

Statement of Matthew Pagano, D.C.
Connecticut Chiropractic Association

Testimony before the Public Health and Program Review Committees
Connecticut General Assembly
Bill 5258

February 25, 2010

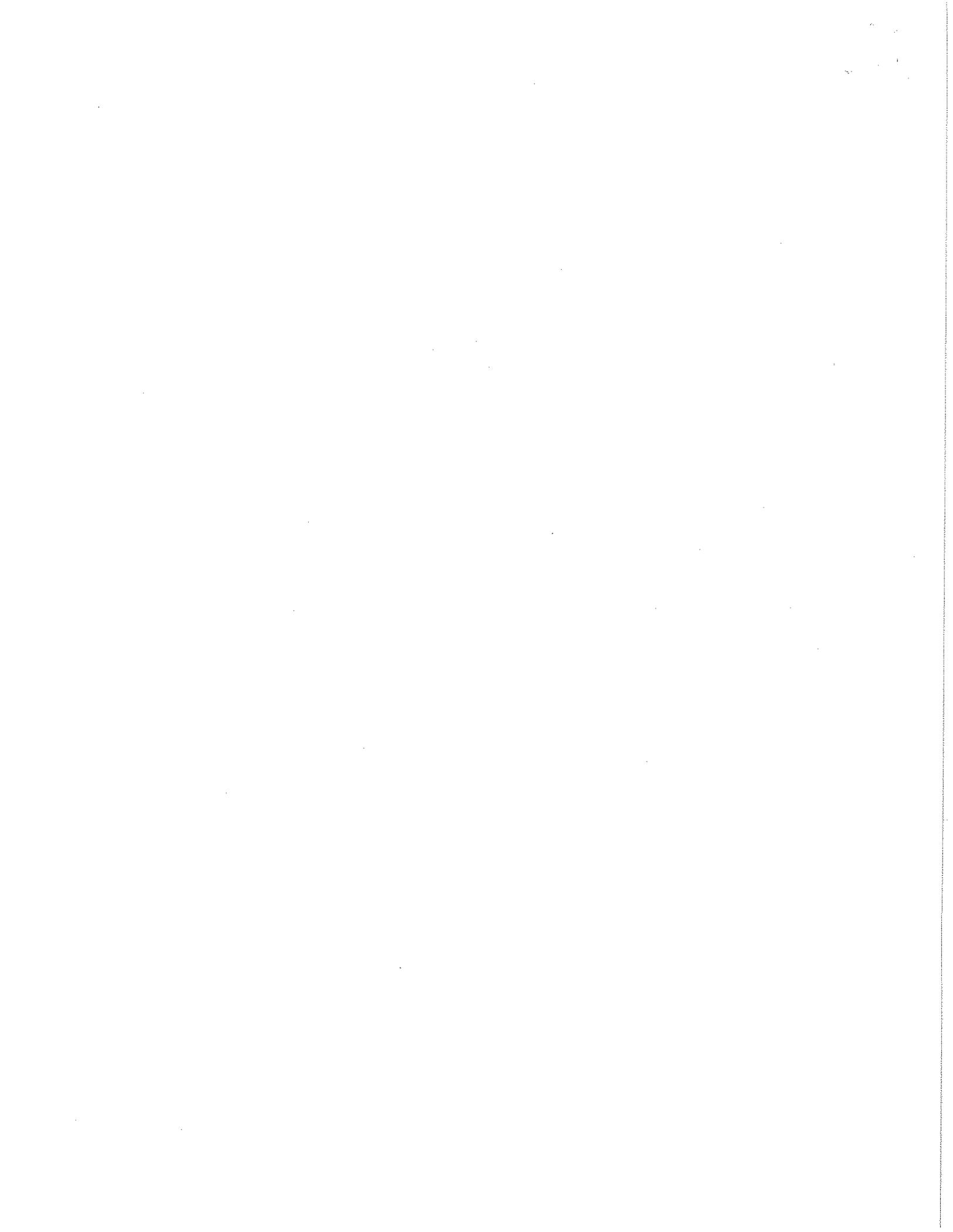
Senators Harris and Kissel, Representatives Mushinky and Ritter, Distinguished Members of the Committees: My name is Matt Pagano. I am a practicing chiropractor in Winsted CT and past-president of the Connecticut Chiropractic Association. I am testifying on their behalf today in opposition to **Bill 5258 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING SCOPE OF PRACTICE DETERMINATIONS FOR HEALTH CARE PROFESSIONS.**

This bill proposes changes to the process by which a health care profession petitions the legislature for a change in their scope of practice. The Program Review and Investigations committee offers up a rationale for this proposed change, and an attempt to streamline the process and make it easier for the legislators to understand the sometimes esoteric subject matter that they may have to deliberate is a laudable goal but the proposed process by which that happens is flawed.

This measure advocates a process by which for every proposed change of scope, an ad-hoc committee would be formed to deliberate the merits of the request. The composition of that proposed committee is what we take exception to. These ad-hoc committees would be comprised of, one member from the profession advocating for the change of scope, one member from a healing arts profession opposed to the scope change, two impartial members of the healing arts, an impartial member of the general public, and a representative of the department of public health.

