The Minnesota Chiropractic Licensing Statute--A Time for Revision

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Note: The Minnesota Chiropractic Licensing Statute—A Time for Revision

I. INTRODUCTION

Recent Minnesota and federal legislation has given chiropractic an increased role in the health care field. The Minnesota Workmen’s Compensation Act was amended to include chiropractic treatments within the benefits to be provided by employers. “Insurance equality” legislation requiring coverage for chiropractic services in health and accident and nonprofit health service policies was also enacted. Similarly, the “privileged communication” statute was amended to allow chiropractors the evidentiary privileges accorded medical doctors, osteopaths and dentists. In the federal field, legislation was enacted to provide chiropractic services under Medicare and to establish standards for chiropractic inclusion in Medicaid.

This recent legislation favoring chiropractic was enacted despite a substantial controversy surrounding the profession. In Minnesota, this increased role for chiropractic has evolved without a corresponding renovation of the chiropractic licensing statute. Statutory provisions which limit the scope of practice,

2. Minn. Laws 1971, ch. 863, amending Minn. Stat. §§ 176.135 & .181 (1969) (codified at Minn. Stat. §§ 176.135 & .181 (1971)). The amendment was apparently enacted in response to Ingebritson v. Tjernlund Mfg. Co., 289 Minn. 232, 183 N.W.2d 552 (1971) in which the court had held that “medical treatment” for the purposes of section 176.135 did not include chiropractic services. The opinion suggested that the then recently convened legislature would have an opportunity to either amend section 176.135 or leave it unchanged.
8. Minn. Stat. §§ 148.01-.101 (1971) (the statute consists of 10 sections). A recent amendment of the statute was an act which changed the licensing or regulatory provisions of 18 professions and trades. The chiropractic licensing statute now provides for “public members” on the board of chiropractic examiners. Minn. Laws 1973, ch. 638, § 10, codified at Minn. Stat. § 148.03 (Supp. 1973). A “public member” is defined as
establish licensing qualifications, set standards for professional conduct and advertising, and outline the composition and powers of the board of examiners are inadequate and need revision. This Note will examine the legal status of chiropractic in Minnesota, including a discussion of the history and nature of the profession and an identification of the interests involved in chiropractic licensure. Following a comparison of the Minnesota chiropractic licensing statute to statutes of other states, this Note will suggest revisions in the Minnesota statute.

II. HISTORY AND NATURE OF CHIROPRACTIC

Daniel D. Palmer is recognized as the founder of the chiropractic method of healing. Formerly a "magnetic healer,"
Palmer performed his first chiropractic adjustment in 1895 on Harvey Lillard, a janitor in Palmer's office. Lillard had experienced some degree of deafness for seventeen years. Palmer discovered a protruding vertebra in Lillard's back and performed a series of hand adjustments to reduce the misalignment. Within a week the protrusion was no longer noticeable, and Lillard's hearing was restored to normal. Since the cure of Lillard and other successful treatments convinced Palmer that healing by spinal adjustment was superior to magnetic healing methods, he considered his search for the basic cause of disease completed.

Palmer's theory was based fundamentally upon the principal that the nervous system conducted "Innate Intelligence," a force essential to the healing process within the body. When the normal flow of this force was transmitted by the nerves, it performed its function of maintaining bodily health. However,
displacement or subluxation of the vertebrae adversely affected this flow by interfering with the nervous system. Palmer found that chiropractic adjustments to properly align the vertebrae relieved such nerve interference and promoted better health.22

Since Palmer's discovery of chiropractic, the profession has grown to include approximately 20,000 chiropractors throughout the nation, of whom almost 500 practice in Minnesota.23 This growth in chiropractic has been accompanied by steady developments in theory and treatment. For example, Willard Carver, an early student of Palmer, postulated that any distortion of a bodily structure can be causally related to disease.24 Theories of vertebral displacement causation, stemming from the mechanical, mental or chemical stresses originally outlined by Palmer, have undergone a corresponding increase in sophistication and complexity.25 The new treatment methods (nonmanipulative as well as manipulative) include dietary guidance,26 therapeutic baths27 and advanced techniques of spinal adjustment.28

Divergence in theory and treatment among chiropractors has divided the profession into two major factions which have formed their own associations—the International Chiropractors Association and the American Chiropractic Association.29 The former consists of about 4,000 members30 who are known as the “straights” because of their belief in spinal adjustment as the exclusive chiropractic therapy.31 The latter group has about 7,800 members32 who are known as the “mixers” because they employ “dietary and nutritional supplementation” and “physiotherapeutic measures” in addition to spinal adjustments.33 However, both groups agree on the basic tenet that chiropractic is a natural healing system based upon the inherent recupera-

22. Id.
23. U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, HEALTH RESOURCE STATISTICS, HEALTH MANPOWER AND HEALTH FACILITIES, 1971, at 59 (1972) (figures include both active and inactive chiropractors) [hereinafter cited as HEW, HEALTH RESOURCE].
24. McClusky, supra note 14, at 76.
27. Id. at 83.
30. Id.
31. Independent Practitioners, supra note 20, at 147.
32. HEW, Health Resource, supra note 23, at 57.
33. Independent Practitioners, supra note 20, at 147.
tive powers of the body with an emphasis on the relationship between the nervous system and the spinal column.\textsuperscript{34}

III. INTERESTS INVOLVED IN CHIROPRACTIC LICENSURE

Chiropractic licensing legislation involves a balancing of the needs and demands of various interests, the most prominent of which are the public, the chiropractic group and the medical group.

A. IDENTIFICATION OF INTERESTS

The public, as the recipient of health care services, has a natural interest in the quality and availability of health care.\textsuperscript{35} This public interest is manifested in two areas—licensure and referrals, both of which have a significant influence upon the delivery of health care. Licensure is intended to serve as a guardian of quality, but it also impairs the delivery of health services by establishing entry requirements for the professions.\textsuperscript{36} Interprofessional referrals are a second aspect of health care delivery not currently dealt with by most health care licensing statutes. At present, if an independent practitioner is unable to give a patient optimal care because of limitations in his training or upon the scope of his license, he refers that patient to another practitioner who is often in a different field of practice. Since such referrals rest upon the professional judgment of individual health professionals, the decision as to who will actually render treatment may be removed from the patient. The public, therefore, has a strong interest in the quality of the decisions underlying any patient referral system.\textsuperscript{37}

\textsuperscript{34} \textit{Wilks, supra} note 14, at 26–27.

\textsuperscript{35} "Good" or at least "adequate" health care has been considered by both the President of the United States and the American Medical Association to approach the status of a basic right. Simons, \textit{National Health Insurance Legislation and the 92nd Congress}, 7 N. Engl. L. Rev. 25, 29 (1971).

\textsuperscript{36} See Note, \textit{Regulation of Health Personnel in Iowa—A Distortion of the Public Interest}, 57 Iowa L. Rev. 1006, 1007 (1972) [hereinafter cited as Iowa Note]. This problem is exacerbated by the current shortage of health personnel. Lave & Lave, \textit{Medical Care and Its Delivery: An Economic Appraisal}, 35 Law & Contemp. Prob. 252, 254 (1970).

\textsuperscript{37} Although a patient may consult several practitioners without the benefit of a referral, this is constrained by the patient's expectations of care from a particular professional, the information available to the patient and his financial situation. See also Lave & Lave, \textit{supra} note 36.
The two groups whose interests are most directly involved in chiropractic licensure are doctors of medicine and chiropractic. Chiropractors, subject to licensure which restricts their professional practices, obviously have a direct interest in the legislative regulation of their livelihood. In contrast, the interest of the medical group in chiropractic licensing legislation may be derived from two sources: first, a professional obligation to assist health care recipients by taking a position on chiropractic, and second, simple economics since doctors of medicine and chiropractic occasionally treat the same conditions.

