3 Hour Communicable Disease / 4 Hour Risk Management /

4 Hour Maryland Jurisprudence / 1 Hour Cultural Competency

Part I – Communicable Disease

1981 History

A drug technician at the Centers for Disease Control (CDC) in the USA noticed an unusually high number of requests for the drug pentamidine used in the treatment of Pneumocystis carinii pneumonia (PCP). This led to a scientific report of PCP occurring unusually in five Los Angeles gay men.

The search began for the cause not only of the PCP in gay men in Los Angeles, but also of the Kaposi's Sarcoma (KS) occurring in gay men in New York. The leading candidate as the cause was poppers or nitrate inhalants. The alternative explanation was that it was caused by an infectious agent.

Later in the year the first cases of PCP appeared in drug addicts.

1982 History

The syndrome, that is the collection of symptoms, was called GRID (Gay-Related Immune Deficiency) by some scientists and it started to be clearer that it was caused by an infectious agent, possibly a virus that could be spread through blood.

The first article appeared in the Wall Street Journal about how GRID also now affected women and male heterosexual drug users. Haitian refugees in Miami were discovered to also be affected by the syndrome, as were hemophiliacs.

The syndrome was renamed because it was clear that it did not just affect gay men. It was given the new name AIDS, standing for Acquired Immune Deficiency Syndrome. It had become clear that it was an illness resulting from a failure, or deficiency, of the immune system to work properly. The word acquired was used because unlike other immune deficiency illnesses, it appeared that it was an illness that you acquired from someone else; as opposed to being something that happened to you, for example, the taking of immune suppressant drugs after an organ transplant.

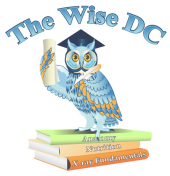
The first blood transfusion recipient was identified with AIDS in the USA, as were the first babies.

AIDS had been reported in fourteen nations world-wide.

1983 History

Doctors at the Institute Pasteur in France believed that they had isolated a new virus, which was the cause of AIDS. The virus was called lymphadenopathy-associated virus or LAV.

It became clear that the disease appeared differently in different parts of the USA. For example, in New Jersey gay men represented a minority of cases, while Injecting drug use accounted for nearly half. This was very different to the epidemic among gay men in other parts of the USA.



In Europe, there were also two AIDS epidemics, one linked to Africa, the other linked to gay men who had visited the USA. The first official report of AIDS in the UK was produced by the UK Department of Health. Three people in the UK had died. The first Australian death from AIDS was recorded in Melbourne.

In May 1983 a report of AIDS occurring in children suggested quite incorrectly the possibility of casual household transmission, and this caused great fear in a number of countries. Considerable public education was required before people were reassured that transmission only occurred in certain very specific ways, and that casual transmission did not occur.

Later in the year the number of children with AIDS had increased, and it became accepted that the children had acquired the infection from their mothers in the womb or during birth. It also became clear that the virus which caused AIDS could be transmitted through blood transfusions.

The first United States conference on AIDS was held in Denver.

AIDS had been reported in 33 countries. 3000 Americans had now had AIDS, of whom 1283 had died.

1984 History

The US Government announced that Dr Robert Gallo, at the National Cancer Institute (NCI) had isolated the retrovirus which caused AIDS and that it has been named HTLV-III. Blood testing was started to detect antibodies to the virus.

The death occurred of Gaetan Dugas, considered by some to be "patient zero", the person who "took" AIDS to North America.

By the end of 1984 7000 Americans had AIDS.

1985 History

The Food And Drug Administration (FDA) in the USA approved Gallo's AIDS diagnostic kit based on the Western blot technique. Soon after the first commercial kit for antibodies was licensed. Later in the year the Pasteur Institute filed a lawsuit against the NCI, claiming a share of the royalties from the NCI's patented AIDS blood test.

Actor Rock Hudson died of AIDS. He was the first major public figure known to have died of AIDS. Also in the USA, Ryan White a 13 year old hemophiliac with AIDS, was barred from school.

The first international conference on AIDS was held in Atlanta.

The initial definition of AIDS had been developed in the USA in 1982, but this definition required laboratory facilities which were not available in most African countries. So in 1985 a new WHO clinical definition of AIDS in Africa was adopted in order that African countries could more accurately assess and report the number of people in their countries who had AIDS.

By the end of the year, AIDS had been reported in 51 countries.

1986 History

It had become clear that the viruses LAV and HTLV-III were actually the same. An international committee ruled that both names should be dropped and replaced by the new name Human Immunodeficiency Virus (HIV).

At the second international AIDS conference in Paris, there were preliminary reports of the use of the drug Zidovudine (AZT) for the treatment of AIDS.

The World Health Organization (WHO) launched its global AIDS strategy. At a WHO meeting on the spread of AIDS among drug abusers, it was recommended that providing sterile needles and syringes to drug abusers should be amongst the preventative action to be taken by individual countries to prevent the spread of AIDS.

In the United States the Surgeon General published a major report on AIDS.

The Ugandan Minister of health declared that his country had AIDS, and other African countries followed suit asking for WHO's assistance. The Zambian Ministry of Health launched a national AIDS education campaign.

In the UK the government set up a Cabinet Committee on AIDS.

1987 History

The FDA in the USA approved AZT as the first antiretroviral drug to be used as a treatment for AIDS. The CDC in the USA also revised their definition of AIDS to place a greater emphasis on HIV infection status.

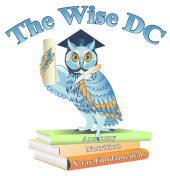
The British government launched a major advertising campaign "Don't Die of Ignorance", and delivered a leaflet about AIDS to every household.

Princess Diana opened the first specialist AIDS hospital ward in England. The fact that she did not wear gloves when shaking hands with people with AIDS, was widely reported in the press and helped to change attitudes to people with AIDS.

President Reagan gave his first speech on AIDS, by which time 36,000 Americans had been diagnosed with AIDS and 20,000 had died.

World-wide, by November 1987, 62,811 cases of AIDS had been officially reported to the World Health Organization (WHO), from 127 countries throughout the world.

Continent	Number of cases	Number of countries or territories reporting 1 or more cases
Africa	5,857	37



Americas	48,591	41
Asia	208	18
Europe	7,477	27
Oceania	678	4
Total	**62,811**	**127**

These were only the cases that had actually been reported, and the number of reported cases was a marked under-estimate of the true incidence of AIDS. WHO estimated that by late 1987 between 100,000 and 150,000 cases of AIDS had actually occurred world-wide.

1988 History

The FDA implemented new regulations which would shorten the time taken for the development of new treatments for AIDS.

The United States became the last major Western industrialized nation to launch a co-ordinated education campaign. The distribution took place of 107 million copies of "Understanding AIDS", a booklet by Surgeon General C. Everett Koop.

In the UK funding was provided for the expansion of the needle exchange schemes to prevent more drug users from becoming infected. The city of New York began a needle exchange program.

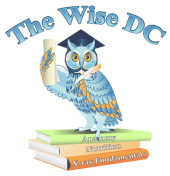
A world summit of ministers of health was held in London to discuss a common AIDS strategy. It focused on programmes for AIDS prevention, and there were delegates from 148 countries. One outcome of the conference was the London Declaration on AIDS prevention, which emphasized education, the free exchange of information and experience, and the need to protect human rights and dignity.

Another outcome was that the WHO's Global Programme on AIDS instituted World AIDS Day as an annual event on December 1st each year.

1989 History

A number of new drugs became available for the treatment of opportunistic infection. Burroughs Wellcome lowered the price of AZT by 20%. A new antiretroviral drug dideoxyinosine (ddI) was authorized by the FDA for use by patients intolerant to AZT.

The trial of AZT in the United States was ended prematurely, after it was discovered that those people who were taking AZT were fighting HIV more effectively than those taking placebo treatments. The



decision was taken so as to allow AZT to be available to everyone, and not just those receiving it in the trial.

1990 History

Just a few months after Ryan White's death the Ryan White CARE Act was passed by Congress. The particular aim of this act was to provide systems of care for people with AIDS who did not have adequate health insurance or other resources.

Also during this year it was reported that a large number of children in Romanian orphanages had become infected with HIV mainly as a result of multiple blood transfusions.

By December 1990 over 307,000 AIDS cases had been officially reported to WHO, but the actual number was estimated to be closer to a million.

The estimate of the number of people world-wide with HIV was 8-10 million. Of the 8 million it was estimated that about 5 million were men, and that 3 million were women.

It was estimated that the 3 million women had collectively given birth to about 3 million infants, of whom over 700,000 were estimated to have been infected with HIV. It had been known for several years that transmission from mother to child could occur before or during birth. It had now become clear that transmission could also occur through breast feeding.

1991 History

There was great public concern over the connection between the dental profession and HIV infection, as Kimberly Bergalis neared death, apparently as the result of becoming infected with HIV from her dentist David Acer. She testified before Congress as well as writing to the American Medical Association requesting the mandatory testing of health care workers.

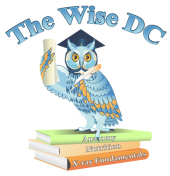
Earvin (Magic) Johnson announced that he had tested HIV positive and that he was retiring from professional basketball as a result, on the advice of his doctors. He decided to become a spokesperson to promote AIDS awareness and safe sex. Two weeks later, Freddie Mercury the lead singer with the rock group Queen, confirmed that he had AIDS, and just a few hours later it was announced that he had died.

The third antiretroviral drug dideoxycytidine (ddC) was authorized by the FDA for use by patients intolerant to AZT. All three of these drugs were in a group known as nucleoside analogues.

However, by this time it had become clear that AZT and these other drugs were only of limited use in the treatment of AIDS, as HIV developed resistance to these drugs, and so the drugs stopped being effective, on average after just one year of use.

By the end of 1991 the second 100,000 AIDS cases had been reported in the United States and there had been 133,000 deaths.

1992 History



The tennis star Arthur Ashe announced that he had been infected with HIV as a result of a blood transfusion in 1983.

The FDA approved the use of ddC in combination with AZT for adult patients with advanced HIV infection who were continuing to show signs of clinical or immunological deterioration. This was the first successful use of combination drug therapy for the treatment of AIDS.

1993 History

In January the Russian ballet star Rudolf Nureyev died of AIDS. In February the tennis player Arthur Ashe also died, less than a year after announcing that he had been infected with the virus.

A European trial known as Concorde, found that AZT was not after all a useful therapy for HIV positive people who have not yet developed symptoms.

1994 History

The filmmaker Derek Jarman died of AIDS, and the actor Tom Hanks won an Oscar for playing a gay man with AIDS in the film Philadelphia.

A study, ACTG 076, showed that AZT reduced by two-thirds the risk of transmission of HIV from infected mothers to their babies.

AIDS had become the leading cause of death amongst Americans between the ages of 25 and 44. 400,000 people in the United States had developed AIDS since 1981, and over 250,000 people had died.

1995 History

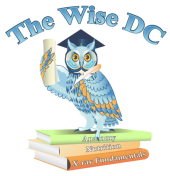
The Delta trial was a major clinical trial of combination antiretroviral therapy. In September 1995 the results of that trial showed that combining AZT with ddI or ddC, did provide a major improvement in treatment compared with AZT on its own. The success of this approach was confirmed by other studies and treatment with dual combination therapy became the standard approach to treatment.

The FDA also during the year approved the use of Saquinavir, the first of a new group of Protease Inhibitor antiretroviral drugs. They also approved the use of 3TC in combination with AZT, and by the end of the year Saquinavir had been authorized for use in combination with the nucleoside analogue group of antiretrovirals.

For years the World Health organization (WHO) had led the international campaign against AIDS. However, it had become increasingly criticized for doing too little at grass-roots level and for focusing too narrowly on medical issues and vaccines. The WHO global program on AIDS was as a result closed at the end of 1995, to be replaced at international level by UNAIDS.

1996 History

The Joint United Nations (UN) Programme on AIDS (UNAIDS) became operational in January 1996. UNAIDS was designed to combine and replace the AIDS work previously undertaken by the WHO



Global Program on AIDS, the UN Children's Fund, the UN Population Fund, the UN Educational Scientific and Cultural Organization, the UN Development Program and the World Bank.

During 1996 an increasing number of drugs received approval from the FDA in the United States, both for use on their own, and/or in combination with other drugs. Another treatment development that had taken place was the viral load test which provided information about the risk of disease progression.

By the time of the international AIDS conference in Vancouver it had also begun to be realized that triple combination therapy, that is three drugs taken together was likely to be even more effective than dual therapy. Three drugs were more likely to suppress the virus, to prevent it from replicating, and so prevent the development of drug resistance.

At the end of the year UNAIDS reported that the number of new HIV infections had declined in many countries due to safer sex practices, although world-wide the rate of infections continued to grow rapidly. Countries that reported a successful slowing of the epidemic included the United States, Australia, New Zealand, northern European countries and parts of Sub-Saharan Africa.

The first AIDS hospice founded in San Francisco closed because fewer people were dying of AIDS in the United States as a result of the new treatments.

1997 History

The FDA granted approval for delavirdine, the first in the latest group of drugs, the non-nucleoside reverse transcriptase inhibitors.

But also during the course of the year it became apparent that the number of people affected by the side effects of the protease inhibitor drugs was greater than had previously been thought. It was also clear that some of the side effects could be serious with the FDA issuing a specific warning concerning diabetes and hyperglycemia in patients receiving protease inhibitors. The development of drug resistance also continued to be of considerable concern, with many of the new drug combinations being extremely complicated and quite difficult to permanently take.

At the end of the year, UNAIDS reported that word-wide the HIV Epidemic far worse than had previously been thought. Updated surveillance techniques suggested that 30 million people were now living with HIV/AIDS and 16,000 new infections were occurring every day.

World-wide, 1 in 100 adults of the 15-49 age group were thought to be infected with HIV; and only 1 in 10 infected people were aware of their infection. It was estimated that by the year 2000 the number of people living with HIV/AIDS will have grown to 40 million.

It was also estimated that 2.3 million people died of AIDS in 1997 - a 50% increase over 1996. Nearly half of those deaths were in women, and 460,000 were in children under 15. UNAIDS reported that they considered that in terms of AIDS mortality the full impact of the epidemic was only just beginning.

1998 History

Side effects known as Lipodystrophy began to cast doubt on the long term safety of combination therapy.

Glaxo Wellcome cut the price of AZT by 75% after a trial in Thailand showed it's effectiveness in preventing mother-to-child transmission. However, even with this price cut it was expected that the drug would still be far too expensive for us in many developing countries.

In June the company AIDSvax started the first human trial of an AIDS vaccine using 5,000 volunteers from across the USA.

The FDA gave approval for various new drugs including Sustiva (efavirenz), another drug in the NNRTI group.

UNAIDS estimated that during the year a further 5.8 million people became infected with HIV, half of them being under 25. It was also estimated that 70% of all new infections and 80% of all deaths were occurring in sub-Saharan Africa.

1999 History

A group of researchers at the University of Alabama, claimed to have discovered that a particular type of chimpanzee, once common in West Central Africa, was the source of HIV.

According to the annual World health Report, AIDS had become the fourth biggest killer world-wide, only twenty years after the epidemic began.

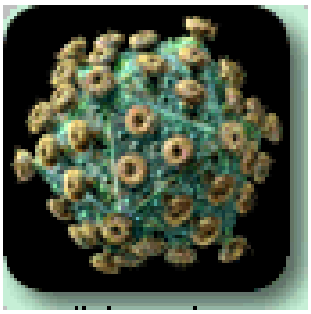
Initial findings from a joint Uganda-US study identified a new drug regimen, a single oral does of the antiretroviral drug nevirapine, as being both more affordable and effective in reducing mother to baby transmission of HIV.

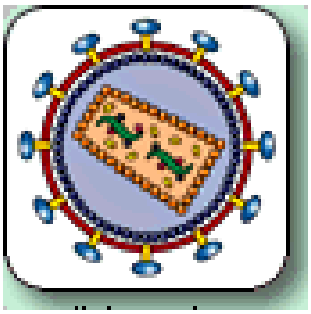
Vaccine development suffered a setback with the news that people infected with a weakened form of HIV more than 17 years ago are now showing signs of AIDS.

By the end of 1999, UNAIDS estimated that 33 million people around the world were living with HIV/AIDS.[i]

HIV Structure

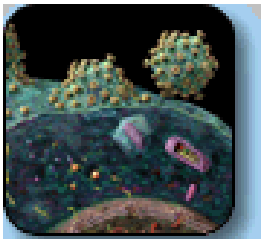
These pictures show the structure of the Human Immunodeficiency Virus (HIV). The outer shell of the virus is known as the viral envelope. Embedded in the viral envelope is a complex protein known as env, which consists of an outer protruding cap glycoprotein (gp) 120, and a stem gp41.
Within the viral envelope is an HIV protein called p17 (matrix), and within this is the viral core or capsid, which is made of another viral protein p24 (core antigen).
The major elements contained within the viral core are two single strands of HIV RNA, a protein p7 (nucleocapsid), and three enzyme proteins, p51 (reverse transcriptase), p11 (protease) and p32 (integrase).

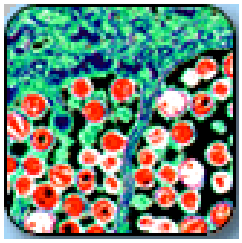


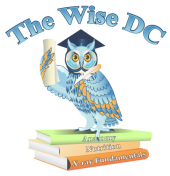


HIV Replication

These pictures are of a cell producing HIV. HIV has a diameter of 1/10,000 of a millimetre.
HIV belongs to a class of viruses called **retroviruses**, which have genes composed of *ribonucleic acid* (RNA) *molecules*. Retroviruses, like all viruses, can only replicate within a living host cell because they contain only RNA and they do not contain DNA. In addition, retroviruses use RNA as a template to make DNA.
Infection begins when an HIV particle encounters a cell with a surface molecule called *CD4*. The virus particle uses gp120 to attach itself to the cell membrane and then enters the cell.
Within the cell the virus particle releases its RNA, and the enzyme reverse transcriptase then converts the viral RNA into DNA. This new HIV DNA then moves into the cell's nucleus where with the help of the enzyme integrase it is then inserted into the host cells DNA. Once it is in the cell's genes HIV DNA is called a *provirus*.
The HIV provirus is then replicated by the host cell, which can then release new infectious virus particles.







Tests to Monitor Health

Treatment decisions can be the hardest decisions a person living with HIV can make. Over the past few years several tests have been developed that can help an infected person and their doctor make informed treatment decisions. The most important tests are the lymphocyte subsets or T4 (or CD4) count, the viral load test, and for women the cervical smear test. More recently Resistance Testing and Therapeutic Drug Monitoring have been developed but these have yet to be introduced as standard part of care in the UK. Caregivers must apply the basic principles of patient consent to administer testing strategies and reporting outcomes, with sensitivity towards confidentiality.

T4 Count

The T4 count is used to predict the current risk of infections by measuring the number of cells in a sample of blood. One blood test alone won't tell you much. You have to look at a series of results to work out the general trend. In general, the lower the T4 count, the greater the risk there is of all opportunistic infections.

Normally T4 cells make up over 25% of the T cells in circulation. A normal count for an uninfected person is between 500 and 1,000. If the count falls below 200 (or 15%) there is a considerable increase in the risk of developing PCP (Pneumocystis Carinii Pneumonia). Women's T4 counts are usually higher than men's are. A woman's T4 count may fluctuate with her menstrual cycle. The oral contraceptive pill may reduce the count.

A T4 count can be affected by infection, smoking, exercise, and the time of day that the blood sample is given. For this last reason, it is sensible to arrange for appointments and blood tests to take place roughly at the same time of day. The proportion of T4 cells (percentage) in circulation, rather than the absolute number, may be a better guide for decision-making, particularly when on a treatment.

Viral Load Tests

The Viral Load test shows the risk of developing AIDS or more severe symptoms of HIV infection. Once antiretroviral treatment has been started it shows what response there has been to the treatment. The viral load test has now become part of clinical practice in the UK, and is often used in conjunction with the more established T4 count that helps place the viral load result in context.

The viral load test measures the amount of HIV in the blood. Whilst it is rarely used to diagnose HIV, in the UK it is now being used regularly (every 2 to 3 months) to monitor viral activity in infected people and inform their treatment decisions. Some studies have shown that if viral load has been reduced by treatment, the infected person will have longer periods of better health.

The aim of the viral load test is to achieve as low a reading as possible. Although some people do manage to achieve 'undetectable' readings, this only means that the levels of HIV are so low that the test cannot detect it. These lower limits vary depending on which test is being used.

Viral load test results can vary by around threefold in normal circumstances and may temporarily rise after an infection or vaccination. Testing should be done during a period of good health so that monitoring can be consistent.

Cervical Smear Tests (Women Only)

Regular cervical smear tests enable the early detection and treatment of abnormalities in the cervix. If these abnormalities are left untreated, they may develop into cancer. HIV may accelerate the progression of cervical cancer.

Uninfected women are recommended to have a cervical smear test every three years in the UK. For women who are infected with HIV it may be advisable to have a cervical smear test more frequently. This is because research has shown that women living with HIV can have increased rates of cervical disorders.

Therapeutic Drug Monitoring (TDM)

What is Therapeutic Drug Monitoring?

Therapeutic Drug Monitoring (TDM) is a process that involves measuring the levels of anti-HIV drugs in the blood of an infected person who is taking medication for their HIV infection. TDM is carried out by analyzing a blood sample taken from an infected person. TDM can help inform treatment decisions and is a relatively cheap method of evaluating the cost-effectiveness of treatment.

TDM can be particularly useful for those people who fail to respond to drug combinations. The minimum drug level needs to be picked up on quickly to find out if it falls beneath the effective dose. TDM is also highly beneficial for those people who experience particularly severe side effects from treatment. The maximum level of drug needs to be detected quickly, to see if it is becoming toxic.

However, TDM is not appropriate for a person on nucleoside analogue monotherapy, as nucleoside analogue drugs undergo many changes before they start working against HIV. Measuring these levels within cells can be very difficult, unlike testing protease inhibitors and non-nucleoside reverse transcriptase inhibitors.

Who currently uses TDM?

While TDM can be extremely helpful in tailoring a person's drug regime, there is currently only one laboratory in the UK carrying out the tests.

Why is Therapeutic Drug Monitoring Useful?

TDM can be extremely useful in tailoring individual drug regimes, as most regimes are based on dosages calculated for the 'average' person. However, different people have different reactions to the same regimes. This can be due to:

· Differences in the way people's bodies digest drugs.

· How efficient a person's liver or kidneys are.

· A person's body weight. While regimes are altered to take into account this is usually if a person has a low body weight or are physically small, but not if they are seriously heavy.

· Drug interactions with one another, and this can sometimes alter the levels of different drugs in a person's blood.

Resistance Testing

HIV, like many viruses, can develop resistance over time to any drug that is used to fight it. Resistance testing is used to determine either if a person's HIV has started to adapt to the drugs being taken, or how effective drugs being taken are. Resistance testing is quite expensive and complicated for clinicians to carry out.

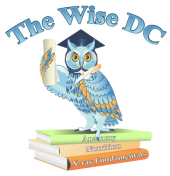
There are two different types of resistance tests; genotypic testing and phenotypic testing. Genotypic testing looks for changes to the HIV gene in a sample of an infected person's blood. For example, if a person has been infected with a strain of HIV that is resistant to the drug 3TC (this resistance is caused by a mutation in the person's reverse transcriptase gene), then genotypic testing would detect this. In order for a genotypic resistance test to be able to give a meaningful result a person needs to have an HIV viral load over 500 - 1,000, depending on the type of genotypic test used. One advantage of using the genotypic rather than the phenotypic test is that the genotypic test examines the HIV gene for changes that lead to resistance and will highlight resistance faster than the phenotypic test that looks for the actual resistance.

Phenotypic testing measures the amount of drug necessary to stop HIV replicating in a sample of blood. As drug resistance develops, the amount of drug needed to be effective will increase. As with genotypic testing, an infected person needs to have a viral load over 500 - 1,000 in order for the phenotypic test to be able to give a meaningful result. The phenotypic test is more simple clinically to carry out and provides faster results than the genotypic test, but in the UK it can still take several weeks to get a phenotypic test result. There is also a lack of clinical understanding as to what exactly phenotypic test results mean. At what point the changes in drug sensitivity (this is what the phenotypic test measures) cease to be clinically significant is unknown.

All resistance tests have difficulties when examining levels of resistance to a drug that does not form the majority of a person's treatment. For example, if a person is on combination therapy and taking drugs A, B and C, with A and B accounting for 85% of the treatment, many resistance tests will have difficulties in detecting resistance to drug C as levels of it will be too low. However, if the amount of drug C and drug B are swapped, then resistance to drug B may not be detected, and will only become apparent again when drug B is increased again. As a result, there is an argument for resistance testing to be ongoing whilst a person is taking treatment to determine what drugs should not be used (as resistance has started to develop), thereby maximizing the treatment options available.

The Origins of Aids & HIV & The First Cases of Aids

Debate around the origin of AIDS has sparked considerable interest and controversy since the beginning of the epidemic. However, in trying to identify where AIDS originated, there is a danger that people may



try and use the debate to attribute blame for the disease to particular groups of individuals or certain lifestyles.

The first cases of AIDS occurred in the USA in 1981, but they provide little information about the source of the disease. There is now clear evidence hat the disease AIDS is caused by the virus HIV. So to find the source of AIDS we need to look for the origin of HIV.

The issue of the origin of HIV could go beyond one of purely academic interest, as an understanding of where the virus originated and how it evolved could be crucial in developing a vaccine against HIV and more effective treatments in the future. Also, a knowledge of how the AIDS epidemic emerged could be important in both mapping the future course of the epidemic and developing effective education and prevention program.

What type of virus is HIV?

HIV is part of a family or group of viruses called lentiviruses. Lentiviruses other than HIV have been found in a wide range of nonhuman primates. These other lentiviruses are known collectively as simian (monkey) viruses (SIV) where a subscript is used to denote their species of origin.

So where did HIV come from? Did HIV come from an SIV?

It is now generally accepted that HIV is a descendant of simian (monkey) immunodeficiency virus (SIV). Certain simian immunodeficiency viruses bear a very close resemblance to HIV-1 and HIV-2, the two types of HIV.

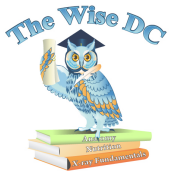
For example, HIV-2 corresponds to a simian immunodeficiency virus found in the sooty mangabey monkey (SIV_{sm}), sometimes known as the green monkey, which is indigenous to western Africa.

The more virulent strain of HIV, namely HIV-1, was until very recently more difficult to place. Until 1999 the closest counterpart that had been identified was the simian (monkey) immunodeficiency virus that was known to infect chimpanzees (SIV_{cpz}), but this virus had significant differences between it and HIV.

So what happened in 1999?
Are chimpanzees now known to be the source of HIV?

In February 1999 it was announced[1] that a group of researchers from the University of Alabama had studied frozen tissue from a chimpanzee and found that the simian virus it carried (SIV_{cpz}) was almost identical to HIV-1. The chimpanzee came from a sub-group of chimpanzees known as Pan troglodytes, which were once common in west-central Africa.