In the document "Key Points" generated by the Program Review and Investigations Committee of the General Assembly dated December 15, 2009, there is recognized that what is at stake here is more than the public good and I quote " *Although public health and safety, including provider competence, and consumers' access to care are key factors cited publicly about scope of practice proposals, privately, financial gain or loss are considered common motivating factors why health care professions either support or oppose scope of practice proposals.*"

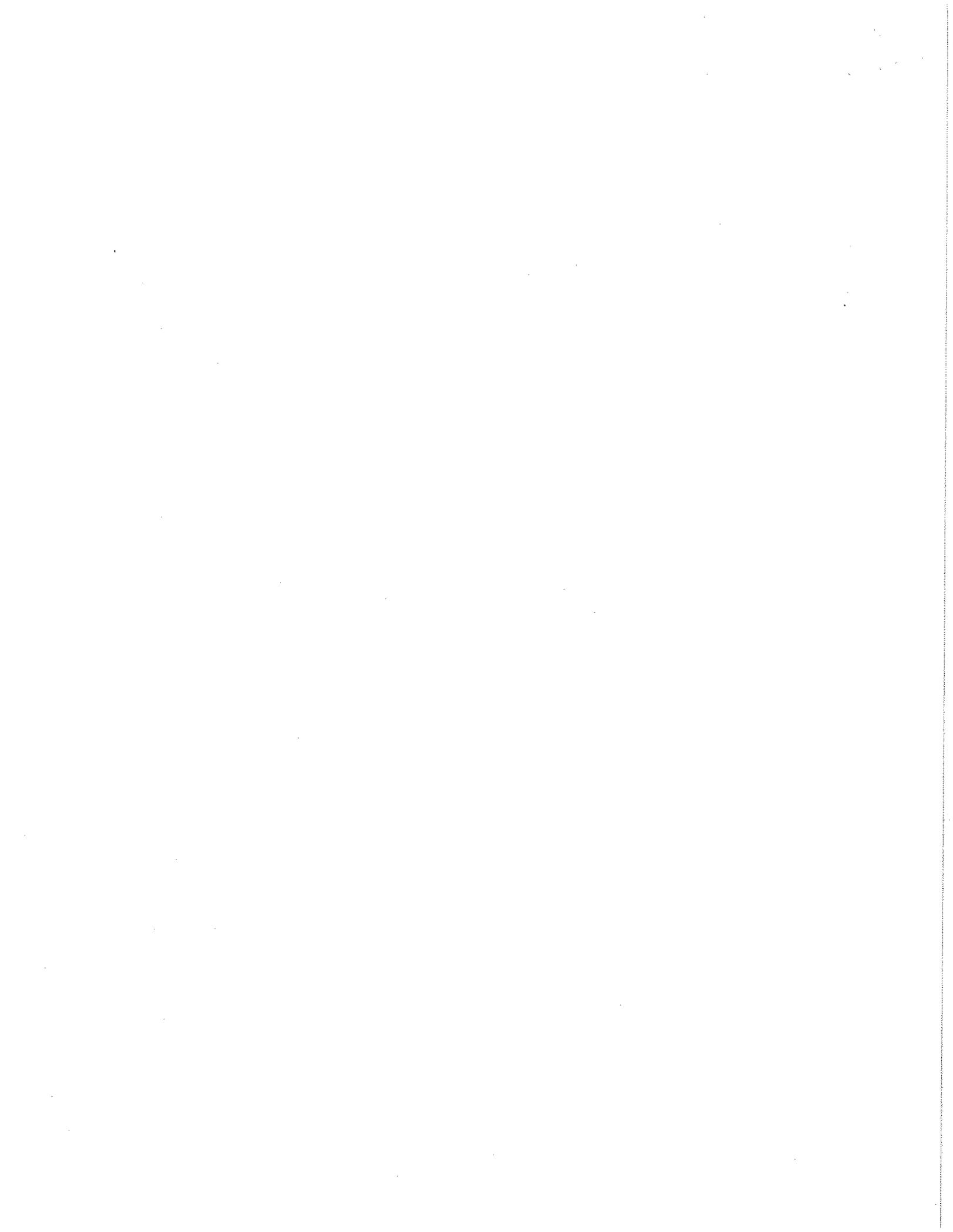
As an example, as it pertains to my profession, chiropractic, we believe this proposed process would make it very easy for the medical profession to squash any attempts at scope change by our profession. The petitioning profession could in effect, be blocked from even submitting legislation, something we view as very un-democratic. The composition of this ad-hoc panel invites anti-competitive behavior. We ask how shall the legislature determine and guarantee the impartiality of the two health care professionals and the member of the general public.



Please understand that our opposition to this measure occurs in the context of historical precedent. I have attached to my testimony a reprint from the Journal of the American Medical Association dated, January 1st, 1988. In this document you will see evidence of a long anti-competitive effort by the AMA against the chiropractic profession. You will see discussion of the fact that the AMA violated the Sherman anti-trust laws in their conspiratorial efforts to eliminate the chiropractic profession. You will see that federal judge Susan Getzendanner found in favor of the chiropractic profession.

It might also interest you to know that the AMA, at present is disseminating a template, via their powerful lobby whereby legislation similar to this is being proposed in state houses throughout the country and I have enclosed that template as well for your perusal. You will find that much of the AMA's proposals have made their way into the language of this very bill you are deliberating. As for their motivation in doing this, I can only contemplate that in this age of a shifting healthcare paradigm the medical profession has recognized that other physician level licensed health care providers might represent competition, and are advocating this flawed legislative initiative as a means of preserving market share as legislatures throughout the country struggle to make sure all citizens have access to affordable health care.

