Muscle testing including dynamic, isokinetic, static and manual [8]
- Functional examination [13]
- Other

B. Diagnostic Imaging

- Plain film radiography [4, 8, 10]
- MRI [4, 10]
- CT [4, 10]
- Diagnostic ultrasound [4, 10]
- Radionuclide bone scan [8]
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

> Regarding radiographic examinations, "The operator shall maintain a record on each exposure of each patient containing the patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors" [14]

For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-0045 requires the facility to determine the typical patient exposure for their most common radiographic examinations (i.e. technique chart).

"Each film shall be properly identified by date of exposure, location of X-ray department, patient's name or number, patient's age, right or left marker and postural position marker." [14]

C. Laboratory

Results of laboratory exams ordered or performed by the physician may include:

- Complete blood count[4]
- Erythrocyte Sedimentation Rate[4]
- Urinalysis[4]
- Chemistry Screen [4]
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

D. Special Examinations

Results of special exams ordered or performed by the physician may include:

- Gynecological examination [8]
- Proctological examination [8]
- Obstetrical examination [8]
- Minor surgical examination [8]
- Electrodiagnostic evaluation [8]
- Vascular evaluation [8]
- Psycho-social assessment
- Testicular
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

Clinical impression or diagnosis

Upon the completion and assessment of the patient's history, subjective complaints, and examination findings, the physician arrives at a clinical impression or diagnosis. The clinical impression or diagnosis must be recorded within the record. [4, 10, 15] Since they may change with new clinical information, time and treatment, it is important that the clinical impression or diagnosis be dated.[4, 10] It is not necessary to update this category at each visit, but periodic re-examinations should be performed and the results included in the record along with any change in the clinical impression or diagnosis. [8]

Accurate recording of the patient's condition frequently requires more than one diagnosis. Of particular concern to the chiropractic practitioner is identification of the biomechanical lesion (subluxation/segmental dysfunction). Recording this information documents the spinal region involved and is the basis for the adjustment/manipulation that is emphasized in chiropractic practice. In addition, the pathoanatomic diagnosis gives the location and severity of specific structures damaged and helps to formulate the prognosis for the patient's condition. A patient may have only a pathoanatomical lesion or only a biomechanical (functional) lesion. However, the biomechanical lesion is most often linked to a pathoanatomical condition. [16]

Components of the clinical impression/diagnosis may include:

- Phase of lesion [8] (e.g. acute, subacute, chronic, acute recurrent, chronic recurrent)
- Severity [4, 8] (e.g. mild, moderate, severe, Grade I, II, III)
- Mechanism of lesion [8] (e.g. traumatic, postural, overuse, hyperextension, torsional)
- Location [4, 8] (e.g. spinal level, muscle, ligament, neurological structures)
- Type of lesion (e.g. sprain, strain, subluxation, myofascitis, DJD)
- Neurological involvement (e.g. nerve root involvement, distribution, site of nerve root or cord compression/irritation)
- Complicating/associated factors [4, 8] (e.g. neurological involvement, DJD, stenosis)
- Resulting anatomical damage or syndrome (e.g. cervicogenic headache, facet syndrome)
- Concomitant pathological diagnoses [4] (e.g. COPD, neoplasm, CHF, HTN)

Treatment plan

The treatment plan is the portion of the patient record that deals with the proposed action by either the treating physician or the patient.[17] The plan arises from the accumulation of clinical data and the initial clinical impression or diagnosis.[4, 10] The treatment plan must be recorded in the patient file.

The treatment plan should include, when applicable:

- The prescribed therapeutic treatment plan (including modes, frequency and duration of care) [4, 10, 17]
- Additional diagnostic testing recommended or being considered [4, 10]
- Reassessment schedule [4, 10]
- Patient education and self-care plan [4, 10, 17]
- Referrals or consultations [4, 10, 17]
- Goals and outcome measures

Chart/progress notes

"Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record."[3] Oregon Administrative Rule 811-015-0005(1)(b)

Chart notes (often referred to as progress notes) are made in a patient's chart to record the patient's state of health, what transpired during patient visits as well as any significant changes in the clinical picture, assessment or treatment plan.[4, 8, 10] Chart notes should document the patient's response to the physician's management of their case. All record should be made in a systematic and organized manner [4, 8, 10] The

record shall be legible and clear enough to allow a peer to assume management of the case after an initial review of the chart notes.[1, 8]

Since the 1970s the classic format has been known as "S.O.A.P." notes.[17] S.O.A.P. is an acronym for Subjective, Objective, Assessment, and Plan or Procedures.[7] This pertinent clinical information can be organized in the SOAP format in a variety of ways. While full S.O.A.P. charting at each visit is strongly recommended, it is not required. Components of the record should include: [8]

