

Information Summary and Recommendations

Chiropractic Scope of Practice Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The Washington State Legislature's intent, as stated in chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act (RCW 18.120.010) says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act (chapter 18.130 RCW).
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.¹ A certified person is subject to the Uniform Disciplinary Act.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act.

¹ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistants-certified, home care aides, and pharmacy technicians.

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EXECUTIVE SUMMARY

Background

Chiropractors have been licensed in Washington since 1919 under chapter 18.25 RCW and chapter 246-808 WAC. Chiropractors are experts in providing spinal manipulation. In Washington, they're authorized to diagnose, analyze and treat "the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body. As part of the chiropractic differential diagnosis, a chiropractor shall perform a physical examination to determine the appropriateness of chiropractic care or the need for referral to other health care providers."² Chiropractic care doesn't include prescriptive authority; procedures involving the application of sound, diathermy or electricity; or any form of venipuncture.

There are currently 2,348 licensed chiropractors in Washington.³ Requirements for licensure under RCW 18.25.020 include completion of "not less than one-half of the requirements for a baccalaureate degree" and graduation from a Council on Chiropractic Education (CCE) accredited chiropractic school or college consisting of a course of study of not less than 4,000 classroom hours of instruction. In addition, applicants must pass the National Board of Chiropractic Examiners (NBCE) examination.⁴

Proposal for Sunrise Review

On May 23, 2013, Representative Eileen Cody, Chair of the House Health Care and Wellness Committee, asked the department to conduct a sunrise review of House Bill (HB) 1573 from the 2013 legislative session. This proposal would prohibit discrimination against chiropractors and require that licensed chiropractors be allowed to perform physical examinations for sports physicals and commercial drivers' licenses.

The applicant for this proposal is the Washington State Chiropractic Association (WSCA). The applicant describes this proposal as a clarification of the scope of practice, not an increase. The applicant report assessing the criteria required in chapter 18.120 RCW included the intent to propose amendments to HB 1573 as follows:

- Remove reference to the Washington Interscholastic Activities Association (WIAA);
- Apply the proposed legislation to all youth sports;
- Add an additional 18-hour training and examination requirement (with an optional challenge to the examination for chiropractors with current Diplomate American Chiropractic of Sports Physicians certification);
- Create an endorsement to licensure for those chiropractors with the additional qualifications to be able to perform pre-participation examinations (PPEs) for student athletes (although this was not clear in the proposal, the applicant made it clear during the public hearing that it intends this to be an endorsement); and

² RCW 18.25.005(3)

³ As of July 1, 2013

⁴ Some chiropractic programs, such as the University of Western States in Oregon and Palmer College in Iowa, provide up to 4,600 classroom hours, exceeding the minimum requirements in statute.

- Require federal motor carrier training for doctors of chiropractic performing the physical examinations that meet the criteria of the Federal Motor Carrier Safety Administration.

In addition, at the public hearing, the applicant's representative stated that there were additional amendments intended to occur last session to HB 1573 that would have included changes to the statutory definitions in the chiropractic scope of practice.

The department is required to evaluate the proposal requested by the legislature. We will attempt to address both the proposal and the many changes later suggested by the applicant.

Recommendations

The department has determined that the sunrise criteria haven't been met in the three versions of the proposal submitted because:

1. **The department doesn't support adoption of HB 1573 as written.** HB 1573 doesn't amend the definitions of chiropractic or chiropractic treatment or care in RCW 18.25.005. Physical examinations for student athletes and commercial drivers are clearly not within the existing statutory scope of practice for chiropractors in Washington.
2. **The department does not support the proposal submitted with the applicant report from the Washington State Chiropractic Association in July, which included a proposal to add additional educational requirements for chiropractors to perform physical examinations of student athletes and commercial drivers.** The applicant report also does not propose to amend the definitions of chiropractic or chiropractic treatment or care in RCW 18.25.005. The applicant's proposal should not be enacted, even with the additional training it intends to include in amendment language, because the proposal still fails to amend RCW 18.25.005 to add the elements of a comprehensive physical examination to the chiropractic scope of practice.
3. **The department does not support expanding the chiropractic scope of practice to include PPEs for student athletes and commercial motor vehicle examinations (CMV exams) for commercial drivers.** Since the department interprets these physicals as outside the chiropractic scope of practice, we reviewed whether changing the definitions in RCW 18.25.005 to expand the scope would meet the sunrise criteria. The department found potential risk of patient harm if PPEs and CMV exams are added to the chiropractic scope of practice. Specifically:
 - Addition of PPEs and CMV exams would expand the chiropractic scope of practice well outside of the current scope of diagnosing and treating conditions relating to the musculoskeletal system.
 - PPEs and CMV exams are intended to be comprehensive physical examinations, not cursory screenings. These exams are sometimes the only examination a person receives regularly. For students, this includes the opportunity to receive age-appropriate vaccinations, which chiropractors can't perform.
 - Chiropractic educational programs do not include adequate focus on pharmacology, which is necessary in both types of physical examinations.

- Although chiropractic training includes basic understanding of body and organ systems, including the cardiovascular system, the department is unable to find that it prepares chiropractors to potentially be the sole evaluator of all or most medical conditions.
- The additional trainings proposed by the applicant do not appear to adequately bridge the gap in training, especially considering the range of education obtained by current licensees. The Diplomate American Chiropractic of Sports Physicians specialty certification training's primary focus also appears to be on spinal and extremity manipulation, exercise physiology, and sports-specific biomechanics without a corresponding focus on broader medical conditions and pharmacology.
- Examining a patient to evaluate his or her overall health should be done by a primary care provider who can use their broad spectrum of training, clinical residency, and experience to conduct the evaluations, and whose daily practice includes functions of primary care.

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SUMMARY OF INFORMATION

Background

Chiropractors have been licensed in Washington since 1919 to diagnose, analyze and treat “the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.” Chiropractors are experts in providing spinal manipulation.

In Washington, chiropractors are regulated by the Chiropractic Quality Assurance Commission (commission) under chapter 18.25 RCW and chapter 246-808 WAC. “As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination...to determine the appropriateness of chiropractic care or the need for referral to other health care providers.”⁵ Chiropractic care does not include prescriptive authority; application of sound, diathermy or electricity; or any form of venipuncture.

As of July 1, 2013, there were 2,348 licensed chiropractors in Washington. Requirements for licensure under RCW 18.25.020 include completion of “not less than one-half of the requirements for a baccalaureate degree” and graduation from a CCE-accredited chiropractic school or college consisting of a course of study of not less than 4,000 classroom hours of instruction. In addition, applicants must pass the National Board of Chiropractic Examiners (NBCE) examination.

Proposal for Sunrise Review

On May 23, 2013, Representative Eileen Cody, chair of the House Health Care and Wellness Committee, asked the department to conduct a sunrise review on House Bill 1573 from the 2013 legislative session, which would prohibit discrimination against chiropractors and require that licensed chiropractors be allowed to perform physical examinations for sports physicals and commercial drivers’ licenses. House Bill 1573, “An act relating to clarifying the prohibitions against discriminating against licensed chiropractors,” included the following language:

“The state and its political subdivisions, including school districts, and all officials, agents, employees, or representatives thereof, are prohibited from in any way discriminating against licensed chiropractors in performing and receiving compensation for services covered by their licenses. Licensed chiropractors must be allowed to perform sports physicals for school athletes and physical examinations required for commercial driver’s licenses.

Notwithstanding any other provision of law, the state and its political subdivisions, and all officials, agents, employees, or representatives thereof, are prohibited from entering into any agreement or contract with any individual, group, association, including the Washington interscholastic activities association, or corporation which in any way, directly or indirectly, discriminates against licensed chiropractors in performing and receiving compensation for services covered by their licenses.”

On June 25, 2013, the Washington State Chiropractic Association (WSCA) submitted its applicant report assessing the criteria required in chapter 18.120 RCW. The applicant states this

⁵ RCW 18.25.005(3)

proposal is a clarification of their scope of practice, not an increase. The applicant report included the intent to propose amendments to HB 1573 as follows:

- Remove reference to the WIAA;
- Apply the proposed legislation to all youth sports;
- Add an additional 18-hour training and examination requirement (with an optional challenge to the examination for chiropractors with current Diplomate American Chiropractic of Sports Physicians certification);
- Create an endorsement to licensure for those with the additional qualifications to be able to perform PPEs. (Although this was not clear in the proposal, the applicant made it clear during the public hearing that it intends this to be an endorsement); and
- Require Federal Motor Carrier training for doctors of chiropractic performing the physical examinations that would meet the criteria of the Federal Motor Carrier Safety Improvement Administration.

In addition, the applicant stated at the public hearing that there were additional amendments intended to occur last session to HB 1573 that would have included changes to the definitions in the chiropractic scope of practice.

Public Participation and Hearing

The department received the request from the legislature to conduct this sunrise review on May 23, 2013, and received the applicant report on June 25, 2013. Interested parties were notified of the sunrise review on June 28, and given the opportunity to provide written comments on the proposal through August 2. We posted the proposal and all applicant materials to the department's website. A public hearing was held August 6, 2013. Written comments were accepted through August 2, and there was an additional comment period after the hearing through August 16. (See Appendix D for public hearing transcript and Appendix E for written comments).

We shared a draft report with the applicant and interested parties October 23 and invited rebuttal comments. The rebuttals and department responses are summarized beginning on page 23 (full rebuttal comments are attached as Appendix H).

Nine people testified at the hearing in support of the proposal and nine in opposition. In addition, we received 15 letters in support of the proposal and 23 in opposition. The following is a summary of the written and oral comments we received during our review.

Support

Themes in the oral and written comments in support of the proposal:

- This was just an oversight in the statute that physicals weren't included.
- It's discrimination against chiropractors that they cannot perform these physicals.
- Chiropractors are well trained and fully prepared to conduct these physicals. They have access to all medical diagnostic tools that are available to other health care providers.

- There's a misunderstanding about chiropractic education, diagnostic ability, and didactic training. Many opposing comments are emotionally charged and hold no factual evidence.
- There's an access issue with primary care providers. Chiropractors often help patients find primary care physicians who are accepting new patients.
- Many patients would prefer a certified sports trainer to do their physicals because they trust them, and their chiropractors know their history.
- Chiropractors conduct PPEs for professional sports teams, Olympic teams, colleges, and high schools across America.
- It was suggested that the sunrise reviewers might wish to visit one or more chiropractic colleges to observe the curriculum and the hands-on doctor/patient relationships being taught.
- Opposing comments attempt to engender concern and fear about potential negative outcomes associated with the proposal. Ironically, the negative outcomes cited are associated with medical physicians' provision of these exams.
- Washington is one of the few remaining states that restrict chiropractors from performing physicals. It's a disservice to Washington residents.
- These are screenings, not treatment.

The applicant offered a response to perceived inaccuracies heard during testimony and to written testimony received by the department. (Appendix C).

Opposed

Themes in the oral and written comments in opposition to the proposal:

- Chiropractors are not qualified and may miss critical issues. Chiropractic teaching falls short of teaching the necessary skill set, especially regarding the ability to diagnose simple or complex patterns of disease and injury. The lack of clinical training in cardiac pathologies and concussion evaluation could be devastating to a young athlete.
- PPEs should be completed by a medical doctor or medical clinician who has the training, background and skills to perform them and recognize heart disease.
- All medical practitioners should stay within their legal scope of practice.
- These visits may be the only time a child or teen sees his or her doctor. The physical addresses the whole patient, and the ideal examiner is the primary care physician who knows a patient's medical history.
- It's a critical time to perform vaccinations, which chiropractors cannot do. In addition, chiropractors do not have prescriptive authority.
- The proposal is antithetical to efforts in the medical community to improve athlete safety on the playing field. Extensive work is being done preventing sudden cardiac death based on trained evaluation of the history and physical examination, proper use of non-invasive cardiovascular testing, and a solid understanding of the conditions associated with sudden cardiac death in athletes.
- The proposal doesn't contain appropriate oversight. It doesn't support the team approach to medical care and the physician-led model.
- The Washington State Medical Association, Washington Osteopathic Medical Association, and Washington State Nurses Association wrote in opposition, citing inadequate training to provide comprehensive physical examinations. They also stated there isn't data supporting the need to expand the scope of practice due to a claimed

shortage of primary care providers, nor is the claim supported that this expansion would benefit the public.

- Sports physicals ascertain medical health status, not chiropractic health status; they should solely remain the professional responsibility of medical practitioners.
- The Athletic Trainers Association asserts that chiropractic training doesn't emphasize the main issues that affect young athletes such as sudden cardiac arrest, heat-related illnesses, concussions and other medical issues.

Education and Training

RCW 18.25.025 authorizes the commission to grant accreditation to chiropractic schools and colleges. The statute requires chiropractic educational programs to include minimum hours of chiropractic curriculum in the following areas:

- Principles of chiropractic – 200 hours;
- Adjustive technique – 400 hours;
- Spinal roentgenology – 175 hours;
- Symptomology and diagnosis – 425 hours; and
- Clinic – 625 hours.

RCW 18.25.020 and WAC 246-808-040(3)(b) require chiropractic educational programs to be a minimum of 4,000 class hours of instruction over a four-year academic term. Some chiropractic programs, such as the University of Western States in Oregon and Palmer College in Iowa, include additional class hours. According to the applicant, these programs include 500 hours of anatomy, 400 hours of physiology, 1,500 hours of diagnosis, and 2,000 hours of clinic, where students see student-patients and patients from the surrounding communities under supervision.

The University of Western States in Oregon and Palmer College of Chiropractic in Iowa submitted comments stating its programs prepare graduates to provide comprehensive health examinations. These colleges included the following information about their programs:

- Palmer College states that of the 4,620 total contact hours of instruction, 570 are in diagnosis, 300 are in radiology procedures and interpretation, and 945 are in practical clinical experiences in the Palmer Chiropractic Clinic system.⁶
- The University of Western States indicates nearly 1,000 of their 4,200 to 4,600 hours of training covers all aspects of ambulatory care patient evaluation, and the analysis and employment of best practices therein. This education includes didactic and practical skills instruction in emergency procedures, physical examination of each body region and system, laboratory diagnosis, differential diagnosis, imaging, triage, evidence based practice, etc. In addition to didactic instruction and practical application, clinical practice training rotations include extensive experience in the application of these competencies on a very diverse array of patients in ambulatory care settings.⁷

Dr. Gary Schultz, representing the applicant at the hearing, stated that chiropractors are trained in all the essential elements that are required in PPEs and CMV exams as a part of their core training. This training includes basic sciences, clinical sciences, and clinical experiences, which

⁶ Letter from Palmer College in response to proposal, dated August 30, 2013

⁷ Letter from University of Western States submitted in response to proposal, dated July 26, 2013

incorporate all areas of the body. It isn't an education focused simply on the neuromuscular skeletal system, but he admits there is a focus in that area because it is the primary area of treatment for most chiropractors' practice. Dr. Schultz further stated that the very broad education prepares chiropractors to diagnose any condition that would likely walk through an ambulatory care center's doors. He said at the very least, chiropractors are responsible to be able know what they can and can't treat and to be able to refer appropriately for conditions they encounter that are not within their scope.

We received many comments in response to this proposal stating that chiropractors have no training outside the musculoskeletal system. Our review of the documentation submitted by the applicant and others shows this to be an oversimplification. Current chiropractic programs provide broad medical training, including supervised clinical training; however, it is minimal in comparison to the substantial training they receive in aspects of chiropractic care. In addition, chiropractic programs are not required to include training in pharmacology. Some programs offer some training in this area, but the amount varies from program to program. Chiropractic schools don't require clinical rotations specific to areas such as family medicine, internal medicine, or pediatrics.

There are voluntary specialty certifications for chiropractors that include:

- American Chiropractic Board of Sports Physicians:
 - Certified Chiropractic Sports Physician (CCSP) which includes 100 hours of class time.
 - The Diplomate American Chiropractic of Sports Physicians which requires a CCSP and an additional 200 class hours, 100 hours of practical experience, plus an examination.

These specialty certifications include a small portion of broad medical training, but the primary focus appears to be on spinal and extremity manipulation, as well as exercise physiology and sports-specific biomechanics or occupational treatment.

- The Department of Labor and Industries offers the following certifications:⁸
 - Chiropractic Consultant Program. Chiropractors with additional clinical and workers' compensation-specific training may be certified to perform second opinion consultations for attending doctors to assist evaluation and care recommendations when a worker's recovery isn't meeting expectations. Training includes 180 post-graduate hours in subject areas such as diagnostic assessment, neurology, occupational health practices, and orthopedics. Only 20 hours are allowed in chiropractic technique.
 - Independent Medical Examiner (IME) certification. Chiropractors with two years of experience as a chiropractic consultant and who have taken an IME seminar may be certified to provide an independent assessment of a patient's status, including rating for permanent impairment.

⁸ <<http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/IICAC/default.asp#4>>, accessed September 11, 2013

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Current Regulation and Practice of Chiropractors

RCW 18.25.005 defines the chiropractic scope of practice:

- (1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
- (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments and extremity manipulation. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity.
- (3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.
- (4) Chiropractic care shall not include the prescription or dispensing of any medicine or drug, the practice of obstetrics or surgery, the use of x-rays or any other form of radiation for therapeutic purposes, colonic irrigation, or any form of venipuncture.

Chiropractors are currently required to perform physical examinations, but the purpose of those examinations is to determine the appropriateness of chiropractic care or the need for referral, not to assess the overall health of an individual. Current Washington law limits the practice of chiropractors to diagnosis, analysis, and care or treatment for restoration and maintenance of health of conditions relating to the musculoskeletal system.

Regulation in Other States

Washington's chiropractic licensing requirements are similar to those in other states, some with much broader scopes of practice. However, public expectations, regulatory policy, and legislatively created scope of practice are quite different. Three other states were mentioned during testimony comparing scopes of practice: Oregon, Michigan and Colorado. This report focuses on those states for comparison, which shows the diverse regulatory policies regarding the practice of chiropractic these states have based on their authorizing environments.

Michigan

Of the three states, Michigan is most like Washington in its approach to the chiropractic scope of practice. Michigan doesn't allow chiropractors to perform pre-participation examinations or commercial motor vehicle examinations exams.

An opinion by Michigan Attorney General⁹ makes it clear that physical examinations aren't within the scope of chiropractic practice:

Public health code doesn't include within chiropractic practice general physical examinations, including: analysis of blood, hair, urine samples, physical observations of throat, mouth, eyes, taking of pulse and blood pressures, and examination of lungs and abdomen, even if information such as that which can be ascertained from urine specimens and blood pressure test would be helpful, if not health preserving, in preparation for chiropractic treatment, since statute limits scope of chiropractic in determining existing subluxations or misalignments of the spine.

Michigan's chiropractic scope of practice statute is a part of Michigan Public Health Code (Excerpt) Act 368 of 1978, Section 333.16401:

(e)"Practice of chiropractic" means that discipline within the healing arts that deals with the human nervous system and the musculoskeletal system and their interrelationship with other body systems. Practice of chiropractic includes the following:

(i) The diagnosis of human conditions and disorders of the human musculoskeletal and nervous systems as they relate to subluxations, misalignments, and joint dysfunctions. These diagnoses shall be for the purpose of detecting and correcting those conditions and disorders or offering advice to seek treatment from other health professionals in order to restore and maintain health.

(ii) The evaluation of conditions or symptoms related to subluxations, misalignments, and joint dysfunction through any of the following:

Oregon

Oregon has a required form and protocol for PPEs (ORS 336.479). PPEs are required for all students participating in extracurricular sports in grades seven through 12. ORS 336-479 Section 1 (5) (e) allows a licensed chiropractor who "has clinical training and experience in detecting cardiopulmonary diseases and defects" to perform PPEs. The clinical training and experience is assumed, by the Oregon Board of Chiropractic Examiners, under the basic chiropractic licensing requirements.

However, Oregon clearly has a different policy view of chiropractic than Washington. Oregon defines a chiropractic physician as an attending physician and allows chiropractors to perform minor surgery and to use antiseptics and local anesthetics in connection with surgery.¹⁰ With additional certifications, they can perform proctology¹¹ and natural childbirth.¹² They are seen as primary care physicians and may sign birth and death certificates and conduct school physicals.¹³ They also perform physicals required by the United States Department of Transportation (USDOT). They may not "administer or write prescriptions for, or dispense drugs, practice optometry or naturopathic medicine or do major surgery"(ORS 684.015 (3)).

⁹ Attorney General, on Behalf of People v. Beno (1985) 373 N.W.2d 544, 422 Mich. 293

¹⁰ <<http://www.leg.state.or.us/ors/684.html>>

¹¹ OAR 811-015-0030 (2)

¹² OAR 811-015-0030(4)

¹³ Oregon Board of Chiropractic Examiners

Colorado

In Colorado, the rules regulating PPEs are left to individual schools or school districts or are delegated to the Colorado High School Athletics Association (CHSAA). Colorado High School Athletics Association requires PPEs to be conducted for student athletic participation in middle school, junior high and high schools.¹⁴ For chiropractors to perform PPEs for junior high and high school student athletes in Colorado, CHSAA requires initial certification and recertification every two years. The initial certification class is seven continuing education hours and covers topics of patient history and physical examination, guidelines for student sports participation in Colorado, and legal precautions.¹⁵

Colorado chiropractors may not perform surgery, practice obstetrics, treat cancer or prescribe legend drugs. Colorado chiropractors may perform an EKG/ECG if they have the required 120 hours of initial and related clinical with didactic training and demonstrated competency in cardiac medicine.¹⁶

Background on PPEs

A PPE is a physical examination that is generally required of student athletes prior to participation in school sports. The goal is to help maintain the health and safety of the athlete in training and competition. PPEs require evaluation of a wide range of body parts, such as eyes/ears/nose/throat, lymph nodes, heart, lungs, abdomen, skin and genitourinary system (for males). They also require an assessment of conditions such as asthma, diabetes, hernia, and heart conditions. The examiner is expected to determine whether a student athlete can safely participate in sports or whether clinical contraindications to practice or participation exist. (See Appendix F for the authorization form recommended by the WIAA).

These physical examinations have taken on more importance in recent years due to an increase in adverse events such as sudden cardiac deaths occurring in young athletes. An underlying or undetected heart condition that increases the risk of sudden cardiac arrest is one of the serious concerns that often escape detection during a PPE. The American Academy of Pediatrics estimates that approximately 2,000 people under the age of 25 die from sudden cardiac arrest in the United States each year. Student athletes run a significantly greater chance of experiencing sudden cardiac arrest than a non-athlete of the same age.¹⁷ Sudden cardiac arrest usually stems from a structural/functional defect in the heart or an electrical disorder. About 40 percent are caused by hypertrophic cardiomyopathy, an excessive thickening of the heart muscle.

Medical providers must be aware of the warning signs and symptoms of sudden cardiac death and respond appropriately with comprehensive cardiovascular evaluation, referral, treatment, and activity restrictions. Work is being done on preventing sudden cardiac death based on trained evaluation of patient history and physical examination, proper use of non-invasive cardiovascular testing, and a solid understanding of the conditions associated with sudden cardiac death in athletes. The Nick of Time Foundation, a nonprofit organization dedicated to preventing sudden

¹⁴ Colorado High School Athletics Association, <<http://www.chsaa.org/home/pdf/StateStauteHandbook.pdf>>

¹⁵ Colorado Chiropractic Association

¹⁶ Examiners 3 CCR 701-1 Colorado state Board of Chiropractic Examiners Rules and Regulations

¹⁷ Pediatrics, Volume 129, Number 4. April 2012. American Academy of Pediatrics Policy Statement

cardiac arrest in athletes, is one organization that is working to restructure the PPE with stricter regulations.

Many children being examined through PPEs have other diagnosed or undiagnosed medical conditions in addition to those on the standard PPE clearance form that may impact their ability to play sports safely. Many of these children are on medications for conditions such as asthma or attention deficit hyperactivity disorder (ADHD), which may carry risk of drug interactions with other prescription and over-the-counter medications. In 2009, it was reported that over a quarter of children in the United States were taking at least one medication on a chronic basis.¹⁸ In addition, according to CDC prevalence rates:

- The national child asthma rate is 9.5percent,¹⁹ many of whom use at least a rescue inhaler;
- In 2007-2008, between 3.7 and 4.7 percent of children in Washington State were on medication for ADHD.²⁰

Individual school districts in Washington have been given authority by the legislature to make rules regarding their interscholastic activities, including PPEs. RCW 28A.600.200 states:

“Each school district board of directors is hereby granted and shall exercise the authority to control, supervise and regulate the conduct of interschool athletic activities and other interschool extracurricular activities of an athletic, cultural, social or recreational nature for students of the district. A board of directors may delegate control, supervision and regulation of any such activity to the Washington interscholastic activities association or any other voluntary nonprofit entity and compensate such entity for services provided; subject to the following conditions . . .”

A school district may contract with the WIAA for administration of its athletic activities. Although the WIAA includes in its handbook a sample form for school districts to use for PPEs, there is a wide variety in the forms actually used by the various school districts and the WIAA’s 800-member high schools and middle/junior high schools.

Background on Commercial Driver’s License Physicals

Commercial motor vehicle data shows that more than 3,000 truck crashes per year result from the driver having a heart attack or other physical impairment.²¹ A medical eligibility clearance (or CMV) exam is required to help prevent medically unqualified drivers from operating commercial vehicles on our highways.

The CMV exam for interstate drivers includes many of the same items/conditions that are included in a PPE, such as cardiovascular conditions (Appendix G). These examinations also include requirements to evaluate and discuss mental health conditions, alcoholism, the effects of medications, and non-disqualifying medical conditions that require remedial care, including:

¹⁸ “So Young and So Many Pills.” *The Wall Street Journal*, December 28, 2010. Study conducted by Medco Health Solutions Inc. 2009.

¹⁹ <<http://www.cdc.gov/asthma/asthmaadata.htm>>, accessed September 11, 2013

²⁰ <<http://www.cdc.gov/ncbddd/adhd/data.html>>, accessed September 11, 2013

²¹ 2007 Study by the Washington State Department of Licensing, <<http://www.dol.wa.gov/driverslicense/cdlmedicalcertificates.html>>

- Possible side effects and interactions of prescription and over-the-counter medications that could negatively affect driving.²²
- Diabetes exemptions that may require blood glucose monitoring.²³

Due to safety concerns, the USDOT's Federal Motor Carrier Safety Administration (FMCSA) has set up a required registry for all health care providers who wish to conduct these examinations for interstate drivers. It describes the registry as:

The National Registry of Certified Medical Examiners (National Registry) is a new FMCSA program. It requires all medical examiners (MEs) who wish to perform physical examinations for interstate commercial motor vehicle (CMV) drivers to be trained and certified in FMCSA physical qualification standards. Medical examiners who have completed the training and successfully passed the test are included in an online directory on the National Registry website.²⁴

The medical examiner training reviews FMCSA-specific knowledge about CMV drivers and the physical and mental demands of the job. This training is required because specialized knowledge of CMV drivers is not included in health care practitioner education and licensure requirements. The training ensures that candidates have baseline instruction in FMCSA's CMV driver physical qualification standards, medical guidelines, and medical examiner responsibilities. Medical scope of practice is defined by each state and demonstrates the practitioner's clinical knowledge. The medical examiner training builds on that clinical knowledge and applies it to the fitness for duty determination for CMV drivers.

If a licensed chiropractor is authorized to perform general physical exams under state statute, they are able to complete the federal training and take the certification test to become a CMV examiner.²⁵ Forty-eight states allow chiropractors to perform CMV exams. Because the performance of physical examinations for reasons other than chiropractic care or referral to another health care provider is outside of the scope of practice for chiropractors in Washington as defined in RCW 18.25.005, chiropractors aren't eligible for FMSCA registry.

Definition of the Problem and Why Regulation is Necessary

The applicant states that the problem it is trying to remedy with the proposal is the arbitrary selection of which health care providers are allowed to perform PPEs and CMV exams in Washington.

These physical examinations are clearly outside the existing chiropractic scope of practice. Allowing performance of these physicals would be a substantial increase to the current scope. This would require the examiner to take on the role of primary care provider, examining and diagnosing systems and issues of the whole body, including assessing possible side effects and interactions of medications. Chiropractors have limited training in pharmacology and no prescriptive authority in

²² Medical Examination Report for Commercial Driver Fitness Determination Form # 649F (6045), <<http://www.fmcsa.dot.gov/documents/safetyprograms/Medical-Report.pdf>>

²³ Medical Advisory Criteria for Evaluation Under 49CFR Part 391.41, <<http://www.fmcsa.dot.gov/rules-regulations/administration/medical.htm>>

²⁴ <<https://nationalregistry.fmcsa.dot.gov/NRPublicUI/home.seam>>

²⁵ Federal Motor Carrier Safety Administration. 49 C.F.R. Section 390.5 Definitions, <<http://www.fmcsa.dot.gov/rules-regulations/administration/fmcsr/fmcsrruletext.aspx?reg=390.5>>

Washington. CMV exams may necessitate the examiner to make highly subjective decisions, such as whether cardiovascular disease should disqualify an individual, or whether a diabetic whose condition is adequately controlled by medication and diet should be allowed to drive.²⁶

The applicant states that chiropractic education prepares chiropractors to perform PPE exams competently. It states that many chiropractors perform cardiopulmonary exams in their offices on a daily basis; however, it acknowledges that not all chiropractors have maintained the level of competency to perform PPEs at the level they should be performed. This is the reason the applicant has stated it is requesting the endorsement to only allow chiropractors with additional training and testing to perform PPEs. This specialty training includes an 18-hour course for PPEs or Diplomate American Chiropractic of Sports Physicians sports medicine certification. The applicant states that chiropractors who don't specialize in PPEs and CMV exams will simply choose not to do them, just as medical doctors don't perform every type of service within their scope of practice.

In order to determine the adequacy of the endorsement proposed by the applicant, the department examined the core chiropractic training of currently licensed chiropractors. These practitioners may have been trained 30 years ago or last year, creating a wide diversity in training. In addition, even current chiropractic programs necessarily have a primary focus on chiropractic treatment, leaving much less time devoted to primary medical education. Some chiropractic programs like the University of Western States exceed the minimum accreditation requirements and incorporate a broader focus on medical training, but not all schools do the same. The department isn't convinced that the specialty certifications for sports medicine chiropractors include enough focus on broad medical training to adequately address the gap.

Concerns have been identified about how PPEs are currently being performed by other medical professions, including allegations that physicians miss underlying or undetected heart conditions that increase the risk of sudden cardiac arrest. These are concerns beyond the scope of this review. Expanding the chiropractic scope of practice won't address these issues. They are currently being debated in the broader health care system and the discussions are leaning toward increased regulations for those providers already performing them.

²⁶ Medical Advisory Criteria for Evaluation Under 49CFR Part 391.41, <<http://www.fmcsa.dot.gov/rules-regulations/administration/medical.htm>>

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, chapter 18.120 RCW, does not specifically address a proposal to modify or expand a profession's scope of practice; but RCW 18.120.010(2) states that when considering regulating health professions for the first time, the profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

The department has applied the criteria in RCW 18.120.010(2) to HB 1573.

First Criterion: Unregulated practice can harm or endanger health or safety.

This criterion has not been met.

Chiropractors are currently a thoroughly regulated profession. The public health and safety benefit of adding PPEs and CMV exams to the chiropractic scope of practice hasn't been proven, and the potential for harm is present. There is evidence that highly trained providers currently conducting PPEs sometimes miss the warning signs of heart conditions, or do not perform PPEs properly. Allowing providers with less training to perform PPEs won't alleviate this issue and may inadvertently compound the problem.

Chiropractic schools include supervised clinical training in many areas, including recognition of cardiac conditions. However, it's minimal in comparison to the substantial training they receive in aspects of chiropractic care; and not all currently licensed chiropractors receive this level of education. In addition, chiropractic programs aren't required to include training in pharmacology, although some programs offer some training in this area. The Diplomate American Chiropractic of Sports Physicians specialty certification has a strong focus on spinal and extremity manipulation, exercise physiology and sports-specific biomechanics.

Second Criterion: The public needs and will benefit from assurance of professional ability.

This criterion has not been met.

There are adequate laws and rules in place to assure the public of chiropractors' initial and continued professional ability for their current scope of practice. Chiropractors are clearly authorized to provide all aspects of care that deal with diagnosis or analysis and care of treatment of musculoskeletal disorders, including spinal adjustments, extremity manipulation, and other modalities. This includes physical examinations determining whether chiropractic treatment is appropriate or whether a referral is necessary to another health care provider. All licensed chiropractors have received training to provide these services.

The three versions of the proposal under review don't contain this assurance because:

- They do not change the chiropractic scope of practice in RCW 18.25.005 to include comprehensive physical examinations.
- Even if the department recommended language to clearly add these examinations in the chiropractic scope of practice, the applicants have not shown adequate training and supervised clinical experience to assure the public of the professional ability of currently practicing chiropractors to perform PPEs or CMV exams.
- Chiropractors have limited training in pharmacology, which can play a significant part in both types of physical examinations.

Third Criterion: Public protection cannot be met by other means in a more cost beneficial manner.

This criterion has not been met.

Public protection is already in place with the current scope of practice of chiropractors. Although the applicant shared anecdotal stories of children who could not find a health care provider to perform a PPE, and has concerns that there may not be sufficient providers to perform CMV exams in the future, they haven't submitted actual evidence that the public will be denied these services if this proposal isn't granted.

Issues have been identified with the PPE. These include studies showing that physicians don't always follow appropriate guidelines and that critical health conditions are often missed. This seems to indicate a need for stricter regulations and guidelines for those already conducting the physicals to follow. None of the versions of the proposal considered address these issues.

DETAILED RECOMMENDATIONS TO LEGISLATURE

In the course of the sunrise review, the department considered three different versions of the proposal and determined the sunrise criteria have not been met:

1. **The department does not support adoption of HB 1573 as written.**

Rationale:

HB 1573 does not amend the definitions of chiropractic or chiropractic treatment or care in RCW 18.25.005. Physical examinations for student athletes and commercial drivers aren't within the current chiropractic scope of practice.

2. **The department does not support the proposal submitted with the applicant report from WSCA in July, which included a proposal to add additional educational requirements for chiropractors to perform PPEs and CMV exams.**

Rationale:

The applicant report also does not propose to amend the definitions of chiropractic or chiropractic treatment or care in RCW 18.25.005. The applicant's proposal shouldn't be enacted, even with the additional training it intends to include in amendment language because the proposal still fails to amend RCW 18.25.005 to add the elements of a comprehensive physical examination to the chiropractic scope of practice.

3. **The department does not support expanding the chiropractic scope of practice to include PPEs and CMV exams.** The legislature requested that the department assess whether the proposal meets the sunrise criteria for expanding the scope of practice for chiropractors. The department interprets these physicals as outside the chiropractic scope of practice and they would be an expansion of that scope, as indicated in the request from the legislature. Therefore, we reviewed whether changing the definitions in RCW 18.25.005 expanding the scope to include these physicals would meet the sunrise criteria.

Rationale:

The department found potential risk of patient harm if PPEs and CMV exams are added to the chiropractic scope of practice. Specifically:

- Addition of PPEs and CMV exams would expand the chiropractic scope of practice well outside of their current capacity of diagnosing and treating conditions relating to the musculoskeletal system.
- PPEs and CMV exams are intended to be comprehensive medical examinations, not cursory screenings. These exams are sometimes the only examination the person receives regularly. For students, this includes the opportunity to receive age-appropriate vaccinations, which chiropractors can't perform.
- Chiropractic educational programs don't include adequate focus on pharmacology, which is necessary in both types of physical examinations.
- Although chiropractic training includes basic understanding of body and organ systems, including the cardiovascular system, the department is unable to find that it prepares chiropractors to potentially be the sole evaluator of all or most medical conditions.

- The additional trainings proposed by the applicant don't appear to adequately bridge the gap in training, especially considering the range of education obtained by current licensees. The Diplomate American Chiropractic of Sports Physicians specialty certification training's primary focus also appears to be on spinal and extremity manipulation, exercise physiology, and sports-specific biomechanics without a corresponding focus on broader medical conditions and pharmacology.
- Examining a patient to evaluate their overall health should be done by a primary care provider who can use their broad spectrum of training, clinical residency, and experience to conduct the evaluation.

REBUTTALS TO DRAFT REPORT

The department shared a draft report and recommendations with interested parties and invited comments before finalizing the report. We received three letters of rebuttal and one letter of correction that are summarized below. In addition, we received four letters in support of the draft recommendations. These letters aren't addressed below but are included in Appendix H.

Applicants

We received two letters of rebuttal from members of the applicant group, Lori Grassi and Dr. Lorri Nichols. We'll summarize the rebuttals and corrections below, along with our response or actions. The full rebuttals are included in Appendix H.

Lori Grassi

1. **Correction:** The applicant identified an error in the background sections of the report reflecting the date when chiropractors were first licensed in Washington.

Department Response

The department made an inadvertent error in this date in both the Executive Summary and Summary of Information sections of the report. The date was changed in both places to indicate chiropractors have been licensed in our state since 1919.

2. **Correction:** The applicant identified an error in citations where the department used the term "may" in relation to chiropractors performing physical examinations to determine the appropriateness of chiropractic care or the need for referral to other health care providers.

Department Response

This was also an inadvertent error. The department was aware that the statute (RCW 18.25.005(3)) uses the term "shall." We have corrected the report to indicate that chiropractors are required to perform these types of examinations to determine the appropriateness of chiropractic care or the need for referral to other health care providers.

3. **Information from Hearing:** The applicant was concerned that the department didn't include information it provided at the public hearing about intended amendments that didn't make it into HB 1573 last session that would have included changes to the definitions.

Department Response

The department has added the applicant's stated intent into the report. However, one of the three versions of the proposal we reviewed included expanding the scope of practice under appropriately amended definitions. Our task in this sunrise review was to review the proposal submitted. We cast a broad net in what we evaluated based on Representative Cody's direction that we provide "an assessment of whether the proposal meets the sunrise criteria for expanding the scope of practice," in her request for sunrise review that we provide

4. **Correction:** The applicant identified an inaccuracy regarding pharmacology training, where the department had stated that chiropractors don't have training in pharmacology. The applicant stated that chiropractors do have pharmacology in their core curriculum and that they review all prescription and over-the-counter medications as part of their basic intake and examination. The applicant specifically referenced the 2013 CCE Accreditation Standards, where it states that "toxicology" is required as part of the clinical sciences requirements, which include, physical, clinical and laboratory diagnosis; neurology; spinal adjustment/manipulation, and other topics, as well as a review of course materials of chiropractic colleges where toxicology or pharmacology were mentioned.

The applicant also took issue with the reference to chiropractors not having prescriptive authority within the report, stating that these examinations don't require prescribing, nor medical interventions.

Department Response

Pharmacology training: The department acknowledges inconsistencies in where we referenced chiropractic training in pharmacology. We have corrected any statement that indicates chiropractors have no pharmacology training. We did not intend to infer there is't training in this area, only that there are varying levels of education in pharmacology, based on when and where a chiropractor graduated. The applicant references in rebuttal comments a CCE Accreditation Standard requirement for a toxicology component. Toxicology and pharmacology are not the same, with toxicology dealing with poisons and their effect; and pharmacology dealing with drug origins, composition, use, and reactions.²⁷

Prescriptive authority: We acknowledge that PPEs and CMV examinations don't specifically require prescribing medications. Our intent was to show that because chiropractors don't have prescribing rights, most schools provide only minimum training in pharmacology.²⁸ We have clarified this in the report. In addition, lack of prescriptive authority becomes an issue if the PPE is a child's only annual examination because vaccinations are a safe and effective way to keep children from getting 14 serious and sometimes deadly diseases.

5. **Multiple Subjects:** The applicant's rebuttal number five had many different components so we are addressing those in pieces.

A. Performing physicals is outside the chiropractic scope of practice: The applicant indicated disagreement with the department's assessment that performing physicals is outside the chiropractic scope of practice for the reasons summarized below:

- The department has alleged chiropractors aren't qualified to perform physicals that would identify both chiropractic and non-chiropractic-related medical conditions. "An exam is an exam."

²⁷ Taken from Merriam-Webster definitions

²⁸ A 2010 press release from National University of Health Sciences stated it has determined that chiropractic physicians would need 90 hours of pharmacology to be able to prescribe safely from a limited formulary. It states that it offers chiropractic students 90 hours. <<http://www.nuhs.edu/news/2010/8/nuhs-prepares-dcs-for-limited-prescription-powers-in-nm/>>

- Because chiropractors are required to perform physical examinations within the chiropractic differential diagnosis, PPEs and CMV exams are also within their scope of practice. The applicant points to the CCE standards included with the applicant report materials as evidence supporting this claim, which the applicant feels the department has ignored.
- The department's assessment in the report that chiropractors cannot perform physicals for purposes other than chiropractic care is also incorrect. It provided the commission's interpretive statement CH-12-13-12 to the department as evidence of this.

Department Response

The department disagrees with these assertions. The current scope of practice in law limits chiropractors to performing physical examinations to determine the appropriateness of chiropractic care or the need for referral to other health care providers, not to do an overall health assessment of an individual. Interpretive statement CH-12-13-12 discusses independent *chiropractic* examinations at the request of a third party and doesn't support the applicant's claim. It states that if a chiropractor provides diagnosis or analysis but stops short of providing care or treatment, the activities are still considered the practice of chiropractic. For instance, if a chiropractor only reviews a patient's file without a physical examination of the patient, that patient review is still considered the practice of chiropractic.

- B. Chiropractic Education:** The applicant stated evidence has already been provided to show that chiropractors are trained to perform these physical exams, including a letter from the University of Western States on the curriculum, but the department ignored this training and subjected chiropractors to a double standard.

Department Response

The department disagrees with this assessment. We reviewed all of the documents the applicant provided and have responded to the educational questions.

- C. Heart Conditions Undetected by Physicians:** The applicant stated that the department acknowledged the existence of heart attacks following USDOT physicals and sudden cardiac death events in athletes who have undergone PPEs as a concern, but didn't attribute these events as occurring in "the medical community's watch."

Department Response

The department has acknowledged these events occur in PPEs already being conducted (on page 14 under Background on PPEs and on page 17 under Definition of the Problem and Why Regulation is Necessary). In response to the applicant's concern, we added more specific language on page 17 that discusses heart conditions undetected by physicians.

- D. Document Reference:** The department had referenced a document on the WSCA's website in a statement about a chiropractor's training being intended for recognizing conditions outside the scope of chiropractic for referral to other health care providers. The applicant stated information from the University of Western States was provided that we should have reviewed, rather than choosing a state association document.

Department Response

We reviewed all of the materials provided from the applicant on the University of Western States curriculum. Our choice to reference the WSCA document wasn't intended to replace the school curriculum but an attempt to capture a middle ground between the varying educational programs. After further review, we have removed the statement entirely.

- E. Diplomate American Chiropractic of Sports Physicians Training:** The applicant took issue with the statement that only four percent of the examination is focused on the PPE.

Department Response

That wasn't the exact context of the statement; however, the department has removed this statement because we have attempted to clarify our position related to this sports medicine certification that isn't based solely on the examination components.

- 6. PPEs are not screening exams:** The applicant argues that the department is incorrect in stating that PPEs aren't merely screenings, but are intended to be comprehensive physical evaluations.

Department Response

The department firmly believes that PPE and CMV exams both require comprehensive physical examinations to determine whether an individual can safely participate in sports or drive commercial vehicles. In order to conduct thorough examinations, the providers performing these physicals should be qualified to make subjective decisions on conditions that may disqualify individuals with conditions like diabetes or asthma from safely participating in sports or driving commercial vehicles. These providers must also be able to assess and discuss side effects and interactions of prescription medications. The instructions for performing CMV exams in CFR 391.43 state "The purpose of this history and physical examination is to *detect the presence of physical, mental, or organic conditions* of such a character and extent as to affect the driver's ability to operate a commercial motor vehicle safely. The examination should be conducted carefully..." (emphasis added).

Review of the Proposal Using Sunrise Criteria

The applicant also had issues with how the department addressed the sunrise criteria in the report. The main points included:

- **First Criterion** - The applicant disagreed with the department's statement "allowing providers with less training to perform PPEs won't alleviate the issue" of highly-trained providers currently conducting PPEs missing warning signs of heart conditions. The applicant stated this is penalizing the chiropractic profession and limiting patient access, and is not appropriate.

Department Response

We don't feel this is penalizing the chiropractic profession. In reviewing scope of practice expansions, the department must look at whether the proposal ensures adequate training, which we feel the current proposals under review don't contain.

The fact that another profession does or doesn't perform PPEs adequately isn't relevant to the review.

- **Second Criterion** – The applicant stated that this criterion requires the scope of practice language to be changed in order to avoid lack of clarity, but “is clearly not a reason to recommend chiropractors that should not perform these exams.” The applicant also stated the department disregarded the information provided on education and training that qualifies chiropractors to be authorized to perform CMV physicals, as well as the decision of the federal government.

Department Response

We clearly stated that changes to the definitions in RCW 18.25.005 must occur in order to accomplish an increase in the scope of practice for chiropractors. The department disagrees that we disregarded the information provided on chiropractic education and the decision of the federal government.

- **Third Criterion** – The applicant stated this criterion has already been met because chiropractors are already regulated.

Department Response

The department disagrees with this statement because public protection is in place with the current scope of practice, but the sunrise proposals don't contain similar assurances.

- **References** – The applicant referenced materials provided with the original sunrise application as well as follow-up after the hearing about American Heart Association guidelines for use in PPEs. The materials discussed lack of compliance with the guidelines by providers doing PPEs.

Department Response

The department acknowledged this lack of compliance with appropriate guidelines in the report, as well as other issues identified with the way PPEs are currently being conducted. We saw these as issues to be addressed, but not with this proposal.

Dr. Lorri Nichols, DC, CCEP

1. **Use of “may” regarding conducting physicals** - Dr. Nichols addressed the incorrect use of “may” in relation to conducting physical examinations and stated that the department made a significant error that she feels represents a bias about chiropractic education, training and daily practice. She further stated this demonstrates that the department is under an unfortunate and incorrect opinion that HB 1573 would be an expansion rather than what she states is really a clarification of the scope of practice. She also added that the information the applicant presented shows chiropractors have adequate education and training, including the Diplomate American Chiropractic of Sports Physician and CCSP specialties.

Department Response

We addressed this issue in our response to Ms. Grassi's rebuttals above, acknowledging the unintentional error and amending it in the report. We disagree that this is a clarification for reasons stated in our responses to Ms. Grassi's rebuttal statements.

2. **Screenings or Physicals** – Dr. Nichols also disagreed with the department's assessment that these examinations are intended to be comprehensive physical examinations. She reiterated Ms. Grassi's argument that doctors who perform these examinations don't prescribe medications.

Department Response

Please see responses to Ms. Grassi's rebuttal comments above.

Dr. Ben McCay, DC

1. **Physical Examination** – "There is no RCW that says comprehensive physical exams are not part of the chiropractic scope of practice. The 'physical examination' I was taught in school is comprehensive."

Department Response

The department reiterates our position that the physical examinations required for PPEs and CMV exams aren't currently included in the chiropractic scope of practice in statute. We have addressed the education and training in our above responses.

2. **Prescriptive Authority** – Prescriptive authority isn't necessary to perform the PPE, only to treat a condition upon referral to an MD.

Department Response

The department addressed this issue in our responses above.

3. **Diplomate American Chiropractic of Sports Physicians Certification** – It is incorrect to state the Diplomate American Chiropractic of Sports Physicians certification focuses primarily on spine, extremities, etc. It is 25 percent emergency medicine, including showing proficiency as an emergency medical technician. Other parts include extensive training in the management of concussion and keys to a proper cardiac exam.

Department Response

In reviewing the Diplomate American Chiropractic of Sports Physicians certification materials, the department is unconvinced that this training bridges the gap in education, especially considering the divergent range of education obtained by current licensees.

4. **MDs Currently Performing PPEs** – Dr. McCay states that many MDs doesn't have a "daily practice that includes functions of primary care," providing examples such as orthopedists and many sports physicians who can perform PPEs.

Department Response

The department has acknowledged issues with the current performance of PPEs and continues to assert that the proposal doesn't address these problems.

5. **No solid evidence the number of deaths in sports will increase if DCs were allowed to perform PPEs** – He states that "the number one killer in sports (hypertrophic

cardiomyopathy) is not traditionally detected through a routine examination. Clues to HCM are only found in the patient history. Therefore, there remains no solid evidence that the number of deaths in sport will increase if DCs were allowed to perform PPEs.”

Department Response

The department doesn’t allege to have evidence to this effect, only that there is a problem with the current process that this proposal doesn’t address.

Washington East Asian Medicine Association

The association requested a correction to a statement in the draft report that chiropractors are allowed to perform dry needling in Oregon. They stated this is no longer correct due to a judicial stay issued by the Oregon Court of Appeals of the enabling administrative rule.

Department Response

The association is correct that dry needling by chiropractors in Oregon is under judicial scrutiny. We have removed the reference to the use of dry needling in Oregon on page 13.

Appendix A

Applicant Report

Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

Legislative proposal being reviewed under the sunrise process (include bill number if available):

HB 1573- This legislation, as drafted, would include school districts in the description of "political subdivisions", and specifically identified the "Washington Interscholastic Activities Association" in the entities not allowed to discriminate in 18.25 RCW. The proposed legislation would also allow doctors of chiropractic to perform sports physicals for school athletes and physicals examinations for commercial truck drivers.

The bill did not move from the House Health Care Committee therefore no amendments were able to be proposed however; we propose the following changes to the initial bill draft:

1. Remove reference to the Washington Interscholastic Activities Association (WIAA); and
2. Apply the proposed legislation to all youth sports; and
3. Propose additional training requirements for those doctors of chiropractic who would be eligible to perform pre-participation physical examinations; and
4. Require Federal Motor Carrier training for doctors of chiropractic performing the physical examinations that would meet the criteria of the Federal Motor Carrier Safety Act.

Name and title of profession the applicant seeks to credential/institute change in scope of practice:

Chiropractic

Applicant's organization:

Washington State Chiropractic Association

Contact person:

Lori Grassi
Executive Director
21400 International Boulevard, Suite 207
SeaTac, WA 98198
LGrassi@chirohealth.org
206-878-6055 (office)
253-988-0500 (cell)

Number of members in the organization:

800

Approximate number of individuals practicing in Washington:

1500-1600

Name(s) and address(es) of national organization(s) with which the state organization is affiliated:

None

Name(s) of other state organizations representing the profession:

None

Outline of Factors to be Addressed

Supporting Documentation Attachments:

Attachment A: Draft bill language

Attachment B: Syllabus for Pre Participation Exam Course

Attachment C: Diplomate of the American Chiropractic Board of Sports

Physicians Candidates Guide

Attachment D: Scope from Other States 2008

Attachment E: Congress of Chiropractic State Associations state by state allowance of PPE, 2013

Attachment F: CCE Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status

Attachment G: Guidance for the Core Curriculum Specifications, Federal Motor Carrier Safety Act, US Department of Transportation

Attachment H: Complete Guide to Medical Examiner Certification

(1) Define the problem and why regulation is necessary:

Regulation is necessary to assure standards of care are met in the performance of physical examinations (PPE) as well as to meet Department of Transportation (DOT) requirements. Regulation assures that a minimum level of competency is obtained by all providers performing these examinations.

The problem identified by the Washington State Chiropractic Association (WSCA) is the arbitrary selection of which health care providers are identified to perform these examinations. Specifically, Doctors of Chiropractic are excluded from the privilege of performing athletic pre-participation examinations (PPE) and Department of Transportation (DOT) examinations in Washington State.

The regulation of DOT professional driver physical examinations are regulated nationally through the Federal Motor Carrier Safety Act (1992). The DOT classifies doctors of chiropractic as health care

providers permitted to perform DOT examinations. The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training. The WSCA requests that the federal DOT rules and regulations also be applied in the State of Washington.

Taken from the Federal Motor Carrier Safety Act, Department of Transportation website, frequently asked questions document:

Q: Who can serve as a Medical Examiner and perform DOT Physical Exams?

A: Federal Motor Carrier Safety Regulations define Medical Examiner as 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.

There are no federal guidelines regarding PPE examinations. States decide on an individual basis who may provide a PPE. Almost half of the states authorize doctors of chiropractic to perform PPE, one State (Colorado) provides for additional certification for interested doctors of chiropractic to become listed on a registry to perform the PPE. Attachments D and E reference application of PPE's in other states.

The WSCA seeks consistency in the scopes of practice in Washington State as compared to others including the Federal Government and States which provide for doctors of chiropractic to perform PPEs.

There is significant demand by the public for these services. The restrictions prohibiting interested chiropractic doctors from providing the care to their patients in a cost effective manner creates delays in health care services and additional expenses for patients because of the shortage of primary care physicians. Additionally, patients have existing and established relationships with their chiropractic doctors. These patient health care provider relationships should not be unnecessary limited in regards to providing cost efficiencies, timeliness and continuity of appropriate health care services.

(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety.

There is minimal to no additional risk to the public because doctors of chiropractic are regulated by the State of Washington under RCW 18.25.005 and these clinicians provide an important role in health care in the State of Washington. The current regulatory scope of practice does not reflect recent advances in the education of the chiropractic profession including specialty and recent trends in voluntary training to demonstrate additional competencies. This proposal recognizes doctors of chiropractic with specialty training or additional voluntary training specific to these areas of practice provide an important quality assurance measure. This proposal will protect public health and safety through education and training.

(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession.

Consumers will benefit by greater access to qualified health care providers with specialized training in the pre-participation examination and federal recognition to perform DOT examinations.

Special certification in the PPE is unique to the chiropractic profession as this group of health care providers meets inclusion through voluntary processes to ensure clinical competencies. The WSCA recognizes the variability of clinical expertise on all health care provider groups. To protect the

citizens of Washington the WSCA promotes additional training and measurements of competency for those doctors of chiropractic who are interested in providing additional services to their patients. The voluntary participation and identification of doctors of chiropractic with special training, as recognized by state or federal regulatory bodies, provides for a measure of quality assurance to consumers that meets or exceeds other health care provider groups.

(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and (ii) The extent to which practitioners are supervised:

Proposed updates to the scope of practice will benefit the public by proving a mechanism whereby the public can be assured that participating licensed doctors of chiropractic who provide DOT or/and PPE examinations meet and maintain additional training in regards to the new services they provide. This proposal defines the level of education required to maintain such training.

(2) The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem:

The proposed changes to scope of practice would clarify current law under RCW 18.25.005 by further defining a subset of doctors of chiropractic specially trained in sports medicine, the performance of a PPE and DOT regulations.

Current law allows for doctors of chiropractic to perform a physical examination, however the PPE is not specifically addressed. The ability to perform the PPE which results in the clearance of athletes to participate in organized sport should be within the scope of practice for trained health care providers including doctors of chiropractic. Due to growth in the profession, there are groups of doctors of chiropractic with special training in certain fields of health care. These fields of specialty training include sports medicine and the performance of DOT examinations. This proposal provides for special acknowledgement in the practice act to define these specially trained doctors of chiropractic.

There are no proposed changes to current law that would affect the current code of ethics of the profession nor changes to RCW 18.130 (Regulation of health professions — uniform disciplinary act).

(3) The alternatives considered: (a) Voluntary efforts, if any, by members of the health profession to: (a) Regulation of business employers or practitioners rather than employee practitioners; (b) Regulation of the program or service rather than the individual practitioners; (c) Registration of all practitioners; (d) Certification of all practitioners; (e) Other alternatives; (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and (g) Why licensing would serve to protect the public interest.

Updating RCW 18.25.005 to the standards as proposed in (Attachment A) would serve the public interest by allowing specially trained doctors of chiropractic to perform services in high public demand. Additionally, this proposal serves as a quality assurance measure by identifying a subgroup of the profession with special training and providing a portal for consumers to access a list of providers that hold State or Federal recognition to provide needed services.

There are no provisions in the proposed standards for services to be performed by anyone other than individuals licensed in RCW 18.25.005. A certification requirement by endorsement to the chiropractor's license is the most effective way to manage the training and certification requirements have been met and that those performing these examinations are safe. Due to the autonomous nature of chiropractic practice endorsement by the Chiropractic Quality Assurance Commission is the most appropriate methodology.

(4) The benefit to the public if regulation is granted. Consumers will benefit from the updated standards now being proposed as these standards will allow the practitioner with special training to provide a broader range of services within the current regulating guidelines for doctors of chiropractic.

Primary care medicine is an underserved need in health care. PPEs and DOT examinations have traditionally been performed by primary care health care providers. Allowing for additional providers with special training to provide PPE/DOT examinations, consumers will benefit from greater access to care as well as the right to seek care from the health care providers they choose.

The public will be assured of quality of care by the educational endorsement requirements described in this statute.

Currently the statute does not reflect the growth of the profession or allow for interested practitioners to fully utilize their specialized post-graduate training for the health and enrichment of the public.

Consumers seeking fitness for duty examinations by qualified Medical Examiners, as defined in the Federal Motor Carrier Safety Act, will benefit by having greater access to providers especially in rural areas of Washington State. Currently there are only 24 total providers listed in the National Registry available to perform Department of Transportation examinations for commercial drivers.

(4)(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation;

This proposal addresses only regulated health care providers. The educational and knowledge assessment procedures are designed to mitigate known concerns. Therefore, in order for doctors of chiropractic to be allowed to perform these examinations the scope of practice must be specifically defined.

(4)(b) Whether the public can identify qualified practitioners.

The Department of Health (DOH) has an easily navigable and searchable Web-site that lists all practitioners by name and license number so the public can identify qualified doctors of chiropractic. All information regarding a chiropractor's current licensing status or issues involving licensure is clearly marked and for public record. This proposal requests that the DOH Chiropractic Quality Assurance Commission add a section to this web site that clearly identifies doctors of chiropractic with specialty training in the PPE or that the Chiropractic Quality Assurance Commission maintain a list of doctors of chiropractic who have received the endorsement following certification and testing. As an additional resource the Washington State Chiropractic Association is able to maintain a list of providers available to consumers and the designation can be identified on its website when searching for chiropractic services.

The doctors of chiropractic engaged in the Federal Motor Carrier Safety fit for duty examinations will be identified through the National Registry of Certified Medical Examiners (National Registry) is a new Federal Motor Carrier Safety Administration (FMCSA) program. It requires all medical examiners (MEs) who wish to perform physical examinations for interstate commercial motor vehicle (CMV)

drivers to be trained and certified in FMCSA physical qualification standards. Medical examiners who have completed the training and successfully passed the test are included in an online directory on the National Registry website.

(4)(c) The extent to which the public can be confident that qualified practitioners are competent.

Based on the testimony of comments provided at the February 21, 2013, hearing in the House Health Care Committee for the proposed legislation, it is clear that the general public, especially our opposition, is unaware of the base chiropractic education.

By statute, a chiropractic doctor must graduate from a Council on Chiropractic Education (CCE) accredited college or university. CCE accredited institutions require the doctor of chiropractic programs to include training in physical diagnosis through an absolute minimum of 4,200 instructional hours, and include curriculum in the following topics: anatomy; biochemistry; physiology; microbiology; pathology; public health; physical, clinical and laboratory diagnosis; gynecology; obstetrics; pediatrics; geriatrics; dermatology; otolaryngology; diagnostic imaging procedures; psychology; nutrition/dietetics; biomechanics; orthopedics; neurology; first aid and emergency procedures; spinal analysis; principles and practice of chiropractic; clinical decision making; adjustive techniques; research methods and procedures; and professional practice ethics.