Please recognize this for what it is, an attempt by one health care profession to protect their market share, and if implemented, a government sanctioned mechanism for anti-competitive behavior. Please oppose the implementation of this plan.



Special Communication

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CHESTER A. WILK, et al.,)
)
Plaintiffs,)
)
v.) No. 76 C
) 3777
AMERICAN MEDICAL ASSOCIATION,)
et al.,)
)
Defendants.)

PERMANENT INJUNCTION ORDER AGAINST AMA

Susan Getzendanner, District Judge

The court conducted a lengthy trial of this case in May and June of 1987 and on August 27, 1987, issued a 101 page opinion finding that the American Medical Association ("AMA") and its members participated in a conspiracy against chiropractors in violation of the nation's antitrust laws. Thereafter an opinion dated September 25, 1987 was substituted for the August 27, 1987 opinion. The question now before the court is the form of injunctive relief that the court will order.

See also p 83.

As part of the injunctive relief to be ordered by the court against the AMA, the AMA shall be required to send a copy of this Permanent Injunction Order to each of its current members. The members of the AMA are bound by the terms of the Permanent Injunction Order if they act in concert with the AMA to violate the terms of the order. Accordingly, it is important that the AMA members understand the order and the reasons why the order has been entered.

The AMA's Boycott and Conspiracy

In the early 1960s, the AMA decided to contain and eliminate chiropractic as a profession. In 1963 the AMA's Committee on Quackery was formed. The committee worked aggressively—both overtly and covertly—to eliminate chiropractic. One of the principal means used by the AMA to achieve its goal was to make it unethical for medical physicians to professionally associate with chiropractors. Under Principle 3 of the AMA's Principles of Medical Ethics, it was unethical for a physician to associate with an "unscientific practitioner," and in 1966 the AMA's House of Delegates passed a resolution calling chiropractic an unscientific cult. To complete the circle, in 1967 the AMA's Judicial Council issued an opinion under Principle 3 holding that it was unethical for a physician to associate professionally with chiropractors.

The AMA's purpose was to prevent medical physicians from referring patients to chiropractors and accepting referrals of patients from chiropractors, to prevent chiropractors from obtaining access to hospital diagnostic services and membership on hospital medical staffs, to prevent medical physicians from teaching at chiropractic colleges or engaging in any joint research, and to prevent any cooperation between the two groups in the delivery of health care services.

The AMA believed that the boycott worked—that chiropractic would have achieved greater gains in the absence of the boycott. Since no medical physician would want to be considered unethical by his peers, the success of the boycott is not surprising. However, chiropractic achieved licensing in all 50 states during the existence of the Committee on Quackery.

The Committee on Quackery was disbanded in 1975 and some of the committee's activities became publicly known. Several lawsuits were filed by or on behalf of chiropractors and this case was filed in 1976.

Change in AMA's Position on Chiropractic

In 1977, the AMA began to change its position on chiropractic. The AMA's Judicial Council adopted new opinions under which medical physicians could refer patients to chiropractors, but there was still the proviso that the medical physician should be confident that the services to be provided on referral would be performed in accordance with accepted scientific standards. In 1979, the AMA's House of Delegates adopted Report UU which said that not everything that a chiropractor may do is without therapeutic value, but it stopped short of saying that such things were based on scientific standards. It was not until 1980 that the AMA revised its Principles of Medical Ethics to eliminate Principle 3. Until Principle 3 was formally eliminated, there was considerable ambiguity about the AMA's position. The ethics code adopted in 1980 provided that a medical physician "shall be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."

The AMA settled three chiropractic lawsuits by stipulating and agreeing that under the current opinions of the Judicial Council a physician may, without fear of discipline or sanction by the AMA, refer a patient to a duly licensed chiropractor when he believes that referral may benefit the patient. The AMA confirmed that a physician may also choose to accept or to decline patients sent to him by a duly licensed chiropractor. Finally, the AMA confirmed that a physician may teach at a chiropractic college or seminar. These settlements were entered into in 1978, 1980, and 1986.