It is claimed by the researchers that this shows that these chimpanzees were the source of HIV-1, and that the virus at some point crossed species from chimpanzees to human. However, it is not necessarily clear that chimpanzees are the original reservoir for HIV-1 because chimpanzees are only rarely infected with SIVcpz. It is therefore possible that both chimpanzees and humans have been infected from a third, as yet unidentified, primate species.[2] In either case at least two separate transfers into the human population would have been required.



How could HIV have crossed species?

It has been known for a long time that certain viruses can pass from animals to humans, and this process is referred to as zoonosis.

The researchers from the University of Alabama have suggested that HIV could have crossed over from chimpanzees as a result of a human killing a chimp and eating it for food.

Some other rather controversial theories have contended that HIV was transferred iatrogenically i.e. via medical experiments. One particularly well publicized theory is that polio vaccines played a role in the transfer.

The journalist Edward Hooper has suggested that HIV could be traced to the testing of an oral polio vaccine called Chat as batches of the Chat vaccine may have been grown in chimp kidney cells in the Congo, the Wistar Institute and Belgium. That could have resulted in the contamination of the vaccine with chimp SIV, the simian version of HIV-1. This vaccine was then given to about a million people in the Belgian Congo, Ruanda and Urundi in the late 1950s.

However, in February 2000 the Wistar Institute in Philadelphia announced that it had discovered in its stores a phial of polio vaccine that had been used as part of this polio vaccination program. The vaccine was subsequently analyzed and in April 2001 it was announced[3] that no trace had been found of either HIV or chimpanzee. A second analysis[4] confirmed that only macaque monkey kidney cells, which cannot be infected with SIV or HIV, were used to make Chat.

What is crucial in regard to the credibility of any theory is the question of when the transfer took place.

Is there any evidence of when the transfer took place?

During the last few years it has become possible not only to determine whether HIV is present in a blood or plasma sample, but also to determine the particular subtype of the virus. Studying the subtype of virus of some of the earliest known instances of HIV infection can help to provide clues about the time of origin and the subsequent evolution of HIV in humans.

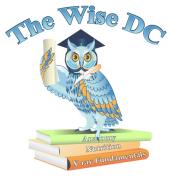
Three of the earliest known instances of HIV infection are as follows:

A plasma sample taken in 1959 from an adult male living in what is now the Democratic Republic of Congo

HIV found in tissue samples from an African-American teenager who died in St. Louis in 1969.

HIV found in tissue samples from a Norwegian sailor who died around 1976.

Analysis in 1998 of the plasma sample from 1959 was interpreted[5] as suggesting that HIV-1 was introduced into humans around the 1940s or the early 1950s, which was earlier than had previously been suggested. Other scientists have suggested that it could have been even longer, perhaps around 100 years or more ago.



In January 2000, the results of a new study presented at the 7th Conference on Retroviruses and Opportunistic Infections, suggested that the first case of HIV infection occurred around 1930 in West Africa. The study was carried out by Dr Bette Korber of the Los Alamos National Laboratory. The estimate of 1930 (which does have a 20 year margin of error), is based on a complicated computer model of HIV's evolution.

Is it known where the emergence of HIV in humans took place?

Many people now assume that because HIV has apparently developed from a form of SIV found in a type of chimpanzee in West Africa, that is was actually in West Africa that HIV first emerged in humans. It is then presumed that HIV spread from there around the world.

However, as discussed above, chimpanzees are not necessarily the original source of HIV and it is likely that the virus crossed over to humans on more than one occasion.[2] So it is quite possible that HIV emerged at the same time in say both South America and Africa, or that it even emerged in the Americas before it emerged in Africa.

We will probably never know exactly when and where the virus first emerged, but what is clear is that sometime in the middle of the 20th century, HIV infection in humans developed into the epidemic of disease around the world that we now refer to as AIDS.

What caused the epidemic to spread so suddenly?

There are a number of factors that may have contributed to the sudden spread including international travel, the blood industry, and widespread drug use.

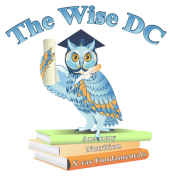
International Travel

The role of international travel in the spread of HIV was highlighted by the case of 'Patient Zero'. Patient Zero was a Canadian flight attendant called Gaetan Dugas who traveled extensively worldwide. Analysis of several of the early cases of AIDS showed that the infected individuals were either direct or indirect sexual contacts of the flight attendant. These cases could be traced to several different American cities demonstrating the role of international travel in spreading the virus. It also suggested that the disease was probably the consequence of a single transmissible agent.

The Blood Industry

As blood transfusions became a routine part of medical practice, this led to a growth of an industry around meeting this increased demand for blood. In some countries such as the USA paid donors were used, including injecting drug use. This blood was then sent worldwide. Also, in the late 1960's hemophiliacs began to benefit from the blood clotting properties of a product called Factor VIII. However, to produce the coagulant, blood from thousands of individual donors had to be pooled. Factor VIII was then distributed worldwide making it likely that hemophiliacs could become exposed to new infections.

Drug Use



The 1970s saw an increase in the availability of heroin following the Vietnam War and other conflicts in the Middle East, which helped stimulate a growth in injecting drug use. This increased availability together with the development of disposable plastic syringes and the establishment of 'shooting galleries' where people could buy drugs and rent equipment provided another route through which the virus could be passed on.

What other theories have there been about the origin of HIV?

Other theories put forward about the origin of HIV include a number of conspiracy theories. Some people have suggested that HIV was manufactured by the CIA whilst others believe that HIV was genetically engineered.

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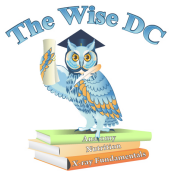


Types, Groups & Subtypes - AIDS Vaccines

What is the difference between HIV-1 and HIV-2?

There are currently two types of HIV: HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1, and generally when people refer to HIV without specifying the type of virus they will be referring to HIV-1. Both HIV-1 and HIV-2 are transmitted by sexual contact, through blood, and from mother to child, and they appear to cause clinically indistinguishable AIDS.

However, HIV-2 is less easily transmitted, and the period between initial infection and illness is longer in the case of HIV-2.

How many subtypes of HIV-1 are there?

HIV-1 is a highly variable virus which mutates very readily. So there are many different strains of HIV-1. These strains can be classified according to groups and subtypes and there are two groups, group M and group O.

In September 1998, French researchers announced that they had found a new strain of HIV in a woman from Cameroon in West Africa. The strain does not belong to either group M or group O, and has only been found in three other people, all in the Cameroon.

Within group M there are currently known to be at least 10 genetically distinct subtypes of HIV-1. These are subtypes A to J. In addition, Group O contains another distinct group of very heterogeneous viruses. The subtypes of group M may differ as much between subtypes as group M differs from group O.

Where are the different subtypes found?

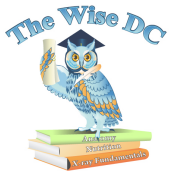
The subtypes are very unevenly distributed throughout the world. For instance, subtype B is mostly found in the Americas, Japan, Australia, the Caribbean and Europe; subtypes A and D predominate in sub-Saharan Africa; subtype C in South Africa and India; and subtype E in Central African Republic, Thailand and other countries of southeast Asia. Subtypes F (Brazil and Romania), G and H (Russia and Central Africa), I (Cyprus), and group O (Cameroon) are of very low prevalence. In Africa, most subtypes are found, although subtype B is less prevalent.

What are the major differences between these subtypes?

The major difference is their genetic composition; biological differences observed in vitro and/or in vivo may reflect this.

It has also been suggested that certain subtypes may be predominantly associated with specific modes of transmission: for example, subtype B with homosexual contact and intravenous drug use (essentially via blood) and subtypes E and C, with heterosexual transmission (via a mucosal route).

Laboratory studies undertaken by Dr Max Essex of the Harvard School of Public Health in Boston have demonstrated that subtypes C and E infect and replicate more efficiently than subtype B in Langerhans cells which are present in the vaginal mucosa, cervix and the foreskin of the penis but not on the wall of



the rectum. These data suggest that HIV subtypes E and C may have a higher potential for heterosexual transmission than subtype B.

However, caution should be exercised in applying in vitro-studies to real-life situations. Other variables which affect the risk of transmission, such as the stage of HIV disease, the frequency of exposure, condom use, and the presence of other sexually transmitted diseases (STDs), must also be taken into consideration before any definite conclusions can be drawn.

Are some subtypes more infectious than others?

Some recent studies have suggested that subtype E spreads more easily than subtype B. In one study conducted in Thailand (Mastro et al., The Lancet, 22 January 1994), it was found that the transmission rate of subtype E among female commercial sex workers and their clients was higher than that for subtype B found among a general population in North America.

In a second study conducted in Thailand (Kunanusont, The Lancet, 29 April 1995), among 185 couples with one partner infected with HIV subtypes E or B, it was found that the probability of both partners in a couple becoming infected was higher for subtype E (69%) than for subtype B (48%). This suggests that subtype E may be more easily transmissible.

However, it is important to note that neither study was designed to fully control for multiple variables which may affect the risk of transmission.

Is subtype E a new subtype?

Subtype E is not new. Stored blood samples show that subtype E was already identified at the beginning of the epidemic in Central Africa and as early as 1989 in Thailand.

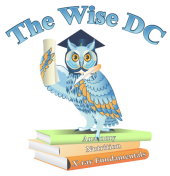
Do conventional HIV antibody tests detect all subtypes?

Routine HIV antibody tests which are currently being used for blood screening and diagnostic purposes detect virtually all subtypes of the HIV. (Most companies have modified their assays so that they detect the newly identified HIV-1 group O strains.)

Are more subtypes likely to "appear"?

It is almost certain that new HIV genetic subtypes will be discovered in the future, and indeed that new subtypes will develop as virus mutation continues to occur. The current subtypes will also continue to spread to new areas as the global epidemic continues.

However, in some countries there is very little monitoring undertaken to detect new sub-types. For example, in Britain, the government's Public Health Laboratory Service which is responsible for monitoring the spread of HIV in Britain, only analyses 2 new infections a month for sub-type information.



What are the implications of HIV variability for research on treatment?

More research needs to be undertaken. Some HIV subtypes have been observed in the laboratory to have different growth and immunological characteristics; these differences need to be demonstrated in vivo.

It is not known whether the genetic variations in subtype E or other subtypes actually make a difference in terms of the risk of transmission or the response to antiviral therapy.

Aids Vaccines

What are the implications for an AIDS vaccine?

The development of an AIDS vaccine is also affected by the range of virus subtypes as well as by the wide variety of human populations who need protection and who differ, for example, in their genetic make-up and their routes of exposure to HIV.

Inevitably, different types of candidate vaccines will have to be tested against various viral subtypes in multiple vaccine trials, conducted in both high-income and developing countries.

Why is an AIDS vaccine needed?

In the long term, a safe, effective and affordable preventive vaccine against HIV is the best hope of bringing the global epidemic under control. However, it would be a mistake to think that the development of such a vaccine will be quick or easy or to expect that once a vaccine is available it will replace other preventive measures.

Scientists are working to understand the kind of immunity a vaccine would have to induce in order to protect someone against HIV infection. The information that they generate is in turn being used by the pharmaceutical and biotechnology industry to develop "candidate vaccines" to be tested in HIV-negative human volunteers. The first human trial of an HIV-preventive vaccine was conducted in 1987 in the United States. Since then, more than 30 small-scale trials have been conducted, including 12 in developing countries (Brazil, China, Cuba, Thailand and Uganda). These trials, carried out with the participation of more than 5000 healthy volunteers have shown that the candidate vaccines are safe and that they induce immune responses that could potentially protect people against HIV infection.

What about large scale trials?

The first large-scale HIV vaccine trials, designed to show whether the candidate vaccines actually protect against HIV infection or disease, were launched in 1998 in the United States and in 1999 in Thailand. The trials involve 8000 healthy volunteers who are given one of two different versions of gp120, a protein located on the outside of the virus, depending on the virus strains prevalent in the two countries. The initial results from these trials may be available within the next two years. In parallel, other candidate HIV vaccines are being developed through different experimental approaches. Some are based on the HIV strains prevalent in developing countries. Most of these newer candidate vaccines will

be tested in small-scale trials in human volunteers, and the best will proceed to large-scale evaluation for efficacy.

Most likely, the initial HIV vaccines will not be 100% effective, and they will have to be delivered as part of a comprehensive prevention package. What is important now is to ensure that countries where there is an urgent need for HIV vaccines participate in the global effort to ensure that a vaccine appropriate for their use is developed. Likewise, it is not too early to start planning how to ensure that a future vaccine is made available in the areas of the world where it is most needed.

Source: The above page was written by Annabel Kanabus with the section on AIDS vaccines adapted from the UNAIDS Report on the global HIV/AIDS epidemic June 2000

The Different Stages of HIV Infection

HIV infects cells in the immune system and the central nervous system. The main cell HIV infects is called a T helper lymphocyte. The T helper cell is a crucial cell in the immune system. It co-ordinates all other immune cells so any damage or loss of the T helper cell seriously affects the immune system.

HIV infects the T Helper cell because it has the protein CD4 on its surface. HIV needs to use CD4 to enter cells it infects. This is why the T helper cell is referred to as a CD4 lymphocyte. Once inside a T helper cell, HIV takes over the cell and the virus then replicates. In this process (which takes around a couple of days) the infected cell dies. New virus then seeks out new T helper cells to infect.

However, battling against this the immune system is rapidly killing HIV and HIV-infected cells, and replacing the T helper cells that have been lost.

HIV progression can generally be broken down into four distinct stages; primary infection, clinically asymptomatic stage, symptomatic HIV infection, and progression from HIV to AIDS.

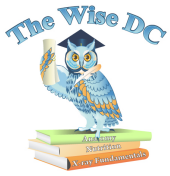
Primary HIV Infection (STAGE 1)

This stage of infection lasts for a few weeks and is often accompanied by a short flu like illness which occurs just after infection. This flu like illness is sometimes referred to as seroconversion illness. In up to about 20% of people the symptoms are serious enough to consult a doctor, but the diagnosis is frequently missed. Even if an HIV antibody test is done at this time, it may not yet be positive.

During this stage there is a large amount of HIV in the peripheral blood and the immune system begins to respond to the virus by producing HIV antibody and cytotoxic lymphocytes.

Clinically Asymptomatic Stage (STAGE 2)

This stage lasts for an average of ten years and as its name suggests, is free from any symptoms, although there may be swollen glands. The level of HIV in the peripheral blood drops to very low levels but people remain infectious and HIV antibodies are detectable in the blood.



Recent research has shown that HIV is not dormant during this stage, but is very active in the lymph nodes. Large amounts of T helper cells are infected and die and a large amount of virus is produced.

A new test is now available to measure the small amount of HIV that escapes the lymph nodes. This test which measures HIV RNA (HIV genetic material) is referred to as the viral load test, and it has an increasingly important role in the treatment of HIV infection.

Symptomatic HIV Infection (STAGE 3)

Over time the immune system loses the struggle to contain HIV. This is for three main reasons:

The lymph nodes and tissues become damaged or 'burnt out' because of the years of activity;

HIV mutates and becomes more pathogenic, in other words stronger and more varied, leading to more T helper cell destruction;

The body fails to keep up with replacing the T helper cells that are lost.

As the immune system fails, so symptoms develop. Initially many of the symptoms are mild, but as the immune system deteriorates the symptoms worsen.

Where do opportunistic infections and cancers occur?

Symptomatic HIV infection is mainly caused by the emergence of opportunistic infections and cancers that normally the immune system would prevent. These can occur in almost all the body systems, but common examples are featured in the table below.

As the table below indicates, symptomatic HIV infection is often characterized by multi-system disease. Treatment for the specific infection or cancer is often carried out, but the underlying cause is the action of HIV as it erodes the immune system. Unless HIV itself can be slowed down the symptoms of immune suppression will continue to worsen.

System	Examples of Infection/Cancer
Respiratory system	Pneumocystis Carinii Pneumonia (PCP) Tuberculosis (TB) Kaposi's Sarcoma (KS)
Gastro-intestinal system	Cryptosporidiosis Candida Cytomegolavirus (CMV) Isosporiasis Kaposi's Sarcoma
Central/peripheral Nervous system	HIV Cytomegolavirus Toxoplasmosis Cryptococcosis Non Hodgkin's lymphoma Varicella Zoster Herpes simplex
Skin	Herpes simplex Kaposi's sarcoma Varicella Zoster

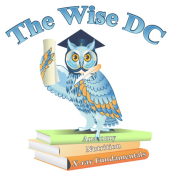
Progression from HIV to AIDS (STAGE 4)

As the immune system becomes more and more damaged the illnesses that present become more and more severe leading eventually to an AIDS diagnosis.

At present in the UK an AIDS diagnosis is confirmed if a person with HIV develops one or more of a specific number of severe opportunistic infections or cancers. However people can still be very ill with HIV but not have an AIDS diagnosis.[ii]

Appropriate Attitudes and behaviors of Care Givers

The caregiver has the obligation to extend to the patient with HIV appropriate compassion and correct treatment options. Several considerations must be applied. The caregiver must eliminate the prejudices regarding the acquisitions of the virus / disease and the limitations created by social factors which the patient cannot control. The method of acquisition is not as important as the correct aspects of the disease process. Such as the stage of the condition, the patient access to information, and treatment options.



Care that is centered on compassion and respect will decrease the chance of the patient feeling condemnation or censure. In essence the caregiver must extend to the patient the same care requirements that he / she would want if the roles were reversed. Because higher levels of HIV are found in various groups the caregiver must take special consideration toward cultural sensitivity. This will increase the comfort and trust of the patient.

OSHA Preambles - Bloodborne Pathogens (29 CFR 1910.1030) - IX. Summary and Explanation of the Standard

OSHA Preambles - Bloodborne Pathogens (29 CFR 1910.1030) - Table of Contents

Record Type: Occupational Exposure to Bloodborne Pathogens

Section: 9

Title: IX. Summary and Explanation of the Standard

OSHA believes that the requirements set forth in this final standard are those, based on currently available data in the record, which are necessary and appropriate to provide adequate protection to employees exposed to blood and other potentially infectious materials. In the development of this final standard, OSHA has carefully considered the comments and testimony from interested parties given in response to the Proposed Standard and the Advance Notice of Proposed Rulemaking. In addition, numerous reference works, journal articles, and other data, collected by OSHA and others since the initiation of this proceeding have been taken into consideration in the development of this final standard.[iii]

The Americans With Disabilities Act and Persons With HIV/Aids

Introduction

The Americans with Disabilities Act (ADA) gives federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications.

An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Persons with HIV disease, both symptomatic and asymptomatic, have physical impairments that substantially limit one or more major life activities and are, therefore, protected by the law.

Persons who are discriminated against because they are regarded as being HIV-positive are also protected. For example, a person who was fired on the basis of a rumor that he had AIDS, even if he did not, would be protected by the law.

Moreover, the ADA protects persons who are discriminated against because they have a known association or relationship with an individual who is HIV-positive. For example, the ADA would protect an HIV-negative woman who was denied a job because her roommate had AIDS.[iv]

Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis

Introduction

Although preventing blood exposures is the primary means of preventing occupationally acquired human immunodeficiency virus (HIV) infection, appropriate postexposure management is an important element of workplace safety. In January 1990, CDC issued a statement on the management of HIV exposures that included considerations for zidovudine (ZDV) use for postexposure prophylaxis (PEP) (1). At that time, data were insufficient to assess the efficacy of ZDV as a prophylactic agent in humans or the toxicity of this drug in persons not infected with HIV. Although there are still only limited data to assess safety and efficacy, additional information is now available that is relevant to this issue.

In December 1995, CDC published a brief report of a retrospective case-control study of health-care workers (HCWs) from France, the United Kingdom, and the United States exposed percutaneously to HIV; the study identified risk factors for HIV transmission and documented that the use of ZDV was associated with a decrease in the risk for HIV seroconversion (2). This information, along with data on ZDV efficacy in preventing perinatal transmission (3) and evidence that PEP prevented or ameliorated retroviral infection in some studies in animals (4), prompted a Public Health Service (PHS) interagency working group *, with expert consultation (5), in June 1996 to issue provisional recommendations for PEP for HCWs after occupational HIV exposure (6).

Since the provisional recommendations were released, several new antiretroviral drugs have been approved by the Food and Drug Administration (FDA), and more information is available about the use and safety of antiretroviral agents in exposed HCWs (7-10). In addition, questions have been raised about the use of chemoprophylaxis in situations not fully addressed in the 1996 recommendations, including when not to offer PEP, what to do when the source of exposure or the HIV status of the source person is unknown, how to approach PEP in HCWs who are or may be pregnant, and considerations for PEP regimens when the source person's virus is known or suspected to be resistant to one or more of the antiretroviral agents recommended for PEP.

In May 1997, a meeting of expert consultants, convened by CDC to consider the new information, prompted a PHS interagency working group ** decision to issue updated recommendations. This document addresses the management of occupational exposure to HIV, including guidance in assessing and treating exposed HCWs, updates previous recommendations for occupational postexposure chemoprophylaxis, and updates and replaces all previous PHS guidelines and recommendations for occupational HIV exposure management for HCWs. Included in this document is an algorithm to guide decisions regarding the use of PEP for HIV exposures. The algorithm and these recommendations together address most issues that may be encountered during postexposure follow-up. As relevant information becomes available, updates of these recommendations will be published. Recommendations for nonoccupational (e.g., sexual or pediatric) exposures are not addressed in these guidelines.[v]

Current Medical Treatment

Current Medical Treatment

There's no cure for HIV/AIDS, but a variety of drugs can be used in combination to control the virus. Each of the classes of anti-HIV drugs blocks the virus in different ways. It's best to combine at least three drugs from two different classes to avoid creating strains of HIV that are immune to single drugs. The classes of anti-HIV drugs include:

- **Non-nucleoside reverse transcriptase inhibitors (NNRTIs).** NNRTIs disable a protein needed by HIV to make copies of itself. Examples include efavirenz (Sustiva), etravirine (Intelence) and nevirapine (Viramune).
- **Nucleoside reverse transcriptase inhibitors (NRTIs).** NRTIs are faulty versions of building blocks that HIV needs to make copies of itself. Examples include Abacavir (Ziagen), and the combination drugs emtricitabine and tenofovir (Truvada), and lamivudine and zidovudine (Combivir).
- **Protease inhibitors (PIs).** PIs disable protease, another protein that HIV needs to make copies of itself. Examples include atazanavir (Reyataz), darunavir (Prezista), fosamprenavir (Lexiva) and ritonavir (Norvir).
- **Entry or fusion inhibitors.** These drugs block HIV's entry into CD4 cells. Examples include enfuvirtide (Fuzeon) and maraviroc (Selzentry).
- **Integrase inhibitors.** Raltegravir (Isentress) works by disabling integrase, a protein that HIV uses to insert its genetic material into CD4 cells.

When to start treatment
Current guidelines indicate that treatment should begin if:

- You have severe symptoms
- Your CD4 count is under 500
- You're pregnant
- You have HIV-related kidney disease
- You're being treated for hepatitis B

Treatment can be difficult
HIV treatment regimens may involve taking multiple pills at specific times every day for the rest of your life. Side effects can include:

- Nausea, vomiting or diarrhea
- Abnormal heartbeats
- Shortness of breath
- Skin rash
- Weakened bones
- Bone death, particularly in the hip joints

Co-diseases and co-treatments
Some health issues that are a natural part of aging may be more difficult to manage if you have HIV. Some medications that are common for age-related cardiovascular, metabolic and bone conditions, for example, may not interact well with anti-HIV medications. Talk to your doctor about other conditions you're receiving medication for. There are also known interactions between anti-HIV drugs and:

- Contraceptives and hormones for women
- Medications for the treatment of tuberculosis
- Drugs to treat hepatitis C

Treatment response
Your response to any treatment is measured by your viral load and CD4 counts. Viral load should be tested at the start of treatment and then every three to four months during therapy. CD4 counts should be checked every three to six months.

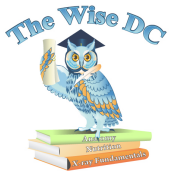
HIV treatment should reduce your viral load to the point that it's undetectable. That doesn't mean your HIV is gone. It just means that the test isn't sensitive enough to detect it. You can still transmit HIV to others when your viral load is undetectable. [vi]

Perinatal HIV-1 Transmission in the United States

Summary

These recommendations update the May 4, 2001 guidelines developed by the Public Health Service for the use of zidovudine (ZDV) to reduce the risk for perinatal human immunodeficiency virus type 1 (HIV-1) transmission This report provides health-care providers with information for discussion with HIV-I infected pregnant women to enable such women to make an informed decision regarding the use of antiretroviral drugs during pregnancy and use of elective cesarean delivery to reduce perinatal HIV-1 transmission, Various circumstances that commonly occur in clinical practice are presented as scenarios and the factors influencing treatment considerations are highlighted in this report. It is recognized that strategies to prevent perinatal transmission and concepts related to management of HIV disease in pregnant women are rapidly evolving. The Perinatal HIV Guidelines Working Group will review new data on an ongoing basis and provide regular updates to the guidelines; the most recent information is available on the HIV/AIDS Treatment Information Service (ATIS) website (http://www.hivatis.org).

In February 1994, the results of Pediatric AIDS Clinical Trials Group (PACTG) Protocol 076 documented that ZDV chemoprophylaxis could reduce perinatal HIV-1 transmission by nearly 70%. Epidemiologic data have since confirmed the efficacy of ZDV for reduction of perinatal transmission and have extended this efficacy to children of women with advanced disease, low CD4+ T-lymphocyte counts, and prior ZDV therapy. Additionally, substantial advances have been made in the understanding of the pathogenesis of HIV-1 infection and in the treatment and monitoring of HIV-I disease. These advances have resulted in changes in standard antiretroviral therapy for HIV-1 infected adults. More aggressive combination drug regimens that maximally suppress viral replication are now recommended. Although considerations associated with pregnancy may affect decisions regarding timing and choice of therapy pregnancy is not a reason to defer standard therapy. The use of antiretroviral drugs in pregnancy requires unique considerations, including the potential need to alter dosing as a result of physiologic changes associated with pregnancy, the potential for adverse short or long-term effects on the fetus and newborn, and the effectiveness for reducing the risk for perinatal transmission. Data to address many of these considerations are not yet available. Therefore, offering antiretroviral therapy to HIV-1 infected women during pregnancy whether primarily to treat HIV-1 infection, to reduce perinatal transmission, or for both purposes, should be accompanied by a discussion of the known and unknown short and long-



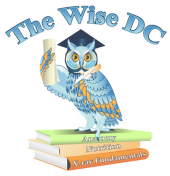
term benefits and risks of such therapy for infected women and their infants. Standard antiretroviral therapy should be discussed with and offered to HIV-1 infected pregnant women. Additionally to prevent perinatal transmission, ZDV chemoprophylaxis should be incorporated into the antiretroviral regimen.[vii]

Comprehensive Human Services - Available to Assist Those with HIV Infection

AIDS Drug Assistance Program

Care Coordinators and /or Case Management and

Community Based AIDS Service Organizations



Part II – Risk Management

What is Risk Management?