The accreditation requirements for CCE can be found in the document titled "Council on Chiropractic Education Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status" A detailed outline of the curriculum pertaining to the physical examination requirements are detailed in attachment F, pages 31-34.

In addition, examinations for license to practice chiropractic shall be developed and administered, or approved, or both, by the commission according to the method deemed by it to be the most practicable and expeditious to test the applicant's qualifications. The commission may approve an examination prepared or administered by a private testing agency or association of licensing authorities. In Washington State the Chiropractic Quality Assurance Commission uses the national examination for chiropractic which is approved by the Council on Chiropractic Education (CCE) and the examination for licensing is administered by National Board of Chiropractic Examiners (NBCE).

Examination subjects may include the following: Anatomy, physiology, spinal anatomy, microbiology-public health, general diagnosis, neuromusculoskeletal diagnosis, X-ray, principles of chiropractic and adjusting, as taught by chiropractic schools and colleges, and any other subject areas consistent with chapter 18.25 RCW. The commission shall set the standards for passing the examination. The commission may enact additional requirements for testing administered by the national board of chiropractic examiners.

All examinations are managed by NBCE including Parts 1- IV which includes the following:

Part I

Includes subject examinations in each of six basic science areas: general anatomy, spinal anatomy, physiology, chemistry, pathology, and microbiology. Each subject examination contains 110 standard multiple-choice questions and is allotted 90 minutes of testing time.

Part II

Consists of 110 multiple-choice questions in each of six clinical science areas, including general diagnosis, neuromusculoskeletal diagnosis, diagnostic imaging, principles of chiropractic, chiropractic practice, and associated clinical sciences. Each Part II subject is allotted 90 minutes of testing time, with a 20-minute break between subjects.

Part III

Addresses nine clinical areas: case history, physical examination, neuromusculoskeletal examination, diagnostic imaging, clinical laboratory and special studies, diagnosis or clinical impression, chiropractic techniques, supportive interventions, and case management. The Part III Examination consists of two books, with a total of 110 standard multiple-choice questions and 10 case vignettes, broken down as follows:

- Each book has 55 standard multiple-choice questions, plus five case vignettes
- Each of the five case vignettes contains three extended multiple-choice questions
- Each extended multiple-choice question requires three answers

Each book is allotted two hours of testing time.

Part IV

The NBCE Part IV Examination tests individuals in three major areas:

- x-ray interpretation and diagnosis
- chiropractic technique
- case management

Results of the Part IV Examination may be used by state licensing authorities in lieu of other practical examinations for licensure. The NBCE Part IV Examination is administered in May and November of each year.

In Washington State the CQAC began using Part IV in May of 1999 to replace their x-ray practical examination but still required the Washington State generated chiropractic practical exam. In 2000, Washington State began requiring Part IV for licensure without further state generated practical tests. Presently, Part IV is accepted in all licensing jurisdictions in the United States except for Illinois, which has no requirement for a practical licensure examination.

(4)(c)(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system.

The regulatory entity for the chiropractic profession in Washington State is in place and there are no additional boards needed if this proposal is implemented. The current Chiropractic Quality Assurance Commission is already established and receives complaints and manages disciplinary action on all chiropractic matters.

(4)(c)(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date.

No grandfather clause is proposed for the PPE, all doctors participating would be required to meet the PPE examination.

The DOT provides for the measurement of competency in regards to the DOT examination. Individuals meeting the federal requirements should be permitted to provide the DOT physical examination service.

(4)(c)(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions.

Currently more than 15 states have special regulations regarding the PPE in their chiropractic practice acts. One state, Colorado, currently requires special certification as proposed in this document. A summary of these regulations is enclosed in appendix E.

The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training. The WSCA requests that the federal DOT rules and regulations also be applied in the State of Washington. The Guidance for the Core Curriculum Specifications is provided as Attachment G, and the Complete Guide to Medical Examiner Certification is provided as Attachment H. All providers must achieve certification to qualify as a DOT Medical Examiner.

(4)(c)(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions.

This is not applicable to a profession regulated under the Secretary of Health.

(4)(c)(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met.

The educational coursework and competency testing would be offered at least once annually. There are two tracks available to Doctors of Chiropractic to become registered to perform the PPE:

1. A 18 hour course that prepares the Doctor of Chiropractic to perform the pre-participation examination and make clearance decisions to participate in sport. The course syllabus is attached in Appendix B. The preparatory PPE course is a 12 hour didactic course that delivers specific PPE education through either live or distance based education accompanied

by a minimum of six additional hours of practical education. The education syllabus would be approved by the Washington Quality Assurance Commission.

AND

An outcome evaluation that measures the learner's competency would be provided. A minimum passing score of 80% or better on a written/practical examination.

Current board certification by the American Chiropractic Board of Sports Physicians as a Diplomate of the American Chiropractic of Sports Physicians (DACBSP) would be eligible to challenge the PPE written examination because of their prior training and education in regards to this topic. The educational requirements for the DACBSP are attached in Attachment C.

No additional supervised field experience is required as part of this training program.

All doctors would be required to demonstrate certification in CPR. CPR training will be obtained outside the PPE course and minimally meet the CPR and AED for the professional rescuer.

To ensure continued competence and knowledge of best practices in performing PPEs, all participating doctors will need to recertify every two (2) years through additional training coursework consisting of four hours followed by an additional competency evaluation. The recertification examination will focus on core learning objectives as well as new information regarding PPEs. Learner outcome examinations will be considered successful with an 80% examination score. The recertified doctor's names would then be updated on the PPE DC Registry.

All course content and examinations would be created by Doctors of Chiropractic holding the highest board certification in sports medicine (Diplomate of the American Chiropractic Board of Sports Physicians) and the clinical expertise in the area of the PPE.

Training and examination development costs would be paid for the Washington State Chiropractic Association.

There are existing training programs for the National Registry of Certified Medical Examiners to provide the prerequisite education. The DOT provides for the examination and maintenance of the DOT related recognition.

(4)(c)(vi) What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected work force, including reentry workers, minorities, placebound students, and others.

As described in (4)(c)(v) additional training for the DOT pathway is already in place and for the PPE additional training in the form of live or distance based education would be required. All training courses would be approved by the Washington State Chiropractic Quality Assurance Commission,

be affiliated with CCE approved educational institutions, and instructors would be required to hold an advanced certification in sports medicine (DACBSP required) as well as a minimum of 5 years of experience in the performance and analysis of the PPE. Institutions providing training must include distance based platforms for training in order to reduce educational costs associated with travel.

(4)(d) Assurance of the public that practitioners have maintained their competence.

Assurance of practitioner competence is achieved through the public's ability to freely access licensing and PPE certification information through the Department of Health Web site or by contacting the Department of Health directly. The list of active certificate holders will provide the public with a list of doctors of chiropractic who have been found to be competent in the PPE by written examination within the previous 2 years.

The Federal government requires all health care providers, regardless of their terminal degree, to be certified and tested through the National Registry of Certified Medical Examiners and provides the necessary training.

(4)(d)(i) Whether the registration, certification, or licensure will carry an expiration date.

The current PPE proposal includes an expiration date of 2 years from certification. Renewal will be allowed by challenge examination for those already certified.

The Federal government manages the National Registry of Certified Medical Examiners.

(4)(d)(ii) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement.

Renewal will be based on the ability to pass a written examination. A small fee for administration expense related to PPE test and database administration will be required as part of the renewal process.

The Federal government manages the related fees for the National Registry of Certified Medical Examiners.

(5) The extent to which regulation might harm the public.

The regulation will provide quality assurance to the public and reduce risk of harm. The proposed regulations improve quality of care by identifying specially trained providers for a service that is in high demand in the State of Washington. This PPE proposal exceeds requirements of other professions currently providing PPE examinations.

(5)(a) The extent to which regulation will restrict entry into the health profession: (i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance.

The proposed standards do not restrict entry based on existing or new licensing requirements; there are no proposed changes to existing licensing requirements. The proposed standards are not more restrictive than necessary as they do not require mandatory use of the techniques by practitioners nor application to every patient.

(5)(a)(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification, and licensure when the other jurisdiction has

substantially equivalent requirements for registration, certification, or licensure as those in this state.

Alternative or equivalent certification programs or education requirements are not accepted.

(5)(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation.

This regulation is not relevant to any other groups or subgroups.

(6) The maintenance of standards: (a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics.

The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(6)(b) How the proposed legislation will assure quality, (i) The extent to which a code of ethics, if any, will be adopted.

The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(6)(b)(ii) The grounds for suspension or revocation of registration, certification, or licensure.

The proposed standards do not change the current code of ethics as regulated by the Quality Assurance Commission.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Doctors of chiropractic in the state of Washington, currently number between 1500-1600. There are no different levels of practice within this group.

(8) The expected costs of regulation:

There will be costs associated with this proposal in terms. These include rulemaking costs, website upkeep and certification maintenance costs. The costs related to the proposed regulation would be the obligation of the professionals selecting these endorsements.

We anticipate additional revenue to the state by the purchase of PPE certification and certification renewal costs.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

The current scope of practice of doctors of chiropractic is defined in WAC Chapter 246-808. A classification of chiropractic procedures and instruments list is available through the Washington Department of Health: <http://www.doh.wa.gov/portals/1/Documents/Pubs/641042.pdf>

The use of these procedures is dependent on the practitioner and no valid estimate of procedures across the entire profession is available at this time.

HOUSE BILL 1573

State of Washington

63rd Legislature

2013 Regular Session

By Representatives Harris, Hope, Pettigrew, Green, Walsh, Cody, Moeller, Stonier, and Morrell

Read first time 01/31/13. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to clarifying the prohibitions against
2 discriminating against licensed chiropractors; and amending RCW
3 18.25.0194 and 18.25.0195.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 18.25.0194 and 1974 ex.s. c 97 s 3 are each amended to
6 read as follows:

7 The state and its political subdivisions, including school
8 districts, and all officials, agents, employees, or representatives
9 thereof, are prohibited from in any way discriminating against licensed
10 chiropractors in performing and receiving compensation for services
11 covered by their licenses. Licensed chiropractors must be allowed to
12 perform sports physicals for school athletes and physical examinations
13 required for commercial driver's licenses.

14 **Sec. 2.** RCW 18.25.0195 and 1974 ex.s. c 97 s 4 are each amended to
15 read as follows:

16 Notwithstanding any other provision of law, the state and its
17 political subdivisions, and all officials, agents, employees, or
18 representatives thereof, are prohibited from entering into any

1 agreement or contract with any individual, group, association,
2 including the Washington interscholastic activities association, or
3 corporation which in any way, directly or indirectly, discriminates
4 against licensed chiropractors in performing and receiving compensation
5 for services covered by their licenses.

--- END ---

Washington State Chiropractic Course Syllabus

Course Name: Pre-participation Examination (PPE)

Hours: 18

Course Description

This 18 hour course will provide Doctors of Chiropractic with current information concerning performing pre-participation examinations. The course is designed for the general practicing Doctor of Chiropractic. This course contains outcome evaluative measures in the form of a final examination. Participants would be expected to repeat this course every two years.

Course Objectives / Outcomes:

- Understand the proper structure and implementation of a PPE
- Know the standard of care concerning the PPE
- Apply the knowledge of physical examination and history taking to provide for the proper assessment of athlete's eligibility to safely participate in sport.
- Learn the key components of the PPE
- Refine the skills associated with obtaining and evaluating a health history.
- Develop further appreciation of the conditions encountered in the athletic population that involve an individual's ability to safely participate in sport.
- Analyze the history and physical examination to determine clearance to participate in sporting activities.
- Recognize and develop the skills to implement the key components of the cardiovascular examination.
- Analyze heart sounds to determine patient selection for referral or additional studies.
- Evaluate several case studies of athletes and perform synthesis of the case study to determine clearance to participate in sporting activity.

Course Outline:

Hour

1. General information regarding the expected standards of care, including the primary and secondary objectives of the pre-participation examination. The protocol for performing and recording the PPE is described in a step-by-step fashion.
2. Classifications of sports including by contact and by cardiovascular stress are described. Administrative, ethical and legal concerns will be addressed.
3. Review of the formats of the pre-participation examination, to include timing setting and structure. The station based versus 1:1 PPE is described along with the advantages and disadvantages of these formats as well as issues and concerns regarding obtaining and evaluating the patient history for the pre-participation exam. Specific

discussion regards to the care of minors and the recognition of the keys to the participation examination history.

4. Marfan Syndrome characteristic signs and symptoms is discussed as it relates to the PPE and proper referral. The female triad is described along with the formulation of a multiple disciplinary care plan.
5. System Based examinations: Obtaining, reviewing and interpreting vital signs. Discussion on how to manage the deconditioned athlete.
6. The physical examination of the head, neck, skin, peripheral vascular and lymphatic systems.
7. One hour lab on the above topic.
8. The general physical examination.
9. One hour lab on the above topic.
10. The methodology and performance of the musculoskeletal examination is investigated.
11. One hour lab in the above topic.
12. The cardiovascular examination to include pulmonary evaluations and assessment of peripheral pulses.
13. Cardiovascular and pulmonary practical skills workshop.
14. Other disqualifying disorders and conditions are discussed.
15. The importance and methodology determining clearance to participate is provided
16. Examination and case study workshop.

Evaluation Methods: A formal multiple-choice examination is administered at the termination of the course materials. There will be at least three questions for every hour of the class. The learner will also be required listen to evaluate heart and chest sounds and complete multiple case-based studies to determine clearance. The learner must score 75% to receive credit for the course and to be listed on the registry.

DACBSP Certification Candidate Handbook can be found at:

<http://www.acbsp.com/pdf/DACBSP%20Candidate%20Handbook2009.pdf>

ABSTRACT 18

A SURVEY OF CHIROPRACTORS ACCESS TO PERFORM PRE-PARTICIPATION EXAMINATIONS (PPEs)

Anne Sorrentino, DC, CCSP, Andrea Sciarrillo, DC, CCSP and Richard Rinzler, DC, DACBSP®, FICC

OBJECTIVE: The purpose of this survey is to determine if there is consistency across the United States in allowing chiropractors to perform pre-participation examinations.

METHODS: Addresses for both the state chiropractic boards (SBCs) and the state athletic associations (AAs) were located via the internet. A letter was generated and emailed to each state. The wording in the letters going to the state boards of chiropractic and athletic associations were altered appropriately. Return receipts were requested. If no answer was received within 2 weeks, a second request was sent. If two more weeks went by without a response, a phone call was placed to the individual. Results were then tallied into an Excel spreadsheet, including specific comments. Responses were received from all states.

RESULTS: 70% (35) of the chiropractic boards have policies allowing PPEs by DCs; 26% (13) have no policy; and 4% (2) specifically deny DCs to perform PPEs. 36% (18) AAs have policies allowing PPEs by DCs; 14% (7) leave the decision up to the local school boards; 42% (21) AAs specifically deny DCs; 4% (2) AAs have no policy; and 4% (2) have policies that require legal interpretation. Colorado uniquely requires the chiropractor to be "school physical certified". Oregon and Washington expressed concerns about the chiropractor's ability to detect cardiac pathologies. Washington has handled this by allowing chiropractors only to perform PPEs as part of a team. Rhode Island and Vermont have no PPE policy. Nevada declares the issue is under review. New Hampshire and Nebraska have policies subject to interpretation. The reason for some of the athletic associations refusing DC-performed PPEs is the issue regarding the DC's ability to detect cardio pathology/cardio-monitoring. They believe chiropractors do not know how to do this, or do not do it with enough regularity.

CONCLUSION: The ability for DCs to perform pre-participation examinations (PPEs) is determined by the policies of three entities: state Board of Chiropractic Examiners (BCE), state high school athletic associations (AA), and, at times, the local school board. There is inconsistency between the BCEs and the AAs, as a majority of BCEs permit chiropractic-performed PPEs, but only a fraction of state AAs allow them. Most state boards of chiropractic have a specific policy regarding PPEs. Those state boards allowing chiropractors to do PPEs consider it "within the scope of practice" based on the fact that physical examinations were taught in chiropractic college. While a chiropractic board will permit a PPE to be performed by a chiropractor, it may not always be accepted by the school requesting the exam. The state's school athletic associations can override the state board decisions. Unfortunately there is not always consistency between the two. And, a local school board can override the athletic associations' decision. There are state athletic associations that have devised specific methods and guidelines to handle their individual concerns.

State PPE Information

STATE	BCE	Ed--Athletic Associations
Alabama	Yes	No
Alaska	Yes	No
Arizona	Yes	Up to local school boards
Arkansas	Yes	Yes
California	Yes	Yes/No definition medical practitioner up to local sch boards
Colorado	no policy	If "School physical certified"
Connecticut	Yes	Yes, per local schools
Delaware	No policy	No, only MD/DO
Florida	No Policy	Yes
Georgia	Yes	No
Hawaii	Yes	No
Idaho	Yes	Yes
Illinois	No Policy	No, only those DCs licensed to practice med in all its branches
Indiana	No Policy	No
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	No policy	Yes, per local school boards
Maine	No policy	up to local school boards
Maryland	Yes	No
Massachusetts	Yes	No
Michigan	No Policy	No
Minnesota	Yes	Yes
Mississippi	No Policy	No
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	Yes	? w/in scope of training, w/in state statutes
Nevada	Yes	no, but they claim they plan on reviewing it
New Hampshire	Yes	? w/in meaning of NH RSA 329 (physicians & surgeons)
New Jersey	no	No
New Mexico	Yes	Yes
New York	Yes	Up to local school boards
North Carolina	Yes	No
North Dakota	Yes	Up to local school boards
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes, but concerned about able to detect cardio pathology
Pennsylvania	Yes-no real policy	No, only MDs, Dos, CRNPs, RNs
Rhode Island	No policy but can do bloodwork	No policy
South Carolina	Yes	No, do not recognize a PPE from a DC
South Dakota	Yes	Yes
Tennessee	Yes	No
Texas	Yes	Yes
Utah	Yes	Yes, I think I might move here-nice people, great skiing
Vermont	no policy	No policy
Virginia	no policy	No
Washington	No	Yes, but not individually-only as part of a team-concerned about cardio path
West Virginia	Yes	Yes, actually cited by the Attorney General, but school can say no
Wisconsin	Yes	No
Wyoming	Yes	No

Congress Of Chiropractic State Associations
Responses to Inquiry on Ability to Perform
Pre Participation Examinations

State	Answer
Alabama	NO
Alaska	statute silent, up to school districts
Arizona	NO
California	YES
Colorado	YES
Connecticut	NO
Delaware	NO
Florida	YES
Georgia	NO
Hawaii	NO
Idaho	YES
Illinois	NO
Indiana	NO
Iowa	YES
Kansas	YES
Kentucky	YES
National Chiropractic Association	YES
Louisiana	statute silent, up to school districts
Maine	NO
Maryland	NO
Massachusetts	NO
Michigan	NO
Minnesota	YES
Mississippi	NO
Missouri	YES
Montana	YES
Nebraska	NO
Nevada	YES
New Jersey	YES
New Mexico	YES
New York	NO
North Carolina	NO
North Dakota	NO
Ohio	YES
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	YES
South Carolina	NO
South Dakota	YES
Tennessee	YES
Texas	YES
Virginia	NO
Vermont	YES
Washington	NO
West Virginia	YES
Wisconsin	NO
Wyoming	YES

CCE Handbook can be found at:

http://cce-usa.org/uploads/2013_CCE_ACCREDITATION_STANDARDS.pdf

Guidance for the Core Curriculum Specifications

The guidance for the core curriculum specifications is intended to assist training organizations in developing programs that would be used to fulfill the proposed requirements in the Federal Motor Carrier Safety Administration's (FMCSA) final rule for the National Registry of Certified Medical Examiners (National Registry). The final rule states that a medical examiner must complete a training program. FMCSA explained in the preamble to the final rule that training providers and organizations must follow the core curriculum specifications in developing training programs for medical examiners who apply for listing on the Agency's National Registry. This training prepares medical examiners to:

- Apply knowledge of FMCSA's driver physical qualifications standards and advisory criteria to findings gathered during the driver's medical examination; and
- Make sound determinations of the driver's medical and physical qualifications for safely operating a commercial motor vehicle (CMV) in interstate commerce.

The rule, 49 CFR 390.105(b), lists eight topics which must be covered in the core curriculum specifications. The core curriculum specifications are arranged below by numbered topic, followed by guidance to assist training providers in developing programs based on the core curriculum specifications.

Guidance for Each of the Core Curriculum Specifications

(1) Background, rationale, mission and goals of the FMCSA medical examiner's role in reducing crashes, injuries and fatalities involving commercial motor vehicles.

Mission and Goals of Federal Motor Carrier Safety Administration (FMCSA)

- Discuss the history of FMCSA and its position within the Department of Transportation including its establishment by the Motor Carrier Safety Improvement Act of 1999 and emphasize FMCSA's Mission to reduce crashes, injuries and fatalities involving large trucks and buses.

Role of the Medical Examiner

- Explain the role of the medical examiner as described in 49 CFR 391.43.

(2) Familiarization with the responsibilities and work environment of commercial motor vehicle (CMV) operations.

The Job of CMV Driving

- Describe the responsibilities, work schedules, physical and emotional demands and lifestyle among CMV drivers and how these vary by the type of driving.
- Discuss factors and job tasks that may be involved in a driver's performance, such as:
 - Loading and unloading trailers;
 - Inspecting the operating condition of the CMV; and
 - Work schedules:

- irregular work, rest, and eating patterns / dietary choices.

(3) Identification of the driver and obtaining, reviewing, and documenting driver medical history, including prescription and over-the-counter medications.

Driver Identification and Medical History:

Discuss the importance of driver identification and review of the following elements of the driver's medical history as related to the tasks of driving a CMV in interstate commerce.

- Inspect a State-issued identification document with the driver's photo to verify the identity of the individual being examined; identify the commercial driver's license or other types of driver's license.
- Identify, query and note issues in a driver's medical record and/or health history as available, which may include:
 - specific information regarding any affirmative responses in the history;
 - any illness, surgery, or injury in the last five years;
 - any other hospitalizations or surgeries;
 - any recent changes in health status;
 - whether he/she has any medical conditions or current complaints;
 - any incidents of disability / physical limitations;
 - current medications and supplements, and potential side effects, which may be potentially disqualifying;
 - his/ her use of recreational/addictive substances (e.g., nicotine, alcohol, inhalants, narcotics or other habit-forming drugs);
 - disorders of the eyes (e.g., retinopathy, cataracts, aphakia, glaucoma, macular degeneration, monocular vision);
 - disorders of the ears (e.g., hearing loss, hearing aids, vertigo, tinnitus, implants);
 - cardiac symptoms and disease (e.g., syncope, dyspnea, chest pain, palpitations, hypertension, congestive heart failure, myocardial infarction, coronary insufficiency, or thrombosis);
 - pulmonary symptoms and disease (e.g., dyspnea, orthopnea, chronic cough, asthma, chronic lung disorders, tuberculosis, previous pulmonary embolus, pneumothorax);
 - sleep disorders (e.g., obstructive sleep apnea, daytime sleepiness, loud snoring, other);
 - gastrointestinal disorders (e.g., liver disease, digestive problems, hernias);
 - genitourinary disorders (e.g., kidney stones and other renal conditions, renal failure, hernias);
 - diabetes mellitus:
 - current medications (type, potential side effects, duration on current medication);
 - complications from diabetes; and
 - presence and frequency of hypoglycemic / hyperglycemic episodes/reactions;
 - other endocrine disorders (e.g., thyroid disorders, interventions / treatment);

- musculoskeletal disorders (e.g., amputations, arthritis, spinal surgery);
- neurologic disorders (e.g., loss of consciousness, seizures, stroke / transient ischemic attack, headaches/ migraines, numbness / weakness) ; or
- psychiatric disorders (e.g., schizophrenia, severe depression, anxiety, bipolar disorder, or other conditions) that could impair a driver's ability to safely function.

(4) Performing, reviewing and documenting the driver's medical examination.

Physical Examination (Qualification/Disqualification Standards (§ 391.41 and 391.43))

- Explain the FMCSA physical examination requirements and advisory criteria in relationship to conducting the driver's physical examination of the following:
 - Eyes (§ 391.41(b)(10))
 - equal reaction of both pupils to light;
 - evidence of nystagmus and exophthalmos;
 - evaluation of extra-ocular movements.
 - Ears (§ 391.41(b)(11))
 - abnormalities of the ear canal and tympanic membrane;
 - presence of a hearing aid.
 - Mouth and throat (§ 391.41(b)(5))
 - conditions contributing to difficulty swallowing, speaking or breathing;
 - Neck (§ 391.41(b)(7))
 - range of motion;
 - soft tissue palpation / examination (e.g., lymph nodes, thyroid gland).
 - Heart (§ 391.41(b)(4)and (b)(6))
 - chest inspection (e.g., surgical scars, pacemaker / implantable automatic defibrillator);
 - auscultation for thrills, murmurs, extra sounds, and enlargement;
 - blood pressure and pulse (rate and rhythm);
 - additional signs of disease (e.g., edema, bruits, diaphoresis, distended neck veins).
 - Lungs, chest, and thorax (§ 391.41(b)(5))
 - respiratory rate and pattern;
 - auscultation for abnormal breath sounds;
 - abnormal chest wall configuration / palpation.
 - Abdomen (§ 391.41(a)(3)(i) and 391.43(f))
 - surgical scars;
 - palpation for enlarged liver or spleen, abnormal masses or bruits / pulsation, abdominal tenderness, hernias (e.g., inguinal, umbilical, ventral, femoral or other abnormalities).
 - Spine (§ 391.41(b)(7))
 - surgical scars and deformities;
 - tenderness and muscle spasm ;
 - loss in range of motion and painful motion;
 - spinal deformities.

- Extremities and trunk (§ 391.41(b)(1), (b)(4) and (b)(7))
 - gait, mobility, and posture while bearing his/her weight; limping or signs of pain ;
 - loss, impairment, or use of orthosis;
 - deformities, atrophy, weakness, paralysis, or surgical scars;
 - elbow and shoulder strength, function, and mobility ;
 - handgrip and prehension relative to requirements for controlling a steering wheel and gear shift;
 - varicosities, skin abnormalities, and cyanosis, clubbing, or edema;
 - leg length discrepancy; lower extremity strength, motion, and function
 - other abnormalities of the trunk.
- Neurologic status (§ 391.41(b)(7), (b)(8) and(b)(9))
 - impaired equilibrium, coordination or speech pattern (e.g., ataxia);
 - sensory or positional abnormalities;
 - tremor;
 - radicular signs ;
 - reflexes (e.g., asymmetric deep-tendon, normal / abnormal patellar and Babinski).
- Mental status (§ 391.41(b)(9))
 - comprehension and interaction;
 - cognitive impairment;
 - signs of depression, paranoia, antagonism, or aggressiveness that may require follow-up with a mental health professional.

(5) Performing, obtaining and documenting diagnostic tests and obtaining additional testing or medical opinion from a medical specialist or treating physician.
Diagnostic Testing and Further Evaluation

- Describe the FMCSA diagnostic testing requirements and the medical examiner's ability to request further testing and evaluation by a specialist.
 - Urine test for specific gravity, protein, blood and glucose (§ 391.41(a)(3)(i));
 - Whisper or audiometric testing (§ 391.41(b)(11));
 - Vision testing for color vision, distant acuity, horizontal field of vision and presence of monocular vision (§ 391.41(b)(10));
 - Other testing as indicated to determine the driver's medical and physical qualifications for safely operating a CMV.
 - Refer to a specialist a driver who exhibits evidence of any of the following disorders (§ 391.43(e) and (f)):
 - vision (e.g., retinopathy, macular degeneration);
 - cardiac (e.g., myocardial infarction, coronary insufficiency, blood pressure control);
 - pulmonary (e.g., emphysema, fibrosis);
 - endocrine (e.g., diabetes);
 - musculoskeletal (e.g., arthritis, neuromuscular disease);

- neurologic (e.g., seizures);
- sleep (e.g., obstructive sleep apnea);
- mental / emotional health (e.g., depression, schizophrenia); or
- other medical condition(s) that may interfere with ability to safely operate a CMV.

(6) Informing and educating the driver about medications and non-disqualifying medical conditions that require remedial care.

Health Counseling

- Inform course participants of the importance of counseling the driver about:
 - possible consequences of non-compliance with a care plan for conditions that have been advised for periodic monitoring with primary healthcare provider;
 - possible side effects and interactions of medications (e.g., narcotics, anticoagulants, psychotropics) including products acquired over-the-counter (e.g., antihistamines, cold and cough medications or dietary supplements) that could negatively affect his/her driving;
 - the effect of fatigue, lack of sleep, poor diet, emotional conditions, stress, and other illnesses that can affect safe driving;
 - if he/she is a contact lens user, the importance of carrying a pair of glasses while driving;
 - if he/she uses a hearing aid, the importance of carrying a spare power source for the device while driving;
 - if he/she has a history of deep vein thrombosis, the risk associated with inactivity while driving and interventions that could prevent another thrombotic event;
 - if he/she has a diabetes exemption, that he/she should:
 - carry a rapidly absorbable form of glucose while driving;
 - self-monitor blood glucose one hour before driving and at least once every four hours while driving;
 - comply with each condition of his/her exemption;
 - plan to submit glucose monitoring logs for each annual recertification;
 - corrective or therapeutic steps needed for conditions which may progress and adversely impact safe driving ability (e.g., seek follow-up from primary care physician);
 - steps needed for reconsideration of medical certification if driver is certified with a limited interval, e.g., the return date and documentation required for extending the certification time period.

(7) Determining driver certification outcome and period for which certification should be valid.

Assessing the Driver's Qualifications and Disposition

- Explain how to assess the driver's medical and physical qualification to operate a CMV safely in interstate commerce using the medical examination findings

weighed against the physical and mental demands associated with operating a CMV by:

- Considering a driver's ability to
 - move his/her body through space while climbing ladders; bend, stoop, and crouch; enter and exit the cab;
 - manipulate steering wheel;
 - perform precision prehension and power grasping;
 - use arms, feet, and legs during CMV operation;
 - inspect the operating condition of a tractor and/or trailer;
 - monitor and adjust to a complex driving situation; and
 - consider the adverse health effects of fatigue associated with extended work hours without breaks;
- Considering identified disease or condition(s) progression rate, stability, and likelihood of gradual or sudden incapacitation for documented conditions (e.g., cardiovascular, neurologic, respiratory, musculoskeletal and other).

Medical Certificate Qualification/Disqualification Decision and Examination Intervals

- Discuss the medical examiner's obligation to consider potential risk to public safety and the driver's medical and physical qualifications to drive safely when issuing a Medical Examiner's Certificate, when to qualify/disqualify the driver and how to determine the expiration date of the certificate by:
 - using the requirements stated in the FMCSRs, with nondiscretionary certification standards to disqualify a driver
 - with a history of epilepsy;
 - with diabetes requiring insulin control (unless accompanied by an exemption);
 - when vision parameters (e.g., acuity, horizontal field of vision, color) fall below minimum standards unless accompanied by an exemption;
 - when hearing measurements with or without a hearing aid fall below minimum standards;
 - currently taking methadone;
 - with a current clinical diagnosis of alcoholism; or
 - who uses a controlled substance including a narcotic, an amphetamine, or another habit-forming drug without a prescription from the treating physician;
 - using clinical expertise, disqualify a driver when evidence shows a driver has a medical condition that in your opinion will likely interfere with the safe operation of a CMV;
 - certifying a driver for an appropriate duration of certification interval;
 - if he/she has a condition for which the medical examiner is deferring the driver's medical certification or disqualifying the driver, informing the driver of the reasons which may include:
 - a vision deficiency (e.g., retinopathy, macular degeneration);
 - the immediate post-operative period;

- results of Substance Abuse Professional evaluations for alcohol and drug use and/or abuse for a driver with
 - alcoholism who completed counseling and treatment to the point of full recovery.
- Medical Examiner's Certificate
 - certification status, which may require:
 - waiver / exemption;
 - wearing corrective lenses;
 - wearing a hearing aid; or
 - a Skill Performance Evaluation Certificate;
 - complete and accurate documentation on medical certification card including:
 - the examiner's name, examination date, office address, and telephone number and Medical Examiner signature; and
 - the driver's signature.

- a cardiac event (e.g., myocardial infarction, coronary insufficiency);
- a chronic pulmonary exacerbation (e.g., emphysema, fibrosis);
- uncontrolled hypertension;
- endocrine dysfunctions (e.g., insulin-dependent diabetes);
- musculoskeletal challenges (e.g., arthritis, neuromuscular disease);
- a neurologic event (e.g., seizures, stroke, TIA);
- a sleep disorder (e.g., obstructive sleep apnea); or
- mental health dysfunctions (e.g., depression, bipolar disorder).

(8) FMCSA reporting and documentation requirements.

Documentation of Medical Examination Findings

Demonstrate the required FMCSA medical examination report forms, appropriate methods for recording the medical examination findings and the rationale for certification decisions including:

- Medical Examination Report Form
 - identification of the driver;
 - use of appropriate Medical Examination Report form;
 - assurance that driver completes and signs driver's portion of the Medical Examination Report form;
 - specifics regarding any affirmative response on the driver's medical history;
 - height/weight, blood pressure, pulse;
 - results of the medical examination, including details of abnormal findings;
 - audiometric and vision testing results;
 - presence of a hearing aid and whether it is required to meet the standard;
 - if obtained, funduscopy examination results;
 - the need for corrective lenses for driving;
 - presence or absence of monocular vision and need for a vision exemption;
 - if driver has diabetes mellitus and is insulin dependent, the need for a diabetes exemption;
 - other laboratory, pulmonary, cardiac testing performed; and
 - the reason(s) for the disqualification and/or referral.
- Other supporting documentation
 - if driver has current vision exemption, include the ophthalmologist's or optometrist's report;
 - if a driver has a diabetes exemption, include the endocrinologist's and ophthalmologist's/optometrist's report;
 - treating physician's work release;
 - if obtained, specialist's evaluation report;
 - if the driver has a current Skill Performance Evaluation Certificate, include it; and

National Registry of Certified Medical Examiners: Complete Guide to Medical Guide Certification can be found at:

https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Complete_Guide_to_ME_Certification_revised_032513.pdf

Appendix B

Request from Legislature And Proposed Bill

State of
Washington
House of
Representatives



May 23, 2013

John Wiesman, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would change the scope of practice for licensed chiropractors to include the performance of physical examinations for sports physicals and commercial driver's licenses.

A copy of the proposal (HB 1573 from the 2013 legislative session) is attached. The House Health Care and Wellness Committee would be interested in an assessment of whether the proposal meets the sunrise criteria for expanding the scope of practice for a regulated health profession in Washington.

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Eileen Cody".

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Karen Jensen, Washington State Department of Health
Lori Grassi, Washington State Chiropractic Association
Jim Morishima, Office of Program Research

HOUSE BILL 1573

State of Washington**63rd Legislature****2013 Regular Session**

By Representatives Harris, Hope, Pettigrew, Green, Walsh, Cody, Moeller, Stonier, and Morrell

Read first time 01/31/13. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to clarifying the prohibitions against
2 discriminating against licensed chiropractors; and amending RCW
3 18.25.0194 and 18.25.0195.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 18.25.0194 and 1974 ex.s. c 97 s 3 are each amended to
6 read as follows:

7 The state and its political subdivisions, including school
8 districts, and all officials, agents, employees, or representatives
9 thereof, are prohibited from in any way discriminating against licensed
10 chiropractors in performing and receiving compensation for services
11 covered by their licenses. Licensed chiropractors must be allowed to
12 perform sports physicals for school athletes and physical examinations
13 required for commercial driver's licenses.

14 **Sec. 2.** RCW 18.25.0195 and 1974 ex.s. c 97 s 4 are each amended to
15 read as follows:

16 Notwithstanding any other provision of law, the state and its
17 political subdivisions, and all officials, agents, employees, or
18 representatives thereof, are prohibited from entering into any

1 agreement or contract with any individual, group, association,
2 including the Washington interscholastic activities association, or
3 corporation which in any way, directly or indirectly, discriminates
4 against licensed chiropractors in performing and receiving compensation
5 for services covered by their licenses.

--- END ---

Appendix C

Applicant Follow Up



WASHINGTON
STATE
CHIROPRACTIC
ASSOCIATION

Department of Health
Sherry Thomas, Sunrise Review Coordinator
PO Box 47850
Olympia, WA 98504-7850

August 16, 2013

Dear Ms. Thomas and Sunrise Panel:

The Washington State Chiropractic Association (WSCA) would like to offer its thanks for the panel's attention, interest and your thoughtful questions regarding our application for clarification of the chiropractic scope of practice relative to pre-participation (PPE) and Department of Transportation "Fit for Duty" (DOT) physical examinations. Your sincere interest in the information submitted in application and presented by our panel of experts was greatly appreciated.

Presentations and written comments by opponents to this application included significant inaccuracies. Most of the comments and oral testimony were focused on preparticipation physical exams (PPE) rather than department of transportation (DOT) physicals. The emphasis in testimony regarding the PPE is reflected in this rebuttal, but in no way should diminish the significance of the WSCA's belief that chiropractic physicians are qualified and should be authorized to perform both PPE and DOT physical examinations. Rather than to rebut the comments during the hearing, as graciously offered by Ms. Weeks, we preferred to research those issues and provide you with a more thorough response to those material inaccuracies than could be accomplished in the available time during the meeting.

Before delving into specifics, the Association would like to comment on our observation of a persistent theme of protectionism and sensationalism that permeated the testimony of this application's detractors. The WSCA wishes to draw attention to these issues to properly characterize the lack of foundation to the counter-arguments and the disregard for providing the panel with accurate information to consider relative to the fundamental questions. Several presenters to the panel cited examples of tragic death or injury in young athletes in an apparent attempt to suggest that those tragic events would be more frequent if doctors of chiropractic were allowed to perform these screening exams. In response, the WSCA offers that the recollections and dramatic examples used had *absolutely no connection* with chiropractic physicians. No doctors of chiropractor were a party to the adverse events described. It is hoped that the relevance of those comments is taken in context as a result.

The WSCA wishes to further clarify that tragic events happen despite all preemptive assessment efforts. Even the highest quality screening examinations, which can be cost

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Page 1 of 7

prohibitive, will fail to detect all serious concerns, some of which result in tragic outcomes regardless of who does the evaluation. Characterizing these inevitable events as being more likely to occur with chiropractors as a tactic to dissuade the panel's favorable consideration of the application is inappropriate. **To be clear, these detractors have failed to produce any credible evidence to suggest that doctors of chiropractic have in the past or would in the future represent a greater risk to patients or provide a lower quality examination than any other eligible provider type.**

One of the written commenters (Jonathan Drezner, MD) is a co-author on a 2013 study published in the British Journal of Sports Medicine titled "Sudden cardiac death screening in adolescent athletes: an evaluation of compliance with national guidelines". As the second author, Dr. Drezner chose not to balance his opinion of doctors of chiropractic by mentioning that his own work revealed that medical practitioners reported near absence of compliance with best practices in the performance of PPE's. Drezner and his coauthors conducted a "confidential survey of the Washington Chapter of the American Academy of Pediatrics (AAP), the Washington Academy of Family Physicians (WAFP) and Washington State high-school athletic directors. Responses were evaluated for compliance with the American Heart Association (AHA) guidelines for SCD screening." (SCD = Sudden Cardiac Death)

The results of this survey stated that "Only 6% of all providers and 0% of schools were in compliance with AHA guidelines. In addition, 47% of the physicians and 6% of the athletic directors reported awareness of the guidelines." The abstract conclusions go on to state "New directions for provider education and policy requirements are needed to improve this implementation gap." This is precisely what the WSCA's application proposes. Chiropractic physician providers of PPE examinations will receive specific education and assessment on these very issues. Based on the data of Drezner and his co-authors, it would appear that an invitation to these groups to attend the WSCA's PPE training program would be beneficial. Again, it is curious that the second author of a study impeaching medical providers' compliance with recognized authoritative guidelines has a problem with chiropractic physicians who are intent to do exactly what he and his coauthors have suggested. The full published study is provided for your reference as **Attachment A**.

In oral testimony the WSMA spokesperson along with other individuals asserted that they knew or had heard of cases where, during visits to chiropractors, certain types of exam procedures were not performed (procedures that would be part of a standard PPE or DOT exam battery). This hearsay had no verification, and in addition not one of these examples was connected to an actual PPE or DOT examination. Rather than respond with counter-storytelling, the WSCA reiterates that every physician conducts examinations in a general practice setting that are tailored to the patient's presenting complaints and needs. As a part of this application, the WSCA is affirming its commitment to ensure that chiropractic physicians are trained to ensure that standards of care are met. The detractors' reliance on unverified stories and innuendo to compel the panel to believe that chiropractic physicians are not trained and are essentially untrainable and are therefore unqualified is outrageous. Detractors have consistently failed to produce any credible evidence to support their story and innuendo-based positions. In fact, the proponents of this application have provided evidence (not opinion) that

disproves and discredits these biased assertions. This discussion should move past antiquated territorial fights and focus instead on what is appropriate and fair to the citizens of Washington.

Last, throughout the written and verbal testimony of detractors, reference was made to chiropractic physicians' inability to offer treatment in the form of prescription medications in the context of a PPE. The purpose of a PPE is not to write prescriptions- in fact it is not to treat the patient at all. The focus of a PPE screening examination is to determine clearance to participate in sport through an appropriate examination. When problems are identified, chiropractic physicians are trained and in support of affecting appropriate referral to those who can best manage the pathology. The WSCA remains committed through this process to ensuring that quality evaluations are available to the citizens of Washington State, and that they have the opportunity to choose their provider type.

In the following section of this rebuttal, the WSCA will detail specific episodes of inaccuracy and misleading information that were felt to be material to the panel's deliberations.

Correction of errors in WSCA's testimony:

The WSCA would like to clarify that panelist Dr. Robert Nelson testified that the International Consensus Conference on Concussion in Sport was held every two years while he was also referencing the recertification of the American Chiropractic Board of Sports Physicians (ACBSP) recertification requirement. Mr. O'Leary was correct that the ICCCS is held every four years. However; the recertification requirement for the ACBSP is every two years indicating that chiropractic physicians have set their own standards higher than what is required by the ICCCS.

Oral Testimony:

During his oral testimony, Mr. O'Leary suggested that the panel listen to the tape of Dr. Nelson's testimony to verify that he "never mentioned the word cardiovascular" in his comments, which he felt was telling of chiropractors' lack of confidence in discussing the subject. We agree with one facet of this testimony- that the panel would do well to actually listen to Dr. Nelson's testimony on the tape. That review will reveal that Dr. Nelson's testimony did, in fact include reference to education on evaluation of the cardiovascular system, including heart examination and the necessary training to identify abnormalities, and emphasized that the Colorado training module, which the Washington proposal is a parallel model to, includes substantial information regarding the PPE cardiac examination and concussion training. Dr. Schultz also referenced chiropractic core educational program inclusion of cardiovascular examination.

Mr. O'Leary also claimed that Dr. Nelson was incorrect in his testimony when he indicated testicular cancer as a leading cause of death. O'Leary said it was not listed on the CDC top 50 causes of death, or on the world life expectancy.com website. Dr. Nelson's comment was referencing page 50 of the Third Edition of the *"Preparticipation Physical Examination"* publication by "The Physician and Sports Medicine" (McGraw-Hill Companies), where it states "testicular cancer is the leading cause of cancer deaths in men 15 to 35 years of age". The intended point of Dr. Nelson's mentioning of testicular cancer

was to emphasize the importance of recognition of age-specific health concerns that need to be addressed in the PPE. The relevant pages from the PPE manual are provided as **Attachment B**.

Mr. O'Leary also testified to the panel that in his review of the UWS chiropractic curriculum he was only able to find one course related to cardiorespiratory diagnosis and treatment. He concluded that 33 hours of content was insufficient to serve as a basis for performing a screening auscultation procedure. First, Mr. O'Leary is not a physician and has no training or qualifications to determine what level of training is required to achieve competency for any examination procedure. Second, Mr. O'Leary conveniently omitted reference to the Clinic Phase course series, the cardiorespiratory physiology courses, the physical examination courses, the differential diagnosis courses, the diagnostic imaging courses, the clinical internship courses or any other courses that make reference to cardiorespiratory conditions and evaluation findings. In short, this facet of his testimony to the panel was inaccurate and misleading.

In another episode of oral testimony Ms. Darla Varrenti referenced an email exchange that occurred during the 2013 legislative session between her and the executive director of the WSCA. She incorrectly indicated that the WSCA Executive Director stated the "104 chiropractors in Washington who would be certified in CCSP/DABSP may not be able to auscultate a heart". This selective recall is misleading. The actual quote from that specific email is as follows (emphasis added):

"CCSP/DACSBP practitioners have built on this foundation, and while all 104 DCs that are certified in Washington State may not be able to auscultate a heart **and provide a diagnosis on par with a Cardiologist; they definitely are more than competent in identifying abnormalities and referring to the appropriate health care provider for further workup.**"

Ms. Varrenti's testimony went on to suggest that only a licensed [medical] physician should perform these examinations and that an EKG must be performed on every child. This practice is not consistent with the standard of care or current PPE guidelines. While the WSCA community sincerely empathizes with Ms. Varrenti in the loss of her son and believes it was a terrible and sad event, this tragedy demonstrates no linkage to the request placed before the panel inasmuch as the PPE provided to her son was performed by someone other than a Doctor of Chiropractic.

The Washington State Medical Association (WSMA) submitted written comments to this Sunrise process and provided oral testimony before the panel. These submissions included several misrepresentations, inaccurate reporting, and in some cases disparaging falsehoods. We offer the following clarifications and corrections for the public record.

WSMA Written comments: Page two, paragraph 1:

The WSMA stated that less than half of the states allow chiropractors to perform DOT evaluations. They referenced the WSCA's application as their source.

This assertion is false: First, the WSCA does not make that assertion in its application. Second, in a survey of 50 states and Washington DC (N=51), 37 reported that chiropractors are allowed to perform

DOT physicals. Seven states did not respond to the survey. The following link will serve as the reference to the chart attached as **Attachment C**.

http://www.professionaltainsol.com/State_DC_Reg/State_DC.htm

WSMA Written comments: Page 3, Paragraph 1 under 1(b):

WSMA argues that chiropractic physicians lack training, experience and knowledge to ensure complete and comprehensive PPE and DOT examinations.

This assertion is incorrect: Every element of the examination procedures recommended for PPE's by the American College of Sports Medicine is taught in the core curriculum of chiropractic programs across the country. <http://www.acsm.org/docs/brochures/pre-participation-physical-examinations.pdf>.

Delineation of the exam procedures is attached as **Attachment D**.

Additionally, every element of the DOT required physical examination as required in the National Registry of Certified Medical Examiners, Complete Guide to Medical Examiner Certification (**Attachment E**), is taught in the core chiropractic college program. Every graduate of every DC program across the country has been assessed on the elements of these examinations. Evidence of this is found in the curricula of individual DC programs, the CCE accreditation standards and the Exam Blueprints of the NBCE Parts 1-4 which are part of the original application. Chiropractic physicians receive didactic and practical skills education as well as clinical experience under supervision in diverse patient populations that receive these exams. Chiropractic physicians in Washington State are within their scope to perform all of these procedures. Last, the additional training advocated in the application serves only to focus and ensure focus on the required procedures of the examination and its outcomes. In so doing, the proposed training further demonstrates the commitment that chiropractic physicians are willing to make to ensure their ability to competently, safely and effectively perform these exams and that the prescribed protocols are followed. This standard is higher than the current medical standard.

WSMA Written comments: Page 4, paragraph 1- page 6:

The WSMA references a comparison of chiropractic training against medical specialties and subspecialties including neurology, internal medicine, psychiatry, radiology, orthopedics and sports medicine. Various tables of comparison to chiropractic education vs. these specialties in their testimony paint an inaccurate and unfavorable picture of chiropractic education against these medical specialties.

These tables are misleading and inaccurate: First, chiropractic education results in a general practitioner outcome- not a specialist or subspecialist. Every comparator to chiropractic in their tables is a specialty or subspecialty of medicine. Second, the sports medicine profile referenced in their charts suggests that sports medicine physicians receive a 4-5 year graduate educational program (residency). In fact, sports medicine is a sub-specialty track that is available within a number of medical specialties; however it is NOT a medical specialty unto itself. The American Board of Medical Specialties chart of specialty and sub-specialty certificates is attached, and a copy is provided for you as **Attachment F**. http://www.abms.org/who_we_help/physicians/specialties.aspx

The 2011 ACGME standards for training in sports medicine depict a 1 year required curriculum. The program requirements are attached and can be found at the website listed below and is provided for you as **Attachment G**.

http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/116-127-333-342_sports_medicine_07012011.pdf.

Eligibility for board certification in their sports medicine sub-specialty requires only a 1 year program of study focused on sports medicine. This document is provided as **Attachment H**.

<https://www.theabfm.org/caq/sports.aspx>.

Additionally, the language of the WSMA's comparisons is misleading and inaccurate. Chiropractic physicians are educated and competent in comprehensive evaluation of any ambulatory care patient. The WSMA's characterization of chiropractic education is that chiropractors only study the neuromuskuloskeletal system and manipulation. Regardless of the "apples to oranges" comparison they offer, the de-facto suggestion that only medical education offers training in differential diagnosis by failing to list it as a component of chiropractic education while listing it as a component of medical education is false and is therefore misleading. The suggestion made by the WSMA that only medical education includes all organ systems by failing to list it as a component of chiropractic education while listing it as a component of medical education is also false and misleading. The suggestion that only medical education integrates clinical applications at every level of training by failing to list it as a component of chiropractic education while listing it as a component of medical education is also false and misleading.

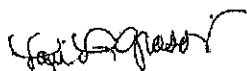
The truth is that chiropractic education includes all these things and evidence to that fact is present in the CCE standards, the NBCE test plans and the individual curricula of every chiropractic college. The framing provided by the WSMA represents not only an inaccurate comparison of chiropractic education, but frames that inappropriate comparison in a way that is clearly designed to diminish the chiropractic educational foundation as well as the profession. Nowhere else in the country are athletes or drivers expected to see a medical specialist or sub-specialist in order to undergo a PPE or DOT physical. These examinations are screening procedures that every competent physician can perform safely, effectively and accurately.

Based on the testimony and written comments, detractors would prefer you to believe that they are better judges of chiropractic education than chiropractic educators. The comments provided to the panel declaring chiropractors untrained, undertrained and incompetent to perform these examinations are not based on one item of evidence to support that claim. Medicine does not have a patent on clinical competency. If the WSCA were asking for privileges to do surgery or psychotherapy, such comparisons would be valid. The WSCA is seeking clarification on basic ambulatory care screening examination procedures that are already within their scope and for which additional focused training and review exist to augment what is already a competent skill set.

The WSCA has offered transparent and thorough disclosure on the comprehensiveness of chiropractic education. That disclosure has demonstrated beyond a reasonable doubt that chiropractic physicians are trained thoroughly and comprehensively in the necessary areas of diagnosis, differential diagnosis, disease detection, triage and appropriate management of patient problems- sick and well alike. Further, the WSCA has produced credible evidence that chiropractic physicians can, and do, routinely perform these types of evaluations competently, effectively and in conjunction with, or in the place of, other qualified providers (as opposed to in addition to). These facts refute the objections posed by this application's detractors (in some cases facts that they themselves generated).

This application and its supplementing evidence contain a thoughtful, thorough and objective review and analysis of these important issues. The WSCA has provided ample evidence that there is no substantiated reason whatsoever that chiropractic physicians should be prevented from operating within their scope of practice and performing these exams. The chiropractic profession is very willing to join other providers who should all be working toward providing the best healthcare for Washington citizens. We sincerely hope that this rebuttal has added clarity and elucidated the truth to the panel and its deliberations. Last, the WSCA would like to once again offer its sincerest thanks to the panel for its time, effort and attention to this very important issue.

Respectfully submitted,



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Executive Director, Washington State Chiropractic Association

Sudden cardiac death screening in adolescent athletes: an evaluation of compliance with national guidelines

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► An additional appendix A is published online only. To view this file please visit the journal online (<http://dx.doi.org/10.1136/bjsports-2012-091670>).

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ABSTRACT

Objective In the USA, the preparticipation physical evaluation (PPE) is the standard of care for screening eight million high-school athletes for their risk of sudden cardiac death (SCD). Our aim was to evaluate both physician and school compliance with national guidelines for SCD screening.

Methods We conducted a confidential survey of the Washington Chapter of the American Academy of Pediatrics (AAP), the Washington Academy of Family Physicians (WAFP) and Washington State high-school athletic directors. Responses were evaluated for compliance with the American Heart Association (AHA) guidelines for SCD screening.

Results We received a response rate of 72% (559/776) from the AAP, 56% (554/990) from the WAFP and 78% (317/409) from the athletic directors. Only 6% of all providers and 0% of schools were in compliance with AHA guidelines. In addition, 47% of the physicians and 6% of athletic directors reported awareness of the guidelines. There was no difference in compliance between physician specialties ($p=0.20$). Physician location, years of experience and exposure to SCD were not significantly associated with compliance. Provider knowledge of the guidelines, number of PPE/month and frequency of referrals to cardiology were all positively associated with improved overall compliance ($p<0.05$).

Conclusions Despite the unaltered presence of the AHA SCD screening guidelines for the past 15 years, compliance with the recommendations is poor. Lack of compliance does not reflect clinical experience, but rather lack of knowledge of the guidelines themselves. New directions for provider education and policy requirements are needed to improve this implementation gap.

INTRODUCTION

In the USA, the Preparticipation Physical Evaluation (PPE) is the standard of care for screening nearly eight million high-school athletes for their risk of sudden cardiac death (SCD).¹ This represents an estimated 50% of all enrolled students. The annual cost of this screening programme is approximately \$250 million.²⁻⁴ Although the PPE has been adopted by nearly every state as a recommended prerequisite to athletic participation, and despite its endorsement by all principal medical organisations, the clinical practice remains variable and its utility remains a topic of debate.³

The purpose of the PPE as identified by the American Medical Association is to accurately identify medical conditions that may affect safe participation in athletic endeavours.¹ The American

Heart Association (AHA) states that the principle objective of PPE screening is to reduce the cardiovascular risks associated with physical activity and enhance the safety of athletic participation.³ Despite the controversy surrounding how best to perform these cardiovascular screenings, the AHA and the European Society of Cardiology jointly agree that screening all athletes is both ethically and medically justified.^{3 5 6}

In 1996 and reaffirmed in 2007, the AHA published consensus recommendations for the cardiovascular screening of athletes.³ These guidelines have established a standard of care in the USA and advocate for the cardiovascular screening of athletes based on a comprehensive history and physical examination (see online supplementary appendix A).³

There remains significant debate regarding the effectiveness of the PPE, and whether the history and physical alone is a sufficiently sensitive and cost-effective strategy for SCD screening.^{7 8} Despite high levels of specificity (75–95%), the PPE is often criticised for its relative lack of sensitivity (5–44%).⁹⁻¹¹ However, the value of the PPE as a screening tool is incompletely understood as there is substantial variability nationally regarding its actual practice. Specifically, it is unknown to what degree providers are in compliance with national consensus guidelines, in particular those put forward by the AHA. In Washington State, providers are not mandated to utilise a particular form or method when screening athletes for sudden cardiac death risk factors. This lack of a standardised process is not unique to Washington State. Currently, 54% of US states lack a mandated PPE form.

The purpose of this study was to evaluate state-wide awareness and compliance of the 2007 AHA consensus guidelines on cardiovascular screening in athletes. Specific focus was given to the three fundamental groups involved in SCD assessment of the high-school athlete in the USA: the paediatrician, the family medicine physician and the high-school athletic director.

METHODS

Inclusion/exclusion criteria

We contacted all members of the Washington Chapter of the American Academy of Pediatrics (776 subjects) and 990 members of the Washington Academy of Family Physicians (WAFP). The entire membership of the WAFP totals 1980 persons; we contacted 50% after a process of randomisation. Each membership's governing body enabled direct communication with their members.

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Contact with the high-school athletic directors in Washington State was facilitated by the Washington Interscholastic Activities Association (WIAA). The WIAA governs 409 of the state's high schools (98% of total), and 100% of all schools which field at least one athletic team. Every school maintains an individual athletic director.

Participation in the study was voluntary without incentives, and responses were kept confidential with removal of all identifiers. All non-responders were contacted twice by mail over a 2-month period (September–November 2010). In addition, American Academy of Pediatrics (AAP) and athletic director non-responders were contacted once every 7 days by email with a link to the web-based version of the survey (University of Washington Catalyst WebQ service). The WAFP limited web-based contact with its members to once every 14 days.

Survey contents

The surveys to the AAP and WAFP were identical. Survey questions evaluated the following: presence of a clinic-specific PPE form, patient population demographics, provider clinical experience, PPE satisfaction, knowledge of AHA cardiovascular screening guidelines, utilisation of each of the 12 individual elements of the AHA guidelines, comfort performing the PPE, frequency of PPE practice, frequency of cardiology referral and willingness to support a statewide universal PPE form.

The survey to the athletic directors was unique relative to the physician survey. Survey questions evaluated the following: WIAA classification (surrogate for school size), WIAA district (surrogate for school location), presence of a school mandated or recommended PPE form, recognition of PPE performed by non-physicians, satisfaction with the PPE, awareness of the AHA guidelines and willingness to support a statewide universal PPE form.

In addition, all physician and athletic directors were requested to share a copy of any PPE forms utilised in their clinical practice or by their school (either mandated or recommended).

Statistical analysis

Provider compliance with each of the 12 AHA components was analysed by the Wilcoxon-Mann-Whitney test (answers options were as follows: always perform, perform most of the time, perform about half of the time, rarely perform and never perform). A subsequent analysis of overall compliance with the AHA guidelines was generated by the creation of a composite score of survey responses of 'always perform' (<4, 5–8, 9–11 and all 12) based on prior study.¹² Analysis of the overall composite score was by an ordinal regression model. Compliance by composite score was analysed according to physician type (AAP/WAFP), practice location (rural, suburban and urban), provider experience (years), provider satisfaction with the PPE, provider knowledge of AHA guidelines, provider referral frequency (avg. #/month) and lifetime experience with SCD.

Athletic director responses were analysed utilising χ^2 analysis and Fisher's exact test depending on the number of variables. Variables were analysed relative to school size (WIAA classification: 1–2B, 1–4A) and school location (WIAA district: 1–9). School size was divided into an ordinal variable (large/small) according to student enrolment data (large school: 3–4A with an average enrolment >1085 students; small school: 1–2B, 1–2A with an average enrolment <1085 students). School location was likewise divided into a categorical variable (urban/non-urban) according to school district data (urban districts: WIAA classification 2 and 8; non-urban districts: WIAA classification 1, 3–7 and 9). The variables analysed included: existence of a

school mandated or recommended PPE form, satisfaction with the PPE, awareness of the AHA guidelines and willingness to support a statewide PPE form.

RESULTS

Physician and athletic director participants

We received a response rate of 72% (559/776) from the AAP, 56% (554/990) from the WAFP and 78% (317/409) from the athletic directors. Responses were fairly evenly distributed between the mail (55%) and web-based (45%) formats. Survey responses were excluded if the responding physician reported that conducting PPEs was not a routine aspect of their practice (AAP: 119/559, WAFP: 71/554).