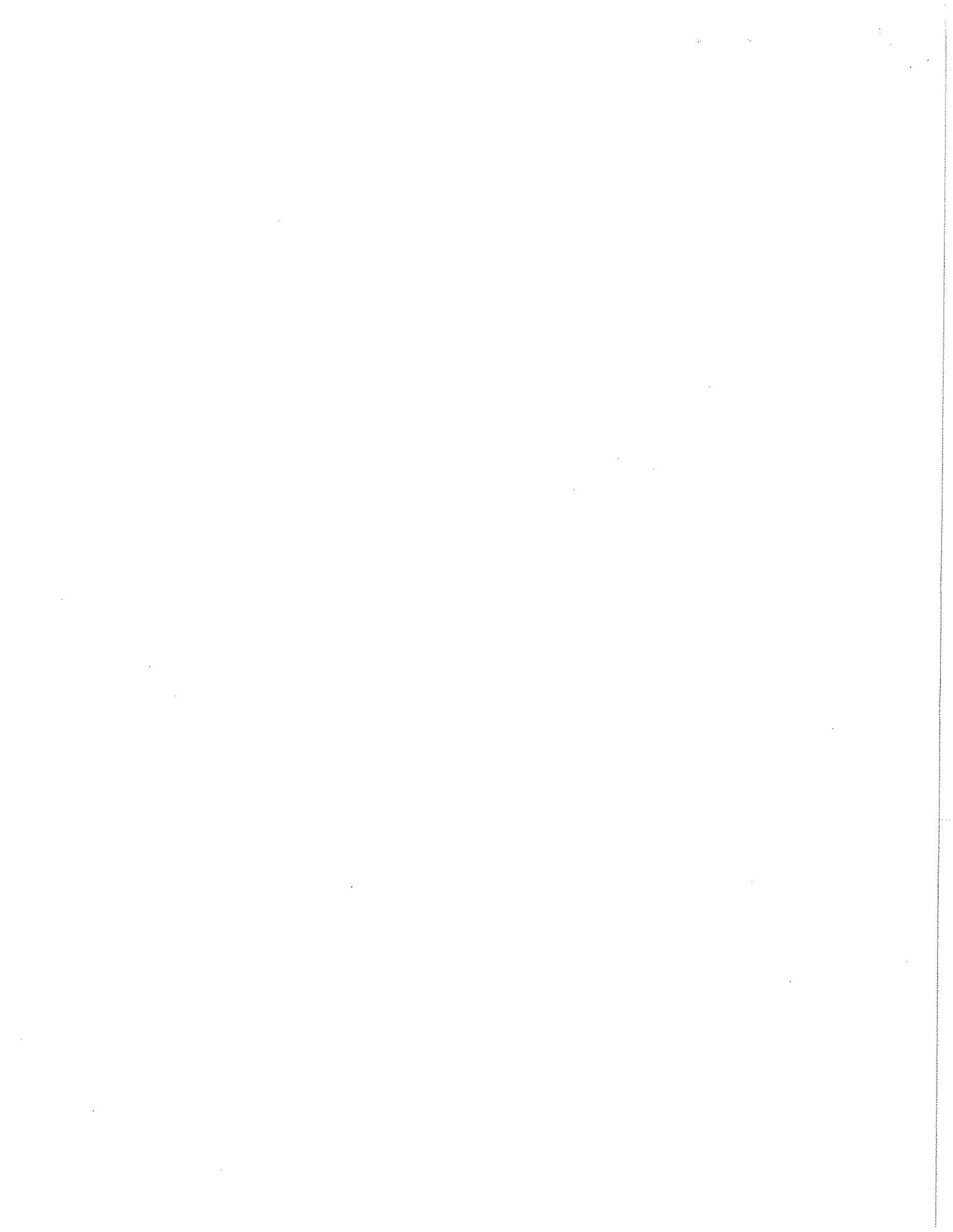
The AMA's present position on chiropractic, as stated to the court, is that it is ethical for a medical physician to professionally associate with chiropractors provided the physician believes that such association is in the best interests of his patient. This position has not previously been communicated by the AMA to its members.

Antitrust Laws

Under the Sherman Act, every combination or conspiracy in restraint of trade is illegal. The court has held that the conduct of the AMA and its members constituted a conspiracy in restraint of trade based on the following facts: the purpose of the boycott was to eliminate chiropractic; chiropractors are in competition with some medical physicians; the boycott had substantial anti-competitive effects; there were no pro-competitive effects of the boycott; and the plaintiffs were injured as a result of the conduct. These facts add up to a violation of the Sherman Act.

In this case, however, the court allowed the defendants the opportunity to establish a "patient care defense" which has the following elements:

(1) that they genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they have entered into a doctor-patient relationship; (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants' promulgation of Principle 3 and in the



conduct intended to implement it; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.

The court concluded that the AMA had a genuine concern for scientific methods in patient care, and that this concern was the dominant factor in motivating the AMA's conduct. However, the AMA failed to establish that throughout the entire period of the boycott, from 1966 to 1980, this concern was objectively reasonable. The court reached that conclusion on the basis of extensive testimony from both witnesses for the plaintiffs and the AMA that some forms of chiropractic treatment are effective and the fact that the AMA recognized that chiropractic began to change in the early 1970s. Since the boycott was not formally over until Principle 3 was eliminated in 1980, the court found that the AMA was unable to establish that during the entire period of the conspiracy its position was objectively reasonable. Finally, the court ruled that the AMA's concern for scientific method in patient care could have been adequately satisfied in a manner less restrictive of competition and that a nationwide conspiracy to eliminate a licensed profession was not justified by the concern for scientific method. On the basis of these findings, the court concluded that the AMA had failed to establish the patient care defense.

None of the court's findings constituted a judicial endorsement of chiropractic. All of the parties to the case, including the plaintiffs and the AMA, agreed that chiropractic treatment of diseases such as diabetes, high blood pressure, cancer, heart disease and infectious disease is not proper, and that the historic theory of chiropractic, that there is a single cause and cure of disease is wrong. There was disagreement between the parties as to whether chiropractors should engage in diagnosis. There was evidence that the chiropractic theory of subluxations was unscientific, and evidence that some chiropractors engaged in unscientific practices. The court did not reach the question of whether chiropractic theory was in fact scientific. However, the evidence in the case was that some forms of chiropractic manipulation of the spine and joints was therapeutic. AMA witnesses, including the present Chairman of the Board of Trustees of the AMA, testified that some forms of treatment by chiropractors, including manipulation, can be therapeutic in the treatment of conditions such as back pain syndrome.

Need for Injunctive Relief

Although the conspiracy ended in 1980, there are lingering effects of the illegal boycott and conspiracy which require an injunction. Some medical physicians' individual decisions on whether or not to professionally associate with chiropractors are still affected by the boycott. The injury to chiropractors' reputations which resulted from the boycott has not been repaired. Chiropractors suffer current economic injury as a result of the boycott. The AMA has never affirmatively acknowledged that there are and should be no collective impediments to professional association and cooperation between chiropractors and medical physicians, except as provided by law. Instead, the AMA has consistently argued that its conduct has not violated the antitrust laws.