Subjective complaints: These should be in the patient's own words when possible, indicating improvement, worsening or no change. [8]

Objective findings: Changes in the clinical signs of a condition should be noted at each visit in the doctor's own words. [8]

Assessment or diagnosis: It is not necessary to update this category at each visit. However, periodic clinical reevaluations should be performed and these results included in the daily entries with any modification of the diagnosis. [18]

Plan of Management: A provisional plan of management should be recorded initially and further entries made as this plan is modified and/or as a patient enters a new phase of treatment. Changes in procedures should be noted. [18] Daily recording of procedures performed should include adjustment/manipulation performed (for example, direction and force of the thrust), soft tissue techniques, modalities used (including time, location and intensity), exercises prescribed, nutritional supplementation or prescribed diet and activity instructions or advice. Any significant adverse response to therapies should be noted. [18]

Financial records
Financial records may be kept in the patient record and may include the following:

- Patient account ledgers (including date and type of services billed, payments received and from which source, account balance) [4, 15]
- Billing statements [4]
- Insurance records (explanation of benefits, proof of payment, etc.) [4]

Internal memoranda regarding patient
Internal memoranda regarding individual patients should be kept in the patient record and may include the following:

- Intra-office staff messages [4]
- Phone messages and/or summaries of phone conversations [4]
- Copies of emails sent/received [4]
- Copies of sign-in sheets [4]

Any correspondence sent out of the treating practitioner's office should contain the doctor and clinic name and address, phone number and current date. [19]

Electronic records

The computerization of the medical record has accelerated rapidly in recent years. The use of electronic or computer-assisted record keeping systems is becoming more common in chiropractic offices. These systems may include computer-assisted writing, voice recognition or other developing technologies. [17] Some systems accept input not only from the computer keyboard, but from touch screens, light pens, scanners and other input devices. [17] If an electronic record-keeping system is used, the provider needs to take reasonable steps to ensure the system is so designed and operated that the record is secure from loss, tampering, interference or unauthorized use or access and complies with all state and federal confidentiality regulations.

EXTERNAL DOCUMENTATION

External documentation includes relevant information received from an outside source and may include correspondence from numerous sources: referring physicians, other previous/concurrent practitioners, attorneys, various pay groups, consultative reports, diagnostic studies, etc. The original of each of those relevant external documents, if available, should be kept in that patient's record. [4, 10, 19]

Any external clinical documents such as reports or diagnostic studies should be initialed, dated and included in the patient's file. This notation provides evidence that the document has been read by the doctor. [1, 3]

CHART/FILE ORGANIZATION

General

Records should be entered in the sequence events took place, and kept in chronological order.[4] Records should be neat, legible, organized and complete, and recorded in dark ink or other permanently retrievable method within 24 hours of occurrence. [1, 4, 9, 20] The record should never be backdated, erased, deleted or altered in any way. [4, 21] If corrections need to be made, a line should be drawn through the error and the change initialed and dated.[4, 15] If records are kept electronically, amendments should be made in such a way that preserves the original record. Records must be complete enough to provide the practitioner with enough information for subsequent care or reporting to outside parties. [4]

Preprinted Forms

Forms may be used based on the practitioner's discretion. Forms provide an orderly means of obtaining the history, noting examination findings and charting progress.[4] If preprinted forms are used, they should include appropriate doctor/clinic identification.[6, 22]If part of a form does not apply to a practitioner's practice, the section should be deleted and the form reprinted.[23]

Abbreviations/Symbols

"Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available." [9] All records sent to a third party should be accompanied by a legend of codes or abbreviations used.[1, 6, 20, 23]

MAINTENANCE OF RECORDS

Oregon Administrative Rules

Records

811-015-0005 (1) It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.

811-015-0005 (3) A patient's records shall be kept by the Chiropractic physician a minimum of seven years. If the patient is a minor, the records shall be kept seven years or until the patient is 18 years of age, whichever is longer.[24]

Disclosure of Records

811-015-0006 (1) A Chiropractic physician shall make available within a reasonable time to a patient or a third party upon the patient's written request, copies or summaries of medical records and originals or copies of the patient's X-rays.

(a) The medical records do not necessarily include the personal office notes of the Chiropractic physician or personal communications between a referring and consulting physician relating to the patient.

(b) The Chiropractic physician shall preserve a patient's medical records from disclosure and will release them only on a patient's written consent stating to whom the records are being released or as required by State and Federal law.