The majority of physician respondents were from suburban locations with a larger proportion of family physicians practicing in a rural location relative to paediatricians (table 1). The distribution of clinical experience was skewed slightly towards those with greater than 20 years of experience (37% of respondents). The majority of physicians described themselves as only somewhat satisfied with the PPE as a screening tool (65%). The average number of PPEs performed per month varied between the provider types with 55% of paediatricians performing at least six PPEs per month, and 25% of family physicians performing at least six PPEs per month. Likewise, 55% of paediatricians refer an average of at least two athletes per year for cardiology evaluation versus only 23% of family physicians, mirroring the volume of PPEs performed. Overall, comfort knowing when to refer to cardiology is similar between physician types with 73% stating they are comfortable 'most of the time'. In addition, the number of physicians who report direct experience with an athlete from their practice suffering an SCD event as a result of an unknown condition is similar (5%).

Knowledge of AHA Guidelines

Less than half of physicians reported an awareness of the AHA Guidelines (47%). No statistical difference exists between physician specialty (49% of the AAP and 45% of the WAFP, $p=0.33$). Only 6% of the athletic directors reported an awareness of the AHA Guidelines (figure 1).

Physician compliance with AHA Guidelines

Only 5.7% of physicians were always in compliance with the AHA Guidelines according to the overall composite score (table 2). While many providers always perform a majority of the elements of the AHA Guidelines, a significant proportion (13%) routinely perform 8 or less of the recommended 12 components.

Compliance with each individual component of the AHA Guidelines was also assessed (figure 2). In total, 72% of physicians always ask about chest pain with exertion, 78% always ask about syncope with exertion and 74% always ask about a family history of premature death. Conversely, 10% of physicians ask about exertional chest pain less than half of the time. Similarly, 6.3% of physicians ask about syncope with exertion and 6.5% ask about a family history of premature death less than half of the time. Only 33% always ask about family members with a known cardiac diagnosis placing them at risk of SCD. In particular, 28% of providers state that they either rarely or never ask about a known family history of specific disorders causing SCD.

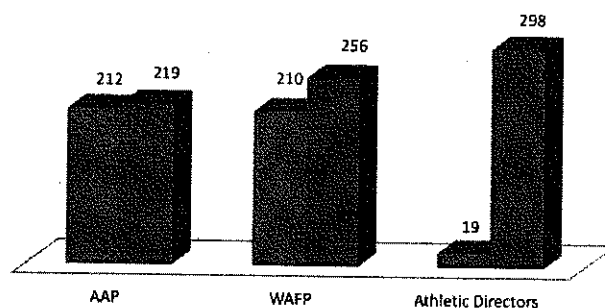
With regard to the physical exam, the vast majority of physicians always listen for the presence of a heart murmur (95%) and always measure brachial artery blood pressure (87%; figure 2). However, 43% of physicians rarely or never perform

Table 1 AAP and WAFP demographic and PPE experience

General demographics	AAP N (%)	WAFP N (%)	Total N (%)
Total providers contacted	776 (N/A)	990 (N/A)	1766 (N/A)
Total responses	559 (72)	554 (56)	1113 (63)
Providers utilising the PPE in clinic practice	440/559 (79)	483/554 (87)	923/1113 (83)
Practice location			
Rural	63 (14.5)	111 (23.2)	174 (19.1)
Suburban	228 (52.7)	243 (50.8)	471 (51.7)
Urban	142 (32.8)	124 (26.0)	266 (29.2)
Years in practice			
0–3	103 (23.5)	32 (6.7)	135 (14.8)
4–10	94 (21.5)	116 (24.4)	210 (23.0)
11–20	109 (24.9)	125 (26.3)	234 (25.6)
>20	132 (30.1)	203 (42.6)	335 (36.6)
Level of satisfaction with PPE			
Very satisfied	64 (14.7)	135 (28.5)	199 (21.9)
Somewhat satisfied	302 (69.6)	283 (59.8)	585 (64.5)
Not satisfied	68 (15.7)	55 (11.7)	123 (13.6)
Number of PPE/month			
1 or less	71 (16.2)	55 (11.8)	126 (13.9)
2–5	126 (28.8)	294 (62.8)	420 (46.4)
6–10	126 (28.8)	89 (19.0)	215 (23.7)
>10	115 (26.2)	30 (6.4)	145 (16.0)
Number of athletes referred/year			
1 or less	196 (45.2)	365 (77.3)	561 (61.9)
2–5	204 (47.0)	102 (21.6)	306 (33.8)
6–10	26 (6.0)	2 (0.5)	28 (3.1)
>10	8 (1.8)	3 (0.6)	11 (1.2)
Comfortable when to refer			
Always	53 (12.2)	92 (19.7)	145 (16.0)
Most of the time	332 (76.1)	329 (70.3)	661 (73.1)
About half of the time	43 (9.9)	45 (9.6)	88 (9.7)
Rarely	8 (1.8)	2 (0.4)	10 (1.2)
SCD experience in clinic panel			
Yes	26 (6.0)	18 (3.8)	44 (4.9)
No	410 (94.0)	454 (96.2)	864 (95.1)
Knowledge of the AHA guidelines			
Yes	212 (49.2)	210 (45.1)	422 (47.0)
No	219 (50.8)	256 (54.9)	475 (53.0)
Support of a statewide PPE form			
Yes	416 (96.5)	440 (94.4)	856 (95.4)
No	15 (3.5)	26 (5.6)	41 (4.6)

AAP, Academy of Pediatrics; AHA, American Heart Association; PPE, physical evaluation; SCD, sudden cardiac death; WAFP, Washington Academy of Family Physicians.

■ Yes ■ No

**Figure 1** Physician (AAP & WAFP) and Athletic Director Knowledge of the AHA Guidelines

► 49% of AAP and 45% of WAFP reported a knowledge of the AHA guidelines ($p=0.33$)

► 6% of athletic directors reported knowledge of the AHA guidelines. This figure demonstrates the number of AAP members, WAFP members and athletic directors who reported knowledge of the contents of the AHA SCD guidelines when surveyed. The total responses 'yes' and 'no' are listed above each column. The percentages are listed with a p value comparison of the AAP and WAFP members demonstrating no significant difference in their responses. AAP, Academy of Pediatrics; AHA, American Heart Association; WAFP, Washington Academy of Family Physicians. This figure is only reproduced in colour in the online version.

Clinical practice location ($p=0.14$), years of experience ($p=0.76$) and experience with SCD in a prior patient ($p=0.71$) were not significantly associated with the overall compliance. However, provider satisfaction with the PPE as a clinical tool ($p<0.001$), comfort knowing when to refer an athlete to cardiology ($p<0.001$), number of cardiology referrals per year ($p=0.003$) and number of PPEs performed per month ($p=0.029$) were all associated with improved compliance. In addition, reported knowledge of the AHA guidelines was associated with improved compliance ($p<0.001$).

Athletic director participants

The responding athletic directors represented every WIAA district (1–9) and school classification (1–2B, 1–4A). Of those athletic directors who replied, 55% (175 schools) noted that their school requires a specific PPE form distributed by the school (table 3). The remaining 45% of schools without a required form are evenly divided between those that recommend a form (77 schools) and those that do not (73 schools). Three schools do not utilise any form at all. Only 44% of the schools recognise PPEs performed by non-physician providers, 74% of which are performed by physician assistants and nurse practitioners. Ten per cent of schools allow completion of a PPE form by a

an evaluation of lower extremity pulses, and 19% of physicians screen for the physical stigmata of Marfan syndrome less than half of the time.

When comparing the physician types, there is no difference between the responses of the AAP and the WAFP relative to their composite score of overall compliance ($p=0.20$). When analysed by each individual component, AAP physicians were more likely to always evaluate femoral pulses ($p<0.001$), Marfan stigmata ($p=0.049$) and inquire about a family history of cardiac disease known to cause SCD ($p<0.001$). The WAFP physicians were more likely to always ask about a history of dyspnoea with exertion ($p=0.005$), a history of a murmur ($p=0.024$) and measure blood pressure ($p=0.003$).

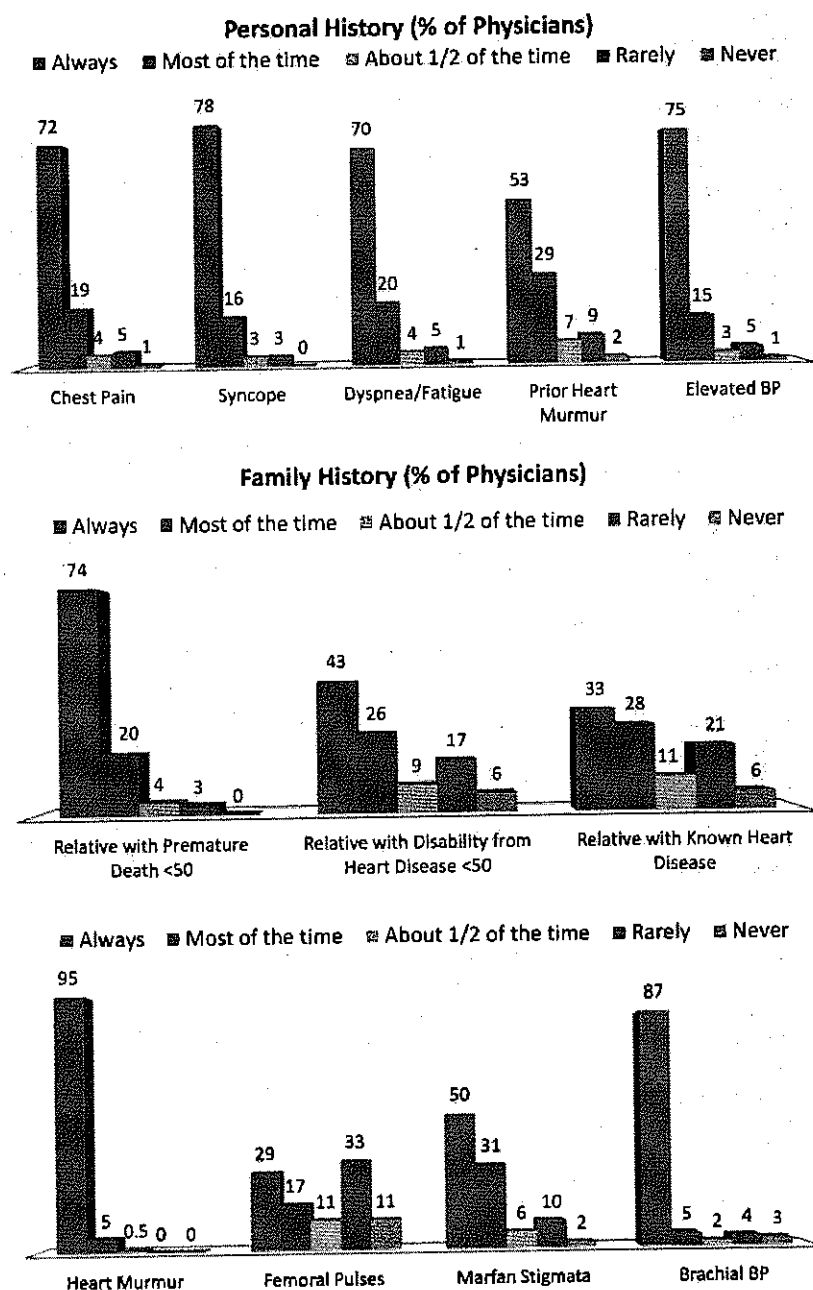
Table 2 Physician (AAP and WAFP) overall AHA Composite Compliance Score

	Overall Compliance Score			
	0–4 (%)	5–8 (%)	9–11 (%)	12 (%)
AAP (466)	4 (0.8)	52 (11.2)	387 (83.0)	23 (5.0)
WAFP (445)	2 (0.5)	59 (13.3)	355 (80.0)	29 (6.5)
Overall (911 total)*	6 (0.7)	111 (12.2)	742 (81.4)	52 (5.7)

*Number of overall responses does not equal total respondents because of missing data.

AAP, Academy of Pediatrics; AHA, American Heart Association; WAFP, Washington Academy of Family Physicians.

Figure 2 Pooled Physician (AAP and WAFP) Compliance with the 12 Elements of AHA Guidelines ► AAP members were more likely to always evaluate femoral pulses, Marfan stigmata, and whether a family member had known heart disease ($p < 0.05$). ► WAFP members were more likely to always evaluate dyspnea with exertion, history of murmur, and blood pressure ($p < 0.05$). These three figures demonstrate to what percentage all physician respondents (pooled AAP and WAFP members) utilise the 12 separate elements of the AHA SCD guidelines. Each physician reported whether they clinically practiced the element in question 'always', 'most of the time', 'about half of the time', 'rarely' and 'never'. The percentage for each category is listed above the columns. In addition, it is also noted which elements demonstrated a statistically significant difference ($p < 0.05$) between the two physician groups. AAP, Academy of Pediatrics; AHA, American Heart Association; SCD, sudden cardiac death; WAFP, Washington Academy of Family Physicians. This figure is only reproduced in colour in the online version.



naturopathic physician, chiropractor or physical therapist. Urban schools were more likely to require a single PPE form ($p=0.023$) and were more likely to allow non-physicians to perform the PPE ($p<0.001$).

Only 6% of athletic directors reported an awareness of the AHA Guidelines for SCD screening. In addition, 114 of the athletic directors, representing schools that require or recommend a school-specific form, submitted these forms along with their survey responses. None of these forms (0/114) were found to be in complete compliance with the AHA Guidelines. The majority (60%) included 8 of the 12 total recommended elements.

Single statewide PPE form

Ninety-five per cent of the physician responders supported the adoption of a single, statewide PPE form. This near unanimous

support was equal between the physician specialties. Sixty-six per cent of the athletic directors were in favour of a statewide PPE form. Those athletic directors in favour of a statewide form were more likely to represent a school that already mandates a single form ($p=0.002$), and more likely to be a small school ($p<0.001$).

DISCUSSION

The PPE is the cornerstone of SCD screening in the USA and is universally supported by all principal medical organisations. The size of the population at risk is substantial, with eight million high-school athletes in the USA. Thus, the development of effective, feasible strategies for prevention is critical.

Sudden cardiac death is the leading cause of death in young athletes during sport, although the exact frequency of these

Table 3 Athletic director demographic data (N=317)*

a	N (%)
WIAA classification	
1B	45 (14.2)
2B	47 (14.9)
1A	55 (17.4)
2A	49 (15.5)
3A	54 (17.1)
4A	66 (20.9)
Percent student athletes (%)	
0–20	11 (3.6)
21–40	86 (27.7)
41–60	103 (33.2)
61–80	91 (29.3)
81–100	18 (5.8)
PPE form required	
Yes	175 (55.4)
No	141 (44.6)
PPE form recommended	
Yes	77 (24.4)
No	73 (23.1)
PPE form if none recommended	
Provider supplied	67 (21.2)
No form—signature only	3 (1.0)
No clearance required	0 (0.0)
Recognise PPE by non-MD providers	
Yes	140 (44.3)
No	169 (53.5)
Other recognised providers	
PA	118 (37.3)
ARNP	115 (36.4)
ND	31 (9.8)
Chiropractor	2 (0.6)
Physical therapist	1 (0.3)
Other	0 (0.0)
Aware of the AHA National Guidelines	
Yes	12 (3.8)
No	287 (90.5)
Willing to adopt statewide PPE	
Yes	209 (65.9)
No	92 (29.0)

*Number of overall responses does not equal total respondents because of missing data.

AHA, American Heart Association; ARNP, advanced registered nurse practitioner; MD, doctor of medicine; ND, doctor of naturopathic medicine; PA, physician assistant; PPE, physical evaluation; WIAA, Washington Interscholastic Activities Association.

catastrophic events is unknown due to the lack of systematic reporting systems. In the USA, Maron *et al* have estimated that the annual incidence is 0.5–0.93/100 000 competitive athletes (age 12–35).^{13–15} Recent estimates of college athletes suggest that the rate is greater at approximately 1/43 000 NCAA participants per year.¹⁶ In Italy, Corrado *et al* reported an SCD incidence of 1:28 000 for young competitive athletes (age 12–35 years) prior to the implementation of a national screening programme.^{17–19} This rate of SCD is further supported by a recent evaluation of the US Department of Defense Cardiovascular Death Registry.²⁰

The AHA has advocated for cardiovascular screening in athletes since 1996.³ After the AHA reaffirmed its

recommendations in 2007, Glover *et al* determined that there had been a significant interval improvement in the state approved history and physical examination questionnaires as compared with 1996.¹² In particular, in 2007, 48 states had approved, but not necessarily mandated, PPE forms as compared with only 43 in 1997. In addition, the strength of the approved forms, as determined by their reliance on the AHA recommendations, was statistically much greater. In 1997, only 40% included more than nine items, whereas by 2007, 81% had more than nine items. However, this study was not able to address the degree of physician or school utilisation of these state-approved forms.

Thus, this study presents new information on the knowledge and compliance of physicians and athletic directors regarding the AHA guidelines. Alarming, less than 6% of primary care providers are in full compliance with national guidelines, and less than one-half of these providers are even aware of the guidelines. While this survey only included physicians practicing in Washington State, the formal medical training for this group of providers occurred throughout the USA, and the results may reflect a broad educational deficiency prevalent in primary care training. In addition, the conditions in Washington State are not unique, as greater than half of the states in the country (54%) are also without a mandated standardised approach to the PPE.

None of the schools in Washington State are compliant with national guidelines, which is especially important considering that over half of the athletic directors who responded reported that their school requires a specific PPE form. While Washington State does have a recommended PPE form in the high-school athletic association handbook, use of the form is not mandated and the current iteration only includes 8 of the 12 elements of the AHA Guidelines.²¹ It is possible that states with laws or policies that mandate use of a specific PPE form would demonstrate better compliance.

Our data suggest that the lack of compliance with the national guidelines is not related to geography, practice location or experience, but rather, it is heavily influenced by knowledge of the guidelines themselves. Physicians who reported an awareness of the guidelines were not only more likely to be compliant with the guidelines; they were more likely to feel comfortable about when to refer a patient for continued evaluation by a cardiologist. Physicians with greater compliance were also more likely to refer an increased number of athletes per year; an important result given the purpose of the PPE is to serve as a sensitive screening tool to bring those at risk to appropriate care. It is also remarkable that increased compliance was positively associated with increased provider satisfaction with PPE screening, suggesting that increased compliance is of benefit to the provider. These findings are particularly illustrative given the common criticism of poor sensitivity that surrounds using history and physical alone as a screening tool.⁷ The more variable the clinical approach, the less likely the proportion of athletes with cardiovascular warning symptoms or a concerning family history would be detected.

Notably, the physician support for a single, standardised form was near unanimous. Similar support was also appreciated from the athletic directors. And importantly, the potential benefit of a standardised form reaches beyond SCD screening alone and benefits how athletes are evaluated for concussion risk, female triad potential and other musculoskeletal injuries. The 4th Edition PPE Monograph created by the AAP, AAFP, American Medical Society for Sports Medicine and the American College of Sports Medicine would serve most optimally as the standard

form as it is consistent with all relevant and necessary guidelines.²²

A primary limitation of survey based investigations can be the response rate. However, the response rate in this study was robust and minimises the potential for selection bias among the respondents versus the non-respondents. There is also the possibility of a social desirability bias in the responses to the individual AHA elements on the survey. Providers may realise that they should be performing these highlighted elements and their survey responses may bias the data in that direction with the potential to falsely elevate compliance. Yet our data already demonstrates poor compliance, and therefore such a bias only serves to strengthen our conclusions.

CONCLUSION

Unfortunately for the high-school athlete, the consensus recommendations by the AHA, which have been present and unaltered for 15 years, are poorly understood and poorly followed by primary care physicians and school districts. According to our data, the burden of responsibility for this suboptimal compliance lies in the lack of awareness of the recommendations. New directions for provider education and policy requirements are needed to improve this implementation gap if the conventional model for PPE screening continues to be endorsed. Given the favourable response of physicians and athletic directors regarding the creation of a single, universal PPE form, it appears that standardising the PPE process should be strongly considered.

What this study adds

Our data provide direct evidence that:

- ▶ Physicians and schools are not following clinical guidelines when screening athletes for sudden cardiac death risk factors.
- ▶ Utilisation of the guidelines by providers improves satisfaction with screening and helps to improve comfort knowing when referral for subspecialty care is necessary.
- ▶ Standardisation of the process is nearly universally supported by physicians.

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Contributors NLM conceptualised and designed the study, gathered the data, analysed the data, drafted the initial manuscript and approved the final manuscript as submitted. JAD assisted with design of the study, reviewed and revised the manuscript and approved the final manuscript as submitted. JCS assisted with design of the study, assisted with data gathering, assisted with data analysis, reviewed and revised the manuscript and approved the final manuscript as submitted.

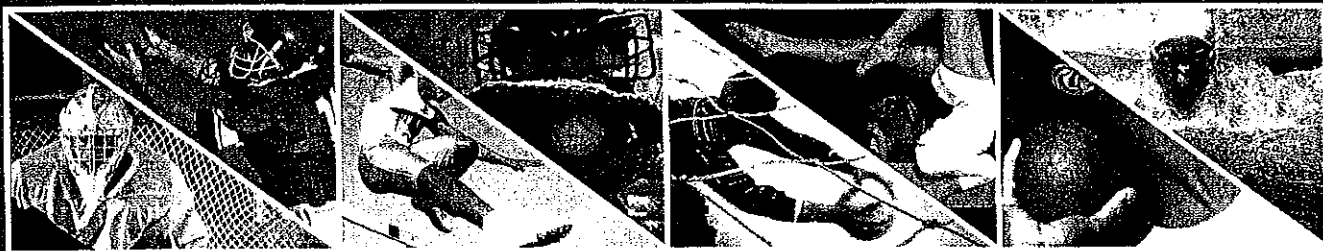
Competing interests None.

Ethics approval Seattle Children's Institutional Review Board.

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Preparticipation Physical Evaluation

THIRD EDITION

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American Academy of Pediatrics

American College of Sports Medicine

American Medical Society for Sports Medicine

American Orthopaedic Society for Sports Medicine

American Osteopathic Academy of Sports Medicine

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cases or types of heart disease,¹⁰ and the appropriate screening questions are embedded in the PPE form. As the AHA states, "A complete and careful personal and family history and physical examination designed to identify, or raise suspicion of, those cardiovascular lesions known to cause sudden death or disease progression in young athletes is the best available and most practical approach to screening populations of competitive sports participants, regardless of age."⁸

Arrhythmias found on examination may require further evaluation, which may include ECG, Holter monitoring, exercise stress testing, and/or additional studies to determine their specific nature. Historically, during ECG evaluation, the disappearance of irregular beats with exercise usually indicates a benign condition in a structurally normal heart. If there are multifocal premature ventricular contractions, doublets, or triplets upon ECG, the athlete should be examined by a cardiologist.

In athletes who may have structural heart disease, the standard evaluation generally includes a history and physical, 12-lead ECG, stress echocardiogram, and graded exercise test. Evaluation beyond these tests usually requires the expertise of an experienced cardiologist. The 26th Bethesda Conference guidelines¹¹ remain an excellent resource for the primary care physician concerning the cardiovascular workup and return-to-play recommendations, as is the AHA's recent consensus statement.¹²

LUNGS

Pulmonary examination should reveal clear breath sounds. Pathologic findings, such as wheezes, rales, prolonged expiratory phase, or significant cough with forced expiration, should be referred for further evaluation and/or appropriate treatment. If the athlete smells of tobacco, a discussion regarding tobacco use may be in order. A normal examination does not exclude EIA, and provocative testing may be needed at a follow-up visit if the history suggests that the athlete has a problem during or immediately after exercise.

ABDOMEN

The abdomen examination should be performed with the athlete supine. The anterior superior iliac spines should be exposed to ensure adequate inspection and palpation of all four quadrants. Abdominal masses, tenderness, rigidity, or enlargement of the liver

or spleen requires further evaluation prior to clearance. Occasionally, an abnormal kidney may be identified by abdomen examination, again requiring further evaluation. The lower abdominal examination in the female athlete should be prefaced by a brief explanation of the reason for additional regional evaluation. This brief introduction will help establish rapport for an exam that is sensitive by nature. If necessary, a chaperone can be obtained at the athlete's discretion. The focus of the examination is to determine the presence of a palpable (gravid) uterus, but a more detailed pelvic examination should be performed by the athlete's primary care physician or a designated specialist.

GENITALIA

The male genitourinary examination should begin with a brief description of and reason for the examination, again, to establish rapport. If necessary, a chaperone can be provided at the athlete's discretion. The focus of the examination is to determine the presence of both testicles, testicular irregularities or masses, and inguinal canal hernias or pain. Counseling concerning participation in contact-collision sports is required for athletes with unpaired or undescended testicles, as discussed on page 76. Inguinal hernias should be evaluated on an individual basis. Inguinal canal pain may indicate a "sports hernia."

Testicular cancer is the leading cause of cancer deaths in men 15 to 35 years of age. The PPE provides an opportunity to introduce the health maintenance practice of testicular self-examination. The examining physician can let the athlete know that his testicles feel normal, encourage self-examination, and advise the athlete to see his physician if there are abnormal findings on the current exam or with future exams.

The genitourinary examination in female athletes is not part of the PPE. If a pelvic exam is warranted on the basis of the athlete's medical history or physical exam, it should be scheduled for a separate time.

Tanner staging for assessing physical maturity has not been contributory in determining clearance and likely would be useful only if the athlete had a history of growth or menstrual abnormalities suggestive of endocrine disease. Therefore, *the author societies no longer recommend Tanner staging as a routine part of the PPE.*^{13,14} However, Tanner staging may be useful in boys 11 to 17 years old as a guide to counseling on topics of growth and development, sport safety, and



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States Boards policy regarding chiropractic drug and alcohol testing

This table represents the compilation of responses from state chiropractic licensing boards to the following questions:

- Can chiropractors in your state collect urine specimens for analysis?
- Can chiropractors in your state interpret urine specimens?
- Can chiropractors in your state perform DOT physical examinations?

Most states responded by e-mail or FAX. Those which did not respond were contacted by telephone and are indicated by **(NO RESPONSE)**. Others responded with qualifications - see below.

This chart is not meant to be a definitive answer regarding a whether these procedures are within the scope of practice of chiropractic in a given state. Chiropractors may wish to contact their state licensing boards or legal counsel for further guidance.

STATE	URINE SPECIMEN COLLECTION	URINE SPECIMEN ANALYSIS	PERFORM DOT PHYSICAL EXAMINATION
Alabama (Telephone)	Y	Y	Y
Alaska (NO RESPONSE)			
Arizona (Telephone)	Y	Y	Y
Arkansas (Telephone)	Y	Y	Y
California	Y	Y	Y
Colorado (Telephone)	Y	Y	Y
Connecticut	Y	Y	Y
Delaware (see below)	Y	Y	Y
D.C. (NO RESPONSE)			

Florida	Y	Y	Y
Georgia (Telephone)	N	?	?
Hawaii (NO RESPONSE)			
Idaho (NO RESPONSE)			
Illinois (per NUHS)	Y	Y	Y
Indiana	Y	Y	Y
Iowa	Y	Y	Y
Kansas (Telephone)	Y	Y	?
Kentucky	Y	Y	Y
Louisiana (see below)	Y	Y	Y
Maine	Y	Y	Y
Maryland (NO RESPONSE)			
Massachusetts	Y	Y	Y
Michigan (NO RESPONSE)			
Minnesota	Y	Y	Y
Mississippi (Telephone)	Y	Y	Y
Missouri	Y	N	Y
Montana	Y	Y	Y
Nebraska (NO RESPONSE)			
Nevada	Y	Y	Y
NH (NOT A BOARD OPINION)	Y	Y	Y
New Jersey	Y	N	Y
New Mexico (NO RESPONSE)			
New York (NO RESPONSE)			
North Carolina	Y	Y	Y
North Dakota	Y	Y	Y
Ohio (Telephone)	Y	Y	Y
Oklahoma (Telephone)	Y	Y	Y

Oregon	Y	Y	Y
Pennsylvania	N	N	Y
Rhode Island	N	N	N
South Carolina	Y	Y	Y
South Dakota	Y	Y	Y
Tennessee (Telephone)	N	N	Y (DIP @Lab)
Texas	Y	Y	Y
Utah	N	N	N
Vermont	Y	Y	Y
Virginia	?	?	?
Washington	Y (DIP only)	Y	N
West Virginia (Telephone)	Y	Y	Y
Wisconsin (NO RESPONSE)			
Wyoming (Telephone)	N	Y	N

Delaware states that urine specimen collection and interpretation may be performed only for subluxation detection.

Louisiana states "Please note that our answers are qualified with the extension, '...as long as it is associated with the functional integrity of the spine' ."

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ACSM Information On...

Pre-Participation Physical Examinations

The pre-participation physical examination (PPE) is an important step toward safe participation in organized sports. The purpose of the PPE is not to disqualify or exclude an athlete from competition, but rather to help maintain the health and safety of the athlete in training and competition.

A COMPLETE PHYSICAL ACTIVITY PROGRAM

A well-rounded physical activity program includes aerobic exercise and strength training exercise, but not necessarily in the same session. This blend helps maintain or improve cardiorespiratory and muscular fitness and overall health and function. Regular physical activity will provide more health benefits than sporadic, high intensity workouts, so choose exercises you are likely to enjoy and that you can incorporate into your schedule.

ACSM's physical activity recommendations for healthy adults, updated in 2011, recommend at least 30 minutes of moderate-intensity physical activity (working hard enough to break a sweat, but still able to carry on a conversation) five days per week, or 20 minutes of more vigorous activity three days per week. Combinations of moderate- and vigorous-intensity activity can be performed to meet this recommendation.

Examples of typical aerobic exercises are:

- Walking
- Running
- Stair climbing
- Cycling
- Rowing
- Cross country skiing
- Swimming.

In addition, strength training should be performed a minimum of two days each week, with 8-12 repetitions of 8-10 different exercises that target all major muscle groups. This type of training can be accomplished using body weight, resistance bands, free weights, medicine balls or weight machines.

The pre-participation physical examination (PPE) has the following goals:

- Identify medical and orthopedic problems that may place the athlete at risk for injury or illness;
- Identify correctable problems that may impair the athlete's ability to perform;
- Maintain the health and safety of the athlete;
- Assess fitness level for specific sports;
- Educate athletes and parents concerning sports, exercise, injuries and other health related issues; and
- Meet legal and insurance requirements.

The PPE is generally a formal requirement prior to participation in junior high, high school, college or professional sports, and interim exams are done annually if required or indicated. The qualifications of the health care professionals who perform the PPE are based on practitioner availability, clinical expertise and individual state laws. The PPE is best done in a medical setting to ensure proper equipment and appropriate privacy; however, the large number of athletes involved, limited time for the exam and deadlines for participation often require the PPE to be done in a format of multiple



“stations,” with several health care providers each focusing on their areas of expertise. The PPE comprises several parts: past medical history, sport-specific history, family history and physical exam.

PAST MEDICAL HISTORY

History of any of the following should be made available to the health care provider:

- Allergies
- Asthma
- Birth defects
- Chicken pox
- Diabetes
- Eating disorders
- Glasses/contacts
- Heart murmur
- Heart problems
- Heat problems
- Hepatitis
- Hernia
- High blood pressure
- Kidney disease
- Measles
- Medications
- Menstrual history
- Mental disorders
- Mononucleosis
- Pneumonia
- Rheumatic fever
- Seizures
- Sickle cell trait or disease
- Tuberculosis

SPORTS-SPECIFIC HISTORY

History of any of the following should be made available to the health care provider:

- Orthopedic injuries (sprains, fractures, dislocations) or surgeries
- Back or neck injuries
- Dental trauma
- Chest pain with exercise
- Feeling faint or having passed out with exercise
- Excessive shortness of breath or fatigue with exercise
- “Burners” or “stingers” — caused by contact that produces burning pain that moves into the extremity
- Withholdings from participating in a sport for medical reason

FAMILY HISTORY

History of any of the following should be made available to the health care provider:

- Heart disease or high blood pressure
- Diabetes
- Unexpected death before the age of 50

PHYSICAL EXAM

The following should be checked during the physical exam:

- Pulse rate
- Blood pressure rate

- Height
- Weight
- Vision
- Hearing

EXAM BY HEALTH CARE PROVIDER

- **Head** — eyes, ears, throat, teeth, neck
- **Thorax** — heart, lungs, chest wall
- **Abdomen** — liver, spleen, kidney, intestines
- **Genitalia** — sexual maturity, testicles, hernias
- **Neurological** — reflexes, strength, coordination
- **Orthopedic** — joints, spine, ligaments, tendons, bones (pain, range of motion, strength)
- **Other exams (laboratory, electrocardiogram, x-rays)** may be done at the discretion of the health care provider.

After a thorough history and physical exam, the health care provider will make a participation decision by answering the following questions:

- Is there a problem that places the athlete at increased risk of injury?
- Is any other participant at risk of injury because of this problem?
- Can the athlete safely participate with treatment of the problem?
- Can limited participation be allowed while treatment is indicated?
- If clearance is denied for certain activities, in what activities can they safely participate?
- Is consultation with another healthcare provider necessary to answer the above question?

Restriction from participation must be made based upon the best medically objective evidence on an individual basis, and it is determined with the musculoskeletal, cardiac and aerobic demands of the proposed activity in mind. If clearance is denied, recommendations for correction prior to participation should be communicated and a follow-up evaluation should be scheduled. If acute illnesses or correctable conditions are resolved, clearance should be given. Although the PPE may identify health problems or needs not associated with exercise, it should not be used to replace ongoing medical care or routine check-ups with primary care physicians.

STAYING ACTIVE PAYS OFF!

Those who are physically active tend to live longer, healthier lives. Research shows that moderate physical activity — such as 30 minutes a day of brisk walking — significantly contributes to longevity. Even a person with risk factors like high blood pressure, diabetes or even a smoking habit can gain real benefits from incorporating regular physical activity into their daily life.

As many dieters have found, exercise can help you stay on a diet and lose weight. What's more — regular exercise can help lower blood pressure, control blood sugar, improve cholesterol levels and build stronger, denser bones.

THE FIRST STEP

Before you begin an exercise program, take a fitness test, or substantially increase your level of activity, make sure to answer the following questions. This physical activity readiness questionnaire (PAR-Q) will help determine if you're ready to begin an exercise routine or program.

- Has your doctor ever said that you have a heart condition or that you should participate in physical activity only as recommended by a doctor?
- Do you feel pain in your chest during physical activity?
- In the past month, have you had chest pain when you were not doing physical activity?
- Do you lose your balance from dizziness? Do you ever lose consciousness?
- Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- Is your doctor currently prescribing drugs for your blood pressure or a heart condition?
- Do you know of any reason you should not participate in physical activity?

If you answered yes to one or more questions, if you are over 40 years of age and have recently been inactive, or if you are concerned about your health, consult a physician before taking a fitness test or substantially increasing your physical activity. If you answered no to each question, then it's likely that you can safely begin exercising.

PRIOR TO EXERCISE

Prior to beginning any exercise program, including the activities depicted in this brochure, individuals should seek medical evaluation and clearance to engage in activity. Not all exercise programs are suitable for everyone, and some programs may result in injury. Activities should be carried out at a pace that is comfortable for the user. Users should discontinue participation in any exercise activity that causes pain or discomfort. In such event, medical consultation should be immediately obtained.



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Applicant Follow Up - Attachment E

Complete Guide to Medical Examiner Certification:

https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Complete_Guide_to_ME_Certification_revised_032513.pdf




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Specialties & Subspecialties

The following chart lists the approved specialty and subspecialty certificates in which the ABMS Member Boards can offer certification.

General Certificate(s)	Subspecialty Certificates
American Board of Allergy and Immunology	
Allergy and Immunology	No Subspecialties
American Board of Anesthesiology	
Anesthesiology	Critical Care Medicine Hospice and Palliative Medicine Pain Medicine Pediatric Anesthesiology Sleep Medicine
American Board of Colon and Rectal Surgery	
Colon and Rectal Surgery	No Subspecialties
American Board of Dermatology	
Dermatology	Dermatopathology Pediatric Dermatology
American Board of Emergency Medicine	
Emergency Medicine	Anesthesiology Critical Care Medicine ¹ Emergency Medical Services Hospice and Palliative Medicine Internal Medicine-Critical Care Medicine Medical Toxicology Pediatric Emergency Medicine Sports Medicine Undersea and Hyperbaric Medicine
American Board of Family Medicine	
Family Medicine	Adolescent Medicine Geriatric Medicine Hospice and Palliative Medicine Sleep Medicine Sports Medicine
American Board of Internal Medicine	
Internal Medicine	Adolescent Medicine

	Adult Congenital Heart Disease ^c Advanced Heart Failure and Transplant Cardiology Cardiovascular Disease Clinical Cardiac Electrophysiology Critical Care Medicine Endocrinology, Diabetes and Metabolism Gastroenterology Geriatric Medicine Hematology Hospice and Palliative Medicine Infectious Disease Interventional Cardiology Medical Oncology Nephrology Pulmonary Disease Rheumatology Sleep Medicine Sports Medicine Transplant Hepatology
American Board of Medical Genetics	
Clinical Biochemical Genetics* Clinical Cytogenetics* Clinical Genetics (MD)* Clinical Molecular Genetics*	Medical Biochemical Genetics Molecular Genetic Pathology
American Board of Neurological Surgery	
Neurological Surgery	No Subspecialties
American Board of Nuclear Medicine	
Nuclear Medicine	No Subspecialties
American Board of Obstetrics and Gynecology	
Obstetrics and Gynecology	Critical Care Medicine Female Pelvic Medicine and Reconstructive Surgery Gynecologic Oncology Hospice and Palliative Medicine Maternal and Fetal Medicine Reproductive Endocrinology/Infertility
American Board of Ophthalmology	
Ophthalmology	No Subspecialties
American Board of Orthopaedic Surgery	
Orthopaedic Surgery	Orthopaedic Sports Medicine Surgery of the Hand
American Board of Otolaryngology	

American Board of Otolaryngology	
Otolaryngology	Neurotology Pediatric Otolaryngology Plastic Surgery Within the Head and Neck Sleep Medicine
American Board of Pathology	
Pathology-Anatomic/Pathology-Clinical* Pathology - Anatomic* Pathology - Clinical*	Blood Banking/Transfusion Medicine Clinical Informatics Cytopathology Dermatopathology Neuropathology Pathology - Chemical Pathology - Forensic Pathology - Hematology Pathology - Medical Microbiology Pathology - Molecular Genetic Pathology - Pediatric
American Board of Pediatrics	
Pediatrics	Adolescent Medicine Child Abuse Pediatrics Developmental-Behavioral Pediatrics Hospice and Palliative Medicine Medical Toxicology Neonatal-Perinatal Medicine Neurodevelopmental Disabilities Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Pulmonology Pediatric Rheumatology Pediatric Transplant Hepatology Sleep Medicine Sports Medicine
American Board of Physical Medicine and Rehabilitation	
Physical Medicine and Rehabilitation	Brain Injury Medicine ³ Hospice and Palliative Medicine Neuromuscular Medicine Pain Medicine Pediatric Rehabilitation Medicine Spinal Cord Injury Medicine Sports Medicine

American Board of Plastic Surgery	
Plastic Surgery	Plastic Surgery Within the Head and Neck Surgery of the Hand
American Board of Preventive Medicine	
Aerospace Medicine* Occupational Medicine* Public Health and General Preventive Medicine*	Clinical Informatics Medical Toxicology Undersea and Hyperbaric Medicine
American Board of Psychiatry and Neurology	
Psychiatry* Neurology* Neurology with Special Qualification in Child Neurology*	Addiction Psychiatry Brain Injury Medicine ³ Child and Adolescent Psychiatry Clinical Neurophysiology Epilepsy Forensic Psychiatry Geriatric Psychiatry Hospice and Palliative Medicine Neurodevelopmental Disabilities Neuromuscular Medicine Pain Medicine Psychosomatic Medicine Sleep Medicine Vascular Neurology
American Board of Radiology	
Diagnostic Radiology* Interventional Radiology and Diagnostic Radiology* ³ Radiation Oncology* Medical Physics*	Hospice and Palliative Medicine Neuroradiology Nuclear Radiology Pediatric Radiology Vascular and Interventional Radiology
American Board of Surgery	
Surgery* Vascular Surgery*	Complex General Surgical Oncology ⁴ Hospice and Palliative Medicine Pediatric Surgery Surgery of the Hand Surgical Critical Care
American Board of Thoracic Surgery	
Thoracic and Cardiac Surgery	Congenital Cardiac Surgery
American Board of Urology	
Urology	Female Pelvic Medicine and Reconstructive Surgery Pediatric Urology

*Specific disciplines within the specialty where certification is offered.

¹Approved 2013; first issue 2014

²Approved 2012; first issue to be determined

³Approved 2011; first issue 2014

⁴Approved 2011; first issue to be determined

To find out the requirements associated with a specific board, call the board directly. A listing of **contact information for the ABMS Member Boards** is available on this Web site.

ACGME Program Requirements for Graduate Medical Education in Sports Medicine

One-year Common Program Requirements are in BOLD

Effective: July 1, 2011

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's and fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. The educational program in sports medicine must be 12 months in length.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

I.A.1. The sponsoring institution must also sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in

emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation.

- I.A.1.a) The sports medicine program must function as an integral part of an ACGME-accredited residency program in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation.

I.B. Participating Sites

- I.B.1. **There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

The PLA should:

- I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for fellows;**
- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**
- I.B.1.c) **specify the duration and content of the educational experience; and**
- I.B.1.d) **state the policies and procedures that will govern fellow education during the assignment.**
- I.B.2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

II. Program Personnel and Resources

II.A. Program Director

There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

- II.A.1. **Qualifications of the program director must include:**

- II.A.1.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
- II.A.1.b) **current certification in the subspecialty by the American**

Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation or subspecialty qualifications that are acceptable to the Review Committee; and

- II.A.1.c) current medical licensure and appropriate medical staff appointment.**
- II.A.2. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. The program director must:**
 - II.A.2.a) prepare and submit all information required and requested by the ACGME;**
 - II.A.2.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
 - II.A.2.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - II.A.2.c).(1) all applications for ACGME accreditation of new programs;**
 - II.A.2.c).(2) changes in fellow complement;**
 - II.A.2.c).(3) major changes in program structure or length of training;**
 - II.A.2.c).(4) progress reports requested by the Review Committee;**
 - II.A.2.c).(5) responses to all proposed adverse actions;**
 - II.A.2.c).(6) requests for increases or any change to fellow duty hours;**
 - II.A.2.c).(7) voluntary withdrawals of ACGME-accredited programs;**
 - II.A.2.c).(8) requests for appeal of an adverse action;**
 - II.A.2.c).(9) appeal presentations to a Board of Appeal or the ACGME; and**
 - II.A.2.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
 - II.A.2.d).(1) program citations; and/or**

- II.A.2.d).(2)** request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.A.2.e) devote at least 10 hours per week, on average, of his or her professional effort to administering the program, and teaching and supervising the sports medicine fellows; and,
- II.A.2.f) delineate fellow responsibilities for patient care and progressive responsibility for patient management and supervision of fellows during all clinical experiences.
- II.B. Faculty**
- II.B.1.** There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.
- II.B.2.** The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.
- II.B.3.** The physician faculty must have current certification in the subspecialty by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation, or possess qualifications acceptable to the Review Committee.
- II.B.4.** The physician faculty must possess current medical licensure and appropriate medical staff appointment.
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:
- II.B.5.b).(1) peer-reviewed funding;
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
- II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or
- II.B.5.b).(4) participation in national committees or educational organizations.

- II.B.5.c) Faculty should encourage and support fellows in scholarly activities.
- II.B.6. In addition to the sports medicine program director, there must be at least one sports medicine faculty member with current subspecialty certification in sports medicine by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation who devotes at least 10 hours per week, on average, of his or her professional time to teaching and supervising the sports medicine fellows.
- II.B.7. The faculty must include at least one Board-certified orthopaedic surgeon who is engaged in the operative management of sports injuries and other conditions and who is readily available to teach and provide consultation to the fellows.
- II.C. Other Program Personnel**
- The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**
- II.C.1. The sports medicine team must include coaches and certified athletic trainers with whom the fellows interact.
- II.C.2. Qualified staff members in behavioral science, clinical imaging, clinical pharmacology, exercise physiology, nutrition, and physical therapy must be available to provide consultations and to assist with teaching fellows.
- II.D. Resources**
- The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements.**
- II.D.1. There must be a patient population that includes patients of all ages and physical abilities, as well as each gender, and is adequate in number and variety to meet the needs of the educational program.
- II.D.2. There must be an identifiable sports medicine clinic that offers continuing care to patients who seek consultation regarding sports-related or exercise-related health problems.
- II.D.2.a) The sports medicine clinic must have up-to-date diagnostic imaging and functional rehabilitation services available and accessible to clinic patients.
- II.D.2.b) Consultation in medical and surgical specialties and subspecialties must be readily available.

- II.D.3. The program must have access to sporting events, team sports, and mass-participation events.
- II.D.4. There must be an acute care facility that provides access to the full range of services typically found in an acute care general hospital.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.

- III.A.1. Prior to appointment in the program, fellows should have completed an ACGME-accredited residency in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation.
- III.A.2. The program director must inform applicants from non-ACGME-accredited programs in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation, prior to appointment and in writing, of the specialty board's policies and procedures that will affect their eligibility for certification.

III.B. Number of Fellows

The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

- IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;**

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies

into the curriculum:

IV.A.2.a)

Patient Care

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:

IV.A.2.a).(1)

must demonstrate competence in the diagnosis and non-operative management of medical illnesses and injuries related to sports and exercise, including hematomas, non-surgical sprains and strains, stress fractures, and traumatic fractures and dislocations; and,

IV.A.2.a).(2)

must demonstrate competence in the diagnosis, and timely referral for operative treatment of sports-related injuries, including hematomas, stress fractures, surgical sprains and strains, and traumatic fractures and dislocations.

IV.A.2.b)

Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:

IV.A.2.b).(1)

must demonstrate a level of expertise in the knowledge of those areas appropriate for a subspecialist in sports medicine, specifically:

IV.A.2.b).(1).(a)

anatomy, physiology, and biomechanics of exercise;

IV.A.2.b).(1).(b)

basic nutritional principles and their application to exercise;

IV.A.2.b).(1).(c)

psychological aspects of exercise, performance, and competition;

IV.A.2.b).(1).(d)

guidelines for appropriate history-taking and physical evaluation prior to participation in exercise and sport;

IV.A.2.b).(1).(e)

physical conditioning requirements for various exercise related activities and sports;

IV.A.2.b).(1).(f)

special considerations related to age, gender, and disability;

IV.A.2.b).(1).(g)

pathology and pathophysiology of illness and injury as they relate to exercise;

IV.A.2.b).(1).(h)	effects of disease on exercise and the use of exercise in the care of medical and musculoskeletal problems;
IV.A.2.b).(1).(i)	prevention, evaluation, management, and rehabilitation of injuries and sports-related illnesses;
IV.A.2.b).(1).(j)	clinical pharmacology relevant to sports medicine and the effects of therapeutic, performance-enhancing, and mood-altering drugs;
IV.A.2.b).(1).(k)	promotion of physical fitness and healthy lifestyles;
IV.A.2.b).(1).(l)	ethical principles as applied to exercise and sports;
IV.A.2.b).(1).(m)	medicolegal aspects of exercise and sports;
IV.A.2.b).(1).(n)	environmental effects on exercise;
IV.A.2.b).(1).(o)	growth and development related to exercise;
IV.A.2.b).(1).(p)	the role of exercise in maintaining the health and function of the elderly; and,
IV.A.2.b).(1).(q)	exercise programs in school-age children.

IV.A.2.c)

Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
IV.A.2.c).(3)	educate patients, members of patients' families, medical students, coaches, athletes, other professionals, and other health care professionals (including nurses and allied health personnel) residents regarding issues related to sports and exercise; and,
IV.A.2.c).(4)	function as a team physician.

IV.A.2.d)

Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

IV.A.2.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.A.2.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

IV.A.3. Curriculum Organization

IV.A.3.a) There must be conferences, seminars, and/or workshops in sports medicine specifically designed to augment fellows' clinical experiences.

IV.A.3.b) Clinical activities in sports medicine must represent a minimum of 60% of fellows' time in the program. The remainder of the time should be spent in didactic and scholarly activities, and in the practice of the fellow's primary specialty.

IV.A.3.c) Fellows must spend at least one half-day per week maintaining their skills in their primary specialty areas.

IV.A.4. Fellow Experiences

IV.A.4.a) Fellows must participate in conducting pre-participation physical evaluations of athletes.

IV.A.4.b) Fellows must have experience with procedures relevant to the practice of sports medicine. Fellows must:

IV.A.4.b).(1) assist with, observe, and perform outpatient non-operative interventional procedures clinically relevant to the practice of sports medicine; and,

IV.A.4.b).(2) assist with, and/or observe, inpatient and outpatient operative musculoskeletal procedures clinically relevant to the practice of sports medicine.

IV.A.4.c) Fellows must have a sports medicine clinic experience.

IV.A.4.c).(1) Fellows must provide sports medicine clinic patients with

- continuing, comprehensive care and provide consultation for health problems related to sports and exercise.
- IV.A.4.c).(2) Each fellow must spend at least one day per week for 10 months in a single sports medicine clinic providing care to patients.
- IV.A.4.c).(3) If a fellow's sports medicine clinic patients are hospitalized, the fellow must either follow them during their inpatient stay and resume outpatient care following the hospitalization, or remain in active communication with the inpatient care team regarding management and treatment decisions and resume outpatient care following the hospitalization.
- IV.A.4.d) Fellows must have experience providing on-site sports care.
- IV.A.4.d).(1) Fellows must plan and implement all aspects of medical care at various sporting events.
- IV.A.4.d).(2) Fellows must participate in providing comprehensive and continuing care to a single sports team where medical care can be provided across seasons, or, to several sports teams across seasons.
- IV.A.4.d).(3) Fellows must have clinical experiences that provide exposure to, and facilitate skill development in, the appropriate recognition, on-field management, and medical transportation of sports medicine urgencies and emergencies.
- IV.A.4.e) Fellows must participate in mass-participation events.
- IV.A.4.e).(1) Fellows must plan and implement all aspects of medical care for at least one mass-participation sports event.
- IV.A.4.e).(2) Fellows must have experience providing medical consultation, direct care-planning, event planning, protection of participants, and coordination with local EMS systems.
- IV.A.4.f) Fellows must have experience working in a community sports medicine network involving parents, coaches, athletic trainers, allied health personnel, residents, and physicians.

IV.B. Fellows' Scholarly Activities

- IV.B.1. Each fellow should complete a scholarly or quality improvement project during the program.
- IV.B.1.a) Evidence of scholarly activity should include at least one of the

following:

- IV.B.1.a).(1) peer-reviewed funding and research;
- IV.B.1.a).(2) publication of original research or review articles; or,
- IV.B.1.a).(3) presentations at local, regional, or national professional and scientific society meetings.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) The faculty must evaluate fellow performance in a timely manner.
- V.A.1.b) The program must:
 - V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
 - V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and
 - V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:

- V.A.2.a) document the fellow's performance during their education, and
- V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) fellow performance;

V.C.1.b) faculty development;

V.C.1.c) performance of program graduates on the certification examination; and,

V.C.1.c).(1) At least 75% of fellows who completed the program in the preceding five years, and were eligible, must have taken the certifying examination.

V.C.1.c).(2) At least 75% of a program's graduates from the preceding five years who took the certifying examination for sports medicine for the first time must have passed.

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) fellows and faculty must have the opportunity to evaluate the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.

- VI.A.3.** The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- VI.A.4.** The learning objectives of the program must:
- VI.A.4.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
 - VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.
- VI.A.5.** The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:
- VI.A.5.a)** assurance of the safety and welfare of patients entrusted to their care;
 - VI.A.5.b)** provision of patient- and family-centered care;
 - VI.A.5.c)** assurance of their fitness for duty;
 - VI.A.5.d)** management of their time before, during, and after clinical assignments;
 - VI.A.5.e)** recognition of impairment, including illness and fatigue, in themselves and in their peers;
 - VI.A.5.f)** attention to lifelong learning;
 - VI.A.5.g)** the monitoring of their patient care performance improvement indicators; and,
 - VI.A.5.h)** honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- VI.A.6.** All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
- VI.B.** Transitions of Care
- VI.B.1.** Programs must design clinical assignments to minimize the number of transitions in patient care.

- VI.B.2.** Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- VI.B.3.** Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
- VI.B.4.** The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.
- VI.C.** Alertness Management/Fatigue Mitigation
 - VI.C.1.** The program must:
 - VI.C.1.a)** educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;
 - VI.C.1.b)** educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
 - VI.C.1.c)** adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
 - VI.C.2.** Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
 - VI.C.3.** The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.
- VI.D.** Supervision of Fellows
 - VI.D.1.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
 - VI.D.1.a)** This information should be available to fellows, faculty members, and patients.
 - VI.D.1.b)** Fellows and faculty members should inform patients of their respective roles in each patient's care.
 - VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.

- VI.D.4.c)** Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.
- VI.D.5.** Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
- VI.D.5.a)** Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.
- VI.E.** **Clinical Responsibilities**
- The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.
- VI.E.1.** The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow.
- VI.F.** **Teamwork**
- Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.
- VI.G.** **Fellow Duty Hours**
- VI.G.1.** **Maximum Hours of Work per Week**
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- VI.G.1.a)** **Duty Hour Exceptions**
- A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
- The Review Committees for Emergency Medicine, Family Medicine, Pediatrics, or Physical Medicine and Rehabilitation will

not consider requests for exceptions to the 80-hour limit to the fellows' work week.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.a) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b) Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.c) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention

to the needs of a patient or family.

VI.G.4.c).(1)

Under those circumstances, the fellow must:

VI.G.4.c).(1).(a)

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.c).(1).(b)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.c).(2)

The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5.

Minimum Time Off between Scheduled Duty Periods

VI.G.5.a)

Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Sports medicine fellows are considered to be in the final years of education.

VI.G.5.a).(1)

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.a).(1).(a)

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

VI.G.5.a).(1).(b)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6.

Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float.

VI.G.7. Maximum In-House On-Call Frequency

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

ACGME Approved: June 17, 2010 Effective: July 1, 2011
Minor Revision Approved: June 11, 2011 Effective: July 1, 2011
Revised Common Program Requirements Effective: July 1, 2011

Appendix D

Public Hearing Transcript

Chiropractic Scope of Practice Sunrise Public Hearing Transcript August 6, 2013

Kristi Weeks, Director of Legal Services and Legislative Liaison at the Department of Health, opened the hearing and introduced staff. She also introduced the hearing panel, who are there to make sure we have all the information we need to make a sound recommendation.

- Mike Weisman is a staff attorney in the Health Systems Quality Assurance Division.
- Shannon Walker is a supervisor in our Investigation and Inspections Office of the Health Systems Quality Assurance Division.
- Vicki Bouvier is the rules coordinator in our Environment Public Health Division.

KRISTI WEEKS: Today's hearing is for the proponents to make their presentation, and for opponents and other interested parties to comment on the proposal. Panel members and department staff will ask questions during the proponents' presentation and public testimony. After the hearing, there will be a 10-day written comment period before we draft the initial report. We want to allow you to provide additional information on topics brought up today, and allow those who could not attend the hearing to submit information. The address for submitting comments is posted on the wall. The recommendations in our report will be based in part on this hearing. We expect the report to go to the Secretary of Health for approval in October.

We ask that you stay after your presentation or testimony if possible, because there may be follow-up questions. You must sign in by 10:00 am to assure we have time for you to speak today. Please be sure you have signed up on the sign-in sheet if you wish to testify. We also use the contact information on this sheet for updating participants during the remainder of the process.

Please keep two things in mind during your presentations and written submissions. First, we are reviewing the language sent to us by the legislature, which was House Bill 1573 from the 2013 legislative session. The statutes guiding the review process say that we will review what the legislature asked us to review and nothing else. Second, the sunrise review process has statutorily mandated criteria. We try to stick to those criteria as much as possible. As this is not a legislative hearing, political arguments or other factors not included in the criteria the legislature has given us will not help or hurt the proposal we are reviewing. It is the legislature's job to take those into account; they specifically have asked us to look only at certain criteria. It will be my job to try to keep us within the time limits as well as the limits of the review. The focus of our discussions should be the applicant's report and the proposed bill.

We hold two or three or four of these hearings each year. Over time, we've been able to identify some strategies for holding a productive hearing:

- Please note this hearing is being recorded and your testimony will be shared with interested parties. Because it is important that the recording is clear so that future listeners can hear and understand it, we ask that you follow these two rules:

1. Please use the microphone when speaking. This includes panel members but not me;
 2. Please do not call out information from the audience. If you are the person at the podium, please do not solicit information from your colleagues in the audience. If there is a question that's been asked and the person who is asked the question does not have the information and you do, feel free to come up at some point and testify but please do not shout things out from the back.
- If your points have already been made by previous speakers, you do not need to repeat their testimony. Indicating your agreement with previous speakers will get your position on record.

I would now like to welcome up the applicants to present their proposal to us. We ask that they please keep their presentation within the 30 minute limit we have provided so that we have time for panel questions and for others to testify. We will begin giving you verbal signals if you go beyond the time limit. Please use your time to focus on the sunrise criteria that are in law and how your proposal addresses those criteria. The panel members are invited to ask questions during this presentation which will be followed by public testimony. The panel members that I have listed are:

- Lori Grassi;
- Dr. Robert Nelson, and;
- Dr. Gary Schultz.

LORI GRASSI: Good morning and thank you for your time today and for being here for this issue. For the record, I am Lori Grassi, Executive Director and lobbyist for the Washington State Chiropractic Association representing the chiropractic profession in Washington State. Throughout my many years with the WSCA we have addressed multiple venues making repeated efforts to clarify the ability for a chiropractor to perform pre-participation physical examinations for school aged athletes. There has been considerable conversation with former legislative bodies, meetings with the medical committee of the Washington Interscholastic Activities Association (WIAA), the Department of Health Chiropractic Quality Assurance Commission (DOH-CQAC), the Washington State Attorney General's office and the Office of Superintendent of Public Instruction (OSPI). In general, each of these venues has delivered some minimal direction of where to take our case; all suggesting legislative clarity. When attempting to address the issue with other professionals, we are met with negative, visceral reaction and some consistent themes

1. A misunderstanding of the chiropractic education;
2. A lack of desire to learn the educational components, and
3. A long-standing bias against the chiropractic profession as a whole. The bias is so deep in some professions, and specifically in individuals, that in our February 2013, hearing, we were even accused of directing patients not to obtain immunizations even though a chiropractor wouldn't sign the waiver and is not allowed to sign the waiver established by the legislature anyway. Bias appears in many forms including testimony by other professions with less than half of the training of a chiropractic profession and they become disparaging and

accusatory. We hope that this venue will provide a more open environment to hear the true facts about the chiropractic education, their examinations and give us the clarity in our scope of practice that we have fought for for years and believe was intended when the current law was written.