Most importantly, the court believes that it is important that the AMA members be made aware of the present AMA position that it is ethical for a medical physician to professionally associate with a chiropractor if the physician believes it is in the best interests of his patient, so that the lingering effects of the illegal group boycott against chiropractors finally can be dissipated.

Under the law, every medical physician, institution, and hospital has the right to make an individual decision as to whether or not that physician, institution, or hospital shall

associate professionally with chiropractors. Individual choice by a medical physician voluntarily to associate professionally with chiropractors should be governed only by restrictions under state law, if any, and by the individual medical physician's personal judgment as to what is in the best interest of a patient or patients. Professional association includes referrals, consultations, group practice in partnerships, Health Maintenance Organizations, Preferred Provider Organizations, and other alternative health care delivery systems; the provision of treatment privileges and diagnostic services (including radiological and other laboratory facilities) in or through hospital facilities; association and cooperation in educational programs for students in chiropractic colleges; and cooperation in research, health care seminars, and continuing education programs.

An injunction is necessary to assure that the AMA does not interfere with the right of a physician, hospital, or other institution to make an individual decision on the question of professional association.

Form of Injunction

1. The AMA, its officers, agents and employees, and all persons who act in active concert with any of them and who receive actual notice of this order are hereby permanently enjoined from restricting, regulating or impeding, or aiding and abetting others from restricting, regulating or impeding, the freedom of any AMA member or any institution or hospital to make an individual decision as to whether or not that AMA member, institution, or hospital shall professionally associate with chiropractors, chiropractic students, or chiropractic institutions.

2. This Permanent Injunction does not and shall not be construed to restrict or otherwise interfere with the AMA's right to take positions on any issue, including chiropractic, and to express or publicize those positions, either alone or in conjunction with others. Nor does this Permanent Injunction restrict or otherwise interfere with the AMA's right to petition or testify before any public body on any legislative or regulatory measure or to join or cooperate with any other entity in so petitioning or testifying. The AMA's membership in a recognized accrediting association or society shall not constitute a violation of this Permanent Injunction.

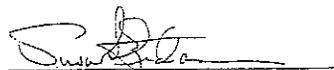
3. The AMA is directed to send a copy of this order to each AMA member and employee, first class mail, postage prepaid, within thirty days of the entry of this order. In the alternative, the AMA shall provide the Clerk of the Court with mailing labels so that the court may send this order to AMA members and employees.

4. The AMA shall cause the publication of this order in JAMA and the indexing of the order under "Chiropractic" so that persons desiring to find the order in the future will be able to do so.

5. The AMA shall prepare a statement of the AMA's present position on chiropractic for inclusion in the current reports and opinions of the Judicial Council with an appropriate heading that refers to professional association between medical physicians and chiropractors, and indexed in the same manner that other reports and opinions are indexed. The court imposes no restrictions on the AMA's statement but only requires that it be consistent with the AMA's statements of its present position to the court.

6. The AMA shall file a report with the court evidencing compliance with this order on or before January 10, 1988.

It is so ordered.



Susan Getzendanner
United States District Judge



Creation of State-based Scope-of-Practice Review Committees

Legislative Template

Scope-of-Practice Campaign
Advocacy Resource Center

AMA
AMERICAN
MEDICAL
ASSOCIATION

2008

**Scope of Practice Campaign:
Creating a State-based Scope of Practice Review Committee**

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**Scope of Practice Campaign:
Creating a State-based Scope of Practice Review Committee**

LEGISLATIVE TEMPLATE

This template provides an overview of various potential elements of legislation and/or regulation to address the creation of state-level scope of practice review committees..

I. GENERAL OVERVIEW

State legislatures are routinely overwhelmed with the number of scope of practice proposals they are asked to consider. Oftentimes legislators do not have available to them a thorough, professional and independent understanding of the health and economic implications of such proposals. The creation of a state-level scope of practice review committee, that assesses scope of practice initiatives *prior to* their introduction at the legislative or regulatory rule-making level, *may* serve to expose such initiatives to the scrutiny of multiple health care disciplines. These committees have the potential to encourage debate by those most appropriately positioned to consider such issues. They provide a procedure for objective review of proposed changes in the scope of practice of nonphysician practitioners licensed in their state to ensure that the changes contribute to the improvement of the overall health of the state's citizens.

Several states have passed legislation similar to the proposed model bill, most notably Arizona and Nebraska. While Arizona has experienced much success with their law, Nebraska's experience has been more tempered. In addition to the Arizona and Nebraska laws, New Mexico and Texas have seen legislation introduced on this issue in the last 2-3 years. Each one of these bills (AZ, NE, NM, TX) is unique and state specific. For example, each state has addressed the composition of the scope of practice review committee in a different manner (i.e. Arizona's committee is primarily composed of legislators, while Texas' committee is a mixture of legislators, state agency leaders, academics and public members). As a result, it is strongly recommended that any state medical association considering this type of legislation take into account its unique state needs, political climate, etc., when determining committee composition and other provisions contained in such legislation.

In this advocacy tool, we have endeavored to highlight various state laws that have attempted to compose scope of practice review committees. We hope that the information in this template will be a useful tool for states that wish to advocate for such legislation.