Risk Management is the development of practice strategies to prevent patient harm and practitioner liability. This is achieved through the development of clearly defined practice guidelines intended to reduce and prevent malpractice actions. Properly implemented risk strategies will decrease the potential for malpractice claims and increase the quality of care for patients.

What is Malpractice?

Malpractice is a dereliction from professional duty or a failure to exercise an accepted degree of professional skill or learning by a physician rendering professional services which results in injury, loss or damage. Malpractice is further defined as an injurious, negligent or improper practice.[viii]

The Doctor of Chiropractic practices in a highly litigious society where legal expenses, settlements and jury awards total in excess of 100 billion dollars per year. While there is a low incidence of legal cases proceeding to jury trial, medical malpractice cases go to trial more frequently than other types of personal injury litigation. This increased incidence of litigation is due to societal fascination with the concept of litigation, sensationalized accounts of enormous jury awards, impersonal health care perceptions and higher expectations of doctors and treatment procedures due to technological advancements.

How is Malpractice Proven?

There are four primary components necessary to successfully prosecute a malpractice claim: Duty, Dereliction of Duty, Direct Causation, and Damage.

Duty

Duty is something that one is expected or required to do by moral or legal obligation. Duty is further defined as an action or task required by one's position or occupation.[ix] The primary element of a successful malpractice action is proving that the physician owed some duty to the claimant. It must be determined that a doctor--patient relationship had been established. This relationship does not require a written contract. For example, rulings have been made which establish a doctor--patient relationship when a doctor gives professional advice during a social encounter. To avoid the establishment of a doctor--patient relationship, avoid giving professional advice during social encounters, train staff not to give professional advice and avoid giving telephone advice. Also, an independent chiropractic examiner should never provide treatment services, or offer a diagnosis, prognosis or future treatment plan to an examinee. Doing so creates a doctor - patient relationship which can result in a malpractice claim. Strict adherence to independent chiropractic examination guidelines and procedures reduces the likelihood of successful malpractice prosecution.

Duties of a Doctor of Chiropractic

The doctor must abide by the rules and regulations promulgated by their State Board of Chiropractic Examiners.

The doctor must provide only those chiropractic treatment services which fall within their states scope of practice.

The doctor must stay abreast of treatment and technological advancements and meet the requirements for their states continuing education credit hours of postgraduate instruction.

The doctor must explain to the patient their treatment plan and the risks of treatment. Also, treatment options should be discussed.

The doctor must receive consent by the patient for treatment.

The doctor must perform a thorough history taking of a patient's subjective complaints.

The doctor must perform a thorough chiropractic, orthopedic and neurological examination of the patient.

The doctor must render an accurate diagnosis.

The doctor must perform appropriate diagnostic testing procedures consistent with the etiology and timing of the patient's injury / condition, patient subjective complaints and the provider of care's objective findings. If radiographic studies are utilized, they must be taken of the area/areas of patient complaint.

The doctor must offer an efficacious course of care with the goal of amelioration of symptomatology or reduction of subluxation, depending upon philosophy.

The doctor must offer quality treatment within a duration of time and at a frequency consistent with general chiropractic and cross discipline treatment parameters and guidelines. A general rule of thumb is the frequency of treatment should decrease over time commensurate with patient progress.

Any adjunctive physiotherapy modalities utilized should be consistent with the diagnosed condition with consideration of the modalities' physiological effects.

The doctor must document daily patient encounters utilizing the S.O.A.P. note format.

Where significant clinical progression is not noted, the prudent DC should refer the patient to the appropriate practitioner for alternative care. Failure to refer may result in the DC being held to the same standard of care as the provider to whom the referral should have been made.

The doctor must document clinical progression to warrant future care consideration.

The doctor must ensure patient confidentiality.

The doctor must never abandon a patient.

The doctor must only bill for those services rendered.

Duties of the Doctor of Chiropractic Imposed by Law

Continuing education credit requirements and license renewal.

State chiropractic laws.

Most states have legislative mandates requiring the DC to report cases of child abuse.

Alterations of Duties:

Duties can be altered by one's state chiropractic association. However, typically, a position espoused by a professional association does not have the force of law.

Duties can be altered by one's state licensing board, which have the full force of law.

Duties can be altered by court rulings.

Dereliction of Duty - any actions or tasks that do not meet the requirements of one's position or profession involving a deviation from standards of care.

Direct Causation - it must be proven that a negligent act occurred which directly caused the patient injury.

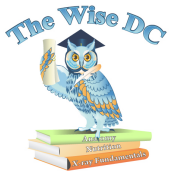
Negligence--failure to exercise the care that a prudent person usually exercises. [x] In a malpractice action it must be proven that the doctor failed to perform his duty with reasonable skill and or performed a procedure that was outside of his scope of practice, expertise and training.

In order to successfully prove malpractice, the plaintiff's attorney must prove causation to a reasonable degree of medical probability. This implies that it is more probable than not, (i.e., there is more than 50% probability) that a certain condition was caused by a negligent action by the accused doctor.

Cause: An agent, circumstance or event which is capable of producing a new effect or aggravating an ongoing or preexisting effect.

Effect: A diagnosis, status, function, condition or impairment which can result from or be aggravated by a cause.

Causation exists when: A given cause (A) and a given effect (B) are associated within a reasonable degree of medical probability. When this is true, all three of the following points are assumed to be correct and medically probable:



The cause (A) is medically probable - (A) is more likely than not the cause and / or aggravator of the problem.

The effect (B) is medically probable – (B) is more likely than not the correct diagnosis or condition.

Cause and effect are not related in a medically probable manner if: Either (A) or (B) or both is considered to be possible, but not probable, the causal association cannot be upheld as being medically probable. Further, no number of possible causes can be taken together and viewed as a probable cause. Clearly, the same notion applies to possible effects.

First, an event took place and is verified. Second, the patient is examined and is found to have an injury. Third, the event could cause the injury, and if so: Fourth, it is medically probable the event caused the injury.

Medically probable: A notion that it is more probable than not that something is true, from a medical standpoint, in other words, a greater than *50%* probable.

Medically possible: A notion that it is more likely than not that something is true from a medical standpoint. In other words, the particular effect could be due to a particular cause, but it is not more than *50%* likely.

Aggravation: A stimulus capable of worsening. The "status quo" of a susceptible entity or condition. The concept of aggravation must be considered as either temporary (self-limited aggravation) or permanent (substantive aggravation). The AMA Guides defines an aggravation as "a physical, chemical or biological factor which may or may not be work related, contributing to the worsening of a preexisting medical condition or infirmity in such a way that the degree of permanent impairment is increased by more than 3%," (AMA Guides, 4th edition glossary P.315).

Exacerbation: Temporary increase in symptoms without persistent effect or event.

Preexisting condition: Antedating event.

A conclusion that a **cause** did contribute to an **effect** or impairment must rely on the documentation of **circumstances** that were present and verification that the **type** and **magnitude** of the factors were sufficient and bore the necessary **temporal** relationship to the condition. Note, there is a relationship between all five factors- Cause, Effect, Type, Magnitude and Temporal Relationship. One must be sure in the cause and effect relationship before definitively stating a causal relationship.

In determining causation and aggravation, the following is often reviewed:

Medical records attributable to a cause.

Medical records attributable to the effect.

Past medical records.

Results of tests or diagnostic procedures.

Damage - a loss sustained by a party for which recovery is sought in a malpractice lawsuit.

If any of the four elements necessary to prove malpractice are absent (Duty, Dereliction of Duty, Direct Causation or Damage) then the accused doctor's chances of winning the lawsuit are greatly increased. In short, a doctor can lose a malpractice claim if the plaintiff's attorney can prove the doctor had a duty, was derelict in his duty, and his actions or inactions directly caused damage to the claimant.

ERRORS

An error is an act or condition of ignorance or imprudent deviation from a code of behavior. Errors fall into two categories;

Errors of Omission--an example would be the failure to diagnose. Diagnosis is the art or act of identifying a disease from its signs and symptoms and distinguishing one disease from another.

Errors of Commission--the performance of an act which results in injury. An example of an error of commission would be fracturing a rib while adjusting a thoracic vertebra.

Analysis of Errors of Omission

A failure to perform any physical examination or the appropriate examination given the history and patient complaints. For example, due to philosophy, some DC's will perform chiropractic analysis (palpation and leg length checks etc), but do not perform review of systems, and orthopedic or neurological evaluation. A protective, risk management strategy is to perform chiropractic analysis, and orthopedic and neurologic examination testing procedures.

A failure to correlate examination findings and render an accurate diagnosis. Failure to diagnose cancer is a primary risk management concern.

Failure to appropriately refer a patient.

Examples of Errors of Commission

Chiropractic Manipulation Resulting in Disc Herniation

Approximately 20% of all chiropractic malpractice claims involve allegations that a chiropractic manipulation resulted in a disc herniation. In a large percentage of these claims, side posture adjusting techniques were identified as the maneuver which caused the disc herniation.

Chiropractic Manipulation Resulting In Fractures

Fractures are a medically possible result of chiropractic manipulation. The most common type of fracture resulting from a chiropractic manipulation is a rib fracture in an osteoporotic female patient.

Chiropractic Manipulation and Cerebrovascular Accidents

Cerebrovascular accidents (CVA) also known as Vertebrobasilar Stroke (VBS) caused by a cervical manipulation result in a disruption of blood flow through the vertebral arteries, which ascend through the transverse foramen in the cervical spine and join together forming the basilar artery. The basilar artery provides vascular input to the posterior portion of the circle of Willis and then to the posterior cerebellar artery. The change in vascular flow through the vertebral artery causes ischemia to the cerebellum or the brainstem, especially the medulla. Ischemia to this area produces the lateral medullary or Wallenberg syndrome, which consists of; an ipsilateral loss of the following cranial nerves (V Trigeminal nerve (sensory - touch, pain and temperature to the face; motor - muscles of mastication); IX Glossopharyngeal nerve (sensory - posterior 1/3 of the tongue; motor - stylopharyngeal muscle); X Vagus nerve (gag reflex) and XI Spinal Accessory nerve (motor - trapezius muscle, and sternocleidomastoid muscle)); cerebellar ataxia (irregular or loss of motor coordination); and contralateral loss of pain and temperature sensation. Damage to the patient due to CVA (stroke) may include hemiparesis, hemiplegia or even death. CVA after manipulation represents 4% of all malpractice suits filed each year.[xi]

Manipulation - Induced Vertebral Artery Syndrome: Identification of Potential Patient at Risk. Incidence - Over 50 documented cases since 1947; over 12 deaths; mean age, 37.9; female patients nearly 2:1.[xii]

Authoritative sources opine that the probability of stroke resulting from a cervical manipulation is one in one million. However, malpractice claims alleging stroke have increased dramatically.[xiii] It is prudent to perform stroke screening tests such as George's Test.

George's Test also known as the Cerebrovascular Craniocervical Functional Test

The test should be performed on everyone over 18 years old.

The test has four parts;

Part I - History

Questions are asked regarding the cardiovascular system and related symptomatology ex. Do you have a history of stroke, hypertension etc.? Affirmative answers are presumptive evidence of a high risk patient.

Part II - Integrity of subclavian arteries

Check blood pressure and compare systolic pressures in both arms. A lower systolic pressure of 10 mm Hg. suggests a possible occlusion of an artery on the low side.

Auscultate the sublcavian arteries at the subclavian fossa for bruits. (Bruit is a sound caused by turbulent blood flow due to an occlusion).

Part III - Integrity of the carotid arteries

Palpate the carotid arteries found at the level of the thyroid cartilage, anterior to the S.C.M. muscle. The carotid sinus is found at the level of C4.

Auscultate the carotid arteries for bruits.

If there is a possible Subclavian (+ Step II, or carotid artery (+ Step III) occlusion, do not perform Step IV.

Part IV - Vertebrobasilar Artery Functional Maneuver

This test is designed to compress the vertebral arteries. Positive indicators of occlusion would be signs of cerebral ischemia such as nausea, fainting, vertigo and nystagmus. The patient is instructed to hyperextend and rotate their head to the left for 3-5 seconds (watch for indicators) and then to the right for 3-5 seconds (once again looking for indicators of occlusion).

If Steps II, III, or IV is positive, do not perform rotary (rotation & extension) cervical manipulations and refer to a cardiovascular specialist or neurologist.

Injury Caused by Therapies

Injuries can be caused by the improper utilization of adjunctive physiotherapy methods and exercise techniques. To protect against this, know the physiological effects, indications and contraindications for all modalities used and the risks of exercise. Instruct the patient on proper lifting techniques.

Sexual Molestation

To avoid allegations of sexual molestation have a witness (staff member of the same sex as the patient) with you during examinations and treatment.

Practice Limitations

A chiropractor is limited to the utilization of diagnostic and therapeutic procedures which fall within their states scope of practice rules and regulations. It is imperative that every chiropractor know the scope of practice for their particular state. Chiropractors should limit the procedures that they employ to those in which they have had documented training approved by an accredited chiropractic college and or their states Board of Chiropractic Examiners.

Chiropractic Standards of Care

Chiropractic standards of care are not established by chiropractic colleges, state organizations or insurance companies. Conversely, chiropractic standards of care are ultimately decided by a court of law. With the growing number of standard of care cases, a number of states such as California have formulated statutory definitions of failure to conform to standards of care. California defines professional negligence as "A negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed." [xiv]

Common Causes of Malpractice Lawsuits and Risk Management Strategies

Deviating from the standard of care by performing services outside of the scope of practice promulgated by a state regulatory body may lead to a malpractice claim. Avoid this scenario by knowing and practicing within your states scope of practice.

Failure to inform the patient of adverse consequences of treatment. This omission can be remedied by devising a standard practice protocol at the time of patient induction into your office. For example, create a form which chronicles your discussion with the patient regarding their condition, proposed treatment, proposed frequency and duration of treatment, risks of the treatment to be utilized, alternative treatment options, and chances of success or failure.

Failure to diagnose, which leads to loss by the patient. This omission can be remedied by increasing your knowledge base in the area of differential diagnosis and following an orderly and strategic clinical reasoning method. Patients seek the services of a physician for two fundamental reasons; 1) to establish the correct diagnosis and 2) to obtain the appropriate treatment. Treatment provided for an incorrect diagnosis fails the patient to the same degree as does diagnosis without appropriate treatment. The diagnosis is obtained only after considering a number of competitive etiologies and progressively eliminating them. This is the process of differential diagnosis. The patients history coupled with their physical examination findings are the most essential components of the differential diagnosis. Approximately 90 percent of the diagnosis is derived directly from the history. While the history plays a significant role in the formulation of a diagnosis, the importance of accurate physical examination findings cannot be overstated. Physical examination findings are valuable in that they demonstrate high sensitivity or specificity for a given pathology.

Deviation from the standard of care through treatment errors such as rib fractures, therapy burns, patient falls from the treatment table and other assorted on table injuries (pinch injuries and finger amputations caused by mechanized tables) is a common cause of malpractice lawsuits. To avoid these errors of commission, perform adjustive techniques which were taught to you at your accredited chiropractic college, train your staff to administer adjunctive physiotherapy modalities, and make sure to guide patients on and off of your treatment table.

Failure to provide adequate exercise and home therapy instruction may result in a malpractice claim. Consequently, it is advisable for the provider of care to demonstrate proper exercise techniques and instruction on self administered home therapy.

Failure to refer the patient for necessary ancillary diagnostic testing or cross discipline examination is common causes for malpractice lawsuits. In a case where significant clinical progression is not noted, the prudent physician should either alter his treatment, or refer the patient for additional testing or examination by another physician. When there is a differential diagnosis containing morbid or potentially fatal conditions, the physician is compelled to pursue a testing strategy to rule out or confirm their presence. The testing procedure that is chosen should have a high specificity and sensitivity to the suspected condition. Appropriate test selection is necessary for diagnostic orientation, patient safety and cost effectiveness.

Patient Abandonment-- abandonment occurs when a doctor, without notice, unilaterally discontinues his professional relationship with a patient who is in need of ongoing health care services. A prudent risk management strategy to avoid a claim of abandonment would be for the doctor to personally inform the patient that he can no longer offer professional services to them and allow them sufficient time to find another provider of care. This conversation should be reinforced by a letter sent certified return receipt requested. In the case of a vacationing doctor, coverage arrangements must be made. Retirement or relocation also requires advanced notice and a reasonable opportunity to secure the services of another provider of care.

Advertisement claims which guarantee a cure are problematic and must be avoided.

The physician who exceeds the consent given to him by the patient may be subject to allegations of battery which can result in civil or criminal actions.

Revealing confidential patient information may result in a lawsuit. It is imperative that the physician personally maintain patient confidentiality and instruct his staff on the importance of patient privacy. Also, the physicians' office should be constructed in such a way to insure privacy. For example, a glass partition between the receptionist and the patient waiting room will assure privacy when discussing collection matters, compliance with treatment and the patient's clinical status.

Sexual Misconduct--Doctors must avoid all situations which give the impression of sexual impropriety. To avoid a claim of sexual misconduct, have a staff member in attendance during the entire patient encounter and only care for a minor in the presence of their parent. When possible, the witness should be of the same gender as the patient.

Office literature can contribute to malpractice claims. Review all office literature carefully. Any literature which makes claims of chiropractic curing specific conditions should be discarded.

Collecting fees can initiate a malpractice action. It is the duty of the doctor to assure all new patients understand the fee arrangements before the patient incurs any charges for services. It is advisable for the physician to separate himself from the actual collection of fees. Disputes arise out of the collection of fees when patients are not satisfied with their care and are being pressured to pay their bill.

The physician should follow up with all patient management discussed with the patient. Failure to maintain proper follow up procedures may result in a malpractice claim.

Lack of physician availability can result in a malpractice action. If an office advertises hours of availability, make sure either the physician or a substitute is available during the stated times.

Chiropractic Malpractice Statistics

According to Princeton Insurance Company, approximately 5 percent of practicing chiropractors are involved in litigation as defendants at any one time. The cost of malpractice insurance is approximately $1500.00 for limits of liability of $1,000,000 for each medical incident and $3,000,000 per annual aggregate.

The average medical specialist pays a six figure annual premium.

Understanding Your Malpractice Insurance Policy

Malpractice premiums are based upon actuarial calculations of risk and claims made for a particular year. The more claims made against a particular specialty, the higher the premium. The relative low cost of chiropractic malpractice premiums is a tribute to the safety of chiropractic treatment methodologies.

Most malpractice insurance policies state that in exchange for a premium payment, the malpractice insurance carrier will defend any claims made against the insured doctor, provide legal services if necessary and pay up to the amount of the policies limits in the case of a doctors errors or omissions stipulated by the policy. Policies typically have limits of liability for each occurrence and per annual aggregate. Therefore, a policy which lists limits of $1,000,000 / $3,000,000 will pay up to$1,000,000 for a single medical occurrence and a total of $3,000,000 for all claims occurring in a single year. The doctor is personally responsible for all claims which exceed either the occurrence or aggregate limits of their insurance policy.

The doctor should review his policy yearly, and be cognizant of and avoid those actions prohibited by his policy. For example, those doctor's performing insurance consulting activities, such as peer review and independent chiropractic examination, should ascertain if these activities are covered by their policy. Also, it is imperative to report claims of malpractice in an expeditious manner and aid the insurance company in defense of a claim. The doctor should make sure that the declaration portion of their policy lists all employees that provide any type of treatment services as named insured's.

By having a chiropractic associate sign a contract as an independent contractor does not shield the "employer" doctor from malpractice liability. The "employer" doctor is ultimately responsible for the action of the associate. This legal concept is known as *Vicarious Liability.*

Two Types of Malpractice Insurance Coverage

Claims - Made Coverage - Provides coverage for claims made and reported during the policy period even if the claims were due to errors or omissions occurring before that period.

Example:

Scenario 1, Dr. I.M. Target has claims-made coverage for the year 200. If a claim is made against Dr. I.M. Target in 2000, then he is covered by his policy.

Scenario 2 - Dr. I.M. Target retires in 2001 and discontinues his malpractice insurance coverage. A claim is then filed in 2001 against Dr. I.M. Target for an action that occurred in 2000. Dr. I.M. Target would not have coverage for this incident. A claim filed in 2001; even for an act occurring in 2000 (when Dr. I.M. Target had coverage) is not covered by a Claims-Made policy. This doctor would have been wise to purchase "tail coverage" for an indefinite period. *Claims-Made* coverage is less expensive than *Occurrence* coverage.

Occurrence Coverage - Provides coverage for claims made because of errors or omissions occurring during the effective period of coverage. Example - Dr. Smith purchases Occurrence coverage effective

in 1995. Any negligent action claim which occurred in 1995 would be covered, even if the claim was made in 1995, 1996 or thereafter. Conversely, there would not be coverage for an act that occurred prior to the inception of the policy in 1995, even if the claim was made in 1995.

Doctors switching from Claims-Made coverage to Occurrence coverage should purchase "Gap" coverage. Purchasing appropriate malpractice insurance is an essential risk management strategy.

Patient Consent for Treatment

Consent is compliance in or approval of what is done or proposed by another.[xv] Consent falls into two categories; Informed Consent and Implied Consent.

Informed Consent

Informed consent involves a verbal interaction between the doctor and patient. Essential elements of informed consent include discussion of the patient's condition, identification and explanation of proposed treatment, warning of the risks or consequences of treatment, disclosure of alternative treatment options and their risks and the probability of success or failure of the proposed treatment. Informed consent should be discussed with the patient before care begins. Having the patient sign a written consent form is a prudent risk management strategy.

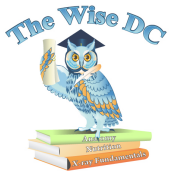
"Where there is risk of significant harm from the treatment proposed, this risk must be disclosed, understood, and accepted by the patient. Such informed consent is required for ethical and legal reasons. The best record of consent is one that is objectively documented, such as, a witness's written consent or videotape."[xvi]

The 1984 case of *Mason v. Forgie* involved the concept of informed consent. The court of New Brunswick awarded Hayden Mason a judgment against Dr. Forgie, DC for more than $200,000 for failing to obtain Hayden Mason's informed consent and failing to advise the patient before initiating treatment of the risks of treatment, particularly the risk of stroke. Hayden Mason was provided a cervical manipulation and suffered a stroke before leaving the doctors office. While the court found that Dr. Forgie was not negligent in using excessive force or with respect to his examination of the patient, he was found negligent in not advising the patient of the risk of stroke.[xvii]

Advise the patient of the risks of treatment and the risks of leaving their condition untreated. Be familiar with statistics regarding unfavorable treatment results. For example, in the *Mason v. Forgie* case, Scott Haldeman, M.D., D.C. opined that the odds of a patient suffering a stroke due to a cervical manipulation are one stroke per one million manipulations.[xviii] Document your discussion of the risks of treatment with the patient and their decision to receive or not receive treatment. If the patient refuses to follow the doctor's treatment recommendations have them sign a notation acknowledging their refusal.

Implied Consent

This form of consent is granted by the patient's voluntary presentation for treatment. Implied consent occurs on each visit to the doctor's office. In general, implied consent takes place after informed consent



with the patient having full knowledge of the proposed care plan and the treatment methods to be employed.

The prudent physician should never breach the doctor--patient relationship contract by exceeding the consent given by the patient. Patients can limit the scope of consent given for treatment. Consent limitations expressed by the patient become an integral part of the contract for services. For example, a patient can instruct their treating chiropractor not to adjust their lumbar spine. The subsequent performance of a lumbar adjustment would be a breach of contract and could trigger a malpractice claim. The unauthorized touching of another is actionable in itself as a battery. The commission of a battery can result in both civil and criminal causes of action.

Written Consent

While laws vary from state to state, written consent of a guardian to treat a minor is typically required prior to treatment.

Example:

Written Consent (For a Minor)

Ian Harmsway, D.C.

Address

Phone #

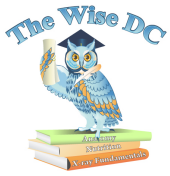
Patient Name: Joe Risky

I authorize Dr. Ian Harmsway to perform ancillary diagnostic tests, render chiropractic adjustments and adjunctive physiotherapy treatment to my minor son, Bob Smith. This authorization extends to all other doctors and staff members associated with Dr. Ian Harmsway. I authorize Dr. Ian Harmsway to utilize radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for my minor son, Joe Risky. If my authority to select and authorize treatment is revoked or altered, I will immediately notify Dr. Ian Harmsway.

Date: _____ Signature: _____

Witness: _____ Relationship to Patient: _____



Informed Consent Document

Utilizing a form and having the patient sign and date the form objectively documents that the informed consent process occurred. An initial informed consent form should be utilized before the initiation of treatment and prior to the performance of diagnostic testing. Also, have the patient sign and date a new informed consent document when treatment is altered and when additional diagnostic testing is performed. Tailor the consent form to the individual patient.

Example:

Informed Consent Document

Dr. Anita Turny

Address

Phone #

Name of Patient: Will Sue

A doctor of chiropractic locates, analyzes and treats vertebral subluxation. The primary chiropractic treatment method is the spinal adjustment. I will use spinal adjustments to treat you.

The Chiropractic Adjustment

I will locate vertebral subluxation, position my hands at these locations and administer a force to correct the subluxation. This procedure may result in an audible sound and you may feel movement.

Risks Associated with Spinal Adjustments

Complications may occur during the deliverance of a spinal adjustment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness.

Risk Probabilities

The above referenced complications are rare. One authoritative source opined that there was a one in one million chance of stroke as the result of a cervical adjustment. (Haldeman, Scott, MD, DC).

Alternative Treatment Options:

Self treatment to include over the counter medication.

Medical treatment to include the use of prescription drugs and physical therapy.

Surgery.

Hospitalization.

Risks of Alternative Treatment

Overuse and improper dosage of over the counter medications may produce undesirable side effects.

Overuse and improper dosage of prescribed medications can lead to undesirable side effects and drug dependence.

Risks associated with surgery include adverse reactions to anesthesia; surgical errors and protracted periods of convalescence.

Risks associated with hospitalization include expense, exposure to disease, and physician and staff errors and omissions.

Risks of Not Receiving Chiropractic Treatment:

Risks associated with not receiving chiropractic treatment may include chronic symptomatology, reduced ranges of motion, the onset of arthritis and reduced activities of daily living.

I hereby attest that Dr. Anita Turney has explained the type of chiropractic treatment to be utilized, the nature and risks of spinal adjustments, the risk probabilities, alternative treatment options and their associated risks and the risks of not receiving chiropractic treatment. I understand the risks involved in undergoing treatment and have of my own volition decided to undergo the treatment provided by Dr. Anita Turney. I hereby give my consent to treatment by Dr. Anita Turney.

Date: _____

Signature: _____

Printed Name: _____

Witness Name: _____

Witness Signature: _____

Diagnosis and Patient Referrals

Failure to accurately diagnose and properly refer a non progressing patient is two common causes of malpractice claims against Doctors of Chiropractic.

Patients seek the services of a chiropractor to establish an accurate diagnosis and obtain appropriate treatment. Approximately 90% of the chiropractor's diagnosis comes from the reported history while the remaining percentage is derived from physical examination findings. This underscores the significance of thorough history taking and comprehensive physical examination skills. During the process of differential diagnosis, the D.C. will, based upon examination findings, eliminate a number of competitive etiologies before formulating an accurate diagnosis. Clinical experience is utilized to differentiate between diagnostic possibilities and diagnostic probabilities. Medically probable is a notion that something is greater than 50% probable.