(2) The Chiropractic physician may establish a reasonable charge to the patient for the costs incurred in providing the patient with copies of any portion of the medical records. A patient shall not be denied summaries or copies of his/her medical records or X-rays because of inability to pay or financial indebtedness to the Chiropractic physician.[25]

Confidentiality

All patient/doctor communications and interactions are privileged and confidential. This is an ethical responsibility as well as a statutory and/or regulatory one. [4, 10, 15] All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

Assurance of confidentiality is necessary if patients are to be open and forthright with the practitioner. Patients have the right to expect that information regarding their health will remain private and secure from public scrutiny.[4, 10, 26]The unauthorized disclosure of patient records by a physician may create legal liability unless the disclosure is to an authorized source, authorized by law, or justified by a superior public interest.[27] A patient who is injured by disclosure of his or her confidential information may pursue legal remedies against the providers not only for breach of privacy, but also for breach of implied contract of confidentiality, malpractice and/or infliction of emotional distress.[26]

The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality. [4, 10, 28]

Records Retention and Retrieval
Health records should be retained in a way that facilitates retrieval. To the extent possible, they should be kept in a centralized location. In most circumstances, recent records are maintained on premises either as hard copy or electronically. After a period of time they can be archived, microfilmed or microfiched and placed in storage.[4, 10] While there are administrative rules governing the length of time that records must be kept, from a patient and risk management perspective, it is desirable for all records to be retained indefinitely by the physician. [26],[29]

If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured. Arrangements should be made through wills or estate plans for the orderly transfer of patient records to another doctor or to a special administrator or caretaker of the records.[22] If health records are to be destroyed, they must be disposed of in a manner protective of patient confidentiality.

Administrative Records
Administrative records are primarily those relating to the non-clinical side of practice, and may include telephone logs, schedules and appointment records, patient personal information, insurance forms and billing documents. These records can be kept separately from the patient file, but they must be maintained in a legible and retrievable form. [4, 10]

Records Transfer
It is mandatory that health care data requested by another provider currently treating a present or former patient be forwarded upon receipt of an appropriate request and patient consent.[4, 9, 10] When responding to a request for patient records, determine whether all or only part of the record is requested. If the nature of the request is not clear, an inquiry to the person making the request will usually clear up what material is required. A subpoena asking for "all medical records pertaining to the care and treatment of 'patient x' between January and June 1995" means that the physician is to produce all medical records for 'patient x' between those dates regardless of the source. A request for "all records documenting your care and treatment of 'patient x' means all records of the physician's own care, not someone else's. [30]

Electronic Records
When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures. Increased use of electronic mail, the Internet and remote access creates new opportunities for tampering. This may result in errors of data identification, authentication, availability, and integrity. Availability refers to the ability of an authorized user to access the medical information. Integrity describes the system's capability to prevent outsiders and/or unauthorized insiders from altering data and unauthorized access.

The federal laws that are most relevant to electronic communications include the Electronic Communications Privacy Act of 1986 (ECPA), 18 U.S.C. 2510 et seq., and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. HIPAA requires health care providers and health plans to "maintain reasonable and appropriate administrative, technical and physical safeguards (a) to ensure confidentiality of the information, and (b) protect against (i) threats or hazards to the security of the information; and (ii) unauthorized uses or disclosures of this information." [28]

Chiropractic Records Ownership Management and Responsibility

The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request.[30] Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time.[25] Although Oregon Law allows release of records under certain circumstances without patient approval,[31] it is strongly recommended prior to release of any records, a properly executed authorization be in place for the full protection of the patient and physician.

When a practice is closed, sold or there is a transfer of ownership, secure retention of the records must be ensured.[4] If a single physician's office is closed, that physician remains responsible for maintenance of records for a minimum period of time, i.e. for adults seven years or for a minor patient, seven years or to the age of 18 whichever is longer.[24] In the case of a group practice closure, the issue of record keeping/maintenance may be dealt with by a contractual agreement.[32] File transfers resulting from the sale/purchase of a practice must follow statute, regulations and policies to ascertain whether a patient authorization is required at the time of the file transfer.[32] If the seller does not keep a copy of the files, the contract/agreement covering the transaction should impose an obligation upon the purchaser to maintain the records and allow access to them by the seller in order to satisfy their professional obligations.[32]

Management of healthcare records in a single physician's office is a relatively straightforward situation where that physician is responsible for all aspects of records management. A more complex set of circumstances occurs when considering records management within the context of a multiple physician/group practice where dissolution, sale, closure or other change is taking place. Many of the potential difficulties with respect to maintenance of records in this type of situation can be avoided with proper contractual arrangements established at the outset of the relationship.[32] Contracts should anticipate the necessity for providing the physician with copies and should establish whose duty it is to provide and pay for duplication.[30] If physicians choose not to retain copies, a release should be obtained from each patient involved guaranteeing access to the records in the future, should the need arise.[30] Keeping a copy of all records after dissolution of a contractual relationship is expensive but vital.[30]