These two groups have engaged in a continuous conflict spanning the nearly 80 years of chiropractic existence. In addition to the disagreements between the chiropractic and medical interest groups, each group is troubled by internal dissension. The portion of the medical interest group represented by the American Medical Association (A.M.A.) denounces chiropractic as an unscientific cult. However, another faction of unknown strength has proposed an integration of chiropractic into medicine as a manipulative specialty. Chiropractors are generally

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38. See Ballantine, Will the Delivery of Health Care be Improved by the Use of Chiropractic Services?, 286 N. ENGL. J. MED. 237, 241 (1972).

39. See McClusky, supra note 14, at 175; Scofield, supra note 14, at 112; Wilk, supra note 14, at 97. Some medical doctors have at least impliedly recognized the economic source of the medical group's interest, e.g., Letter from Ronald Klar, M.D. & Duncan Neuhauser, Ph.D. to the Editor of the New England Journal of Medicine, April 27, 1972, in 286 N. ENGL. J. MED. 951, 952 (1972). Others have responded with exasperation or denial. "[W]e were being considered competitors[.] for patients." Angrist, Inevitable Decline of Chiropractic, 73 N.Y. STATE J. MED., 324, 325 (1973) [hereinafter cited as Angrist]. "Nothing could be farther from the truth." Hunter, Health Quackery: Chiropractic, 125 J. LA. STATE MEDICAL SOC'Y, 113, 115 (1973).

40. See, e.g., McClusky, supra note 14, at 81-174 (description of diseases treated by chiropractors, including some comparative medical and chiropractic therapies).


It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.


42. See Wilk, supra note 14, at 97; Nadel, Different Look at Chiropractic, 285 N. ENGL. J. MED. 692 (1971); Note, The Minnesota Supreme Court, 56 Minn. L. REV. 928, 971-72 (1972).
united in opposing medical criticism directed against chiropractic as a whole but are weakened in countering specific medical charges by their own inconsistencies in theory and practice.43

B. AREAS OF CONFLICT BETWEEN THE INTEREST GROUPS

The principal conflicts between the medical and chiropractic interest groups are in chiropractic theory, practice, diagnosis and education.

Palmer based his theory of chiropractic on the concept of nerve interference following vertebral subluxation.44 This theory has been analogized to a simple mechanical model in which the nerves are subject to impingement much like a water hose may be constricted,45 but it has also been explained in detail using anatomical terminology.46 Despite such explanations, the medical interest group, with few exceptions,47 condemns chiropractic theory as both unscientific and irrational,48 contending that vertebral nerve interference is not responsible for all of the bodily disturbances claimed by chiropractors.49 The chiropractic response to such medical criticism is not consistent.50 Several chiropractic writers have asserted that Palmer's theory is either proved51 or at least fundamentally correct.52 Others advise caution in theoretical dialogues until certain aspects are scientif-

43. See text accompanying notes 29-33 supra.
44. McClusky, supra note 14, at 25.
48. See note 41 supra.
49. See Angrist, supra note 39, at 326.
50. The use of the term "Innate Intelligence" illustrates the inconsistency among chiropractors. Several use the term to explain chiropractic theory. See P. Curcuruto, The A.B.C. of Chiropractic 67 (1946) [hereinafter cited as Curcuruto]; Homewood, supra note 19, at 239; Scofield, supra note 14, at 19. However, Homewood retreats from this position when advising prospective chiropractic expert witnesses by urging that no reliance be placed on the concept of "Innate Intelligence" since it is a matter "understood only by chiropractors." See A. Homewod, The Chiropractor and the Law 267 (1965). But cf. Homewood, supra note 19, at 31, in which he states: "Volumes would be wasted trying to explain and prove Innate Intelligence for this is beyond the finite knowledge." The latter work is used as a principal textbook for courses at six chiropractic colleges. Independent Practitioners, supra note 20, at 307.
51. McClusky, supra note 14, at 47.
52. Curcuruto, supra note 50, at 67.
ically explained\(^5\) and discourage reliance upon simplifications of the theory.\(^6\)

The medical and chiropractic interest groups both agree that manipulative therapy is useful in treating certain musculoskeletal conditions.\(^5\) Although these disorders are frequently treated by chiropractors\(^6\) and are the most common reason for a patient to consult a chiropractor in Minnesota,\(^5\) the scope of chiropractic practice is not confined to these conditions. Chiropractic writers assert that a variety of diseases such as asthma, the common cold and cardiovascular conditions have responded to chiropractic care.\(^6\) Their texts propound various methods, including special exercises and diets, to treat many non-musculoskeletal conditions.\(^5\)

Medical doctors, sociologists and lay writers have proposed numerous contrary reasons—such as spontaneous remissions and the healing of psychosomatic illnesses through suggestive therapy—to explain why patients may be satisfied by chiropractic treatments.\(^6\)

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5. See Wilk, supra note 14, at 32-33.
5. See Wilk, supra note 14, at 32-33.
5. See Johnson, supra note 26. One of the difficulties in citing or quoting chiropractic literature is the risk of using an alleged "exception" as a source, and thereby incurring criticism from other factions. See Wilk, supra note 14, at 71.
Opinion among chiropractors is divided on the merits of diagnosing either the patient's vertebral subluxations alone or both the vertebral subluxations and the manifested disease. Adherents of the former position believe that only the diagnosis of vertebral subluxations is critical since correction of the nerve interference allows optimal transmission of the bodily healing force ("Innate Intelligence") and corresponding health.\(^6\) Chiropractors embracing the latter position insist that the diagnosis should reach a specific disease because some conditions, such as cancer, can be treated more effectively by other healing arts.\(^6\) Members of the medical interest group contend that both groups of chiropractors lack diagnostic ability because they are too poorly trained to recognize many diseases.\(^6\) As a result, they allege that chiropractic treatments simply delay necessary medical care.\(^6\)

In the area of educational requirements, the two interest groups also conflict. The medical interest group contends that chiropractic education is markedly inferior to medical education and that chiropractors are thereby exempted from the rigors of a comprehensive scientific education common to all other health professionals.\(^6\) The question of standards is fundamen-

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\(^6\) See Angrist, supra note 39, at 327; Rowland, The Successful Outcast, 75 Pa. Medicine, Aug., 1973, at 20; Wardwell, supra note 60, at 346. (f) Satisfaction of the patient's desires for sympathy and understanding. See Angrist, supra note 39, at 327; Editorial, In the Spinal Analysis 54 J. Kan. Medical Soc'y, Feb., 1973, at 55; McCorkle, supra note 60, at 22; Wardwell, supra note 60, at 346. (g) The mysticism of "the laying on of hands." See J. Vernor, supra note 46, at 70; Angrist, supra note 39, at 327; McCorkle, supra note 60, at 22.

Similarly, the reasons why patients choose the services of a chiropractor rather than some other form of treatment have been hypothesized. They include: (a) A legitimation of the patient's status as sick. See Wardwell, supra note 60, at 346; (b) The patients being "medical antagonists." See Rowland, supra note 60, at 20; (c) The minority group camaraderie of the waiting room prior to chiropractic treatments. See id.; and (d) The mechanical model of chiropractic theory which appeals to the patient's common sense. See McCorkle, supra note 60, at 22.

61. See Scofield, supra note 14, at 43; Opportunities in a Chiropractic Career 14 (1967) (No author, but "[p]roduced with the cooperation of the American Chiropractic Association and the International Chiropractors Association.").

62. See McClusky, supra note 14, at 39; Wilk, supra note 14, at 46. But cf. McClusky, supra note 14, at 193 ("Thus wrong diagnosis to [the chiropractor] is never a pitfall.").