NOTE:

The AMA does not have model state legislation that addresses the creation of scope of practice review committees, nor is there specific AMA policy that addresses this issue. The AMA's Advocacy Resource Center (ARC) is currently working with staff from several state medical associations that are considering the introduction of this type of legislation during the 2008 legislative sessions. This template provides the Federation with a proactive mechanism that establishes review committees that span the authority of more than one health professional regulatory board in the state. Notably, the template combines the "best of" provisions from legislation introduced on this issue to date and allows for flexibility when defining the composition of the scope of practice review committee.

II. LEGISLATIVE PURPOSE

The following is a compilation of the "best of" provisions from all legislation introduced on this issue. This is meant only as an example and can be altered on an as needed basis:

The Legislature hereby finds and declares that:

- a. The Legislature is routinely overwhelmed with the number of proposals it is asked to consider that recommend changes in healthcare practitioner scopes of practice.*
- b. Oftentimes legislators may not have available to them a thorough, professional and independent understanding of the health and economic implications of such recommendations on an individual basis.*
- c. Currently, when a healthcare practitioner scope of practice change is proposed, the [INSERT NAME OF STATE] Legislature must consider many complex issues in a relatively short time frame.*
- d. Effective legislative decision-making is dependent on each legislator having access to balanced, thoroughly researched information.*
- e. The purpose of this Act is to:*
 - i. Provide a procedure for objective review of proposed changes in the scope of practice of healthcare practitioners licensed in this state to ensure that the changes contribute to the improvement of the overall health of people in this state; and*

I

- ii. *Establish a committee to make recommendations to the [INSERT NAME OF STATE] Legislature.*

III. APPLICATION

a. In General

The legislation should cover any health professional group or organization or individual that proposes to increase the scope of practice of a health profession.

b. Examples of Legislative Language

"'Applicant group' means any health professional group or organization, any individual or any other interested party that proposes that any health professional group not presently regulated be regulated or that proposes to increase the scope of practice of a health profession."

ARIZ. REV. STAT. ANN. § 32-3101 (1).

"'Applicant group' shall mean any health professional group or organization, any individual or any other interested party that proposes that any health professional group not presently regulated be regulated or that proposes to increase the scope of practice of a regulated health profession."

NEB. REV. STAT. § 71-6204.

"... A member of a licensing board, a licensee or the licensing board or any other person seeking a change in the scope of practice of a health profession..." NM SB 381 (First Session, 2005) (Sec. 4(A)).

"... A person who seeks to change the scope of practice of a health profession, including a person who is a member of the relevant licensing entity or a license holder in that profession..."

TX HB 2706 (2005) (Sec. 113.101(a)).

IV. DEFINITIONS

Every state will have to determine what definitions it needs to provide in order to ensure this legislation is clear and unambiguous. Each statute or piece of legislation discussed in this template differs in this regard. The following is a sampling of definitions that ARC staff recommends that any state medical association consider prior to introduction of this type of legislation:

- a. *"Applicant group" means any health professional group or organization, any individual or any other interested party that proposes to increase the scope of practice of its profession.*

- b. "Committee" means the Scope of Practice Review Committee.
- c. "Health profession" means a health-related activity or occupation for which a person must hold a license under this title.
- d. "License" includes a license, certificate, registration, permit, or other authorization issued by a licensing entity.
- e. "Licensing entity" means an agency, board, department, commission, or other entity that issues a license under this title to practice a specific health profession.
- f. "Scope of practice" means those activities that a person licensed to practice a health profession is permitted to perform, as prescribed by the appropriate statutes and by rules adopted by the appropriate licensing entity.

V. REQUIREMENTS

- a. Composition of the Scope of Practice Review Committee
 - i. When establishing a scope of practice review committee, a state should ensure that it is administratively attached to a specific state agency.
 - ii. The members of the Committee ought to be defined in statute.¹

DRAFTING NOTE

Arizona approach: consisting of five members of the senate appointed by the president of the senate, one of whom shall be a member of the senate appropriations committee, and two members of the house of representatives appointed by the speaker of the house of representatives. One of whom shall be a member of the house of representatives appropriations committee. Selected members shall be based on their understanding and interests in legislation that covers the profession. No more than three appointees shall be from the same political party. The president and the speaker shall designate one of the appointed members as chairman of their respective legislative branch. The chairman of the senate committee shall serve for the term of each legislature. The chairman of the house committee shall alternate. The president of the senate and the speaker of the house of representatives shall also serve as ex-officio members of the committee.

¹ The issue of committee composition is a critical one. Several states (AZ, NE, NM, TX) have approached the committee composition issue, which the resulting legislative language differing significantly from one state to the next. Any state medical association considering this type of legislation needs to consider its unique state needs, political climate, etc., when determining committee composition.

² ARIZ. REV. STAT. ANN. § 32-3101 et seq.

DRAFTING NOTE (cont.)

Nebraska approach: The director [of Regulation and Licensure] with the advice of the [state] board [of health] shall appoint an appropriate technical committee to examine and investigate each application. The committee shall consist of six appointed members and one member of the board designated by the board who shall serve as chairperson of the committee. The chairperson of the committee shall not be a member of the applicant group, or any health profession which is directly or indirectly affected by the application. The director shall ensure that the total composition of the committee is fair, impartial, and equitable. In no event shall more than two members of the same regulated health profession, the applicant group, serve on the technical committee.