Virtually all state disciplinary actions and malpractice suits turn on the content of the record.[30] The physician who does not maintain custody is at the mercy of the others who may lose, alter or attempt to deny access to records essential to their own defense.[30] Perhaps the best way for the physician to ensure access to the records (e.g. employment contracts, managed care groups, nursing homes, etc.) is to have the patient sign a release (preferably at the initial visit) entitling the physician to obtain complete copies of any medical records containing information related to that physician's care of the patient.[30]

Within the context of a physician leaving a practice, the dissolution of a group practice, or an associate physician arrangement, there are several different scenarios that require further discussion with respect to records management.

- If a patient has been seen by more than one physician, the original file or a copy should be maintained at the clinic.[32]
- If the original file is removed, a signed, dated authorization form should be received from the patient directing that file be provided to a specific practitioner. [32]
- If the patient has been seen only by the remaining physician/s, a copy may be provided to the departing physician with a signed, dated authorization form. [32]

- If the patient has been seen only by the departing physician/s, no consent form is necessary to remove the file unless the file was opened in the name of a group practice or there is a separate agreement stating all records are the property of the clinic. [32] In this case, a copy or the original should be maintained at the clinic and a written authorization for transfer of records out of the facility is required. [32]
- With respect to files where radiographs are involved, due to the costly nature of reproduction, the original films should be kept as part of the original file. [32]

When a practice facility changes status, e.g. purchase/sale, dissolution of a contractual relationship, etc. the most vital concerns with respect to records management are maintenance of privacy/confidentiality and ensuring intact records are readily accessible for the benefit of the patient/s healthcare. In a multi-physician/group practice, an explicit contract defining the responsibilities of all parties involved is a critical component of ensuring proper maintenance of records.

PATIENT CONSENTS

Informed consent must be recorded for evaluation and treatment, treating a minor, obtaining or releasing health records, taking and releasing photos or videos, participation in research or inclusion in publication.[12] The original of any signed written form regarding these consent issues belongs in the patient file.

While legal experts are strong advocates of written consent forms, [4], [10] doctors are reminded that forms may not provide full protection against lawsuits.[33] [17] Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference. For further discussion of informed consent including the PAR/PARQ notation, refer to the Patient/Doctor Relationship Chapter.

Written forms for the release or procurement of health records are required. Written forms for permission to treat a minor are recommended. [17, 34] If a second doctor observes and/or treats the patient, a second consent is necessary. [33]

MALPRACTICE TIPS

Today's practice environment requires careful documentation of patient care. [35] The patient as a plaintiff has the burden of proving that a health care professional has acted negligently.[36] **The most useful factor defending against an accusation of malpractice is the record,**[6] and risk-management is the best line of defense. [6, 36] Patient records allow the professional to show that *proper* rather than negligent care was provided. [36], [23]

The legal definition of malpractice includes four criteria:[6]

1) There must be a duty between the two parties, i.e. a patient/doctor relationship.[3]
2) There must be a breach of that duty, i.e. something wrong has to have occurred between the two parties.[3]

(Note: Anger toward the doctor is the most frequent instigating factor.[6])

3) Harm or injury must result from that breach of duty. [6]
4) There has to be 'proximate cause', i.e. a relationship in time between the breach and the injury. [6]

If a lawsuit occurs and the patient file (including all billings[6]) cannot be provided or is incomplete, inaccurate or illegible [23], the doctor could be found liable even though not at fault. [6] If documents are lost and not included or billings are not provided (even though the doctor may have not known they needed to be included), the doctor's credibility may be compromised.)

In the event a potential malpractice situation actually does occur, the chiropractic physician should stay calm and act responsibly. The physician should avoid repeating the procedure, monitor the patient, follow any risk-management procedures as outlined by your insurance company and document the incident. The chiropractic physician should contact legal counsel prior to meeting with the plaintiff(s) and/or their attorneys. [6]

The following is a list of suggestions, habits and/or *risk-management techniques* that create good patient records:

- Stay within licensure boundaries.[22]
  - (See the Chapter 811 Oregon Administrative Rules for those details.)

- Explain procedures and treatments as care proceeds. [6]
  - This treatment narration aids in building rapport with the patient which has been shown to be one of the best defenses against anger and/or malpractice behaviors. [6]

- Make accurate statements about the prognosis. [6]
  - Avoid exaggeration of what may be achieved from the treatment[6]

- Records should not be edited or altered even for the most innocent reason [35], [36], [37]
  - Refuse a request to "change" a record.[22]
  - Deliberately changing or altering a record can be considered a fraudulent action.[35]
  - Most malpractice carriers have a clause which voids coverage in the case of hiding any important information, misleading, attempting to defraud or lying.