Patient Management Duties

Upon initial presentation by an individual, and following the history taking and physical examination processes, the doctor must determine if the individual is a candidate for chiropractic treatment. The presence of vital signs is not the sole determining factor of ones candidacy for chiropractic treatment. Reason, logic, experience and intuition will guide you in this determination.

The doctor must arrive at an accurate clinical diagnosis, inform the patient of his findings and treatment plan, receive patient consent and provide quality care directed at resolution of the patients condition.

The doctor must document daily the patient's response to care noting progression and non-progression.

The doctor must alter treatment for the non-progressing patient.

The doctor must refrain from utilizing treatment methodologies that are not within their states scope of practice, which demonstrate no physiological benefits or which aggravate the patient's condition.

Referral Liability

Is the chiropractor liable for the negligent actions of a doctor to whom the patient is referred? In a 1973 New Jersey malpractice case, *Tramutola v. Bortone*, the court ruled that a family doctor who referred his patient to a surgeon was not liable for the surgeon's negligent actions. The court opined that only if the referring family doctor had reason to suspect that an injury was likely and failed to disclose that belief, would the referring doctor be liable. This would only be possible if the referring doctor had knowledge of disciplinary actions or malpractice claims against the referral doctor.[xix]

Historically the courts have concluded that the referring doctor is not liable for the negligent acts of the referral doctor. The exception to this would be two doctors working together in the treatment of a patient. If one of these doctors performs a negligent act, then, both of the doctors would be liable for injuries to the patient.

Reducing Referral Liability

Research the credentials of the referral doctor.

Offer the patient a choice of more than one qualified doctor in a particular specialty.

Refer the patient to the appropriate specialist.

Document the referral. Forward all pertinent patient records and authorizations to the referral doctor.

If the patient is returning to your care after the referral, correlate the information derived from the referral encounter to the patient's condition and treatment plan.

Determine if the patient followed through with referral recommendations.

What Type of Patient should be Referred?

The patient that demonstrates non progression.

The patient whose condition has worsened during the course of chiropractic treatment and is no longer amenable to chiropractic intervention.

Understanding Characteristics of a Non-Progressing Patient

Persistent subjective complaints of pain.

Minimal or no intervals of relief from pain.

Little or no improvement in activity of daily living levels.

Failure to achieve treatment goals.

No change in work status.

Continuous observation by the doctor of these patient characteristics should be a warning signal. The prudent doctor should either alter his treatment approach or refer the patient to another physician specialty. The timing of altering treatment or referral will be different for each individual patient, depending upon their age, sex, diagnosis and the presence of complicating factors.

Risk Management through Documentation

Primary Functions of Health Care Records

Health care records document the immediate care and treatment of the patient. They allow the physician to gauge daily progress.

Records allow other members of your own health care team or other health care providers to have an understanding of the patient's daily subjective complaints, objective findings, procedures performed, and the patient's response to therapy.

Records document your services for reimbursement purposes - they should be clear, concise and legible, written in ink and should not be erased or altered.

Records are critical for legal purposes, including malpractice claims.

Doctor identification on each record is critical especially in the case of multi doctor offices.

Writing in a Medical Record

Medical writing should be accurate, legible, brief, and clear.

Never exaggerate, record falsely, or make up data before examining and treating a patient.

Information should be objective and should never contain criticisms of other physicians or of the patient.

Report information concisely, utilizing short, succinct sentences and standardized abbreviations. Handwriting must be legible and easily read.

Sign every entry that you make into the medical record using your legal signature. (Especially in a multi-doctor office).

The name of the patient should be legible on each notation and nicknames should never be used.

Notes discuss the patient, therefore, do not refer to yourself.

Documentation Strategies

Protective Strategies

Maintain a daily patient sign in sheet. Never allow your receptionist to sign in for the patient and keep a cover over previous patient signatures to ensure confidently.

Have the patient periodically handwrite a list of symptoms and complaints which coincides with the submission of progress reports.

Have the patient periodically hand write, date and sign a progress form which qualifies their status.

Know what is in your forms.

Tailor your patient intake forms to your practice. Read over every form in your office. Forms which contain treatment related historical information at the top of the page and insurance and reimbursement information at the bottom of the page should be separated into two forms. This will reduce inferences that your main concern is reimbursement and not the health and well being of the patient.

Respect the patient's privacy. *For example*, intake forms should not include unnecessary questions about a personal or patient's sexual history. Also, history taking and any other discussions of a personal nature should be done in private. Compliance with HIPPA regulations is strongly stressed.

Every condition or complaint identified by the patient should be addressed.

Avoid the use of treatment frequency schedules as these schedules infer a cookie cutter approach to treatment. The frequency of treatment and the type of treatment provided should be dependent upon the patient's diagnosis, documented response to treatment and clinical progress.

Approximately 90 percent of a doctor's diagnostic impression is derived from information attained during the history taking process. Consequently, the development of accurate and thorough history taking skills is essential. The information derived from the history taking process allows the doctor to arrive at a working diagnosis, develop short term and long term goals and a treatment plan, and render appropriate treatment methodologies.

Never use the terms "Omissions and Errors Included" or "Dictated but Not Read" in any of your documents. This infers a lack of thoroughness and professionalism. Thorough and accurate record keeping is a standard of care and is mandated by many state chiropractic laws.

Document patient noncompliance with prescribed treatment plans. Also, document dates where the patient did not keep a scheduled appointment and record an explanation.

Keep patient records forever. The statute of limitations (the law which establishes a timeframe beyond which a suit cannot be brought) varies from state to state and is subject to a wide range of judicial interpretation. In some states, the time clock doesn't start running until the injury is discovered or, in the case of a child, until they reach adulthood.

Record daily patient encounters utilizing S. O. A. P. notations. These notations should be documented contemporaneous with the patient encounter. Avoid writing all of your patients daily office notes at one time at the end of the day because recollection can be skewed with the passage of time.

Case Scenario--During the course of a trial a chiropractor testifies that he provided services to a patient on January 2, 2004. However, evidence is produced which reveals this patient was actually in another state on vacation on January 2, 2004. What effect would these facts have on the credibility of the chiropractor? While mistakes can occur, billing for services which were not provided can result in insurance fraud investigation and manual claims review of all of that doctor's billing submissions.

Introduction to S. O. A. P. Notes

The Gold Standard for daily office notations is the S. O. A. P. note. S. O. A. P. is an acronym, with each letter representing a section of the patient note. S. stands for subjective complaints; O. stands for objective findings; A. stands for clinical assessment; and P. stands for treatment plan.

The S. O. A. P. note was introduced by Dr. Lawrence Weed as a method of organizing medical records.

The S. O. A. P. note records what the physician does to manage the patient’s condition on a daily basis and is a standardized form of communication. Third party payers make decisions about reimbursement based on the quality, legibility, and completeness of daily office notations. The method of writing S. O. A. P. notes helps the physician to organize the thought processes involved in patient care and offers a structured way of thinking for problem solving. They are also used for quality assurance and improvement purposes and chronicle subjective and objective improvement, patient response to treatment, and the efficacy of care.

S - Writing Subjective Complaints

Document the patient’s subjective complaints in the words of the patient. The subjective complaint will include information regarding the patient’s area/areas of pain, level of function, response to treatment, emotions, goals of care, lifestyle or home situation, emotions and attitudes.

It is acceptable to use “Pt.” the first time, but do not repeat it with every sentence, as it is implied that the information in this section came from the patient.

Quoting the patient verbatim is the most appropriate method of conveying subjective information. Some reasons for using direct quotes from the patient might be to illustrate confusion or loss of memory, denial, attitude toward therapy or the use of abusive language.

The subjective portion of the note includes pertinent information that will assist the physician with setting treatment goals for the patient, planning the patients treatment, and deciding when to discontinue treatment.

O - Writing Objective Findings

The objective part of the note is the section in which the results of tests and measurements performed and the physician's objective observations of the patient are recorded. Objective data are the measurable or observable information used to plan patient treatment. Objective information reported in one note can be compared with measurements taken and recorded in the past to monitor patient progress.

Objective findings which may be found in S. O. A. P. notes may include orthopedic, neurologic, and chiropractic findings. A testing procedure that illicit a positive finding should be noted and re-tested on the next date of treatment.

Information derived from objective testing should be organized under headings, should be written in a clear and concise manner and should list the results of objective measurement procedures performed by the physician.

A - Writing Assessment

The assessment section of the daily office note provides a summary of the patients major problems as written in the Subjective and Objective parts of the note. Assessment includes diagnostic impressions, patient response to treatment, short term goals, long term goals and expected functional outcomes.

Goals: 1) Written to help plan treatment that meets the needs and problems of the patient, 2) Prioritize treatment and measure effectiveness, 3) Communicate to a third party the duration, frequency and types of treatment needed to resolve the patients problem.

Short term goals are written as steps along the way to achieving long term goals.

Long term goals are written to describe how each of the patient's problems will be finally resolved.

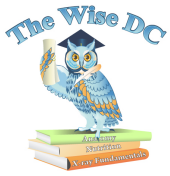
Expected functional outcomes list the functional level that the patient is expected to reach by the time he or she is discharged from therapy.

P - Writing Plan

The Plan part of the note is the final step in the planning process for patient care.

Information that must be included in the plan section of a note: 1) Frequency that the patient will be seen. 2) Treatment provided and proposed.

Information that may be included in the plan section of a note: 1) Location of the treatment (in office, at home, in a pool, gym). 2) Plans for further assessment, reassessment, or discharge 3) Equipment needs and equipment ordered. 4) Referral for cross discipline examination/treatment or ancillary diagnostic testing.



S.O.A.P. Note Example:

Date: ___1/01/02_____

Patient's Name: ____I.M Hurtin____

Patient's Signature: _____

Doctor's Signature:_____

S - "I have a pain in my neck which travels down into my right arm and numbness in my right hand and fingers. I feel about the same as I did yesterday."

O - Decreased, painful cervical flexion 35o/50 o; extension 28 o/60o; right rotation 54o/80o; right lateral flexion 37o/45o; (+) positive Cervical Distraction, and Foraminal Compression on the right; all upper extremity reflexes are normal (biceps, C5; brachioradialis C6; triceps C7; finger flexors C8; hand intrinsic C8); (+) positive Tinels and Phalin's Tests.

A - Cervical nerve root compression; carpal tunnel syndrome right wrist. Patient's response to treatment has been slow, complicated by work duties as a secretary. Short term goal is pain relief.

P - A change in treatment was discussed with the patient and implemented. Patient consent was given (see consent form). Diversified cervical adjustments to C5 PL and C6 PL remain unchanged. The use of heat therapy to the cervical spine was discontinued, replaced by manual cervical traction. Treatment is to continue at 3x per week for 1 week followed by re-examination. Referral for neurological evaluation was advised. Drs. Johnson and Smith were recommended. The patient wants to consider this option and we will discuss further in one week.

Summary of Do's and Don'ts of Record Keeping

Do.

Maintain records in ink.

Make additions and changes appropriately.

Identify patient name, date and year of service. Document unusual events.

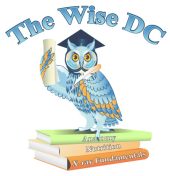
Identify the record keeper.

Record all patient contacts.

Maintain legibility.

Maintain a legend for any codes used.

Maintain records forever.



Fill in all blanks or make a line through blank spaces.

Initial all documents rather than scratching out the entire record.

Customize the forms used.

Document patient non-compliance.

Proof-read correspondence and reports.

Don't:

Erase, skip lines, leave spaces, "squeeze in" notes, use correction fluid, or back date or alter.

Say anything disparaging about the patient.

Avoid judgmental words.

Ever enter data prematurely.

Avoid ambiguous words.

Criticize other providers.

Use two different pens on the same day's entry.

Alter records.

Use computer generated notes unless individualized.

Other Types of Protective Documentation

Patient Sign - In Sheets

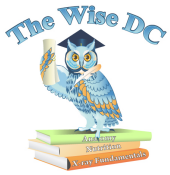
Daily patient sign-in sheets provide a handwritten record of a patient's presentation for care on a particular date. This protects against allegations of insurance fraud. Only the patient should sign the sheet with no substitutions. Some practice management companies tell their students to list 5, 10 or 15 fictitious names on their daily sign-in sheet before their first patient of the day arrives to produce an illusion of a successful office. This practice should be avoided. If uncovered, this dishonest act could destroy the credibility of the doctor in his community and could be a valuable tool for a plaintiff's attorney in a malpractice suit.

Patient Symptoms List

Create a symptoms list form and have the patient handwrite their symptoms and complaints. These lists can be used periodically, such as at the time of a re-examination, as their daily use would be too time consuming.

Example Symptoms List

Today I have neck, back and right leg pain with numbness in my right foot.



Date: _____

Patient:__I.M. Hurting_____

Patient Signature: _____

Patient Progress Report

A patient progress report, written in their own words or checked off in a list format, done periodically, can offer a record of the patient's perception of clinical progress. For ultimate malpractice protection, the form must be completed, dated and signed by the patient only.

Example:

Patient Progress Report

Since my last exam:

1. Improved _____
2. Unchanged _____
3. Worse _____
4. Resolved _____
5. Other _____

Date: _____ Patient Name:_____ Patient Signature:_____

Document Patient Non Compliance

A patient's failure to follow through with a doctor's recommendations should be documented. Every doctor will have a different tolerance level for non compliant patients. Examples of patient non compliance include:

Failure of the patient to show for scheduled appointments.

Failure of the patient to perform prescribed at home therapy such as the use of ice/heat or exercise.

Failure of the patient to refrain from working, lifting, bending, sports activities, school, driving and housework.

Failure of the patient to heed recommendations for life style modifications.

Non-Compliance Notifications

Non-compliant patients should be discharged from care, notified of their non-compliance specifying discussed and agreed to treatment plans, dates and types of non-compliance and referred to another provider of care when appropriate to prevent a claim of abandonment.

How Long Should You Keep Records?

As a general rule of thumb, maintain patient records forever. Also, be knowledgeable of the statute of limitations for your particular state. Most states have statutes of limitation of 3 - 7 years. This means that a malpractice claim must be must be made within 3-7 years after the date of the negligent act. There is an exception which applies to a negligent act against a child. A person that claims to have been a victim of a negligent act while they were a child must bring suit within one year after their 18th birthday.

Discharge Notations

Discharge notes summarize the treatment the patient received, the total number treatments received, patient response to treatment, any patient education performed, instructions or equipment given or sold to the patient, and recommendations for future treatment or follow up care.

Documentation Forms

Documentation forms decrease the amount of writing by the physician, increase the efficiency of documenting patient care, increase the consistency of documentation, provide consistent data gathering and present organized, clinical information that is more easily read by all of the parties who use the information.

Computerized Documentation

Advantages of Computerization Documentation

Computers can have all of the orthopedic, neurologic and chiropractic tests and measurements readily available to the physician.

Limitless space to place the information gathered.

Documentation tailored to the specific needs of the physician.

Information is presented in a clear, concise and legible manner.

Quick data entry by simply touching a stylus to the computer screen.

Disadvantages of computerized documentation

Repetitive, unaltered reporting of daily subjective complaints, objective findings, assessment and plan will raise a red flag. Static clinical information implies unresponsiveness to the treatment rendered.

Limitations of the computer program may limit reporting capabilities.

Consent to X-ray a Pre-menopausal Patient

The prudent doctor will advise all pre-menopausal patients of the risks of radiographic examination of the pelvic region during pregnancy. Inform the patient that embryo damage following radiation exposure during the first trimester of pregnancy has been chronicled. Have the patient document the date of onset of their last menses, and sign consent to x-ray. Create a consent form which states the risk of x-ray during pregnancy, have the patient respond to questions regarding their pregnancy status, use of contraceptives, regularity of menstrual periods, and gynecological history, such as a history of hysterectomy and date of their last menstrual period. Have the patient sign and date the form and include a witness signature.

Telephone Call Form

Create a telephone log form and make entries for all calls which have clinical significance. This form should always be used when a patient calls the doctor to discuss a clinical aspect of their case. The form is not needed when a patient calls to schedule an appointment. The telephone call form is dated and lists all calls from all patients on a particular day. Do not use separate call logs for each patient. Documenting calls from all patients in one daily telephone call form offers an accurate and believable call chronology and reduces any perception that a documented call was fabricated.

Patient Survey

Utilize patient surveys to determine your patient's level of satisfaction with your care, and with your staff. If the survey chronicles a number of consistent complaints, take the appropriate actions to remedy the problem.

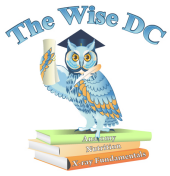
Some practice management groups have advised their students to utilize Release of all Claims forms to rectify patient complaints about the effectiveness of care and demands for monetary refunds. A release is a binding contract, in which a patient agrees to sell his right to make a claim against a doctor in exchange for an agreed to amount of money. This type of an agreement can easily be construed as an admission of guilt by the doctor. Many malpractice insurance carriers have specific policy language forbidding the insured doctor from attempting to settle his own claims. Consequently, it is advisable to not create or sign Release of All Claims forms.

Child Abuse and Neglect Reports

The child protection laws of most states mandate a doctor report all suspected cases of child abuse and neglect. Failure to do so may result in a malpractice suit, (brought by the victim or their guardian arguing that additional damages may have been mitigated if a report was filed); fine; or imprisonment.

Patient Authorization

Before releasing a patients records to a third party, have the patient sign an authorization consenting to the release of their medical records. Never release original records and make sure that the authorizations are current (not more than approximately 60-90 days old).



(Example) Patient Authorization to Release Information and Medical Records

I authorize Dr. Purdy Careful and his employees to provide to the person(s) listed below, all medical information, and records requested, pertaining to any examination, treatment, or condition that I have had in the past, presently have, or may have in the future.

Party Requesting Records

Name: ____Dr. John Smith____

Address: _____

_____

Patient Name: _____

Patient's Signature: _____

Patient Address: _____

_____

Date: _____

Treatment Withdrawal Letter

A treatment withdrawal letter, where a doctor unilaterally withdraws from providing services to a patient, is a letter of last resort. Prior to sending this letter, the doctor should send the patient a non-compliance notification specifying the patient's non-compliant actions (ex. Failure to perform prescribed at-home therapy, failure to lose weight, failure to follow work restrictions, and failure to make scheduled appointments etc.). If the patient's non-compliance can not be remedied, then it is advisable for the doctor to withdraw from treating the patient. In the withdrawal letter the doctor must; offer the patient sufficient notice of withdrawal allowing the patient to find another doctor; send the letter certified, return receipt requested; maintain record of the letter in the patient's file. It is not imperative that the doctor specify the reasons for his withdrawal of treatment as the reasons were clearly specified in the prior non-compliance notification.

Peer/Record Review Preparation

The following documents must be submitted for third party review;

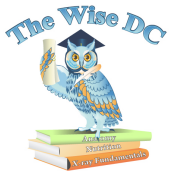
Initial Narrative Report

Initial Examination Findings

Roentgenological Report

Periodic Re-Examination Findings

Daily Office Notations



Billing Statements

Cross Discipline Examination Findings

Ancillary Diagnostic Test Results

Letters of Medical Necessity

Discharge Summary

Follow Up / Final Narrative Reports.

Recording a History of Care

Each document must have the date of the procedure

Date of injury / mechanism of injury / emergency room treatment, hospitalization records.

Treatment history prior to chiropractic treatment

Synopsis of chiropractic treatment to include duration / frequency of care, total number of visits, type of treatment

Synopsis of treatment rendered by other providers of care, and ancillary diagnostic test results

Current frequency of care, diagnosis, type of treatment, concurrent treatment, recent diagnostic tests, provider's rationale for treatment and recommendations for future care

Recording History and Examination

Initial Case History

Date and mechanism of the onset

Nature and location of the injuries sustained

Presenting subjective complaints (note the intensity, character, duration and frequency of the complaint)

Past medical history

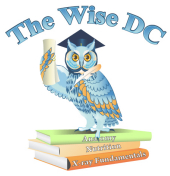
Prior treatment for the presenting complaint

Social/work/family history

Physical, Orthopedic, Neurologic, Chiropractic Examination.

Diagnostic x-rays and or other studies indicated by examination.

Formulation of a Diagnostic Impression / Treatment Goals / Treatment Plan.



Chiropractic treatment - manipulation, passive physiotherapy and active rehabilitation.

Periodic re-examination performed approximately every 8-10 visits, every 30 days or as clinically necessary in the judgment of the attending physician.

Narrative Report Writing

All narrative reports should contain the following;

The Beginning - which paints a picture for the reader explaining the onset of an injury or illnes;

The Middle - which contains the patients current condition and the physical examination

The End - This contains the bottom line of the report specifying the author's conclusions.

Report Format

Introduction (Beginning)

This portion of the report identifies the author, and date of the report, who requested the report, who the report is about, why the report was done, the date of accident and the type of examination performed.

Dear Mr. Shady:

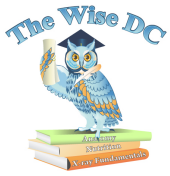
Brent Bumper is a 27 year old male whom I examined at your request on January 2, 2004 for evaluation of injuries sustained in an automobile accident on December 20, 2003. I performed chiropractic evaluation of his head, spine, torso, and upper and lower extremities. The results of my evaluation are contained in the body of this report.

History of the Injury/Cause

This portion of the report should describe the date of injury, the mechanism of injury and the nature and location of the injuries sustained. Identify what transpired after the accident including any type of emergency room treatment or hospitalization. Avoid embellishing the history with graphic terms that may infer bias. For example, "The patient experienced a bone-jarring impact that severely injured his spine".

Effect on Work or ADL's

Identify the patient's ability or inability to perform his normal and customary job requirements.



Past History

This section is used to reveal injuries, illnesses or accidents which may have a bearing on this particular accident. Identify prior accidents, treating providers, type of care rendered, the length of treatment, permanent restrictions or impairments and how long it has been since the patient was treated for that particular injury.

Surgical History

Record all surgical procedures.

Middle of the Report

Current Condition

This portion of the report should describe the patient's condition from head to toe. Each area of the body should be reported on, whether the patient complains of problems or not.

Physical Examination

Reproduce your examination form findings in this portion of the narrative report to include vital signs, chiropractic analysis, range of motion, orthopedic and neurologic findings.

Roentgenological Analysis

Identify the date of examination, number and position of the views taken, assessment of bone alignment and quality, assessment of soft tissue structures, culminating with your clinical impression and diagnosis.

Diagnosis

This portion of the report states the condition detected. It is important to remember that the diagnosis should be a condition, such as subluxation and not a symptom, such as cervicalgia. Avoid embellishing the diagnosis and using vague terms. For example; using the term multiple spinopelvic disrelationships, instead of pelvic subluxation. The diagnosis must be compatible with other portions of the report, understandable to others and summarize the patient's condition.

End of the Report

Comments and Conclusions

This portion of the report is often read first by third parties. Consequently, this section is often started with a summary of the facts of the case followed by your response to questions posed by the referral source regarding reasonableness and necessity of care, causal relation, apportionment permanent impairment and maximum chiropractic improvement.

Prognosis

In this section the author is asked to predict the future for the patient. Rely on your past experience in treating similar cases and support your opinions with available, current literature.

Future Medical Care

Opine whether future care will be curative or palliative in nature. Curative care provides improvement in the condition and infers the patient has yet to reach maximum chiropractic improvement. Palliative care provides relief for the patient but does not cure the effects of the injury.

Documenting Maximum Chiropractic Improvement

Clinical Criteria for Ending Care acknowledgment - (Medical--Legal Issues In Chiropractic, Volume 1, 1990, Stephen M. Forman)

When the upper and lower limits of subjective pain have been established after a trial period of treatment. *For example,* if after two months of regular chiropractic treatment, the patient reports feeling great for 24 hours following the adjustment only to return to the same intensity as before the adjustment. This signifies the patient will only attain palliative relief from the treatment and maximum improvement has been achieved.

When the patient fails to progress clinically between treatments.

When the patients symptoms worsen during the treatment program.[xx]

Documenting the Reasonableness and Necessity of Supportive Care

The following criteria must be documented to substantiate the reasonableness and necessity of supportive care;

The patient must be deemed to have reached a point of maximum chiropractic improvement.

There must be documented, objective evidence of a permanent injury.

There must be documented, clinical trials of withdrawal from treatment which resulted in exacerbation.

Supportive treatment should never be prescheduled and should be provided solely in response to a documented exacerbation.

Supportive treatment should provide relief of symptoms/increased activities of daily living.

Record attempts at alternate care and the patient's response

Exhaust other forms of possible treatment

Generally, this care will average approximately 2 visits per month.

Documenting the Reasonableness and Necessity of Ancillary Diagnostic Testing

The purpose of ancillary diagnostic testing (i.e. advanced imagery, electrodiagnostics, labs, etc.) is to aid in the development of a differential diagnosis. In general, to justify the referral for, or the provision of an ancillary diagnostic testing procedure, there must first have been a trial course of treatment which did not result in resolution of the patients condition. Secondly, the attending chiropractor must document positive objective findings consistent with the type of testing procedure ordered or performed. Thirdly, the timing of the testing procedure is essential. For example, an E. M. G. test would not be clinically indicated on the date of injury. Lastly, the attending chiropractor must correlate the information derived from the testing procedure to the patient's condition and treatment plan.

Applying CPT Coding

The use of Physicians' Current Procedural Terminology is the most accurate method of documenting the level of work a physician performs and reporting the array of physician level services delivered.

Goal of Treatment - Select and administer those services which will most likely yield the greatest therapeutic benefit in the shortest period of time.

Always inform the patient and insurer in a timely manner of treatment goals and plans after giving consideration to normal healing times, phase of care and complicating factors.

Benefits of CPT Coding

The work values of CPT codes are developed through an established measurement process which is based on the time, technical skill and mental effort required to perform each service.

Drawback of CPT Coding

There are inherent limitations in the CPT process that may not adhere to a provider's philosophical perspective. It creates a rigid format for recording services. The CPT process may also be formulated in error, such as placing a code in the wrong family of codes. Corrections of this mistake may take months or years to correct and could impact reimbursement negatively.

Components of Physicians' Total Work Time for Manipulation Procedures

The "Work per unit of time" or work value of CPT codes in general are based not only on the amount of time spent with a patient, but also the amount of work (including physician skill and judgment that is required in the visit.) This work per unit of time is divided into three sections:

Pre-service (before patient arrives)

Documentation and chart review

Imaging review

Test interpretation and care planning

Intra-service (face-to-face time with patient)

Pre-manipulation (e.g., palpation, ROM, etc.)

Manipulation

Post manipulation (e.g., assessment, procedures, etc.)

Post-service period (after patient leaves)

Chart documentation

Consultation

Reporting

Generally, the higher the work unit value, the larger the payment.

CMT Code Descriptions for Chiropractic Services

Four Chiropractic Manipulative Treatment (CMT) codes (CPT 98940 - 98943) were added to the Medicine Section of CPT in 1997. The three spinal CMT codes replace the A2000 code, in the Medicare Fee Schedule.