63. See note 41 supra.

64. See Angrist, supra note 39, at 326; Hunter, supra note 39, at 115.

65. See Angrist, supra note 39, at 324; Ballantine, supra note 38,
tal to this conflict over chiropractic education. The medical interest group emphasizes a strong pre-professional student background, the quality of college facilities and the academic credentials of the faculty as significant criteria in professional education. In contrast, the chiropractic interest group, recognizes the relevance of these indices but frequently cites required classroom hours and the curricula in chiropractic colleges as proof that chiropractic education compares in many respects to medical education. Several writers have contended that the medical group's criticism is unfair since chiropractic is a relatively young profession unaided by a long tradition of educational development comparable to that which has accompanied medicine. Proponents of this view argue that as late as 1910, when the Flexner report was published, many medical schools were inadequate despite medicine's lengthy tradition. Chiropractic writers contend that commendation rather than retribution is in order since chiropractic colleges are private institutions which have voluntarily improved themselves and, unlike medical schools, have done so without a great influx of governmental and other outside aid.

IV. REGULATION OF CHIROPRACTIC—
THE STATE LICENSING STATUTES

The growth of chiropractic has prompted the enactment of chiropractic licensing statutes in 49 states, Puerto Rico and the District of Columbia. These statutes regulate the profession by enumerating both licensing standards which define the scope of practice, articulate a code of professional conduct, require examinations and establish educational and personal requirements. Boards of examiners are generally delegated broad powers to enforce these standards. While the state statutes vary in many respects, the following four areas are the most common

66. See L. Coggeshell, Planning for Medical Progress Through Education 4, 5 (1965); J. Hubbard, Measuring Medical Education vii (1971). See also A. Flexner, Medical Education in the United States and Canada (1910).
67. See Wilk, supra note 14, at 48.
68. See Curcuruto, supra note 50, at 45.
70. See Wilk, supra note 14, at 122.
71. Id. at 132.
72. Louisiana is the sole exception.
foci of interest group conflict: (1) scope of practice, (2) qualifications for licensing, (3) professional conduct and advertising and (4) composition and powers of the boards of examiners.

A. Scope of Practice

The principal area of conflict between doctors of medicine and chiropractic relates to the scope of chiropractic practice. Despite the importance of clearly establishing the respective spheres of practice of the two groups, the statutory provisions which outline the areas and methods of permitted chiropractic practice are often loosely defined. The Minnesota licensing statute defines the scope of practice in three ways. First, the statutory definition of chiropractic permits licensees to adjust abnormal articulations found anywhere in the body "for the purpose of giving freedom of action to impinged nerves." Second, the statute prohibits the practice of medicine, surgery, osteopathy and obstetrics and the prescription of internal drugs. Finally, the statute provides a statement of privileges

73. Minn. Stat. § 148.01(1) (1971) provides:

For the purposes of sections 148.01 to 148.10, "chiropractic" is hereby defined as being the science of adjusting any abnormal articulations of the human body, especially those of the spinal column, for the purpose of giving freedom of action to impinged nerves that may cause pain or deranged function.


The practices of medicine and surgery have been defined for the purpose of another state's chiropractic statute respectively as the "... use of drugs and medical preparations and the severing or penetrating of the tissues of human beings." People v. Fowler, 32 Cal. App. 2d 750, 59 P.2d 326, 333 (1938). It is important to consider the intent of the statute's draftsmen in using the term "medicine," because it is a word susceptible of distinct meanings; one indicating nothing more than a remedial agent that has the property of curing or mitigating diseases, or is used for that purpose, while the other indicates an art of healing or science which has for its province the treatment of diseases generally. Commonwealth v. Seibert, 262 Pa. 345, 348, 105 A. 507, 508 (1918).

Defining the practice of osteopathy in relation to chiropractic is difficult because both stress manipulative therapy. See Morgan v. State, 155 Neb. 247, 51 N.W.2d 382 (1952). Although osteopathy was historically distinguished by its additional emphasis on blood-vascular relationships and its employment of soft tissue manipulation, the line was nevertheless vague. See Burke v. Kansas State Osteopathic Ass'n, 111 F.2d 250 (10th Cir. 1940). An older definition of osteopathy included elements of chiropractic theory:

Osteopathy is defined... as: "[a] method of treating diseases of the human body without the use of drugs, by means of manipulations applied to various nerve centers,—chiefly those along the spine,—with a view to inducing free circulation of blood and lymph, and an equal distribution of the nerve force."

Parks v. State, 159 Ind. 211, 229, 64 N.E. 862, 869 (1902). Because mod-
An examination of the statutory language reveals the presence of many expansive terms which preclude a careful delimitation of the scope of practice. It is unclear whether “the purpose of giving freedom of action to impinged nerves” is an explicit qualification for chiropractic adjustments or is merely explanatory. Moreover, the statutory definition of chiropractic does not limit the methods of treatment which may be used nor prescribe the treatment of specific diseases. While the prohibitions on the practice of several of the healing arts and the prescription of internal drugs provide certain basic limitations upon chiropractic practice, it is equally clear that many interstitial questions remain unanswered. The Minnesota Supreme Court has

Osteopathic training includes a full medical curriculum, see Falcone v. Middlesex County Medical Soc'y, 34 N.J. 582, 565, 170 A.2d 791, 793 (1961), the present distinction between osteopathy and chiropractic is much greater than that between osteopathy and medicine. Although the practice of osteopathy was not legislatively defined when the chiropractic licensing statute was enacted in 1919, it had previously been declared to be “distinct” from the practice of medicine or surgery. Minn. Stat. § 4994 (1913). The legislature subsequently enacted the following language as part of Minn. Laws 1923, ch. 343, § 2:

Osteopathic physicians, when duly licensed, shall have the right to practice osteopathy as taught in reputable colleges of osteopathy, including the use and administration in connection with the practice of obstetrics, minor surgery and toxicology only of anesthetics, narcotics, antidotes and antiseptics, subject, however, to the same state and federal restrictions and limitations as are by law applicable to physicians and surgeons licensed to practice medicine and surgery.

The present statute defining the scope of osteopathic practice includes a substantially similar provision. See Minn. Stat. § 147.031 (2) (1971).

Obstetrics has been defined as “the branch of medical science which has to do with the care of women during pregnancy and parturition.” Stoike v. Weseman, 167 Minn. 266, 208 N.W. 993 (1926).

Drugs have been deemed to include all medicinal substances and preparations. See the definition in the Minnesota pharmacy statute, Minn. Stat. § 151.01(5) (1971). While this definition is narrower than the definition of “medicine” in Minn. Stat. § 151.01(6) (1971), it has been construed to include vitamins, Culver v. Nelson, 237 Minn. 65, 54 N.W.2d 7 (1952), and such common products as “Alka-Seltzer,” “Anacin,” “Aspergum” and “Ex-Lax,” State v. Red Owl Stores, Inc., 262 Minn. 31, 115 N.W.2d 643 (1962).

75. Minn. Stat. § 148.08 (2) (1971):

Chiropractors shall be subject to the same rules and regulations, both municipal and state, that govern other licensed doctors or physicians in the control of contagious and infectious diseases, and shall be entitled to sign health and death certificates, and to all rights and privileges of other doctors or physicians in all matters pertaining to the public health, except prescribing internal drugs or the practice of surgery and obstetrics.

offered little guidance in defining the scope of practice.\textsuperscript{77} The Minnesota Attorney General has issued one opinion which states that licensees may employ diagnostic X-rays,\textsuperscript{78} urological or hemotological analysis,\textsuperscript{79} and blood pressure tests,\textsuperscript{80} with certain qualifications.\textsuperscript{81} However, the use of therapeutic X-ray treatment\textsuperscript{82} and the prescription of non-food dietary supplements or vitamins\textsuperscript{83} is deemed to be unauthorized. With the exception of the above authority, a licensee has very little guidance in interpreting the vague language of the scope of practice provisions.