- If asked to not make a record, consider the legal obligations.
  - Failure to comply with these obligations may result in severe penalties. [6]
  - Explore the motive behind the request (the wish to not weaken one's battle in court, to avoid stigma for political or other reasons, celebrity status, a concern about possible embarrassment, paranoia, abuse[22]).
  - Suggestions for refuting the request without offending the patient include
    1) acknowledge and gently allay concerns,
    2) explain the need to keep a record,
    3) describe your confidentiality procedures (e.g. the HIPAA protections),
    4) negotiate some acceptable form of recording and/or write only the minimum needed to convey reasonable care has been delivered,
    5) consider refusing the case.[22]

- Correct errors with a line, signature or initials, and date it [1], [23],,[30], [38]
  - Avoid obliteration of any entry [39]
  - Learn to think: "The first draft is the final product"[1]

- Use the SOAP or equivalent format for office notes and progress notes. [1], [6], [23]

  Have patient's name, chart number (if used), doctor/clinic identification on every page of chart notes. [1], [40], [39]

  - Date and sign/initial every entry. [1], [6, 39]
  - Write legibly [35],[23],[1] in dark ink; [1],[39]
  - Use standard abbreviations; [1], [6], [23] [39]
  - Use the patient's own words to describe how they are feeling; [6]
  - Make an assessment about the patient's progress; [6]
  - Avoid signing/initialing any entry not written by you.[1]
  - Have staff sign their own entries, then the chiropractic physician may countersign the entries; [39]
  - Make a habit of charting upon occurrence to avoid omissions. [30] Make your entries within 24 hours of contact; [1],[30]
  - Chart the procedures and/or treatments that occurred during that date of service, including any recommended home treatments; [6]
  - Avoid blank spaces between dates of service; [1], [39]
  - Computer-generated and written chart notes must be sufficiently individualized to accurately reflect the clinical findings at each visit;
  - Record patient's relevant family, marital, and job stresses;[1],[39]
  - Proof read *and initial* dictated records; [6],[23]
  - Attempt to document every patient contact [30] such at telephone calls, emails, etc. [6],[23],[39]

- Record a full and complete history and physical examination. [23], [37] Make a diagnosis only after an appropriate physical examination. [6]
  - Record the relevant facts accurately [1], [35], [37]
  - Chart the negative as well as the positive.[39] Avoid exaggeration or making the patient sound worse than he/she is. [39]
  - Use objective, non-judgmental, language. [1], [6], [23], [39]
  - Write an opinion supported by the relevant facts.[35] Include your recommendation for follow-up and [23, 39] include any prescription(s) given [1], [6]

- Avoid recording derogatory, trivial or loose comments about or from patients and/or other health care professionals. [1], [35], [39] Avoid egotistical remarks. [39]

- Document all procedures or treatments recommended by the doctor and refused by the patient, including any non-compliance of treatment recommended by other health care professionals. [1], [23],[37],[39]

- Chart important events or adverse reactions conspicuously, rather than burying them in the record. [39]

- Consider including a written informed consent in the file [1, 6, 23]
  - Oregon Administrative Rules do not *require* this document, but many legal sources recommend the use of a form. *(Read 'Informed Consent' in the Patient/Doctor Relationship chapter of this volume.)*
  - Whether a form is used or not, include a notation documenting your consent discussion with the patient.[39]

- Tailor forms to your individual office. [37]

- Respond to each Request for Records, releasing only the information specifically requested. [30]
  - *Before releasing any records, be certain to meet compliance with state and federal privacy guidelines.* [35]

- Retain all original records. [37]

- Records should be kept according OAR 811-015-0005.
  - The rule states " …a minimum of 7 years. If the patient is a minor, the records shall be kept seven years or until the patient is 18, whichever is longer" [24]
  - Protect patient confidentiality (refer to Section III - HIPAA).[35]

Implement a system to ensure that important patient information can be located and is easily accessible. [23]

Section 3

HIPAA - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The following material is a summary of Federal Law.

With the advent and extensive use of electronic media in the health care realm, there is a greater possibility of widespread dissemination and abuse of a patient's Protected Health Information (PHI). "Protected Health Information means individually identifiable health information created, maintained or in the possession of our practice relating to the past, present or future physical or mental health of any individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual." [41] Even if the information provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. [42]

In August 1996 the Health Insurance Portability and Accountability Act (HIPAA) bill was passed giving the Federal Government the ability to regulate how covered entities (health care plans, providers, and clearing houses) use, store, disclose and transmit Protected Health Information.