New Mexico approach: The commission responsible under this chapter is the New Mexico Health Policy Commission, which is an independent state agency whose mission is to improve access and quality health care for all New Mexicans by providing timely, relevant health care information and analysis on health policy research and planning issues. This commission has the authority to appoint an advisory review panel of sufficient number and expertise to review and make recommendations on the proposed change. The panel shall include one or more members of the licensing board for the health profession in which the proposed change in scope of practice originally applies, include one additional member from the profession from which the proposed change originates, and shall be from the professional associations, trade professions, and (3) shall include at least one fourth of its membership as individuals who do not have economic interest in the profession obtaining the requested change in scope of practice.

Texas approach: (a) The commission consists of the following members: (1) the commissioner of the Department of State Health Services; (2) one member from the Texas State Board of Health; (3) one member from the Texas Health Care Services Commission; (4) one member from the Center for Public Health Practice, University of Texas at Dallas; (5) one member from the School of Law, University of Texas at Dallas; (6) one member from the University of Houston; (7) one member from the Texas State Board of Health; (8) one member who has expertise in consumer protection; (9) one representative of the public; (10) one member who is a representative of the health care industry; (11) one member who is a representative of an institution of higher education; and (12) one member from the Department of Health. (b) The governor shall appoint the public members of the commission.

³ NEB. REV. STAT. § 71-6201 et seq. Notably, Nebraska's law provides that the technical committee file a report with the state board of health and the director of regulation and licensure. The state board of health then files a separate report with the director of regulation and licensure. Finally, the director of regulation and licensure prepares a final report for various members of the Legislature.

⁴ NM SB 381 (First Session, 2005)

⁵ TX HB 2706 (2005)

- iii. If a state decides to include, as a member of the Committee, an employee of a state agency or representative of an institution of higher education, that member ought to be designated by that agency or institution.
- iv. States should consider allowing their respective governor to appoint any public members of the Committee.
- v. States should consider naming the commissioner of the appropriate state department or agency as the chair of the Committee.

b. Restriction on Public Membership

Texas' legislation, in Sec. 113.053, places restrictions on public membership. This is an important component to this legislation. It ensures a balanced composition of this Committee. The following are some examples of possible language – all taken from Texas' HB 2706:

- i. *In this section, "[INSERT NAME OF STATE] trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.*
- ii. *A person may not be a public member of the Committee if:*
 - 1. *The person is an officer, employee, manager, or paid consultant of a [INSERT NAME OF STATE] trade association in the field of health care;*
 - 2. *The person's spouse is an officer, manager, or paid consultant of a [INSERT NAME OF STATE] trade association in the field of health care;*
 - 3. *The person is required to register as a lobbyist under [INSERT CITATION OF APPROPRIATE STATE STATUTE] because the person's activities for compensation on behalf of a health profession related to the activities of the Committee; or*
 - 4. *The person has a direct financial interest in a health care profession or is employed within the health care industry.*

iii. Other Examples of Legislative Language

Some states, rather than address the issue of public membership in a separate section of the legislation, simply define "public member" in the definitions section. Examples of this tactic are as follows:

"'Public member' means an individual who is not and never has been a member or spouse of a member of the health profession being regulated and who does not have and never has had a material financial interest in either the rendering of the health professional service being regulated or an activity directly related to the profession being regulated." ARIZ. REV. STAT. ANN. § 32-3101(10).

"Public member, defined. Public member shall mean an individual who is not, and never was, a member of the health profession being regulated, the spouse of a member, or an individual who does not have and never has had a material financial interest in the rendering of the health professional service being regulated or an activity directly related to the profession being regulated."
NEB. REV. STAT. § 71-6216.

c. Compensation

i. In General

When considering this legislation, states ought to consider requiring that any member of the Committee not receive compensation for service as a Committee member. TX HB 2706 (2005) (Sec. 113.055).

ii. Examples of Other Legislative Language

"Committee members shall receive no salary, but shall be reimbursed for their actual and necessary expenses as provided in sections . . ."
NEB. REV. STAT. § 71-6227(3).

VI. CREATION OF REVIEW PANEL/SUBCOMMITTEE/WORKING GROUP

a. In General

States considering the development of this type of legislation, should consider allowing the Committee to create a review panel, subcommittee or working group to assist in performing the Committee's duties.

b. Points of Interest

- i. It ought to be mandated that any such panel/subcommittee/working group ought to consist of persons other than members of the Committee.
- ii. Also, the name, occupation, employer, and community of residence of each member of the review panel/ subcommittee/working group must be made part of the record of the Committee and detailed in any report resulting from the work of the review panel/subcommittee/working group. TX HB 2706 (2005) (Sec. 113.056).

VII. APPLICANTS FOR INCREASE IN SCOPE OF PRACTICE; FACTORS

Each statute or piece of legislation discussed in this template differs in this regard. The following is a sampling of factors that ARC staff recommends that any state medical association consider prior to introduction of this type of legislation. This language is a compilation of the "best of" provisions found in existing law and/or legislation.