Other states and the federal government have also attempted to resolve the problem of defining the scope of practice. The 49 state licensing statutes all confer privileges and impose limitations upon the practice but only 41 states define either chiropractic or the practice of chiropractic.\textsuperscript{84} Although all of these definitions include spinal adjustments within the purview of chiropractic, numerous variations exist. Fifteen states specify that adjustment shall be by hand or by hand only;\textsuperscript{85} four others

\textsuperscript{77} In State v. Rolph, 140 Minn. 190, 167 N.W. 553 (1918), decided prior to the passage of the chiropractic licensing statute, the court affirmed the conviction of a chiropractor for illegally practicing medicine. In State v. Fahey, 152 Minn. 220, 188 N.W. 260 (1927), the court held that chiropractors were not authorized to sign death certificates since their practice was confined to a limited field which did not include medicine or surgery. In Ingebritson v. Tjernlund Mfg. Co., 289 Minn. 232, 183 N.W.2d 552 (1971), the court disallowed compensation for chiropractic services under the Workmen's Compensation Statute. All three cases were reversed by legislation within a year. See Minn. Laws 1919, ch. 64; Minn. Laws 1927, ch. 230, § 8(b); and Minn. Laws 1971, ch. 863, § 1, amending Minn. Stat. § 176.135 (1969) (codified at Minn. Stat. § 176.135 (1971)) respectively.


\textsuperscript{79} Id.

\textsuperscript{80} Id.

\textsuperscript{81} The Attorney General stated that "the practice of chiropractic encompasses any diagnostic or therapeutic technique reasonably appropriate to the adjustment of abnormal articulations for the purposes of giving freedom of action to impinged nerves." Id. at 155. The relationship in each case was deemed to be a question of fact. Id.

\textsuperscript{82} Id. at 154.

\textsuperscript{83} Id. at 154-55.

\textsuperscript{84} Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia and Wyoming have such definitions.

observe this limitation but also allow other therapies. The remaining states either allow a variety of therapies or, like Minnesota, have few specific limitations in the definition. Some states include elements of chiropractic theory in their definitions or employ a definition of chiropractic by reference to what is taught in chiropractic schools.

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86. NEV. REV. STAT. § 634.010 (1973); N.Y. EDUC. LAW § 6551(1) (McKinney 1972) ("manual or mechanical"); ORE. REV. STAT. § 684.010 (1973); R.I. GEN. LAWS ANN. § 5-30-1 (1950).

87. E.g., ALASKA STAT. § 08.20.220 (1982): Chiropractic is the science of locating and correcting interference with nerve energy transmission and expression within the human body, and the employment and practice of drugless therapeutics including physiotherapy, hydrotherapy, mechanotherapy, phythotherapy, electrotherapy, chromotherapy, thermotherapy, thalmotherapy, correcting and orthopedic gymnastics, and dietetics which includes the use of foods and those biochemical tissue building products and cell salts found within the normal human body, without the use of drugs or surgery.

The other states with a "mixed" chiropractic definition generally include one or more of the above therapeutic techniques.


89. E.g., COLO. REV. STAT. ANN. § 23-1-2(2) (1963): The application of the dynamic adjustive thrust is designed and intended to produce and usually elicits audible and perceptible release of tensions and movement of tissues or anatomical parts for the purpose of removing or correcting interference to nerve transmission and expression.

FLA. STAT. ANN. § 460.11(1) (1965):

For all purposes chiropractic is defined to be a non-combative principle and practice consisting of the science of the adjustment, manipulation and treatment of the human body in which vertebral subluxations and other mal-positioned articulations and structures that are interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs, and tissue cells of the body, thereby causing disease, are adjusted, manipulated or treated thus restoring the normal flow of nerve impulse which produce [sic] normal function and consequent health.

N.C. GEN. STAT. § 50-143 (Supp. 1973):

Chiropractic is therein defined to be the science of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body.

90. See, e.g., IDAHO CODE ANN. § 54-712 (1947); CAL. BUS. & PROF. CODE § 1000-7 (West 1962). The California provision has been narrowed by judicial interpretation to authorize only the practice of chiropractic using standard methods which were recognized at the time the statute was enacted. See People v. Mangiagli, 97 Cal. App. 2d 935, 218 P.2d
Many states have statutes like the Minnesota statute prohibiting chiropractors from engaging in the practice of medicine, surgery, osteopathy and obstetrics, and the prescription of drugs. Some states additionally prohibit the practice of dentistry, optometry, chiropody, naturopathy, acupuncture, massage and "lomilomi." The states also vary in expressly granting to chiropractors certain privileges such as the drawing of blood for diagnostic purposes, the use of food extracts and concentrates, the use of hygienic measures, the practice of first aid or minor surgery, and the employment of diagnostic X-ray treatment. New York is particularly re-


91. E.g., CAL. BUS. & PROF. CODE § 1000-7 (West 1962) (medicine, surgery, osteopathy and the prescription of drugs are among the proscribed practices); PA. STAT. ANN. tit. 63, § 602 (Purdon 1968) (includes obstetrics among the disallowed practices).

92. E.g., CAL. BUS. & PROF. CODE § 1000-7 (West 1962); ME. REV. STAT. ANN. tit. 32, § 451 (1964).

93. E.g., DEL. CODE ANN. tit. 24, § 701 (1953).


96. fla. ADMIN. CODE ch. 21D-1, § .03 (effective May 19, 1973).

97. HAWAII REV. STAT. § 442-1 (1968); accord, MINN. STAT. § 148.34 (1971).

98. HAWAII REV. STAT. § 442-1 (1968).


100. E.g., N.M. STAT. ANN. § 67-3-10(A) (Supp. 1973).


102. E.g., NEV. REV. STAT. § 634.010 (1973).

103. FLA. STAT. ANN. § 465.11(2) (b) (1965).

104. ORE. REV. STAT. § 684.010(2) (1973). “Minor surgery” is defined as:

105. E.g., MASS. ANN. LAWS ch. 112, § 89 (Supp. 1973). The use of X-ray by chiropractors is an additional, although minor, point of contention between the medical and chiropractic interest groups. The medical interest group criticizes chiropractors for using 14 x 36 inch film which requires greater patient X-ray exposure than smaller film and for not protecting patients from harmful radiation when gonadal shielding devices are available. See SMITH, supra note 60, at 102. The chiropractors respond that the valuable diagnostic benefits provided by X-ray outweigh the hazards (deemed slight) of radiation. SCOFIELD, supra note 14, at 30.
strictive in extending X-ray privileges to chiropractors.\textsuperscript{106} All chiropractors using X-ray must also observe federal standards.\textsuperscript{107}

The most specific state provisions limiting the scope of practice are those which limit the chiropractic treatment of generic types of diseases or specific illnesses. Massachusetts\textsuperscript{108} and New York\textsuperscript{109} generally employ a generic type of limitation by prohibiting the treatment of, among others, infectious and cardio-pulmonary diseases. In contrast, Florida\textsuperscript{110} proscribes the treatment of cancer, syphilis, leukemia and other specific diseases. Following the inclusion of chiropractic services in Medicaid and Medicare,\textsuperscript{111} the federal government has limited the scope of compensable chiropractic practice by restricting payments to the manual correction of those vertebral subluxations, detected by X-ray, which have produced neuromusculoskeletal conditions.\textsuperscript{112}