Because the WIAA provides recommendations and guidelines to school districts regarding high school PPE's, we initially perceived that they were the entity that our legislation be focused on. HB 1573 was drafted because the WSCA believed that the WIAA was violating antidiscrimination statutes (18.25.0192-18.25.0197) because of its relationship with the OSPI. After joint meetings with the current Superintendent and the WIAA, we began identifying the concerns that needed to be addressed. The WIAA felt that if the chiropractic scope more clearly stated that chiropractors could perform pre-participation examinations, then they would modify their guidelines but it was their legal interpretation that the statute did not clearly allow for these exams and suggested we run legislation. Additional efforts within the Department of Health included an Assistant AG's opinion that a grammatical correction to the current scope be made that would allow chiropractors to perform these exams. At this recommendation, the WSCA felt it would be more appropriate and lead to greater clarity if the change to the scope was specific and direct in its language allowing for specific examinations to occur and to avoid future legal challenge on a statute that was changed only by grammar. The proposed legislation in 2013 was not amended prior to the deadline in legislative committee, which is why the title of the bill sent for Sunrise is different than the direction of the applicant report, yet we still feel there is a strong relationship. Amendments were drafted and had sponsors but since the policy cut-off occurred, there was no opportunity for amendments even though the legislators expected the change. Also, the prime sponsor of the Bill, Representative Harris, and the legislator referring the bill to sunrise, Representative Cody, agreed on the amendments but they were still not managed before the Session completed. To that end, we still believe our report addresses the intent of the bill.

While the PPE challenges were occurring at the state level, a Federal ruling was made that chiropractors be allowed to perform Department of Transportation "Fit for Duty" examinations. The criteria for all provider categories performing these examinations is described and taught by DOT and includes MD's, DO's, PA's, DC's and ARNP's. As of August 5, 2013, there are only 25 providers of DOT exams in the entire state. This clearly identifies a shortage of providers to give these exams to drivers needing certification before going to work. Since the federal government has identified the provider types allowed to perform these exams and designates the exact same training be given to all of their medical examiners, chiropractors in Washington who prefer to specialize in this training should be allowed to perform these exams also. Clarification in the scope language will allow this to occur.

This is not to state that all chiropractors will choose to perform either of these exams but they deserve the opportunity and patients deserve their choice of provider to deliver the service for those who do choose to specialize. Providers can choose to specialize in pediatrics, orthopedics or obstetrics but an obstetrician doesn't perform orthopedic surgery. In the same way that all medical doctors do not perform every type of service, a chiropractor who doesn't specialize in PPE and DOT examinations and their requirements, is not going to perform the PPE or DOT exams. There is no chiropractor in the state that would intentionally put their career, education and their lives on the line without the proper training to perform these services safely, and most importantly, effectively.

As presented in our applicant report, many states allow chiropractors to perform PPE and DOT exams. In some of those states, no additional training is required and in some states there is

required training that follows a national model such as the Diplomate in American Chiropractic Sports Physicians (DACBSP), or the Certified Chiropractic Sports Physicians (CCSP) and in some states there is a specific training module written, which is what we have proposed modeling after the State of Colorado.

There is a presumption that the chiropractor only performs services that are “musculoskeletal” in nature. While we believe they are the experts of these services, there is much more to chiropractic care than just musculoskeletal services or their training and education wouldn’t require learning of all the systems of the body. Chiropractors have been “boxed into” a type of care by an insurance model which is unfair and part of what creates the bias against the profession. Like all other primary care providers, chiropractors must perform an examination on every patient, every visit, every time by statute (18.25.005 (3)). The specificity of a PPE or a DOT examination is an extension of this already required exam.

With me today is Dr. Robert Nelson, of Colorado, who has been in practice for 27 years in Lakewood, Colorado, and holds certification as a Diplomate of American Chiropractic Sports Physician and was instrumental in implementing the pre-participation examination requirements in the State of Colorado.

I also have Dr. Gary Schultz, Vice President of Academic Affairs from the University of Western States in Portland, who will emphasize the chiropractic education and graduation examination requirements.

Thank you for your time and I am available for questions.

DR. ROBERT NELSON: Good Morning. My name is Dr. Robert Nelson. I am the chiropractor. I am the past president of the Colorado Chiropractic Association and the current president of the American Chiropractic Board of Sports Physicians. The ACBSP is the certifying body for all CCSPs and DACBSPs in the United States. I am the Colorado delegate to the American Chiropractic Association. I am board certified in sports medicine, DACSP. I am on the editorial review board for the Journal of Chiropractic Medicine. I also have an APC, advanced practice chiropractic certification, from the State of New Mexico. I’m licensed in Colorado, Wyoming, New Mexico, Missouri and Illinois. I have several articles published in peer review journals and I have been the team chiropractor for the Pro Rodeo Cowboy Association and the team chiropractor for the Colorado Rapids of Major League Soccer. I also teach for five chiropractic colleges across the United States. I am here in support of the changes in the state of Washington, which will allow trained chiropractors to conduct pre-participation physicals and DOT examinations.

I’d like to start by saying that when other professionals state that they feel chiropractors cannot conduct these examinations, I know that they are either uninformed or misinformed about our education and preparation to perform these examinations or, perhaps, there is a certain amount of bias in what they say. There are others here today who will speak to the educational process and standards but I will say that our schools are certified, not only by the Council on Chiropractic Education, but independent regional accreditation agencies as well. The same agency that accredits the University of Washington Medical School accredits the University of Western States in Portland, a chiropractic university. When I was going to school at Logan College of Chiropractic in St. Louis, Missouri, the regional accreditation agency that certified our courses also certified the Harvard Medical School and the University of Colorado Medical School. As part of my clinical rotations, I had to perform a certain number of complete physicals as part of the requirements for graduation. I performed pre- and post-fight physicals for the

Golden Glove Association of St. Louis. This included eye exams, hearing exams, heart evaluations, history, musculoskeletal, hernia examinations, just to list a few. Every patient who comes into my clinic has to be evaluated so that I can determine the differential diagnosis, everything from concussions to cardiac contusions. Is someone is in a car accident, do they have whiplash, do they have a disc, did they hit the steering wheel, what kind of problems do they have? Those evaluations, those performances, have to be done on every single patient every single time. We do these evaluations routinely. It's part of our practice; part of our law.

First, I'd like to talk about the Department of Transportation fit for duty exams. The DOT has set up new guidelines for these examinations. They have identified three types of physicians: MDs, DOs and DCs, as well as, nurse practitioners and PAs, as the ones who can do these examinations. Without regard to their degrees, all of these providers will have to undergo the same training and take the same test before they become certified examiners. The cutoff date is April, 2014. After that date, no one, but certified examiners, will be allowed to conduct these examinations. The American Chiropractic Association supports this regulation and the training required for all practitioners of any type who wish to become certified. To date, the largest group of certified examiners are chiropractors thanks, in part, to the educational tools provided by the ACA and other agencies.

Now, I would like to address the PPEs for school physicals. I support trained chiropractors as having the right to perform school physicals. As Ms. Grassi stated, I have worked for many years implementing the pre-participation examination requirements in the state of Colorado. We have a program similar to the one now proposed for the state of Washington. For over eleven years, chiropractors in Colorado have been conducting PPEs for our school districts. I think we are one of the only states which allows chiropractors to do PPEs that requires a certification course with labs and a written test with recertification every two years. Chiropractors in my state have conducted thousands of examinations of this type without a single complication. Our course is heavy on the cardiac examination and the newest guidelines concerning concussions. We recertify every two years because the new international guidelines on concussion come out every two years (whether that would be Prague, Vienna, Zurich guidelines...they come out every two years) and we want our doctors to have the very latest information on this subject. The 18 hours proposed for the Washington State chiropractors is fair and sufficient based on the extensive knowledge and training that doctors of chiropractic already possess. The ACBSP, who oversees the CCSP and diplomate programs, set up the criteria for board certification in sports medicine with education that has the most current information that can be obtained and we have to have continuing education to maintain that certification. The ACBSP has, also, instituted a concussion certification course with recertification every two years. Participants from any profession may take the course and after completion, they are listed on a registry and receive a certificate from the ACBSP as well as from the Center for Disease Control (CDC). Even the monograph, which most people use for the pre-participation physical evaluation, 4th addition, which is used for the Colorado program and the ACBSP sports medicine program, states:

Many states allow healthcare professionals, other than MDs and DOs, to perform the evaluation. Regardless of their training, practitioners performing PPEs should completely screen athletes for the types of problems that would affect participation or place the athlete at undo risk.

I believe that the training suggested for this program and the baseline education standard chiropractors already possess, will insure that the examination will be of the highest quality and a great benefit to the people of Washington State.

Thank you for your time. I'm available for questions.

DR. GARY SCHULTZ: Good morning. Point of clarification, Ms. Grassi indicated that I was vice-president for academic affairs and, as of July 1st, I transitioned into being a full professor and chair of the clinical sciences department. I have only, in the last few days, been able to control the smile that has existed on my face since July 1st. So you'll understand if I just happen to crack a smile for no apparent reason whatsoever. It's been a wonderful transition. Can I just say that? Wonderful.

I want to thank you for the opportunity to be heard today. A little bit, a very brief background, on where I've travelled. I am a board certified chiropractic radiologist. I did my residency in Los Angeles. I am currently vice-president for the American Chiropractic College of Radiology. I am, also, on the counsel for chiropractic education as a counselor and I also serve as the counselor at large member of the executive committee for the CCE.

I am going to focus my comments today on the core basic chiropractic physician training that exists. You'll understand that my reference point and my bias is the University of Western States, where I am employed and have been for the last seven years, but many of the comments that I am going to provide are generalizable to any chiropractic program across the country. For the record, I believe that the majority of practicing chiropractors in the state of Washington are UWS alumni.

I want to provide you with some facts. I was astonished to hear some of the testimony from February and the lack of understanding and the lack of information in the core training in chiropractic. First of all, chiropractors are physicians and that's Code 5 RCW 18.25.090. Second of all, chiropractic physicians are trained in all the essential elements that are required in pre-participation evaluations and DOT physical evaluations as a part of their core training. They have all of that information already. It is extremely important for the panel to understand that chiropractic physician training includes basic sciences education, clinical sciences education, and clinical experiences, which incorporate all areas of the body. It is not an education focused simply on the neuromuscular skeletal system as has been often referenced. Certainly, there is a focus in that area. That is the primary area of treatment for most chiropractic scopes but the evaluation, the critical thinking, the differential diagnosis of the education in those areas for chiropractic physicians is far broader than the area of treatment. So, yes, chiropractors do know how to auscultate the heart and lungs. Yes, they know how to do a neurological evaluation, a complete neurological evaluation. They are trained in differential diagnosis of closed head injuries and a variety of other conditions. They have course work in cardio-respiratory evaluation and diagnosis, gastrointestinal, genital/urinary, obstetrics, dermatology. So there is a very broad education focused on evaluation, differential diagnosis and diagnosis of any condition that would likely walk through an ambulatory care center's doors. That is why chiropractors are...in the Council of Chiropractic Education standards, they are required to be primary contact chiropractic physicians. So they are required to be able to evaluate, and to triage, and in some cases to manage pretty much anything that walks through the door; at the very least, they are responsible to be able know what they can and can't treat and to be able to refer appropriately for conditions they encounter that are not within their scope. The course work, as I have already referenced, is visible at the University of Western States website. Go to the doctor of the chiropractic program. You can see all of the coursework. There is over 4600 hours of education to include all the areas I have previously referenced.

I would next like to address some of the issues related to accreditation of chiropractic programs. As Dr. Nelson correctly observed, all but one chiropractic institution in the United States has regional accreditation through one of the six regional accreditors recognized by the Department of Education. In addition, every single chiropractic program in the United States has recognition by the Council of Chiropractic Education, which is the DOE recognized specialty accreditor for chiropractic programs. Within the 2013 standards of the CCE, there are reference points which help to guide the panel in understanding that the education chiropractic physicians receive is comprehensive and inclusive of all body systems, not just the musculoskeletal system, and I would direct your attention to Appendix 1, meta competency 1 and 2, as good starting points. Next, as if the standards for the CCE were not sufficient, every chiropractic physician who is eligible for licensure, I believe, in 47 states now, must complete a battery of four National Board of Chiropractic examiner examinations. The part 1 examination is focused on the basics sciences to include anatomy, physiology, biochemistry, pathology, toxicology, and pharmacology. Part 2 focuses on didactic clinical sciences. Part 3 focuses on critical thinking and differential diagnosis of clinical conditions and Part 4 is a practical examination which focuses on the skill set and critical thinking abilities of chiropractic physicians. These are pre-licensure requirements so it is clear that chiropractors are well educated and they are frequently evaluated. They are competent to perform these basic procedures by the time they are licensed.

In Washington State, chiropractors are licensed and I have heard testimony from past meetings that chiropractors are not licensed to perform these kinds of physicals. The reality is that, within, oh, gosh, I thought I had it written down...but within the rules for chiropractors they are allowed to evaluate for chiropractic lesions and to evaluate for those things that are not chiropractic lesions. That is certainly what we are looking for in this context.

The last thing that I will share with you is that this core training that every chiropractor receives serves as a sound foundation and a base. I think the addition of additional training on top of that, for me, is icing on the cake. I'm available for questions.

KRISTI WEEKS: Ok, at this time, does the panel have questions for this panel?

MIKE WEISMAN: Can I ask a question?

KRISTI WEEKS: You can ask whatever you want. That's what you are here for.

MIKE WEISMAN: Ok. I have a couple of questions. I'd like you, sir, and I'm sorry you don't have name tags, umm, nice things like this, so I'm sorry Dr.?

DR. ROBERT NELSON: Nelson.

MIKE WEISMAN: Dr. Nelson. Dr. Nelson, could you just run through very briefly for me what you do when you conduct a PPE, that's a pre-performance?

DR. ROBERT NELSON: Evaluation.

MIKE WEISMAN: Evaluation. Yeah. I'd like to focus on that for just a second. You've been doing these for a while so go ahead and run with it.

DR. ROBERT NELSON: The thing is, what we do is we follow the outline of the monograph that was produced by the ACSM and the major thing that happens is a history. 70% of the

problems that may be related to an athlete come up in the history. OK? And then the examination consists of an eye examination, eyes, ears, nose and throat, lung, cardiac...

MIKE WEISMAN: Let me stop you for just a second.

DR. ROBERT NELSON: Sure.

MIKE WEISMAN: So do you have one of those charts that everyone uses for seeing in your office?

DR. ROBERT NELSON: Yes

MIKE WEISMAN: And then when you do ears, nose and throat, for example, do you have one of those scopes? I'm sorry but I don't know all the nicknames.

DR. ROBERT NELSON: An otoscope, yes

MIKE WEISMAN: An otoscope and you look at all that stuff.

DR. ROBERT NELSON: Yes, we look in there...the Snellen chart...essentially what the PPE is concerned with is that the athlete is not what is termed "one eyed". So they must be at least 20/40 corrected to be able to participate in a collision sport. And so a Snellen chart evaluation will allow us to see what their acuity in their eyes are. We, also, look inside of the eyes to see if there is any bulging of the optic nerve or if there is any clogging of the arteries. We look in the nose for septal defects. We look in the ears. We look in the mouth for any lesions that may be there. We check the lymph glands. We do a full musculoskeletal examination to see if their joints are available or rehabbed enough to be able to participate in sports. We also do a hernia examination on male patients. We do a full body analysis. We check the viscera. We do all four quadrants of the abdominal area checking for an enlarged spleen or enlarged liver because hepatomegaly and splenomegaly are contraindication for participation in collision sports. Mostly in these individuals the splenomegaly comes up with mononucleosis, you know, and if they haven't recovered from that, they shouldn't be allowed to be doing a collision sport. Also, you know, the thing is that when they come in for an examination, have they rehabbed from an ankle injury, I was skateboarding and twisted my ankle? Where's the mobility? Where's the proprioception? Where's the joint stability? Have you rehabbed this? All of those are questions. We do a full family history to make sure they haven't got any familial problems with heart. Has someone in your family suddenly died before the age of 50? Then you ask the question again – Have they died of a heart problem? Which leads you to that. Are you on asthma medication? The American Asthmatic Association wants their patients involved as athletes but you must be able to control that and make sure they have their emergency inhalers if necessary. Are you a diabetic? Is your diabetes controlled? The American Diabetic Association want their athletes being able to participate because it's better for their health but, you know, those things have to be brought forward and either the doctor assigned to the team or coach should be aware that these individuals will either need their emergency inhaler or they'll need their insulin on hand in case of an emergency situation comes up.

MIKE WEISMAN: I have a follow up question. When, you talked about looking inside the eye and also to use the otoscope. Where did you learn to do those things?

DR. ROBERT NELSON: Basic science course in chiropractic college. It is required for our examination. That is part of the core curriculum.

MIKE WEISMAN: Are you telling us today that chiropractors here in Washington...is it your understanding that they are expected to do an exam like that when a patient comes to them?

DR. ROBERT NELSON: If it is required for the condition that is presented, OK? The thing is that you don't do every examination for every patient. I'm not going to do genetic testing on somebody or I'm not going to do a blood test but you have to have the critical thinking when a patient presents to you what examinations you are going to conduct. So if someone comes in with migraines or something like that, sure, I'm going to evaluate the cervical spine but I'm also going to look inside the eyes and I'm going to see if there are any problems there, evaluate the blood pressure, so forth and so on. We have the skills to perform them but not any doctor, I don't care who it is, MD, DO, DC, they don't perform every exam they are trained in on every single patient but they have to make the evaluation, the decision, which ones to do.

MIKE WEISMAN: Thank you for that clarification. And then I have a question for you, Dr. and I'm sorry I forgot your name.

DR. GARY SCHULTZ: Schultz.

MIKE WEISMAN: Dr. Schultz. Thank you. I'll make a note here. Dr. Schultz, so your in Western States down in Portland?

DR. GARY SCHULTZ: I am.

MIKE WEISMAN: So when students are going through your program, are they instructed to do all these kinds of exams?

DR. GARY SCHULTZ: They are.

MIKE WEISMAN: How does that occur? Does that occur on actor/patients or on each other? Or? I'm just kind of curious on how that instruction occurs.

DR. GARY SCHULTZ: Sure. The short answer is all of the above. They receive didactic instruction. And they have in the basic courses, for example, they have two physical examination courses and two attending laboratory courses that go along with those lecture courses. In those courses in the laboratory skill development section, they practice on each other. They have a three course series just as they are entering the clinic. It's called, we call it, clean phase courses. Those are courses where they perform examination procedures and they are evaluated on those examination procedures on what we call "standardized" patients, which are actors and actresses which provide the appearance of having a problem. And when they are in their clinical training and internship, they also perform these examinations on outpatients who walk in through the doors. Our interns have educational opportunities in a variety of venues so they see quite a diversity of patients with a diversity of conditions.

MIKE WEISMAN: So I have a question for you following up on what we just heard from Dr. Nelson. In this phase, with the standardized patients, for example, do the students exam a patient with symptoms of like, for example, of like a detached retina or some sort of eye injury or close headed...some sort of neurological injury that might be from a closed head injury or

traumatic brain injury which, I think, we are all familiar with. There's a lot of concern these days about that with student athletes, both male and female.

DR. GARY SCHULTZ: Yes. Yes, they do.

MIKE WEISMAN: Are the standardized patients pediatric patients?

DR. GARY SCHULTZ: Generally not. Generally not. They have a pediatrics course and children are brought in for demonstration purposes and for that. But, for obvious reasons, in a didactic educational setting like that, it is not an environment you want to subject kids to two hours of being examined by interns.

MIKE WEISMAN: Ok. I can understand that. I understand that but I'm still trying to find out so, in the proposal that we are looking at here today, at least for the school physicals, all of these patients would be pediatric patients.

DR. GARY SCHULTZ: Correct.

MIKE WEISMAN: So I'm trying to put together how the practitioner gains experience examining those.

DR. GARY SCHULTZ: They see children and adolescents through their internship. That is part of the outpatient experience. So they see patients of all age groups and all types.

MIKE WEISMAN: Ok. But in their, well, and the internship is part of their education so that is something that is being supervised and graded and getting feedback and so forth.

DR. GARY SCHULTZ: Absolutely. They will tell you way too much.

MIKE WEISMAN: Ok. Let me see what else I have. One of the things that may be a part of this based on my research is making sure that patients are up-to-date in all their vaccinations. Does your school have a position on how chiropractors approach the issue of vaccinations?

DR. GARY SCHULTZ: That is a very interesting question. To state that the institution has a position, a formal position for or against, is an extremely broad brush. If I had to give you that summary...

MIKE WEISMAN: If I used imprecise language, I'm sorry. I don't want to assume anything.

DR. GARY SCHULTZ: The institution in its public health courses and its microbiology and its toxicology courses, speaks to the issue of vaccinations. And if you are asking if the institution is pro or anti, has a patently anti immunization stance, absolutely not. The institution is favorably inclined to the responsible application of all necessary preventative measures for patients. So that includes immunizations where appropriate. Now there are, within the healthcare community, there are controversies. There are some immunization procedures which remain controversial and, as part of their education, students are provided both sides of that argument so that they can make an informed decision. As part of our the institution has really focused on the use of evidence based practice methods and so as we go through teaching students procedures that they are going to perform and practice or advise they are going to give patients. We really try to force them to be informed about the most current healthcare literature on the

subject, to be understanding of and tolerant of differences of opinion based on controversies and gaps in the evidence.

MIKE WEISMAN: Ok. One question I had was. I want go back to Dr. Nelson for a second. Are patients disrobed at any time during the exam?

DR. ROBERT NELSON: Yes, they have to be appropriately dressed. Male patients are in shorts and females are in a tank top and shorts.

MIKE WEISMAN: Is there any point in the evaluation, you mentioned a hernia exam. We don't need to get into too much detail but we can talk about what that involves very briefly.

DR. ROBERT NELSON: Well, essentially what your checking for is hernias.

MIKE WEISMAN: You're talking about inguinal.

DR. ROBERT NELSON: Inguinal hernias, yes. And it is, not to be specific, but you glove up and you go upside of the scrotum and have them cough to see if there is a tapping back and forth. You are also, at that point, looking for in that athlete undescended testicles, single testicles and also checking for any masses because the leading cause of death in young people, as Lance Armstrong will tell you, is testicular cancer. And so those have to be some of the things that we test for.

MIKE WEISMAN: Is there a similar kind of exam you would perform on female athletes as well?

DR. ROBERT NELSON: The gentle urinary exam on females is not part of the PPE.

MIKE WEISMAN: Ok, any thoughts on why that...I mean, you can probably tell us is it not deemed necessary?

DR. ROBERT NELSON: Well, the thing is if you look at the warnings for the PPE. Let's say that a female came in with only one ovary, she can play any sports that she wants. But if a male comes in with only one testicle, he has to be warned to wear appropriate equipment and the consequences thereof. Also, the external exam on a male is more appropriate than an examination of a female. Internal examinations on females aren't until they turn adult. Now, part of the questioning on a female is when did they start their menses, how long have they started it? Have they had any gaps because you've to wonder, number one, if they have primary or secondary amenorrhea or, if, gee, in high school this might happen, they might be pregnant. Ok?

MIKE WEISMAN: Well, that was one of my questions.

DR. ROBERT NELSON: So the thing is, is that part of the, if we have any concerns that we think that they are pregnant, then they must have a negative pregnancy test before they are allowed to participate or they have to be referred to an ob/gyn who can follow the pregnancy if allowed. Same thing if we find a person with only one kidney, ok, the kidney has been removed. For contact sports, they have to be followed by a nephrologist to allow for contact sports.

MIKE WEISMAN: So just so I'm understanding kind of what would happen here. If, for example, a female athlete, and there are a lot of female athletes certainly, if a female athlete

had, for example, amenorrhea, a pause in menses at some point, and I know this is common among high performance female athletes, then the practitioner would refer them for follow up to another practitioner like an ob/gyn or something like that?

DR. ROBERT NELSON: Well, the thing is that it depends on whether it is primary or secondary amenorrhea. Primary amenorrhea means that they have not started their menses by the age of 16. Most females now because of the estrogens in the plastic bottles and so forth are starting at 12 and 13, OK? We also have to do their body fat analysis to determine if they are under 20 percent body fat because at under 20 percent body fat, the hormones stop producing and that's one of the reasons. Part of the thing is that comes from female athletic triad, which has been diagnosed. It started essentially in 1972 with passage of Title 9. At that time there were 1 in 27 females who were involved in sports. Now it's estimated that 1 in 3 females are involved in sports. And, so, with that as the body composition has changed. As an example, your Olympic gymnasts, as a rule our Olympic gymnasts are 20 pounds lighter than their counterparts were 20 years ago. That's a huge change. And, so, a female athletic triad cannot be done by one practitioner. It's a group effort. You have to have support, you have to have nutrition, you have to have maybe psychological, you have to do that to encourage them to at least gain enough weight or have the proper nutrition to regain their period. The thing that is concerning about that with the loss of menses, they are estimated to be able to lose about four percent of their bone mass per year, which can continue for at least four to five years after they regain their period. Now we've all been, we hear commercials from Sally Fields and everybody else, that they can regain, you know, their bone mass but it is felt now due to studies that bone loss lost in their teenage years and their young adulthood, twenties, is irreversible. So, you do the math, 20 times five, you know, 20 to 25 percent of bone loss that will never be recovered. And a recent study that was conducted on female athletic triad, they tried to find out what all was affected so they looked at their estrogen levels, their bone loss. Obviously, estrogen levels were down, bone loss was down, but what they also did was they measured the brachial artery's ability to expand, and they found that it was not being able to expand as well as it should, which, in essence, is hardening of the arteries at age 20.

MIKE WEISMAN: So let me just interrupt you for a second.

DR. ROBERT NELSON: I'm sorry. I get started on this and I just...

(laughter)

MIKE WEISMAN: Well, it's a very interesting area and it's really important because, as you indicate, so many women, young women, are today involved in sports. Many are high performance athletes and they certainly need attention and that's what these pre-performance exams are intended to do.

DR. ROBERT NELSON: Right.

MIKE WEISMAN: But so it sounds a little bit to me like a lot of female athletes are probably going to require a pre-performance exam to be provided by more than one practitioner.

DR. ROBERT NELSON: If the conditions warrant it. I mean everything is, you know, condition warranted and I wouldn't say a lot, because, you know, not everyone has gone down below that 20 percent body fat. But, you know, if you are looking at high performance, if you look at any population, very little of it is high performance. OK? I mean, you have very little elite athletes.

MIKE WEISMAN: Well, as I understand it from the application, the pre-performance exams could go all the way up to age 21.

DR. ROBERT NELSON: Correct.

MIKE WEISMAN: So you would have college age. You would have women and men who are college age athletes.

DR. ROBERT NELSON: Yes. And remember, the PPE is a screening exam. It is to find problems. And if you do find problems, then it is incumbent up on you to make the appropriate recommendations or referrals necessary. Less than one percent of all PPEs are denied access to participation. Ninety-nine percent are passed on because they don't have the red flags or they don't need the referral. So less than one percent but that's the job, is to find that one percent and if you do, then it is incumbent on a doctor, no matter who it is, to make the appropriate referrals.

MIKE WEISMAN: I have a question for..let's follow up on that for a second. Then I have a question for you, Ms. Grassi, and that is, as you understand this proposal, would it include college age, you know, students, college age patients, who might be participating in sports at that level, is that something that is contemplated as well?

LORI GRASSI: I suppose it would apply to that if they required a pre-participation examination in the same manner that an interscholastic athlete would. However, after age 18, a patient could self-refer themselves wherever they want. It would be incumbent upon the institution that they are an athlete for to require a particular form or examination type and then that institution usually would designate who's allowed to perform it if it's not explicit in their particular statute.

MIKE WEISMAN: Well, I get that and I can imagine that, say, the University of Washington or maybe any other university or college that has student athletes might say to their students, you know, we require that these exams be conducted by a medical doctor or whatever they would say. So is it your proposal that their ability to limit that would be affected by the proposal that you're making?

LORI GRASSI: I would say yes, because..

MIKE WEISMAN: So they couldn't so limit?

LORI GRASSI: Correct, but I believe they couldn't so limit now because...I believe that under the way the scope is written, with this grammatical issue, it's possible that they could limit now. But at age 18, a patient can self-refer and chiropractic doesn't require a referral so if the institution limited to a particular provider type, it could possibly violate one of our anti-discrimination statutes. It would have to go to a lawyer, which I am not, to decide does this apply or not. But if it was simply which form did the institution require to be used on the exam and it be the same screening tool as an interscholastic sport, then if this were enacted, then a chiropractor would be able to perform it.

MIKE WEISMAN: A minute ago, you talked about how if the particular university or college wanted athletes to be screened by, and they had their own process, and they said, well, you have to go see a medical doctor or an ARNP or something like that. If higher education can do that, why wouldn't K-12 be able to do that if they felt that was what they wanted to do?

LORI GRASSI: They can do that today which is why we are here. Because the OSPI delegates the authority to the Washington Interscholastic Activities Association, a nonprofit, which is why the bill was drafted the way it was because it was perceived that they were the entity blocking and they said no, if the statute is clear, more clear, that you can explicitly do these, then we don't have an opinion. We will write you into our guidelines.

MIKE WEISMAN: Ok, but as I understand the proposal, then the proposal would be broader than just K-12 if the language that you are proposing, or something like it, because I understand it could very well change, it would also effect students over the age of 18 who might be involved in collegiate athletics as well.

LORI GRASSI: I would agree and I don't believe our report was intended to limit to K-12. It was just the examples that we have at this time and the way the bill was drafted at the initial phase.

MIKE WEISMAN: Ok. And, Dr. Nelson, it sounds like you are also doing exams at the collegiate level in your practice as well.

DR. ROBERT NELSON: Well, I am if allowed but remember the collegiate level involves scholarships and that's a contractual agreement and you cannot break contractual law. I am giving you a scholarship. If you want the scholarship, you follow our rules.

MIKE WEISMAN: Well, those are for scholarship athletes, which is a tiny...

DR. ROBERT NELSON: It's a tiny but, you know, you're talking about intermural and so forth and so on.

MIKE WEISMAN: Yeah, most athletes, even in varsity sports and intermural sports and everything, are not on scholarship.

DR. ROBERT NELSON: No.

MIKE WEISMAN: And I know the universities have some sort of pre-screening they want you to do. And you're doing those now and those are basically adult..

DR. ROBERT NELSON: Yeah, they're adult and, you know, we do adolescents, we do juveniles, we do young adults, we do, you know, older adults who want to start engaging in sports. Say you want to start an exercise program, let's do the physical before you get involved in this. I think it's only safe and prudent.

MIKE WEISMAN: Ok, all right, I'm going to take a pass now for a while since I've asked you a lot of questions. Thank you so much for your responses. I really appreciate it.

KRISTI WEEKS: Shannon? Vicki?

VICKI BOUVIER: I do but you can go first.

SHANNON WALKER: Actually, you answered all of the questions I had so go ahead.

VICKI BOUVIER: I apologize. I'm terrible with names. Ms. Grassi, you had said that there are 25 doctors in Washington State who perform the CLE exam.

LORI GRASSI: Well, there are currently 25 doctors in the registry.

VICKI BOUVIER: In the registry...

LORI GRASSI: Which isn't effective until 2014.

VICKI BOUVIER: Ok. And since you view this as a scope clarification of the statute, are there chiropractors who are registered and performing these exams right now?

LORI GRASSI: Not in Washington State. No, because the federal registry will not accept them until we correct the statute.

VICKI BOUVIER: The statute?

LORI GRASSI: Because it does not explicitly call out DOT, they won't. There are two states. You can address this better than I can but there are two states that the federal government is not allowing chiropractors because of the way the scope of practice is drafted. Washington is one and I don't recall the other.

VICKI BOUVIER: And the other states that allow it, they have statutes that explicitly identify the DOT exam or...

DR. ROBERT NELSON: The language allows for it. For the physical examinations. I'm not familiar with the exact language that they are talking about but in 48 states, chiropractors are taking the same examinations as MDs and DOs and are performing and have clinics open for DOT physicals.

LORI GRASSI: This goes to the issue of the grammatical issue that the Chiropractor Quality Assurance Commission Assistant Attorney General initially recommended a grammatical change and I couldn't come up with where it was supposed to be at the time but it was to add "and/or". And when that was proposed back to us, we...

MIKE WEISMAN: Do you know which section it was supposed to be in?

LORI GRASSI: It would be in sub three, 18.25.005 sub 3, and I believe line, well on mine. It would be "as part of the chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays" and I'm not exactly positive where that and/or goes because I am not a lawyer, but I believe it was here.. "and/or to determine the appropriateness of chiropractic care." And there may be others that, in the room, I'm just not sure. I'd have to ask some people if they recall this. But it didn't seem a clear enough resolution to the issue when we went to two lawyers outside of our own lawyer and the Assistant AG's recommendation, because we felt it that would only result in a battle and a legal challenge with the professions that oppose us already and we preferred to be more clear and address the issue straightforward.

MIKE WEISMAN: Ok, I understand.

KRISTI WEEKS: Vicki, did that answer your question?

VICKI BOUVIER: Umm, yeah.

KRISTI WEEKS: Do you have any others?

VICKI BOUVIER: Yes, let me look at my notes. Dr. Nelson, you said that in Colorado, chiropractors have performed thousands of PPE exams without a single complication.

DR. ROBERT NELSON: Correct.

VICKI BOUVIER: What does that mean?

DR. ROBERT NELSON: What that means is that if someone cleared them for a PPE, you know, cleared them for competition and then, later on, a situation arise where there was a misdiagnosis or an undetected. There have been none of those in eleven years.

VICKI BOUVIER: Ok. And then, Ms. Grassi, maybe you can explain this to me or maybe you have an idea on this. How many people in Washington State use chiropractors for their primary care physicians?

LORI GRASSI: That's an interesting question. How many patients? I saw a study recently in the last couple of weeks that is not yet published so I saw pre-data, that said throughout the country the average, the chiropractic penetration of the public is somewhere between eight and twelve percent but I don't have any of the caveats on the study. I have nothing to reference but it is just one thing that I remember from a study. You know, the general population of consumers who seek chiropractic care is dramatically less than what seeks other providers for primary care.

VICKI BOUVIER: That's all I have now. You've answered all my other questions.

KRISTI WEEKS: Shannon, do you have one now?

SHANNON WALKER: I have a follow up.

KRISTI WEEKS: Speak up.

SHANNON WALKER: I do have a follow up question. And we are talking about the information that we don't, that there has not been an adverse diagnosis. Is that a reporting requirement? How do we know for sure that there has been no adverse...

DR. ROBERT NELSON: No reports have been made to CHSAA, the Colorado High School Activities Association.

SHANNON WALKER: Ok. So that's where you are getting your information.

DR. ROBERT NELSON: Yes.

SHANNON WALKER: Is that a required reporting?

DR. ROBERT NELSON: There is not a required reporting, but no incident has been reported.

SHANNON WALKER: Ok, so that, ok. Thank you.

MICHAEL WEISMAN: I have a couple of follow up questions. Ms. Grassi, do chiropractors today perform school exams? As I, forgive me if I'm not stating this accurately. As I understand, there is a difference between a school entry exam and a sports exam. I may be wrong on that. Is that accurate or close?

LORI GRASSI: I may have to defer that to a practicing chiropractor but it is my understanding that anybody under 18 would need an adult to bring them in or to give them permission to see a chiropractor or any provider for that matter. Depending on what the need is. I know that females can seek other care pending certain laws. But I would say a chiropractor does not perform a school exam differently than any other exam they would do on a child, such as scoliosis screening and things like that because of the way the scope is written today. Our association has been very clear in educating chiropractors in the state for the 13 years I have been there that you don't perform these exams because you'll get in trouble. It is not in your scope and until we clarify it your scope, don't do it. So we've been telling people not to do it. In terms of what might differentiate between a PPE and a school exam, I would have to...I know there is a chiropractor who is going to testify and he may be able to address that.

MICHAEL WEISMAN: Ok, I'll save that one. But I want to address another question to Dr. Nelson since you're the practitioner who's doing this most and seems... Do you carry malpractice, sir?

DR. ROBERT NELSON: Yes, \$1,000,000/\$3,000,000.

MICHAEL WEISMAN: And so is this something...is this particular scope doing these kinds of exams something that was of interest to your malpractice carrier?

DR. ROBERT NELSON: No.

MICHAEL WEISMAN: No. They didn't charge anything different for this kind of thing?

DR. ROBERT NELSON: They don't charge for me going to any other state even when I follow the Colorado Rodeo. I just have to inform them.

MICHAEL WEISMAN: And back to Ms. Grassi then for a second. The proposal, as I read it, proposes that the chiropractic, that the Chiropractic Quality Assurance Commission would maintain some sort of certification list or something like that, that would...it says it would be online or it would be public. I'm not quite sure about how that would look. Can you fill me in on what you have in mind?

LORI GRASSI: Yes, the legislature would have to direct by statute what the commission should do in order to implement this type of legislation. And one idea that we had is the extensive website for the Department of Health clearly delineates, say, a chiropractor and a chiropractic x-ray technician, much like the physical therapy profession. There's physical therapist, physical therapy aide, physical therapy assistant. So you would designate in that manner. And those that did the training for the PPEs and DOTs would submit that and the commission would have to implement that and create a separate category for endorsement is what I was looking for. It would appear when you do a search of professions. It would appear that way.

MICHAEL WEISMAN: So when you looked that person up, that would appear?

LORI GRASSI: Yes.

MICHAEL WEISMAN: Ok.

LORI GRASSI: And I'm predicting what legislation, what a bill would look like, but that was our proposal.

MICHAEL WEISMAN: Yeah, ok. And would the Chiropractic Quality Assurance Commission then be in charge of certifying these individuals? I mean, it seems to me, and I'm just guessing, that your proposal anticipates that they would somehow have to make these endorsements. You know, that there would be some paperwork involved certainly, but that they would have to somehow process all of that and determine if the person was qualified.

LORI GRASSI: We would expect that to occur and that there would be a fee attached to those who would want the endorsement because the statute requires that all licensing of health professions be...you pay for yourself basically.

MICHAEL WEISMAN: Self supporting. Ok. All right. OK. Thanks. Thank you.

LORI GRASSI: Thank you.

KRISTI WEEKS: Anything else? Ok. We will now take public testimony. You will be called up in the order in which you signed in. First, we will have Jason Passey from the Washington State Chiropractors Association.

JASON PASSEY: Do I come up here?

KRISTI WEEKS: You do. Please come up, identify yourself and speak into the microphone.

DR. JASON PASSEY: Well, my name is Dr. Jason Passey. I am a practicing chiropractor, actually, here in Olympia. I have been in practice for about five and a half years now. So I just wanted to testify to a couple of points based on what I saw with the February testimony and hearing and then some of the comments I have heard.

First of all, there are two big issues. One, from a chiropractic perspective, I would like to speak to the issue of...well, actually, to answer your question, Mr. Weisman. You asked about pre-participation exams versus school entrance exams and, in all honesty, I'm not familiar with a special school entrance exam that differentiates from a pre-participation exam, so, from my perspective. There may be something else, but I'm not aware of one.

MICHAEL WEISMAN: Ok.

DR. JASON PASSEY: As a chiropractor, one of my big concerns is access especially in this city. Just yesterday I was on the phone with a radiologist with South Sound Radiology discussing a patient of mine who was in a motor vehicle accident and, between her and I, we have contacted at least 10 offices and she is unable to get in with any primary care provider because nobody is taking new patients in this area. And he, the radiologist, told me that, he, himself, when he has family or friends that needs primary care, he has to make personal phone calls and call in favors just to get somebody into an appointment. So, we as chiropractors, many times, we act as the primary care portal of entry to many of our patients. And if we have

the ability to perform these exams, it will expand their access to those things without having to get on a three or four month wait list to get into an office especially with DOT physicals where that's the person livelihood. They may need that within days. And if it takes them three or four months because they are new in town, that's not a good thing.

Also, I'd like to speak to the point that as chiropractors, as primary care for many of our patients, we do know their medical history best many times and that should be taken into account when doing this type of exam versus if they just go to the clinic that is just whipping through 50 of these in a hour just to sign the paperwork. We can actually do a much better job of knowing their history and knowing their family history and that sort of a thing.

Speaking to the training, I can speak first hand. I am a graduate of the University of Western States and I can attest that my training is very thorough in all of the aspects that a PPE requires. And what we are proposing with the additional training, the certification that will take place every two years, is not to replace that training but just to keep brushed up on it and to keep current.

That's the second point I want to address is I know there is a concern about safety, especially with pediatrics and our children. They are a specialized group that we want to be very careful of. First of all, we are not trying to replace their pediatricians. We are not trying to replace the cardiologist. We are simply trying to offer our services to help with the screening process to make appropriate referrals as Dr. Nelson attested to.

I read a research study. The British Journal of Sports Medicine actually published a study early this year in which they said that only, it was self-reported from over a thousand physicians, all of which were from Washington State for this study. And it says that only 47 percent of practicing physicians even are familiar with the current American Heart Association ballpoint guidelines for cardiac review in a PPE. And only 5.7 percent of physicians currently adhere to those guidelines 100% of the time. By proposing that we have extra training of chiropractors every two years, insures that they are up to date on all of that, and that they utilize that consistently which, to me, is quite frightening if only 5.7 percent of physicians are currently using that knowledge and less than half are even aware of those guidelines. They are not proposing, or, we are proposing that make the people doing these a very safe thing and that they are aware of the guidelines and are using those appropriately.

So those are the comments I wanted to attest to. I'll answer any questions you may have for me.

KRISTI WEEKS: Questions?

VICKI BOUVIER: I do have a question.

DR. JASON PASSEY: Yes?

VICKI BOUVIER: What percentage of your clients seek you out as a primary care practitioner?

DR. JASON PASSEY: You know, I have never actually pooled the statistics. If I were to take kind of an intuitive guess on that, I would say roughly 15 – 20 percent of my patients come in and don't really have established other care currently. But I do try to work consistently with patients who do have established primary care to make sure that we do proper cross referrals, coordination of care, that sort of thing. So, again, we are not trying to replace any other

profession. We are just trying to help and make access a little easier and to screen as appropriate.

VICKI BOUVIER: Are there differences in the way that you treat those patients who have you as their primary care provider as opposed to a patient that who has a primary care physician already? Aside from the cross communication.

DR. JASON PASSEY: You know, as far as treatment and exam, there's not a whole lot of difference. I think the biggest difference those that use us more for primary care, I do an awful lot of coordination with specialists. I make a lot phone calls to, you know, the orthopedist to try to find them appropriate referrals. I do a lot of referral for diagnostic imaging. We can refer out for blood work as appropriate for patients that need that. So in that sense, it's different. There's a little more work involved.

MICHAEL WEISMANN: I have....

VICKI BOUVIER: Do you..

MICHAEL WEISMANN: Oh, go ahead.

VICKI BOUVIER: And you interpret their lab results and their x-rays?

DR. JASON PASSEY: Yes. We're well trained in all of that and, like I said, just yesterday I was on the phone with the radiologist to get some clarification on a few things to make sure we got appropriate case management for the results of that particular exam.

VICKI BOUVIER: I'm done.

MICHAEL WEISMANN: I've just got...following up on Vicki's question. So when you refer patients out for blood work or for panels, you review that...the results because I guess no one else is doing it?

DR. JASON PASSEY: Yeah.

MICHAEL WEISMANN: You're their primary. You're reviewing all those results and you're making the diagnosis based on that information.

DR. JASON PASSEY: And, again, you know, I do that...when I do that as a screening procedure, if something comes up of concern, then I seek the appropriate referral with somebody who is more qualified for management of that claim. But you know, but acting as primary care, it's kind of my job to try to diagnose if there is something out of the ordinary that does need further management outside of my scope. I'm not too proud to send them out to the appropriate place to do that.

MICHAEL WEISMANN: Ok, Well, maybe I'm just not tracking something but these patients, if what you're seeing, if a panel comes back and you see values that might indicate that a patient has cancer or a patient has diabetes, how are you getting them into see somebody if nobody is taking patients? I'm not quite tracking how this is...

DR. JASON PASSEY: Well, the difference there is portal of entry primary care versus specialist. Specialists will always take referrals from other healthcare providers, granted it may

not be the next day, but you can get them in versus just trying to find somebody to just have a general primary care medical doctor who can see them for whatever ailment they may have as their portal of entry. That's the difference there.

MICHAEL WEISMANN: Ok. So you're referring people generally to specialists?

DR. JASON PASSEY: Yes.

MICHAEL WEISMANN: So they're taking your referrals?

DR. JASON PASSEY: Or those who may already have established primary care, I may refer them back to that primary care for the follow up to some outside my scope.

MICHAEL WEISMANN: Ok. When you do chiropractic exams, is there any point at which the patient is disrobed?

DR. JASON PASSEY: Again, as Dr. Nelson indicated, as appropriate. Generally, at the initial examination, I do like access to the back. It's not a complete disrobe but, you know, you want to check to skin lesions and check what we can see as far as bony landmarks and that sort of thing so, yes, as appropriate.

MICHAEL WEISMANN: That's all I have.

KRISTI WEEKS: Thank you. Next up, we have Carl Nelson from the Washington State Medical Association.

CARL NELSON: Good morning. I'm Carl Nelson from the Washington State Medical Association representing 9,800 physicians and physician assistants here today in opposition to this proposal.

The WSMA is opposed to expanding the scope of practice for licensed chiropractors to include the performance of sports exams and commercial driver's licenses. The decision to exclude doctors of chiropractic is well founded and based on the fact that physicians and osteopathic physicians have more training, particularly in the areas of cardiac, pulmonary, and neurological. And those are the areas the legislature has said we don't want to see anymore headlines of kids going down on basketball courts and football games from undetected, undiagnosed diseases.

Regarding the licensure of commercial drivers' licenses, if you look at the literature on the internet at least, the three major things they talk about are sleep apnea, medicine abuse and misuse and cardiac care. And those, again, are three areas which physicians and osteopathic physicians, PAs and the others are well trained. Much more trained than the chiropractors are in their course of training.

With regard to demand for services, even though there is a significant demand for services for physical examinations for sports physicals in particular, the athletic...allowing chiropractors to perform them at the cost of quality is not a benefit to the public. It puts individuals at risk of injury in our opinion. Chiropractors providing these exams delays the healthcare services, creates additional expenses for the patients and again puts the athlete at risk.

We strongly dispute the claims of the chiropractic perform these two types of examinations certainly, as stated, the WSCA stated that because doctors are regulated under RCW 18.25.,

they would be capable of performing these drivers' exams, that doesn't even go into effect until next year. And so the numbers of practitioners signed up for that may vary, change from the existing 24 to a larger number as we get closer to implementation of that Act.

To the extent, I want to address issue as to the extent to which consumers need or would benefit from the proposed legislation, even with additional training and certification, chiropractors lack the training, experience and knowledge to insure complete and comprehensive sports and commercial drivers' license exams. Allowing chiropractors to perform these exams would endanger patients by increasing the risk of dangerous health conditions would be unidentified, undetected or misdiagnosed.

And, again, we doubt that an additional 18 hours of training will make the difference here. If you look at page four of our submission, you will see the beginnings of a chart that outlines the difference between the chiropractic training and the physician training. Just as an example, a medical student will do a rotation in urology that may be for six weeks, 80 hours a week, just at the beginning then is a 480-hour rotation through one specialty, let alone all of the others that they have to go through before they even finish medical school and start their residencies.

The extent of the autonomy a practitioner, as indicated, will impact this and, again, I'm trying to run down the statutory and it gets kind of lengthy and I'm trying to abbreviate for you. The additional training for chiropractors fails to adequately prepare doctors of chiropractic for the wide array of medical issues. Again, I refer back to that and if you look at the whole AMA document that was submitted to you, it gets into even more detail than what was submitted there.

We believe that the amount of training, education and expertise proposed by WSCA would not adequately prepare doctors of chiropractic to perform complete and comprehensive exams. We do not disagree, however, with WSCA's statement that primary care medicine is an underserved needed healthcare. However, the fact that the public could benefit from increased access to primary care services does not support the claim that chiropractors should have an expanded scope of practice to allow for the performance of sports and commercial drivers' license exams.

And, then, lastly, once again, we disagree that chiropractors should have an extended scope of practice to allow sports and commercial driver's license exams, and, therefore, we believe that they should not be listed as being qualified to do such. And, being more specific about the piece of legislation, the legislation is really quite broad and we think it's overly broad and not the way to proceed. One of the reasons that is before you is the legislature didn't want to deal with it and so they sent it to you, is typical in pieces of scope of practice legislation that they are not comfortable with. So we urge you to reject this piece of legislation. We believe that it won't enhance access to physical examinations; that the current system works as well as it can. The public, the legislature and the professions are demanding for a tighter, more thorough review of, particularly, of student athletes so that the undetected diseases don't strike them down in their youth. The same with the driver's licenses. The legislature, once again, doesn't like seeing headlines about busses crashing and killing people. What they want is a more stringent review. Probably we could anticipate legislation that would require them to undergo more specialized type training rather than less. Same with student athletes. They are more likely to see public health officials and educators move in that direction than in the direction of the proposed legislation here. So, once again, we urge that you reject the legislation. Thank you. I'll take any questions you have.

KRISTI WEEKS: Questions for Mr. Nelson?

SHANNON WALKER: I don't have any. Thank you.

CARL NELSON: Good.

KRISTI WEEKS: Next up we have Richard O'Leary.

RICHARD O'LEARY: Good morning to each of you. And, in advance, thank you for your time. I appreciate you taking the time and allowing me to speak. I am here not as a representative of any association. I am here as a public citizen. I happen to be an athletic director at a high school in the area. So, in that role, I have the ultimate responsibility for the health and safety of nearly a thousand student athletes. I am particularly concerned about the proposal in front of us today. I would like to address a number of points starting with the misunderstanding that seems to be out there about chiropractors. I can see how that misunderstanding would occur because there were statements made this morning that were simply not factual. Dr. Nelson, for example, I believe it was, stated that chiropractors, the sports chiropractors, are the ones we are talking about as being trained to do the sports physicals and, yet, his colleague Dr. Schultz said that all chiropractors are prepared and trained to do the sports physicals. So I am confused about which we are talking about. Ok? It was indicated that the sports chiropractor's recertify for their DOT exams every two years because the concussion guidelines are released every two years. In fact, those concussion guidelines come out every four years. The Prague, Vienna, etc., Zurich conferences have occurred in 2000, 2004, 2008, 2012. I'm no expert in math but I believe that is every four years, not two.

I have no long-standing bias here. I have a cousin who is a chiropractor. I've been treated by a chiropractor. My mother has been treated by a chiropractor. I have never seen my cousin carry a stethoscope. In my mother's and my trips to chiropractors, I have never had my heart or lungs listened to by a chiropractor.

In youth sports, there are three things that kill young athletes; heat, head and heart. The University of...in a submission by the University of Western States, they gave you quite an elaborate listing of the clock hours that their students spend learning things including the brain. Neuromuscular diagnosis 1, 2, 3, neuroanatomy, neurophysiology; well over a hundred, maybe even two hundred clock hours. Mr. Weismann, you asked them to...asked the folks to explain the particulars of a pre-participation physical exam. If you play back the tape, you will find that never once did they mention cardiovascular. That is my concern – the cardiovascular. There are too many young people dying from undiagnosed heart conditions, and, yes, maybe 70 percent of those are picked up by history but the physical exam is an important part of it too. History and physical together are what catch those things, not just the history. If it was all about history, I could take a physical because I can read the questionnaire. But there is much more to it than that.

As an athletic director, I have a number of coaches, approximately 30, who have their CDLs and we have never had a problem getting their medical exams done.

Most of them, not most but many, of my students see their doctors once a year. And they see their doctor once a year because we require their medical exams once a year. Without that requirement for physicals, doctors tell me some of those children would not get their immunizations. So if the chiropractors can't immunize, we're talking about an added burden on the healthcare system. Going to chiropractors for their physical and then to their family practice physician for their immunizations. And as you know, at the high school age, there are a number

of immunizations that are either required or certainly very important, not the least of which would be the HPV series.

Another source of misunderstanding, I believe it was Dr. Nelson made the comment that testicular cancer is the leading cause of death in young people. I pulled up the Centers for Disease Control website. The five leading causes of death among people age 10-24 years as of 2010, testicular cancer is not listed there anywhere. And, at another website, the worldlifeexpectancy.com – USA causes of death by age and gender-for ages 0-14 and 15-24, nowhere in the top 50 causes of death is testicular cancer listed so I am not sure what he was talking about there other than maybe trying to smoke screen the committee here.

Cardiac assessment is the key to saving lives in a pre-participation physical exam. I simply don't see, in their training, where that assessment occurs, where that knowledge occurs or is gained. On the University of Western States website I can only find one course that addresses cardiorespiratory or cardiovascular diagnosis and treatment. That is their course number CSC 7163. It is a three credit class, 33 clock hours. For comparisons sake, they have two taping and splinting laboratory classes, a total of 2 credits, a total of 22 clock hours. I have coaches that do taping ankles and wrists and things. If we are only talking about 50 percent more training than for taping and splinting, I think there is something wrong.

If chiropractors' training was appropriate for performing PPEs, why are they not authorized to prescribe medications? They talked about diagnosing medical conditions, I would have liked to have heard them describe how they diagnose asthma and what they would do then once that diagnosis is reached. Do they refer to a pulmonologist? Do they refer to someone else? If they can't provide a rescue inhaler or long term management medication themselves, what are they doing? That was never addressed. I would have liked to have heard them describe what an S3 heart sound sounds like and what that would mean in terms of a physical exam. Why that would be abnormal. What risk...what additional risk that athlete might have because of that.

Mr. Weismann, I believe you asked the question about collegiate sports. The NCAA requires that a DO or an MD perform the physical exams for all collegiate athletics, whether they are scholarship athletes or not. The only exceptions to that are ARNPs or PAs working directly under the MDs and DOs, not sole practitioners. So when Ms. Grassi said the institution can designate who can perform, it's already been done by the NCAA. And in their wisdom, whatever that might be, the NCAA has not seen fit to allow chiropractors or, again, even ARNPs or PAs unless supervised by an MD or DO. Ms. Grassi made the point about obstetricians not doing certain evaluations and, you know, staying within their scope. I may not like the fact that in this state an obstetrician can sign a sports physical for one of my athletes but I accept that because I know that at least that obstetrician has had not only four years of medical school but several years after that of residency. I also know that every time during our three pregnancies that my wife went in for an evaluation, she had a complete heart and lung evaluation by her obstetrician. So I do feel confident in that regard, at least, that, yes, while an obstetrician may not be specializing in sports physicals, they've got an awful lot of experience listening to hearts and lungs.

I thank you all for your time and, again, I am greatly opposed to this proposal.

KRISTI WEEKS: Done?

RICHARD O'LEARY: Yes.

KRISTI WEEKS: Any questions?

MICHAEL WEISMANN: I have a question. Mr. O'Leary, have you ever had a student that was not cleared for participation by the exam.

RICHARD O'LEARY: Yes. In fact...

MICHAEL WEISMANN: What's your experience on that?

RICHARD O'LEARY: We host sports physicals at our school annually. I bring in about 20 doctors. I bring in specialists from every area and we set up stations. The musculoskeletal exam is done by an orthopedist. The internal medicine exam – heart, lungs - is done by an internal medicine folks and family practice physicians. I always have at least one cardiologist who can give an immediate second opinion about murmurs that are heard, about anything that is abnormal in the area of cardiovascular. We average about six to seven percent that need some sort of follow up or some sort of second opinion, whether it be the cardiologist right there or further workup for abnormal heart sounds, family history, things like that. Those are usually benign issues that are quickly resolved, but, again, it takes even those experts there on site saying we need to delve a little deeper. And I am confident that those people have the knowledge and the training to make those decisions. I don't have that confidence about the chiropractors. I think chiropractors have a place in the sports medicine team. Dr. Nelson, I believe, described himself as the team chiropractor. That's a big distinction between the team physician and the team chiropractor. Chiropractors are on our sports medicine team but they are not EMTs. They are not PTs. They are not athletic trainers. They are not the team physician. They are one piece of the sports medicine team, not the sole provider. I hope I answered your question before I got a little off topic there.

MICHAEL WEISMANN: Yeah, I think the proposal is, as I understand it, is that a chiropractor, for example, if they discerned an issue, they would refer the person on for a second opinion.

RICHARD O'LEARY: And my answer would...

MICHAEL WEISMANN: I don't think they would be necessarily in all cases making a final decision but that's up to their licensure.

RICHARD O'LEARY: Sure and my answer to that would be how do you know to refer if your training does not tell you that you are seeing or hearing something abnormal? And, again, if we go back to their training, at least from their website, I don't see where 33 clock hours is enough to really learn the intricacies of the cardiovascular system. Any other questions? Ok. Well, thank you again for your time.

KRISTI WEEKS: Ok. Next up we have...Oh, sorry. I'm just motoring through it. I promised them a break. So we will take five minutes and come back in five. Thank you.

<BREAK>

<RESUME>

KRISTI WEEKS: Ok, folks we are going to go ahead and get started. The next person who is scheduled to testify, I hope she has returned if she left, is Darla Varrenti. Ok.

DARLA VARRENTI: Thank you for allowing me to speak this morning. My name is Darla Varrenti and I am Executive Director for the Nick of Time Foundation. We are a non-profit that is based here in Washington State and our sole purpose is focusing on sudden cardiac arrest awareness and sudden cardiac arrest prevention in children and young adults.

I am here today to express my strong concern about extending the current chiropractic scope of practice to allow chiropractors to perform sports physicals and driver license examinations. Our foundation, along with several other groups in our state, have been working very hard to get the current PPE revised and updated to provide the best possible exam that young athletes need. Supporting this change in the chiropractic scope of practice would be a huge step backwards. Young athletes need a complete evaluation that includes an ECG and pre-concussion testing before being cleared for sports. Chiropractors are not trained or licensed to provide this kind of physical to keep our young athletes safe.

This proposal is contrary to continued efforts in the medical community to improve athletes' safety on the playing field. Chiropractors are not trained in providing comprehensive medical services, including cardiovascular and other internal medical conditions which are, in fact, the most critical components of these evaluations. The musculoskeletal portions of these examinations, while important, is only a portion of these physicals.

Sudden cardiac death from an underlying heart condition is the leading cause of death in exercising young athletes not cancer as the doctor stated. I know firsthand the devastation this causes the families and communities as my 16-year-old son, Nicholas, a multi-sport athlete, died from sudden cardiac arrest in 2004.

There has been extensive medical work done on preventing sudden cardiac death in young athletes that is based on trained evaluation of the history and physical. There is, also, a growing recognition of the critical importance of assessing for prior head injuries and concussions in a highly structured and rigorous process. I support multidisciplinary approaches to healthcare and believe in all specialties practicing the full scope of what they are trained to do completely. Chiropractors are simply not trained to conduct a complete medical sports physical. The NCAA does not allow chiropractors to perform pre-participation physicals for these reasons.

The assertion that chiropractors can simply evaluate medical conditions, especially ones that place young athletes at risk for sudden death and catastrophic outcomes, is risky. Our foundation is pushing for stricter guidelines and a more in depth look at the heart for future PPEs. There was an email and some conversation that I exchanged with Ms. Grassi from the chiropractic association and we talked about chiropractors listening to kids' hearts. She said not all 104 DCs that are certified in Washington State may not be able to oscillate a heart as well as cardiologists but I, also, feel that they may not be able to do it as well as a family physician just, simply, because they don't do it as often. The medical professionals who currently conduct PPEs work in pediatrics or family medicine clinics and evaluate kids all the time for medical issues pertinent to the PPEs, well child exams, family histories, asthma, chest pain and illness. I do not believe that the general chiropractor evaluates medical issues such as these on a regular basis and I suspect that the reason for a visit to the chiropractor's office is predominately, if not entirely, musculoskeletal. If you do not conduct these evaluations on a regular basis, I'm not sure that it matters if you once learned about the heart and other systems.