Prior to the passage of HIPAA there were no national or industry standards mandating or regulating the privacy and confidentiality of a patient's PHI. Individual states had a variety of rulings related to patient privacy and disclosure of PHI that were very often disjointed and incomplete. HIPAA provides national standards for the protection and security of one's PHI, while improving the efficacy of healthcare provision by providing standards for transmitting patient's financial information to which all covered entities must adhere. The Privacy Rule holds violators accountable by imposing civil and criminal penalties HIPAA generally encompasses two rules- The Privacy Rule and the Security Standard. The Privacy Rule, (Standards for Privacy of Individually Identifiable Health Information), regulates the use and disclosure of PHI and encompasses three essential purposes. The first purpose is to protect the rights of patients by providing them access to their PHI and the ability to control the use and disclosure of it. The second purpose is to restore public trust in the healthcare delivery system, and the third is to improve the efficiency and effectiveness of healthcare delivery in the US by creating a national framework of healthcare privacy. [43]

The Privacy Rule provides the first national standards for protecting the privacy of health information. It mandates how covered entities (healthcare plans, providers, and clearing houses) use, store, disclose, and transmit PHI. It sets boundaries on the use and disclosure of medical records, by requiring safeguards that most healthcare entities must provide to protect the privacy of health information. It encompasses the practitioner's use of the patients' PHI within their office or health care setting and the disclosure of PHI outside of the office setting. It states that protected health information can only be used and disclosed for treatment, payment, or healthcare operations without a patient authorization. Any other uses require a patient authorization prior to the PHI being released. The rule also generally limits the release of information to the minimum necessary for the purpose of the disclosure so that irrelevant information is not released unnecessarily. This limitation of only releasing the minimum necessary information does not apply when the PHI is disclosed to another practitioner for direct treatment purposes. The rules make allowances with public health responsibilities as well to allow the collection of information used to prevent or control disease, injury, disability, including public health surveillance, investigation and intervention.

The HIPAA limitations do not apply to information that is de-identified so that the patient can not be connected with their PHI. The following is a table listing what is considered identifiable information:

Identifiable Information

1. Name
2. Any address specification such as street, city, county, precinct, and zip code
3. All dates except for the year including birthdates, admission date, discharge date, date of death and all ages over 89
4. Telephone number
5. Fax number
6. Electronic mail address
7. Social Security number
8. Medical record number
9. Health plan beneficiary number
10. Account number maintained by the healthcare provider
11. Certificate or license number such as driver's license number
12. Vehicle identifier and serial number including license plate number
13. Medical device identifier and serial number such as pace maker serial number
14. Web site address
15. Internet protocol (IP) address number
16. Biometric identifier including finger and voice prints
17. Full face photographic images and any comparable image, and
18. Any other unique identifying number characteristic or code

Table courtesy of HIPAA Privacy Manual A how-to Guide for Your Medical Practice 2nd Edition. Developed by Gates, Moore & Co. for The American College of Obstetricians and Gynecologists. 2002

Beyond limiting the practitioner's ability to use or disclose PHI without a patient's authorization, the Privacy Rule empowers patients to have more control over their health information. The first step in providing the patient with more control is the mandatory requirement of each health care provider to provide the patient with a copy of the "Notice of Privacy Practices." If the initial contact with a patient is electronic, then an electronic copy of the Notice of Privacy Practices must be provided at that time. The Notice of Privacy Practices outlines the patient's rights to privacy and how personal health information will be routinely used for treatment, payment and healthcare operations within the healthcare setting. The provider must also obtain a written acknowledgment from the patient that a copy of the notice was received. [44]

Release of PHI for purposes other than treatment, payment or healthcare operations requires a signed authorization from the patient. This allows patients to make informed choices about how their individual health information may be used and/or disclosed. The HIPAA privacy rules go beyond requiring an authorization for release of information by requiring tracking what disclosures of PHI have been made. This enables patients to find out how their health information has been used or released. The patient also has the right to obtain a copy of their medical record and can review and correct or amend the PHI. There must be policies and procedures in place for patient review, correction or amendment of their PHI. The provider is not required to change medical records at the request of the patient, but they should be able to link the amended information to the original chart. Corrections or amendments to the health record requested by the patient can only be made with their physician's approval.