Chiropractic manipulative treatment is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

Chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

Additional evaluation and management services may be reported separately using the modifier -25, if and only if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

The Five Spinal Regions for CMT

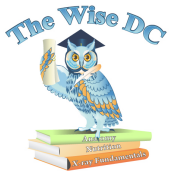
Cervical Region

Thoracic Region - including costovertebral and costotransverse joints

Lumbar Region

Sacral Region

Pelvic Region



The five extraspinal regions referred to are:

Head - temporomandibular joint, excluding atlanto-occipital region

Lower extremities

Upper extremities

Rib Cage - excluding costotransverse & costovertebral joints

Abdomen

Breakdown of Codes

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions.

98941 Spinal, three to four regions.

98942 Spinal, five regions.

98943 Extraspinal, one or more regions.[xxi]

Spinal / Extraspinal Manipulative Treatment

Spinal - Regardless of how many manipulations are performed in any given spinal region (cervical, thoracic, etc.) it counts as one region under the CMT codes. For example, chiropractic manipulation applied to C2, C3 and C5, during one patient visit would represent treatment to one region (cervical) and, if these were the only manipulations performed during the visit, the appropriate code to use would be 98940.

Extraspinal - It is appropriate to use code 98943 to describe Chiropractic Manipulative Treatment to one or more extra-spinal regions, regardless of how many individual extra spinal manipulations are actually performed. The extra-spinal CMT code 98943 can be used either by itself or in conjunction with a spinal CMT code. In those cases when 98943 is used in conjunction with a spinal CMT code, it is necessary to add a -51 modifier (98943-51).

Clinical Scenarios

CMT 98940 - Chiropractic manipulative treatment (CMT); spinal, one to two regions.

Example: 32-year-old female established patient presents with mid and low back pain; brief evaluation including review of systems and a focused examination reveals that manipulation is indicated in 2 regions, the thoracic region (T6) and lumbar region (L4); treatment - diversified manipulation (T6, and L4); chart entry and documentation.

CMT 98941 - Spinal, three to four regions.

CMT 98942 - Spinal, five regions.

CMT 98943 - Extraspinal, one or more regions.

Example: 56-year-old female; established patient; right and left hand and wrist pain; brief evaluation including review of systems and a focused examination reveals that extraspinal manipulation is indicated in two regions; the right and left upper extremities (Right / Left hand and wrist); treatment - manipulation of Right / Left hand and wrist; post service work to include chart entry and documentation.

Note for use of extraspinal code: The extraspinal code can be used by itself or in conjunction with a spinal CMT code. When used on the same day as another CMT code, the extraspinal code should have a "-51" modifier attached. The -51 modifier reduces the RVU of 98943 by 50 percent under the Medicare payment system.

Important Points

You could use E / M codes and 97140 (Manual Therapy Techniques) codes together.

E / M code can be used with a CMT code; however the E / M code would necessitate a -25 modifier. *Example:* E / M 99202-25

Precursors to utilizing CMT Codes

Patient Complaint

Objective finding of subluxation

Diagnosis of subluxation

Medicare P.A.R.T. Guidelines

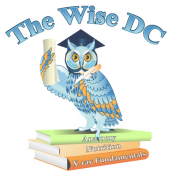
January 1, 2000 marked the end of the mandated X-ray era for Chiropractic's Medicare patients. Medicare guidelines were revised to give the option of using x-rays or using P.A.R.T. (Pain, Asymmetry/Misalignment, Range of Motion Abnormality, and Tissue/ Tone).

Medicare carriers Manual Utilization Guidelines (Section 2251.2)

Subluxation-Subluxation is defined as a motion segment, in which alignment, movement integrity and/ or physiological function of the spine are altered although contact between joint surfaces remains intact.

Documentation of Subluxation-A subluxation may be demonstrated by an x-ray or by physical examination, as described below.

Demonstrated by X-Ray: An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken not more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain



cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

Demonstrated by Physical Examination-Evaluation of musculoskeletal nervous system to identify:

Pain/tenderness evaluated in terms of location, quality, and intensity

Asymmetry/misalignment identified on a sectional or segmental level

Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and

Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under "physical examination" are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Documenting History

The history recorded in the patient record should include the following:

Symptoms causing patient to seek treatment;

Family history if relevant;

Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);

Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

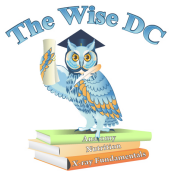
Prior interventions, treatments, medications, secondary complaints.

Documentation Requirements- Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

a.) History as stated above.

b.) Description of present illness including:



Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

Prior interventions, treatments, medications, secondary complaints;

Symptoms causing the patient to seek treatment.

Symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine, muscle, bone, rib, and joint and be reported as pain, inflammation, or as signs such as swelling, spasticity.

Evaluation of the musculoskeletal/nervous system through physical examination.

Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

Treatment plan: The treatment plan should include the following:

Recommended level of care (duration and frequency of visits);

Specific treatment goals; and

Objective measures to evaluate treatment effectiveness.

Date of the initial treatment.

Documentation Requirements – Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination

a.) History

Review of chief complaint.

Changes since last visit.

System review if relevant.

b.) Physical exam

Exam of area of spine involved in diagnosis.

Assessment of change in patient condition since last visit.

Evaluation of treatment effectiveness.

c.) Documentation of treatment given on day of visit.[xxii]

E/M Codes Unbundling (ChiroCode Desk Book 2004)

There are two types of unbundling: the first is unintentional which results from a misunderstanding of coding, and second is intentional, used by providers to manipulate coding in order to maximize payment. Unbundling is essentially the billing of multiple procedures codes for a group of procedures that are covered by a single comprehensive code. Correct coding means reporting a group of procedures with the appropriate single comprehensive code. Examples of unbundling are:

Fragmenting one service into component parts and coding each component part as if it were a separate service. An example would be coding for a routine 99202 (E/M services) with a 98941 (Manipulation/Adjustment), unless the E/M component is for significant separately identifiable service as in new accident work up. (The later case would be expressed with a '-25' modifier.)

Mutually Exclusive Procedures are those which cannot be performed reasonably during the same operative or patient session. Codes should not be reported together when the same or similar repair or treatment is by two different methods, i.e. Chiropractic Manipulation Treatment (CMT) and Osteopathic Manipulation Treatment (OMT).

Component procedures are those that are in a family of codes. In a family of codes, there are more than 2 components that should not be reported separately because they are included in a more comprehensive code as member of the code family. The component codes are members of the comprehensive code family and represent parts of the procedure that should not be listed separately when the complete procedure is done. i.e. CMT-98940 is a component of 98941 and 98942 and should not be listed separately.[xxiii]

CPT Position on the Use of CMT Codes

"Chiropractic manipulation treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional Evaluation and Management services may be reported separately using a modifier.

When to use E/M codes? When Significant Separately Identifiable Services exist! It could be with either new or established patients or in initial or subsequent care settings.

The most common occasions for such E/M service encounters in addition to CMT would be:

Initial evaluation

Periodic re-evaluation

Exacerbation

Re-injury

Release or discharge from active care

Examples:

Example of CMT care with significant new patient E/M services:

There is an initial workup and care which required a significant separately identifiable History, Examination and Clinical decision making, with nominal Counseling time.

98941 CMT 3-4 spinal regions

99203-25 Significant E/M service for new patient

Example of subsequent CMT care with major E/M Counseling services:

There is a nominal history, examination (which is a routine part of the CMT service), but there is also a significant separately identifiable doctor-patient face-to-face counseling time and/or coordination of care factor. (Counseling has 7 components: report of findings, prognosis, risks and benefits of treatment options, instructions for treatment and/or follow-up, importance of compliance, risk factor reduction, or patient/family education).

98941 CMT 3-4 spinal regions

99213-25 Significant E/M service for established patient

When you provide valid significant and separately identifiable E/M services which are not a part of routine CMT care, you are entitled to file for reimbursement (except for Medicare and others who deviate from CPT guidelines).

E/M Background

One of the least understood elements of proper chiropractic coding is Evaluation and Management (E/M) coding. It was introduced in 1992 following a 10 year study by the Health Care Financing Administration (HCFA) and the American Medical Association (AMA). The purpose of the new codes was to establish parity between health care providers in the reimbursement process.

E/M Rules

E/M coding has specific rules and requirements for usage. If you provide valid E/M services, you are entitled to bill for reimbursement (except for Medicare, which only recognizes the three CMT codes.)

Billing an E/M code to cover manipulation visits is not appropriate. However, an E/M code can and should be used when it is a separately identifiable procedure.[xxiv]

Evaluation and Management (E/M) Services

E / M codes are divided into broad categories (i.e. office visits, hospital visits, and consultations). There are two subcategories for office visits (new patient and established patient. E / M codes are determined by the following:

The place of service, e.g. office, hospital, etc.

Type of service, e.g. initial evaluation, follow up visit

Content of the service - type of history and examination, e.g. comprehensive history and examination.

Degree of medical decision making, e.g. straightforward, low complexity, moderate complexity, high complexity.

Nature of the presenting problems, e.g. self limited or minor → moderate to high severity.

The time typically required to provide the service is specified e.g. 99201 is 10 minutes; 99205 is 60 minutes.

Selecting the Appropriate level of E/M Service – 5 Key Components

1. History
2. Examination
3. Medical decision making
4. Nature of presenting problem
5. Time

The first three of these components (i.e., history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services.

Determine the Extent of History Obtained

The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: chief complaint; brief history of present illness or problem.

Expanded problem focused: chief complaint; brief history of present illness; problem pertinent system review.

Detailed: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.

Comprehensive: chief complaint: extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.[xxv]

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: a limited examination of the affected body area or organ system.

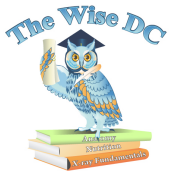
Expanded problem focused: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: a general multi-system examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

Musculoskeletal Examination – Single Organ System

System/Body Area	Elements of Examination
Constitution	Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight, (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities,
Cardiovascular	Examination of peripheral vascular system by observation (pulses, temperature,



	edema, tenderness)
Lymphatic	Palpation of lymph nodes in neck, axillae, groin and/or other location
*Musculoskeleta*l	Examination of gait and station Examination of joint(s), bone(s) and muscle(s) / tendon(s) of four of the six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: Inspection, percussion and/or; Assessment of range of motion with notation of any pain (straight leg raising), crepitation or contracture Assessment of stability with notation of any dislocation (luxation), subluxation or laxity Assessment of muscle strength and tone with notation of any atrophy or abnormal movements
Skin	Inspection and/or palpation of skin and subcutaneous tissue (scars, rashes, lesions, ulcers) in four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.

Neurological/Psychiatric

Test coordination (e.g. finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Examination of deep tendon reflexes and/or nerve stretch test noting pathological reflexes (e.g., Babinski)

Examination of sensation (e.g., by touch pin, vibration, proprioception)

Brief assessment of mental status, including:

Orientation of time, place, and person

Mood and affect (e.g., depression, anxiety, agitation)

Single Organ System Examination - The performance and documentation of the following number of examination elements determine a specific level of exam.

Level of Exam	
One to five elements identified by a bullet	Focused
At least six elements identified by a bullet	Expanded
At least twelve elements identified by a bullet	Detailed
All elements identified by a bullet	Comprehensive

Neurological Examination - Single Organ System

System/Body	Area Elements of Examination
Constitution	Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature,

	6) height, 7) weight. General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Cardiovascular	Examination of carotid arteries (e.g., pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs
Neurological	Evaluation of higher integrative functions, including: Orientation of time, place and person Recent and remote memory Attention span and concentration Language (e.g., naming objects, repeating phrases, spontaneous speech) Fund of knowledge (e.g., awareness of current events, past history vocabulary)
Musculoskeletal	Examination of gait and station Assessment of motor function, including: Muscle strength in upper and lower extremities Muscle tone in upper and lower extremities (e.g., flaccid, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation)

Single Organ System Examination -The performance and documentation of the following number of examination elements determines a specific level of exam.

Level of Exam	
One to five elements identified by a bullet	Focused
At least six elements identified by a bullet	Expanded
At least twelve elements identified by a bullet	Detailed
All elements identified by a bullet	Comprehensive

Determine the Complexity of Medical (Clinical) Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

The number of possible diagnoses and/or the number of management options that must be considered.

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

The risk of significant complications, morbidity and/or mortality associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements must be met or exceeded.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E / M codes recognize five types of presenting problems:

Minimal - A problem that may not require the presence of the physician, but service is provided under the physician's supervision. *Example:* headache - physician Rx medication.

Self-limited or minor -A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management compliance. *Example:* mild strain / sprain injury.

Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment. Full recovery without functional impairment is expected. *Example:* moderate strain / sprain injury.

Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment. *Example:* disc herniation.

High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment. – *Example:* aneurysm.

Determining Time

Face-to-face time

That time that the physician spends face-to-face with the patient and / or family. Obtaining a history, performing an examination, counseling the patient, and treatment.

Non face-to-face time

(Pre- and post-encounter time) is not included in the time component described in the E/M codes

E/M Service Codes – New Patient

99201- Office or other out patient visit for the evaluation and management of a new patient, which requires these three key components:

A problem focused history

A problem focused examination

Straightforward medical decision making

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

Example: Initial office visit for new patient with a jammed finger.

99202- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components.

An expanded problem focused history

And expanded problem focused examination

Straightforward medical decision making.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and / or family.

Example: Initial office visit with 26-year-old female who awoke with neck stiffness, pain and immobility, but no radiation. One day duration. History of washing walls at home yesterday and slept with window open last evening. No prior history.

99203 - Office or other visit for the evaluation and management of a new patient, which requires these three components:

A detailed focused history

A detailed examination

Medical decision making of low capacity

Usually, the presenting problems(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and / or family.

Example: Initial office visit for evaluation of 13 year old female with progressive scoliosis.

99204- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

A comprehensive history

A comprehensive examination

Medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and / or family

Example: Initial office visit for 26-year-old female injured in auto accident one week prior. She complains of neck and low back pain with right hip pain, left arm pain to the elbow and headaches. History of x-ray exam in hospital emergency room with a prescription for medication that provided no relief of pain.

99205- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

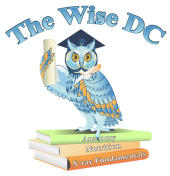
A comprehensive history

A comprehensive examination

Medical decision making of high complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and / or family.

Example: Initial office visit for 72-year-old female with disabling mid-thoracic pain, osteoporosis and evidence of healed compression fractures. She slipped on rug at home and fell onto her buttocks with sharp mid back pain and muscle spasm following. Most, if not all, movement extremely difficult.



Established Patient Codes

99211 - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Usually the presenting problem(s) are minimal.

Typically, 5 minutes are spent performing or supervising these services.

Example: Office visit for blood pressure check.

99212 - Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components:

A problem focused history

A problem focused examination

A straightforward medical decision making

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

Example: Office visit with 65-year-old female, established patient returns for 3 week follow-up for resolving moderate to severe ankle sprain. No manipulation performed.

99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

An expanded problem focused history

An expanded problem focused examination

Medical decision making of low complexity

Usually, the presenting problems(s) are of low to moderate severity. Physicians spend 15 minutes face-to-face with the patient and / or family.

Example: A 42-year-old male, established patient, presents with complaint of pain in the neck, right arm and lumbar regions. He relates new symptoms of numbness and tingling in the right arm and legs since the last visit. Re-evaluation includes expanded problem focused history, expanded problem focused exam (musculoskeletal and neurological examination to the cervical, lumbar and upper and lower extremities), medical decision-making of low complexity.

99214 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

A detailed history

A detailed examination

Medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Example: Office visit for examination of new condition of low back pain with radiation to right thigh and mild lumbar antalgia. An established patient seen in past for low back pain only.

99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

A comprehensive history

A comprehensive examination

Medical decision making of high complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and / or family.

Example: Examination of established 32-year-old female patient for new injuries suffered in auto accident involving acceleration / deceleration trauma; overlying history of neck and back complaints.[xxvi]

Use of E/M Codes with CMT Codes

E / M codes can be used on the same day of service as a CMT code when clinically warranted. The use of an E/M code in conjunction with the CMT codes requires a -25 modifier.

Example: - A 63-year-old female presents for initial visit with complaints of neck stiffness. No injury, or significant past medical history. Expanded problem focused history and examination with straightforward medical decision making were performed. Diagnosis: Cervicalgia. Cervical (C3, C6) spinal manipulation was administered.

CMT Code: **98940** (One spinal region - cervical)

E/M Code: **99202-25** (Expanded problem-focused history and expanded problem focused examination with straightforward medical decision making meet the audit requirements for 99202)

Expanded and CPT Code Modifiers

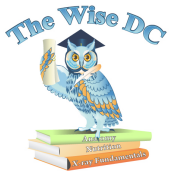
Modifiers may be used to indicate:

A service or procedure has both a professional and technical component.

A service or procedure was performed by more than one physician and / or in more than one location.

A service or procedure has been increased or reduced

Only part of a service was performed



An adjunctive service was performed

A bilateral procedure was performed

A service or procedure was provided more than once

Unusual events occurred

Modifiers available in E/M

-21 Prolonged Evaluation and Management Services

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure:

-51 Multiple Procedures

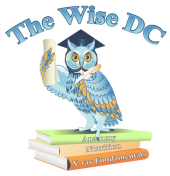
-52 Reduced Services

Part III – Maryland Jurisprudence

Title 10 Department Of Health And Mental Hygiene
Subtitle 43. Board Of Chiropractic & Massage Therapy Examiners

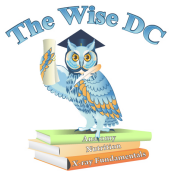
10.43.01 General Regulations
.01 Rules of Order.
All proceedings of the Board in regular session shall be governed by Robert's Rules of Order.
.02 Board Officers, Members, and Staff.
A. The Board shall, as the appointing authority, direct the operation of the staff through the executive director.
B. Board members may not have monetary, pecuniary, or other interest in the affairs of any:
(1) Staff member; or
(2) Organization engaged in business with the Board, including:
(a) Businesses;
(b) Enterprises; or
(c) Other for-profit organizations.

C. A Board member or Board staff may not serve for compensation as an instructor in a continuing education course or program under Board cognizance over which that Board member or staff member serves in an approval capacity.
.03 Preliminary Educational Qualifications Credits.
Preliminary educational qualifications credits acceptable to the Board are:
A. Certificates or diplomas issued by public and private high schools accredited by the National Council of Secondary Educational Institutions or as recognized by the state or city issuing them.
B. Certificates issued by the department of education of the states and possessions of the United States to applicants having 15 or more units to their credit.
C. Applicants presenting foreign credits of preliminary education shall have them certified by the consul or the embassy of the country in which they were acquired.
D. Bachelor's degree accredited by the State.
.04 Examination Requirements.
A. The Board shall accept examination results only from the National Board of Chiropractic Examiners for applicants for a chiropractic license, including applicants seeking to practice chiropractic with physical therapy privileges.
B. The Board shall set the minimum passing score for each section of the National Board of Chiropractic Examiners' examination.
C. The Board shall administer a jurisprudence examination at least twice a year at times and places to be announced by the Board.
D. An applicant for the jurisprudence examination shall [have]:
(1) Have first successfully completed all required parts of the National Board of Chiropractic and Massage Therapy Examiners’ examination to the satisfaction of the Board; and
(2) Submit all documentation and fees at least 45 days before the examination date.
E. The examination shall begin promptly at a time announced by the Board and shall be proctored by a Board member or Board staff member.
F. The applicant shall present a letter of admission and at least one form of personal, valid, current, U.S. government or state issued photo identification. There is no excuse, waiver, or exception for this requirement.
G. The application shall be executed, verified, and submitted to the Board at least 45 days before the date of examination.



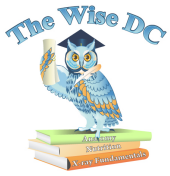
H. The applicant shall follow all directions of the examination proctor.
I. The examination paper shall be retained by the Board as follows:
(1) Passing examination papers shall be retained for 30 days;
(2) Failing examination papers shall be retained for 90 days;
(3) All examination papers shall be destroyed after the expiration of the time periods established under §I(1) and (2) of this regulation; and
(4) Retained examination papers may not be reviewed by the applicant following the completion of the applicant's examination.
J. The Board shall administer the jurisprudence examination in the English language with no provisions made by the Board to accommodate the examination in any foreign language.
K. An applicant who fails the jurisprudence examination three times may not retake the examination until the Board has reviewed the applicant's file and approved a retake.
.05 Licenses.
A. Temporary Licenses. The Board may not issue any temporary license to practice chiropractic in Maryland.
B. An individual practicing chiropractic without a license shall be prosecuted and subject to penalties as prescribed in Health Occupations Article, Title 3, Subtitle 5, Annotated Code of Maryland.
C. The Board shall issue a license only upon an applicant's successful completion of the:
(1) National Board of Chiropractic Examiners' examination, Parts I, II, III, and IV;
(2) Jurisprudence examination; and
(3) National Board of Chiropractic Examiners' Physiotherapy examination, if applicable.
D. The Board may waive educational or examination requirements for any licensed chiropractor applying to practice exclusively with a visiting organization for not more than 30 days per calendar year if the:
(1) Chiropractor practices in a Board-approved, recognized jurisdiction with an active license in good standing; and
(2) Practice is limited exclusively to members of the visiting organization.
E. Display of License in Office. A license holder shall display conspicuously at all times at the license holders' place of business the license granted by the Board.
F. A license holder shall maintain a current, correct mailing address with the Board.
G. Licensure by Credential.
(1) An application for licensure by credential shall be based on a written SPEC examination administered by the National Board of Chiropractic Examiners, a jurisprudence examination administered by the Board, and the education and professional qualifications of the applicant.
(2) At the Board's discretion, an applicant for licensure by credential shall appear before the Board in person before the license is granted.
H. Renewals.
(1) A license holder failing to renew a license shall:
(a) Be notified by the Board by certified mail of the delinquency; and

(b) Have the license revoked if the license holder does not renew by September 30th of the renewal year.
(2) Continuing Education.
(a) Upon renewal, when audited by the Board, a license holder shall submit written evidence of the successful completion of the number of continuing education hours and cardiopulmonary resuscitation (CPR) certification required by the Board for renewal.
(b) The license holder shall have completed the required credit hours by the time of renewal.
(c) This evidence may include a photocopy of the official transcript or a report of the completion of the course.

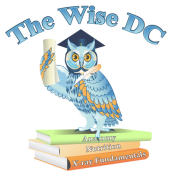


(d) Only a course program approved by the Board may be used to meet the continuing education requirement of §H(2) of this regulation.
(e) The requirement may be waived by the Board upon proof of unusual and extreme hardship or disability, and upon application to the Board at least 60 days before September 1.
I. Reinstatements. An applicant for reinstatement of a license that has lapsed for a period of more than 2 years shall be admitted only after satisfying the Board as to the applicant's efficiency by examination and the payment of fees due.
J. Types of Licenses.
(1) The Board shall issue two types of license:
(a) A license covering the practice of chiropractic and physical therapy, as defined in Health Occupations Article, §3-101(f) and (g), Annotated Code of Maryland; and
(b) A license permitting the holder to practice chiropractic as defined in Health Occupations Article, §3-101(f) and (g), Annotated Code of Maryland.
(2) An individual holding the chiropractic license and wishing to qualify for the license to practice physical therapy in conjunction with a practice of chiropractic may do so by taking 270 hours (60 minute hours) instruction in physical therapy in a chiropractic school or college teaching an approved course in the subject, and by passing the National Board of Chiropractic Examiners Physiotherapy examination with a minimum score of 75 percent.
.06 Disclosure for Compelling Public Purpose.
A. The Board may find that a compelling public purpose warrants disclosure of information in an application, certification, licensing, or investigative file, regardless of whether there has been a request for the information, if:
(1) The information concerns possible criminal activity and the disclosure is to a federal, state, or local law enforcement or prosecutorial official or authority;
(2) The information concerns a possible violation of law and the disclosure is to a federal, state, or local authority that has jurisdiction over the individual whose conduct may be a violation, and the information disclosed is limited to information relevant to the possible violation by that individual; or
(3) The information concerns conduct by an individual that the Board reasonably believes may pose a risk to the public health, safety, or welfare, and the disclosure is to a law enforcement authority, administrative official, or agency that regulates the individual, or to a hospital or other health care facility where the individual has privileges.
B. Other Disclosures. This regulation does not prohibit or limit the Board's ability to disclose general licensing information as provided in State Government Article, §10-617(h), Annotated Code of Maryland, or any information that the Board may otherwise disclose by law.

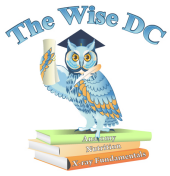
10.43.02 Chiropractic and Massage Therapy — Rules of Procedure for Board Hearings
Authority: Health Occupations Article, §3-205(a)(1); State Government Article, §10-206; Annotated Code of Maryland
.01 Scope.
This chapter applies to all contested case hearings before the Board of Chiropractic and Massage Therapy Examiners or before the Office of Administrative Hearings. It does not apply to conferences or other informal investigations or proceedings.
.02 Notice of Hearing.
A. Written notice of a hearing shall be sent by the Board to all interested parties at least 30 days before the hearing. The notice shall state the date, time, and place of the hearing. It shall also state the issues or charges involved in the proceeding, provided, however, that if by reason of the nature of the proceeding, the issues cannot be fully stated in advance of the hearing, or if subsequent amendment of the issues is necessary, they shall be fully stated as soon as practicable.



B. Service upon a party shall be by delivery of the charging document and a copy of the complaint to the party in person. Instead of personal service, the Board may serve the charging document and a copy of the complaint by registered or certified mail, restricted delivery, return receipt requested.
.03 Representation of Parties.
Every party appearing at formal hearings has the right to appear in proper person, or by or with counsel.
.04 Pre-Hearing Procedures.
A. Pre-hearing Conferences. The Board may set a pre-hearing conference as it deems appropriate.
B. Oaths and Subpoenas. The Board may administer oaths and compel the attendance of witnesses and the production of physical evidence before it from witnesses upon whom process is served anywhere within the State as in civil cases in the circuit court of the county or of Baltimore City, by subpoena issued over the signature of the President or Secretary and the seal of the Board. Upon a request by a party and statement under oath that the testimony or evidence is necessary to their defense, the Board shall issue a subpoena in their behalf.
C. All motions filed by a party with the Board or the Office of Administrative Hearings, as appropriate, shall be accompanied by a memorandum of points and authorities and shall be filed at least 15 days before the hearing. A copy shall be served on the opposing party. Any response shall be filed with the Board or the Office of Administrative Hearings, as appropriate, at least 7 days before the hearing and a copy shall be served on the opposing party.
D. Discovery on Request. By written request served on the other party and filed with the Board or the Office of Administrative Hearings, as appropriate, a party may require another party to produce, within 15 days, the following:
(1) A list of witnesses to be called;
(2) Copies of documents intended to be produced at the hearing; or
(3) Both §A(1) and (2) of this regulation.
E. Mandatory Discovery.
(1) Each party shall provide to the other party not later than 15 days before the prehearing conference, if scheduled, or 45 days before the scheduled hearing date, whichever is earlier:
(a) The name and curriculum vitae of any expert witness who will testify at the hearing; and
(b) A detailed written report summarizing the expert's testimony, which includes the opinion offered and the factual basis and reasons underlying the opinion.
(2) If the Board or the Office of Administrative Hearings, as appropriate, finds that the report is not sufficiently specific, or otherwise fails to comply with the requirements of this section, the Board or the Office of Administrative Hearings, as appropriate, shall exclude from the hearing the testimony and any report of the expert.
(3) The Board or the Office of Administrative Hearings, as appropriate, shall consider and decide arguments regarding the sufficiency of the report.
(a) At the prehearing conference, if scheduled; or
(b) Immediately before the scheduled hearing.
(4) If an expert adopts a sufficiently specific charging document as the expert's report, that adoption satisfies the requirements set forth in this section.
F. Parties are not entitled to discovery of items other than as listed in §§D and E of this regulation.
G. Both parties have a continuing duty to supplement their disclosures of witnesses and documents.
H. Absent unforeseen circumstances which would otherwise impose an extraordinary hardship on a party, witnesses or documents may not be added to the list:
(1) After the prehearing conference, if scheduled; or
(2) Later than 15 days before the hearing, if no prehearing conference is scheduled.
I. The prohibition against adding witnesses does not apply to witnesses or documents to be used for impeachment or rebuttal purposes.
J. Construction.