The idea that it doesn't seem to be an issue with the group is troubling to me. Listening is not enough. History and physical is not enough. At the very least, an EKG needs to be performed to also take a picture of the heart. These conditions that kill young people and young athletes

from sudden cardiac arrest, you can't hear them. You have to take a picture. At the very least an EKG needs to be done and I don't even know how many, if any, of the chiropractors' offices have an EKG machines.

I am in agreement with the other groups represented here today that a good chiropractor is a useful partner in a complete program of care but sport physicals are not something that should be done by anyone other than a licensed physician. There will always be those families who seek out the care of a chiropractor for a variety of things but we hope by educating the public about how important comprehensive heart health is for our young people, they will think twice about getting a less than thorough PPE or sports evaluation. I believe that there are enough interested parties who will work to make sure enough questions are raised to insure that this proposal is not passed out of your committee. In a perfect world, everyone will work together in each of their specific fields to make sure our young people are healthy and perfectly safe to play the sport they love. Thank you.

KRISTI WEEKS: Any questions?

MICHAEL WEISMANN: I have a question. Do you know how many, what the instances is of sudden cardiac death in Washington?

DARLA VARRENTI: Not in Washington but I know nationwide they estimate between 4,000 and 6,000 children each year suffer sudden cardiac arrest. One of our programs through our foundation we do youth heart screenings because we know that the PPEs are not enough. We go into schools every month throughout the school year and conduct heart screenings on the students that come. It's a voluntary thing. We do up to 500 students at a time and, based on our numbers, we are in partnership with the University of Washington and Seattle Children's Hospital, we find one percent of the children that we screen have some kind of underlying heart condition that needs referral. We've had children that have had all kinds of procedures done, including open heart surgery, from underlying heart conditions that their parents had no idea and weren't picked up on a PPE, a normal PPE, without an EKG. So this is something that we feel very strongly about. That is what my son died from, an underlying heart condition, that we had no idea that he had. He'd had a sports physical five months before and it wasn't picked up. So this is not something to take lightly. This is something that needs to be more strict and more strident in the testing that is done to be able to pick these conditions up.

MICHAEL WEISMANN: Thank you.

DARLA VARRENTI: Thank you.

KRISTI WEEKS: Thank you very much. And next we have Dr. Joe Pfeifer from University of Western States.

DR. JOSEPH PFEIFER: Good morning. Thanks for the opportunity to address you. I'm Joe Pfeifer. I am a chiropractic physician and the vice president of clinic affairs for the University of Western States. While I am licensed and work in Oregon, I am also a resident of the state of Washington and have two students in the school district as well.

I'm here today to address some of the information about chiropractic clinical education and training, specifically, with respect to the competency requirements of the undergraduate training of chiropractors. In doing so, I hope to clarify some of the misconceptions that came out in the earlier testimony, including some of the testimony that was provided today with regard to the

misperception about chiropractors being limited to the diagnosis and management of musculoskeletal conditions.

While it is true that the musculoskeletal system is an area of chiropractic specialty and expertise, chiropractors are also trained to evaluate whole body systems in their whole patient approach to healthcare. Chiropractic physicians perform and interpret through medical histories. They perform and interpret a wide variety of physical examination procedures including vital signs, including cardiac auscultation, and a complete cardio-pulmonary examination as well as neurological exams of the central and peripheral nervous systems. The order and routine and advanced diagnostic tests apply widely accepted differential diagnostic material to determine the nature of patients' conditions and determine the need for chiropractic care and the need for referral to other providers. These competencies are required of all graduates of chiropractic institutions.

To become a licensed chiropractic physician in the state of Washington, one must have graduated from an approved and accredited chiropractic college and all graduates of chiropractic colleges accredited by the Council on Chiropractic Education must demonstrate competencies in a variety of areas including those domains of patient evaluation that are required for PPEs and DOT physicals. Those required competencies specifically include, among others, I'll name a few:

- compiling a case appropriate history of any present illness,
- a systems review and review of past family and psychosocial history for the purpose of clinical decision making,
- perform case appropriate physical examinations that include evaluations of body regions and organ systems that assist the clinician in developing a clinical diagnosis,
- utilization of diagnostic studies and consultations including the (inaudible) and clinical laboratory and forming diagnoses supported by information gathered from the history, examination and diagnostic studies,
- establishing a management plan appropriate for the diagnosis and determining the need for emergency care and referral as well as collaborative care.

Chiropractic physicians having been trained to perform and having demonstrated competency in those general areas that are required for PPEs and DOT physicals are really eminently qualified to perform those screening examinations and these are, in fact, screening examinations. They are not for the purpose of treatment and management of any abnormality that one may find on these screening exams. As you have heard today, these screening exams, by their nature, will not have the capacity to pick up all abnormalities or prevent any potential future problems. They do have the capacity to reduce those numbers of issues that happen either on the field or during driving events. Therefore, I fully support the proposed clarification of the scope of practice for chiropractic physicians in the state of Washington. I would like to address a couple of the issues made about increased costs and access. Certainly, expanding or clarifying the chiropractic scope to include these examinations will, in fact, improve access for certain patients that primarily do see a chiropractic physician and don't necessarily have the access to see other medical physicians or healthcare providers. I fail to see the link between expanding chiropractic scope to include these, or clarifying chiropractic scope to include these examinations and increased costs. Generally, chiropractic services are provided at a lower cost than similar other services provided by medical providers and there is likely a cost savings to providing these services through chiropractic physicians. These are not duplicative services. They are actually replacement services and will thereby increase access and reduce costs. I want to clarify an

earlier comment that I heard about the assumption that allowing chiropractors to perform these actually increases access but at an increased risk. I'm not aware of any evidence at all to suggest that having chiropractors perform these types of examinations, which they do in many jurisdictions around the US, actually increase the likelihood or propensity of adverse outcomes as the result of these examinations and screenings. I'm certainly happy to answer any questions and I appreciate the opportunity.

KRISTI WEEKS: Do you have any questions? Thank you. According to the sign-in sheet, we have now had everyone testify who wanted to testify. Did I miss anybody who wanted to testify? OK. Would the proponents like a brief rebuttal?

LORI GRASSI: We can do that in writing.

KRISTI WEEKS: Thank you. Speaking of writing, for those of you brought your testimony today and were reading from testimony, if you could provide us with a copy, we would love to have it if you are comfortable with that. Otherwise, we hope the recorders picked it all up.

Thank you for taking part in this public hearing. Here are the next steps in the process:

- There is an additional 10-day written comment period starting today through August 16th at 5:00pm for anything you feel has not been addressed.
- We will share an initial draft report with interested parties in September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- We will incorporate rebuttal comments into the report and submit it to the Secretary of the Department of Health for approval in October.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the Governor, legislature, and state agencies.
- It will be released to the legislature prior to the legislative session in 2014, and will be posted to our Web site once the legislature receives it.

That is all and thank you.

Appendix E

Written Comments

Chiropractic Scope of Practice Sunrise Written Comments Received

Doug Attig	I would like to strongly object to chiropractors performing sports physicals. They have no training outside the musculoskeletal system, and any "additional qualifications" they claim to have are obtained under the auspices of other chiropractors, are not evidence-based, and the educational requirements are inadequate. They will miss heart problems, diabetes, systemic disease, developmental problems and many, many others. I have similar objections to their performing CDL exams. They have no training to pick up on diabetes, heart disease or many other disqualifying conditions. Again, many chiropractors claim "advanced qualifications", but have obtained these from other chiropractors who are similarly under-trained. The State has recently added burdensome requirements to MD's in order to do CDL exams. I have stopped doing them because I do not have the time to comply, though I am trained, and have done them for many years. If my MD training is inadequate, I would submit that any chiropractor's is as well. Allowing the Board of Chiropractic to maintain that they are qualified to do these exams is ludicrous. To add these things to chiropractic practice would degrade quality of care, and both proposals should be dismissed outright.
Doug Groenig	I do not feel that the chiropractic scope of practice should include physical exams for commercial drivers nor for sports physicals UNLESS doctors of physical therapy are also allowed to perform them.
Marc Van Driessche D.C., C.C.E.P., C.V.C.P	This is in reference to the email which I received regarding the public hearing being held on August 6th, 2013 on the scope of practice change for Chiropractors to include sport physicals for junior high and high school students (which are under the WIAA regulations) and commercial driver license physicals. As you may be aware I have been a strong advocate for Chiropractors to be allowed to perform sport physicals and department of health examinations. Unfortunately, it has taken over 15 years of hard work by many people to finally see this brought forward. I have written hundreds of pages regarding this topic (which can be supplied to you by request) I have addressed this issue with the WIAA, Washington State Board of Health, Washington Chiropractic Association, and Washington Quality Assurance Commission multiple times. I feel it has been an oversight on the way the RCW code was written so that certain groups could use this as a loop hole to exclude Chiropractors from performing these tasks that are well within the scope of practice and our

	educational standards. Unfortunately, I cannot be there in person to testify on this matter. I have given the Washington State Chiropractic Association all of my research and communication with each of the above groups. It is my hope that this oversight can be corrected so that future groups cannot use these loop holes to discriminate against Chiropractors performing these tasks. I would like to take this opportunity to thank the Washington State Chiropractic Association for bringing this topic up for resolution. I hope the State Board of Health and the Quality Assurance Commission both realize how much of a problem this has caused the Washington State Chiropractic profession and the doctors that deal with these specific groups on a regular basis. It is my hope that by opening this practice act these issues will be resolved and that the Chiropractic profession and, specifically those doctors that deal with this on a regular basis, will not be discriminated any further; as I truly believe that the level of care that Chiropractors provide is beyond reproach. If I can be of any further assistance in this matter it would be my pleasure to help in any way possible; to assure that this injustice is corrected.
Tri-Cities Community Health Signed by Jennifer Robinson, RN, BSN, MBA	Tri-Cities Community Health Center, a federally qualified health center, believes that sports physicals should be completed by a medical doctor or medical clinician. Medical providers have the training, medical skills, background and experience to obtain a detailed family history of heart disease, perform the physical exam and recognize heart disease. These exams are often the only visit a child or teenager may have with their provider annually. This time affords the medical provider a chance to give the child a thorough physical exam and address important questions, especially with teenagers, including adolescent issues of drinking, smoking, drugs, sexual activity and depression. It is also a time to verify that the child is up-to-date with immunizations such as the most recent tetanus, the hepatitis B series, the chickenpox vaccine, and the measles immunization. These are not areas of expertise for a Chiropractor and are not services that a Chiropractor can deliver. The sports form is not just a piece of paper to be filled out and signed for sake of compliance for a child to participate in sports. It's successfully completed when appropriately addressing the whole patient, not solely a patient's physical well-being. The ideal examiner is the child's personal medical provider who already knows the child's health history and family history in depth. A family physician and/or pediatrician have the broad training to pick up potential problems in all areas that a Chiropractor doesn't have. A student may have an obvious chiropractic condition requiring an excuse from sports, however, this is very different from the comprehensive physical exam required to certify that a student is fit to participate in strenuous school athletic activities.

	<u>Family Practice physicians and clinicians are qualified to complete these exams. Chiropractors and other alternative providers are not, even with special certification and training.</u> physical exam required to certify that a student is fit to participate in strenuous school athletic activities. <u>Family Practice physicians and clinicians are qualified to complete these exams. Chiropractors and other alternative providers are not, even with special certification and training</u>
Nicholas Harrison PA-C A.T.,C Physician Assistant.	I am writing in response to the legislatures call for the DOH to review the chiropractors request to perform sports physicals and CDL physical exams. I find it worrisome that chiropractors are attempting permission to provide a service of performing these especially important exams for our young athletes and heavy equipment operators. It is inappropriate for someone of their educational background and clinical knowledge to be providing such delicate services. History and Physical exams for these two populations are more than just musculoskeletal exams. Medical history alone requires knowledge of several disease processes and medication management. Chiropractors do not possess prescription authority in their scope of practice, and many disease processes are outside of their clinical realm. For example hypertension, cardiomyopathies, depression, anxiety, and diabetes management are not in the chiropractors scope of practice. These conditions need to be identified during these physicals. The physical exam is also important in these populations. Chiropractors do not have the clinical knowledge to perform complete physical exams that include systems such as cardiopulmonary, genitourinary and HEENT. Every year we have athlete deaths related to cardiac history. Preventing these deaths is of utmost concern & priority. It is in our best interest that this measure does not pass as our young athletes and heavy equipment operators health and livelihoods are at stake.
Central Washington University Athletic Training Staff Kari Gage, ATC, AT/L Charity McCright, ATC, AT/L Shea Gembol,	As members of the National Athletic Trainers' Association and Certified/Licensed Athletic Trainers in the State of Washington we would like to express our concern about the following proposal to change the scope of practice for chiropractors to include the ability to perform physical examinations for sports physicals. Having worked in the athletic setting and with student-athletes for the last 11 years, we have been though countless pre-participation physicals and dealt with many injuries and illnesses. The pre-participating physical is an important aspect in ensuring our student-athletes are healthy and safe with concerns of orthopedic injuries, cardiovascular abnormalities, neurological, metabolic, psychological concerns and sickle cell trait. As a member of an NCAA sponsored institution it

	is a requirement for our student-athletes to have yearly exams by our team physician. It is also a requirement that incoming student-athletes have a pre-participation physical in the last six months performed by a physician. Below is the current bylaw that we have to adhere to: NCAA Division II Manual By Law 17.1.5 Mandatory Medical Examination. Prior to participation in any practice, competition or out of-season conditioning activities (or, in Division I, permissible voluntary summer conditioning in basketball and football or voluntary individual workouts pursuant to the safety exception), student-athletes who are beginning their initial season of eligibility and students who are trying out for a team shall be required to undergo a medical examination or evaluation administered or supervised by a physician (e.g., family physician, team physician). The examination or evaluation must be administered within six months prior to participation in any practice, competition or out-of-season conditioning activities. In following years, an updated history of the student-athlete's medical condition shall be administered by an institutional medical staff member (e.g., sports medicine staff, team physician) to determine if additional examinations (e.g., physical, cardiovascular, neurological) are required. The updated history must be administered within six months prior to the student-athlete's participation in any practice, competition or out-of-season conditioning activities for the applicable academic year. <i>(Adopted: 1/8/07 effective 8/1/07, Revised: 5/23/08)</i> 17.1.5.1 Sickle Cell Solubility Test. The examination or evaluation of student-athletes who are beginning their initial season of eligibility and students who are trying out for a team shall include a sickle cell solubility test (SST), unless documented results of a prior test are provided to the institution or the student-athlete declines the test and signs a written release. <i>(Adopted: 1/14/12 effective 8/1/12)</i> Our concerns as health care providers are a chiropractor's inability to have access to medical diagnostic tools in order to diagnosis certain health care concerns that can appear in a physical examination like cardiovascular abnormalities, metabolic, or blood issues that might be a determining factor to limit participation. Another major concern is history of concussions. A chiropractor is not a concussion specialist and there are concerns that this would come up in a pre-participation physical where an athlete should not be cleared to participate. A physician that performs pre-participation physicals needs to have a comprehensive understanding about all health issues that would either limit or exclude an athlete from participating. We do appreciate and use chiropractic services quite often. We believe they can play an intricate part in returning an athlete to play after an injury. However, there are just too many issue outside of neuromuscular and musculoskeletal
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	injuries that could arise and therefore be missed during a pre-participation exam that are not in the scope of practice for a chiropractor. This is a major concern when looking at the health and safety of young athletes. <i>Scope of practice for Chiropractic</i> In 2005 the WHO published a document, <i>WHO guidelines on basic training and safety in chiropractic</i> Chiropractic is licensed and regulated in every State (Lamm, 1995). State statutes and regulations determine the scope of clinical procedures chiropractors may legally perform in their respective jurisdictions. Providing care for musculoskeletal conditions using manipulation as a primary intervention is within the legal scope of chiropractic practice in all 50 States. The legal right to use other procedures including modalities, myofascial work, acupuncture, and nutritional therapy varies from State to State. All States currently exclude prescribing drugs and performing major surgery from chiropractic practice. Thank you for your time and consideration.
Gary Schultz, DC, DACBR Professor and Chair, Department of Clinical Sciences College of Chiropractic University of Western States	On behalf of president Brimhall, I would like to submit the attached written comments for consideration in the chiropractic scope of practice Sunrise Hearing which is slated to occur on August 6, 2013. If you have any questions please do not hesitate to contact me, Attachments: NBCE Written Examinations, National Board of Chiropractic Examiners, Fall 2013 The Council on Chiropractic Education, CCE Accreditation Standards
Marla Kaufman, M.D.	I am writing to express <u>strong</u> concern about the Proposal to Change Chiropractor Scope of Practice, which proposes allowing chiropractors to perform sports physicals and driver's license examinations. My concern is that chiropractors are NOT trained in providing comprehensive medical services, including cardiovascular and other internal medical conditions, that are, in fact, often the most critical component of these evaluations. The musculoskeletal portion of these examinations, while important, are only a portion of these physicals. Sudden cardiac death is the leading cause of death in exercising young athletes. There has been extensive medical work done on preventing sudden cardiac death in young athletes that is based on trained evaluation of the history and physical examination. There is also a growing recognition of the critical importance of assessing for prior head injuries and concussions in a highly structured and rigorous process, and the importance of proper evaluation and management of traumatic brain injuries is underscored by the number of investigations and lawsuits now coming out regarding recurrent football injuries

	starting as early as grade school and high school. I support multi-disciplinary approaches to health care, and believe in all specialties practicing the full scope of WHAT THEY ARE TRAINED TO DO COMPETENTLY. This does NOT extend to chiropractors providing medical services without a medical license. Please let me know if I can provide any more background or information about these concerns.
Stan Herring, M.D.	I would like to correspond with you in regard to the notice of Sunrise Review and Public Hearing – Proposal to Change Chiropractic Scope of Practice. I have reviewed the Sunrise webpage to see the proposal and the additional information related to this proposal, including the educational coursework and competency testing which is suggested for a doctor of chiropractic to pass in order to perform a pre-participation examination and make clearance decisions to participate in sport. I am writing to express my strong concerns about changing the scope of practice to allow chiropractors to perform pre-participation physical examinations for sporting activity. I have been involved in the practice of sports medicine for three decades. I am a professor at the University of Washington where I serve as Director of Sports Spine & Orthopedic Health for UW Medicine, and I am a team physician for the Seattle Seahawks and the Seattle Mariners, as well as a consultant to the Seattle Storm. I am a member of the NFL Head, Neck and Spine Committee, and I chair the Clinical Sports Medicine Leadership Committee for the American College of Sports Medicine. I have also served as a board member of the American College of Sports Medicine, and I am a founding member of the American Medical Society for Sports Medicine. I have published peer-reviewed articles, edited textbooks, and served on editorial review boards for journals regarding sports medicine issues. My clinical practice has been devoted to the care of active people and athletes with sports medicine-related injuries. My experience in sports medicine has allowed me to work with a variety of different practitioners, including many of my chiropractic colleagues for whom I have much respect. I have enjoyed those working relationships as they relate to certain injuries in sport; however, I do not believe that chiropractors are trained and have the experience to assess all of the comprehensive medical, musculoskeletal and neurological conditions that are an essential part of a pre-participation physical examination. The proposed educational requirements are insufficient and are not a substitute for clinical training and experience particularly for such issues as cardiac screening, sickle cell disease, exercise induced bronchospasm, concussion, absence of a paired organ, seizure disorder, ligamentous injury to the knee, and

	multidirectional shoulder instability to name only a few of the areas that must be addressed as part of any pre-participation physical examination. I have spent my career treating patients as well as advocating for the health and safety of young athletes. I will continue to enjoy the interactions I have with different healthcare professionals; however, pre-participation physical examinations are an area that should not be included in the scope of chiropractic care. Such a decision would put our young athletes at undue risk for potentially catastrophic and/or disabling consequences, and it is my personal opinion that this upcoming Sunrise Review on August 6, 2013, should not approve the proposal to change the scope of practice for chiropractors to include the performance of pre-participation physical examinations for sports physicals. Thank you for your consideration, and please feel free to contact me if I can provide any further information.
Jonathan Drezner, MD	I am writing to express my <u>strong</u> concern about the Chiropractic Scope of Practice Sunrise Review previously reviewed during the 2013 legislative session as HB 1573. This proposal would allow chiropractors to perform sports physicals and driver's license examinations. ~As immediate Past-President of the American Medical Society for Sports Medicine, medical team physician for the Seattle Seahawks, and Director of the Center for Sports Cardiology at the University of Washington, this proposal is antithetical to continued efforts in the medical community to improve athlete safety on the playing field. Chiropractors are NOT trained in providing comprehensive medical services, including cardiovascular and other internal medical conditions, that are in fact the most critical component of these pre-participation evaluations. ~The musculoskeletal portion of these examinations, while important, is only a portion of these physicals. ~ Sudden cardiac death from an underlying heart condition is the leading cause of death in exercising young athletes.~ There has been extensive medical work done on preventing sudden cardiac death in young athletes that is based on trained evaluation of the history and physical examination, proper use of non-invasive cardiovascular testing, and a solid understanding of the conditions associated with sudden cardiac death in young athletes. ~There is also a growing recognition of the critical importance of assessing for prior head injuries and concussions in a highly structured and rigorous process – the importance of which is underscored by the number of investigations and lawsuits now coming out regarding recurrent football injuries starting as early as grade school and high school.~ I support multi-disciplinary approaches to health care, and believe in all

	specialties practicing the full scope of WHAT THEY ARE TRAINED TO DO COMPETENTLY. ~Chiropractors are simply NOT trained or competent to conduct a medical sports physical. I would never endorse a child receiving “heart clearance” from a chiropractor, no more than I would support someone piloting a commercial jet just because they’ve taken a simulator class. The assertion that chiropractors can appropriately evaluate medical conditions, especially ones that place athletes at risk for sudden death or catastrophic outcomes, is both absurd and dangerous. I urge you to oppose this Chiropractic Scope of Practice Sunrise Review (HB 1573). Please contact me if I can be of any help or provide more information.
Jana Wiley, R.N., M.S. East Asian Medicine Practitioner	I have been a registered nurse /acupuncturist for over two decades. After reading the proposal to expand the scope of practice for chiropractors, I did a double take. Please, it would be to everyone's advantage to stay within their own scope of practice for patient safety. I agree with the position of the WA State AMA entirely, which strongly emphasized safety concerns and lack of adequate training. The comparison charts embedded within their comment letter highlight the inadequacy of the chiropractic colleges to prepare their students for comprehensive physical exams, which go beyond the musculoskeletal system. A lack of CLINICAL training in cardiac pathologies and concussion evaluation would be devastating to a young athlete. For example, to work with cardiac patients in a busy hospital setting, I had 320 hours of extra training and a one year mentoring program on the cardiac floor. Neurology is a whole separate field. Inversely, I would not recommend that M.D.s, P.A.s or ARNPs perform chiropractic manipulations. Ditto for people who are not academically and clinically trained in acupuncture who want to insert acupuncture needles into their patients. I think we need to stay within our training, which is reflected in our legal scope of practice.
Douglas L. Daniels M.Ac., Dipl.Ac. (NCCAOM) East Asian Medicine Practitioner	I oppose the expansion of the current Chiropractic Scope of Practice proposed in H.B. 1573. Chiropractic didactic and clinical training falls far short of teaching skill sets necessary to perform these extra procedures with competence and safety, especially regarding the ability to diagnose simple or complex patterns of disease and injury. Many potentially serious problems may be overlooked in athletes and drivers, simply due to the lack of knowledge, training and experience of the Chiropractic Doctor. As with any other modality of allopathic or alternative medicine, adequate professional training should dictate what procedures are allowed in a scope of practice. While attending seminars, lectures and taking courses by correspondence are superficially beneficial to medical practice, nothing replaces intensive didactic and hands on clinical experience in the learning process, to be fully competent in performing a procedure.

Kelly Golob D.C.	I am submitting these written comments about the Chiropractic Scope of Practice Sunrise Review (HB 1573). I am in favor of allowing Chiropractic physicians to perform physical examinations for sport's physicals and commercial driver's licenses. Chiropractic physicians are thoroughly trained in physical examination and differential diagnosis. Although many of us choose to focus our clinical practices on the treatment of musculoskeletal injuries, we perform detailed medical history taking and physical examinations daily in our offices, and it is our responsibility to rule out and make proper referrals when necessary for any medical condition that a patient may present with. Also, pre-participation physicals are part of our training in chiropractic schools, and during my time as a chiropractic student in California (where pre-participation physicals are included in the scope of every chiropractor, regardless of advanced post-graduate training) I helped perform hundreds of sports physical for high school students under the supervision of licensed chiropractors. During these physicals we carefully assessed each athletes overall health and screened for any potential risk factors (including heart disease, lung disease, orthopedic issues, and more...) that might prevent them from safely participating in their sport. Many of the written objections to this legislation that I have read appear anything but objective. Most of these objections seem to be written by those very unaware of the actual clinical training that Chiropractic physicians receive, and their opinions are based on anecdotal personal experiences at best. Most of the critics of this legislation would have us believe that there would be more serious athletic injuries if chiropractors were allowed to perform sports physicals, however this privilege has already been allowed in the scope of Chiropractic Physicians for many years in dozens of other states and I have not read any peer-reviewed research that demonstrates these states have suffered because of it. Also, these critics ignore that fact that Chiropractic Physicians care for our nation's most elite athletes. Many of our Olympic teams travel to their international events with a treating Chiropractor as their attending physician responsible for clearing them to return to play after every injury, including concussions. While many opponents of Chiropractic Physicians will resort to hearsay and scare tactics to justify their objection to this legislation, it is my professional opinion, based on personal experience and the available research, that allowing Chiropractic Physicians to perform sports physicals and commercial driver's license physicals in the state of Washington would be a benefit to our patients
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	and the entire health-care system.
Lorri Nichols DC, CCEP	On August 6, 2013 I had the opportunity to attend the Department of Health Sunrise Review hearing regarding Doctors of Chiropractic's ability to perform Department of Transportation "Fit for Duty" Physical Exams and Pre-Participation Sports Physicals. I would first like to thank the panel members for the opportunity to present our information. It was clear that each panel member had a sincere desire to thoroughly understand the information presented to them and I appreciate both their time and efforts. I fully support the testimony of Dr. Gary Schultz, Dr. Robert Nelson, Dr. Jason Passey, and Ms. Lori Grassi. These individuals thoroughly and accurately presented chiropractic education, clinical expertise and chiropractic practice detailing the components of the DOT and PPE examination that are taught in the college core curriculum of a Doctor of Chiropractic. Dr. Shultz and Nelson further discussed the additional training in the CCEP, DACBSP and course outlined by the DOT for all participating providers. It is terribly disappointing to observe the testimony of Mr. Carl Nelson of the WSMA, athletic director Mr. O'Leary and Ms. Darla Varretti. The testimony presented by these individual was clearly inaccurate, emotional and bias. Additionally, Mr. O'Leary also misrepresented and inaccurately represented Dr. Nelson's testimony which is particularly shocking since he is not a physician of any specialty nor in the position to give an informed opinion in this matter. The core curriculum of the Doctor of Chiropractic clearly contains the component necessary to perform these SCREENING examinations. DCs do not claim to be neurologist or cardiologist; however our training does clearly prepare us to screen both athletes and commercial drivers for their ability to perform their duties and/or make referrals when any abnormalities are detected. As an additional measure, the WSCA is also proposing specific training programs for DCs interested in performing these exams as refresher courses and for added assurance. The DOT requires these courses for ALL physicians to perform these examinations; DC, MD and DO. I am a Doctor of Chiropractic licensed in Washington with 30 years of clinical experience. I have additional national certifications in extremity work (CCEP) and am Board Eligible in Spinal Rehabilitation (DACRB). I have served 8 years on the Department of Health Quality Assurance Commission, and as President of the Washington State Chiropractic Association. I currently remain a WSCA Board member. As such I would respectfully ask the panel to objectively and thoroughly study the information submitted by both sides of the argument and

	come to the only logical, factual conclusion.
Ben McCay, DC	After reading through the other comments posted regarding chiropractors performing PPEs, it is obvious that many health care providers know little about the chiropractic education process. Performing PPEs (including cardiac exams) are certainly well-within the educational curriculum taught at chiropractic colleges. Chiropractors are well-trained in the clinical knowledge to perform complete physical exams that include systems such as cardiopulmonary, genitourinary, and EENT. The knowledge and skill to perform such examinations is a prerequisite to passing both the core curriculum of any DC program and the national board exams (especially part III). It is simple ignorance to assert otherwise. With that said, it is also true that chiropractors might forget the necessary components to a cardiac evaluation after not performing one in years. And the same is true for medical doctors who don't routinely auscultate hearts. But the incompetent MD doesn't lower the practice standards of the medical profession, and neither should the incompetent DC. Our scope of practice should include the examinations we were trained to perform.
Murray L. Smith, D.C. Tumwater, Washington	Please accept my written comments for support of HB1573. The written statements I've read to date have persuaded me to exercise my prerogative to provide comments in favor of allowing Chiropractic Physicians to perform physical examinations for sports physicals and commercial driver's licenses. Chiropractic Physicians are thoroughly trained to perform these physicals. Dr. Joseph Brimhall, D.C., President of the University of Western States, affirms the facts in his letter regarding our education. Old data on Chiropractic education that may be referenced to dissuade acceptance of HB 1573 should be held null. As he has confirmed, the training to perform a thorough history and examination with the scientific training more than adequately establishes a Chiropractic Physician's ability to carry out these physicals. Hearsay and personal belief should carry no weight in such an important process. Washington State is one of the few remaining states restricting Chiropractic Physicians from performing these physicals. In the upcoming years the face of healthcare may dramatically change. A very real shortage of portal of entry providers to perform patient evaluation and management seems eminent. As a progressive state, Washington owes its residents access to all physicians competent to perform duties they are trained to carry out. To not allow competent Chiropractic Physicians to perform these physicals is a disservice to Washington residents.
Dr. Marc Y Van	I have read through the 44 pages of written comments sent in on HB 1573. There seems to be a vast misunderstanding about Chiropractic education,

Driessche D.C., C.C.E.P, C.V.C.P Board Eligible in Sports Medicine C.C.S.P.	diagnostic ability, and didactic training. Many of the doctors of medicine that wrote in are misinformed as to the issue that is now before the department of health. The way RCW code 18.25.005 is written allows for a loop hole to exist where certain groups manage to use that loop hole to exclude Chiropractors from performing physical examination without performing Chiropractic care. I believe that this is a politically charged and emotionally sensitive topic and comes down to a public safety issue. Will a Chiropractor cause injury by performing a physical examination on a high school or junior high athlete and/or a department of licensing exam? The answer to this question is emphatically NO! A Chiropractors education far surpasses the current requirements for performing a high school or junior high and/or department of licensing exam. The problem has originated from the RCW code 28A.58.125 which was enacted in 1976 to authorize the WIAA to control high school and junior high athletes. The fact of the matter is that doctors of Chiropractic meet and surpass the educational and training requirements to fulfill any and all of the physical examination findings for high school and junior high and department of licensing exams. Groups like the WIAA have constantly discriminated against the Chiropractic profession using the loop hole found in RCW code 18.25.005. I contacted Mr. Olson who at the time, was the lawyer for the WIAA, and he stated to me that the problem was never a Chiropractor's education or abilities to do a physical examination but rather the way the RCW code was being interpreted, by fixing this we would truly alleviate a huge discrimination of groups against health care providers that have been performing these exams for years without any problems. As with any physical examination done by any primary health care provider if an abnormality is found during physical examination if a referral is warranted to complete the examination then the patient is referred to a specialist. This does not change if the Chiropractor is doing the examination. I do not believe Chiropractors in the State of Washington should be used as a doormat for any other health care provider and I find it truly insulting that another doctor who has not investigated my credentials or experience in striving to be the best at what I do tries to dictate and make up stories about my education and/or experience. As a matter of public safety I strongly urge the department of health to look past the emotionally charged comments of doctors whom are simply uninformed, uneducated, and bias towards their specific organization. While reading the 44 pages of comments, I have found many medical doctors whom I have worked with in the past. It saddens me that my expertise in sports and physical examination was okay for them to use for 20 years but now when clarification of my abilities has come to light through a sunrise act they look to limit my abilities to help an athlete or perform a department of licensing exam. I have constantly improved my education standards by studying concussions and sports medicine to improve my understanding of current health
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	care issues. I am nationally board certified in concussions by the ACSM Certificate no. 69420. I am also currently board eligible for the certified Chiropractic sports physician program. I believe all physicians regardless of their degree strive to increase their educational standards in order to be proficient at their diagnostic and didactic skills. I hope the Department of Health can see past the emotionally charged comments that hold no factual evidence and rather look at the education standards and the requirements to do a high school and junior high and department of licensing physical exam. I believe the most factual evidence in the written comments was given to you on behalf of Western State University written by Dr. Joseph Brimhall. In Dr. Brimhall's statement are all of the definitions and requirements that could possibly be needed to prove that Chiropractors in the state of Washington are both capable and meet the educational requirements necessary to perform sports physicals at the high school and junior high as well a department of licensing exams.
Dr. John Huynh	My name is Dr. John Huynh, chiropractor in Bonney Lake Washington and going to be passing the Certified Chiropractic Sports Physician program here shortly. I can attest that my training specifically outweighs most of the providers in providing adequate yet thorough care via examinations and sport physicals. I know many in other professions that do the very minimal in examinations and physicals, yet with our training and education it surpasses others in which I am in favor of my profession being allowed to do physicals and on field work. Here in my town, I partner with Mutlicare sports clinic and we co treat patients from 5 year old to 90 year old athletes with one objective - their health. As you know, many in other professions oppose, not because of our qualifications, but deep false assumptions about my profession which cannot be upheld to this degree in today's society. Many patients would prefer a certified sports chiropractor to do their physicals than a regular physician or athletic trainer b/c 1. we know their history. 2. they trust us. 3. we have helped them in their previous conditions. 4. they have full confidence in our abilities. 5. our training and expertise is well rounded and proven. 6. many states in our country already have this capability for their Chiropractors, yet Washington is lagging behind. I hope this will help in advancing Chiropractic profession thru the state of Washington for the treatments used is already in professional sports teams, Olympic teams, and throughout college and high school teams across America.
Lyle E Ronning DC	I am writing in support of the sunrise review application proposing to change the scope of practice for licensed chiropractors to include the performance of

	physical examinations for sports physicals and commercial driver's licenses. Chiropractors have been excluded from performing these types of examinations in the past due to the particular wording of our scope of practice. The particular wording limits our physical examinations to determining the appropriateness of chiropractic care or the need for referral to other healthcare providers. This oversight simultaneously limits chiropractic evaluation and treatment to musculoskeletal conditions while at the same time makes us responsible for examining all other body systems so appropriate referral may take place as necessary. To this end, chiropractors are well-trained and compelled (due to liability issues) to complete full examinations such as the ones currently in question as explained in the letter from Western States Chiropractic College by Dr. Joseph Brimhall. I have reviewed the details of the procedures necessary for these two examinations and see nothing outside the normal scope of examinations performed in chiropractic offices every day throughout the state of Washington as well as in my own practice. It saddens me to read the responses from other healthcare providers in our state which show the ignorance that exists regarding the general level of training and responsibility of chiropractic physicians. Chiropractic colleges train their students to enable them to practice competently in any state. I am a graduate of Western States Chiropractic College in Oregon where the scope of practice includes minor surgery, obstetrics, gynecology, and genitourinary procedures. Just because our practice has been limited in this state by oversights in legal wording does not mean that the practitioners are not sufficiently trained and capable of performing these examinations in a professional manner with due regard for public safety.
Bryson J. Langel, DC	Chiropractic offers a unique service that is separate and distinct from any other health profession; it is not part of the practice of medicine (alternative or mainstream). The purpose of Chiropractic is to locate, analyze and correct the Vertebral Subluxation Complex (VSC) because it interferes with the proper function of the nervous system and disrupts one's ability to experience a sense of well-being. When Chiropractors examine the skeletal and nervous systems they do so with the focus on how the VSC is affecting one's health – this service is unique to the Chiropractic profession. Some of the physical, orthopedic and neurological tests used by Chiropractors may resemble those used by medical doctors but it is not the intent of Chiropractors to practice medicine. Because sports physicals are performed to assess a person's medical health

	status, which is different from their chiropractic health status, they should solely remain the professional responsibility of medical practitioners (MD, DO, PA, NP).
Khai Lam, DC Sutton Chiropractic and Massage	I am writing you in support of chiropractic physicians performing sport and CDL physical examinations. After viewing the submitted responses thus far it is clear that there is a gross misunderstanding as to the education and abilities of a chiropractic physician. To suggest that chiropractic physicians perform anything less than a thorough and complete physical examination with a complete history, in compliance with the needs of sport and CDL physicals, is purely unfounded skepticism and clearly reflects a lack of knowledge and understanding of chiropractic schooling, credentialing and scope. Contrary to the belief of the uninformed, chiropractors are most definitely trained in complete physical exams including cardiopulmonary, genitourinary, and HEENT. Furthermore, the National Board of Chiropractic Examiners thoroughly tests on these matters as several other states allow these examinations to be performed by chiropractic physicians. A simple search into chiropractic education would reveal that chiropractic physicians have advanced schooling in organ and neuromusculoskeletal systems along with differential diagnostic and neurological assessment. I urge those unfamiliar with the chiropractic profession to have an informed opinion before discussing said "limitations" to the chiropractic profession. Chiropractic physicians have access to all medical diagnostic tools available to other healthcare providers, in that our scope allows for the ordering of advanced medical imaging, urinalysis, and blood work. The importance of neurological and cardiovascular health to pre-participation of sports is not lost on the chiropractic profession, and like all other health care fields, proper assessment and management is of grave importance. Thus any properly trained healthcare professional would refer to the services of a specialist when needed, but to assume a chiropractic physician is unable to recognize that importance is a baseless assumption. It is in my opinion that I and those in my field are completely competent in performing these examinations and I highly recommend a review of the chiropractic education be conducted to solidify this. Thank you very much.
Thomas R Hurst, DC Clinic Director Hurst Chiropractic, PC	I wish to express my support for the proposal that chiropractors in this state be permitted to perform PPE and DOT exams. We already have the professional training to do these type exams, we do examinations routinely. It is proposed that those chiropractors that wish to provide these specific exams will have some additional training required and protocols to follow. I am confident that my colleagues will do a fine job with this service for their patients. It feels very unfair and discriminatory to not allow our interested chiropractors the opportunity to acquire additional training and provide these examinations.

Paul Buehrens MD Lakeshore Clinic Totem Lake	I am writing to express strong opposition to permitting chiropractors to perform DOT or sports participation physicals. They may be skilled in spinal manipulation, but their skill set as a profession is less than that of a PA or a nurse practitioner, and a chiropractor could not be trusted to detect a congenital heart defect that puts an athlete at risk, nor to assess and detect sleep apnea in a truck driver. Allowing chiropractors to make these judgments will endanger certain individuals, and overall for the State of Washington, such a move will jeopardize the public health. I could elaborate at length on the missing skills required to protect patients from sports injuries and the public from unsafe drivers, but you get the point.
Dr. Avery N. Martin Practicing Chiropractor since 1977	I would like to encourage a positive input on allowing Chiropractors to provide pre-participation examinations and DOT physicals. Before practicing in Washington state, I practiced in Alaska and performed this function in our clinic for years to the satisfaction of parents, businesses, the local schools and coaches. Many parents liked the extra testing that was performed in a Chiropractors office because of our training and expertise in structural and joint problems. I would hope that this issue could move beyond political issues and for the benefit of the public, that Chiropractors would be able to provide this service in the State of Washington. I hope the committee provides the positive input to keep this process moving. thank you in advance for accepting this public input.
Dennis Marchiori, D.C., Ph.D. Chancellor, Palmer College of Chiropractic	As chancellor of Palmer College of Chiropractic, the first and largest chiropractic college, I'd like to extend my support to the efforts of my colleagues in the Washington State Chiropractic Association and the Association of Chiropractic Colleges to clarify the scope of practice for chiropractors in Washington, specifically regarding pre-participation physical examinations and Department of Transportation "Fit for Duty" physical exams. I echo my colleague David O'Bryon's comments regarding misinformation about the standards and curriculum for the Doctor of Chiropractic degree. It seems this misinformation has been perpetuated throughout the legislative process to clarify chiropractic scope of practice for these types of physical examinations. Chiropractors in general, and Palmer graduates specifically, are highly skilled in providing comprehensive health examinations. The Palmer College of Chiropractic Doctor of Chiropractic program curriculum is a five-academic-year post-graduate program including 4,620 total contact hours of instruction. Of these contact hours, 570 are in diagnosis, 300 in radiology procedures and interpretation, and 945 in practical clinical experience in the Palmer Chiropractic Clinic system. Palmer's curriculum produces professionals who are highly trained and experienced in assessment and diagnosis as well as clinical-reasoning skills --

	and are eligible for licensure in all 50 states. Palmer's D.C. curriculum is accredited by the Council on Chiropractic Education, the recognized accrediting body for the chiropractic profession. All three of our campuses are regionally accredited by the Higher Learning Commission and are members of the North Central Association. Doctors of Chiropractic are included as eligible health care providers to provide physical examinations by the United States Department of Transportation (DOT). In fact, two faculty clinicians at the Palmer Chiropractic Clinics in the Quad Cities (Davenport and Bettendorf, Iowa, and Moline and Rock Island, Ill.) are recognized by the DOT to provide "Fit for Duty" physical exams and have completed the coursework to sit for the upcoming national registry examination that will be required in 2014. The DOT physical is a comprehensive evaluation covering all systems of the body, including a comprehensive health history and review along with a urinalysis screening. All of these examination aspects are taught and tested as part of Palmer's Doctor of Chiropractic curriculum, in both the academic and clinical portion of the education. Palmer College of Chiropractic's main campus is located in Davenport, Iowa. All Iowa high school students participating in sports are required to obtain a pre-participation physical examination. All Iowa school districts in the Quad Cities approve pre-participation physical examinations provided by chiropractors. Our two outpatient clinics in the Quad Cities offer sports physicals throughout the school year with a special push at the beginning of each school year, and have provided 1,555 of these physicals during the last three years. This year, after four weeks of a two-month program offering sports physicals to area students, our Quad-Cities clinics have provided more than 300 sports physicals. Many parents have commented that these pre-participation physical examinations are the most comprehensive their children have ever received. I urge you to consider all of these facts as you formulate your recommendation regarding the current proposed chiropractic scope of care legislation. The citizens of Washington deserve the opportunity to receive thorough physical examinations from licensed and qualified health care professionals, including chiropractors.
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Welliever, Danielle M (DOH)

From: Gary Schultz <gschultz@uws.edu>
Sent: Monday, July 29, 2013 5:56 PM
To: DOH HSQA Sunrise
Cc: Joseph Brimhall; Amber Massey
Subject: Sunrise Hearing- Chiropractic scope of practice
Attachments: Attachment 1.A- 2013_CCE_ACCREDITATION_STDS.PDF; Attachment 1.B- 2013-04_CCE_Manual_of_Policies.pdf; Attachment 2.A- NBCE Parts 1-3 + PT Manual.pdf; Attachment 2.B- NBCE Part IV manual.pdf; UWS Written Comments- Sunrise Hearing 8-6-13- Chiropractic Scope of Practice.pdf

Dear Ms. Thomas,

On behalf of president Brimhall, I would like to submit the attached written comments for consideration in the chiropractic scope of practice Sunrise Hearing which is slated to occur on August 6, 2013. If you have any questions please do not hesitate to contact me or Dr. Brimhall (copied herein, along with his Executive Assistant Ms. Massey).

Thank you,

Gary Schultz, DC, DACBR
Professor and Chair, Department of Clinical Sciences
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The mission of the University of Western States is to improve the health of society and advance the science and art of integrated health care through leadership and excellence in health sciences education, service, and the enhancement of knowledge through research and scholarship



July 26, 2013

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

RE: Sunrise Hearing August 6, 2013: **Chiropractic Scope of Practice**

Dear Ms. Thomas,

This letter is written on behalf of the University of Western States (UWS) College of Chiropractic, a key stakeholder in matters of scope of practice in Washington. UWS fully supports the proposed clarification of scope of practice for chiropractic physicians in the state of Washington, with particular focus on the following issues pursuant to the Sunrise panel's deliberations.

- 1. Chiropractic physicians are qualified to perform these procedures by professional education, clinical training and daily practice.**

Chiropractic physicians receive didactic instruction along with practical and supervised clinical training to competently, safely and effectively perform preparticipation physical examinations of k-12 students as well as US Department of Transportation (DOT) physical examinations. The doctor of chiropractic degree program at UWS requires nearly 1000 hours of formal training in all aspects of ambulatory care patient evaluation, and the analysis and employment of best practices therein. This education includes didactic and practical skills instruction in emergency procedures, physical examination of each body region and system, laboratory diagnosis, differential diagnosis, imaging, triage, evidence based practice, etc. In addition to didactic instruction and practical application, clinical practice training rotations include extensive experience in the application of these competencies on a very diverse array of patients in ambulatory care settings from all socioeconomic, ethnic, gender and age demographics.

Chiropractic physicians are eminently qualified to perform patient screening physical examinations. Additional evidence supporting this conclusion can be seen in the Council on Chiropractic Education (CCE) Standards for chiropractic programs. (Attachment 1- 2013 CCE Standards). CCE is the programmatic accreditor for all doctor of chiropractic degree programs in the USA, and is recognized as such by the US Department (Secretary) of Education, by licensing boards in the US and internationally and by the Council for Higher Education Accreditation. The exam blueprints for the National Board of Chiropractic Examiners (NBCE) Parts I - IV and Physiotherapy board examinations also serve as

evidence of the expectations for competency in this area of practice. (Attachment 2- NBCE Parts I-IV test manuals). These tests evaluate both the written and practical ability of chiropractic physicians to engage in a broad spectrum of patient types and concerns, and are required for licensure eligibility in Washington State. The procedural requirements for DOT and preparticipation physical examinations are clearly included within these preparation and examination requirements and hence, the competencies and abilities of all licensed Washington chiropractic physicians. Last, additional training is available to practitioners who desire a refresher in either of these arenas through UWS postgraduate offerings.

2. The conduct of preparticipation physical examinations and DOT physical exams fall within the Washington scope of chiropractic as defined by law and rule.

Under RCW 18.25.005 (3) (bold and color emphasis added), the definition of chiropractic includes examinations and differential diagnosis for chiropractic conditions and examination of the body for the purpose of identifying abnormalities for which referral would be appropriate:

RCW 18.25.005(3) "Chiropractic" defined:

As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter.

This point is further emphasized under RCW 18.25.006(8) (bold and color emphasis added):

"Chiropractic differential diagnosis" means a diagnosis to determine the existence of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder, and the appropriateness of chiropractic care or the need for referral to other health care providers.

Both sections obligate a chiropractic physician to engage in diagnostic procedures that would elucidate an infinite number of non-chiropractic conditions. In other words, full scope diagnosis is a requirement of chiropractic physicians as they pursue the applicability and appropriateness of chiropractic treatment options. The purpose of preparticipation physical examinations as well as DOT physical examinations is to identify findings for which a chiropractic physician would diagnose non-chiropractic conditions and refer the patient to other health care providers.

For example, the discovery of stage 1 or 2 hypertension, visual acuity deficits or uncontrolled diabetes would be expected of a competent chiropractic physician under any clinical situation, not just a DOT physical. In those circumstances, the chiropractic physician is trained to initiate an appropriate referral to another qualified health care provider regardless of the reason for the physical. Similarly, a chiropractic physician is trained to detect a cardiac bruit or an inguinal hernia, and to make an appropriate referral, whether the patient is being seen for a preparticipation physical or for another specific health concern.

Patients often don't know what their health status or diagnosis is when they go to their chiropractic physician, or to any other health care provider for that matter. The purpose of the chiropractic physician's examination is to identify the nature and cause of the patient's symptoms and findings. As such, in all cases the diagnostic investigation must be broader in its search for causes of a complaint than the treatment scope of the practitioner. This is true of all other health care practitioners, including medical specialists. For example, an orthopedic surgeon would be expected to differentiate a metastatic bone lesion from a sprain/strain, but would probably not treat the metastatic lesion, which is exactly what a chiropractic physician would be expected to do in the same situation.

3. Chiropractic physicians can provide diagnostic evaluations and opinions in the absence of an intention to treat the patient.

The belief that chiropractic physicians are not allowed to perform diagnostic evaluations in the absence of intent to provide chiropractic care is incorrect. Interpretive Statement Number: CH-12-13-12: Practice of Chiropractic - Independent Chiropractic Examinations rendered by the Chiropractic Quality Assurance Commission clarifies this issue:

"...Given the purpose of the statute and the scope of practice stated in RCW 18.25.005, the Commission interprets the definition of chiropractic to include activities which involve diagnosis or analysis, as well as activities that include care or treatment. It is not necessary that both diagnosis or analysis and care or treatment occur together to be considered the practice of chiropractic.

If a chiropractor provides diagnosis or analysis but stops short of providing care or treatment, the activities are considered the practice of chiropractic. Similarly, if a chiropractor provides care or treatment based on another chiropractor's diagnosis or analysis, the activities are considered the practice of chiropractic."

4. Doctors of chiropractic are trained and qualified to provide concussion evaluation and return to play assessment

The Washington scope of practice for chiropractic physicians already includes authorization to perform examinations designed to rule-in or rule-out conditions of any nature- including those which would not fall within the scope of chiropractic practice to manage (RCW 18.25.005 (3), RCW 18.25.006(8)). The 2013 CCE Accreditation Standards demonstrate the expectation that chiropractic program graduates are evaluated for competency in a broad variety of health conditions, including many for which referral to another practitioner would be the most appropriate management choice. For instance, the curricula of chiropractic programs include extensive education in the evaluation, diagnosis, differential diagnosis and management of an extensive array of orthopedic, neurological and musculoskeletal conditions. The NBCE examination batteries verify that licentiates have demonstrated competency in the evaluation, differential diagnosis, triage, management and referral of a broad variety of patient problems and conditions.

Within this universe, doctors of chiropractic are educated and trained in the evaluation, differential diagnosis and management of mild traumatic brain injury (MTBI, or concussion). This education occurs in a variety of courses including orthopedics, neurology and emergency procedures. Chiropractic physicians are required to understand and be familiar with current published guidelines on the assessment, diagnosis, differential diagnosis, management and return to play assessment for individuals who have suffered mild traumatic brain injury. This education includes didactic, practical and clinical training experiences. The table below lists courses at the University of Western States where relevant information on various aspects of mild traumatic brain injury are addressed...

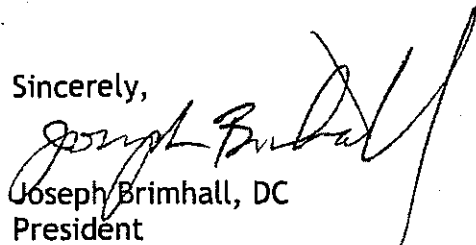
Course	Lecture	Lab	Clock Hours
Neuroanatomy	6	2	88
Neurophysiology	6	0	66
Neuromusculoskeletal Diagnosis & Treatment I Lecture	6	0	66
Neuromusculoskeletal Diagnosis & Treatment I Laboratory	0	2	22
Neuromusculoskeletal Diagnosis & Treatment II Lecture	3	0	33
Neuromusculoskeletal Diagnosis & Treatment II Laboratory	0	1	11
Neuromusculoskeletal Diagnosis & Treatment III Lecture	3	0	33
Neuromusculoskeletal Diagnosis & Treatment III Laboratory	0	1	11

Emergency Care	1	0	11
Clinic Phase 3	0	1	11

Some doctors of chiropractic whose focus is on treating athletes more extensively as a specialty practice can receive advanced didactic, practical and clinical experience education in postgraduate educational curricula relating to concussion identification, management and return to play assessment. Seventy nine chiropractic physicians possessing certification at an advanced level practice in the state of Washington.

The University of Western States supports the requested clarification to unambiguously include these examinations for chiropractic physicians licensed in Washington. UWS believes the exams are in fact within the scope of chiropractic practice in WA as they are in the vast majority of other licensing jurisdictions. Prohibition from practicing the legal scope in these specific situations and from allowing licensed chiropractic physicians to provide examinations and evaluations for which they are explicitly trained appears to be discriminatory and against the best interests of the citizens of Washington.

Sincerely,



Joseph Brimhall, DC
President

cc: Leo Romero, DC Chair, Board of Trustees
Gary Schultz, DC, DACBR, Professor and Chair, Clinical Sciences Department

MEMORANDUM

DATE: July 20, 2013

TO: Sherry Thomas, Department of Health

FROM: Warren B. Howe, MD
4222 Northridge Way
Bellingham, WA 98226

CC: Sherrise Martin, DOH

SUBJ: comments regarding Chiropractic Scope of Practice Sunrise Review (HB 1573)

I am submitting these written comments about the Chiropractic Scope of Practice Sunrise Review (HB 1573), specifically regarding the proposal to change the chiropractic scope of practice to include the performance of physical examinations for sports participation and commercial driver licenses. I am opposed to the proposal.

My concerns about the proposed changes are most directly related to the proposal that chiropractors be authorized to perform preparticipation sports physical examinations, but they can be generalized to the concept of having chiropractors perform examinations for commercial driver qualification as well. They are rooted in my 40+ year career as a sports physician, during which I have performed thousands of preparticipation evaluations (PPE), have made presentations about the PPE to medical organizations and continuing medical education sessions, and contributed my comments and expertise to many professional medical groups seeking to improve the standards for performing the PPE.

In my experience, the performance of the preparticipation evaluation for sports participation is one of the most challenging responsibilities that a sports physician faces. The examination is for the purpose of detecting problems that may interfere with the participant's safe pursuit of his/her activity, including problems that may predispose the participant to the risk of death. The ability to identify those few individuals at such risk is limited, but not absent; in my career I have identified and counseled a number of athletes for whom sports activity posed an inordinate risk, perhaps prolonging their useful lives thereby. The PPE, by definition, is comprehensive. Meaningful performance of the PPE requires the examiner to integrate the subject's medical and family history with a careful physical examination and perhaps with electrocardiographic evaluations, consider the findings in the light of cardiovascular and exercise physiology and the demands of the proposed sport participation, and make decisions about participation and/or the need for further evaluation utilizing the depth and breadth of the examiner's training and experience. This is a daunting task for a well-trained primary care physician. Truth be told, not every physician is entirely competent to perform this task well, and even fewer PA's and ARNP's are, because of insufficient or too-specialized training and experience or lack of the instincts that are based on and honed by comprehensive day-to-day practice.

Chiropractors are currently authorized to perform physical examinations “to determine the appropriateness of chiropractic care.”¹ That is, and remains, entirely appropriate, since such activity is based on, and complements, the chiropractor’s education and ongoing experience. But chiropractors are not trained or experienced in the comprehensive evaluation required in the PPE. They are not trained in “whole-body” assessment of individuals, nor are they significantly trained or experienced in the most important aspects of cardiovascular physiology, examination, disease detection or treatment. According to the Council on Chiropractic Education (CCE), which provides accreditation of chiropractic education programs, “the neuromusculoskeletal examination is the foundation of the chiropractic approach toward evaluating the patient.” CCE’s accreditation standards do not mention, among other subjects critical to the PPE, evaluation or treatment of the cardiovascular system. The CCE licensure exam does not include cardiovascular evaluation in its list of required topics. Not only are chiropractors not educated in the evaluation of the cardiovascular system or detection of potential cardiovascular risks in the evaluation of patients, but their day-to-day practice does not expose them to regular and repetitive experience in evaluating patients from a cardiovascular standpoint. Chiropractors, by virtue of their training and experience, may be adequate to evaluate the musculoskeletal fitness of sports participants, but because of the narrow scope of their training and experience they are at a distinct disadvantage in evaluating the cardiovascular and metabolic fitness of such persons, thereby increasing the risk of adverse outcome or sudden death in participants they “clear.”

The content and performance of the PPE is under continuing critique and modification by the medical profession. There has, for instance, been intense discussion recently about the potential role for and wisdom of including electrocardiographic (EKG) screening in the PPE to make it more effective at finding persons at potential risk of sudden cardiac death. The American Medical Society for Sports Medicine (AMSSM) has developed an excellent set of educational materials for primary care physicians to use in improving skill in interpreting athlete EKG’s to detect such risk. I note that although the certification examination of the American Chiropractic Board of Sports Physicians (ACBSP) includes “electrodiagnostics” in its content guidelines, electrocardiography is not listed there (nor should it be, because chiropractors are neither trained in nor expected to perform electrocardiographic interpretation). In its recommended reading list, the ACBSP does not include a single textbook, monograph or journal article on PPE, or on cardiovascular evaluation, diagnosis or therapy, except for one ACBSP position paper on PPE dated 1998. In that position paper, the ACBSP states that its diplomates are “fully qualified to perform PPEs” and lists the “standard components of history and physical examination” (which are generally NOT part of the usual chiropractor’s education and experience) as if such listing confers ability and skill in performance. The paper endorses the clearance guidelines for cardiovascular conditions established by the 26th Bethesda Conference (1994), despite the current Bethesda Conference Report being the 36th (2005). The same reading list references the Preparticipation Physical Evaluation monograph by five sports medicine organizations, 2nd edition (1997), when the current edition of that standard-setting monograph is the 4th (2010). The chiropractic profession is not up-to-date on the PPE, probably because it is not attuned, by training, practice content or tradition, to be interested in the subject, and perhaps because it naively sees it as a simple “check-list” procedure or perhaps a patient-finding, practice-building tool.

The Washington State Chiropractic Association purports to remedy the deficits in chiropractic training and experience for PPE performance by providing a “Pre-participation Examination (PPE) Course” of 18 hours length, designed “for the general practicing Doctor of Chiropractic.”

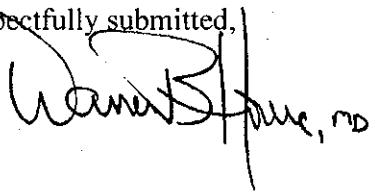
¹ RCW 18.25.005(3)

The concept of compensating for a chiropractor's lack of basic training and ongoing experience related to the PPE with an 18-hour course delivered every two years would be laughable were it not so potentially dangerous. Just learning to do cardiac auscultation with any skill requires many hours of instruction followed by literally years of continuing practice and acquisition of experience in interpreting what one hears; that is just one part of the comprehensive PPE.

I am not of the opinion that chiropractors are incompetent in sports medicine. To the contrary, I find that many of them have a unique and valuable niche in the care of athletes. I have worked side-by-side with chiropractors providing athlete care at major sporting events, and appreciate their expertise and viewpoint. On many occasions I have referred athlete patients to chiropractors for therapy and been pleased with the results. What I do believe is that chiropractors, by virtue of their training, experience, and practice philosophy, are not competent to perform the comprehensive evaluation and decision-making required for a meaningful PPE, and that doing so should not be part of their scope of practice in the State of Washington.

Washington State has been a leader in promoting safe sport participation for our youth. The "Lystedt Law" regarding concussions has been a model for the rest of the country, and illustrates the seriousness with which sports safety is approached by our state. Expanding the chiropractic scope of practice to include performance of PPE's would be a major backward step from where we are at present, and has the potential to result in tragedy. I urge that the proposed modifications be rejected.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "W. B. Hume, MD". The signature is written in a cursive style with a vertical line through the middle.



Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas,

I am writing to you on behalf of the Washington State Athletic Trainers' Association (WSATA) regarding the Department of Health Sunrise Review of the proposal to change the scope of practice for chiropractors to include the performance of physical examinations for sports physicals and commercial driver's licenses. Consistent with several other health care professions responsible for the health and safety of young athletes in Washington we are opposed to this bill.

As licensed athletic trainers we are charged with ensuring that athletes have been properly evaluated by appropriately trained medical professionals prior to participation in sports, to reduce the risk of exacerbating pre-existing medical conditions, injury and even death. As you may know, sudden cardiac arrest is the leading cause of death in young athletes. While this is the most imminently catastrophic statistic there are several other medical conditions that if left unidentified can lead to similar catastrophic outcomes.

The pre-participation physical exam is the main medical screening that can help identify any number of medical issues that may either need follow up evaluation by a specialist, require further monitoring or even affect specific physical activity or preclude activity based on the significant risk posed to the athlete with the identified medical condition. A pre-participation physical exam performed by the appropriately educated and trained medical professional is crucial to ensuring safe participation in physical activity and even preventing death in young athletes. Restricting or limiting an athlete from sports participation requires medically trained individuals who have competence in the recognition and treatment of potentially life threatening conditions such as: cardiomyopathy, asthma, seizures, heat illness, congenital anomalies, diabetes, ocular disorders, cancer, concussions, eating disorders and many other genetic predispositions based on family history. The evaluation, management and treatment of these conditions should be performed by trained medical professionals who can order and interpret appropriate tests and medications that will aid the athlete in the safe performance of their chosen sport or exclude them from activities that are potentially life threatening.

Physicians have very strict rules for athletic participation when it comes to the management of specific medical conditions such as asthma, diabetes, seizure disorders, etc. Is it within the chiropractors' scope of practice to prescribe the medications and develop a plan to ensure safe exertional activities for the athlete? Does a chiropractor have the extensive training to identify congenital or acquired heart conditions including arrhythmias, murmurs, and hypertension? Can a chiropractor order, interpret and treat a heart condition based on blood pressure, electrocardiogram or echocardiogram? Would a chiropractor be able to prescribe proper medication and counsel an athlete, his/her parents and coach regarding the appropriate use of inhaler medications and pre-activity priming? These are just a few of the more common medical issues young athletes face.

In February 2013, HB 1573 had a hearing in the House Health Care Committee. During that meeting, a representative to the Washington State Chiropractor's Association (WSCA) stated one reason the WSCA was fighting to become authorized to perform sports physicals was to

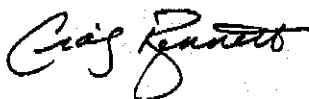
make it easier on families who have multiple members treating with a particular chiropractic clinic. We would argue that there is much more at stake here for the young athlete than whether his or her parents are able to save time. We think that all children have the right to be evaluated with a thorough, medically sound procedure administered by a thoroughly-trained medical doctor, physician's assistant or nurse practitioner.

While we understand that the revised language in the bill creates the desire only to allow chiropractors who have completed additional credentialing programs in the Certified Chiropractic Sports Physician (CCSP) and/or the Diplomate American Board of Chiropractic Physicians (DABCSP) it is imperative that the Department of Health closely evaluate the quality and detail of these credentials as it relates to the principles of pre-participation physical exams as more than just a musculoskeletal exam. Medical Doctors, Doctors of Osteopathic Medicine, Physician Assistants and Advanced Nurse Practitioners undergo hundreds if not thousands of hours of clinical training dedicated to the recognition of cardiovascular and other systemic anomalies that require further evaluation and testing before participating in potentially harmful activities. You will not find this same level of specific education or dedicated training in the CCSP or DABCSP credentials.

The pre-participation physical exam for sports is a very specialized screening process that we should be looking to make more rigorous and detailed rather than looking to accept a minimal standard of care out of desire to be included in a process. Expanding the chiropractic scope of practice to include the examination, management and treatment of athletes in the pre-participation physical exam will result in potential harm to our student athletes. If this bill is passed and we expand the scope of practice of the chiropractic profession in our state, we are allowing this profession to recognize, diagnose, treat and clear athletes with potentially life threatening conditions, that they do not actively see or treat and therefore will do more harm than good.

We appreciate your time and thorough evaluation of this process and we welcome the opportunity to participate in the proceedings as necessary.

Respectfully,



Craig Bennett
President
Washington State Athletic Trainers' Association.



The Association of Washington Healthcare Plans

August 2, 2013

Submitted via Electronic Mail to sunrise@doh.wa.gov

The Honorable John Wiesman, DrPH, MPH
Secretary of Health
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Re: Chiropractic Scope of Practice Sunrise Review

Dear Secretary Wiesman,

On behalf of Association of Washington Healthcare Plan (AWHP) member healthcare plans, thank you for the opportunity to provide input as part of the Department of Health's (DOH) sunrise review of the House Bill 1573 proposal to expand chiropractors' scope of practice to include performance of physical examinations for sports physicals and commercial driver's licenses.

AWHP is an alliance of our state's fifteen largest Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), and Disability insurers. Its diverse membership is comprised of local, regional, and national healthcare plans serving the needs of consumers, employers and public purchasers. Together, AWHP member healthcare plans provide health care coverage to over 4 million residents of Washington State.

We have significant concerns with the proposal to expand the scope of practice for licensed chiropractors and hope the following comments will be of assistance during your review.

Patient Safety

Our first and foremost concern with the proposed scope of practice expansion is patient safety. Chiropractors are not currently allowed to perform physical examinations for sports physicals and commercial driver's licenses and lack appropriate training in non-muscular/skeleton health issues. The current sports examination form includes a number of questions directly related to cardiovascular and cardiopulmonary systems and other vital organ functions not within the scope of chiropractic training. Chiropractic training does not include detailed medical history, physical exams, and diagnosis of vital health concerns such as cardiovascular issues and pulmonary risks. Pharmacy management is also an important component of sports physicals and commercial driver's license examinations; however chiropractors are not trained in pharmacology and cannot prescribe controlled medications.

Based on these patient safety concerns, AWHP healthcare plans are opposed to the proposed scope expansion.

Cost & Duplication

Also of concern is cost and duplication. If chiropractors' scope of practice is expanded to allow them to perform a portion of the sports examination, students may then also need to visit a medical doctor for the remainder of the examination involving the brain, cardiovascular system, pulmonary system, and prescribed medications. This could result in creating two claims for the exams and increasing healthcare costs. We are unaware of any unmet access needs requiring such an arrangement.

Problematic HB 1537 Proposal Title

The proposed HB 1537 expansion of chiropractors' scope of practice is titled *"Clarifying the prohibitions against discriminating against licensed chiropractors."* We are puzzled as to how it could be considered discriminatory to not allow chiropractors to perform services outside their licensure and scope of practice. It is our understanding physicians are licensed to perform physical examinations, while chiropractors are not. To frame this as being discriminatory appears misleading. We believe the proposed change constitutes a benefit mandate.

Again, we hope this input is helpful and thank you for the opportunity to provide comments for your consideration. Please do not hesitate to contact me with any questions or to discuss.

Sincerely,



Sydney Smith Zvara
Executive Director

Association of Washington Healthcare Plans
7252 Fairway Ave SE
Snoqualmie, WA 98065
Tel 425-396-5375
Cell 425-246-5942
Fax 425-396-5372
AWHP@comcast.net

AWHP members include Aetna, Amerigroup, CIGNA, Columbia United Providers, Community Health Plan of WA, Coordinated Care, Group Health, Kaiser Permanente, Molina, HealthNet, Premera Blue Cross, Providence Health Plan, Regence BlueShield, SoundPath, & United Healthcare.



WASHINGTON STATE NURSES ASSOCIATION

575 ANDOVER PARK WEST, SUITE 101, SEATTLE WA 98188 206-575-7979 206-575-1908 FAX WWW.WSNA.ORG

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas,

On behalf of the Washington State Nurses Association (WSNA) and its 17,000 registered nurse and advanced practice nurses, we are submitting comments on the Sunrise Review to expand a chiropractor's scope of practice to allow for the authority to perform sports physicals and commercial driver's license exams. Thank you for the opportunity to share our comments. We look forward to working with you as the Department of Health moves forward with this proposal.

The WSNA has concerns expanding the scope of practice for licensed chiropractors to include the performance of sports physical exams.

Advanced practice registered nurses, physicians, osteopathic physicians, and physician assistants complete training that covers a broader array of medical issues in greater depth than the training completed by chiropractors.

Pediatric patients (defined as up to age 21), are often the most challenging population to capture for screening and preventive exams. Sports physical exams are necessary because many individuals may have undetected health conditions and only a specially trained provider is able to identify potential health concerns before the individual engages in a high risk activity like sports.

ARNP training, like physicians, naturopaths, osteopathic physicians, and physician assistants include identifying and treatment of a much wider range of medical conditions. They can examine, diagnose, and treat health conditions related to cardiac, pulmonary, or neurologic deficiencies. In addition, they have more in depth knowledge about pharmacology.

Expanding the chiropractic scope of practice does not assure care coordination with primary care providers like nurse practitioners who have the training and education to diagnose a broader range of health concerns. Eighteen hours of class time proposed by the WA State Chiropractic Association would be sufficient to prepare a chiropractor to perform an exam as well and as extensively as an ARNP. The WSCA does not demonstrate that the additional training proposed by the statutory change would sufficiently prepare doctors of chiropractic to perform exams of the same caliber as physicians.

Therefore allowing Chiropractors to perform sports physicals would not alleviate preventing harm to young athletes that want to participate in sports.

If there is a shortage of providers to provide physical examinations, efforts should focus on increasing the supply of providers that already have the broad training to perform the exam.

Sincerely,

Sofia Aragon, JD, RN
Senior Governmental Advisor
Washington State Nurses Association

August 2, 2013

Nicholas Rajacich, MD
President

Dale Reisner, MD
President-Elect

Douglas Myers, MD
Past President

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1st Vice President

Brian Seppi, MD
2nd Vice President

Bruce Andison, MD
Secretary-Treasurer

Donna Smith, MD
Assistant Secretary-Treasurer

Jennifer Hanscom
Executive Director/CEO

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Re: Chiropractic Scope of Practice

Dear Ms. Thomas,

On behalf of the Washington State Medical Association (WSMA) and its 9,800 physician and physician assistant members, we are submitting comments on the Sunrise Review to expand a chiropractor's scope of practice to allow for the authority to perform sports physicals and commercial driver's license exams. Thank you for the opportunity to share our comments. We look forward to working with you as the Department of Health (Department) moves forward with this proposal.

The WSMA is opposed to expanding the scope of practice for licensed chiropractors to include the performance of sports physical exams and commercial driver's license physical exams. Please see the analysis below supporting our position.

(1) Defining the problem and why regulation is necessary:

The WSMA disagrees with the fundamental premise of the Washington State Chiropractic Association (WSCA) which states that the selection of health care providers allowed to perform sports physical examinations and to meet the federal Department of Transportation (DOT) requirements for commercial driver's licenses is arbitrary.

The decision to limit who may perform these exams, and specifically, to exclude doctors of chiropractic, is well founded and based on the fact that physicians, osteopathic physicians, physician assistants, and advance practice registered nurses complete training that covers a broader array of medical issues in greater depth than the training completed by chiropractors. This is discussed in greater detail below.

Regarding commercial driver's license exams: The WSCA includes a reference to the National Registry of Certified Medical Examiners (registry) and states that the federal DOT allows for doctors of chiropractic to become certified medical examiners should they become registered via the registry. What WSCA does not include is that the registry requires individuals to be "licensed, certified, or registered in accordance with applicable State laws and regulations to perform physical

examination” before they are eligible to become a Certified Medical Examiner.¹ Washington State has no record of allowing doctors of chiropractic to perform commercial driver’s license exams.

Second, the request to apply the standards laid out in the federal law² does not conclude that the training and core competencies for performing commercial driver’s license exams will be sufficient.³ Also, as noted in the WSCA application, a majority of states do not allow doctors of chiropractic to perform commercial driver’s license exams, and the registry will not accept the application for certification to become a medical examiner.

Regarding sports physical exams: When the WSCA identifies that nearly half of the states authorize doctors of chiropractic to perform sports physical exams, it fails to analyze these states’ laws, or explain the standards by which doctors of chiropractic in these states become certified to perform examinations. In light of this absence, the argument that Washington should change its laws simply because such action would align it with other states is unsupported and unpersuasive.

Regarding a demand for services: While we do not dispute that there is a significant demand for performing commercial driver’s license exams and sports physical exams, it is not clear that the demand for these services requires an expansion of a doctor of chiropractic scope of practice, nor does it imply that the demand for these services should be met by a doctor of chiropractic performing the services. The WSCA fails to present any evidence which substantiates its claim that there is an unmet need for health care professionals to perform sports and commercial driver’s license examination. Furthermore, athletic activity and commercial driving can pose health risks, particularly to individuals who have unidentified health conditions. These examinations are required because a proper medical examination can identify potentially dangerous conditions and ultimately prevent injury or death. In light of this concern, increasing the availability of these exams by allowing chiropractors to perform them, at the cost of quality, is not beneficial to the public if it puts individuals at risk of injury. The very purpose of requiring exams is to ensure that physicians identify conditions that an individual may not be aware they have,

Regarding additional expense: The WSMA was not able to substantiate the WSCA’s claims that the restriction on doctors of chiropractic from providing these types of exams delays healthcare services and creates additional expense for patients because of the shortage of primary care physicians. We could identify no data or cited resources that are referenced in this claim. We are therefore highly concerned that it could not be substantiated. More importantly, if we assume that there is indeed a shortage of providers to provide physical examinations, it does not require an expansion of the doctor of chiropractic scope practice. In fact, there are other options to make sports physical examinations and commercial driver’s license exams more accessible to the general public.

1(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety.

We strongly dispute the claim that allowing doctors of chiropractic to perform these types of exams would not create additional risk to the public. The WSCA stated that because doctors of chiropractic are regulated under RCW 18.25.005, which defines the practice of chiropractic, they therefore pose no additional risk to the public in performing these exams. We are unclear as to how the definitions found in RCW 18.25.005 are sufficient to justify this claim. Moreover, the claim that the current regulatory scope of practice does not include recent advances in education for chiropractors fails to substantiate the

¹ See: https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Medical_Examiner-trifold_final_version_for_website.pdf.

² Motor Carrier Safety Improvement Act of 1999 (49 U.S.C. 113).

³ Please refer to the section below comparing education of a physician to that of a doctor of chiropractic.

conclusion that allowing doctors of chiropractic to perform physical exams would not pose additional risks to patient and public safety.

1(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession.

We disagree with the claim that consumers will benefit by seeing greater access to “qualified healthcare providers” (doctors of chiropractic with an expanded scope of practice) who can provide sports and commercial driver’s license exams. We argue that, even with additional training and certification, doctors of chiropractic lack the training, experience and knowledge to ensure complete and comprehensive sports and commercial driver’s license exams. Consequently, allowing doctors of chiropractic to perform these exams would endanger patients by increasing the risk that dangerous health conditions will be unidentified or misdiagnosed.

Regarding training and education: The WSMA believes that allowing doctors of chiropractic to perform these exams could harm or endanger public health, safety, and welfare by increasing the possibility that patient conditions will go unidentified or misdiagnosed. This is, in part, because doctors of chiropractic do not complete the extensive schooling and clinical programs physicians complete. The uniquely rigorous training physicians complete teaches them to identify and diagnose a much wider range of medical conditions than other medical professionals (for example, examining and identifying heart and lung conditions that would prevent an individual from safely participating in school sport programs). Unlike doctors of chiropractic, physicians complete extensive training with relevant medical specialties such as cardiology, neurology, pulmonology, orthopedics, pharmacology and emergency medicine. Furthermore, doctors of chiropractic lack the knowledge of pharmacology and medications which the other health care professionals possess, and which is necessary to safely and completely perform a sports or commercial driver’s license examination.

It is doubtful that the 18 hours of class time proposed by the WSCA would be sufficient to prepare a chiropractor to perform an exam as well and as extensively as a physician, and a multiple choice style test, no matter how intense, would be a poor way to measure a chiropractor’s ability to perform a physical examination on an actual patient in order to successfully identify problematic health issues. The WSCA does not, and we believe cannot, demonstrate that the additional training proposed by the statutory change would sufficiently prepare doctors of chiropractic to perform exams of the same caliber as physicians.

Included below is information regarding training that doctors of chiropractic undergo as opposed to the training required of a physician. The comparison illustrates the disparity in preparation that we believe leaves doctors of chiropractic unprepared to perform adequate physical exams. This lack of training is one reason why the WSCA’s request to expand the scope of practice for doctors of chiropractic places the public in danger: such an expansion will increase the likelihood that a patient’s dangerous medical condition will be misdiagnosed or unidentified. For example, the WSMA is concerned that doctors of chiropractic will not have sufficient skill and experience to identify potentially problematic heart murmurs, and that their lack of training and experience in pharmacology and prescription medicines will leave them insufficiently prepared to evaluate an applicant for a commercial driver’s license who might be on multiple medications.

According to the American Medical Association, medical and osteopathic school students “must cover all organ systems, and include the important aspects of preventative, acute, chronic, continuing,

rehabilitative, and end-of-life care.”⁴ Medical student education prepares students to “enter any field of graduate medical education,” and includes “content and clinical experiences related to each phase of the human lifecycle,” such that physicians can competently “assist patients in addressing health related issues involving all organ systems.”⁵ Generally, standards required for chiropractic education do not require education in individual courses.⁶ Chiropractic education does not require students to complete a residency.⁷

Regarding physicians’ and chiropractors’ orthopedic education and training, please see the comparison below:⁸

ORTHOPEDIC SURGEONS’ EDUCATION AND TRAINING	SPORTS MEDICINE PHYSICIANS’ EDUCATION AND TRAINING	CHIROPRACTORS’ EDUCATION AND TRAINING
-Four years of medical or osteopathic medical education -Five years of graduate medical education -Covers all organ and other systems in the human body -Differential diagnostic and pharmacologic applications integrated into every level of training	-Four years of medical or osteopathic medical education -Four to five years of graduate medical education -Covers all organ and other systems in the human body -Differential diagnostic and neurologic applications integrated into every level of training	-Four years of chiropractic college -Basic sciences with neurology included in clinical sciences - Focus on spinal manipulation

⁴ Liaison Committee on Medical Education (LCME). Functions and Structure of a Medical School. Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. May 2012.

⁵ *Id.*

⁶ CCE. Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status. January 2007. Curriculum in doctor of chiropractic programs must include course work on the following subjects, *though not necessarily in individual courses for each subject [emphasis added]*: anatomy; biochemistry; physiology; microbiology; pathology; public health; physical, clinical and laboratory diagnosis; gynecology; obstetrics; pediatrics; geriatrics; dermatology; otolaryngology; diagnostic imaging procedures; psychology; nutrition/dietetics; biomechanics; orthopedics; neurology; first aid and emergency procedures; spinal analysis; principles and practice of chiropractic; clinical decision making; adjustive techniques; research methods and procedures; and professional practice ethics.

⁷ See attached publication. American Medical Association, Advocacy Resource Center. *Issue Brief: Chiropractic*, at 6 (2012).

⁸ *Id.* at 5.

Regarding physicians' and chiropractors' neurologic training, please see the comparison below:⁹

NEUROLOGISTS' EDUCATION AND TRAINING	PHYSIATRISTS' EDUCATION AND TRAINING	CHIROPRACTORS' EDUCATION AND TRAINING
-Four years of medical or osteopathic medical education -Five to seven years of graduate medical education -Covers all organ and other systems in the human body -Differential diagnostic and neurologic applications integrated into every level of training	-Four years of medical or osteopathic medical education -Four years of graduate medical education -Covers all organ and other systems in the human body -Differential diagnostic and neurologic applications integrated into every level of training	-Four years of chiropractic college -Basic sciences with neurology included in clinical sciences - Focus on spinal manipulation

Regarding physicians' and chiropractors' radiologic training, please see the comparison below:¹⁰

RADIOLOGISTS' EDUCATION AND TRAINING	CHIROPRACTORS' EDUCATION AND TRAINING
-Four years of medical or osteopathic medical education -At least five years of graduate medical education -Covers all organ and other systems in the human body	-Four years of chiropractic college -Basic sciences with imaging included in clinical sciences program -Focus on spinal manipulation

⁹ *Id.* at 7-9.

¹⁰ *Id.* at 9-10.

Regarding physicians' and chiropractors' pharmacologic training, please see the comparison below:¹¹

PHYSICIANS' PHARMACOLOGIC EDUCATION AND TRAINING	CHIROPRACTORS' EDUCATION AND TRAINING
-Begins in medical or osteopathic medical school; continues through residency -Emphasis on clinical application of pharmacologic interventions -Covers all organ and other systems in the human body - Differential diagnostic and pharmacologic applications integrated into every level of training	-Limited to didactic overview during chiropractic education -No residency requirement of clinical application

In sum, a doctor of chiropractic is not required to complete or undergo the level of subsequent training that medical and osteopathic medical students receive.¹²

1(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and (ii) The extent to which practitioners are supervised:

Please see the comment above. We disagree with the claim that proposed updates to the scope of practice will benefit the public by "providing a mechanism whereby the public can be assured participating licensed doctors of chiropractic providing...[these exams]..." will receive adequate training in regards to the new services they provide. The additional training for chiropractors proposed by the WSCA fails to adequately prepare doctors of chiropractic for the wide array of medical issues a patient may have. Even with the proposed additional training, doctors of chiropractic lack the range of exposure and depth of knowledge necessary to perform a comprehensive and complete examination.

(2) The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and (b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem:

WSCA's comments fail to address the requirement to identify how the expansion of the doctor of chiropractic scope of practice will "help to resolve disputes between health practitioners and consumers." "Clarifying" current law, as WSCA proposes, does nothing to further an ethical code or resolve disputes between health care professionals and patients; indeed, it creates additional confusion for patients regarding which health care professions are best trained to perform these important examinations.

¹¹ *Id.*

¹² *Id.*

(3) The alternatives considered: (a) Voluntary efforts, if any, by members of the health profession to: (a) Regulation of business employers or practitioners rather than employee practitioners; (b) Regulation of the program or service rather than the individual practitioners; (c) Registration of all practitioners; (d) Certification of all practitioners; (e) Other alternatives; (f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and (g) Why licensing would serve to protect the public interest.

The WSMA finds no support for WSCA's implication that updating the standards as proposed in HB 1573 would "serve the public interest by allowing specially trained doctors of chiropractic to perform services in high public demand."¹³ Furthermore, HB 1573 is silent on any reference related to public demand of the services of physical exams.

We also disagree with WSCA's claim that their proposal will "serve as a quality assurance measure by identifying a subgroup of the profession with special training."¹⁴ The fact that a doctor of chiropractic would receive some additional training does not by itself makes him or her qualified to perform comprehensive and complete physical exams. Furthermore, the WSCA's proposal to provide consumers with an easily accessible list of providers, which would implicitly assure the public that these providers are qualified to perform medical exams, does not in itself show that doctors of chiropractic should be allowed to perform these exams or that their scope of practice should be expanded.

(4) The benefit to the public if regulation is granted.

The WSMA disagrees with WSCA's claim that consumers will benefit from "updated standards." There is no basis on which to presume that expanding the doctor of chiropractic scope of practice to include the performance of these types of exams will be in the public's best interest. The transition and limited amount of additional education will be insufficient to provide complete comprehensive physical exams. WSCA presents no evidence to support their claim, or explain why the training will be sufficient, other than to repeatedly assert the notably unsupported claim that it will be. We believe that the amount of training, education, and expertise proposed by the WSCA would not adequately prepare doctors of chiropractic to perform complete and comprehensive exams.

We do not disagree with WSCA's statement that "primary care medicine is an underserved need in healthcare." However, the fact that the public could benefit from increased access to primary care services does not support the claim that a doctor of chiropractic should have an expanded scope of practice to allow for the performance of sports and commercial driver's license exams with only a very limited amount of additional training.

Lastly, the claim that there are only 24 total providers listed in the registry as available to perform examinations for commercial driver's is disingenuous, since the federal requirements for certification do not become effective until May 2014. This is a new program, and physicians and other qualified health care professionals need time to become familiar with the new requirements. This in no way demonstrates that the public demand is greater than the availability, such that it would necessitate an increase in the number of providers.

¹³ Washington State Chiropractic Association, *Applicant Report Cover Sheet and Outline Washington State Department of Health Sunrise Review*, pg. 4. Accessed July 30, 2013 at: <http://www.doh.wa.gov/Portals/1/Documents/2000/ChiroAppRptAndAppendAandB.pdf>.

¹⁴ *Id.*

(4)(a) The extent to which the incidence of specific problems present in the unregulated health.

We have no comment on this section.

(4)(b) Whether the public can identify qualified practitioners.

We agree that the Department of Health has a navigable and searchable website that lists practitioners by name and license number for the purposes of public identification of qualified providers. However, for the reasons stated in previous sections, we disagree that chiropractors should have an expanded scope of practice to allow for sports and commercial driver's license physical exams, and therefore we believe they should not be listed as being qualified for such on any public website.

(4)(c) The extent to which the public can be confident that qualified practitioners are competent.

The WSCA references the amount of education required to become a doctor of chiropractic. We do not disagree with the amount of training required to become a doctor of chiropractic. However, as we state above, we disagree that the training of a doctor of chiropractic is sufficient to perform complete comprehensive physical exams, even with the proposed additional pre-certification training. We also disagree that the scope of practice for a doctor of chiropractic should be expanded to allow for the performance of sports and commercial driver's license physical exams.

(4)(c)(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system.

We have no comment on this section.

(4)(c)(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date.

We have no comment on this section.

(4)(c)(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions.

We have no comment on the section.

(4)(c)(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions.

We have no comment on this section.

*

(4)(c)(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met.

We do not disagree that the stated amount of training will be made available for a doctor of chiropractic who wishes to apply for authorization to perform physical exams. However, for the reasons stated in section 1(b), we disagree that the proposed additional training or education would be sufficient for a doctor of chiropractic to perform comprehensive and complete physical exams.

We have no comment on sections (4)(c)(vi) through (4) (d)(ii).

(5) The extent to which regulation might harm the public.

Please see our comments above. We disagree that the proposal will improve the quality of care by identifying specially trained providers. We also disagree that this service has been demonstrated to be in high demand for Washington State. Lastly, the WSCA states that the proposal exceeds requirements of other professions already providing these exams. We disagree that the initial training and education of a doctor of chiropractic and supplemental education and training of a doctor of chiropractic will be sufficient to perform a complete comprehensive physical exam and thus the requested expansion places the public at unnecessary risk of harm.

We have no comment on sections 5(a) through 9.

Thank you for the opportunity to share our concerns. If you have any questions, please feel free to contact Kathryn Kolan at (360) 352-4848 or Denny Maher at (206) 956-3640.

Sincerely,

//sd//

Denny Maher, MD, JD
Director of Legal Affairs

//sd//

Kathryn Kolan, JD
Director of Legislative and Regulatory Affairs

cc: WSMA Senior Staff

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
sunrise@doh.wa.gov
PO Box 47850
Olympia, WA 98504-7850

RE: Proposal to Change Chiropractor Scope of Practice

Ms. Thomas,

The Washington Chapter of the American Academy of Pediatrics strongly opposes the proposal to change the scope of practice for chiropractors in the state of Washington, which would allow chiropractors to perform sports physicals for school athletes and physical examinations required for commercial driver's licenses.

Prohibiting chiropractors from performing pre-participation sports exams protects adolescents and children. Healthy athletes don't just need their musculoskeletal systems evaluated, they require the entire body – including brain, lungs, heart, kidneys and liver – to be in working order to participate safely. Chiropractors are not trained in providing comprehensive medical services to allow for adequate assessment of the whole athlete.

Chiropractors do not:

- Check vision, hearing or blood pressure;
- Examine the heart;
- Interpret family cardiac and genetic history;
- Examine boys' genitalia for the presence of a hernia .

They cannot assess the safety of participation of an athlete who has suffered a concussion, has congenital heart disease or a genetic syndrome, asthma or diabetes.

Risks to athletes

Sudden cardiac death, though rare, is the leading cause of death in exercising young athletes. There has been extensive work done in the pre-participation evaluation of athletes to detect cardiac anomalies and catch those at risk. There is also a growing recognition of the critical importance of assessing for prior head injuries and concussions in a highly structured and rigorous manner.

Some teens try to get their sports forms signed when it is inappropriate. One patient in a WCAAP member's practice had a severe head injury from a motor vehicle accident and tried to get cleared to play football at a school-sponsored physical event by hiding his injury. Having athletes screened in their medical home where their full medical and family history is known is crucial.

Additional risks

In Washington State, in 2011, only 78% of teens had their Tdap vaccine to prevent whooping cough, 70% had their meningococcal vaccine to prevent a form of meningitis, and 35% of female teens had their complete HPV series to prevent cervical cancer. Part of the reason these rates are so low is that it is challenging to get adolescents in for exams. Sometimes the requirement of a pre-participation sports exam is the only way to incent an adolescent to come in for care. Chiropractors are not licensed to provide immunizations and some discourage the practice of immunization.

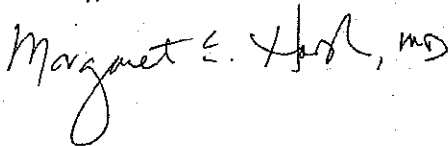
Additionally, chiropractors do not address the 30% of children who are obese, the 1 in 5 teens who are using tobacco products and need help with cessation treatment, and the 1 in 5 adolescents with depression or anxiety who need mental health screening and treatment. In 2011, 5,574 Washington teens gave birth; in 2010, 6500 Washington teens were treated for Chlamydia, 445 were treated for gonorrhea, and another 310 for other sexually transmitted infections. Pre-participation exams provide an opportunity for physicians to address these serious health issues with adolescents.

Sports exams in the medical home

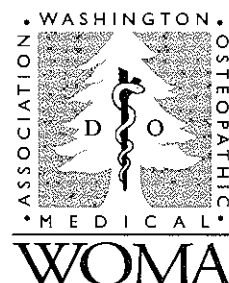
The national academies of pediatrics, osteopathy, family practice and sports medicine recommend pre-participation exams be done in the medical home integrated every two years as part of well child exams by trained MDs or DOs; well child exams should be done yearly. Sports exams aren't a simple matter and should be performed by professionals who can provide high quality, comprehensive care and address the needs of each adolescent individually.

To best ensure the safety and health of Washington athletes, do not allow this change in scope. Though chiropractors devote their expertise to caring for musculoskeletal health, and clearly care deeply about their patients, they are not appropriate care providers to perform these exams.

Sincerely,



Maggie Hood, MD, FAAP
President, Washington Chapter of the American Academy of Pediatrics



July 29, 2013

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Re: Sunrise Review of Chiropractic

Dear Ms. Thomas,

Thank you for the opportunity to comment on the Sunrise Review to expand a chiropractor's scope of practice to allow for the authority to perform sports physicals and commercial driver's license exams.

The Washington Osteopathic Medical Association supports the "team" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. While we value the contributions of chiropractors to the health care delivery system, we believe any expansion of their authority to provide services to patients without appropriate oversight should be directly related to additional education, training and competency demonstration requirements.

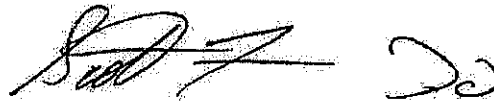
- a. Osteopathic physicians complete four years of osteopathic medical school, which includes two years of didactic study and two years of clinical rotations. Clinical rotations in the third and fourth years are done in community hospitals, major medical centers and doctors' offices. This is followed by three to seven years of postgraduate medical education, i.e., residencies, where DOs develop advanced knowledge and clinical skills relating to a wide variety of patient conditions. Physicians have both extensive medical education and comprehensive training that prepare them to understand medical treatment of disease, complex case management and safe prescribing practices.
 - b. In addition, osteopathic physicians have strenuous continuing education requirements and the AOA board certified physicians participate in Osteopathic Continuous Certification. This process ensures that board certified DOs maintain currency and demonstrate competency in their specialty area. It includes lifelong learning and continuous education, cognitive assessment and practice performance and assessment.
 - c. Collaborative agreements and the physician-led, team-based care model allows physicians to monitor progress in a non-physician clinicians' abilities and adjust their practice rights based on competency demonstration without jeopardizing patient safety or the quality of care delivered.
2. Chiropractor education standards are not equivalent to that of osteopathic physicians, and do not provide enough training to complete unsupervised physical evaluations.
- a. Again, all members of the health care team are valuable and the care they provide is essential to treating the whole patient in an efficient manner. Chiropractors should practice to the full scope of what

they are trained to do competently, which does not extend to providing unsupervised medical treatment.

- b. Osteopathic physicians complete 10,000 supervised clinical hours during their training, which is necessary to understand the complexities of comprehensive patient care and perform a complete evaluation of a patient.
 - c. An additional 100 hours of training for chiropractors is not adequate to address these concerns, as that represents only 1% of the hours of supervised clinical training an osteopathic physician achieves.
3. Many times attempts to increase scope of practice for non-physician clinicians are supported by claims that chiropractors can help fill physician workforce shortages, particularly in rural and underserved areas.
- a. Generally scope of practice bills fail to put in place restrictions or other provisions that incentivize non-physician clinicians to practice in rural and underserved areas. Additionally, data shows that non-physician clinicians in Washington tend to practice in the same areas as physicians.
 - b. While improving access to care is important, quality of care must not suffer as a result. Chiropractors are **not** trained in providing comprehensive medical services, including cardiovascular and examinations for other internal medical conditions, which are in fact the most critical component of physical evaluations. Sudden cardiac death is the leading cause of death in exercising young athletes. There has been extensive medical work done on preventing sudden cardiac death in young athletes that is based on trained evaluation of the history and physical examination.
4. Another major issue with physical examinations among student athletes is concussions. In 2006, a thirteen year old in Washington sustained a concussion during a middle school football game, but was allowed to continue playing.¹ Shortly after the game ended, the child collapsed and spent 31 days in a coma and 20 months on a feeding tube.² Three years after his injury, the individual was able to walk with assistance and Washington enacted the nation's first statute to address youth athlete concussions.³
- a. A 2011 study found that high school concussions are most likely to be assessed by a certified athletic trainer (94%), followed by a general physician (58%), orthopedic physician (4.7%), nurse practitioner (2.4%) and neurologist (2.1%).⁴ Chiropractors were not among that list.
 - b. Chiropractors have not been involved in assessing high school concussions, and the extra 100 hours of training would not be sufficient for making these determinations.

Thank you for allowing us to share our concerns on this issue.

Sincerely,



Scott Fannin, DO
President-Elect

¹ David Haugh, *Seattle-area teen helps NFL, others see dangers in concussions from football*, Chicago Tribune, Oct. 17, 2010, available at http://articles.chicagotribune.com/2010-10-17/sports/ct-spt-1017-haugh-football-coconcussio20101016_1_concussions-zackery-lystedt-law-sarah-jane-brain-foundation.

² Id.; CDC, *The Lystedt Law*, *supra*

³ CDC, *The Lystedt Law*, *supra*

⁴ William P. Meehan III, MD, Pierre d'Hemecourt, MD, Christy L. Collins, MA, and Dawn Comstock, PhD, *Assessment and Management of Sport-Related Concussions in United States High Schools*, 39(11) Am. J. Sports Med., 2304-2310, Nov. 2011.

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Rebuttal: Sunrise Hearing August 6, 2013: Chiropractic Scope of Practice Expansion for Pre-Participation Exams (PPE) and Department of Transportation (DOT) exams

Ms. Thomas,

I am writing you in my role as Executive Director of the Washington State Medical Quality Assurance Commission. The Commission is the entity responsible for licensing, discipline, policy, and education of medical practitioners in Washington. The Commission is composed of 13 medical doctors, two physician assistants-certified, and six public members. Through the actions of the Commission, patient safety is enhanced, the integrity of the medical profession is maintained, and the standard for medical care is set in this state. These are essentials to a functioning public health system. As the Governor-appointed representatives for the people of Washington in matters relating to patient safety and determining acceptable standards of medical care, the Medical Commission opposes the proposed scope of practice expansion for the chiropractic profession in Washington.

Our colleague from Congressional District two, Dr. Warren Howe, provided his personal comments on this issue prior to the August 6, 2013 hearing. His comments are based on over forty years of practice in sports medicine and noted expertise in this area. After monitoring the aforementioned hearing and reviewing the written comments, the Medical Commission would like to fully support and reaffirm the comments of Dr. Howe and expand on several points.

Training Considerations

All professions listed in this section require a Bachelor of Science degree with specific requirements for chemistry, mathematics, and other areas of scientific focus. With this consideration in mind, the following discussion does not take the BS training time into account. Many comments relating to this issue revolve around training time, to which the chiropractic association answers that the 4,200 clock hours of instruction is sufficient to perform the PPE and DOT exams. An Advance Practice Nurse receives a minimum of 1,300 clock hours after their BS in Nursing. By comparison, a masters level PA trained at Washington's MEDEX receives approximately 4,320 clock hours of instruction. A Doctor of Medicine or Doctor of Osteopathy receives a minimum of 5,200 clock hours of instruction in medical school alone. In postgraduate clinical training settings, the minimum amount of training a Doctor of Osteopathy can receive before becoming eligible a full license is 2,088 clinical hours. In many situations, Doctors of Osteopathy will receive the same amount of training as a Doctor of Medicine. A Doctor of Medicine will

receive 5,760 hours of postgraduate clinical training at minimum, which eclipses the core chiropractic training (4,200) and the Diplomate in Chiropractic Sports Medicine (200) clock hours. At nearly 11,000 hours of education and training time for DOs and MDs, the statement that Doctors of Chiropractic have enough training to perform the PPE or DOT exam lacks validity and understanding. The issue of contention is not possessing adequate training to perform the exam, but possessing and utilizing the training well enough to identify small indicators that represent a larger systemic problem. Those that are in favor of scope expansion have failed to successfully argue that training is sufficient.

Primary Care

The reference materials make mention of the patient interaction and case management skills developed in chiropractic training with examples ranging from 20 patient histories, 16 non-student exams, diagnosis, and lab interpretations. By comparison, a Family Practice trainee is required to conduct 1,650 patient visits, with 150 occurring in the first year. Additional requirements for Family Practice trainees mandate that they be patient scheduled for a minimum of 40 weeks per year and ensure 24 hour access of provider to patients while in training. This prepares the trainee for the expectations of practice in the primary care setting. The Medical Commission has seen no evidence in the materials provided that chiropractors receive training equivalent to existing standards of medical education or postgraduate medical training considered separately or combined. In no section of the materials provided were any references to care of those with disabilities, either in or out of the sports medicine setting. We must stress that these are just comparing minimum standards for Family Practice trainees, which is the quickest route to direct practice. Additional training is required for specialties such as Sports Medicine, Pediatrics, or Internal Medicine. Those that are in favor of scope expansion have failed to successfully argue that clinical experience is sufficient.

The comments made by chiropractors during the testimony of August 6 indicate a fundamental misunderstanding relating to the concept of a primary care physician. Both individuals testifying pro and members of WSCA testified that chiropractors are the primary care providers for their patients. The Medical Commission believes that this is outside the scope of practice for a chiropractor. The absence of another provider does not mandate the chiropractor into the role of the primary care physician. The chiropractor is a specialist just as an ophthalmologist or podiatrist is a specialist. However, neither the ophthalmologist or podiatrist should be considered a primary care physician due to training and, perhaps the most important issue, the function of primary care is not a part of their daily practice. The same is true of chiropractors in that they do not routinely operate in the role of a primary care capacity. They do not possess the education and clinical training to do so and typically do not operate as part of a medical home.

Public Health System

The final points the Commission would like to make relate to the practice of medicine within our current and evolving system. As Washington moves forward with the implementation of the Affordable Care Act and the encouraged formation of Accountable Care Organizations and Patient Centered Medical Homes, we must look at this scope expansion within that framework. Too often, the PPE and DOT exam is relegated to a lowest common denominator, mass operation in noisy settings. Even the most qualified medical or osteopathic sports medicine specialist has difficulty performing these crucial exams in typical

settings. To allow chiropractors with their significantly reduced training to conduct these exams will move Washington further away from the concept of team based medicine, impose a practitioner into the process that does not perform essential functions of medicine on a regular basis, and has not received any of the postgraduate clinical training mandated for those who currently conduct these exams.

Conclusions and Recommendations

Washington is considered a national leader in many areas of medical regulation and practice. The representatives of WSCA stated that Washington is one of two states that do not allow chiropractors to conduct the DOT exam. The Medical Commission views this as medically appropriate and would encourage the state to maintain this position. Under no circumstances should a chiropractor be authorized to conduct a PPE for someone with disabilities.

Finally, the Washington State Medical Commission recommends that all PPEs be performed in a quiet setting by the primary care provider, whether that is a Doctor of Medicine, Doctor of Osteopathy, Advance Practice Nurse, or supervised Physician Assistant-Certified. The Commission considers a team-based approach within a medical home model as ideal from the standpoints of patient safety, reduction in handoffs, facilitation of communication, and appropriate referrals. This model represents a robust and effective public health delivery system. The Commission is supportive of any effort to raise the standard of care for the PPE or DOT exam.

Sincerely,

A handwritten signature in cursive script that reads "Maryella E. Jansen".

Maryella E. Jansen
Executive Director, Washington State Medical Commission

August 16, 2013

Department of Health
Sherry Thomas, Sunrise Review Coordinator, and Sunrise Panel
P. O. Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas and Sunrise Panel:

I am writing in support of the Washington State Chiropractic Association's application for clarification of the chiropractic scope of practice relative to pre-participation (PPE) and Department of Transportation "Fit for Duty" (DOT) physical examinations. I appreciate the time and attention the panel has dedicated to deliberation of this matter.

As the former Chief of Staff for Clinical Services and Dean of Chiropractic Clinical Education at New York Chiropractic College and the current Vice President of Clinic Affairs at the University of Western States, as well as a Councilor and Executive Committee member of the Council on Chiropractic Education, I attest to the competence of graduates of doctor of chiropractic programs in the domains of patient assessment and diagnosis required to perform the screening examinations in question. Ample testimony and documentation have been provided to the panel to substantiate that chiropractic physicians in the State of Washington, by virtue of training and licensure, are competent to perform PPE and DOT examinations.

As a chiropractor, I am disturbed and offended by written and oral comments provided by opponents of the WSCA's application that have attempted to engender concern and fear about potential negative outcomes associated with chiropractic physicians providing PPE and DOT examinations. Ironically, the negative outcomes cited in support of that position were associated with medical physicians' provision of screening examinations. To my knowledge, there is no evidence of increased risk associated with chiropractic physicians' provision of these examinations in the numerous jurisdictions they are engaged in performing them.

As a resident of the State of Washington and parent of two children in the Camas school district, I am confident in the ability of duly licensed chiropractic physicians to perform these examinations competently and safely. I support the proposed clarification of scope of practice for chiropractic physicians in Washington to include the provision of PPE and DOT physical examinations.

Thank you for your thoughtful consideration of this issue.

Sincerely,



Joseph E. Pfeifer, D.C.



INHEALTH, PLLC

CHIROPRACTIC - ACUPUNCTURE - MASSAGE THERAPY

www.InHealthSeattle.com

Department of Health
Sherry Thomas, Sunrise Review Coordinator
PO Box 47850
Olympia, WA 98504-7850

August 14, 2013

Dear Ms. Thomas and Sunrise Panel:

I would like to personally thank you for considering Sunrise Bill 1573, which relates to Chiropractors performing Sports Physicals and DOT Physicals. I believe this is a step in the right direction and will provide Washingtonians greater and more affordable access to these services by Chiropractors. As was reviewed in the 8/6/13 Sunrise hearing, Chiropractors have extensive education in differential diagnosis, pathology, physical, orthopedic and neurological examination and are well equipped to provide a more than competent examination to these patient populations. I agree that the additional training as was laid out in this Sunrise Bill, of DABCSP and Certified Medical Examiner is an important component to this bill and will ensure the highest standards are required for those who are granted the privilege of offering these examinations.

I am currently working towards my DABCSP and have achieved the initial step in this process by earning my CCSP (the first 100 hours of the 300 hour diplomate) and hope to have the opportunity of providing these services once I have earned this additional level of board certification. It is important to note that this certification adds to the previous training that has equipped myself, and all other Chiropractors with the skills to perform a physical exam, auscultate the heart, evaluate for a concussion, perform an orthopedic and neurological, and musculoskeletal examination. These skills have been validated in the Chiropractic training we received (as described in the testimony) and competency validated by the National Board of Chiropractic Examiners. For me, this training is in addition to my undergraduate training as an Exercise Science major, where cardiovascular assessment was a significant component of the curriculum. I perform auscultation of the heart, and the above-mentioned exams, on a daily basis in my clinic and routinely refer out to other healthcare providers when I detect abnormalities.

This bill is important to me, as I have a practice that focuses on sports injuries. Therefore, I work with dozens of youth athletes. Having the ability to perform a pre-participation sports physical will allow more convenience to the parents of the athletes I work with, because they are already seeing me for musculoskeletal (MSK) related injuries. More importantly, I can monitor their overall health more closely, as I often have the opportunity of interacting them on a more frequent basis than

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their primary care provider. I work closely with several Medical Doctors at Children's hospital, the University of Washington Medical Services, and several private practice Medical Doctors and frequently refer patients to these Physicians for evaluation of symptoms that are out of my scope of practice. It is not infrequent for a patient to bring up other health concerns when I am focusing on their MSK health and I believe that this will allow patients the opportunity to have greater opportunity to monitor their health. I would like to emphasize that this is not a substitute for these athlete's normal follow up with their primary care Medical Doctor, but rather one more opportunity for oversight of their health.

I am very troubled by the tactics used by the groups opposing this bill. There are several well-documented instances where inaccurate and misleading information has been shared to the public as "fact" to misrepresent the education and skill level of Chiropractors. This is a coordinated effort by representatives of the Washington State Medical Association, Washington State Athletic Trainers Association, and the Director of the Nick of Time Foundation to knowingly distribute inaccurate information to discredit the Chiropractic profession and limit the scope of practice of Doctors of Chiropractic for a procedure they are qualified to perform and do so daily, and competently, in their private practices. Please see the attached email correspondence for examples of these coercive tactics, one specifically by Ms. Varrenti of the Nick of Time Foundation. This instance dates back to February 2013, but she used the same inaccurate information (after she was already corrected and acknowledged her actions) on 8/6/13 during her testimony to the legislature. This type of behavior is similar to methods used by the AMA prior to the Wilk v. the AMA decision in the 1980's, where the AMA was found guilty of knowingly spreading misleading and inaccurate information about the Chiropractic profession in attempt to negatively impact the scope and growth of this profession. The type of behavior we have seen by the groups opposing this bill harkens back to the pre-Wilk days and non-passage of this bill enables the opposition's behavior and efforts to use false information to defame the Chiropractic profession. I do want to point out that this is a very small percentage of the above named organization's members; in general, Chiropractors have very positive and productive working relationships with the Medical Doctors, Nurses, and other professionals mentioned above and we hope that these positive relationships continue in an effort to best serve our patients.

As a background on my experience, I have served as a volunteer clinician at the US Olympic Training Center in Colorado Springs, a traveling member of the Sports Medicine programs for USA Ice Hockey and USA Swimming, and a professional running (Brooks Beast Professional Track and Field Team) and cycling team

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(Garmin-Cervelo Professional Cycling Team). A career highlight was being a part of the 2012 US Olympic Swim Team Staff as a healthcare provider. All of these experiences have given me incredible opportunity to work in a multi-disciplinary environment and take care of many of the most successful athletes in the world in collaboration with Medical Doctors, Nurse Practitioners, Physician Assistants, Athletic Trainers, Physical Therapists, and Massage Therapists. As part of my training for these opportunities, I have consistently demonstrated competency in providing a level of examination that exceeds the skills required or complexity of exam that is performed in a pre-participation sport physical and believe that it is warranted, for those with a similar level of certification and experience to perform the services mentioned in this bill.

Thank you again for your consideration of Sunrise bill 1573 and please feel free to contact me if I can ever help provide clarification on the education or skills possessed by a licensed Doctor of Chiropractic.

Best Regards,

Kevin Rindal, DC, CSCS, CCSP

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206-315-7998

Darla Varrenti <darla@nickoftimefoundation.org>
To: Kevin Rindal
RE: HB 1573

February 20, 2013 2:29 PM

Kevin-

Point taken...

We have amazing doctors of all specialties who volunteer and help us screen young hearts at least once a month. I invite you to stop by and check out our program, I think it would also help you understand where my heart lies.

Our Puget Sound area screening schedule for 2012/2013 is published on our website at:

www.nickoftimefoundation.org/programs/screenings

We also have a short video that gives you a good idea of what our program looks like: <http://www.youtube.com/watch?v=ytr5l0xyBhk>

Darla

From: Kevin Rindal [mailto:krindal@mac.com]
Sent: Wednesday, February 20, 2013 2:02 PM
To: Darla Varrenti
Cc: 'Lori Grassi'; 'Jonathan Drezner'; 'Nichols Lorri'; 'Butters David'
Subject: Re: HB 1573

Darla, thank you for your email....it appears that you have taken this statement out of context. If you complete the sentence it says on **par with a Cardiologist**. Please confirm with me that the expectation of ND's, PA's, and ARNP's is that their auscultatory skills are on par with those of a Cardiologist. If we take your comments in context, then only Cardiologists would be licensed to perform PPE's. Thank goodness we have Cardiologists who are experts in this area and they are able to take referrals from those of us who are competent in identifying abnormal findings on an exam and have good working relationships with these specialists; all of which happens on a regular basis at my office. I have a lot of respect for the Nick of Time Foundation and what you have done to help protect youth athletes. I hope to have the opportunity to meet you at some point. Keep up the good work.

Best Regards,

Kevin Rindal, DC, CSCS, CCSP
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On Feb 20, 2013, at 1:40 PM, Darla Varrenti wrote:

Lori-

Thank you for including me on the string of information but frankly I see nothing in your list of requirements that would make me change my mind about Chiropractors being qualified to sign off on a young athletes PPE.

Our foundation is pushing for stricter guidelines and a more in-depth look at the heart for future PPE's and the idea that "all 104 DCs that are certified in Washington State may not be able to auscultate a heart"

seems to not be an issue with your group, is troubling. Listening is not enough, at the very least an EKG needs to be performed to also take a picture of the heart.

I am in agreement with Dr. Drezner that a good chiropractor is a useful partner in a complete program of care but sports physicals are not something that should be done by anyone other than a licensed physician.

There will always be those families who will seek out the care of a chiropractor for a variety of things, but we hope by educating the public about how important heart health is for our young people they will think twice about getting a less than through PPE or sports evaluation.

As you stated, we all probably won't ever agree on the scope of HB 1573 and I hope your "fishing" expedition has shown there are quite a few interested parties who oppose this bill.

I believe they will also work to make sure enough questions are raised to ensure it doesn't get passed out of committee.

In a perfect world everyone would work together, in each of their specific fields, to make sure our young people are healthy and perfectly safe to play the sport they love.

Darla

Darla Varrenti
Executive Director
Nick of Time Foundation
Office 206-457-5270
Fax 206-457-5275
www.nickoftimefoundation.org

"One person can have a profound effect on another. And two people...well, two people can work miracles. They can change a whole town. They can change the world."

<image009.png> <image010.png> <image011.png> <image012.png>

From: Lori Grassi [mailto:L.Grassi@ChiroHealth.org]
Sent: Wednesday, February 20, 2013 12:42 PM
To: Jonathan Drezner
Cc: Darla Varrenti; krindal@mac.com; Nichols Lorri; Butters David
Subject: RE: HB 1573

Dr. Drezner,

We are likely not going to come to agreement or full understanding regarding this issue over email. I would like to discuss this with you further or arrange for a time for Dr. Kevin Rindal, CCSP to speak with you in person. We do respect the extent of your knowledge and contribution to AED and sudden cardiac death; much of your research is covered in the CCSP and DACBSP program. Ultimately we would like to develop a positive relationship with you and open communication.

I wanted to give you a little more background regarding the education of Chiropractors as I believe it is critical that you understand that it is more than "basic anatomy physiology and 3 hours of cardiovascular diagnosis." Chiropractors take the following courses as part of the standard DC curriculum, each of these courses are 3-6 credit hours: Gross Anatomy I/II, Spinal Anatomy I/II, CNS I/II, PNS I/II, Embryology I/II, Neurophysiology I/II, Cell Biology, Microbiology I/II, Histology, Dermatology/Infectious Disease, Physiology I/II, Renal Physiology, Biochemistry I/II, Pathology I/II, Diagnosis I/II, Public Health/Infectious Disease, Physical Exam, Orthopedic Exam, Neurological Exam. Competency in performing a Physical exam is tested in clinic, in lab, and in National Boards. Also, many of these courses (i.e. Gross Anatomy, Embryology, Neurophysiology, Physiology, Pathology, Diagnosis, and Public Health) cover Cardiopulmonary function and analysis, disease/congenital defect identification, risk factors and prevalence of congenital heart disease in the general/athletic population, and education regarding when it is appropriate to refer to a Cardiopulmonary specialist.

CCSP/DACBSP practitioners have built on this foundation, and while all 104 DCs that are certified in Washington State may not be able to auscultate a heart and provide a diagnosis on par with a Cardiologist; they definitely are more than competent in identifying abnormalities and referring to the appropriate health care provider for further workup.

I know you are very busy, but I would like to hear your opinion regarding the educational background of PA's, ANRP's, and ND's relative to what is described above and why this does not "threaten the working relationship between you and them." Also, please provide me evidence that these three professions have received more education on this subject than DC's.

I spoke with Dr. Rindal to find out his experience with performing Cardio exams at his office. Here is his response "I perform heart auscultation at the 5 points in the heart (i.e. Aortic, Tricuspid, Pulmonic, Mitral, and Erb's point; sometimes using valsalva's maneuver if I hear an abnormality), Blood pressure (usually seated, occasionally seated and supine if warranted), and auscultation of the carotid arteries on about 60% of my new patients (anyone with neck, upper back, chest, thorax, lower back, and/or headache symptoms). I usually do not perform these exams on someone who comes in with a sprained ankle or shoulder, for instance, when a full workup is not needed. I also take height and weight. Our intake form asks about cardiovascular history and family history; if there is any history that would warrant further investigation, I do this verbally. I have a strong

working relationship with several Cardiologists, Neurologists, Neurosurgeons, Family Practice, and Orthopedic Physicians. I refer to these professionals on a regular basis and receive referrals from them."

Dr. Drezner, please take this email as an opportunity to be better acquainted with what Chiropractors do and their level of training. We hope that this dialogue leads to better multi-disciplinary communication and care for Washington State citizens and youth athletes.

Best Regards,
Lori

Lori L. (Bielinski) Grassi
Executive Director and Lobbyist
Washington State Chiropractic Association
21400 Int'l Blvd. Ste. 207
SeaTac, WA 98198
206-878-6055
206-878-6055(p)
206-878-8699(f)
253-988-0500(c)

From: Jonathan Drezner [mailto:drezner@fammed.washington.edu]
Sent: Wednesday, February 20, 2013 12:05 AM
To: Lori Grassi
Cc: Darla Varrenti; krindal@mac.com; Nichols Lorri; Butters David
Subject: Re: HB 1573

Lori,
High school and undergraduate students take classes in anatomy and physiology. They cannot do medical evaluations.

I see General Physical Diagnosis is provided 12 credit hours and Cardiovascular Diagnosis a full 3 credit hours. Are you implying that after some basic anatomy and physiology, 3 hours of cardiovascular diagnosis training allows one to properly evaluate the heart and understand pathologic cardiac conditions? I really just don't understand the logic here -- the training deficiency is so glaring. To reverse this example, maybe if I take a 3 hour course on spine manipulation I will be competent in it?

You state that chiropractic students spend thousands of hours on physical exam and diagnosis. How much is actually spent focused on the heart? I'd like to hear more about the "cardio-pulmonary exams on a daily basis" that chiropractors perform. Do they listen to heart sounds? In what positions? Use a stethoscope? Check blood pressure? Femoral pulses? Ask about cardiovascular symptoms? Family history? Assess and counsel regarding cardiovascular risk factors? And in what age groups?

And the PPE is so much more than just the heart. An additional training course as you propose will not be sufficient to adequately and competently conduct a medical PPE.

As I mentioned before, my chiropractor colleagues are valuable members of my healthcare team in the treatment of athletes and patients. In the shared management of any patient and the utilization of any healthcare professional, confidence in someone's scope of practice is essential so that providers do well what they are trained to do, and know what they don't know. In my opinion, this proposal questions the credibility of the chiropractic community by claiming competence and expertise in areas that are not justified, and this threatens the foundation of working relationships between healthcare professionals. I hope you have considered the potential negative ramifications from the primary care and sports medicine community if such a bill is passed.

Sincerely,

Jonathan Drezner, MD
Professor, Department of Family Medicine
President, American Medical Society for Sports Medicine
Team Physician, Seattle Seahawks & UW Huskies
University of Washington, Box 354410
Seattle, WA 98195

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"Lori Grassi" <LGrassi@ChiroHealth.org> writes:

Dr. Drezner,

Thank you for your time last week to discuss HB1573. I would like to give you a little background on the education a Chiropractor receives:

After completing four years of undergraduate studies in the physical and biological sciences at a college or university, chiropractic students complete an additional 4600 hours of lecture, lab and clinical studies at an accredited Chiropractic College or University over an additional four year period. This course of study includes 500 hours of anatomy, 400 hours of physiology, 1500 hours of diagnosis and 2000 of clinic, wherein the skills acquired during lecture are put to clinical application under the supervision of a licensed, practicing physician with both student patients and patients from the surrounding communities.

With specific regard to cardiovascular and neurological examination, chiropractic education includes all the basic anatomy, physiology and embryology necessary to understand the mechanism of these systems. In addition there are specific classes in diagnosis of all body systems, including heart and brain. General Physical Diagnosis begins with 12 credit hours. There is an additional 17 credit hours for Neuromusculoskeletal diagnosis (including brain and spinal cord) and 3 credit hours specific to Cardiovascular Diagnosis. During the 2000 hours of clinic, students are required to complete a thorough patient history and complete physical examination on all clinic patients, under the supervision of a Supervising Chiropractic Physician. From that examination a working diagnosis is prepared and a treatment plan developed. Those patients who present with a condition that requires medical intervention are referred to the appropriate provider.

While Chiropractors receive the education that allows them to be able to perform PPE exams competently and they perform neuro-musculoskeletal and cardio-pulmonary exams on a daily basis in their offices, we acknowledge that not all Chiropractors have maintained the level of competency to perform PPE's at the level they should be performed. This is why we are including in this bill that ONLY Chiropractors who have received additional training that specifically educates and tests competency in performing PPE's may perform these exams.

Ultimately, we believe that passage of this bill will benefit all youth athletes in Washington State. Many youth athletes see their Chiropractor for MSK injuries several times a year. Allowing Chiropractors, with additional specific sports training, to perform PPE's will provide the opportunity for these Chiropractors to become better acquainted with the overall health of the youth athletes they see and provide greater oversight than a Physician who only sees a healthcare provider one time for a sports physical with no follow up. A major component of the CCSP/DACBSP post-Doctorate certification is also determining abnormal findings and referring out to the appropriate specialist for additional testing. We believe that Chiropractors with this additional training are not only competent at performing PPE's but also well equipped to identify pathology and refer out to the appropriate specialist, but will also be able to perform a higher level of healthcare management to youth athletes who choose to see Chiropractors for athletic injuries.