\subsection*{B. Licensing Qualifications}

The enactment of high standards for the licensing of chiropractors represents an attempt to promote higher quality health care by screening out unqualified applicants. In addition, since

\begin{itemize}
  \item Chiropractors are not allowed to use X-ray in New York until they have passed an examination on its use and effects. N.Y. Educ. Law § 6556 (McKinney 1972). Furthermore,
    \begin{enumerate}
      \item X-ray shall only be used for the purposes of chiropractic analysis;
      \item such use of X-ray shall be confined to persons over the age of 18; and
      \item the area of such X-ray exposure shall not extend below the level of the top of the first lumbar vertebra.
    \end{enumerate}
  \item Id., § 6551(2a). New York has also issued health regulations concerning the use of X-ray by chiropractors. See N.Y. ADMIN. RULES & REGS. tit. 10, §§ 90.1–9. They include the prohibition of X-ray when the patient is an "apparently pregnant" female of any age, id. at § 90.3; a requirement of shielding the pelvic area, id. at § 90.4; and a requirement that films be of sufficient size to show the furthest extension of the X-ray beam, id. at § 90.5. See generally MINN. STAT. § 144.12(15) (1971); Minn. Laws 1974, ch. 81, amending MINN. STAT. § 144.121 (1971); Minn. Reg., MHD 182 (1971). The Minnesota rules are much less restrictive.
  \item MASS. ANN. LAWS ch. 112, § 89 (Supp. 1973).
  \item N.Y. Educ. Law § 6551(3) (McKinney 1972).
  \item FLA. ADMIN. CODE ch. 21D–1, § .02 (effective June 18, 1971).
  \item See notes 6–7 supra.
  \item 42 U.S.C. §§ 1395x(r) (5), 1396d(g) (Supp. II, 1972). The proposed rules state:
    Payment may be made only for the chiropractor's manual manipulation of the spine to correct a subluxation (demonstrated by X-ray to exist) which has resulted in a neuromus-
the enforcement of the limited scope of practice provisions depends upon the licensee's ability to make an informed judgment as to whether a patient should be treated or referred to another health care practitioner, high standards also further the public interest in referrals.

Minnesota employs educational requirements, examinations and personal qualifications to aid in achieving high standards within the profession. Applicants must complete a two-year, pre-chiropractic curriculum of college subjects approved by the board and a four-year resident course in an accredited school or college of chiropractic.113 The chiropractic school or college curriculum must include instruction in the following subjects: anatomy, physiology, symptomatology, pathology, hygiene, dietetics, urinalysis, chiropractic orthopedy, intellectual adaptation, and the science and art of chiropractic.114 Applicants must also pass an examination consisting of a written portion comprised of questions on the above subjects and a practical section requiring a demonstration of vertebral palpation, nerve tracing and adjusting.115 The board of examiners may waive the written portion of the examination if they accept the applicant's scores on the written examination administered by the national board of chiropractic examiners or if the applicant holds a valid certificate from the national board.116 Applicants licensed in states with similar requirements may petition the board for exemption from both the written and the practical tests.117 Finally, pro-

113. Minn. Laws 1974, ch. 564 § 1(1), amending Minn. Stat. § 148.06 (1971). The chiropractic schools or colleges must have minimum terms of eight months per year; the council on chiropractic education or the association of chiropractic colleges or their successors are the designated accrediting bodies.
114. Id. On July 1, 1975, or upon the second anniversary of the issuance of a license, whichever occurs last, licensees are required to complete at least five hours of "continuing education" activities per year. Id. § 1(2).
115. Id. § 1(1). The written section is satisfactorily completed by correctly answering 75 percent of the questions. Id. This requirement might be a meaningful qualification if the examination questions were of consistent difficulty. However, Minn. Stat. § 214.03 (Supp. 1973) merely provides that licensing boards "shall" use nationally standardized tests for objective, non-practical portions of examinations if "appropriate."
117. Id.
professional conduct standards must be met by applicants.118

The measures adopted by Minnesota to ensure professional competence through educational standards, examinations and personal qualifications are also employed in various forms by the other states. Every state which licenses chiropractors requires graduation from a school or college of chiropractic. However, certain state statutes also require: (1) approval of chiropractic colleges either by the board of examiners,119 by the state department of health120 or by various professional associations;121 (2) certain courses, including X-ray,122 obstetrics and gynecology,123 clinical work124 and histology;125 (3) a minimum length of study stated as a number of years alone,126 years with minimum terms,127 hours alone,128 hours with minimum minutes per hour,129 hours listed by subject130 or a combination of years and hours;131 (4) pre-professional education consisting of either high school132 or high school plus one133 or two years of college;134 and (5) post-graduate seminar attendance.135 Many states specify by statute the subjects which are to be covered by the examination. Although most of these subjects are the same as those required in Minnesota, some statutes also require examination in “spino-
ography,”136 “Public Health Service,”137 “adjustology”138 and the

118. MINN. STAT. § 148.10(1) (1971).
120. E.g., Neb. REV. STAT. § 71-180 (1971).
121. Miss. CODE ANN. § 73-6-13 (Supp. 1973). Approval by the Inter-
national Chiropractors Association or the American Chiropractic As-
sociation is required.
122. Id.
123. HAWAII REV. STAT. § 442-2 (1968).
125. E.g., OKLA. STAT. ANN. tit. 59, § 164(b) (Supp. 1972).
126. E.g., Ala. CODE tit. 46, § 297(7) (Supp. 1971) (four years).
127. E.g., N.J. STAT. ANN. § 45:9-41.5 (1963) (four years of nine
month terms); Tex. REV. CIV. STAT. art. 4512b, § 10 (Vernon 1960) (four
years of eight month terms).
129. E.g., Pa. STAT. ANN. tit. 63, § 608 (Purdon 1968) (4,000 hours
of 50 minutes each).
130. E.g., Okla. STAT. ANN. tit. 59, § 164(b) (Supp. 1972).
131. N.H. REV. STAT. ANN. § 316.10 (Supp. 1973) (4,000 hours
in four academic years).
132. E.g., IOWA CODE ANN. § 151.3 (1972).
133. E.g., Utah CODE ANN. § 58-12-2(3) (1953).
134. E.g., N.Y. EDUC. LAW § 6554(2) (McKinney 1972).
137. Id. § 164.
138. Id.
Several states employ basic science examinations while others join Minnesota in allowing the substitution of national board scores for the state board examinations. Again, personal qualifications such as good moral character and minimum age are frequently required by other states.

C. PROFESSIONAL CONDUCT AND ADVERTISING

Standards of professional conduct serve as a guide to practitioners and as a basis for the issuance and revocation of licenses. They also aid in maintaining high levels of professional competence. Advertising is regulated under these standards since it is a component of professional conduct which has a special impact upon the delivery of chiropractic services.

The Minnesota chiropractic licensing statute enumerates standards of professional conduct and authorizes the board of

140. The following states require basic or fundamental science certificates: Alabama, Arkansas, Colorado, Connecticut, Nebraska, Nevada, Oregon, South Dakota, Tennessee, Texas, Utah, Washington and Wisconsin. Provisions of the basic science statute of Minnesota, Minn. Stat. §§ 146.01-22 (1971), which required chiropractors to pass examinations in bacteriology and chemistry, two subjects not required by the chiropractic licensing statute, were repealed by Minn. Laws 1974, ch. 224.

Grounds. The state board of chiropractic examiners may refuse to grant, or may revoke, a license to practice chiropractic, or may cause the name of a person licensed to be removed from the records in the office of the clerk of the district court for:

1. the publishing or distributing, or causing to be published or distributed, in newspapers, magazines, directories, pamphlets, posters, cards, or in any other manner by advertisement, wherein the term "cure" or "guarantee to cure" or similar terms are used; which is hereby declared to be fraudulent and misleading to the general public;
2. the employment of fraud or deception in applying for a license or in passing the examination provided for in section 148.06;
3. the practice of chiropractic under a false or assumed name or the impersonation of another practitioner of like or different name;
4. the conviction of a crime involving moral turpitude;
5. habitual intemperance in the use of ardent spirits, narcotics, or stimulants;
6. failure to pay the annual renewal license fee herein provided;
7. professional misconduct.
The statute bans the following practices, all of which are also prohibited by other states: fraud in obtaining a license, practice of chiropractic under false pretenses, conviction of a crime involving moral turpitude, habitual intemperance in the use of alcohol or drugs, failure to pay the annual license renewal fee and professional misconduct. Other states have enumerated additional grounds of professional misconduct which include the receipt of fees upon the assurance that incurable diseases can be permanently cured, fee-splitting, betrayal of professional confidentiality, practice or association with suspended or unlicensed chiropractors and involvement in criminal abortions.