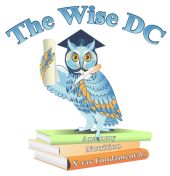


(1) In hearings conducted by an administrative law judge of the Office of Administrative Hearings, this regulation shall, whenever possible, be construed as supplementing and in harmony with COMAR 28.02.01.
(2) In the event of a conflict between this regulation and COMAR 28.02.01, this regulation applies.
.05 Conduct of the Hearing.
A. Duties of Presiding Officer.
(1) The Board shall conduct hearings before a quorum of the Board.
(2) For purposes of a hearing under this chapter, four Board members present and entitled to vote shall constitute a quorum.
(3) Board action shall be by majority vote of all the members then serving.
(4) The President, or the President's designee, shall be the presiding officer, and shall have complete charge of the hearing, permit the examination of witnesses, admit evidence, rule on the admissibility of evidence, and adjourn or recess the hearing from time to time.
(5) The presiding officer may set reasonable time limits in arguments and presentation of evidence.
(6) The presiding officer shall be responsible for decorum in hearings and can suspend the proceedings as necessary to maintain decorum.
B. Legal Advisor and Counsel for the Board.
(1) The presiding officer may request the Office of the Attorney General to participate in any hearing to present the case on behalf of the Board, and, upon such a request, this counsel has all the rights with regard to the:
(a) Submission of evidence, examination and cross-examination of witnesses;
(b) Presentation of summation and argument; and
(c) Filing of objections, exceptions, and motions as counsel for any party.
(2) The presiding officer may also request a representative of the Office of the Attorney General to act as legal advisor to the Board as to questions of evidence and law.
C. Order of Procedure. The State shall present its case first. Then the respondent shall present his case. After this the State may present rebuttal.
D. Examination of Witnesses and Introduction of Evidence.
(1) The rules of evidence in all hearings under these regulations shall be as set forth in State Government Article, §§10-208 and 10-209, Annotated Code of Maryland.
(2) Every party has the right on every genuine issue to:
(a) Call witnesses and present evidence;
(b) Cross-examine every witness called by the agency, or other party;
(c) Submit rebuttal evidence, present summation and argument; and
(d) File objections, exceptions, and motions, except that when a party is represented by counsel, all the submissions of evidence, examination and cross-examination of witnesses, and filing of objections, exceptions, and motions shall be done and presented solely by this counsel.
(3) The presiding officer, or the presiding officer's designee, may examine:
(a) A witness called by a party; and
(b) An individual in attendance at the hearing.
(4) A member of the Board may examine a witness called by a party.
(5) The Board may submit evidence from an investigative file to other administrative and criminal investigative offices to assist in the investigation and prosecution of a case.
.06 Records and Transcripts.
A. The Board shall prepare an official record, which shall include all pleadings, testimony, exhibits, and other memoranda or material filed in the proceeding.
B. A stenographic record of the proceedings shall be made at the expense of the Board. This record need not be transcribed, however, unless requested by a party, or by the Board. The cost of any typewritten transcripts of any proceeding, or part of it, shall be paid by the party requesting the transcript.



.07 Decision and Order.
A. Every decision and order rendered by the Board shall be in writing and shall be accompanied by findings of fact and conclusions of law.
B. A copy of the decision and order and accompanying findings and conclusions shall be delivered or mailed promptly to each party or attorney of record.
C. Decisions and orders are public documents. The Board shall report to the National Practitioners Database and publish on the Board's database and the Board's web site decisions and orders within 30 days of the decision.
.08 Rehearings.
A. Any party aggrieved by the decision and order rendered may apply for rehearing within 10 days after service on him of the decision and order. Action on an application shall lie in the discretion of the Board.
B. Unless otherwise ordered, neither the rehearing nor the application for it shall stay the enforcement of the order, or excuse the person affected by it for failure to comply with its terms.
C. The Board may consider facts not presented in the original hearing, including facts arising after the date of the original hearing, and may by new order abrogate, change, or modify its original order.
.09 Appeal.
Any person whose license has been revoked or suspended by the Board, or any person placed on probation or reprimand under the regulations in this chapter, may appeal the Board's decision as provided by law.

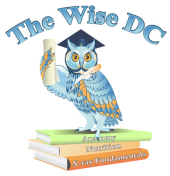
10.43.03 Chiropractic — Advertising
Authority: Health Occupations Article, §3-401, Annotated Code of Maryland
.01 Scope.
A chiropractor may advertise his services subject to the provisions of this chapter.
.02 Qualifications.
A. In an advertisement, a chiropractor shall include at least the chiropractor's:
(1) Name;
(2) Office address;
(3) Telephone number; and
(4) Educational degree.
B. In an advertisement, a chiropractor may state the name of the chiropractor's specialty only if that specialty is approved by the Board.
.03 Prohibitions.
An advertisement may not contain statements that:
A. Contain a misrepresentation of facts or do not reasonably identify the practice as chiropractic;
B. Are likely to mislead or deceive because in context the statement makes only a partial disclosure of relevant facts;
C. Intend to, or are likely to, create false or unjustified expectations of favorable results;
D. Relate to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully disclosing all variables and other relevant factors;
E. Convey the impression that the chiropractor could influence improperly any public body, official, corporation, or any person on behalf of a patient;
F. Contain representations or implications that in reasonable probability can be expected to cause an ordinary prudent person to misunderstand or to be deceived;
G. Contain representations that the chiropractor is willing to perform any procedure which is illegal under the laws or regulations of Maryland or the United States;
H. Contain representations regarding the use of any equipment, treatment, or procedure not within the accepted, prudent practice of chiropractic;



I. Promise payment, compensation, prizes, or remuneration of any intrinsic value; or
J. Utilize an unauthorized trade name.
.04 Solicitation.
A. A chiropractor may not engage in solicitation, including but not limited to, in-person, telephone, or direct mail solicitation which:
(1) Amounts to fraud, undue influence, intimidation, or overreaching;
(2) Contains statements which would be improper under Regulation .03 of this chapter.
B. A chiropractor shall also be accountable under this regulation if the chiropractor uses an agent, partnership, professional association, or health maintenance organization to implement actions prohibited by this regulation.

10.43.04 Licensure by Credentials for Chiropractors
Authority: Health Occupations Article, §3-305, Annotated Code of Maryland
.01 Preface and Scope.
A. Preface. The Board of Chiropractic and Massage Therapy Examiners has established guidelines for licensure by credentials. This method of licensure is a special privilege granted by present statute, and is secured for those candidates who possess the necessary credentials required to practice chiropractic in the State. The requirements for licensure are stringent in order to insure the public is adequately protected and that licensure may be granted only to those who qualify by virtue of clinical competency and professional expertise.
B. Scope. This chapter applies to all chiropractors seeking licensure by credentials in Maryland. Since licensure by credentials is a privilege, the Board reserves the right to accept or deny this method of licensure based on Regulation .02 of this chapter.
.02 Eligibility.
A. A chiropractor is eligible for licensure by credentials if the applicant has graduated and received the degree Doctor of Chiropractic (D.C.) from a chiropractic college accredited by the Council on Chiropractic Education (C.C.E.) or its successor.
B. The applicant shall:
(1) Be of good moral character and have submitted to the Board three letters of recommendation, one of which shall be sent by the state licensing board in which the applicant is currently licensed;
(2) Meet all the qualifications set forth in the Health Occupations Article, §3-302, Annotated Code of Maryland;
(3) Be currently licensed in another state by virtue of passing an examination that is similar to the examination for which the applicant is seeking licensure by credentials;
(4) Have been in active clinical practice in the state for which the applicant was licensed by examination for the 5 years preceding application or has had full-time faculty status at a chiropractic college accredited by the Council on Chiropractic Education or its successor for at least 5 years before application;
(5) Take and pass the Maryland jurisprudence and the National Board of Chiropractic Examiners SPEC examinations with minimum scores of 75 percent.
.03 Application Procedures.
A. An applicant shall submit the necessary information as set forth in the Health Occupations Article, §3-303, Annotated Code Maryland.
B. The Board may investigate the applicant to insure compliance with all provisions of this chapter.
.04 Requirements of Licensure.
At the Board's discretion, an applicant shall appear before the Board and demonstrate clinical competency in a manner and time to be determined by the Board.

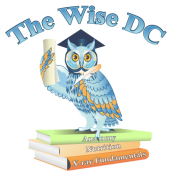
.05 Fees.



A. The fee for licensure by credentials shall be the same as that for licensure by examination.
B. Additional fees may be assessed by the Board for investigatory purposes.
C. The application fee is non-refundable.

10.43.05 Chiropractic Externship Program
Authority: Health Occupations Article, §§3-205 and 3-301, Annotated Code of Maryland
.01 Scope.
These regulations apply to all chiropractic externs and licensed chiropractors who are extension faculty members of a chiropractic college accredited by the Council on Chiropractic Education or its successor.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Accredited college" means a chiropractic school or college accredited by the Council on Chiropractic Education or its successor.
(2) “Approved program” means a program that has been approved by the Board of Chiropractic and Massage Therapy Examiners and the Council on Chiropractic Education or its successor.
(3) “Board” means the Maryland Board of Chiropractic and Massage Therapy Examiners.
(4) “Chiropractic extern program” means a 2-semester clinical program:
(a) In which chiropractic externs participate under the direct supervision of a licensed chiropractor who has been approved by the Board to serve as a preceptor; and
(b) That operates in a facility where chiropractic services have been approved by the Board of Chiropractic and Massage Therapy Examiners.
(5) “Direct supervision” means a licensed chiropractor remains on the premises at all times and directly supervises and continuously monitors the extern’s performance within the practice.

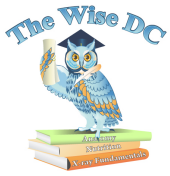
(6) "Extern" means an individual enrolled in an accredited chiropractic college who has completed all requirements for the Doctor of Chiropractic program except for the final clinical phase of the program.
(7) "Extern applicant" means an individual who applies to the Board to be approved for the chiropractic externship program.
(8) "Licensed chiropractor" means a chiropractor who is licensed by the Board to practice chiropractic or to practice chiropractic with the right to practice physical therapy, and whose license is in good standing.
(9) "Preceptor or extension faculty member" means a licensed chiropractor actively practicing in the State in good standing who has been appointed to the extension faculty of an accredited chiropractic college and approved by the Board.
.03 Eligibility.
A. An extern applicant is eligible for approval in the chiropractic extern program if the applicant is currently enrolled in an approved program that is recognized by the Board of Chiropractic and Massage Therapy Examiners as requiring adequate clinical training and as maintaining an acceptable course of chiropractic instruction.
B. An extern applicant shall:
(1) Meet all the qualifications as set forth in Health Occupations Article, §§3-302 and 3-303, Annotated Code of Maryland.
(2) Be in good standing at the chiropractic college.
(3) File the necessary application forms as required by the Board and pay an application fee as set forth in COMAR 10.43.06.
(4) Have three letters of recommendation sent directly to the Board from clinical science professors at the extern's chiropractic college attesting to the applicant's good moral character and clinical abilities.
.04 Permitted Delegation.



A. A preceptor who is an extension faculty member may delegate duties within the scope of one's license, which constitute the practice of chiropractic, to an extern in accordance with these regulations.
B. A preceptor may permit an extern to perform chiropractic duties as part of a clinical program, subject to the following conditions:
(1) The preceptor shall maintain direct supervision of the extern.
(2) The clinical training program shall be governed by a written agreement between the extern's chiropractic college and the preceptor that:
(a) Has been approved by the Board;
(b) Describes the specific program;
(c) Enumerates the functions the extern may perform;
(d) Indicates the legal responsibilities assumed by the extern's chiropractic college.
(3) The chiropractic college shall submit to the Board the names of those doctors selected as extension faculty members. The Board shall notify the college of those approved for the program.
(4) A licensed chiropractor may not supervise more than one extern during the same period.
(5) A licensed chiropractor may delegate or permit only duties and functions which are established as part of the clinical training program and none other.
(6) The extern may not supervise chiropractic assistants or trainees.
C. Malpractice insurance in an amount defined by the Council on Chiropractic Education shall be obtained by the extern's chiropractic college and extension faculty member participating in the clinical program before the beginning of the clinical program.

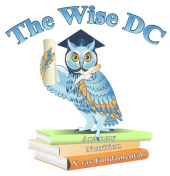
D. A licensed chiropractor seeking preceptor status shall:
(1) Make written application to the Board;
(2) Pay the fee as set forth in COMAR 10.43.06;
(3) Provide written evidence of malpractice insurance as requested by the Board; and
(4) Agree to an administrative inspection of the chiropractic office spaces, equipment, and records as directed by the Board.

10.43.06 Chiropractic and Massage Therapy — Fees
Authority: Health Occupations Article, §§3-205, 3-206, 3-5A-02, and
3-5A-03, Annotated Code of Maryland
.01 Scope.
This chapter governs those who are licensed and certified or who are applying for licensure and certification by the Board.
.02 Fees for Chiropractic Licensure and Registration.
The following fees are established by the Board:
A. Application fee . . . $200;
B. Examination fee . . . $300;
C. Licensure fee . . . $200;
D. Reexamination fee . . . $400;
E. Renewal fee to be paid on or before August 31 of the renewal year . . . $700;
F. Late renewal fee to be paid, in addition to the renewal fee, for renewal submitted within 30 days after August 31 . . . $500;
G. Reinstatement fee, in addition to the renewal fee and late fee in §§E and F of this regulation, for each renewal period that the license was expired after September 30 . . . $300;
H. Duplicate license fee . . . $50;
I. Duplicate license ordered at renewal . . . $25;
J. Inactive status fee . . . $350;
K. Reactivation fee charged to move licensure status from inactive to active status . . . $200;

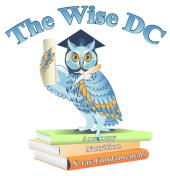


L. Preceptorship application fee . . . $300;
M. Extern application fee . . . $50;
N. Licensure by credentials . . . $750;
O. Penalty for returned checks . . . $50;
P. Verification of licensure . . . $35;
Q. Chiropractic assistant examination fee . . . $300;
R. Chiropractic assistant renewal fee . . . $250;
S. Penalty for failure to maintain correct address with the Board . . . $200;
T. Late renewal fee for chiropractic assistants . . . $200;
U. Supervising chiropractor application fee . . . $300;
V. Continuing Education Course processing review fee per hourly course unit . . . $25;
W. Mailing labels or roster . . . $200;
X. Chiropractic assistant registration fee . . . $100;
Y. Paper copy of laws and regulations . . . $25.
.03 Fees for Massage Therapy Licensure and Registration.
The following fees are established by the Board:
A. Application fee . . . $150;
B. License fee . . . $200;
C. State examination fee . . . $275;
D. Reexamination fee . . . $300;
E. Biennial renewal fee . . . $250;
F. Late renewal fee (within 30 days of certificate expiration, in addition to renewal fee) . . . $200;
G. Reinstatement fee (after 31 days of expiration of certificate or registration, in addition to renewal and late fees) . . . $200;
H. Inactive renewal fee . . . $50;
I. Reactivation fee . . . $100;
J. Duplicate license or registration fee . . . $40;
K. Duplicate license or registration ordered at renewal . . . $20;
L. Verification fee . . . $35;
M. Penalty for returned checks . . . $50;
N. Mailing labels or rosters . . . $200;
O. Penalty for failure to maintain correct address with the Board . . . $100;
P. Continuing Education Course processing fee per hourly course unit . . . $25;
Q. Paper copy of laws and regulations . . . $25.
.04 Refunds.
A. Fees are nonrefundable with the exception of the examination fee.
B. The examination fee may be refunded at the discretion of the Board if the applicant's written request is received by registered mail at least 14 days before the examination.
.05 Assessment for Health Care Professionals.
The applicant shall pay at the time of license renewal a fee for health care professionals, assessed by the Maryland Health Care Commission (MHCC), as specified in COMAR 10.25.02.

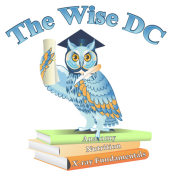
10.43.07 Chiropractic Assistants
Authority: Health Occupations Article, §§3-205 and 3-404, Annotated Code of Maryland
.01 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Applicant" means a person who is undergoing training to become a chiropractic assistant.
(2) "Board" means the Board of Chiropractic and Massage Therapy Examiners.



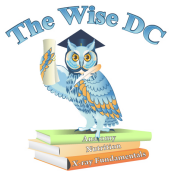
(3) "Chiropractic assistant" means an individual who is registered by the Board to perform the duties authorized under this chapter.
(4) "Direct supervision" means supervision provided by a supervising chiropractor who is personally present and immediately available in the area where the procedures are performed to give aid, direction, and instruction when certain procedures or activities are performed.
(5) "Supervising chiropractor" means a chiropractor licensed by the Board in chiropractic with the right to practice physical therapy as set forth in Health Occupations Article, §3-301(c), Annotated Code of Maryland, and approved as a supervising chiropractor by the Board.
.02 Requirements for Achieving Supervising Chiropractor Status.
A. Only a supervising chiropractor may work with or train a chiropractic assistant or applicant.
B. Only an active, licensed chiropractor who holds physical therapy privileges and has no outstanding disciplinary orders may qualify for supervising chiropractor status.
C. An applicant for supervising chiropractor status shall:
(1) Submit to the Board the required application and fee; and
(2) Successfully pass the Board supervising chiropractor examination and interview.
.03 Responsibilities of the Supervising Chiropractor.
The supervising chiropractor shall:
A. Submit:
(1) The required Board Notification of Employment form before undertaking any hands on training or coursework with any chiropractic assistant applicant; and
(2) All other Board-required reports and forms in a timely manner as determined by the Board.
B. Notify the Board and course instructor or instructors of any change in status of any chiropractic applicant or assistant within 10 days of the change, including:
(1) Reasons for the change in status;
(2) Training received by the applicant or assistant;
(3) Hours completed by the applicant or assistant; and
(4) The applicant's or assistant's forwarding address;
C. Maintain accurate, legible, and comprehensive records of all clinical training provided to the chiropractic applicant or assistant, including, but not limited to:
(1) Dates and times and duration of training as described in Regulation .05 of this chapter;
(2) Modalities;
(3) Equipment used; and
(4) Any other information as directed by the Board;
D. Immediately produce the records described in §C of this regulation upon request or audit by the Board;
E. Promptly:
(1) Report a chiropractic applicant or assistant not making satisfactory training progress; and
(2) Report before the Board as directed regarding the details of the training program issue;
F. Maintain competency in knowledge of applicable laws and regulations and successfully complete any jurisprudence requirements that may be directed by the Board;
G. Ensure that all patient records accurately and legibly reflect the extent and degree of the involvement or assistance of the chiropractic applicant or assistant;
H. Submit the in-service training hours and verification of chiropractic applicant or assistant competency on a form provided by the Board within 30 days of completion of training or transfer of the chiropractic applicant or assistant to another supervising chiropractor;
I. Be fully responsible for the safe and competent performance of the chiropractic applicant or assistant at all times; and
J. Provide direct supervision to not more than [two chiropractic applicants and three chiropractic assistants] five chiropractic assistants or applicants.



.04 Supervising Chiropractor Prohibited Acts.
A. The supervising chiropractor may not:
(1) Delegate responsibilities in any manner to anyone not holding supervising chiropractor status;
(2) Leave the treatment area when:
(a) Treating a patient; or
(b) A chiropractic applicant or assistant is treating a patient; or
(3) Permit a chiropractic applicant or assistant to treat a patient without the presence of the supervising chiropractor in the treatment area.
B. The license of a licensee who violates this regulation shall be subject to the penalties set forth in COMAR 10.43.10.
.05 Chiropractic Applicant or Assistant Qualifications and Training.
A. A chiropractic assistant or applicant shall:
(1) Be 18 years old or older and of good moral character at the time of application;
(2) Have proof of satisfactory completion of high school or an equivalent education;
(3) Receive, within 1 year of application, minimum training consisting of:
(a) A minimum of 520 in-service training hours, with:
(i) The initial 40 hours consisting of observation procedures as listed in Regulation .09 of this chapter performed by the supervising chiropractor or registered chiropractic assistant; and
(ii) The remaining 480 hours consisting of direct supervision by a supervising chiropractor in the treatment area;
(b) 24 Board-approved hours in anatomy and terminology;
(c) 76 Board-approved classroom hours in physical therapy modalities, indications, and contraindications;
(d) 3 Board-approved hours in jurisprudence and risk management; and
(e) Certification by the American Red Cross or American Heart Association in cardiopulmonary resuscitation (CPR) at the provider level; and
(4) Successfully complete the Board-approved classroom program and in-service training and Board examination within 1 year of application unless waived on a case-by-case basis due to hardship or extenuating circumstances, as provided in §C of this regulation.
B. The Board shall approve all educational courses, programs, texts, equipment, instructors, and study materials.
C. Waiver of Educational Requirements.
(1) Upon written request to the Board, a licensed, certified, or registered healthcare provider in good standing in a Board-recognized jurisdiction, who otherwise meets the requirements of this chapter, may receive a waiver of the educational requirements of this regulation.
(2) An applicant whose educational requirements are waived shall successfully pass:
(a) Both the chiropractic assistant and jurisprudence examination; and
(b) A discretionary Board interview.
.06 Term and Renewal of Registration.
A. A registration expires every 2 years, unless the registration is renewed for a 2-year term.
B. Before a registration expires, the registrant periodically may renew it for another term if the registrant:
(1) Otherwise is entitled to be registered;
(2) Pays a renewal fee as set forth in COMAR 10.43.06;
(3) Submits to the Board a renewal application on the form that the Board requires; and
(4) Submits to the Board verification of at least 10 hours of continuing education in courses approved by the Board.
.07 Examinations.

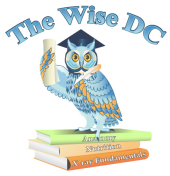


A. An applicant who otherwise qualifies for registration is entitled to be examined as provided in this regulation.
B. The applicant shall pass a Board proficiency and jurisprudence examination.
C. The applicant shall pay to the Board an examination fee as set forth in COMAR 10.43.06.
D. The Board shall:
(1) Give examinations to applicants twice a year, at the times and places that the Board determines;
(2) Notify each qualified applicant of the time and place of examinations; and
(3) Determine the subject scope, form, and passing score for examination.
E. Reexaminations.
(1) If the applicant fails the examination twice, the applicant may retake the examination only if the applicant:
(a) Pays the reexamination fee; and
(b) Completes additional minimum 10 hour refresher classroom training courses as approved by the Board in areas of deficiency.
(2) An applicant who fails the examination twice may not perform in-service training duties in direct patient care or treatment under Regulation .03 of this chapter.
.08 Activities That May Be Performed by Chiropractic Applicants and Assistants Without Direct Supervision.
Only a chiropractic applicant or assistant may perform the following activities without the direct supervision of a supervising chiropractor:
A. Taking the height, the weight, and vital signs of a patient and recording them in the patient record;
B. Assisting in the dressing, undressing, and draping of a patient;
C. Removing and applying assistive and supportive devices;
D. Observing treatments and modalities as authorized by the supervising chiropractor; and
E. Providing preprinted non-patient specific health and chiropractic concepts and information that has been approved and reviewed by the supervising chiropractor.
.09 Activities That May Be Performed by Chiropractic Applicants and Assistants Under Direct Supervision of a Supervising Chiropractor.
A chiropractic applicant or assistant may perform the following activities only under the direct supervision of a supervising chiropractor who is in the treatment area:
A. Functional activities of daily living and hygiene;
B. Gait practice and ambulation;
C. Demonstration of routine follow-up exercise;
D. Assist in moving a patient within the treatment area;
E. Contrast baths;
F. Hot and cold packs;
G. Hubbard tank;
H. Infrared, ultraviolet irradiation, non-laser light therapy, and cold laser light therapy;
I. Muscle stimulation;
J. Electrotherapy;
K. Paraffin baths;
L. Traction therapy;
M. Ultrasound;
N. Whirlpool;
O. Diathermy;
P. Therapeutic massage, if licensed under Health Occupations Article, §3-5A-01, Annotated Code of Maryland; and
Q. Mechanical or computerized examination procedures for the sole purpose of collecting data subject to the following conditions:



(1) All data will later be used and interpreted by the chiropractor to form a diagnosis and treatment plan; and
(2) No test may be performed that requires diagnosis or interpretation as part of the data collecting or testing procedure.
.10 Chiropractic Applicant or Assistant Prohibited Acts.
A chiropractic applicant or assistant may not engage in any of the following activities:
A. Communicate an evaluation or diagnosis to a patient or third parties;
B. Perform an act requiring the professional skill or judgment of a licensed chiropractor;
C. Take x-rays or position patients for x-rays; or
D. Perform orthopedic or neurological tests.
.11 Practicing Without Registration.
A. Except as otherwise provided in this chapter, a person may not practice, attempt to practice, or offer to practice as a chiropractic assistant in this State unless registered by the Board
B. A person may not serve as a chiropractic applicant or assistant unless approved by the Board.
.12 Penalties for Violations of This Chapter.
A. Violations of these regulations may result in disciplinary action against the supervising chiropractor as set forth in Health Occupations Article, §3-313, Annotated Code of Maryland
B. A person practicing as a chiropractic assistant without being registered, except as provided in these regulations, is guilty of a misdemeanor, and may be fined $5,000 or imprisoned for 1 year, or both.
C. A chiropractic assistant and an applicant for registration is subject to the Board's disciplinary authority under Health Occupations Article, §3-313, Annotated Code of Maryland.
.13 Display of Registration.
A chiropractic assistant shall display the registration and any current renewal registration conspicuously in the space where the license holder is engaged in practice, including in any temporary space, or in any exhibit location.