Thank you again for your time and discussion and for reference I have copied the three chiropractors who are working on this issue for our profession.

Sincerely,

Lori L. Grassi
Executive Director & Lobbyist
Washington State Chiropractic Association
206-878-6055 office
253-988-0500 cell
Lgrassi@chirohealth.org

On Feb 18, 2013, at 11:10 PM, "Jonathan Drezner" <jdrezner@fammed.washington.edu> wrote:

Lori,

Thanks again for speaking with us. As I mentioned, I am highly skeptical that a chiropractor is competent to conduct a heart screen or a medical pre-participation evaluation in a young athlete. This concept to me is both illogical and dangerous. I'd be happy to discuss further or provide a sports medicine perspective if that will help guide your organization in its role with young athletes.

Thanks,
Jon

Jonathan Drezner, MD
Professor, Department of Family Medicine
President, American Medical Society for Sports Medicine
Team Physician, Seattle Seahawks & UW Huskies
University of Washington, Box 354410
Seattle, WA 98195

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Darla Varrenti <darla@nickoftimefoundation.org> writes:

Hi-

Thanks for talking with us this morning.

I look forward to hearing more.

I have also cc'd Dr. Drezner on this email.

Darla Varrenti
Executive Director
Nick of Time Foundation
o- 206-457-5270
www.nickoftimefoundation.org

(Sent from my iPhone, so please excuse the sometimes infamous auto-correct)

On Feb 15, 2013, at 6:39 AM, "Lori Grassi" <LGrassi@ChiroHealth.org> wrote:

Hi Darla,

My cell is in my email, 253-988-0500. However, I am only able to answer when I am not testifying in a hearing or in a meeting. I have a conference call this morning at 9 and can call you after that... does that work for you?

Thanks, Lori

&n bsp;

Lori L. Grassi

Executive Director

Washington State Chiropractic Association

21400 International Boulevard, Suite 207

SeaTac, WA 98198

206-878-6055 (office)

206-878-8699 (fax)

253-988-0500 (cell)

From: Darla Varrenti [<mailto:darla@nickofthefoundation.org>]

Sent: Thursday, February 14, 2013 4:56 PM

To: Lori Grassi

Subject: RE: HB 1573

I believe the number we have is your office.

If you could give a date and time you would be available?

We can try to connect by phone.

From: Lori Grassi [<mailto:L.Grassi@ChiroHealth.org>]

Sent: Thursday, February 14, 2013 11:18 AM

To: Darla Varrenti

Cc: lgrassi@chirohealth.org

Subject: Re: HB 1573

Hi Darla,

I have not received any calls from your organization! Are you calling my office?

I work in Olympia daily so I can be available for an appointment.

Thanks, Lori

Lori L. (Bielinski) Grassi

Executive Director and Lobbyist

WA State Chiropractic Assoc.

253-988-0500

LGrassi@chirohealth.org

On Feb 14, 2013, at 11:01 AM, "Darla Varrenti" <darla@nickoftimefoundation.org> wrote:

Lori-

I received your contact information through our contacts at the Firefig hters union.

We have tried to reach you by phone concerning our opposition to this bill.

If you would like to speck to someone from our organization could you please let me know a good time to reach you?

Thanks

Darla Varrenti

Executive Director

Nick of Time Foundation

Office 206-457-5270

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www.nickoftimefoundation.org

"One person can have a profound effect on another. And two people...well, two people can work miracles. They can change a whole town. They can change the world."

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Appendix F

Preparticipation Physical Evaluation Form

*Recommended by Washington
Interscholastic Activities Association (WIAA)*

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height _____	Weight _____	☐ Male ☐ Female	
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

Appendix G

Medical Examination Report For Commercial Driver Fitness Determination

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION

Driver completes this section

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam
Address	City, State, Zip Code	Work Tel: () Home Tel: ()	Driver License No.	License Class ☐ A ☐ C ☐ B ☐ D ☐ Other		State of Issue

2. HEALTH HISTORY

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes No	Yes No	Yes No
☐ ☐ Any illness or injury in the last 5 years?	☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis	☐ ☐ Fainting, dizziness
☐ ☐ Head/Brain injuries, disorders or illnesses	☐ ☐ Kidney disease, dialysis	☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐ ☐ Seizures, epilepsy ☐ medication _____	☐ ☐ Liver disease	
☐ ☐ Eye disorders or impaired vision (except corrective lenses)	☐ ☐ Digestive problems	☐ ☐ Stroke or paralysis
☐ ☐ Ear disorders, loss of hearing or balance	☐ ☐ Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin	☐ ☐ Missing or impaired hand, arm, foot, leg, finger, toe
☐ ☐ Heart disease or heart attack; other cardiovascular condition ☐ medication _____	☐ ☐ Nervous or psychiatric disorders, e.g., severe depression ☐ medication _____	☐ ☐ Spinal injury or disease
☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker) ☐ medication _____	☐ ☐ Loss of, or altered consciousness	☐ ☐ Chronic low back pain
☐ ☐ High blood pressure		☐ ☐ Regular, frequent alcohol use
☐ ☐ Muscular disease		☐ ☐ Narcotic or habit forming drug use
☐ ☐ Shortness of breath		

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature _____ Date _____

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

3.

VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. ***Monocular drivers are not qualified.***

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye ☐
Left Eye	20/	20/	Left Eye ☐
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors ?

☐ Yes
 ☐ No

Applicant meets visual acuity requirement only when wearing:

☐ Corrective Lenses

Monocular Vision:

☐ Yes

☐ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination

Name of Ophthalmologist or Optometrist (print)

Tel. No.

License No./ State of Issue

Signature

4.

HEARING

Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB
☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.

Right ear

\ Feet

Left Ear

\ Feet

b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951)

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

5.

BLOOD PRESSURE/ PULSE RATE

Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure

Systolic

Diastolic

Driver qualified if ≤140/90.

Pulse Rate:

☐ Regular

☐ Irregular

Record Pulse Rate: _____

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤140/90
≥180/110	Stage 3	6 months from date of exam if ≤140/90	6 months if ≤ 140/90

6.

LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
----------------	---------	---------	-------	-------

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.
 Other Testing (Describe and record) _____

7. PHYSICAL EXAMINATION

Height: _____ (in.) Weight: _____ (lbs.)

Name: Last,

First,

Middle,

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See *Instructions to the Medical Examiner* for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.			7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.			8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.			9. Genito-urinary System	Hernias.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.			10. Extremities- Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger, Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.			11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest.			12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		

***COMMENTS:** _____

Note certification status here. See *Instructions to the Medical Examiner* for guidance.

- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
☐ Does not meet standards
☐ Meets standards, but periodic monitoring required due to _____
 Driver qualified only for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other

Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on _____

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- ☐ Wearing corrective lense
☐ Wearing hearing aid
☐ Accompanied by a _____ waiver/ exemption. Driver must present exemption at time of certification.
☐ Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (See 49 CFR 391.62)
☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's signature _____

Medical Examiner's name _____

Address _____

Telephone Number _____

If meets standards, complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

49 CFR 391.41 Physical Qualifications for Drivers

THE DRIVER'S ROLE

Responsibilities, work schedules, physical and emotional demands, and lifestyles among commercial drivers vary by the type of driving that they do. Some of the main types of drivers include the following: turn around or short relay (drivers return to their home base each evening); long relay (drivers drive 9-11 hours and then have at least a 10-hour off-duty period), straight through haul (cross country drivers); and team drivers (drivers share the driving by alternating their 5-hour driving periods and 5-hour rest periods.)

The following factors may be involved in a driver's performance of duties: abrupt schedule changes and rotating work schedules, which may result in irregular sleep patterns and a driver beginning a trip in a fatigued condition; long hours; extended time away from family and friends, which may result in lack of social support; tight pickup and delivery schedules, with irregularity in work, rest, and eating patterns, adverse road, weather and traffic conditions, which may cause delays and lead to hurriedly loading or unloading cargo in order to compensate for the lost time; and environmental conditions such as excessive vibration, noise, and extremes in temperature. Transporting passengers or hazardous materials may add to the demands on the commercial driver.

There may be duties in addition to the driving task for which a driver is responsible and needs to be fit. Some of these responsibilities are: coupling and uncoupling trailer(s) from the tractor, loading and unloading trailer(s) (sometimes a driver may lift a heavy load or unload as much as 50,000 lbs. of freight after sitting for a long period of time without any stretching period); inspecting the operating condition of tractor and/or trailer(s) before, during and after delivery of cargo; lifting, installing, and removing heavy tire chains; and, lifting heavy tarpaulins to cover open top trailers. The above tasks demand agility, the ability to bend and stoop, the ability to maintain a crouching position to inspect the underside of the vehicle, frequent entering and exiting of the cab, and the ability to climb ladders on the tractor and/or trailer(s).

In addition, a driver must have the perceptual skills to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas.

§391.41 PHYSICAL QUALIFICATIONS FOR DRIVERS

(a) A person shall not drive a commercial motor vehicle unless he is physically qualified to do so and, except as provided in §391.67, has on his person the original, or a photographic copy, of a medical examiner's certificate that he is physically qualified to drive a commercial motor vehicle.

(b) A person is physically qualified to drive a motor vehicle if that person:

- (1) Has no loss of a foot, a leg, a hand, or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate (formerly Limb Waiver Program) pursuant to §391.49.
- (2) Has no impairment of: (i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or has been granted a SPE Certificate pursuant to §391.49.
- (3) Has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control;
- (4) Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure.
- (5) Has no established medical history or clinical diagnosis

of a respiratory dysfunction likely to interfere with his ability to control and drive a commercial motor vehicle safely.

(6) Has no current clinical diagnosis of high blood pressure likely to interfere with his ability to operate a commercial motor vehicle safely.

(7) Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which interferes with his ability to control and operate a commercial motor vehicle safely.

(8) Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a commercial motor vehicle;

(9) Has no mental, nervous, organic, or functional disease or psychiatric disorder likely to interfere with his ability to drive a commercial motor vehicle safely;

(10) Has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green and amber;

(11) First perceives a forced whispered voice in the better ear not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not

have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz and 2,000 Hz with or without a hearing device when the audiometric device is calibrated to the American National Standard (formerly ASA Standard) Z24.5-1951;

(12)(i) Does not use any drug or substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic, or other habit-forming drug.

(ii) Does not use any non-Schedule I drug or substance that is identified in the other Schedules in 21 part 1308 except when the use is prescribed by a licensed medical practitioner, as defined in § 382.107, who is familiar with the driver's medical history and has advised the driver that the substance will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

(13) Has no current clinical diagnosis of alcoholism.

INSTRUCTIONS TO THE MEDICAL EXAMINER

General Information

The purpose of this examination is to determine a driver's physical qualification to operate a commercial motor vehicle (CMV) in interstate commerce according to the requirements in 49 CFR 391.41-49. Therefore, the medical examiner must be knowledgeable of these requirements and guidelines developed by the FMCSA to assist the medical examiner in making the qualification determination. The medical examiner should be familiar with the driver's responsibilities and work environment and is referred to the section on the form, **The Driver's Role**.

In addition to reviewing the **Health History** section with the driver and conducting the physical examination, the medical examiner should discuss common prescriptions and over-the-counter medications relative to the side effects and hazards of these medications while driving. Educate the driver to read warning labels on all medications. History of certain conditions may be cause for rejection, particularly if required by regulation, or may indicate the need for additional laboratory tests or more stringent examination perhaps by a medical specialist. These decisions are usually made by the medical examiner in light of the driver's job responsibilities, work schedule and potential for the conditions to render the driver unsafe.

Medical conditions should be recorded even if they are not cause for denial, and they should be discussed with the driver to encourage appropriate remedial care. This advice is especially needed when a condition, if neglected, could develop into a serious illness that could affect driving.

If the medical examiner determines that the driver is fit to drive and is also able to perform non-driving responsibilities as may be required, the medical examiner signs the medical certificate which the driver must carry with his/her license. The certificate must be dated. **Under current regulations, the certificate is valid for two years, unless the driver has a medical condition that does not prohibit driving but does require more frequent monitoring.** In such situations, the medical certificate should be issued for a shorter length of time. The physical examination should be done carefully and at least as complete as is indicated by the attached form. Contact the FMCSA at (202) 366-4001 for further information (a vision exemption, qualifying drivers under 49 CFR 391.64, etc.).

Interpretation of Medical Standards

Since the issuance of the regulations for physical qualifications of commercial drivers, the Federal Motor Carrier Safety Administration (FMCSA) has published recommendations called Advisory Criteria to help medical examiners in determining whether a driver meets the physical qualifications for commercial driving. These recommendations have been condensed to provide information to medical examiners that (1) is directly relevant to the physical examination and (2) is not already included in the medical examination form. The specific regulation is printed in italics and its reference by section is highlighted.

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Federal Motor Carrier Safety Regulations -Advisory Criteria-

Loss of Limb:

§391.41(b)(1)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no loss of a foot, leg, hand or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate pursuant to Section 391.49.

Limb Impairment:

§391.41(b)(2)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no impairment of: (i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or (iii) Any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or (iv) Has been granted a Skill Performance Evaluation (SPE) Certificate pursuant to Section 391.49.

A person who suffers loss of a foot, leg, hand or arm or whose limb impairment in any way interferes with the safe performance of normal tasks associated with operating a commercial motor vehicle is subject to the Skill Performance Evaluation Certification Program pursuant to section 391.49, assuming the person is otherwise qualified.

With the advancement of technology, medical aids and equipment modifications have been developed to compensate for certain disabilities. The SPE Certification Program (formerly the Limb Waiver Program) was designed to allow persons with the loss of a foot or limb or with functional impairment to qualify under the Federal Motor Carrier Safety Regulations (FMCSRs) by use of prosthetic devices or equipment modifications which enable them to safely operate a commercial motor vehicle. Since there are no medical aids equivalent to the original body or limb, certain risks are still present, and thus restrictions may be included on individual SPE certificates when a State Director for the FMCSA determines they are necessary to be consistent with safety and public interest.

If the driver is found otherwise medically qualified (391.41(b)(3) through (13)), the medical examiner must check on the medical certificate that the driver is qualified only if accompanied by a SPE certificate. The driver and the employing motor carrier are subject to appropriate penalty if the driver operates a motor vehicle in interstate or foreign commerce without a current SPE certificate for his/her physical disability.

Diabetes

§391.41(b)(3)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control.

Diabetes mellitus is a disease which, on occasion, can result in a loss of consciousness or disorientation in time and space. Individuals who require insulin for control have conditions which can get out of control by the use of too much or too little insulin, or food intake not consistent with the insulin dosage. Incapacitation may occur from symptoms of hyperglycemic or hypoglycemic reactions (drowsiness, semiconsciousness, diabetic coma or insulin shock).

The administration of insulin is, within itself, a complicated process requiring insulin, syringe, needle, alcohol sponge and a sterile technique. Factors related to long-haul commercial motor vehicle operations, such as fatigue, lack of sleep, poor diet, emotional conditions, stress, and concomitant illness, compound the dangers, the FMCSA has consistently held that a diabetic who uses insulin for control does not meet the minimum physical requirements of the FMCSRs.

Hypoglycemic drugs, taken orally, are sometimes prescribed for diabetic individuals to help stimulate natural body production of insulin. If the condition can be controlled by the use of oral medication and diet, then an individual may be qualified under the present rule. CMV drivers who do not meet the Federal diabetes standard may call (703) 448-3094 for an application for a diabetes exemption.

(See Conference Report on Diabetic Disorders and Commercial Drivers and Insulin-Using Commercial Motor Vehicle Drivers at:

<http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Cardiovascular Condition

§391.41(b)(4)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure.

The term "has no current clinical diagnosis of" is specifically designed to encompass: "a clinical diagnosis of" (1) a current cardiovascular condition, or (2) a cardiovascular condition which has not fully stabilized regardless of the time limit. The term "known to be

accompanied by" is designed to include a clinical diagnosis of a cardiovascular disease (1) which is accompanied by symptoms of syncope, dyspnea, collapse or congestive cardiac failure; and/or (2) which is likely to cause syncope, dyspnea, collapse or congestive cardiac failure.

It is the intent of the FMCSRs to render unqualified, a driver who has a current cardiovascular disease which is accompanied by and/or likely to cause symptoms of syncope, dyspnea, collapse, or congestive cardiac failure. However, the subjective decision of whether the nature and severity of an individual's condition will likely cause symptoms of cardiovascular insufficiency is on an individual basis and qualification rests with the medical examiner and the motor carrier. In those cases where there is an occurrence of cardiovascular insufficiency (myocardial infarction, thrombosis, etc.), it is suggested before a driver is certified that he or she have a normal resting and stress electrocardiogram (ECG), no residual complications and no physical limitations, and is taking no medication likely to interfere with safe driving.

Coronary artery bypass surgery and pacemaker implantation are remedial procedures and thus, not unqualifying. Implantable cardioverter defibrillators are disqualifying due to risk of syncope. Coumadin is a medical treatment which can improve the health and safety of the driver and should not, by its use, medically disqualify the commercial driver. The emphasis should be on the underlying medical condition(s) which require treatment and the general health of the driver. The FMCSA should be contacted at (202) 366-4001 for additional recommendations regarding the physical qualification of drivers on coumadin. (See Cardiovascular Advisory Panel Guidelines for the Medical examination of Commercial Motor Vehicle Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Respiratory Dysfunction

§391.41(b)(5)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with ability to control and drive a commercial motor vehicle safely.

Since a driver must be alert at all times, any change in his or her mental state is in direct conflict with highway safety. Even the slightest impairment in respiratory function under emergency conditions (when greater oxygen supply is necessary for performance) may be detrimental to safe driving.

There are many conditions that interfere with oxygen exchange and may result in incapacitation, including emphysema, chronic asthma, carcinoma, tuberculosis, chronic bronchitis and sleep apnea. If the medical examiner detects a respiratory dysfunction, that in any way is likely to interfere with the driver's ability to safely control and drive a commercial motor vehicle, the driver must be referred to a specialist for further evaluation and therapy. Anticoagulation therapy for deep vein thrombosis and/or pulmonary thromboembolism is not unqualifying once optimum dose is achieved, provided lower extremity venous examinations remain normal and the treating physician gives a favorable recommendation.

(See Conference on Pulmonary/Respiratory Disorders and Commercial Drivers at:

<http://www.fmcsa.dot.gov/rulesregs/medreports.htm>

Hypertension

§391.41(b)(6)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no current clinical diagnosis of high blood pressure likely to interfere with ability to operate a commercial motor vehicle safely.

Hypertension alone is unlikely to cause sudden collapse; however, the likelihood increases when target organ damage, particularly cerebral vascular disease, is present. This regulatory criteria is based on FMCSA's Cardiovascular Advisory Guidelines for the Examination of CMV Drivers, which used the Sixth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1997).

Stage 1 hypertension corresponds to a systolic BP of 140-159 mmHg and/or a diastolic BP of 90-99 mmHg. The driver with a BP in this range is at low risk for hypertension-related acute incapacitation and may be medically certified to drive for a one-year period. Certification examinations should be done annually thereafter and should be at or less than 140/90. If less than 160/100, certification may be extended one time for 3 months.

A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension, and the driver is not necessarily unqualified during evaluation and institution of treatment. The driver is given a one time certification of three months to reduce his or her blood pressure to less than or equal to 140/90. A blood pressure in this range is an absolute indication for anti-hypertensive drug therapy. Provided treatment is well tolerated and the driver demonstrates a BP value of 140/90 or less, he or she may be certified for one year from date of the initial exam. The driver is certified annually thereafter.

A blood pressure at or greater than 180 (systolic) and 110 (diastolic) is considered Stage 3, high risk for an acute BP-related event. The driver may not be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may be certified for 6 months and biannually (every 6 months) thereafter if at recheck BP is 140/90 or less.

Annual recertification is recommended if the medical examiner does not know the severity of hypertension prior to treatment.

An elevated blood pressure finding should be confirmed by at least two subsequent measurements on different days.

Treatment includes nonpharmacologic and pharmacologic modalities as well as counseling to reduce other risk factors. Most antihypertensive medications also have side effects, the importance of which must be judged on an individual basis. Individuals must be alerted to the hazards of these medications while driving. Side effects of somnolence or syncope are particularly undesirable in commercial drivers.

Secondary hypertension is based on the above stages. Evaluation is warranted if patient is persistently hypertensive

on maximal or near-maximal doses of 2-3 pharmacologic agents. Some causes of secondary hypertension may be amenable to surgical intervention or specific pharmacologic disease.

(See Cardiovascular Advisory Panel Guidelines for the Medical Examination of Commercial Motor Vehicle Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Rheumatic, Arthritic, Orthopedic, Muscular, Neuromuscular or Vascular Disease §391.41(b)(7)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease which interferes with the ability to control and operate a commercial motor vehicle safely.

Certain diseases are known to have acute episodes of transient muscle weakness, poor muscular coordination (ataxia), abnormal sensations (paresthesia), decreased muscular tone (hypotonia), visual disturbances and pain which may be suddenly incapacitating. With each recurring episode, these symptoms may become more pronounced and remain for longer periods of time. Other diseases have more insidious onsets and display symptoms of muscle wasting (atrophy), swelling and paresthesia which may not suddenly incapacitate a person but may restrict his/her movements and eventually interfere with the ability to safely operate a motor vehicle. In many instances these diseases are degenerative in nature or may result in deterioration of the involved area.

Once the individual has been diagnosed as having a rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease, then he/she has an established history of that disease. The physician, when examining an individual, should consider the following: (1) the nature and severity of the individual's condition (such as sensory loss or loss of strength); (2) the degree of limitation present (such as range of motion); (3) the likelihood of progressive limitation (not always present initially but may manifest itself over time); and (4) the likelihood of sudden incapacitation. If severe functional impairment exists, the driver does not qualify. In cases where more frequent monitoring is required, a certificate for a shorter period of time may be issued. (See Conference on Neurological Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Epilepsy

§391.41(b)(8)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle.

Epilepsy is a chronic functional disease characterized by seizures or episodes that occur without warning, resulting in loss of voluntary control which may lead to loss of consciousness and/or seizures. Therefore, the following drivers cannot be qualified: (1) a driver who has a medical history of epilepsy; (2) a driver who has a current clinical diagnosis of epilepsy; or (3) a driver who is taking antiseizure medication.

If an individual has had a sudden episode of a nonepileptic seizure or loss of consciousness of unknown cause which did not require antiseizure medication, the decision as to whether that person's condition will likely cause loss of consciousness or loss of ability to control a motor vehicle is made on an individual basis by the medical examiner in consultation with the treating physician. Before certification is considered, it is suggested that a 6 month waiting period elapse from the time of the episode. Following the waiting period, it is suggested that the individual have a complete neurological examination. If the results of the examination are negative and antiseizure medication is not required, then the driver may be qualified.

In those individual cases where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (e.g., drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking antiseizure medication.

Drivers with a history of epilepsy/seizures off antiseizure medication **and** seizure-free for 10 years may be qualified to drive a CMV in interstate commerce. Interstate drivers with a history of a single unprovoked seizure may be qualified to drive a CMV in interstate commerce if seizure-free **and** off antiseizure medication for a 5-year period or more.

(See Conference on Neurological Disorders and Commercial Drivers at:

<http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Mental Disorders

§391.41(b)(9)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with ability to drive a motor vehicle safely.

Emotional or adjustment problems contribute directly to an individual's level of memory, reasoning, attention, and judgment. These problems often underlie physical disorders. A variety of functional disorders can cause drowsiness, dizziness, confusion, weakness or paralysis that may lead to incoordination, inattention, loss of functional control and susceptibility to accidents while driving. Physical fatigue, headache, impaired coordination, recurring physical ailments and chronic "nagging" pain may be present to such a degree that certification for commercial driving is inadvisable. Somatic and psychosomatic complaints should be thoroughly examined when determining an individual's overall fitness to drive. Disorders of a periodically incapacitating nature, even in the early stages of development, may warrant disqualification.

Many bus and truck drivers have documented that "nervous trouble" related to neurotic, personality, or emotional or adjustment problems is responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to appreciate, evaluate and adequately respond to environmental strain and emotional stress is critical when assessing an individual's mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.

When examining the driver, it should be kept in mind that individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, instinctive, impulsive, openly aggressive, paranoid or severely depressed behavior greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications in the overall qualification determination. See Psychiatric Conference Report for specific recommendations on the use of medications and potential hazards for driving.

(See Conference on Psychiatric Disorders and Commercial Drivers at:

<http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Vision

§391.41(b)(10)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has distant visual acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

The term "ability to recognize the colors of" is interpreted to mean if a person can recognize and distinguish among traffic control signals and devices showing standard red, green and amber, he or she meets the minimum standard, even though he or she may have some type of color perception deficiency. If certain color perception tests are administered, (such as Ishihara, Pseudoisochromatic, Yarn) and doubtful findings are discovered, a controlled test using signal red, green and amber may be employed to determine the driver's ability to recognize these colors.

Contact lenses are permissible if there is sufficient evidence to indicate that the driver has good tolerance and is well adapted to their use. Use of a contact lens in one eye for distance visual acuity and another lens in the other eye for near vision is not acceptable, nor telescopic lenses acceptable for the driving of commercial motor vehicles.

If an individual meets the criteria by the use of glasses or contact lenses, the following statement shall appear on the Medical Examiner's Certificate: "Qualified only if wearing corrective lenses."

CMV drivers who do not meet the Federal vision standard may call (703) 448-3094 for an application for a vision exemption.

(See Visual Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Hearing

§391.41(b)(11)

A person is physically qualified to drive a commercial motor vehicle if that person:

First perceives a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ADA Standard) Z24.5-1951.

Since the prescribed standard under the FMCSRs is the American Standards Association (ANSI), it may be necessary to convert the audiometric results from the ISO standard to the ANSI standard. Instructions are included on the Medical Examination report form.

If an individual meets the criteria by using a hearing aid, the driver must wear that hearing aid and have it in operation at all times while driving. Also, the driver must be in possession of a spare power source for the hearing aid.

For the whispered voice test, the individual should be stationed at least 5 feet from the examiner with the ear being tested turned toward the examiner. The other ear is covered. Using the breath which remains after a normal expiration, the examiner whispers words or random numbers such as 66, 18,

23, etc. The examiner should not use only sibilants (s sounding materials). The opposite ear should be tested in the same manner. If the individual fails the whispered voice test, the audiometric test should be administered.

If an individual meets the criteria by the use of a hearing aid, the following statement must appear on the Medical Examiner's Certificate "Qualified only when wearing a hearing aid." (See Hearing Disorders and Commercial Motor Vehicle Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Drug Use

§391.41(b)(12)

A person is physically qualified to drive a commercial motor vehicle if that person does not use any drug or substance identified in 21 CFR 1308.11, an amphetamine, a narcotic, or other habit-forming drug. A driver may use a non-Schedule I drug or substance that is identified in the other Schedules in 21 part 1308 if the substance or drug is prescribed by a licensed medical practitioner who: (A) is familiar with the driver's medical history, and assigned duties; and (B) has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

This exception does not apply to methadone. The intent of the medical certification process is

to medically evaluate a driver to ensure that the driver has no medical condition which interferes with the safe performance of driving tasks on a public road. If a driver uses an amphetamine, a narcotic or any other habit-forming drug, it may be cause for the driver to be found medically unqualified. If a driver uses a Schedule I drug or substance, it will be cause for the driver to be found medically unqualified. Motor carriers are encouraged to obtain a practitioner's written statement about the effects on transportation safety of the use of a particular drug.

A test for controlled substances is not required as part of this biennial certification process. The FMCSA or the driver's employer should be contacted directly for information on controlled substances and alcohol testing under Part 382 of the FMCSRs.

The term "uses" is designed to encompass instances of prohibited drug use determined by a physician through established medical means. This may or may not involve body fluid testing. If body fluid testing takes place, positive test results should be confirmed by a second test of greater specificity. The term "habit-forming" is intended to include any drug or medication generally recognized as capable of becoming habitual, and which may impair the user's ability to operate a commercial motor vehicle safely.

The driver is medically unqualified for the duration of the prohibited drug(s) use and until a second examination shows the driver is free

from the prohibited drug(s) use. Recertification may involve a substance abuse evaluation, the successful completion of a drug rehabilitation program, and a negative drug test result. Additionally, given that the certification period is normally two years, the examiner has the option to certify for a period of less than 2 years if this examiner determines more frequent monitoring is required.

(See Conference on Neurological Disorders and Commercial Drivers and Conference on Psychiatric Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/rulesregs/medreports.htm>)

Alcoholism

§391.41(b)(13)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no current clinical diagnosis of alcoholism.

The term "current clinical diagnosis of" is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol-use problem, he or she should be referred to a specialist. After counseling and/or treatment, he or she may be considered for certification.

Appendix H

Rebuttals to Draft Recommendations

Chiropractic Scope of Practice Sunrise Rebuttals to Draft Report

Thank you for the opportunity to respond to the initial findings of the Chiropractic Scope of Practice Sunrise Review. After reading the draft document and the recommendations of the panel I would like to provide the following input:

On Page 7 of the Summary of Information/Background the committee misquotes RCW 18.25.005 which state “As part of a chiropractic differential diagnosis, a chiropractor **SHALL** perform a physical examination. The Draft Document mistakenly substitutes the word “may” for “shall” which is a very significant error. May implies that this level of physical examination is optional while shall indicates that these physical examinations are performed routinely on all patients and are critical in the process of differential diagnosis. Clearly this error reflects and underlying bias and misinformation in the understanding of the education, training and daily practice of the Doctor of Chiropractic.

Based upon the error in language above, It appears that the Department is under the unfortunate and incorrect opinion that that HB1573 would be an expansion of the scope of a Doctor of Chiropractic when in reality it is a clarification of the existing scope. Extensive information was presented on the curriculum of chiropractic colleges and universities that supported the position that Doctors of Chiropractic have the education and training in all components of physical examination as well as the additional training outlined in the DACBSP and CCSP specialties. It is simply incorrect that the education does not exist in the chiropractic programs and that the specialty programs primarily focus are on spinal and extremity manipulation, exercise physiology and sports-specific biomechanics. Is it possible that there is some confusion with other specialty programs such as the CCEP and DACRB which to focus more on spinal and extremity or that the information provided detailing the parameters of the DACBSP and CCSP programs were essentially ignored or dismissed?

PPEs and DOT examinations are indeed Screenings exams; most evident by the fact that these examinations are performed by primary level providers who clearly “screen” for anomalies that would place and student athlete or DOT driver at risk and make appropriate referrals for any anomaly. These doctors do not provide treatment for these conditions that may be discovered during the course of these screening examinations. Similarly for the concern regarding prescriptive authority or focus on pharmacology, doctors of any specialty who perform these examination do not prescribe medication for these individuals.

It is disappointing that, although the supportive evidence presented regarding the curriculum, education and training of a Doctor of Chiropractic clearly demonstrates that these examinations are with the DCs scope of practice, that the Department can come to this conclusion. Doctors of Chiropractic in 48 states are performing these examinations which is of significant benefit to their patients and community. Myself and my colleagues in Washington state would sincerely appreciate a review of the facts and explicit detail presented in this case. If the review is thorough, fair and comprehensive I remain certain that the panel would come to a far different conclusion.

Thank you for your time and consideration.
Dr. Lorri Nichols DC, CCEP



WASHINGTON
STATE
CHIROPRACTIC
ASSOCIATION

November 4, 2013

Sherry Thomas
Sunrise Review Coordinator
Department of Health
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas and Sunrise Panel:

On October 24, 2013 the Washington State Chiropractic Association (WSCA) received the preliminary report from the Sunrise Review Panel in electronic format. While we enjoyed a professional exchange with the panelists at the August 6 hearing we have somehow seen a turn for what feels more as if a bias has worked its way into the process rather than a factual review of the materials submitted in the application as well as additional supporting information in our written rebuttal of August 16, 2013.

The WSCA is formally challenging the preliminary report and the direction that it leads the reader in order to correct material errors of fact and interpretation the panel propagated and in some cases used as a basis for its decision to not support the application.

We also believe that the criteria for a scope of practice modification may not be best suited by the Sunrise criteria since it was really created by the legislature to review the possible creation of a new profession.

Introduction

The WSCA wishes first to express its disappointment with number and significance of inaccuracies in this report. The panel failed to reflect facts and evidence provided in our initial application and in our written rebuttal following the public hearing. This disregard grants legitimacy instead to misinformation, rumor and hearsay. Regardless, this response will once again attempt to bring facts back into focus and not what feels like a strong bias against the chiropractic profession and its education.

Errors of Fact

1. Chiropractic as a licensed profession:

The first of factual errors occurs on page 3 of the Executive Summary, in the first sentence of the section entitled "Background". The report begins stating that "chiropractors have been licensed in Washington since 1975 under chapter 18.25 RCW and chapter 246-808 WAC". This is incorrect.

Chiropractic was established as a licensed profession on January 21, 1919. Chapter 5 of the laws of 1917 (HB 61), in fact, is the first reference to the establishment of chiropractic as a licensed profession in the state of Washington. The Governor initially vetoed the bill in 1917 and the legislature overrode the Governor's veto and the law became effective January 21, 1919. This document is provided under Exhibit A (22 pages). **This is an egregious error by greater than half a century.**

2. Physical examination requirement:

Still in the Background section of the Executive Summary, the report states (emphasis added): "As part of the differential diagnosis a chiropractor may perform a physical examination to determine the appropriateness of chiropractic care or the need for referral to other health care providers."

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This is incorrect. The cited statute actually reads (emphasis added):

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers.

The statute language is consistent with the training and the National Board of Chiropractic Examiners (NBCE) expectations of learning and proof in testing of every Doctor of Chiropractic-which is material. To misstate the statute leaves the impression that chiropractic physicians might not have to do this and that the panel believes this is optional-which is incorrect. The fact that the statutory language indicates the word “shall” and not “may” is critical to the performance of the differential diagnosis.

Performance of a comprehensive examination is expected to be performed on every patient in order to be safe, provide effective care and to determine if co-management is required or to assure that a referral to a specialist is appropriate. It is also a critical component in the scope of practice separating physician level providers from non-physician level providers.

3. Definition of chiropractic

The panel was advised of the legislative issues regarding the definition of chiropractic. They were advised of the process that was in play at the time of the initial legislative hearing. That the panel chose to use this as an opportunity to recommend against the profession is an unfortunate choice and not germane to the criteria for this application. Because it feels that there was little review of the actual application and the materials supporting our case, as well as the rebuttal and supporting materials, the preliminary report is more than disappointing and almost disturbing. In this response, we would like the report to reflect the facts, however.

As stated in the hearing held on August 6, 2013, the proposed bill would have been amended in the House Health Care Committee to address all of the issues necessary to allow for chiropractors to perform pre-participation and Department of Transportation (DOT), Fit for Duty examinations. Legislation for a future bill draft was not drafted for the Sunrise panel because it was premature and might need to reflect other possible recommendations by the panel. These proposed changes will need to be drafted by a lawyer, a legislative sponsor will need to be sought and the legislative Code Reviser will have final review of proposed language in order to be considered in the 2014 legislative session. We recognize that the definition would need to be modified in order to assure that these examinations could be performed by chiropractors and not be challenged in court by entities that have an anti-chiropractic agenda.

4. Prescription authority required

On page 16, under the heading “Definition of the Problem and Why Regulation is Necessary”, the panel states the following: “Chiropractors do not have training in pharmacology, nor do they have prescriptive authority.”

The former is incorrect. Chiropractors do have pharmacology as a part of their core curriculum training. Additionally, chiropractors review all medications (prescription and over the counter, as well as nutritional, herbiceutical or other natural substances) as a part of their basic intake and examination. This information is incorporated into the patient’s file and into the clinical decision making for the determination of treatment, prognosis and the potential of interactions between medications and other substances. This information was shared with the panel in written and oral testimony and in various materials submitted in the initial report usually referenced as

pharmacology or toxicology. Specifically, the information was also provided in Attachment F of the initial report, page 22 (toxicology) which we have copied here (emphasis added):

*Clinical Sciences – physical, clinical and laboratory diagnosis; diagnostic imaging; spinal analysis; orthopedics; biomechanics; neurology; spinal adjustment/manipulation; extremities manipulation; rehabilitation and therapeutic modalities/procedures (active and passive care); **toxicology**; patient management; nutrition; organ systems; special populations; first aid and emergency procedures; wellness and public health; and clinical decision making.*

In an effort to discover if these materials were easily accessible on the internet we searched for course curriculum and course schedules for Palmer College of Chiropractic in Davenport, IA, Logan University in St. Louis, MO, University of Western States in Portland, OR, and Southern California University of Health Sciences, Whittier, CA-all of which reference training in either pharmacology or toxicology, or both, in their online manuals.

The latter is also incorrect. According to the guidelines for DOT exams, the Medical Examiner communicates with the prescribing physician- they do not prescribe or treat. The examiner does not treat the patient under the banner of a DOT or PPE physical examination- they only examine the patient in the context of the DOT examination and protocols. In fact nowhere in the National Registry Core Curriculum is any discussion of prescribing medications by the examiner. Further, nowhere in 49 CFR 391.43 is any reference made to an examiner prescribing anything in the context of the DOT examination. The exam is an investigation, not an opportunity for treatment intervention- the examiner should not be prescribing medications as a part of the DOT physical examination. The manual was provided to the panel in the initial application as Attachment H and references throughout the document that the “medical examiners role is to determine if the condition interferes with the ability of the driver to safely operate a Commercial Motor Vehicle (CMV)”, it mentions nothing about treatment of the patient. Attachment B & C

5. Performing physicals is outside the chiropractic scope:

The panel accepts that the chiropractic scope of practice obligates chiropractic doctors to “perform a physical examination” (page 12 of the preliminary report citing the 18.25.005 (3) RCW) to identify when and why it is appropriate for them to not be the treating provider, yet the report alleges that chiropractic physicians are not qualified to do a physical which would be the mechanism to identify both chiropractic and non-chiropractic related medical conditions. The Panel’s contentions seem to be conflicted. An exam is an exam and chiropractors operating within their scope and in compliance with the mandates therein render BOTH diagnoses that they would treat and those that they would refer. Trying to parse the examination outcomes legitimacy to only those things that a practitioner can treat is simply incorrect. All healing arts, especially those with a differential diagnosis in their scope, have a wider scope of competency than scope of practice. It is required in order that the practitioner retains the ability to diagnose and recognize the need for consultation and referral.

What is more relevant is the panel’s belief that the DOT and PPE physicals are not within the scope of WA chiropractic physicians’ scope of practice. That belief is simply incorrect. Chiropractic physicians are, indeed, required to perform physical examinations. The panel was repeatedly advised of this fact and evidence of CCE standards and an example of curricular inclusion of this was provided. Ignoring it does not change the fact that they are trained and licensed to do these very things. We have once again included these references and pray that the panel will actually review these materials and amend this report appropriately rather than continuing to promulgate misleading and incorrect assertions.

On page 16, under “Background on Commercial Driver’s License Physicals” the panel incorrectly states that chiropractors can’t perform physicals for purposes other than chiropractic care. They state “Because the performance of physical exams for reasons other than chiropractic care are outside of the scope of practice for chiropractors in Washington as defined in RCW 18.25.005, chiropractors are not eligible for FMSCA registry.”

The Panel is incorrect. Written testimony demonstrating the scope inclusion of diagnostic evaluations was provided to the panel. Specifically the panel was advised of Interpretive Statement Number: CH-12-13-12: Practice of Chiropractic – Independent Chiropractic Examinations rendered by the Chiropractic Quality Assurance Commission clarifies this issue:

“...Given the purpose of the statute and the scope of practice stated in RCW 18.25.005, the Commission interprets the definition of chiropractic to include activities which involve diagnosis or analysis, as well as activities that include care or treatment. It is not necessary that both diagnosis or analysis and care or treatment occur together to be considered the practice of chiropractic.

If a chiropractor provides diagnosis or analysis but stops short of providing care or treatment, the activities are considered the practice of chiropractic. Similarly, if a chiropractor provides care or treatment based on another chiropractor’s diagnosis or analysis, the activities are considered the practice of chiropractic.”

Further, the purpose of any physical is to evaluate normality and/or to detect health conditions. The suggestion that chiropractic physicians only perform an exam that is capable of identifying things they can treat is nonsensical and operationally incorrect. 18.25.005 (3) supports our position and testimony and written documentation to this fact was provided. Specifically, the report ignores the fact that chiropractic physicians employ physical exams to identify ALL health conditions, including those that would require referral to another provider type as well as those conditions that they would treat. They do this JUST LIKE EVERY OTHER PHYSICIAN. A family practitioner MD performs screening tests to identify the possible presence of prostate cancer. Should findings of concern be detected, he/she does not treat it- he/she refers it to the appropriate provider for a definitive diagnosis and any appropriate treatment. The treatment of prostate cancer is the responsibility of another specialty. To suggest that an exam can be focused to only those things that would be within the chiropractic scope is completely incorrect.

In 48 states chiropractors are considered qualified to perform DOT physicals. The federal rules have included chiropractic physicians since 1992. The Panel’s disregard on the scope of practice issue is noted for what it is- incorrect and feels like a complete rationalization for a preconceived bias about the rigorous education of chiropractic physicians.

The WSCA noted with interest the panel’s acknowledgement of the existence of heart attacks and other such tragedies following DOT physicals and sudden death cardiac events in athletes (who have undergone PPE) as a real concern. However; it is clear that the panel did not attribute the fact that these things are occurring on the medical community’s watch of these very individuals! How many PPE or DOT physicals does a medical resident do in their training? How often do they perform examinations during their training outside the hospital? In fact, on page 10 of the report, the panel even acknowledges they received a letter from Palmer College states that as part of their

chiropractic curriculum 945 hours practical clinical experience where these issues would present themselves to the student chiropractor.

Also on page 10 of the panel report they indicate receipt of a letter (emphasis added) from the “University of Western States indicates nearly 1,000 of their 4,200 to 4,600 hours of training covers all aspects of ambulatory care patient evaluation, and the analysis and employment of best practices therein. This education includes didactic and practical skills instruction in emergency procedures, physical examination of each body region and system, laboratory diagnosis, differential diagnosis, imaging, triage, evidence based practice, etc. In addition to didactic instruction and practical application, clinical practice training rotations include extensive experience in the application of these competencies on a very diverse array of patients in ambulatory care settings.”

The reality is that the chiropractic physician is being subjected to a double standard by the panel- we have to prove that we are better than medicine to be considered equal for this process. The WSCA accepts a single standard- but expects it to be articulated in terms of didactic classroom training followed up with competency testing and applied equally under the process, which is not happening in this case.

On page 12 of the draft report, the panel stated “Washington law clearly limits the practice of chiropractors to diagnosis, analysis, and care or treatment for restoration and maintenance of health of conditions relating to the musculoskeletal system.”

The panel went on to reference other states with broader scopes than the State of Washington. It is curious how the exact same training in chiropractic school is considered adequate for those scopes, yet the chiropractic training is considered “less than adequate” for chiropractors in Washington. Once again, the panel cannot have it both ways... they cannot acknowledge the scope in other jurisdictions as valid based on the same training yet disavow the ability of chiropractors to perform the same functions in WA state. The fact is that the chiropractic training qualifying the physician to perform a physical examination in WA State is the same as Oregon, Colorado, or any other state.

On page 11 of the panel preliminary report a reference is made to the Washington State Chiropractic Association website stating “A chiropractor’s medical training is just a portion of their required hours, and it is intended for recognizing those conditions outside the scope of chiropractic for referral to other health care practitioners”. The WSCA is *not* an educational institution and provides the generic summary of chiropractic to consumers who may be searching for a chiropractor. The National Board of Chiropractic Examiners (NBCE) training requirements were provided in the initial application and review of that material is more appropriate than referencing a professional association’s website whose purpose is to support the practice of the profession, direct patient referrals and advocate for the profession, not to provide licensing. In addition, provided for the panel in Attachments B and C are the University of Western States Abilities and Competencies and the University of Western States Curriculum.

Last, on page 17 the report states:

“The specialty certifications for sports medicine chiropractors have a heavy focus on spinal and extremity manipulation, exercise physiology and sports specific biomechanics, with only four percent of the certification examination devoted to systemic conditions, diabetes, asthma, etc.”

We believe that the comparisons were made to create the appearance of lack of training. The curriculum provided by the DACBSP describes the entire training program and the entire

assessment instrument and fails to actually address the component of the program dedicated to the PPE process. That the overall assessment of these issues represents 4% of the test is not a predictor of how much discussion received in the classroom. Nor is it evidence of how much of that 4% is focused on the PPE. In reality, the panel has no basis whatsoever to declare the education and assessment of these doctors as inadequate based on this information. And, we should mention that the DACBSP should have “a strong focus on spinal and extremity manipulation, exercise physiology and sports specific biomechanics” as these screening exams are also expected to address concerns of a youth playing a sport-which is greatly biomechanical.

The reference to the DACBSP being focused on “*a strong focus on spinal and extremity manipulation, exercise physiology and sports specific biomechanics*” is in line with what is appropriate for a pre-participation exam. These screening exams are also expected to address injuries that may occur for the youth playing a sport-which is greatly biomechanical.

That they chose to do so is concerning. The evidence shows is that these issues, in the context of a PPE, are taught and examined. The WSCA reminds the panel that this is a screening exam- and it is not designed to establish a basis for treatment of the athlete! It is, in fact, to identify conditions, not to treat them. Treatment should not be performed under the banner of a PPE context.

The actual ACBSP document is quite thorough in its training and it even references the compliance with the following organizations:

The ACBSP™ recommends that any chiropractor who performs PPEs should do so in accordance with the practical guidelines set forth in Pre-participation Physical Evaluation, 2nd Edition, published by the AAFP, AAP, AMSSM, AOSSM and AOASM.

The WSCA would encourage a stronger review of the program provided and note that the State of Colorado program submitted in our initial applicant report is currently in use in Colorado for those chiropractors who will provide pre-participation examinations for youth athletes.

6. PPEs and CMV exams are not screening exams:

On page 5 of the draft report, the panel states: “PPEs and CMV exams are not merely “screenings.” They are intended to be comprehensive physical examinations, and are sometimes the only examination the person receives regularly.”

The panel is incorrect. PPE’s are, in fact screening exams to determine if the athlete is safe to participate in sports. Note the study provided in the Applicant Rebuttal, and its title, “*Sudden cardiac death screening in adolescent athletes: an evaluation of compliance with national guidelines*”. In the study, performed by medical physicians, they use the term “screen” or “screenings” in not only the title of their study but more than 30 times within their article.

CMV exams are likewise screening exams that require specific training and testing established by the Federal government and they specifically endorse chiropractors who are trained to conduct these physicals in 48 of the 50 states. The WSCA finds it curious that the panel accepted the necessity and value of the CMV training program for evaluators, but chose to ignore the proposed training of PPE examiners... once again, a double standard exists.

Review of the Proposal Using Sunrise Criteria

The first criterion mentioned by the panel is only supported by a lack of understanding or review of the chiropractic education. In many cases the chiropractic doctor, especially those with who are Diplomates as Chiropractic Sports Physicians, may receive greater training than other providers already allowed to perform these exams, yet they are allowed to perform the physicals. The decision to disallow a profession from performing the DOT and PPE exams because of studies we brought to light doesn't support the panel's opinion that "There is evidence that highly trained providers currently conducting PPEs sometimes miss the warning signs of heart conditions, or do not perform PPEs properly. Allowing providers with less training to perform PPEs will not alleviate this issue and may inadvertently compound the problem". Penalizing the chiropractic profession and limiting patient access is not appropriate.

The second criterion does require us to change the scope of practice language, which will have to occur in order to avoid lack of clarity in the future should the legislature support the change, but is clearly not a reason to recommend that chiropractors should not perform these exams. The statute already requires a chiropractor to perform an examination- we have proven that in 18.25.005(3) RCW; the fact that PPE and DOT exams have specific protocols does not change the expectation of the chiropractor in performing an exam.

The Sunrise panel has completely disregarded the education and training in the overall chiropractic program, which exceeds 4500 hours, and specifically in toxicology and pharmacology already mentioned. The Federal Government has listed chiropractors as Certified Medical Examiners and ALL providers who want to perform CVL exams must take the same course work regardless of their base education. It seems that the Sunrise panel is disregarding the decision of the Federal Government, also.

The third criterion has already been met because chiropractors are already regulated.

Conclusion: The fact that the panel ignored so many facts and made so many errors is disturbing, at the minimum. The lack of facts in the panel's preliminary report is upsetting since it appears to be in disregard for detailed information provided and is not referenced, yet the reference to the WSCA website for educational support is used when we are not an educational institution. The fact that there is only a ten day response process to so many errors is a limitation in the entire Sunrise Review process.

Attachment D of the initial application provided the panel with an abstract titled "A SURVEY OF CHIROPRACTORS ACCESS TO PERFORM PRE-PARTICIPATION EXAMINATIONS (PPEs)" which showed that 70% of the chiropractic boards have policies allowing PPE's by doctors of chiropractic and we have no significant issues of error in the examinations provided to young athletes in those states.

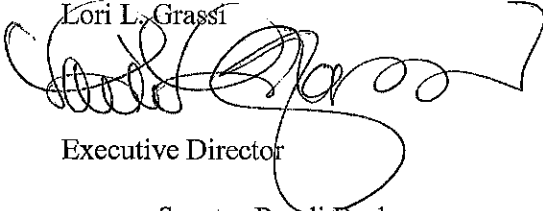
In our rebuttal to the August 6, 2013 hearing we referenced the study titled "Sudden cardiac death screening in adolescent athletes: an evaluation of compliance with National guidelines" also referenced above, which identifies that of the medical providers who responded to the study, who perform student pre-participation examinations **"Only 6% of all providers and 0% of schools were in compliance with AHA guidelines. In addition, 47% of the physicians and 6% of athletic directors reported awareness of the guidelines."**

They went on to say **"Lack of compliance does not reflect clinical experience, but rather lack of knowledge of the guidelines themselves. New directions for provider education and policy requirements are needed to improve this implementation gap."**

Could it possibly be that improving this compliance gap could be partially addressed by allowing the chiropractic profession the opportunity to provide thorough examinations for these populations?

This response is respectfully submitted on behalf of the Washington State Chiropractic Association, Board of Directors.

Lori L. Grassi

A handwritten signature in black ink, appearing to read 'Lori L. Grassi', written over the printed name.

Executive Director

cc: Senator Randi Becker
Senator Karen Keiser
Representative Eileen Cody
Representative Joe Schmick

ATTACHMENT

A

Interchange-
able terms. SEC. 21. The words "certificates" and "li-
censes" shall be known as interchangeable terms in
this act.

Repealing
clause. SEC. 22. All acts and parts of acts in conflict
herewith are hereby repealed.

Emergency. SEC. 23. This act is necessary for the immediate
preservation of the public peace, health and safety,
and shall take effect immediately.

Passed the House February 24, 1917.

Passed the Senate March 5, 1917.

Vetoed by the Governor March 17, 1917.

Passed over the Governor's veto January 21,
1919.

CHAPTER 5.

[H. B. 61, Session of 1917.]

REGULATING CHIROPRACTIC PRACTICE.

AN ACT to authorize and regulate the practice of Chiropractic, to provide for the licensing and examination of Chiropractors, to create a state board of examination and registration, to provide for the appointment of same, to establish rules and regulations governing said board, to provide a curriculum, and establish a standard of efficiency, to provide prerequisites and establish a fee for examination, to provide for the disposal of the fund arising from said fee, to regulate the holding of meetings of said board and issuance of licenses to practice Chiropractic, to provide a penalty for practicing Chiropractic without a license as provided by this act, and to repeal all acts and parts of acts in conflict herewith.

*Be it enacted by the Legislature of the State of
Washington:*

Board of
examiners. SECTION 1. That there is hereby created and
established a board to be known by the name and
style of the state board of chiropractic examiners,
and said board shall be composed of three (3) prac-
ticing chiropractors of integrity and ability, who
shall be residents of the state for a period of at

least one year, and who shall have practiced chiropractic only continually in the state for this same year. No two members of said board shall be graduates from the same school or college of chiropractic.

Sec. 2. The Governor shall within thirty (30) days after the taking effect of this act, appoint three (3) chiropractors, who shall possess the qualifications, specified in section 1 of this act, to constitute the members of said board. Said members shall be classified by the Governor that the term of office of one shall expire in one year, one in two years, and one in three years from the date of appointment. Annually thereafter the Governor shall appoint one member who shall be a licensed practitioner and possesses [possess] the qualifications specified in section 1 of this act, to serve for a period of three years and shall fill all vacancies in said board caused by death or otherwise as soon as practicable.

Appointment
of examiners.

Sec. 3. (a) Said board of chiropractic examiners shall convene within thirty (30) days after their appointment and elect a president, a vice-president, and a secretary-treasurer from their membership.

Organization
of board.

(b) Said board shall hold regular sessions at such places as the board may decide the first week in January and July, respectively, of each year, and shall publish such dates for examinations and place of meeting in some newspaper of general circulation at least fifteen (15) days prior to said meeting.

Time and
place of
meetings.

(c) Said board shall have authority to administer oaths, take affidavits, summon witnesses and take testimony as to matters pertaining to their duties. They shall adopt a seal, which shall be affixed to all licenses issued by them and shall from time to time adopt such rules and regulations as they deem proper and necessary for the performance of their duties, and they shall adopt a schedule

Powers and
duties.

of minimum educational requirements, which shall be without prejudice, partiality or discrimination as to the different schools of chiropractic. The secretary of said board shall at all times keep a record of the proceedings of the board which shall at all times be open to public inspection. Said board shall also keep on file with the Secretary of State a copy of their rules and regulations for public inspection, and shall elect annually a president, vice-president, and a secretary-treasurer. A majority of the board shall constitute a quorum.

Record of
proceedings.

Officers.

(d) No professor or person financially interested in any chiropractic school or college shall be a member of said board.

Disqualifica-
tions for
membership.

(e) A license to practice chiropractic within this state shall be issued to the individual members of said board at the first meeting of said board upon payment of the regular fee as provided for in this act.

Licenses
to board
members.

SEC. 4. It shall be unlawful for any person to practice chiropractic in this state, unless they shall have obtained a license as provided in this act: *Provided, however,* That nothing in this act shall apply to or affect any persons who are now actually engaged in the practice of such profession, except as hereinafter provided.

Practicing
without
license,
unlawful.

SEC. 5. (a) Any person wishing the right to practice chiropractic in this state, before it shall be lawful for him to do so, shall make application to said board of chiropractic examiners through the secretary-treasurer thereon [thereof], upon such form thereof and in such manner as may be adopted and directed by the board at least fifteen (15) days prior to any meeting of said board. Each applicant shall be a graduate of a chartered chiropractic school or college which teaches a course of two years of nine months each or more, or its equivalent, requiring actual attendance in same. Applications shall be in

Application
for license.

Qualifica-
tions
required.

writing and shall be signed by the applicant in his own handwriting and shall be sworn to before some officer authorized to administer oath[s], and shall recite the history of the applicant as to his educational advantages, his experience in matters pertaining to a knowledge of the care of the sick, how long he has studied chiropractic, under what teachers, what collateral branches, if any, he has studied, the length of time he has engaged in clinical practice; accompanying the same by reference therein, with any proof thereof in the shape of diplomas, certificates, and shall accompany said application with satisfactory evidence of good character and reputation.

(b) There shall be paid to the secretary-treasurer of the state board of chiropractic examiners by each applicant for a license, a fee of \$25.00, ten dollars of which shall accompany application and the remainder, \$15.00, shall be paid upon issuance of license. Like fees shall be paid for any subsequent examination and application.

License and
examina-
tion fees.

Sec. 6. Examinations for license to practice chiropractic shall be made by said board according to the method deemed by it to be the most practicable and expeditious to test the applicant's qualifications. Such application shall be designated by a number instead of his or her name, so that the identity [shall] not be discovered or disclosed to the members of the board until after the examination papers are graded.

Examina-
tions, how
conducted.

(b) All examinations shall be made in writing, the subject of which shall be as follows: Anatomy, physiology, hygiene, symptomatology, nerve-tracing, chiropractic-orthopedy, principles of chiropractic and adjusting, as taught by chiropractic schools and colleges. A license shall be granted to all applicants who shall correctly answer seventy-five per centum (75%) of all questions asked, and if any applicant

Subjects
for ex-
amination.

shall fail to answer correctly sixty per centum (60%) of the questions on any branch of said examination, he or she shall not be entitled to a license.

Character
of practice
permitted.

(c) Any chiropractor who has complied with the provisions of this act may adjust by hand any articulation of the spine, but shall not prescribe for or administer to any person any medicine or drugs now or hereafter included in *Materia Medica*, nor practice obstetrics, nor practice osteopathy or surgery.

Examina-
tions dis-
persed with,
when.

SEC. 7. All chiropractors practicing within this state six (6) months prior to the passage of this act and who shall be a graduate of a chartered school or college of chiropractic requiring actual attendance in the same, during his course, shall be granted a license as herein provided, without examination, provided that application be made within sixty (60) days after the taking effect of this act and accompanied by the required fee, as herein provided.

Revocation
and refusal
of licenses.

SEC. 8. (a) The state board of chiropractic examiners may refuse to grant or may revoke a license to practice chiropractic in this state or may cause a licentiate's name to be removed from the records in the office of the county clerk of any county in this state upon any of the following grounds, to-wit: The employment of fraud or deception in applying for a license or in passing an examination provided for in this act; the practice of chiropractic under a false or assumed name, or the impersonation of another practitioner of like or different name; the conviction of a crime involving moral turpitude; habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate him or her for the performance of their professional duties, exploiting or advertising through the press, or by the use of handbills, circulars or other periodicals, other than professional cards, giving only name, address, profes-

sion, office hours and telephone connections. Any person who is a licentiate, or who is an applicant for a license to practice chiropractic against whom any of the foregoing grounds for revoking or refusing a license, is presented to said board with a view of having the board revoke or refuse to grant a license, shall be furnished with a copy of the complaint, and shall have a hearing before said board in person or by attorney, and witnesses may be examined by said board respecting the guilt or innocence of said accused.

(b) Said board may at any time within two years of the refusal or revocation or cancellation of registration under this section, by a majority vote, issue a new license or grant a license to the person affected, restoring him to, or conferring upon him all the rights and privileges of, and pertaining to the practice of chiropractic as defined and regulated by this act. Any person to whom such have been resotred [restored] shall pay to the secretary-treasurer the sum of \$25.00 upon issuance of a new license.

Restoration
of right to
practice.

Sec. 9. (a) Every person who shall receive a license from the state board of chiropractic examiners shall have it recorded in the office of the county clerk of the county of which he resides and shall likewise have it recorded in the counties to which he shall subsequently remove for the purpose of practicing chiropractic.

Recordation
of licenses.

(b) The failure or refusal on the part of the holder of a license to have it recorded before he or she shall begin the practice of chiropractic in this state after having been notified by the state board of chiropractic examiners to do so, shall be sufficient grounds to revoke or cancel a license and render it null and void. The county clerk shall keep for public inspection, in a book provided for that purpose, a complete list and description of the licenses recorded by him. When any such licenses

Failure to
record,
ground for
cancellation.

shall be presented to him for record, he shall stamp upon the face thereof his signed memorandum of the date when such license was presented for record.

Annual li-
cense fee.

Notice to
practitioners.