Chiropractic advertising in Minnesota is limited both by a professional conduct provision and by board rules and regulations. No advertisement may use "cure," "guarantee to cure" or similar terms and all non-institutional advertisements

must name the sponsoring chiropractor or chiropractors. The use of testimonials in advertisements which summarize types or examples of treatment is prohibited. Finally, utilizing untruthful, improbable, misleading or impossible statements in advertising chiropractic practice, treatment or advice is also forbidden. Other states display a great diversity in advertising standards. Among the stricter states are Alabama, Arkansas, Kansas, Mississippi and Missouri. These states prohibit almost all advertising except for professional cards, listings in official publications, professional registers or telephone books, announcements of changes in location or associates, and institutional advertisements. Other states either expressly allow certain types of advertisements and prohibit others or, like Minnesota, merely ban certain types of advertising. States in the former category permit advertisements within the parameters of general decorum and reasonableness, including certain radio and television commercials, personal testimonials, direct mail of educational

161. Minn. Reg., Chi. 2 (approved June 30, 1964); see Minnesota Academy of Chiropractors, Inc. v. Minnesota State Bd. of Chiropractic Exam'rs, 283 Minn. 474, 169 N.W.2d 26 (1969).
166. MISS. CODE ANN. § 73-6-25 (a) (3) (Supp. 1973).
172. MISS. CODE ANN. § 73-6-25 (a) (3) (Supp. 1973).
174. FLA. ADMIN. CODE ch. 21D-2.01 (amended Mar. 22, 1974); GA. RULES AND REGS. ch. 100-4, § .01 (revised Mar. 18, 1971).
175. E.g., MICH. COMP. LAWS ANN. § 338.157 (h) (Supp. 1974).
176. GA. RULES AND REGS. ch. 100-4, § .01 (revised Mar. 18, 1971) provides:
(c) Radio: Permitted: 15-minute programs, or less, from professional scripts. Dignified spot announcements during better music programs.
(d) Television: This field is best left to those who prepare themselves through training and with counsel of the TV industry. Permitted: Correctly and professionally prepared and edited film material. Prohibited: Any impromptu appearances by doctors, inexperienced or untrained in television work, except in public interest discussion forums.
177. Id. at § .01 (h) (only if used in national publications).
materials178 and small signs.179 The latter group includes states which seek to eliminate advertisements that engender price competition or are fraudulent or garish. Among the prohibited advertisements are offers of free services,180 offers of discounts or coupons,181 price advertisements,182 claims of superior treatment or technique,183 advertisements of secret184 or painless185 or various other disease cures,186 certain sign types such as neon lights,187 "box-type" listings in classified telephone directories,188 handbills,189 and imprinted commercial items such as pens and calendars.190

D. COMPOSITION AND POWERS OF THE BOARDS OF EXAMINERS

All jurisdictions which license chiropractors have established a board of examiners to conduct examinations and to issue and revoke licenses. Although these boards vary in composition, seats are principally held by practicing chiropractors with other health professionals and laymen in the minority. State legislatures have frequently delegated to these boards broad powers to regulate the profession.

The Minnesota State Board of Chiropractic Examiners is

182. E.g., Iowa Code Ann. § 151.7 (1972).
186. E.g., Cal. Bus. & Prof. Code § 1000-10(2) (West 1962) (sexual disorders); Ohio Rev. Code Ann. § 4731.22(c) (Page 1953) (tuberculosis, consumption, cancer, Bright's disease, kidney disease, diabetes, venereal or genitourinary organ diseases).
composed of seven members.\textsuperscript{191} Five board members are chiropractors who must: (1) be residents who have practiced in Minnesota for at least three years immediately prior to appointment, (2) have taken a chiropractic course, (3) have no financial interest in any chiropractic school or college, and (4) have no affiliation with the practice of the other healing arts which are regulated in Minnesota.\textsuperscript{192} No more than two chiropractic members of the board may be graduates from the same school or college of chiropractic.\textsuperscript{193} The two remaining seats on the board are held by public members\textsuperscript{194} who must be disinterested in chiropractic.\textsuperscript{195}

The board of examiners has the power to perform quasi-judicial functions,\textsuperscript{196} to set licensing qualifications within statutory parameters,\textsuperscript{197} and to formulate rules to govern its actions.\textsuperscript{198} Under the first of these powers, the board may hold hearings to determine whether applicants or licensees have violated the standards of professional conduct.\textsuperscript{199} Board officers are empowered to summon witnesses, administer oaths, and take testimony.\textsuperscript{200} Under the second power, the board establishes license qualifications\textsuperscript{201} and examines applicants.\textsuperscript{202} In perform-
ing its examination duties, the board exercises considerable discretion in selecting examination questions, in accepting or rejecting the grades or certificates which applicants receive from the national board of chiropractic examiners, and in waiving examination of applicants licensed in other states.203 Finally, the board possesses the procedural powers common to most administrative boards in Minnesota.204 Although the board has the power to promulgate rules and regulations covering significant areas such as examinations and annual license renewals,206 only two regulations have been established.206 These regulations are both advertising restraints which were issued under the board’s power to prescribe “interpretative rules” for the standards of professional conduct.207

Licensing boards in other states take one of three forms: (1) chiropractic and all other healing arts are licensed by a board with minority chiropractic representation (six states);208 (2) a board composed of a majority of chiropractors licenses chiropractors exclusively (eight states);209 or (3) chiropractors

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204. See Minn. Stat. § 15.0412 (1971).
207. See Minnesota Academy of Chiropractors, Inc. v. Minnesota State Bd. of Chiropractic Exam’rs, 283 Minn. 474, 475, 169 N.W.2d 26, 27 (1969).
208. Ill. Ann. Stat. ch. 177, § 60a (Smith-Hurd 1966) (five medical doctors (M.D.), one doctor of osteopathy and one doctor of chiropractic); Ind. Ann. Stat. § 63-1305 (1962) (five M.D.’s, one osteopath and one chiropractor); Kan. Stat. Ann. § 65-2813 (1972) (five M.D.’s, three osteopaths and three chiropractors); N.J. Stat. Ann. § 45:9-1 (1963) (nine M.D.’s, one osteopath, one chiropractor, one chiropodist, one director of a licensed bio-analytical laboratory who may be an M.D. and two additional chiropractors when chiropractic applicants are examined); Ohio Rev. Code Ann. §§ 4731.01, .17 (1953) (seven M.D.’s, one osteopath and one chiropractor who may sit with the board to examine chiropractic applicants); Va. Code Ann. § 54-282 (1970) (11 M.D.’s, one osteopath, one chiropractor, one podiatrist, one naturopath and one clinical psychologist).
209. Colo. Rev. Stat. Ann. § 23-1-3 (1963) (four chiropractors and one public member); Mass. Ann. Laws ch. 13, § 84 (1973) (four chiropractors, two M.D.’s and one public representative; if one or both M.D.’s refuse to serve then chiropractors may serve in their place); Miss. Code Ann. §§ 73-6-3 (1973) (five chiropractors and the executive officer of the state board of health or his designee); N.Y. Educ. Law § 6553 (McKinney 1972) (four chiropractors, one M.D., one osteopath and one educator with a doctorate or equivalent in anatomy, physiology, pathology,
are licensed exclusively by a board consisting only of chiropractors (thirty-four states).\textsuperscript{210} The qualifications for board membership as a chiropractor in other states are in general agreement with those of Minnesota. Requirements of residency,\textsuperscript{211} active practice for a period of years,\textsuperscript{212} graduation from a chiropractic course\textsuperscript{213} and lack of financial interest in any school or college of chiropractic\textsuperscript{214} are common. Several states have a similar requirement of diversity in the chiropractic college backgrounds of the board members,\textsuperscript{215} and Missouri joins Minnesota in prohibiting chiropractic members of the board from being affiliated with the other healing arts.\textsuperscript{216} Some states impose additional requirements such as good moral character\textsuperscript{217} or limitations on the number of board members who may be selected from either of the state chiropractic associations.\textsuperscript{218} In contrast, restrictions upon the qualifications of public members are less diverse since only three states in addition to Minnesota seat public members on chiropractic boards.\textsuperscript{219}