10.43.08 Chiropractic and Massage Therapy: Licensure and Registration Examination—Special Needs Applicants
Authority: Health Occupations Article, §§3-205 and 3-304, Annotated Code of Maryland
.01 Scope.
These regulations establish the procedures to be followed by examination applicants who have special needs because of a handicap or religious convictions.
.02 Eligibility Requirements.
A. An applicant with a disability may request modifications in examination materials or procedures by making a written request to the Board that includes:
(1) The applicant's name;
(2) The date of the examination to be modified;
(3) A letter from the appropriate medical professional that:
(a) Confirms the disability; and
(b) Provides information describing the accommodations required; and
(4) A letter from the applicant's education program, indicating what modifications, if any, were granted by the program.
B. The applicant shall send the request for modification and supporting documentation to the Board by the application deadline.
C. The Board reserves the right to review each special needs application and evaluate each on its individual merit.
D. The applicant may be required to bear the cost of special arrangements or procedures to accommodate the applicant's special needs.



10.43.10 Chiropractic — Monetary Penalties

Authority: Health Occupations Article, §3-314, Annotated Code of Maryland

.01 Scope.

This chapter establishes standards for the imposition of penalties not exceeding $5,000 against any chiropractor in the State if, after a hearing, the Board finds that there are grounds under Health Occupations Article, §3-313, Annotated Code of Maryland, to suspend or revoke a license.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Board" means the State Board of Chiropractic and Massage Therapy Examiners.

(2) "License" means a license issued by the Board to practice chiropractic or to practice chiropractic with the right to practice physical therapy.

(3) "Licensee" means a chiropractor who is licensed by the Board to practice chiropractic or to practice chiropractic with the right to practice physical therapy.

(4) "Penalty" means monetary penalty.

.03 Imposition of a Penalty — General.

A. Imposition of a Penalty After a Hearing. If, after a hearing under Health Occupations Article, §3-315, Annotated Code of Maryland, the Board finds that there are grounds under Health Occupations Article, §3-313, to suspend or revoke a license, the Board may impose a penalty of not more than $5,000:

(1) Instead of, or in addition to, suspending the license; or

(2) In addition to revoking the license.

B. Imposition of a Penalty Without a Hearing. If, after disciplinary procedures have been brought against a licensee, the licensee waives the right to a hearing required under this subtitle, and if the Board finds that there are grounds under Health Occupations Article, §3-313, Annotated Code of Maryland, to reprimand the licensee, place the licensee on probation, or suspend or revoke a license, the Board may impose a penalty not exceeding $5,000 for each violation in addition to reprimanding, placing the licensee on probation, or suspending or revoking the license.

.04 Imposition of a Penalty on a Chiropractor.

A. The Board may impose a penalty of not less than $100 or more than $2,000 on a chiropractor found guilty of any of the following, if the chiropractor:

(1) Willfully fails to file or record a report as required by law; or

(2) Refuses, withholds from, denies, or discriminates against an individual with regard to the provision of professional services for which the licensee is licensed and qualified to render because the individual is HIV positive.

B. The Board may impose a penalty of not less than $300 or more than $3,500 on a chiropractor found guilty of any of the following, if the chiropractor:

(1) Practices chiropractic under a false name or trade name;

(2) Provides professional services while:

(a) Under the influence of alcohol; or

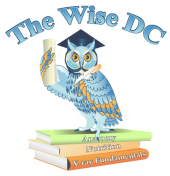
(b) Using any narcotic or controlled dangerous substance as defined in Criminal Law Article, Title 5, Subtitle 4, Annotated Code of Maryland, or other drug that is in excess of therapeutic amounts, or without valid medical indication;

(3) Solicits or advertises in a false or misleading manner, or in any other manner not approved by the Board;

(4) Abandons a patient;

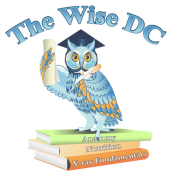
(5) Misrepresents the effectiveness of any treatment, drugs, devices, appliances, or goods to a patient so as to exploit the patient for financial gain;

(6) Willfully impedes or obstructs the filing or recording of a report, or induces another to fail to file or record the report;

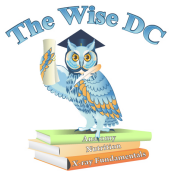


(7) Pays or agrees to pay a sum to an individual for bringing or referring a patient; or
(8) Violates any rule or regulation adopted by the Board.
C. The Board may impose a penalty of not less than $500 or more than $5,000 on a chiropractor found guilty of any of the following:
(1) Fraudulently or deceptively obtaining or attempting to obtain a license for the applicant or licensee, or for another;
(2) Fraudulently or deceptively using a license;
(3) Impersonating another practitioner;
(4) Having been convicted of or pleading guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether any appeal or other proceeding is pending to have the conviction or plea set aside;
(5) Unethically conducting the practice of chiropractic;
(6) Being professionally, physically, or mentally incompetent;
(7) Grossly and willfully:
(a) Overcharging for professional services; or
(b) Submitting false statements to collect fees for which services are not provided;
(8) Having been disciplined by a licensing or disciplinary authority of any other state or country or convicted by a court of any state or country for an act that would be grounds for disciplinary action under Health Occupations Article, §3-313, Annotated Code of Maryland;
(9) Practicing chiropractic with an unauthorized individual or supervising or aiding an unauthorized individual in the practice of chiropractic;
(10) Behaving immorally in the practice of chiropractic; or
(11) Committing an act of unprofessional conduct in the practice of chiropractic.
.05 Factors to be Considered in the Assessment of a Penalty.
In those cases in which the Board determines that the imposition of a penalty is appropriate, the Board shall take into consideration the following factors, without limitations, in determining the amount of penalty:
A. The extent to which the chiropractor derived any financial benefit from unprofessional or improper conduct;
B. The willfulness of the unprofessional or improper conduct;
C. The extent of actual or potential public harm caused by the unprofessional or improper conduct; and
D. The cost of investigating and prosecuting the case against the chiropractor.
.06 Payment of a Penalty.
A. A chiropractor shall pay to the Board a penalty imposed under these regulations as of the date the Board's order is issued, unless the Board's order specifies otherwise.
B. Filing an appeal under State Government Article, §10-215, Annotated Code of Maryland, or Health Occupations Article, §3-316, Annotated Code of Maryland, does not automatically stay payment of a penalty imposed by the Board pursuant to these regulations.
C. If a chiropractor fails to pay, in whole or in part, a penalty imposed by the Board pursuant to these regulations, the Board may not restore, reinstate, or renew a license until the penalty has been paid in full.
D. In its discretion, the Board may refer all cases of delinquent payment to the Central Collection Unit of the Department of Budget and Fiscal Planning to institute and maintain proceedings to ensure prompt payment.
E. The Board shall pay all monies collected pursuant to these regulations into the State's General Fund.

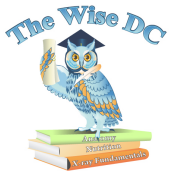
10.43.11 Chiropractic — Continuing Education Requirements
Authority: Health Occupations Article, §§3-308 and 3-313, Annotated Code of Maryland
.01 Scope.



This chapter governs continuing education for all individuals licensed to practice chiropractic in Maryland.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Board" means the Maryland Board of Chiropractic and Massage Therapy Examiners.
(2) "Credit hour" means 1 program hour.
(3) "Licensee" means a chiropractor licensed by the Board.
(4) "Sponsor" means the Maryland Chiropractic Association, the American Chiropractic Association, the International Chiropractors Association, schools or colleges accredited by the Council on Chiropractic Education (CCE), agencies approved by the Board of Physician Quality Assurance, and schools and organizations approved by the Board.
.03 License Renewal.
A. A licensee shall complete 48 hours of continuing education in the 2-year period before each renewal and provide verification to the Board if requested.
B. The licensee shall obtain a minimum of:
(1) 3 hours in approved communicable-disease and sanitary procedures;
(2) 1 hour in diversity education;
(3) 3 hours in risk management; and
(4) 1 hour in jurisprudence.
C. The Board may refuse to renew the license of any chiropractor who fails to comply with this chapter.
D. The Board shall conduct an audit of licensees before or during the renewal period to ensure compliance with this chapter.
.04 Accreditation.
A. The Board shall base the accreditation of continuing education programs solely upon their content. The Board shall ensure that these programs are directed toward improvement, advancement, and extension of professional skill and knowledge relating to the practice of chiropractic.
B. The Board may approve credit for the following, after reviewing the program content:
(1) Courses sponsored by the Maryland Chiropractic Association;
(2) Courses sponsored by the American Chiropractic Association or the International Chiropractors Association;
(3) Courses offered or cosponsored by schools or colleges accredited by the CCE;
(4) Course hours approved by the Board of Physician Quality Assurance for continuing medical education; or
(5) Other sponsored programs and courses determined by the Board to meet the professional standards of chiropractic.
C. The continuing medical education courses described in §B(4) of this regulation may not exceed 12 hours during any renewal period.
D. The sponsor of a continuing education course or the licensee shall apply for approval of the course by the Board at least 90 days before the starting date of the course, and shall submit the following written information to the Board:
(1) Title, location, and dates of the course;
(2) Sponsor;
(3) Course objective;
(4) Hours of study;
(5) Name or names of the instructor or instructors;
(6) Instructor's educational background and experience;
(7) Name of the attendance-certifying officer and the method of certification;
(8) Required textbooks or equipment;



(9) Course syllabus; and
(10) Number of credits.
E. After review of program content, the Board shall send the sponsor or licensee making the application a letter of:
(1) Approval, containing the title of the course, the dates of the course, and the number of hours credited; or
(2) Denial, stating the reasons for denial.
F. The Board may approve, for license renewal credit, a program consisting of one of the following subjects or a combination of these subjects:
(1) Chiropractic principles and adjusting techniques;
(2) Chiropractic ethics and jurisprudence;
(3) X-ray quality assurance program;
(4) Diagnostic imaging;
(5) Physical diagnosis;
(6) Clinical laboratory diagnosis;
(7) Orthopedic diagnosis;
(8) Neurological diagnosis;
(9) Rehabilitative procedures;
(10) Nutritional procedures;
(11) Physical therapy;
(12) Risk management;
(13) Cultural competency or diversity awareness; or
(14) A subject with clinical application approved by the Board.
G. A licensee shall maintain current certification of cardiopulmonary resuscitation (CPR) at the healthcare provider level of the American Red Cross or American Heart Association or their authorized agents for each renewal period in addition to the 48 hours of continuing education.
H. Approved credits are not transferable and are acceptable toward fulfillment of the continuing education requirement only in the renewal period in which they are earned.
.05 Substantiation of Credits.
A. The licensee shall keep accurate records of attendance at approved continuing education programs and be able to substantiate those records upon request.
B. The Board shall conduct a random audit before or during the license renewal period to ensure compliance with this chapter.
C. The Board shall disallow the continuing education credits for a licensee who is unable to substantiate the credits and may refuse to renew the license if credits are disallowed.
D. The Board may require additional verification or verify independently any information received regarding content and certification of, and attendance at, a continuing education program.
E. The Board may grant an extension of time for the licensee to obtain required continuing education credits if the licensee presents evidence satisfactory to the Board that failure to comply was due to circumstances beyond the licensee's control.
F. The Board may not accept continuing education credits from a previous renewal period.
G. The Board shall renew a license for the first renewal period following the issuance of the original license without requiring continuing education credits if the original license was issued 1 year or less before the expiration date of the license.
H. A licensee shall maintain complete and accurate records of the licensee's continuing education credits for the preceding 4 years and present them to the Board upon request.
I. The Board may waive the continuing education requirements when it determines that the licensee was unable to comply due to hardship.



J. The Board may institute disciplinary action, pursuant to Health Occupations Article, §3-313, Annotated Code of Maryland, against a chiropractor who submits fraudulent information to the Board.

10.43.12 Chiropractic — Licensure Examination

Authority: Health Occupations Article, §§3-202, 3-205, and 3-301—3-304, Annotated Code of Maryland

.01 Scope.

This chapter establishes the requirements for licensure by examination for all applicants, except applicants who qualify for licensure under Health Occupations Article, §3-305, Annotated Code of Maryland.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Accredited college" means a chiropractic school approved by the Council on Chiropractic Education, or its successor, and approved by the Board.

(2) "Board" means the State Board of Chiropractic and Massage Therapy Examiners.

(3) "Letter of admission" means a document sent by the Board to the applicant approving the applicant's request to take the licensure examination.

(4) "Maryland Board examination" means the jurisprudence examination administered by the Board to measure competency under Health Occupations Article, Title 3, Annotated Code of Maryland, and COMAR 10.43.01—.19.

(5) "National Board examination" means the written tests administered by the National Board of Chiropractic Examiners to measure competency in chiropractic.

.03 Application for Examination and Licensure.

A. An individual is eligible to take the Maryland Board examination for licensure if the individual, at least 45 days before the examination, submits documentation verifying that the individual has:

(1) Been awarded a bachelor's degree from a Board-recognized, accredited college;

(2) Graduated from a college of chiropractic approved by the Board, pursuant to Health Occupations Article, §3-402, Annotated Code of Maryland;

(3) Successfully completed parts one and two of the National Board examination with a passing score established by the National Board of Chiropractic Examiners, and all other parts with a passing score of at least 75 percent;

(4) Provided two letters of reference attesting to the applicant's good moral character;

(5) Certified or affirmed that the individual has not practiced chiropractic without a license in the State;

(6) Filed an application and paid the required application fee as specified in COMAR 10.43.06; and

(7) Paid the required examination fee as specified in COMAR 10.43.06.

B. The Board may not refund an application fee.

C. The Board shall refund the examination fee to an applicant whom the Board determines is not qualified to take the examination.

D. The Board shall send to an approved applicant a letter of admission to the examination.

E. The Board may refund examination fees to an applicant unable to be present for the examination if the applicant submits verification of hardship and a written request for a refund.

.04 Physical Therapy Privileges.

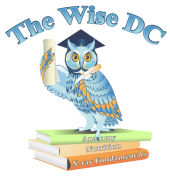
An applicant seeking physical therapy privileges shall have obtained:

A. A minimum of 270 hours of instruction in physical therapy; and

B. A minimum score of 75 percent on the National Board Physiotherapy Examination.

.05 Examination Misconduct.

After a hearing, the Board may permanently deny licensure to an applicant found to have cheated on or subverted an examination taken to qualify for Maryland licensure.



10.43.13 Chiropractic and Massage Therapy — Procedures for Clinical Demonstrations in Public Places

Authority: Health Occupations Article, §3-205, Annotated Code of Maryland

.01 Scope.

This chapter governs all chiropractic clinical demonstrations in public places by licensed chiropractors in Maryland.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Chiropractic display facility" means an area where chiropractic procedures are demonstrated.

(2) "Chiropractic procedure" means examinations, mensurations, analyses, evaluations, screenings, or clinical determinations related to the practice of chiropractic in a public place.

(3) "Cursory postural screening" means a visualization, by a licensed chiropractor, of an individual's posture to detect possible structural deviations.

(4) "Demonstration" means performing chiropractic procedures in public places.

.03 Chiropractic Demonstrations in Public Places.

A. When performing chiropractic procedures in a public place, the chiropractor shall:

(1) Prominently display the chiropractor's current license;

(2) Provide adequate facilities for patients to disrobe;

(3) Ensure that the patient is properly draped for examination; and

(4) Maintain the privacy of the patient at all times.

B. The chiropractor may perform a cursory postural screening while the patient is fully clothed.

.04 Chiropractic Display Facilities in Public Places.

For procedures that require partial or complete disrobing of the patient, the chiropractor shall ensure that the chiropractic display facility:

A. Has a partition that is at least 7 feet high from the floor;

B. Has a ceiling, when necessary, to protect the patient's privacy;

C. Provides a space at least 8 feet by 10 feet; and

D. Is opaque and obscures from view any shadow or silhouette of the patient and chiropractor.

.05 Prohibitions.

An unlicensed individual may not perform chiropractic procedures in public places.

.06 Exceptions.

This chapter does not preclude a salesperson from demonstrating chiropractic equipment during a convention or educational seminar.

.07 Penalty.

The Board may initiate disciplinary proceedings, pursuant to Health Occupations Article, §3-313, Annotated Code of Maryland, against a chiropractor found in violation of this chapter.

10.43.14 Chiropractic — Code of Ethics

Authority: Health Occupations Article, §§1-212, 3-205, and 3-313, Annotated Code of Maryland

.01 Scope.

This chapter applies to licensed chiropractors and registered chiropractic assistants.

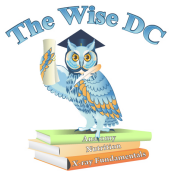
.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

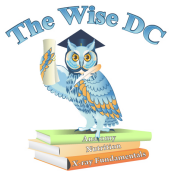
B. Terms Defined.

(1) "Chiropractic assistant" means an individual who is registered by the Board to perform the duties authorized under COMAR 10.43.07.

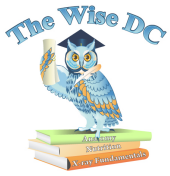
(2) "Chiropractor" means an individual licensed by the Board:



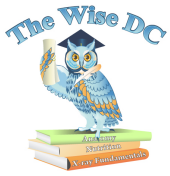
(a) To practice chiropractic; or
(b) To practice chiropractic with the right to practice physical therapy.
(3) "Non-bona-fide treatment" means when a chiropractor or chiropractic assistant treats or examines a patient in a way that involves sexual contact, but there is no medical reason for the procedure, or the procedure falls outside the scope of reasonable chiropractic practices.
(4) "Sexually exploitative relationship" means when sexual contact occurs in an existing therapeutic relationship or within a period of time after formal termination of the relationship when the patient may still be vulnerable to the power imbalance that exists in the practitioner-patient relationship, even if the relationship may appear to be or is mutually consensual.
(5) "Therapeutic deception" means when a chiropractor or chiropractic assistant misrepresents sexual conduct as a legitimate form of treatment.
.03 Standards of Practice.
A. A chiropractor and chiropractic assistant shall concern themselves primarily with the welfare of the patient.
B. A chiropractor or chiropractic assistant who suffers from a physical, mental, or emotional impairment, including chemical abuse, that impacts the individual's ability to practice chiropractic or provide chiropractic assistance shall seek professional treatment and refrain from the practice of chiropractic or the practice of chiropractic assistance until the impairment no longer exists or reasonable accommodations can be made.
C. A chiropractor and chiropractic assistant shall:
(1) Use professional discretion and integrity in relationships with a member of the health care community;
(2) Be professional in conduct, with honesty, integrity, self-respect, and fairness;
(3) Remain free from conflict of interest while fulfilling the objectives and maintaining the integrity of the chiropractic profession;
(4) Provide accurate fee information to the patient, the individual responsible for payment for treatment, and the insurer;
(5) At all times respect the patient's dignity, autonomy, and privacy;
(6) Practice chiropractic only as defined in the scope of practice set forth in Health Occupations Article, §3-101(f) and (g), Annotated Code of Maryland;
(7) Provide chiropractic assistance only within the parameters set forth in Health Occupations Article, §3-404, Annotated Code of Maryland, and COMAR 10.43.07;
(8) Cooperate with any lawful investigation conducted by the Board, including:
(a) Furnishing information requested;
(b) Complying with a subpoena;
(c) Responding to a complaint at the request of the Board; and
(d) Providing meaningful and timely access to relevant patient records; and
(9) Report to the Board, or other appropriate authority, conduct in the practice of chiropractic that indicates a violation of:
(a) This chapter;
(b) Health Occupations Article, Title 3, Annotated Code of Maryland; or
(c) Any other law, including but not limited to aiding or abetting the unauthorized practice of chiropractic.
D. A chiropractor or chiropractic assistant may not:
(1) Misrepresent credentials, qualifications, or affiliations and shall attempt to correct others who misrepresent the chiropractor's or the chiropractic assistant's credentials, qualifications, or affiliations;
(2) Knowingly engage in or condone behavior that is fraudulent, dishonest, or deceitful, or involves moral turpitude;



(3) Engage in a commercial activity which conflicts with the duties of a chiropractor and chiropractic assistant;
(4) Perform chiropractic on a patient if a contraindication against chiropractic treatment exists;
(5) Discriminate against a patient or a health care provider based on race, religion, age, gender, sexual orientation, national origin, or disability;
(6) Intimidate, threaten, influence, or attempt to influence any person regarding any violation of law or regulation; or
(7) Aid or abet any individual violating or attempting to violate any provision of law or regulation.
.04 Relationship with Patient.
A. A chiropractor shall:
(1) Use professional judgment in the use of evaluation and treatment procedures;
(2) Decline to administer treatment if the chiropractor believes that a treatment is contraindicated or unjustified;
(3) Terminate a professional relationship with a patient in an appropriate manner, such as:
(a) Providing the patient with sufficient notice to permit the patient to obtain the services of another professional;
(b) Assisting the patient by providing referrals if appropriate; or
(c) Continuing to provide emergency treatment to the patient if treatment is required before a reasonable time has passed to allow the patient to obtain the services of another health care provider;
(4) Maintain a written record of treatment of the patient under the chiropractor's care for at least:
(a) 5 years after the termination of treatment; and
(b) 5 years after the patient becomes 18 years old, if applicable;
(5) Make the written records of treatment available to the patient upon request, in compliance with applicable laws for disclosure of medical records;
(6) Make arrangements for another professional to provide for the needs of the patient during anticipated absences when the chiropractor is unavailable to the patient;
(7) Make referrals only to other qualified and duly licensed health care providers;
(8) Accurately inform the patient, other health care professionals, and the public of the limitations of the practice of chiropractic;
(9) Adequately assess the patient to determine if contraindications against chiropractic treatment exist and refer the patient to an appropriate health care practitioner;
(10) Exercise independent professional judgment in the treatment or evaluation of the patient regardless of whether the patient was referred by another health care provider;
(11) Ensure clear and concise professional communications with patients regarding:
(a) Nature and duration of treatment;
(b) Diagnoses;
(c) Costs;
(d) Billing; and
(e) Insurance; and
(12) Administer fair and equitable fees to patients regardless of status or insurance.
B. A chiropractor may not:
(1) Accept a client for treatment, or continue unnecessary treatment, when the patient cannot be reasonably expected to benefit from the treatment;
(2) Receive remuneration from, or provide remuneration to, or split a fee, for either making or accepting a referral of the patient to or from another health care provider;
(3) Make a guarantee or promise about the efficacy of a particular treatment, the chiropractor's practice, or the result of a treatment unless supported by scientific principles accepted by the profession; or
(4) Exploit the professional relationship by:
(a) Continuing treatment unnecessarily; or



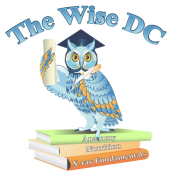
(b) Charging for a service:
(i) Not provided; or
(ii) Different from those actually provided.
.05 Professional Boundaries.
A. A chiropractor and chiropractic assistant shall:
(1) Maintain professional boundaries, even when the patient initiates crossing the boundaries of the professional relationship; and
(2) Respect and maintain professional boundaries and respect the patient's reasonable expectation of professional conduct.
B. A chiropractor and chiropractic assistant may not:
(1) Exploit a relationship with a patient for the chiropractor's or chiropractic assistant's personal advantage including, but not limited to, a personal, sexual, romantic, or financial relationship;
(2) Engage in a sexually intimate act with a patient; or
(3) Engage in sexual misconduct, which includes but is not limited to:
(a) Therapeutic deception;
(b) Non-bona-fide treatment; and
(c) A sexually exploitative relationship.
.06 Records, Confidentiality, and Informed Consent.
A chiropractor shall:
A. Respect and maintain the privacy and confidentiality of the patient;
B. Disclose the patient's records or information about the patient only with the patient's consent or as required by law;
C. Adequately safeguard confidential patient information, including storage and disposal of records;
D. Provide sufficient information to a patient to allow the patient to make an informed decision regarding treatment, including:
(1) The purpose and nature of an evaluation or treatment regimen;
(2) Alternatives to treatment;
(3) Side effects and benefits of a treatment regimen proposed and alternatives to that treatment;
(4) The estimated cost of treatment and alternatives to treatment;
(5) The right of the patient to withdraw from treatment at any time, including the risks associated with withdrawing from treatment; and
(6) The patient's right to decline to participate in treatment if an aspect of the treatment will be recorded, documented, photographed, observed, or otherwise used in an educational program;
E. Obtain the full informed consent of a patient participating in a human research program, without communicating a direct or implied penalty for the patient's refusal to participate in the program and with due regard for the patient's autonomy and dignity;
F. Comply with applicable federal and State laws for human research programs; and
G. Promptly and efficiently respond to any patient or Board request for records.
.07 Education and Training.
A. A chiropractor or chiropractic assistant shall:
(1) Obtain additional training, information, and supervision as needed to perform a new technique or service in a new specialty area or when employing a new treatment modality; and
(2) Be current in the qualifications to practice, including meeting continuing education requirements established by the Board.
B. The chiropractor or chiropractic assistant may not perform a treatment or provide a service that the chiropractor or chiropractic assistant is not qualified to perform or which is beyond the scope of the chiropractor's or chiropractic assistant’s education, training, capabilities, experience, and scope of practice.
.08 Advertising.



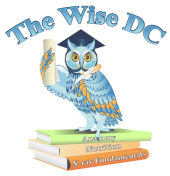
A. A chiropractor may advertise services subject to COMAR 10.43.03.
B. A chiropractor is accountable under this regulation if the chiropractor uses an agent, partnership, professional association, or health maintenance organization to implement an action prohibited by COMAR 10.43.03.05.
.09 Ethical, Legal, and Professional Responsibilities.
A chiropractor and chiropractic assistant may not construe any failure to specify a particular ethical, legal, or professional duty in this chapter as a denial of the existence of other ethical, legal, or professional duties or responsibilities that are equally as important and generally recognized in the chiropractic profession.
.10 Penalties.
Violation of a regulation in this chapter may result in the Board taking action pursuant to Health Occupations Article, §3-313, Annotated Code of Maryland.