To assure that the HIPAA privacy rules are enforced, health care providers are required to designate a privacy officer within the clinic. This person is responsible for implementing the privacy rules. There should also be a designated contact person, who may be the same individual, to receive complaints and provide information to the public related to the privacy policies. The final piece of the privacy rules relates to the need for staff education related to patient privacy and their responsibilities to comply with the HIPAA regulations. There should be documented education with all staff and appropriate policies and procedures in place to demonstrate that the office is doing their due diligence in assuring that the patient's privacy is maintained. The office should also look at their routine operations and make a concerted effort to minimize the chance for inadvertent disclosure of PHI due to processes in place such as leaving patient records in plain sight at the receptionist's desk or having computer screens with PHI easily visible in areas where patients are present.

The other rule HIPAA encompasses is the Security Rule which is composed of two major standards; the security standard and the electronic signature standard [45]

The Security Standard requires a secure electronic environment in which a covered entity would maintain, store, or transmit all PHI. The rule defines and requires a secure electronic environment as; an environment with physical, procedural, technical and administrative procedures, services, and mechanisms.

What is a Secure Electronic Environment?

A **Secure Electronic Environment** is an environment that has administrative procedures, physical safeguard and technical security services and mechanisms in place. It also includes the implementation of an electronic signature standard if the practice uses an electronic signature.

Administrative Procedures are formal, documented practices to protect PHI. This includes the selection and execution of security measures and the management of personnel as it relates to protecting PHI.

Physical Safeguards are procedures to protect computer systems, buildings and other equipment from fire and other natural and environmental hazards, as well as from intrusion.

Technical Security Services are processes that are implemented to control and monitor access to PHI such as passwords.

Technical Security Mechanisms are processes implemented to prevent unauthorized access to data that is transmitted over a communications network (Internet, Intranet, fax machine, etc.)

Table courtesy of HIPAA Privacy Manual A how-to Guide for Your Medical Practice 2nd Edition. Developed by Gates, Moore & Co. for The American College of Obstetricians and Gynecologists. 2002

The Electronic Signature Standard

An electronic signature is a data component that is incorporated into an electronic document for the purpose of uniquely identifying the signer. Practices are not required to use electronic signatures, however if a provider uses electronic signatures, then the Security Standard Rule requires that HIPAA signature standards be used to verify the identity of the message sender, or the signer of a document. [46]

With the implementation of HIPAA regulation, the government has imposed national rules and standards that will greatly improve the security of a patient's protected health information, while giving them more control over where and how it can be used. Securing and standardizing the electronic environment will greatly expedite and secure the transfer of data and Protected Health Information.

Section 4

PRACTICE STANDARDS

1. The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request.[30]

2. Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time.[25]

3. Clinicians must ensure that their documentation of a patient's health status is understandable by others on the health care team. [4]

4. The patient record must include documentation of informed consent.

5. Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference.

6. Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available upon request.[9]

7. The record should never be backdated, erased, deleted or altered in any way.[4,21] If corrections need to be made, a line should be drawn through the error and the change initialed and dated.[4,15] If records are kept electronically, amendments should be made in such a way that preserves the original record.

8. All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

9. The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality.[4,10,28]

10. If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured.[4]

11. When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures.

12. Reports with clinical findings received from external sources should be reviewed, initialed, and dated upon receipt.[4,9,10]

13. The clinical impression or diagnosis must be recorded within the record.[4,10,15] When more than one diagnosis is made (for example, biomechanical assessment and pathoanatomic diagnosis), these must be differentiated and recorded.[14]