\begin{table}[h]
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\begin{tabular}{|c|}
\hline
| Requirement | Description |
\hline
| Chemistry or microbiology | (five chiropractors and the Superintendent of Public Instruction) |
| R.L. Gen. Laws Ann. §§ 5-26-2, 3 (1956) | (two chiropractors and one M.D.) |
| S.D. Comp. Laws Ann. §§ 36-5-3, 3.1 (1973) | (three chiropractors and one lay member) |
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\end{tabular}
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210. The 34 states having boards composed exclusively of chiropractors are as follows: (1) three members: Alaska, Arizona, Arkansas, Connecticut, Delaware, Florida, Hawaii, Idaho, Iowa, Kentucky, Maryland, Missouri, Montana, Nebraska, New Mexico, North Carolina, Oklahoma, Oregon, Tennessee, Utah, Vermont, Washington, Wisconsin and Wyoming; (2) four members: South Carolina; (3) five members: Alabama, California, Georgia, Maine, Michigan, Missouri, New Hampshire, Nevada and North Dakota; (4) nine members: Texas.

218. Miss. Code Ann. § 73-6-3 (Supp. 1973) (“No more than three (3) members of the board shall be members of either the Mississippi Society of Chiropractors or the Mississippi Chiropractic Association.”).
Unlike Minnesota, several states give their boards power to inspect and accredit chiropractic colleges and to define the scope of practice. These provisions are significant because they permit the regulation of the most critical and controversial contemporary issues concerning chiropractic. The California board of examiners is empowered to define minimum requirements for teachers in chiropractic schools and colleges and to approve applicants' schools. Similar power to investigate and personally inspect chiropractic colleges is held by the Florida, Kansas and Maryland boards. Kansas further provides that a school which refuses to permit board inspection cannot be accredited. The Iowa board is required to recommend colleges to the department of health for accreditation. Some state boards have also been granted broad powers over the definition of the scope of practice. For example, the Florida board has exercised its authority to prohibit the use of certain instruments, the treatment of specified diseases and the use of acupuncture.

V. PROPOSED STATUTORY REVISIONS

The Minnesota chiropractic licensing statute has failed to adequately reconcile the public, chiropractic, and medical interests in chiropractic regulation. This failure might perhaps be attributed to the orthodox role of professional licensing. Several recent commentators have concluded that health care licensing contributes to inefficient manpower uses by rigid compartmentalization of health professionals. This guild approach to health care licensing has been asserted to be detri-
mental to the public interest because it allows duplication of health services and promotes inter-professional rivalry. To remedy this defect, it has been proposed that the states establish central administrative boards which would coordinate all health manpower.\footnote{See Carlson, supra note 230, at 877; \textit{Iowa Note}, supra note 36, at 1153.} Chiropractic would be included within the healing arts to be regulated under this new system.

Other commentators have suggested integrating chiropractic into medicine in order to eliminate the need for inter-professional referrals and to offer a greater range of health care services to patients.\footnote{See Note, Chiropractic—Its Status Under Limited State Licenses, 34 \textit{Notre Dame Law.} 562, 574-75 (1959).} However, this proposed integration would require that current animosities between doctors of chiropractic and medicine subside and that chiropractors forego their independent practices in favor of positions as manipulative specialists under the supervision of medical doctors. Both conditions are unrealistic since chiropractors are strenuously opposed to any integration with medicine on these terms.\footnote{See \textit{Wilk}, supra note 14, at 97.} Placing doctors of medicine and chiropractic on a parity, as was true following the reconciliation of medicine and osteopathy,\footnote{Members of both groups may receive unlimited licenses in Minnesota. \textit{See Minn. Stat.} § 147.01-29 (1971).} might be a politically feasible solution to the integration problem. However, the stage for the reconciliation between medicine and osteopathy was set when osteopathic colleges began to teach medical practice subjects.\footnote{\textit{See Mills, Osteopathic Education,} 66 \textit{J. Am. Osteopathic Ass'n} 531, 550-51 (1967).} Since chiropractic colleges have not yet demonstrated a similar inclination to include these subjects in their curricula, it is unlikely that chiropractors will qualify for unlimited licenses in the near future.\footnote{See R. Grim, \textit{The Truth About Chiropractic} (1970); 1972-73 Catalog, Northwestern College of Chiropractic 16.}

Although the above proposals might be adopted for future health care systems, the enactment of effective chiropractic laws cannot be delayed pending such sweeping changes in health care regulation. While the proposals which follow do not necessarily meet the preceding objections directed at health licensing laws generally, they should at least be considered as interim measures designed to reverse the increasing delegation of power to chiropractic interests and to promote the public interest in
chiropractic regulation under the present independent practitioner system.

A. Scope of Practice

Minnesota allows chiropractors to employ only a limited range of therapies but places no limitations on the diseases that they may treat. The "abnormal articulations" that chiropractors are authorized to treat are not clearly defined and could suggest either skeletal conditions per se or merely "vertebral subluxations." Because of this ambiguity, the statute provides little aid to chiropractors in resolving their basic dilemma—whether to treat a patient within the scope of the licensed therapies and allow the inherent recuperative powers of the body to restore health naturally or to refer the patient to a practitioner who is licensed to employ additional therapies.

In light of this dilemma, the central issue in the regulation of the scope of practice in Minnesota becomes the extent to which the legislature has delegated discretion to the chiropractor: first, to employ therapeutic techniques which do not involve the practice of medicine, surgery, osteopathy or obstetrics, or the prescription of internal drugs; and second, to make a professional judgment whether to treat a patient or to refer him to another practitioner. The recent case of State Board of Medical Examiners v. Olson illustrates the extent of the delegation in the first area. In that case, a chiropractor was charged with the unauthorized practice of medicine because he had employed various therapeutic devices in his practice. The chiropractic board departed from its role as the arbiter of the defendant's scope of practice, intervened in his behalf, and construed the statute as favoring expanded treatment methods. Thus, the ambiguity in the scope of practice provisions facilitated a broad

237. MINN. STAT. § 148.01(1) (1971).
238. See Wilk, supra note 14, at 27.
239. Chiropractors recognize the merits of medical and surgical treatments for certain conditions. See id. at 42, 45.
240. 295 Minn. 379, 206 N.W.2d 12 (1973). The court remanded the case to the trial court to determine whether the activities of the defendant were permitted under the Minnesota laws relating to chiropractors.
241. The devices were: (1) an Aloesine device (muscle stimulator which uses low-voltage current), (2) a Magason VI device (ultrasonic device used for therapy), (3) a Dallans device (electronic muscle stimulator which may be used in conjunction with the Magason VI) and (4) a Liebel-Flarsheim device (short wave diathermy device used for therapy). Id. at 381, 206 N.W.2d at 14.
interpretation by the same group the statute intended to limit. The failure to adequately restrict the diseases or conditions a chiropractor may treat has also given chiropractors in Minnesota complete responsibility over the decision to treat or refer a patient to another health professional. In contrast, New York has prohibited chiropractic treatment for a variety of disorders.\textsuperscript{242} New York has also resolved several of the ambiguities concerning permissible treatment or diagnostic methods, left unsettled under the Minnesota statute, by enacting explicit provisions governing such matters as the use of X-ray by chiropractors.\textsuperscript{243}