SEC. 10. All persons practicing chiropractic within this state shall pay on or before the first day of September of each year, after a license is issued to them as herein provided, to said board of chiropractic examiners a renewal license fee of five (\$5.00) dollars. The secretary-treasurer shall, thirty (30) days or more before September 1st, of each year mail to all chiropractors in this state a notice of the fact that the renewal fee will be due on or before the first of September. Nothing in this act shall be construed so as to require that the receipts shall be recorded as original licenses are required to be recorded.

Disposition
of fees.

SEC. 11. (a) All examinations and renewal fees received by the state board of chiropractic examiners under this act shall be paid to the secretary-treasurer of said board, who shall on or before the tenth (10) day of the succeeding month deposit the same with the State Treasurer, together with a verified statement showing the sources from which the money was derived.

Annual
fiscal
reports.

(b) The secretary-treasurer shall keep a true and accurate account of all funds received and all vouchers issued by the board; and on the first day of December of each year he shall file with the Governor of this state a report of all receipts and disbursements, and the proceedings of said board for the fiscal year.

Per diem
and travel-
ing expenses
of board.

(c) The members of said board shall receive a per diem of five (\$5.00) dollars for each day during which they shall be actually engaged in the discharge of their duties in attendance upon the meetings of the board and in going to and returning from the place of meeting, and all necessary expenses incurred in attendance of such meetings.

(d) All such compensation and expenses, and all other expenses incident to the execution of the provisions of this act, shall be paid by warrants drawn by the State Auditor upon the presentation of vouchers to be approved by a majority of the board, as in the case of state officers.

Payment of compensation and expenses.

Sec. 12. Chiropractic practitioners shall observe and be subject to all state and municipal regulations relating to the control of contagious and infectious diseases, sign death certificates and any and all matters pertaining to public health, reporting to the proper health officers the same as other practitioners.

Practitioners subject to health regulations.

Sec. 13. The treasurer of said board shall give bond in such sum and with such sureties as the board may deem proper. Upon sufficient proof to the Governor of the inability or misconduct of a member of the board, said member shall be dismissed and the Governor shall appoint as his successor some licensed chiropractor practicing in this state who shall be a graduate of a different school than those represented on the board.

Bond of treasurer of board.

Removal of board members.

Sec. 14. Persons licensed to practice chiropractic under the laws of any other state having equal requirements of this act, may, in the discretion of the board, be issued a license to practice in this state without examination, upon payment of the fee of twenty-five (\$25.00) dollars as herein provided.

Licensing practitioners from other states.

Sec. 15. Any person who shall practice or attempt to practice chiropractic, or any person who shall buy, sell, or fraudulently obtain any diploma or license to practice chiropractic, whether recorded or not, or who shall use the title chiropractor, D. C. Ph. C., or any word or title to induce belief that he is engaged in the practice of chiropractic without first complying with the provisions of this act, or any person who shall violate any of the provisions

Illegally practicing, a misdemeanor.

False personation, a felony.

of this act, shall be guilty of a misdemeanor, and every person filing for record, or attempting to file for record, the certificate issued to another, falsely claiming himself to be the person named in said certificate, or falsely claiming himself to be the person entitled to the same, shall be guilty of a felony. All subsequent offenses shall be punished in like manner. Nothing herein shall be held to apply or to regulate any kind of treatment by prayer: *Provided*, That on all cards, books, papers, signs or other written or printed means of giving information to the public, used by those licensed by this act to practice chiropractic, the practitioner shall use after or below his name the term chiropractor or D. C. Ph. C. designating his line of drugless practice, and shall not use the word "doctor" abbreviation "Dr." or the letters M. D. or D. O.

Advertising matter, style of.

Prosecutions for violations of act.

Sec. 16. It shall be the duty of the several prosecuting attorneys of this state to prosecute all persons charged with the violation of any of the provisions of this act. It shall be the duty of the secretary-treasurer of said board, under the direction of said board, to aid said attorneys of this state in the enforcement of this act.

Repealing clause.

Sec. 17. All acts and parts of acts in conflict herewith are hereby repealed.

Passed the House February 24, 1917.

Passed the Senate March 5, 1917.

Vetoed by the Governor March 17, 1917.

Passed over the Governor's veto January 21, 1919.

ATTACHMENT

B

TeamCME_{LLC}
Nationwide Network of DQT Medical Examiners

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November 4, 2013

Sunrise Committee
 State of Washinton

Re: Commercial Driver Medical Examination

Dear Members of the Committee,

In 2005, I was appointed to the Federal Motor Carrier Safety Administration (FMCSA) National Registry of Certified Medical Examiners Working Integrated Project Team. As a member of this ten member physician team, we were responsible to assist FMCSA in the initial development of the National Registry program including the basis for certification, the required physician training course, and development of the National Registry certification test.

I am writing in response to the committees determination regarding Doctors of Chiropractic performing the commercial driver medical examination in the State of Washington.

FMCSA regulations identify a person who can be a medical examiner by two criteria: professional licensure and scope of practice that includes performing physical examination. The medical examiner term includes, but is not limited to, doctors of medicine and osteopathy, advanced practice nurses, physician assistants and chiropractors (49CFR 390.5 Definitions).

The significance of this definition is that FMCSA recognizes that chiropractic training and skill does include those components necessary to perform the commercial driver medical examination. Based upon the second criteria of state scope of practice, forty eight states recognize the ability for doctors of chiropractic to perform physical exams.

This is in agreement with state regulations designed to protect the public. States that require doctors of chiropractic to recognize medical conditions and refer those patients to an appropriate medical provider realize that the only method that can be used to identify previously undetected medical conditions is thru a complete physical examination. If Doctors of Chiropractic can not perform a physical exam, they can not protect the public from delay in treatment of an undetected medical condition that is otherwise outside of those conditions typically treated by chiropractic.

The commercial driver medical exam falls exactly into the category of performing a physical exam looking for undetected medical conditions. This exam is defined as a

"Fitness for Duty" examination (FMCSA Online Medical Examiner Handbook: Medical Examination Guidelines (B) Driver/Medical Examiner Relationship, (1) Assess Medical Fitness for Duty).

As the medical examiner, you are examining for medical fitness for duty, not diagnosing and treating personal medical conditions. You do have the responsibility to educate and refer the driver for further evaluation if you suspect an undiagnosed or worsening medical problem (FMCSA Online Medical Examiner Handbook: Medical Examination Guidelines, (B)(4) Medical Examiner Dos).

Because the medical examiner does not diagnose or treat medical conditions, they typically work closely with the treating physician. Drivers are required to have a prescription for all controlled substances, and for certain categories of medication, the medical examiner is required to have clearance from the prescribing physician.

In conclusion, I do not believe that the committee's findings are consistent with the role of the medical examiner in not diagnosing or treating the driver's medical conditions, the purpose and definition of the commercial driver medical examination as a fitness for duty examine, or the state requirement that doctors of chiropractic are required to detect medical conditions and refer patients to the appropriate provider. The determination that Doctors of Chiropractic can not perform this type puts the public in danger, rather than provide public protection.

Sincerely,



Michael Megelke, DC

ATTACHMENT

C

§391.43

safely operate a commercial motor vehicle; and

(13) Has no current clinical diagnosis of alcoholism.

[35 FR 6460, Apr. 22, 1970, as amended at 35 FR 17420, Nov. 13, 1970; 36 FR 223, Jan. 7, 1971; 36 FR 12857, July 8, 1971; 43 FR 56900, Dec. 5, 1978; 55 FR 3654, Feb. 1, 1990; 60 FR 38744, July 28, 1995; 62 FR 37152, July 11, 1997; 65 FR 59369, Oct. 5, 2000; 67 FR 61824, Oct. 2, 2002; 73 FR 73127, Dec. 1, 2008, 75 FR 28502, May 21, 2010]

§391.43 Medical examination; certificate of physical examination.

(a) Except as provided by paragraph (b) of this section, the medical examination shall be performed by a licensed medical examiner as defined in §390.5 of this subchapter.

(b) A licensed optometrist may perform so much of the medical examination as pertains to visual acuity, field of vision, and the ability to recognize colors as specified in paragraph (10) of §391.41(b).

(c) Medical examiners shall:

(1) Be knowledgeable of the specific physical and mental demands associated with operating a commercial motor vehicle and the requirements of this subpart, including the medical advisory criteria prepared by the FMCSA as guidelines to aid the medical examiner in making the qualification determination; and

(2) Be proficient in the use of and use the medical protocols necessary to adequately perform the medical examination required by this section.

(d) Any driver authorized to operate a commercial motor vehicle within an exempt intracity zone pursuant to §391.62 of this part shall furnish the examining medical examiner with a copy of the medical findings that led to the issuance of the first certificate of medical examination which allowed the driver to operate a commercial motor vehicle wholly within an exempt intracity zone.

(e) Any driver operating under a limited exemption authorized by §391.64 shall furnish the medical examiner with a copy of the annual medical findings of the endocrinologist, ophthalmologist or optometrist, as required under that section. If the medical examiner finds the driver qualified under the limited exemption in §391.64, such

49 CFR Ch. III (10-1-11 Edition)

fact shall be noted on the Medical Examiner's Certificate.

(f) The medical examination shall be performed, and its results shall be recorded, substantially in accordance with the following instructions and examination form. Existing forms may be used until current printed supplies are depleted or until September 30, 2004, whichever occurs first.

INSTRUCTIONS FOR PERFORMING AND RECORDING PHYSICAL EXAMINATIONS

The medical examiner must be familiar with 49 CFR 391.41, Physical qualifications for drivers, and should review these instructions before performing the physical examination. Answer each question "yes" or "no" and record numerical readings where indicated on the physical examination form.

The medical examiner must be aware of the rigorous physical, mental, and emotional demands placed on the driver of a commercial motor vehicle. In the interest of public safety, the medical examiner is required to certify that the driver does not have any physical, mental, or organic condition that might affect the driver's ability to operate a commercial motor vehicle safely.

General information. The purpose of this history and physical examination is to detect the presence of physical, mental, or organic conditions of such a character and extent as to affect the driver's ability to operate a commercial motor vehicle safely. The examination should be conducted carefully and should at least include all of the information requested in the following form. History of certain conditions may be cause for rejection. Indicate the need for further testing and/or require evaluation by a specialist. Conditions may be recorded which do not, because of their character or degree, indicate that certification of physical fitness should be denied. However, these conditions should be discussed with the driver and he/she should be advised to take the necessary steps to insure correction, particularly of those conditions which, if neglected, might affect the driver's ability to drive safely.

General appearance and development. Note marked overweight. Note any postural defect, perceptible limp, tremor, or other conditions that might be caused by alcoholism, thyroid intoxication or other illnesses.

Head-eyes. When other than the Snellen chart is used, the results of such test must be expressed in values comparable to the standard Snellen test. If the driver wears corrective lenses for driving, these should be worn while driver's visual acuity is being tested. If contact lenses are worn, there should be sufficient evidence of good tolerance of and adaptation to their use. Indicate the driver's need to wear corrective lenses to

meet the vision standard on the Medical Examiner's Certificate by checking the box, "Qualified only when wearing corrective lenses." In recording distance vision use 20 feet as normal. Report all vision as a fraction with 20 as the numerator and the smallest type read at 20 feet as the denominator. Monocular drivers are not qualified to operate commercial motor vehicles in interstate commerce.

Ears. Note evidence of any ear disease, symptoms of aural vertigo, or Meniere's Syndrome. When recording hearing, record distance from patient at which a forced whispered voice can first be heard. For the whispered voice test, the individual should be stationed at least 5 feet from the examiner with the ear being tested turned toward the examiner. The other ear is covered. Using the breath which remains after a normal expiration, the examiner whispers words or random numbers such as 66, 18, 23, etc. The examiner should not use only sibilants (s-sounding test materials). The opposite ear should be tested in the same manner. If the individual fails the whispered voice test, the audiometric test should be administered. For the audiometric test, record decibel loss at 500 Hz, 1,000 Hz, and 2,000 Hz. Average the decibel loss at 500 Hz, 1,000 Hz and 2,000 Hz and record as described on the form. If the individual fails the audiometric test and the whispered voice test has not been administered, the whispered voice test should be performed to determine if the standard applicable to that test can be met.

Throat. Note any irremediable deformities likely to interfere with breathing or swallowing.

Heart. Note murmurs and arrhythmias, and any history of an enlarged heart, congestive heart failure, or cardiovascular disease that is accompanied by syncope, dyspnea, or collapse. Indicate onset date, diagnosis, medication, and any current limitation. An electrocardiogram is required when findings so indicate.

Blood pressure (BP). If a driver has hypertension and/or is being medicated for hypertension, he or she should be recertified more frequently. An individual diagnosed with Stage 1 hypertension (BP is 140/90-159/99) may be certified for one year. At recertification, an individual with a BP equal to or less than 140/90 may be certified for one year; however, if his or her BP is greater than 140/90 but less than 160/100, a one-time certificate for 3 months can be issued. An individual diagnosed with Stage 2 (BP is 160/100-179/109) should be treated and a one-time certificate for 3-month certification can be issued. Once the driver has reduced his or her BP to equal to or less than 140/90, he or she may be recertified annually thereafter. An individual diagnosed with Stage 3 hypertension (BP equal to or greater than 180/110) should not be certified until his or her BP is reduced to 140/90

or less, and may be recertified every 6 months.

Lungs. Note abnormal chest wall expansion, respiratory rate, breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, or cyanosis. Abnormal finds on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.

Abdomen and Viscera. Note enlarged liver, enlarged spleen, abnormal masses, bruits, hernia, and significant abdominal wall muscle weakness and tenderness. If this diagnosis suggests that the condition might interfere with the control and safe operation of a commercial motor vehicle, further testing and evaluation is required.

Genital-urinary and rectal examination. A urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problems. Note hernias. A condition causing discomfort should be evaluated to determine the extent to which the condition might interfere with the control and safe operation of a commercial motor vehicle.

Neurological. Note impaired equilibrium, coordination, or speech pattern; paresthesia; asymmetric deep tendon reflexes; sensory or positional abnormalities; abnormal patellar and Babinski's reflexes; ataxia. Abnormal neurological responses may be an indication for further testing to rule out an underlying medical condition. Any neurological condition should be evaluated for the nature and severity of the condition, the degree of limitation present, the likelihood of progressive limitation, and the potential for sudden incapacitation. In instances where the medical examiner has determined that more frequent monitoring of a condition is appropriate, a certificate for a shorter period should be issued.

Spine, musculoskeletal. Previous surgery, deformities, limitation of motion, and tenderness should be noted. Findings may indicate additional testing and evaluation should be conducted.

Extremities. Carefully examine upper and lower extremities and note any loss or impairment of leg, foot, toe, arm, hand, or finger. Note any deformities, atrophy, paralysis, partial paralysis, clubbing, edema, or hypotonia. If a hand or finger deformity exists, determine whether prehension and power grasp are sufficient to enable the driver to maintain steering wheel grip and to control other vehicle equipment during routine and emergency driving operations. If a foot or leg deformity exists, determine whether sufficient mobility and strength exist to enable the driver to operate pedals properly. In the case of any loss or impairment to an extremity which may interfere

§ 391.43

with the driver's ability to operate a commercial motor vehicle safely, the medical examiner should state on the medical certificate "medically unqualified unless accompanied by a Skill Performance Evaluation Certificate." The driver must then apply to the Field Service Center of the FMCSA, for the State in which the driver has legal residence, for a Skill Performance Evaluation Certificate under § 391.49.

Laboratory and other testing. Other test(s) may be indicated based upon the medical history or findings of the physical examination.

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Diabetes. If insulin is necessary to control a diabetic driver's condition, the driver is not qualified to operate a commercial motor vehicle in interstate commerce. If mild diabetes is present and it is controlled by use of an oral hypoglycemic drug and/or diet and exercise, it should not be considered disqualifying. However, the driver must remain under adequate medical supervision.

Upon completion of the examination, the medical examiner must date and sign the form, provide his/her full name, office address and telephone number. The completed medical examination form shall be retained on file at the office of the medical examiner.

649-F (6045)

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my

Date_____

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

TESTING (Medical Examiner completes Section 3 through 7) Name: Last, First, Middle,

3. VISION Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. *Monocular drivers are not qualified.*

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective Lenses

Monocular Vision: ☐ Yes ☐ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination Name of Ophthalmologist or Optometrist (print) Tel. No. License No./ State of Issue Signature

4. HEARING Standard: a) Must first perceive forced whispered voice ≥ 5 ft. with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB ☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -8.5 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.

Right Ear	Left Ear	1 Foot	1 Foot

b) If audiometer is used, record hearing loss in decibels. (ec. to ANSI Z39.1-1981)

Right Ear	Left Ear	500 Hz	1,000 Hz	2,000 Hz	500 Hz	1,000 Hz	2,000 Hz	Average

5. BLOOD PRESSURE/PULSE RATE Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤140/90
≥180/110	Stage 3	6 months from date of exam if ≤140/90	6 months if ≤140/90

Driver qualified if ≤140/90. Pulse Rate: ☐ Regular ☐ Irregular

Record Pulse Rate:

6. LABORATORY AND OTHER TEST FINDINGS Numerical readings must be recorded. Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record)

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR

7. PHYSICAL EXAMINATION Height: _____ (in.) Weight: _____ (lbs.) Name: Last, First, Middle, _____

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See *Instructions to the Medical Examiner* for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tumor, signs of alcoholism, problem drinking, or drug abuse.			7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, visual acuity, visual fields, visual evoked potentials, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.			8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.		
3. Ears	Swelling of tympanic membrane, occlusion of external canal, perforated eardrums.			9. Genito-urinary System	Hernias.		
4. Mouth and Throat	Irreparable deformities likely to interfere with breathing or swallowing.			10. Extremities- Limb	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension to operate pedals properly. Insufficient mobility and strength to lower limb to operate pedals properly.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.			11. Spine, other musculoskeletal	Previous surgery, deformities. Initiation of motion, tenderness.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.			12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities; abnormal patellar and Babinski reflexes, ataxia.		

***COMMENTS:** _____

Note certification status here. See *Instructions to the Medical Examiner* for guidance.

☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
☐ Does not meet standards
☐ Meets standards, but periodic monitoring required due to _____
 Driver qualified only for _____ months ☐ 6 months ☐ 1 year ☐ Other _____

Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on _____

If meets standards, complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

Medical Examiner's signature _____
 Address _____
 Telephone Number _____

☐ Wearing corrective lenses
☐ Wearing hearing aid
☐ Asymmetric hearing aid
☐ Waiver/ exemption. Driver must present exemption at time of certification.
☐ Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (See 49 CFR 391.62)
☐ Qualified by operation of 49 CFR 391.64

49 CFR 391.41 Physical Qualifications for Drivers

THE DRIVER'S ROLE

Responsibilities, work schedules, physical and emotional demands, and lifestyles among commercial drivers vary by the type of driving that they do. Some of the main types of drivers include the following: turn around or short relay (drivers return to their home base each evening); long relay (drivers drive 9-11 hours and then have at least a 10-hour off-duty period); straight through haul (cross country drivers); and team drivers (drivers share the driving by alternating their 5-hour driving periods and 5-hour rest periods).

The following factors may be involved in a driver's performance of duties: abrupt schedule changes and rotating work schedules, which may result in irregular sleep patterns and a driver beginning a trip in a fatigued condition; long hours; extended time away from family and friends, which may result in lack of social support; tight pickup and delivery schedules, with irregularity in work, rest, and eating patterns; adverse road, weather and traffic conditions, which may cause delays and lead to hurriedly loading or unloading cargo in order to compensate for the lost time; and environmental conditions such as excessive vibration, noise, and extremes in temperature. Transporting passengers or hazardous materials may add to the demands on the commercial driver.

There may be duties in addition to the driving task for which a driver is responsible and needs to be fit. Some of these responsibilities are: coupling and uncoupling trailer(s) from the tractor, loading and unloading trailer(s) (sometimes a driver may lift a heavy load or unload as much as 50,000 lbs. of freight after sitting for a long period of time without any stretching period); inspecting the operating condition of tractor and/or trailer(s) before, during and after delivery of cargo; lifting, installing, and removing heavy the chains; and, lifting heavy tarpaulins to cover open top trailers. The above tasks demand agility, the ability to bend and stoop, the ability to maintain a crouching position to inspect the underside of the vehicle, frequent entering and exiting of the cab, and the ability to climb ladders on the tractor and/or trailer(s).

In addition, a driver must have the perceptual skills to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas.

§391.43 PHYSICAL QUALIFICATIONS FOR DRIVERS

(a) A person shall not drive a commercial motor vehicle unless he is physically qualified to do so and, except as provided in §391.57, has on his person the original, or a photographic copy, of a medical examiner's certificate that he is physically qualified to drive a commercial motor vehicle.

(b) A person is physically qualified to drive a motor vehicle if that person:

- (1) Has no loss of a foot, a leg, a hand, or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate (formerly Limb Waiver Program) pursuant to §391.49.
- (2) Has no impairment of: (i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or has been granted a SPE Certificate pursuant to §391.49.
- (3) Has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control;
- (4) Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure.
- (5) Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his ability to control and drive a commercial motor vehicle safely.
- (6) Has no current clinical diagnosis of high blood pressure likely to interfere with his ability to operate a commercial motor vehicle safely.

(7) Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which interferes with his ability to control and operate a commercial motor vehicle safely.

(8) Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a commercial motor vehicle.

(9) Has no mental, nervous, organic, or functional disease or psychiatric disorder likely to interfere with his ability to drive a commercial motor vehicle safely.

(10) Has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses. Distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses. Field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard colors used on vehicles.

(11) Fit to receive a forced whispered voice in the better ear not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz and 2,000 Hz with or without a hearing device, when the audiometric device is calibrated to the American National Standard (formerly ASA Standard) Z24.5-1961.

(12) (i) Does not use a controlled substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic, or any other habit-forming drug. (ii) Exception: A driver may use such a substance or drug, if the substance or drug is prescribed by a licensed medical practitioner who: (A) is familiar with the driver's medical history and assigned duties; and (B) has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle; and (13) Has no current clinical diagnosis of alcoholism.

INSTRUCTIONS TO THE MEDICAL EXAMINER

General Information

The purpose of this examination is to determine a driver's physical qualification to operate a commercial motor vehicle (CMV) in interstate commerce according to the requirements in 49 CFR 391.41-49. Therefore, the medical examiner must be knowledgeable of these requirements and guidelines developed by the FMCSA to assist the medical examiner in making the qualification determination. The medical examiner should be familiar with the driver's responsibilities and work environment and is referred to the section on the form, **The Driver's Role**.

In addition to reviewing the Health History section with the driver and conducting the physical examination, the medical examiner should discuss common prescriptions and over-the-counter medications relative to the effects and hazards of those medications while driving. Educate the driver to read warning labels on all medications. History of certain conditions may be cause for rejection, particularly if required by regulation, or may indicate the need for additional laboratory tests or more stringent examination perhaps by a medical specialist. These decisions are usually made by the medical examiner in light of the driver's job responsibilities, work schedule and policies by the conditions to render the driver unsafe.

Medical conditions should be recorded even if they are not cause for denial, and they should be discussed with the driver to encourage appropriate remedial care. This advice is especially needed when a condition, if neglected, could develop into a serious illness that could affect driving.

If the medical examiner determines that the driver is fit to drive and is also able to perform non-driving responsibilities as may be required, the medical examiner signs the medical certificate which this driver must carry with his/her license. The certificate must be dated. Under current regulations, the certificate is valid for two years, unless the driver has a medical condition that does not prohibit driving but does require more frequent monitoring. In such situations, the medical certificate should be issued for a shorter length of time. The physical examination should be done carefully and at least as complete as is indicated by the attached form. Contact the FMCSA at (202) 368-1780 for further information (e vision exemption, qualifying drivers under 49 CFR 391.64, etc.).

Interpretation of Medical Standards

Since the issuance of the regulations for physical qualifications of commercial drivers, the Federal Motor Carrier Safety Administration (FMCSA) has published recommendations called Advisory Criteria to help medical examiners in determining whether a driver meets the physical qualifications for commercial driving. These recommendations have been condensed to provide information to medical examiners that (1) is directly relevant to the physical examination and (2) is not already included in the medical examination form. The specific regulation is printed in italics and it's reference by section is highlighted.

Federal Motor Carrier Safety Regulations

-Advisory Criteria-

Loss of Limb:

§391.41(b)(1)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no loss of a foot, leg, hand or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate pursuant to Section 391.48.

Limb Impairment:

§391.41(b)(2)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no impairment of:
(i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a motor vehicle; or (iii) A foot, leg, hand or arm or finger which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or (iv) Has been granted a Skill Performance Evaluation (SPE) Certificate pursuant to Section 391.48.

A person who suffers loss of a foot, leg, hand or arm or performance of normal tasks associated with the safe operation of a commercial motor vehicle is subject to the Skill Performance Evaluation (SPE) program in 49 CFR 391.49, assuming the person is otherwise qualified.

With the advancement of technology, medical aids and equipment modifications have been developed to compensate for certain disabilities. The SPE Certification Program (formerly the Limb Waiver Program) was designed to allow persons with the loss of a foot or limb or with functional impairment to qualify under the Federal Motor Carrier Safety Regulations (FMCSRs) by use of prosthetic devices or equipment modifications which enable them to safely operate a motor vehicle. SPE certificates are issued to safety aids equivalent to the original body or limb, certain risks are still present, and thus restrictions may be included on individual SPE certificates when a State Director for the FMCSA determines they are necessary to be consistent with safety and public interest.

If the driver is found otherwise medically qualified (391.41(b)(3) through (13)), the medical examiner must check on the medical certificate that the driver is qualified only if operating a motor vehicle without a current SPE certificate. The driver operates a motor vehicle in interstate or foreign commerce without a current SPE certificate for his/her physical disability.

Diabetes

§391.41(b)(3)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control.

Diabetes mellitus is a disease which, on occasion, can result in a loss of consciousness or disorientation in time and space. Individuals who require insulin for control have conditions which can get out of control by the use of too much or too little insulin, or food intake not consistent with insulin requirements. Symptoms of hypoglycemic or hypoglycemic reactions (drowsiness, semiconsciousness, diabetic coma or insulin shock).

The administration of insulin is, within itself, a complicated process requiring insulin, syringe, needle, alcohol sponge and a sterile technique. Factors related to long-haul commercial motor vehicle operations, such as fatigue, lack of sleep, poor diet, emotional conditions, and the use of alcohol, can contribute to insulin shock. The FMCSA has consistently held that a diabetic who uses insulin for control does not meet the minimum physical requirements of the FMCSRs.

Hypoglycemic drugs, taken orally, are sometimes prescribed for diabetic individuals to help stimulate natural body production of insulin. If the condition can be controlled by the use of oral medication and diet, then an individual may be qualified under the present rule. CMV drivers who do not meet the Federal diabetes standard may call (202) 368-1780 for an application for a diabetes exemption. (See Conference Report on Diabetic Disorders and Commercial Drivers and Insulin-Using Commercial Motor Vehicle Drivers at: <http://www.fmcsa.dot.gov/rulesregs/mesareports.htm>)

Cardiovascular Condition

§391.41(b)(4)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure.

The term "has no current clinical diagnosis of" is specifically designed to encompass: a clinical diagnosis of (1) a current cardiovascular condition; (2) a cardiovascular condition which has been previously diagnosed regardless of the time limit. The term "known to be

on maximal or near-maximal doses of 2-3 pharmacologic agents. Some causes of secondary hypertension may be amenable to surgical intervention or specific pharmacologic disease. (See Cardiovascular Advisory Panel Guidelines for the Medical Examination of Commercial Motor Vehicle Drivers at <http://www.fmcsa.dot.gov/rulesregs/mcdreports.htm>)

Rheumatic, Arthritic, Orthopedic, Muscular, Neurological or Vascular Disease §391.41(b)(7)
A person is physically qualified to drive a commercial motor vehicle if:
• Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease which interferes with the ability to control and operate a commercial motor vehicle safely.

Certain diseases are known to have acute episodes of incident muscle weakness, poor muscular coordination (ataxia), abnormal sensations (paresthesia), decreased muscular tone (hypotonia), visual disturbances and pain which may be suddenly incapacitating. With each recurring episode, these symptoms may become more pronounced and remain for longer periods of time. Other diseases have more insidious onsets and display symptoms of muscle wasting (atrophy), swelling and paresthesia which may not suddenly incapacitate a person but may resist further movements and eventually interfere with the ability to safely operate a motor vehicle. In many instances these diseases are degenerative in nature or may result in deterioration of the involved area.

Once the individual has been diagnosed as having a rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease, then he/she has an established history of that disease. The physician, when examining an individual, should consider the following: (1) the nature and severity of the individual's condition (such as sensory loss or loss of strength); (2) the degree of limitation present (such as range of motion); (3) the likelihood of progressive limitation (not always present initially but may manifest itself over time); and (4) the likelihood of sudden incapacitation. If severe functional impairment exists, the driver does not qualify. In cases where more frequent monitoring is required, a certificate for a shorter period of time may be issued. (See Conference on Neurological Disorders and Commercial Drivers at <http://www.fmcsa.dot.gov/rulesregs/mcdreports.htm>)

(See Conference on Pulmonary/Respiratory Disorders and Commercial Drivers at <http://www.fmcsa.dot.gov/rulesregs/mcdreports.htm>)

Hypertension §391.41(b)(8)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no current clinical diagnosis of high blood pressure likely to interfere with ability to operate a commercial motor vehicle safely.

Hypertension alone is unlikely to cause sudden collapse; however, the likelihood increases when large organs, such as the heart, brain, or kidneys, are affected. If disease, is present. This regulatory criteria is based on FMCSA's Cardiovascular Advisory Guidelines for the Examination of CMV Drivers, which used the Sixth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1987).

Stage 4 hypertension corresponds to a systolic BP of 140-159 mmHg and/or a diastolic BP of 90-99 mmHg. The driver with this stage of hypertension is not automatically disqualified to drive for a one-year period.

Certification examinations should be done annually thereafter and should be at or less than 140/90. If less than 180/100, certification may be extended one time for 3 months.

A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension. The driver is disqualified to drive for a one-year period. The driver must have a medical evaluation and certification of treatment. The driver is given a one time certification of three months to reduce his or her blood pressure to less than or equal to 140/90. A blood pressure in this range is an absolute indication for anti-hypertensive drug therapy. Provided treatment is well tolerated and the driver demonstrates a BP value of 140/90 or less, he or she may be certified for one year from date of the final exam.

A blood pressure of or greater than 180 (systolic) and 110 (diastolic) is considered Stage 3, high risk for an acute BP-related event. The driver may not be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may be certified for 6 months and biannually (every 6 months) thereafter at reduced BP of 140/90 or less. Annual medical certification is recommended if the medical examiner does not know the severity of hypertension prior to treatment.

An elevated blood pressure finding should be confirmed by at least two subsequent measurements on different days.

Treatment includes nonpharmacologic and pharmacologic modalities as well as counseling to reduce risk factors. The physician should be aware that medications also have side effects, the importance of which must be judged on an individual basis. Individuals must be alerted to the hazards of these medications while driving. Side effects of somnolence or syncope are particularly undesirable in commercial drivers.

Secondary hypertension is based on the above stages. Evaluation is warranted if patient is persistently hypertensive.

accompanied by" is designed to include a clinical diagnosis of a cardiovascular disease (1) which is accompanied by symptoms of syncope, dyspnea, collapse or congestive cardiac failure; and/or (2) which is likely to cause syncope, dyspnea, collapse or congestive cardiac failure.

It is the intent of the FMCSA to render unqualified a driver with a medical condition that causes symptoms of syncope, dyspnea, collapse, or congestive cardiac failure. However, the subjective decision of whether the nature and severity of an individual's condition will likely cause symptoms of cardiovascular insufficiency is on an individual basis and qualification rests with the medical examiner and the motor carrier. In those cases where there is an established medical condition that causes symptoms of syncope, dyspnea, collapse, or congestive cardiac failure, it is suggested before a driver is certified that he or she have a normal resting and stress electrocardiogram (ECG), no residual complications and no physical limitations, and is taking no medication likely to interfere with safe driving.

Coronary artery bypass surgery and pacemaker implantation are remedial procedures and thus, not qualifying. Implantable cardioverter defibrillators are implantable medical devices that can monitor the heart rate of the driver and should not, by its use, medically disqualify the commercial driver. The emphasis should be on the underlying medical condition(s) which require treatment and the general health of the driver. The FMCSA should be contacted at (202) 365-7780 for additional recommendations regarding the physical qualification of drivers with implanted medical devices. (See Cardiovascular Advisory Panel Guidelines for the Medical Examination of Commercial Motor Vehicle Drivers at <http://www.fmcsa.dot.gov/rulesregs/mcdreports.htm>)

Respiratory Dysfunction §391.41(b)(9)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with ability to control and drive a commercial motor vehicle safely.

Since a driver must be alert at all times, any change in his or her mental state is in direct conflict with highway safety. Even the slightest impairment in respiratory function under emergency conditions (when greater oxygen supply is necessary for performance) may be detrimental to safe driving.

There are many conditions that interfere with oxygen exchange and may result in incapacitation, including emphysema, chronic asthma, carcinoma, tuberculosis, chronic bronchitis and sleep apnea. If the medical examiner detects a respiratory dysfunction, that in any way is likely to interfere with the driver's ability to safely control a commercial motor vehicle, the driver must be referred to a specialist for further evaluation and treatment. Anticoagulation therapy for deep vein thrombosis and/or pulmonary thromboembolism is not unqualifying once optimum dose is achieved, provided lower extremity venous examinations remain normal and the treating physician gives a favorable recommendation.

Vision**\$391.41(b)(10)**

A person is physically qualified to drive a commercial motor vehicle if that person:

Has distant visual acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses or visual acuity separately connected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian, and an ability to distinguish the color of traffic signals and devices showing standard red, green, and amber.

The term "ability to recognize the colors of" is interpreted to mean if a person can recognize and distinguish among traffic control signals and devices showing standard red, green and amber, he or she meets the minimum standard, even though he or she may have some type of color perception deficiency. If a person has a color vision deficiency that is not correctable by tinted lenses, contact lenses, or other means, the person is not qualified to drive a commercial motor vehicle.

Contact lenses are permissible if there is sufficient evidence to indicate that the driver has good tolerance and it will be adapted to the color of standard traffic control signals. Vision is not acceptable, nor telescopic lenses acceptable for the driving of commercial motor vehicles.

If an individual meets the criteria by the use of glasses or contact lenses, the following statement shall appear on the Medical Examiner's Certificate: "Qualified only if wearing corrective lenses."

Persons who do not meet the Federal vision standard may call (202) 365-1780 for an application for a vision exemption.

(See Visual Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/visualdisorders.htm>)

Hearing**\$391.41(b)(11)**

A person is physically qualified to drive a commercial motor vehicle if that person:

Has perceived a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid.

Persons who do not meet the Federal hearing standard may call (202) 365-1780 for an application for a hearing exemption.

(See Hearing Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/hearingdisorders.htm>)

Since the prescribed standard under the FMCSRs is the American Standards Association (ANSI), it may be necessary to convert the audiometric results from the ISO standard to the ANSI standard. Instructions are included on the Medical Examination report form.

If an individual meets the criteria by using a hearing aid, the driver must be able to hear the aid and have it in operation at all times while driving. Also, the driver must be in possession of a spare power source for the hearing aid.

For the whispered voice test, the individual should be stationed at least 5 feet from the examiner with the ear being tested turned toward the examiner. The other ear is covered. Using the breath which remains after a normal expiration, the examiner whispers words or random numbers such as 86, 16,

Mental Disorders**\$391.41(b)(9)**

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with ability to drive a motor vehicle safely.

Emotional or adjustment problems contribute directly to an individual's level of memory, reasoning, attention, and judgment. These problems often underlie physical disorders. A variety of conditions, including depression, anxiety, and stress, may lead to incoordination, inattention, loss of functional control and susceptibility to accidents while driving. Physical fatigue, headache, impaired coordination, recurring physical ailments and chronic "ragging" pain may be present to such a degree that certification for commercial driving is inadvisable. Somatic and psychosomatic conditions should be thoroughly examined.

Disorders of a particularly incapacitating nature, even in the early stages of development, may warrant disqualification. Many bus and truck drivers have documented that "nervous trouble" related to neurotic, personality, or emotional or adjustment problems is responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to control stress and emotional stress is critical when assessing an individual's mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.

Individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, vindictive, impulsive, openly hostile, or excessively fearful individuals may be greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications.

Individuals who are taking medications that may have potential hazards for driving. (See Conference on Psychiatric Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/psychiatricdisorders.htm>)

When examining the driver, it should be kept in mind that individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, vindictive, impulsive, openly hostile, or excessively fearful individuals may be greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications.

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Individuals who are taking medications that may have potential hazards for driving. (See Conference on Psychiatric Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/psychiatricdisorders.htm>)

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Epilepsy**\$391.41(b)(8)**

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle.

Epilepsy is a chronic functional disease characterized by seizures or episodes that occur without warning, resulting in loss of voluntary control which may lead to loss of consciousness and/or injury to the driver or others. There are several types of epilepsy. A driver who has a current clinical diagnosis of epilepsy, (2) a driver who has a current clinical diagnosis of epilepsy, or (3) a driver who is taking antiepileptic medication.

If an individual has had a sudden episode of a nonepileptic seizure or loss of consciousness of unknown cause which did not require antiepileptic medication, the decision as to whether that person's condition will likely cause loss of consciousness or loss of ability to control a motor vehicle must be made on an individual basis by the medical examiner. The medical examiner should consult with the treating physician.

Before certification is considered, it is suggested that a 6 month waiting period elapse from the time of the episode. Following the waiting period, it is suggested that the individual have a complete neurological examination. If the results of the examination are negative and antiepileptic medication is not required, then the driver may be qualified to drive a commercial motor vehicle.

Individuals who have a seizure or an episode of loss of consciousness where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (e.g., drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking antiepileptic medication.

Individuals who have a seizure or an episode of loss of consciousness where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (e.g., drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking antiepileptic medication.

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22, etc. The examiner should not use only sibilants (s sounding materials). The opposite ear should be tested in the same manner. If the individual fails the whispered voice test, the audiometric test should be administered. If an individual meets the criteria by the use of a hearing aid, the following statement must appear on the Medical Examiner's Certificate "Qualified only when wearing a hearing aid." (See Hearing Disorders and Commercial Motor Vehicle Drivers at <http://www.fmcsa.dot.gov/rulesregs/reg-491001.htm>)

Drug Use

§391.41(b)(12)
A person is physically qualified to drive a commercial motor vehicle if that person:

Does not use a controlled substance identified in 21 CFR 1308.11.

Exception. A driver may use such a substance or drug, if the substance or drug is prescribed by a physician through the driver's medical history and assigned driver, and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

This exception does not apply to methadone. The intent of the medical certification process is to medically evaluate a driver to ensure that the driver has no medical condition that would prevent the driver from safe operation of driving based on a public road. If a driver uses a Schedule I drug or other substance, an amphetamine, a narcotic, or any other habit-forming drug, it may be cause for the driver to be found medically unqualified.

Motor carriers are encouraged to obtain a practitioner's written statement about the effects on transportation safety of the use of a particular drug. A test for controlled substances is not required as part of this physical examination process. If a driver is found to be using a controlled substance, contact directly for information on controlled substances and alcohol testing under Part 382 of the FMCSRs.

The term "uses" is designed to encompass instances of prohibited drug use determined by a physician through established medical means. This may or may not involve body fluid testing. If body fluid testing takes place, the test must be conducted in a laboratory setting. The term "habit-forming" is intended to include any drug or medication generally recognized as capable of becoming habitual, and which may impair the user's ability to operate a commercial motor vehicle safely.

The driver is medically unqualified for the duration of the prohibited drug(s) use and until a second examination shows the driver free from the substance. For the purpose of this exception, the driver must be re-evaluated, the successful completion of a drug rehabilitation program, and a negative drug test result. Additionally, given that the certification period is normally two years, the examiner has the option to certify for a period of less than two years if this examiner determines more frequent monitoring is required.

For references on Neurological Disorders and Commercial Drivers and Conferences on Psychiatric Disorders and Commercial Drivers at: <http://www.fmcsa.dot.gov/rulesregs/reg-491001.htm>

Alcoholism

§391.41(b)(13)
A person is physically qualified to drive a commercial motor vehicle if that person:

Has no current clinical diagnosis of alcoholism.

The term "current clinical diagnosis of" is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol use disorder, the examiner should advise the driver of the consequences of continuing alcohol treatment, he or she may be considered for certification.

(g)(1) If the medical examiner finds that the person examined is physically qualified to operate a commercial motor vehicle in accordance with §391.41(b), the medical examiner should complete a certificate in the form prescribed in paragraph (h) of this section and furnish the original to the person

who was examined. The examiner may provide a copy to a prospective or current employing motor carrier who requests it.

(2) For all drivers examined, the medical examiner should retain a copy of the Medical Examination Report at

Federal Motor Carrier Safety Administration, DOT

§ 391.43

least 3 years from the date of the examination. If the driver was certified as physically qualified, then the medical examiner should also retain the medical certificate as well for at least 3-years from the date the certificate was issued.

(h) The medical examiner's certificate shall be substantially in accordance with the following form. Existing forms may be used until current printed supplies are depleted or until November 6, 2001, whichever occurs first.

MEDICAL EXAMINER'S CERTIFICATE	
I certify that I have examined _____ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when: ☐ wearing corrective lenses ☐ wearing hearing aid ☐ accompanied by a _____ waiver/exemption ☐ driving within an exempt intracity zone (49 CFR 391.62) ☐ accompanied by a Skill Performance Evaluation Certificate (SPE) ☐ Qualified by operation of 49 CFR 391.64	
The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.	
SIGNATURE OF MEDICAL EXAMINER	DATE
MEDICAL EXAMINER'S NAME (PRINT)	☐ MD ☐ DO ☐ Chiropractor ☐ Physician Assistant ☐ Advanced Practice Nurse
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE	
SIGNATURE OF DRIVER	DRIVER'S LICENSE NO. STATE
ADDRESS OF DRIVER	
MEDICAL CERTIFICATE EXPIRATION DATE	

[36 FR 6460, Apr. 22, 1970]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 391.43, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

1) RCW 18.25.005(3) says, "As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination..." There is no RCW that says comprehensive physical exams are not part of the chiropractic scope of practice. The "physical examination" I was taught at school is comprehensive.

2) Prescriptive authority is not necessary to perform a PPE. It is only necessary to treat a condition (such as asthma) that may be apparent through an examination, in which case an appropriate referral to an MD would be warranted.

3) It is incorrect to say that the DACBSP certification focuses primarily on spine, extremities, and biomechanics (in other words, orthopedics). 25% of the CCSP/DACBSP is Emergency Medicine. Further, to achieve a DACBSP, one must perform an EMS practical examination to show proficiency as an emergency medical technician. Other parts of the CCSP/DACBSP training include extensive training in the management of concussion, and further there is emphasis on the keys to a proper cardiac exam (especially as it relates to a PPE).

4) Many of the MD's qualified to perform PPE's do not have a "daily practice that includes functions of primary care." For example, orthopedists, physiatrists, and many sports physicians all have daily patient encounters that are comparable to that of a chiropractor and not a General Practitioner. These three specialties are examples of MD's that do not daily auscultate hearts and palpate abdomens, yet they are still allowed to perform PPE's.

5) Preventing death in sport is certainly the biggest consideration. But the number one killer in sport (hypertrophic cardiomyopathy) is not traditionally detected through a routine examination. Clues to HCM are only found in the patient history. Therefore, there remains no solid evidence that the number of deaths in sport will increase if DC's were allowed to perform PPEs.

Ben McCay, DC

I am writing on behalf of Association of Washington Healthcare Plan (AWHP) members regarding the Department of Health's (DOH) draft sunrise review report on the House Bill 1573 proposal to expand chiropractors' scope of practice to include performance of physical examinations for sports physicals and commercial driver's licenses.

We appreciate the extensive research and careful evaluation that went into crafting the DOH draft sunrise review report findings and recommendations.

We agree with the report findings that support that examining a patient to evaluate his or her overall health is the job of a primary care provider who can use his or her broad spectrum of training, clinical residency, and experience. It also found sports physical examinations and commercial driver's license physical examinations are not merely screenings, but rather are intended to be comprehensive physical examinations. Additionally, it concluded these examinations are clearly not within the current scope of practice for chiropractors in Washington, and adding them would place patients at risk of harm. We are in agreement with these findings.

Given that our first and foremost concern with the proposed scope of practice expansion is patient safety, we believe these DOH findings should be taken very seriously. Accordingly, we are convinced it is in the best interest of those we serve to strongly support DOH's draft sunrise review report recommendation that the applicant's proposal and HB 1573 not be adopted.

Thank you for the opportunity to provide these comments. Please do not hesitate to contact me with any questions or to discuss.

I respectfully, strongly agree with the draft response of the Department of Health. Pre-Participation Sports Physical Examinations and Commercial Driver's License Physicals do not fall within chiropractic scope of practice, and certainly not with 18 hours of continuing education.

Thank you for the opportunity to comment.
Gordon Oakes

I concur with the below thoughts. I do not support chiropractors practicing outside their scope.
Jason Attaman

The department does not support expanding the chiropractic scope of practice to include PPEs for student athletes and commercial driver's license physicals (CMV exams). Since the department believes these physicals are outside the chiropractic scope of practice, we reviewed whether changing the definitions in RCW 18.25.005 to expand the scope would meet the sunrise criteria. The department found risk of patient harm if PPEs and CMV exams are added to the chiropractic scope of practice. Specifically:

- Addition of PPEs and CMV exams would expand the chiropractic scope of practice well outside of their current scope of diagnosing and treating conditions relating to the musculoskeletal system.
- The chiropractic scope of practice does not contain prescriptive authority, nor do the educational programs include a focus on pharmacology, which is necessary in both types of physical examinations.
- Although chiropractic training includes basic understanding of body and organ systems, including the cardiovascular system, the department is unable to find that it prepares chiropractors to potentially be the sole evaluators of all or most medical conditions.
- The DACBSP specialty certification training's primary focus also appears to be on spinal and extremity manipulation, exercise physiology, and sports-specific biomechanics.

DRAFT Chiropractic Sunrise Page 5

- Examining a patient to evaluate his or her overall health is the job of a primary care provider who can use his or her broad spectrum of training, clinical residency, and experience to conduct the evaluations, and whose daily practice includes functions of primary care.
- PPEs and CMV exams are not merely "screenings." They are intended to be comprehensive physical examinations, and are sometimes the only examination the person receives regularly.
- If the scope of practice is expanded for these types of examinations, it could open the door to expanding it for all physical examinations.

Jason G. Attaman, DO, FAAPMR

My name is Matt Brennan, and I am a licensed athletic trainer in the state of Washington. I support the Department of Health's position of not endorsing a change in the chiropractor's scope of practice. The WSCA's statement that they are being discriminated against for not being allowed to perform PPE's is nonsense! Healthcare providers have role delineations. As an athletic trainer, I am not allowed to perform

manipulations of the spine. This is role delineation, not discrimination. Heart surgeons do not perform spinal fusion surgeries. Neurosurgeons do not perform ACL reconstructions of the knee. The list goes on. I ask you to refuse their request without hesitation.

Matt Brennan, ATC, AT-L
Stanwood High School

On behalf of all the chiropractic college programs in the United States, all accredited by the United States Department of Education's recognized accreditors, I write to support inclusion of doctors of chiropractic in the PPEs. The question before this body is whether the doctor of chiropractic has the education and training to meet the requirements for PPE in the state of Washington. They do.

The education and training received at doctor of chiropractic programs fulfill the needs and diagnostic ability to perform the PPE as they have and do across the country (from California to Georgia and back to Nevada for example). Doctors of chiropractic have five academic years of post undergraduate education to receive their clinical doctorate which has been recognized and accepted by the US Department of Transportation for their certification process. In fact doctors of chiropractic and medical doctors sit side by side in their certifying exams.

To exclude one is to exclude the other.

Among many points the Washington state statute uses the term "shall" in reference to examinations by doctors of chiropractic, not the alternative "may", so legal counsel will provide the distinction that it is a requirement not an alternative.

David O'Bryon, JD, CAE, Executive Director, Association of Chiropractic Colleges



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October 28, 2013

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

Please accept our comments on the draft Chiropractic Scope of Practice Sunrise Review.

At page 13 the draft report states that Oregon allows chiropractors to perform dry needling. The footnote references OAR 811-015-0036, a regulation promulgated by Oregon's Board of Chiropractic Examiners. This statement is no longer correct.

On July 29, 2011 the Oregon Court of Appeals granted a motion to stay the operation of OAR 811-015-0036, pending full judicial review. The Board moved for reconsideration of the stay, and the Court denied that motion on November 10, 2011. We have enclosed both the Order granting the stay and the Order denying reconsideration.

Meanwhile, the Board of Chiropractic Examiners issued a press release May 13, 2013 (also enclosed), which states, "Chiropractic physicians who have been certified should cease all practice of dry needling."

Most recently, the Court of Appeals heard arguments on July 17, 2013. No decision has been issued as of this writing.

We hope this information updates the draft report, and we ask that the final report include this more current description of the status of dry needling in Oregon.

Thank you for the opportunity to comment on the draft report.

Sincerely,

The WEAMA Board of Directors

Enclosures: Stay and Denial of Reconsideration, Oregon Court of Appeals No. A148924
OBCE press release



Oregon

John A. Kitzhaber, M.D., Governor

Oregon Board of Chiropractic Examiners

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Appeals Court Commissioner Stays Dry Needling Rule

May 13, 2013 Update below

Notice to Oregon Chiropractic Physicians & Interested Persons

July 10, 2012 - "The OAAOM now has until July 20th to file a reply brief. The court will schedule oral argument for sometime after September, probably. After argument, the court will either affirm without opinion within a few weeks (3 or so), or will write an opinion deciding the case, which could take a year or more, but usually takes about 6 months."

The Court of Appeals Appellate Commissioner issued a Stay Order dated July 29, 2011.

This suspends the new rule until the issue is resolved by a full panel of judges after hearing a full presentation of the arguments.

The OBCE's dry needling rule is no longer in effect pending a full proceeding and argument before the Oregon Court of Appeals. This could be a lengthy process.

Chiropractic physicians who have been certified should cease all practice of dry needling. The OBCE may not certify any new chiropractic physicians during the period of the Stay.

(Visit the OBCE's website, and look under Current Topics to access the web links)

May 13, 2013	Oral Argument before the Court of Appeals - The court has set oral argument for July 17th at 1:30 in the Supreme Court courtroom, 1163 State Street, Salem Oregon (due East of the State Capitol). This is open to the public to observe. It lasts about an hour, with attorney for the plaintiffs and the respondent (OBCE) making the case to a three-judge panel. The judges ask questions. There is no public comment or testimony accepted. The Court then considers the case. Recent experience has shown it could be up to a year before a ruling is issued.
Aug. 2, 2012	University of Western States Answering Brief (38 pgs)
July 10, 2012	OBCE Answering Brief (27 pgs)
Mar. 14, 2012	OAAOM Opening Brief 3-14-12.pdf (79 pgs) Pgs 1-39 and Pgs 40-79
Nov. 14, 2011	Order Denying Motions for Reconsideration (2 pgs)
Oct. 26, 2011	OBCE's Reply to Response to Motion - Reconsideration of Order Staying Administrative Rule (21 pgs)
Oct. 12, 2011	OAAOM's Memorandum in Opposition to Respondent OBCE's Motion for Reconsideration of Order Staying Administrative Rule (25 pgs)
Continued...	
Sept. 22, 2011	OBCE's Motion Reconsideration of Order Staying Administrative Rule (78 pages) Pgs 1 – 40 and Pgs 41- 78

July 29, 2011	<u>(Court's) Order Staying Administrative Rule Pending Judicial Review</u> (3 pgs)
July 21, 2011	<u>OBCE's Response in Opposition to Petitioner's Motion — Stay</u> (13 pgs)
July 7, 2011	OAAOM's Motion for Stay Pending Judicial Review (66 pgs) <u>Pgs 1 – 33</u> and <u>Pgs 34 - 66</u>

IN THE COURT OF APPEALS OF THE STATE OF OREGON
OREGON ASSOCIATION OF ACUPUNCTURE AND ORIENTAL MEDICINE,
Petitioner,

v.

BOARD OF CHIROPRACTIC EXAMINERS,
Respondent.

LANDYE BENNETT
BLUMSTEIN LLP
AUG 01 2011

Board of Chiropractic Examiners

Court of Appeals No. A148924

ORDER STAYING ADMINISTRATIVE RULE PENDING JUDICIAL REVIEW

Petitioner has moved to stay an administrative rule adopted by respondent Board of Chiropractic Examiners, OAR 811-015-0036, which permits chiropractors to practice "dry needling," pending this judicial review of the Board's authority to adopt the rule.

The court has the inherent authority to stay enforcement of an administrative rule based on a showing of irreparable harm. *See Northwestern Title Loans v. Division of Finance and Corporate Securities*, 180 Or App 1, 11-12, 42 P3d 313 (2002), *vacated as moot by order dated June 12, 2002*. In addition to requiring a showing that the failure to stay enforcement of the rule pending judicial review will result in irreparable harm, the court also considers the likelihood that petitioner will prevail on judicial review.

The court determines that petitioner has made a showing that it is reasonably likely to prevail on judicial review. Petitioner has made a *prima facie* showing that "dry needling" is substantially the same as acupuncture. Respondent argues that, because the practice of acupuncture can include additional techniques and modalities, dry needling is not acupuncture. Regardless of whether acupuncture includes additional techniques and modalities, acupuncture also includes the insertion of needles to stimulate acupuncture points and meridians. ORS 677.757(1)(a). OAR 811-015-0036 defines "dry needling" as "a technique used to evaluate and treat myofascial trigger points that uses a dry needle, without medication, that is inserted into a trigger point * * *." Petitioner has shown that there is a 93.3% concurrence between "acupuncture points" and "myofascial trigger points" and a 76-90% concurrence between acupuncture meridians and myofascial referred pain patterns. Thus, it appears, dry needling is substantially the same as the insertion of needles treatment modality of acupuncture.

ORDER STAYING ADMINISTRATIVE RULE PENDING JUDICIAL REVIEW

REPLIES SHOULD BE DIRECTED TO: State Court Administrator, Records Section,
Supreme Court Building, 1163 State Street, Salem, OR 97301-2563

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Petitioner has shown that virtually no approved chiropractic school regularly teaches acupuncture or dry needling as a regular part of its curriculum, which is important because part of the definition of “chiropractic” is that it include “employment of all rational therapeutic measures as taught in approved chiropractic colleges.” ORS 684.010(2)(b). Petitioner also has shown that ORS 677.759 confers authority on the Oregon Medical Board to regulate the practice of acupuncture, that respondent previously considered acupuncture outside chiropractic medicine, and that respondent previously disciplined chiropractors who have treated patients with acupuncture.

Even if the practice of dry needling or acupuncture could reasonably be construed as within the meaning of chiropractic medicine generally as defined in ORS 684.010, any attempt by respondent to authorize “dry needling” appears to run afoul of ORS 684.025(2):

“Neither this section nor ORS 684.010 authorizes the administration of any substance by the penetration of the skin or mucous membrane of the human body for a therapeutic purpose.”

Respondent has not argued that needles used in “dry needling” are not a substance within the meaning of ORS 684.025(2), or that dry needling is not administered for a therapeutic purpose.

Respecting whether petitioner has shown that irreparable harm will result if the administrative rule is not stayed pending judicial review, the court concurs with respondent that petitioner has not shown that the association itself or even its individual practitioner members are likely to suffer irreparable harm as the court applied that term in *Northwestern Title Loans*, 180 Or App at 13 (petitioner did not show that failure to stay enforcement of the administrative rule would force petitioner out of business). *But see Arlington Sch. Dist. No. 3 v. Arlington Ed. Assoc.*, 184 Or App 97, 101-02, 55 P3d 546 (2002) (“irreparable harm” means injury that reasonably cannot be completely remedied in court of law).

In addition to potential harm to the party invoking the court’s jurisdiction, the court also may consider whether the failure to act could irreparably harm others. Petitioner contends that the failure to stay the rule in question will result in irreparable harm to patients of chiropractic practitioners who engage in dry needling because the amount of training required of a chiropractor to engage in that practice is inadequate. The administrative rule requires practitioners to complete a 24-hour practicum, with no clinical component. According to the declaration of Alfred Thieme, an expert in the practice of acupuncture, adverse effects of the practice of dry needling can include small bleeding, hemotoma, dizziness, fainting, nausea, increase in pain symptoms, infection, and pneumothorax (puncturing of the lung), which can be particularly serious. Respondent has attempted to minimize the significant of the potential adverse effects, but has not rebutted that those conditions are recognized potential adverse effects of improper dry needling.

ORDER STAYING ADMINISTRATIVE RULE PENDING JUDICIAL REVIEW

REPLIES SHOULD BE DIRECTED TO: State Court Administrator, Records Section,
Supreme Court Building, 1163 State Street, Salem, OR 97301-2563

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Petitioner also has shown that the Accreditation Commission for Acupuncture and Oriental Medicine requires 705 hours devoted to acupuncture theory and 660 hours of clinical practice in its training program. The American Board of Chiropractic Acupuncturists requires 300 hours of training, and the National Board of Chiropractic Examiners requires 100 hours of training. Even recognizing that "dry needling" is but one technique or modality within the broader practice of acupuncture, respondent has not explained how 24 hours of training, with no clinical component, provides sufficient training to chiropractors to adequately protect patients.

For the foregoing reasons, petitioner's motion is granted and OAR 811-015-0036 is stayed pending further order of this court or upon issuance of the appellate judgment terminating this judicial review.

JUL 29 2011

DATE



James W. Nass, Appellate Commissioner

c: Thane W Tienson
Judy C Lucas

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ORDER STAYING ADMINISTRATIVE RULE PENDING JUDICIAL REVIEW

REPLIES SHOULD BE DIRECTED TO: State Court Administrator, Records Section,
Supreme Court Building, 1163 State Street, Salem, OR 97301-2563
Page 3 of 3

IN THE COURT OF APPEALS OF THE STATE OF OREGON
OREGON ASSOCIATION OF ACUPUNCTURE AND ORIENTAL MEDICINE, ALFRED
TIEME AND E. CHRISTO GORAWSKI,
Petitioners,

v.

BOARD OF CHIROPRACTIC EXAMINERS,
Respondent,

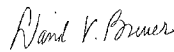
and,

UNIVERSITY OF WESTERN STATES AND JOHN L. V. PLATT, D.C., P.C. dba
WOODSTOCK CHIROPRACTIC CLINIC,
Interveners-Respondents.

Court of Appeals No. A148924

ORDER DENYING MOTIONS FOR RECONSIDERATION

Respondents have moved for reconsideration of the Appellate Commissioner's order granting petitioners' motion for stay of the challenged rule pending judicial review. The stay was proper based on a showing by petitioner of irreparable harm and the likelihood of prevailing on the merits. The motions are denied.



11/10/2011
10:11:07 AM

DAVID V. BREWER
CHIEF JUDGE, COURT OF APPEALS

c: Thane W Tienson
Jona Jolyne Maukonen
Andrew T Reilly
Judy C Lucas

ej09/28/2011

ORDER DENYING MOTIONS FOR RECONSIDERATION

REPLIES SHOULD BE DIRECTED TO: State Court Administrator, Records Section,
Supreme Court Building, 1163 State Street, Salem, OR 97301-2563