Section 5

REFERENCES

1. Scott RW, *Legal aspects of documenting patient care.* 1994: p. 31-82.
2. Maule K, *Record Keeping: Is it really that important?* Journal of the American Chiropractic Association, 2000(June 2000): p. 20-22.
3. *Oregon Administrative Rules Chapter 811*. 2003.
4. Haldeman S, Chapman-Smith D, and Peterson DM, *Guidelines for Chiropractic Quality Assurance and Practice Parameters*. 1993, Aspen Publishers, Inc: Gaithersburg, MD. p. 222.
5. Ventura JM, Justice BD, and Iannelli GC, *Developing a quality-based chiropractic practice.* Chiropractic Technique, 1997. **9**(4): p. 157-161.
6. *Malpractice: Without conscientious care and record keeping, you could lose it all.* Journal of the American Chiropractic Association, 1999: p. 6-14.
7. Behmlander JL, *Documentation: Create better reports faster*. Journal of the American Chiropractic Association, 2001(February 2001): p. 44-45.
8. OBCE, *Oregon Chiropractic Practices and Utilization Guidelines*. 1991: Oregon.
9. *Clinical Guidelines for Chiropractic Practice in Canada*, Canadian Chiropractic Association.
10. *International Chiropractic Association Guidelines protocol*, International Chiropractic Association. p. 197-198.
11. Reinke TS and Jahn WT, *Preventing legal suicide with medical records.* J Manipulative Physiol Ther, 1988. **11**(6): p. 511-3.
12. College of Chiropractors of Ontario, *Record Keeping: Standard of practice*. 1996: Ontario Canada. p. 1-4.
13. Liebensen C, *Rehabilitation of the spine: A practitioner's Manual*. 1996, Baltimore: Wms & Wilkens.
14. *Oregon Administrative Rules Chapter 811*. 2003.
15. Can Chiro Assn, *Clinical Guidelines for Chiropractic Practice in Canada*.
16. Gatterman MI, *Chiropractic management of spine related disorders.* 2003: p. 435.
17. Yeomans SG, *The Clinical Application of Outcomes Assessment*, Stamford CT: Appleton & Lange. Ch 20.
18. OBCE, *Oregon Chiropractic Practices and Utilization Guidelines - Chapter 3*, in *Ch 3 - Record keeping and report writing*. 1991: Oregon.
19. Metz RD, *The chiropractic clinical record and quality management as viewed from the perspective of the insurance payer*. Top of Clin Chiropr. Vol. 7. 2000: Aspen Publishers, Inc. 61-66.
20. Baker SK, *The 25 warning signs of poor documentation.* American Medical News, 1996: p. 22.
21. NCMIC Examiner, National Chiropractic Mutual Insurance Company Examiner, 2003(Spring 2003).
22. Gutheil TG and Hilliard JT, *Don't write me down.* American Journal of Psychotherapy, 2001. **55**(2): p. 157-165.
23. NaPier PM and NaPier BL, *Medical charts and malpractice: How to avoid costly errors and omissions.* Hawaii Medical Journal, 1989. **48**(1): p. 596-7, 599,607.
24. *Oregon Administrative Rules Chapter 811*. 2003.
25. *Oregon Administrative Rules Chapter 811*. 2003.
26. Theisler CW. *Legal aspects of chiropractic practice*. in *NCMIC Malpractice Avoidance Seminar*.

27. Hirsh H L and B. MS, *Physician Responsibilities in Medical Record Keeping.* Journal of the Medical Society of New Jersey. **77**(6 Jun 1980): p. 406-7.
28. *Health Insurance Portability and Accountability Act*, in *Title 1*. 1996.
29. Kopf R, *The medical record: Make it your asset, not a liability*, in *APMA News*. 1999. p. 42-45.
30. Harty-Golder B, *The Back-Pocket Lawyer - For the record.* Journal of the Florida Medical Association, 1995. **82**(11): p. 769-772.
31. Statute, O.R., *House Bill 2305 Authorization to Release Confidential Records*. 2003.
32. Freedman AM, *Transfer of patient files.* J Can Chiro Assoc, 1999. **43**(3): p. 189-191.
33. Gorney M, Martello J, and Hart L, *The Medical Record: Informing your patients before they consent.* Clinics in Plastic Surgery, 1999. **26**(1): p. 57-68.
34. Weintraub M, *Documentation and informed consent.* Neurologic Clinics, 1999. **17**(2): p. 371-381.
35. Hirsh, H.L. and J. Bromberg, *Physician responsibilities in medical record keeping.* J Med Soc N J, 1980. **77**(6): p. 406-7.
36. Cross AT, *Perspectives in Practice: Legal requirements of private practice medical records.* Journal of the American Dietetic Association, 1988. **88**(10): p. 1272-1274.
37. Rondberg TA and Feuling T, *CBS: Malpractice Prevention Program*, Chiropractic Benefit Services. p. 12-13, 19-29.
38. Hirsh HL and Bromberg J, *Featuring: Physician responsibilities in medical record keeping.* Journal of the Medical Society of New Jersey, 1980. **77**(6): p. 406-7.
39. Baker SD, *The 25 warning signs of poor documentation.* American Medical News, 1996: p. 22.
40. *Oregon Administrative Rules Chapter 811*, in *Chapter 811*. 2003.
41. Brown and Rudnick, *eSolutions.Definitions*, Brown, Rudnick.
42. US DHHS, *Health Insurance Portability and Accountability Act.* 2002.
43. Gates and Moore & Co., *HIPAA Privacy Manual - A how-to guide for your medical practice*. 2nd ed, ed. M.C. Gates. 2002.
44. Conklin S, *Medical Privacy and Data Security: HIPAA Privacy Handbook*, ed. O.M. Assn. 2001: Cooney & Crew, LLP.
45. *HIPAA*, in *45 CFR*. 2003. p. 8334-8381.
46. Prady et al, *Guidelines for electronic communications with patients.* J AM Med Inform Assn, 2001. 8: p. 344-8.