To achieve more effective regulation of the chiropractic profession, the legislature should either enact specific provisions defining the scope of practice or delegate this function to an administrative body. The first approach would require the creation of an expert panel to make scientific judgments regarding the scope of practice and to propose statutes defining the nature and extent of health care which should be provided by chiropractors. Such a panel could additionally promulgate a code for peer review as a post-licensure monitor of health care to be used by health review organizations\textsuperscript{244} and could advise the board of chiropractic examiners upon developments in chiropractic.\textsuperscript{245} It is important that all interest groups be represented on such a panel in order to alleviate the current animosities between doctors of medicine and chiropractic over the scope of practice. In the past, two government panels have been criticized for considering chiropractic theory and practice in the absence of members of the chiropractic interest group.\textsuperscript{246} As an example of the second approach, the board of examiners could be employed as the administrative body to formulate scope of practice provisions. However, broad interest group representation would again be required to prevent the infusion of self-interest that was recently illustrated in the Olson case.

\textsuperscript{242} N.Y. Educ. Law § 6551 (3) (McKinney 1972).
\textsuperscript{243} Id. § 6551 (2).
\textsuperscript{244} See Minn. Stat. §§ 145.61–67 (1971).
\textsuperscript{245} Similar advisory boards have been suggested to aid in the licensure of dental paraprofessionals. See Note, Restrictive Licensing of Dental Paraprofessionals, 83 Yale L.J. 806, 826 (1974).
\textsuperscript{246} The review panels which produced Independent Practitioners, supra note 20, and Report of the Chiropractic Study Committee to the Governors' Health Planning and Policy Task Force (1972) (Wisconsin) both recommended excluding chiropractors. These reports were criticized, respectively, in Am. Chiropractic Ass'n, et al., Chiropractic's "White Paper" 6 (1969) and in Wilk, supra note 14, at 65.
B. LICENSING QUALIFICATIONS

The Minnesota statute employs educational standards and examinations as the principal means to assure quality chiropractic care. Although examinations may be necessary to screen out unqualified applicants and do serve as both an incentive for students and a guideline for instructors, they have at best an indirect effect in upgrading the abilities of applicants. The assurance of quality chiropractic care is best fulfilled by educational standards which require that schools be capable of imparting knowledge and skills to their students. Examinations alone cannot measure the degree to which the schools succeed in this task. The current indices of professional education, including the requirement of certain subjects such as "intellectual adaption," specifications of the time to be spent in study, and college accreditation by bodies representing the chiropractic interest group do not guarantee that chiropractors receive the high quality education demanded of other health professionals. Those standards related to course work are meaningful only if the subjects and their instruction have intrinsic merit. The issue of quality must be raised since no chiropractic college had ever received accreditation by a recognized non-chiropractic body until August, 1973. The only chiropractic college in Minnesota has not yet been independently accredited, but easily meets the requirements of the Minnesota licensing statute. This compliance has been achieved principally through course offerings, the length of its degree program, and accreditation by chiropractic bodies, notwithstanding the limited academic credentials of its faculty. To remedy these defective standards, the chiropractic licensing statute should be amended to require, as a condition for licensure, that applicants graduate from a chi-

249. See 1972-73 Catalog, supra note 236, at 2, 16. The school claims approval by the Minnesota State Board of Chiropractic Examiners. Id. at 2. However, there is no specific statutory authority under which the board could give such approval.
250. The 30 faculty members at the Northwestern College of Chiropractic include only seven individuals holding bachelor's degrees. On the other hand, 27 faculty members do possess the "doctor of chiropractic," 18 of which were granted by Northwestern. Id., at 27-30.
ropractic college or school accredited by an independent body or by the state board of chiropractic examiners acting within explicit statutory guidelines.

C. Professional Conduct and Advertising

Chiropractic as a profession is regulated by standards of conduct which serve as the basis for license refusal or revocation. While the existing standards do restrain many forms of unprofessional conduct, they should be extended to include abusive fee practices and unnecessary or excessive treatment. Although health review organizations can issue guidelines to regulate such practices, these guidelines lack the specific sanctions available under professional conduct standards. At present, these standards are generally included by inference within the “professional misconduct” provision. A separate enumeration of the standards within the statute would alert practitioners to their importance.

Chiropractors compete economically with medical doctors and osteopaths in the treatment of certain conditions. Unlike these professionals, however, chiropractors are allowed to advertise their services in Minnesota. While institutional advertisements may enhance the public image of a profession long subjected to medical criticism, individual chiropractors should be restrained from advertising since such conduct is antithetical to professionalism.

D. The Board of Examiners

Primary responsibility for implementing the licensing statute resides in the board of chiropractic examiners. Since the majority of the board presently consists of members whose live-

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251. One method for a chiropractic college to achieve independent accreditation is by affiliation with a recognized university. The Northwestern College of Chiropractic has moved in this direction by educating their students in part at St. Thomas College in St. Paul, Minnesota. See 1972-73 Catalog, supra note 236, at 15. Such an affiliation would improve access to outside funds and better research facilities, thereby aiding in the resolution of conflicts over chiropractic theory. This solution is presently unrealistic, of course, in light of the hostility between medicine and chiropractic.


253. Such abuses are common to many professions and should be dealt with in other licensing statutes as well. See Iowa Note, supra note 36, at 1106.

lihood is directly related to chiropractic, it is unlikely that they would impose limitations upon members of their own profession. The public members of the board, who must be disinterested and whose vote is relatively insignificant, serve, at best, in a watchdog capacity. The parochial nature of the majority is assured by their mandatory disaffiliation with the other healing arts. The board's abandonment of its intended role as an arbiter in scope of practice questions by intervening as an advocate in Olson is additional evidence of a vested chiropractic interest group orientation that should be reversed. The board should either be reconstituted or its functions should be assumed by an impartial administrative body, such as a healing arts board, which would license all health care professionals.  

At present, the chiropractic board has no explicit powers to investigate chiropractic education or to define the scope of practice. Delegation of such power to a reconstituted board, subject to review, would further the public interest in these two important areas. The legislature should either establish meaningful standards for chiropractic education which would then serve as a guide for board rules and regulations or adopt an external standard. Under the former alternative, the board would be empowered to inspect colleges and accredit those which meet the standards. An example of an external standard under the latter alternative would be independent accreditation by a recognized body with the board being required to maintain a list of approved schools. If the legislature elects to forego an expert panel as a means of clarifying the scope of practice provisions, the board should also be required to revise these provisions.

VI. CONCLUSION

The chiropractic interest group has too long enjoyed a statutory sanctuary in health care. This shelter should be eliminated by amending the chiropractic licensing statute to clearly define

255. A general healing arts board which retains the licensing system but consolidates the separate boards may be a first step in meeting objections raised by recent health care commentators. See note 230 supra. However, such legislation would require the cooperation of all health interest groups, thus severely delaying its implementation.

256. The current ambiguity frustrates judicial review. It is imperative that critical provisions such as these not only facilitate but, for the interest of the public, be expressly subject to review. See Note, Due Process Limitations on Occupational Licensing, 59 VA. L. REV. 1097, 1128 (1973).
the scope of practice, to establish significant educational standards, to constrain chiropractic advertising and to reconstitute the board of examiners and modify its powers. The safety-oriented X-ray provisions of New York are merely examples of the means which are presently available to end this sanctuary. Although such measures may be interim provisions before more comprehensive changes are made in health care regulation, they are necessary and demand enactment.

[Editor's note: While this Note was in the printing stage, Louisiana became the final state to enact a chiropractic licensing statute. La. Laws 1974, Act no. 39.]