- a. *Applicants, applicant groups, members of a licensing board, a licensee of the licensing board or any other person seeking a change in the scope of practice of a healthcare practitioner profession shall notify the respective licensing board and request a hearing on the proposal.*
- b. *This request shall be submitted on or before August 1 prior to the start of the legislative session for which the legislation is proposed.*
- c. *The licensing board, upon receiving such request, shall notify the Committee and shall:*
 - i. *Collect data, including information from the applicant and all other appropriate persons, necessary to review the proposal;*
 - ii. *Conduct a technical assessment of the proposal, if necessary, with the assistance of a technical review panel established for that specific purpose, to determine whether the proposal is within the profession's current scope of practice; and*
 - iii. *Provide its analysis, conclusions and any recommendations, together with all materials gathered for the review, to the Committee.*
- d. *The person or entity seeking the change in scope of practice shall provide the licensing board with all information requested, including:*

- i. *A definition of the problem and why a change in scope of practice is necessary including the extent to which consumers need and will benefit from practitioners with this scope of practice;*
- ii. *The extent to which the public can be confident that qualified practitioners are competent including:*
 - 1. *Evidence that the profession's regulatory board has functioned adequately in protecting the public;*
 - 2. *Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or endorse standards or a code of ethics; and*
 - 3. *Evidence that state approved educational programs provide or are willing to provide core curriculum adequate to prepare practitioners at the proposed level.*
- iii. *The extent to which the proposed scope of practice increase may harm the public including the extent to which the proposed increase will restrict entry into practice and whether the proposed increase requires registered, certified 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 as those in this state;*
- iv. *The cost to [INSERT NAME OF STATE] and to the general public of implementing the proposed scope of practice increase; and*
- v. *Any proposal which contains a continuing education requirement for a health profession shall be accompanied by evidence that such a requirement has been proven effective for the health profession.*

VIII. COMMITTEE SCOPE OF PRACTICE REVIEWS AND ANALYSIS

Each statute or piece of legislation discussed in this template differs in this regard. The following is a sampling of requirements related to a Committee's review and analysis that ARC staff recommends that any state medical association consider prior to introduction of this type of legislation. This language is a compilation of the "best of" provisions found in existing law and/or legislation.

- a. *Upon receipt of notice, as required under Section 4 (c) (b) of this Act, the Committee shall review and make recommendations on the proposed scope of practice change.*

- b. *In performing its duties under this Section, the Committee shall:*
- i. *Familiarize itself with the Committee's rules on procedures and criteria for such reviews;*
 - ii. *Ensure appropriate public notice of its proceedings;*
 - iii. *Invite testimony from persons with special knowledge in the field of the proposed change;*
 - iv. *Assess the proposal using the following criteria:*
 1. *Whether the proposed change could potentially harm the public health, safety, or welfare;*
 2. *Whether the proposed change will benefit the health, safety and welfare of health consumers;*
 3. *What economic impact on overall health care delivery the proposed change is likely to have;*
 4. *Whether potential benefits of the proposed change outweighs potential harm; and*
 5. *The extent to which the proposed changes will affect the availability, accessibility, delivery and quality of health care in [INSERT NAME OF STATE].*
 - v. *Evaluate the quality and quantity of the training provided by health care professional degree curricula and post-graduate training programs to healthcare practitioners in active practice with regard to the increased scope of practice proposed;*
 - vi. *Determine whether a need exists for the proposed scope of practice change;*
 - vii. *Draft a report that includes findings from subparagraph (iv) above, as well as:*
 1. *A review of other states that have a scope of practice for the relevant profession that is identical or similar to the proposed change and any available information on how that scope of practice has affected the quality and cost of health care in the state;*

2. *A review of any statutory or regulatory changes that were required in the other state to implement the identical or similar scope of practice change;*
 3. *An objective and balanced review that examines the extent to which the potential benefits predicted by proponents of the change or concerns raised by opponents of the change materialized after the scope of practice change took effect in the other state;*
 4. *This report must include evidence-based legislative recommendations for each proposed scope of practice change submitted to the Committee; and*
- viii. *The Committee shall report, not later than December 31 of each year, the results of its review to the:*
1. *Governor;*
 2. *Lieutenant Governor;*
 3. *Speaker of the House of Representatives;*
 4. *President of the Senate; and*
 5. *standing committees of the [INSERT NAME OF STATE] Senate and House of Representatives having jurisdiction over [INSERT APPROPRIATE ISSUES, I.E. STATE FINANCE, HEALTH AND HUMAN SERVICES, ETC.].*

IX. FAILURE TO SUBMIT

Any state considering this type of legislation ought to address the issue of an applicant groups failure to submit their legislative proposal for a scope of practice expansion by the deadline set forth in this legislation.

An example of this type of language is as follows: “[a]ny bill that proposes to expand, contract or change the scope of practice of a healthcare practitioner profession that was not submitted to the Committee will not be considered by [INSERT NAME OF STATE] Legislature.”

X. OTHER COMMITTEE DUTIES

States ought to consider mandating that as the Committee determines appropriate, the Committee ought to conduct other reviews and perform research on issues related to the

scope of practice of a health profession, including retrospective reviews of scope of practice changes.

In addition, this Committee ought to be allowed to provide assistance to the respective states' Legislature, on an as needed basis, with regard to a proposed health profession scope of practice change.

This Committee should also provide staff services to any review panel/subcommittee/working group established under this law.

Finally, states ought to consider allowing these Committees to have the power of legislative subpoena. ARIZ. REV. STAT. ANN. § 41-1279(C)(3).

XI. NOTICE AND PUBLIC HEARING

States considering this type of legislation ought to legislate the following to ensure an open and fair process: (1) that the Committee shall notify, on an annual basis, each licensing entity and, whenever possible, each professional association and group of health professions, of both the Committee's duties under this Act; and (2) that a public hearing conducted under this Act shall be open to the public and is subject to the requirements of the appropriate state statute.