10.43.15 Chiropractic — Record Keeping

Authority: Health Occupations Article, §3-205, Annotated Code of Maryland
.01 Scope.
This chapter establishes the minimum standards for the documentation of patient care by the chiropractor.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) “Board” means the Maryland Board of Chiropractic and Massage Therapy Examiners.
(2) "Diagnosis" means the determination by the chiropractor of the nature and cause of a disease or injury through evaluation of patient history, examination, and review of any laboratory and radiological data.
(3) "Examination" means varied procedures such as analysis, assessment, and evaluation performed by the chiropractor to determine a diagnosis.
(4) "History" means the patient's account of past, present, and familial health.
(5) "Subjective, objective, assessment, and plan (SOAP) notes" means the written record maintained by the chiropractor of:
(a) The patient's qualitative or quantitative description of the patient's condition;
(b) Findings pertaining to the patient's condition based on examination and tests;
(c) The chiropractor's clinical opinion of the condition; and
(d) Instructions given to the patient, orthopedic appliances provided to the patient with instructions for usage, and recommendations for treatment, including modalities used and areas treated.
.03 Record Keeping.
A. The chiropractor shall maintain accurate, detailed, legible, and organized records, documenting all data collected pertaining to the patient's health status.
B. The chiropractor may not erase, alter, or conceal patient records but shall initial and date any changes made in the corresponding margin.
C. The Patient Record.
(1) The chiropractor shall create a record for each patient.
(2) The chiropractor shall state the patient's name or identification number on each document contained in the patient record.
(3) The chiropractor shall include the following information in the patient record:
(a) Chiropractor and clinic name identification;
(b) Patient history;
(c) Examination findings;



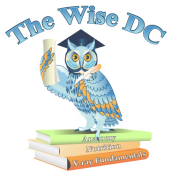
(d) Diagnoses;
(e) Treatment plan;
(f) SOAP notes;
(g) Financial records;
(h) Records of telephone conversations;
(i) Copies of correspondence and reports sent to other health care providers, diagnostic facilities, and legal representatives;
(j) Records and reports provided by other health care providers and diagnostic facilities; and
(k) The signed consent of the patient or the parent or guardian of a minor patient or incompetent patient.
D. Correspondence. The chiropractor shall identify the name of the attending chiropractor, clinic name, address, and telephone number on patient records and reports sent to another health care provider.
E. Maintenance and Release of Patient Records.
(1) The chiropractor shall keep confidential all information contained in the patient file, in accordance with Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland.
(2) The chiropractor shall release patient records when release is:
(a) Authorized by the patient in writing; or
(b) Compelled by law.
(3) The chiropractor may assess fees for duplicating patient records for the patient or for another health care provider in accordance with Health-General Article, §4-304, Annotated Code of Maryland.
(4) The chiropractor shall maintain records in accordance with Health-General Article, §4-403, Annotated Code of Maryland.
.04 Supervisory Responsibilities.
A. The chiropractor is responsible for record keeping, consent forms, billing, and other patient-related documentation handled, maintained, or managed by the chiropractor's staff.
B. The chiropractor shall ensure that employees involved in the preparation, organization, and filing of records adhere to the regulations of this chapter.
.05 Patient History.
The chiropractor shall include the following in the patient history:
A. Personal data, including:
(1) Name,
(2) Address,
(3) Telephone number,
(4) Date of birth,
(5) Race,
(6) Sex, and
(7) Current occupation;
B. Complaint or complaints, including:
(1) Description of the complaint or complaints,
(2) Quality and character of the complaint or complaints,
(3) Intensity,
(4) Frequency,
(5) Location,
(6) Radiation,
(7) Onset,
(8) Duration,
(9) Palliative and provocative factors, and
(10) History of present complaint or complaints;
C. Family health history;
D. Past health history, including:



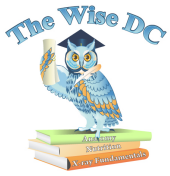
(1) General state of health,
(2) Previous illnesses,
(3) Surgical history,
(4) Previous injuries,
(5) Hospitalizations,
(6) Previous treatment and diagnostic testing,
(7) Prescribed and nonprescribed medications and supplements,
(8) Allergies, and
(9) Mental illness;
E. Systems review, including:
(1) Musculoskeletal,
(2) Cardiovascular,
(3) Respiratory,
(4) Gastrointestinal,
(5) Neurological,
(6) Ophthalmological,
(7) Otolaryngological,
(8) Endocrine,
(9) Peripheral vascular, and
(10) Psychiatric; and
F. Personal history, including:
(1) Occupational,
(2) Activities,
(3) Exercise, and
(4) Health habits.
.06 Penalties.
Violation of this chapter may result in disciplinary action against the chiropractor, as set forth in Health Occupations Article, §3-313, Annotated Code of Maryland.

10.43.17 Massage Therapy – General Regulations

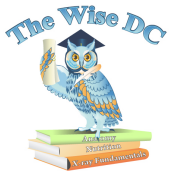
Authority: Health Occupations Article, §§3-5A-01, 3-5A-02, 3-5A-05, 3-5A-06, 3-5A-07, 3-5A-09, and 3-5A-12, Annotated Code of Maryland
.01 Scope.
Except as specifically provided in this chapter, this chapter does not limit the right of an individual to:
A. Practice a health occupation that the individual is otherwise authorized to practice under the Health Occupations Article, Annotated Code of Maryland; or
B. Advertise an occupation that the individual is otherwise authorized to practice under the Health Occupations Article, Annotated Code of Maryland.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Board" means the State Board of Chiropractic and Massage Therapy Examiners.
(2) "Health care facility" has the meaning stated in Health-General Article, §19-114(d), Annotated Code of Maryland.
(3) "License" means the document issued by the Board to an individual qualified to practice massage therapy.
(4) "Licensed massage therapist" means an individual who is licensed by the Board to practice massage therapy.



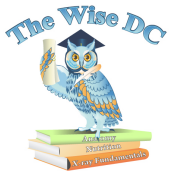
(5) "Maryland Massage Therapy Jurisprudence Examination" means the test developed by the Board to assess an applicant's knowledge of the statute and regulations governing massage therapy in the State.
(6) Massage Therapy.
(a) "Massage therapy" means the use of manual techniques on soft tissues of the human body including effleurage (stroking), petrissage (kneading), tapotement (tapping), stretching, compression, vibration, and friction.
(b) "Massage therapy" includes massage, myotherapy, and synonyms or derivatives of these terms, with or without the aid of:
(i) Cold packs;
(ii) Nonlegend topical applications; or
(iii) Heat limited to hot packs and heating pads.
(c) "Massage therapy" does not include the:
(i) Diagnosis or treatment of illness, disease, or injury;
(ii) Adjustment, manipulation, or mobilization of any of the articulations of the osseous structures of the body or spine; or
(iii) Laying on of hands, consisting of pressure or movement, with the exception of such techniques described in §B(7)(a) of this regulation on a fully clothed individual to specifically affect the electromagnetic energy or energetic field of the human body.
(7) "Massage therapy education program" means a course of study that prepares individuals in subjects related to the knowledge, techniques, skills, and abilities used in the practice of massage therapy.
(8) "Practice massage therapy" means to engage professionally and for compensation in massage therapy.
(9) "Practice non-therapeutic massage" means to engage professionally and for compensation in massage therapy in a setting that is not a health care facility.
(10) "Registered massage practitioner" means an individual who is registered by the Board to practice non-therapeutic massage.
(11) "Registration" means, unless the context requires otherwise, a document issued by the Board to practice non-therapeutic massage.
.03 Licensure or Registration Required; Exceptions.
An individual shall be licensed by the Board in order to practice massage therapy, and shall be registered by the Board in order to practice non-therapeutic massage, except for the following:
A. A student enrolled in an approved education program as determined by the Board while performing massage therapy in the program;
B. An individual who has qualified to practice massage therapy in another state or country that has substantially similar requirements for authorization to practice massage therapy as determined by the Board, and the individual is in Maryland for not more than 7 consecutive days, or a total of 30 days during a period of 1 calendar year;
C. A family member performing massage therapy on another family member;
D. An athletic trainer while functioning in the scope of the athletic trainer's professional capacity;
E. An individual employed by the federal government to practice massage therapy while practicing within the scope of the individual's employment; or
F. An individual working in a beauty salon for which the person who operates the beauty salon has obtained a permit from the State Board of Cosmetology as required under Business Occupations and Professions Article, §5-501, Annotated Code of Maryland, if the individual is practicing within the scope of a license issued by the State Board of Cosmetology.
.04 Application for Certification Licensure or Registration.
A. An applicant for licensure or registration to practice massage therapy shall:
(1) Complete the application provided by the Board;
(2) Pay the application fee as specified in COMAR 10.43.06;



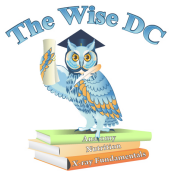
(3) Submit two recent 2 inch × 2 inch passport type photographs of the applicant;
(4) Provide evidence that the applicant is:
(a) Of good moral character; and
(b) 18 years old or older;
(5) Pass the Maryland Massage Therapy Jurisprudence Examination, which is administered by the Board, with a score of at least 75 percent;
(6) Have sent directly to the Board by the administering authority proof of:
(a) Having passed:
(i) The National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) examination; or
(ii) The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Asian Bodywork Therapy examination; or
(b) The results of an examination approved by the Board;
(7) Have certified copies of transcripts sent directly to the Board from the schools the applicant graduated from that documents completion of at least 500 classroom hours in a massage therapy education program that is:
(a) Approved by the Maryland Higher Education Commission (MHEC) or by the higher education commission or comparable authority of the state or country in which the applicant's school is located; and
(b) Accredited by the Commission on Massage Therapy Accreditation (COMTA) or approved or accredited by an accrediting agency recognized by the United States Department of Education, with the instructors teaching massage related curriculum:
(i) Certified by the National Certification Board of Therapeutic Massage Body Work (NCBTMB); and
(ii) Licensed or certified in the instructors' state of residence, if applicable;
(8) Provide an official sealed transcript of satisfactory completion of at least 60 credit hours of education at an institution of higher education as defined in Education Article, §10-101, Annotated Code of Maryland, and approved by the Board and MHEC or comparable authority in the state in which the school is located; and
(9) Have verification of status sent directly to the Board by the issuing state, if certified, licensed, or registered to practice massage therapy in another state.
B. An applicant for registration to practice nontherapeutic massage shall:
(1) Complete the application provided by the Board;
(2) Pay the application fee as specified in COMAR 10.43.06; and
(3) Satisfy the requirements set forth in §A(3)—(7) and (9) of this regulation.
.05 Required Education and Training.
A. Classroom Training.
(1) Of the minimum 500 hours classroom training required in Regulation .04A(7) of this chapter:
(a) At least 100 hours shall consist of:
(i) Anatomy;
(ii) Physiology;
(iii) Pathology; and
(iv) Kinesiology; and
(b) The remaining 400 hours shall include a majority of hours in:
(i) Massage therapy theory;
(ii) Technique;
(iii) Supervised practice;
(iv) Professional ethics;
(v) Professional standards;
(vi) Business practices;



(vii) Health and hygiene; and
(viii) Contraindications of massage.
(2) Cardiopulmonary resuscitation (CPR) and first aid shall be included but do not count toward the 500-hour minimum.
(3) An applicant may attend more than one training institution, if the applicant graduates from a school requiring satisfactory completion of a minimum of 500 classroom hours in massage therapy education.
(4) Correspondence courses are not recognized by the Board.
B. Education and Training in a Foreign Country.
(1) The Board may grant a license to practice massage therapy or a registration to practice non-therapeutic massage to an applicant who completed an educational program in a foreign country if the applicant:
(a) Can demonstrate through a Board-approved certifying agency that the applicant's education and training were substantially equivalent to the requirements of Regulation .04A(7) of this chapter and §A of this regulation through a Board-approved certifying agency; and
(b) Meets the examination and other requirements of this chapter.
(2) The Board may interview an applicant under this section to determine whether the applicant's education and training meet the requirements of this chapter.
(3) An applicant shall arrange and pay for the professional translation into English of all documentation required under this chapter if the documentation is in a language other than English.
.06 Licensure.
A. The Board shall:
(1) Issue a license to an approved applicant that:
(a) Is not valid for more than 2 years, and
(b) Expires on the date set by the Board; or
(2) Notify an applicant not approved for licensure by letter which specifies the reason or reasons for disapproval.
B. The license holder shall notify the Board of any change in the name or address of the license holder, in writing, within 60 days after the change occurs.
C. Display of License. A license holder shall display the license and any current renewal license conspicuously in the space where the license holder is engaged in practice, including in any temporary space or in any exhibit location.
.07 Registration.
A. The Board shall:
(1) Issue a registration to an approved applicant that:
(a) Is not valid for more than 2 years, and
(b) Expires on the date set by the Board; or
(2) Notify an applicant not approved for registration, by a letter which specifies the reason or reasons for disapproval.
B. The registration holder shall notify the Board, in writing, of any change in the name or address of the registration holder within 60 days after the change occurs.
C. Display of Registration. A registration holder shall display the registration and any current renewal registration conspicuously in the space where the registration holder is engaged in practice, including in any temporary space or in any exhibit location.
.08 Renewals.
A. The Board shall send each license and registration holder a renewal notice that states the:
(1) Date on which the current license or current registration expires;
(2) Latest date by which the renewal application and documentation can be received by the Board in order for the renewal license or current registration to be issued before the current license or current registration expires; and

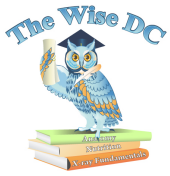


(3) Amount of the renewal fee as specified in COMAR 10.43.06.
B. At least 30 days before the current license or current registration expires, the Board shall send the renewal notice by first class mail to the last known address of the license or registration holder, as updated pursuant to Regulations .06B and .07B of this chapter.
C. The license or registration holder shall notify the Board of non-receipt of a renewal notice at least 15 days before the expiration date of the license or registration.
.09 Reinstatement.
A. The Board shall reinstate an individual whose license or registration has expired if the individual meets the renewal requirements of this chapter and pays the:
(1) Late fee in addition to the renewal fee as specified in COMAR 10.43.06, if the request is received by the Board within 30 days of the expiration date of the certificate or registration; or
(2) Late and reinstatement fees in addition to the renewal fee as specified in COMAR 10.43.06, if the request is received by the Board more than 30 days after the expiration date of the license or registration.
B. The massage therapist who fails to apply for licensure renewal within 2 years after the expiration date of the license shall meet the requirements in effect at the time of the request in order to be licensed to practice massage therapy.
C. The massage practitioner who fails to apply for registration renewal within 2 years after the expiration date of the registration shall meet the requirements in effect at the time of the request in order to be registered to practice non-therapeutic massage.
.10 Inactive Status.
A. The Board shall place a license or registration holder on inactive status if the license or registration holder submits to the Board the:
(1) Completed application for inactive status on the form provided by the Board; and
(2) Biennial fee for inactive status as specified in COMAR 10.43.06.
B. The license holder on inactive status may reactivate the license at any time if the license holder pays the reactivation fee as specified in COMAR 10.43.06.
.11 Duplicate Licenses and Registrations.
The Board shall issue a duplicate license or registration to the license or registration holder if:
A. The license or registration holder has a change of name, loses or damages the original, practices in multiple locations; and
(1) Makes the request to the Board in writing;
(2) Provides appropriate legal documentation of the change;
(3) Pays the fee as specified in COMAR 10.43.06; and
(4) Surrenders the current license or registration;
B. The Board, as a result of its error, issues an incorrect license or registration and the license or registration holder:
(1) Notifies the Board in writing within 6 weeks of receipt of the incorrect license or registration; and
(2) Surrenders the incorrect license or registration; or
C. The license or registration holder does not receive the license or registration within 6 weeks of issuance and the license or registration holder provides a statement to the Board attesting to the nonreceipt of the license or registration within 4 months of the date the license or registration was issued by the Board.
.12 Penalties.
If a license or registration holder fails to notify the Board of a change of name or address within the time required in Regulations .06B and .07B of this chapter, subject to the hearing provisions of Health Occupations Article, §3-315, Annotated Code of Maryland, the Board may impose an administrative penalty of $100.

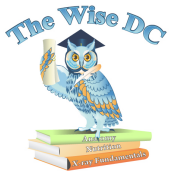


10.43.18 Massage Therapy – Code of Ethics

Authority: Health Occupations Article, §§1-212, 3-5A-02, and 3-5A-09, Annotated Code of Maryland
.01 Scope.
This chapter applies to licensed massage therapists and registered massage practitioners.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) “License holder” means an individual who is licensed by the Board to practice massage therapy.
(2) “Non bona fide treatment” means when a license holder or registration holder treats or examines a client in a way that involves sexual contact, but there is no therapeutic reason for the procedure, or the procedure falls outside of reasonable massage therapy or non-therapeutic massage practices.
(3) "Registration holder" means an individual who is registered by the Board to practice non-therapeutic massage.
(4) “Sexually exploitative relationship” means when sexual contact occurs in an existing therapeutic relationship, or within a period of time after formal termination of the therapeutic relationship where the client may still be vulnerable to the power imbalance that exists in the relationship between the license holder or the registration holder and the client, even if the relationship may appear to be mutually consensual.
(5) “Therapeutic deception” means when a license holder or registration holder misrepresents sexual conduct as a legitimate form of treatment.
.03 Standards of Practice.
A. The license holder or registration holder shall be concerned primarily with the welfare of the client.
B. A license holder or registration holder who suffers from a physical, mental, or emotional impairment, including chemical abuse, which impacts the license holder's or registration holder's ability to practice massage therapy or non-therapeutic massage, shall proactively seek professional treatment and shall refrain from the practice of massage therapy or non-therapeutic massage until such time as the impairment no longer exists or reasonable accommodations can be made.
C. A license holder or registration holder shall:
(1) Use professional discretion and integrity in relationships with members of the public and health care community;
(2) Engage in professional conduct at all times, with honesty, integrity, self-respect, and fairness;
(3) Remain free from conflict of interest while fulfilling the objectives and maintaining the integrity of the massage therapy profession;
(4) Provide accurate fee information to the client, the individual responsible for payment for treatment, and the insurer;
(5) At all times respect the client's dignity, autonomy, and privacy;
(6) Practice massage therapy or non-therapeutic massage only as defined in the scope of practice set out in Health Occupations Article, §3-5A-01, Annotated Code of Maryland;
(7) Cooperate with a lawful investigation conducted by the Board of Chiropractic and Massage Therapy Examiners, including:
(a) Furnishing information requested;
(b) Complying with a subpoena;
(c) Responding to a complaint at the request of the Board; and
(d) Providing meaningful and timely access to relevant client records;
(8) Report to the Board of Chiropractic and Massage Therapy Examiners, or other appropriate authority, conduct in the practice of massage therapy that indicates a violation of:
(a) This chapter;
(b) Health Occupations Article, Title 3, Subtitle 5A, Annotated Code of Maryland; or



(c) Any other law, including but not limited to aiding or abetting the unauthorized practice of massage therapy or non-therapeutic massage; and
(9) Attempt to correct others who misrepresent the license holder's or registration holder's credentials, qualifications, education, or affiliations.
D. A license holder or registration holder may not:
(1) Misrepresent professional credentials, qualifications, education, or affiliations;
(2) Knowingly engage in or condone behavior that:
(a) Is fraudulent;
(b) Is dishonest;
(c) Is deceitful; or
(d) Involves moral turpitude;
(3) Engage in a commercial activity that conflicts with the duties of a licensed massage therapist or registered massage practitioner;
(4) Perform massage therapy or non-therapeutic massage on a client if a contraindication against this treatment exists;
(5) Discriminate against a client or a health care provider based on race, religion, age, gender, sexual orientation, national origin, or disability; or
(6) Aid or abet any individual violating or attempting to violate any provision of law or regulation.
.04 Relationship with Client.
A. A license holder or registration holder shall:
(1) Use professional judgment in the use of evaluation and treatment procedure;
(2) Decline to administer treatment when the treatment is contraindicated or unjustified;
(3) Terminate a professional relationship with a client in an appropriate manner, such as:
(a) Providing the client with sufficient notice to permit the client to obtain the services of another professional; or
(b) Assisting the client by providing referrals, if appropriate.
(4) Maintain legible, organized written records of treatment of any client under the care of the license holder or registration holder for at least 5 years after termination of treatment and as provided by applicable provisions of Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland;
(5) Make the written records available to the client upon request, in compliance with applicable laws for disclosure of medical records;
(6) Make arrangements for another professional to provide for the needs of the clients during anticipated absences when not available to clients;
(7) Make referrals only to other qualified and duly licensed or certified health care providers or practitioners, or both;
(8) Accurately inform clients, other health care professionals, and the public of the limitations of massage therapy and non-therapeutic massage;
(9) Adequately assess the client to determine if contraindications against massage therapy or non-therapeutic massage exist and refer the client to an appropriate health care practitioner; and
(10) Exercise independent professional judgment in the treatment or evaluation, or both, of clients, regardless of whether the client was referred by another health care provider.
B. A license holder or registration holder may not:
(1) Accept a client for treatment, or continue unnecessary treatment, when the client cannot be reasonably expected to benefit from the treatment;
(2) Receive remuneration from, or provide remuneration to, or split a fee with another health care provider or individual, or both, for either making or accepting a referral of the client to the health care provider or individual, or both;

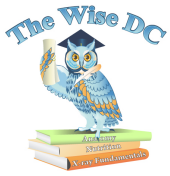


(3) Make a guarantee or promise about the efficacy of a particular treatment, the license holder's or registration holder's practice, or the results of a treatment unless supported by scientific principles accepted by the profession as determined by the governing board; or
(4) Exploit the professional relationship by:
(a) Continuing treatment unnecessarily; or
(b) Charging for a service:
(i) Not provided; or
(ii) Different from those actually provided.
.05 Professional Boundaries.
A. A license holder or registration holder shall:
(1) Maintain professional boundaries, even when the client initiates crossing the professional boundaries of the professional relationship; and
(2) Respect and maintain professional boundaries and respect the client's reasonable expectation of professional conduct.
B. A license holder or registration holder may not:
(1) Exploit a relationship with a client for the license holder's or registration holder's personal advantage, including, but not limited to, a personal, sexual, romantic, or financial relationship;
(2) Engage in a sexually intimate act with a client; or
(3) Engage in sexual misconduct that includes, but is not limited to:
(a) Therapeutic deception;
(b) Non bona fide treatment; or
(c) A sexually exploitative relationship.
.06 Records, Confidentiality, and Informed Consent.
A license holder or registration holder shall:
A. Respect and maintain the privacy and confidentiality of the client;
B. Disclose the client's record or information about the client only with the client's consent or as required by law;
C. Adequately safeguard confidential client information, including storage and disposal of records;
D. Provide sufficient information to a client to allow the client to make an informed decision regarding treatment, including:
(1) The purpose or nature of an evaluation or treatment regimen;
(2) Alternatives to treatment;
(3) Side effects and benefits of a proposed treatment regimen and the alternatives to that treatment;
(4) The estimated cost of treatment and alternatives to treatment;
(5) The right of the client to withdraw from treatment at any time, including the risks associated with withdrawing from treatment; and
(6) The client's right to decline to participate in treatment if an aspect of the treatment will be recorded, documented, photographed, observed, or otherwise used in an educational program;
E. Obtain the full informed consent of a client participating in a human research program, without a direct or implied penalty for the client's refusal to participate in the program, and with due regard for the client's autonomy and dignity;
F. Comply with applicable federal and State laws for human research programs; and
G. Comply with applicable provisions of Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland.
.07 Education and Training.
A. A license holder or registration holder shall:
(1) Recognize the license holder’s or registration holder’s limitations and qualifications and practice massage therapy within the limits of these limitations and qualifications;

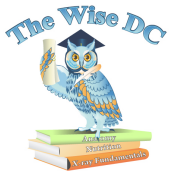
(2) Obtain additional training, information, and supervision as needed to perform a new technique or service in a new specialty area or when employing a new treatment modality; and
(3) Maintain a current license or registration to practice massage therapy or non-therapeutic massage.
B. The license holder or registration holder may not perform a treatment or provide a service which:
(1) The license holder or registration holder is not qualified to perform; or
(2) Is beyond the scope of the license holder's or registration holder's education, training, capabilities, experience, and scope of practice.
.08 Ethical, Legal, and Professional Responsibilities of Massage Therapist and Practitioners.
A license holder or registration holder may not construe a failure to specify a particular ethical, legal, or professional duty in this chapter as a denial of the existence of other ethical, legal, or professional duties or responsibilities that are equally as important and as generally recognized in the profession.
.09 Penalties.
If a license holder or registration holder violates a regulation in this chapter, the Board may take action pursuant to Health Occupations Article, §3-5A-09, Annotated Code of Maryland. The Board may also impose a penalty not exceeding $5,000.

10.43.19 Massage Therapy – Advertising

Authority: Health Occupations Article, §§3-5A-01, 3-5A-02, 3-5A-07, and 3-5A-09; Annotated Code of Maryland
.01 Scope.
This chapter governs advertising by individuals licensed as massage therapists or registered as massage practitioners by the Board of Chiropractic and Massage Therapy Examiners in Maryland.
.02 Definitions.
A. In this chapter, the following terms have the meanings indicated.
B. Terms Defined.
(1) "Advertising" means calling to the attention of the public the services one has to offer.
(2) "Board" means the Board of Chiropractic and Massage Therapy Examiners.
(3) "License holder" means an individual who is licensed by the Board to practice massage therapy.
(4) "Registration holder" means an individual who is registered by the Board to practice non-therapeutic massage.
.03 Advertising.
A. A license holder or registration holder may advertise massage services subject to the provisions of this chapter.
B. The license holder or registration holder shall state in the advertisement that the:
(1) License holder is a "State of Maryland licensed massage therapist"; or
(2) Registration holder is a "State of Maryland registered massage practitioner".
C. An advertisement shall state at a minimum the:
(1) Authorized trade name;
(2) Practitioner's name;
(3) Practitioner's status as a licensee or registrant; and
(4) Practice address and telephone number.
D. Trade Name.
(1) An advertisement may only use the trade name authorized by the Board.
(2) Trade names used in advertising:
(a) Shall be pre-approved by the Board in writing;
(b) Shall be used on all advertising including:
(i) Signs;

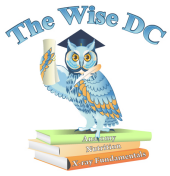


(ii) Billing statements;
(iii) Business cards;
(iv) Stationary;
(v) Receipts; and
(vi) Correspondence; and
(c) May not be used in any false or misleading advertisements.
(3) Only one trade name may be issued to a license or registration holder per geographic practice location.
(4) A trade name shall be distinct in order to clearly identify the practitioner.
E. An advertisement may not include statements that:
(1) Contain misrepresentations of facts;
(2) Are likely to mislead or deceive due to making only a partial disclosure of relevant facts when the statements are placed in context;
(3) Intend to or are likely to create false or unjustified expectations of favorable results;
(4) Refer to fees without reasonable disclosure of all relevant variables, conditions, and exceptions so that the statement may be misunderstood or deceptive to laypersons;
(5) Convey the impression that the license holder or registration holder may improperly influence any public body, official, corporation, or person on behalf of the public;
(6) Make representations or implications that in reasonable probability may cause an ordinarily prudent individual to misunderstand or be deceived by the representations or implications;
(7) Misrepresent any professional qualifications, education, experience, or affiliation; or
(8) Make representations or implications that the license holder or registration holder is willing to provide services that are illegal under the laws or regulations of Maryland or the United States.
F. An individual who is a registered massage practitioner or a business entity that employs or contracts with registered massage practitioners may not advertise that the individual or business entity provides health-related therapeutic massage services.
G. An individual may not advertise that the individual practices massage therapy or non-therapeutic massage in Maryland if:
(1) The individual is otherwise qualified to practice massage therapy in any other state or country that has substantially similar requirements for authorization to practice massage therapy and the individual is in this State for not more than 7 days;
(2) The individual's application for a license or registration is pending before the Board, and the individual has not taken the examination required by the Board; or
(3) The individual has taken an examination required by the Board, but the results of the examination are not yet known.
H. An individual whose license or registration has been suspended or revoked by the Board may not advertise or initiate any advertising during the period of suspension or revocation.
.04 Solicitation.
A license holder or registration holder may not engage in solicitation, including, but not limited to, in-person, telephone, electronic, or direct mail solicitation, that:
A. Amounts to fraud, undue influence, intimidation, or over reaching; or
B. Contains statements which would be improper under Regulation .03C of this chapter.
.05 Accountability.
A license holder or registration holder shall be accountable under this chapter if the license holder or registration holder uses an agent, partnership, professional association, health maintenance organization, or any other entity or means to implement actions prohibited by this chapter.
.06 Penalties for Violation.
A violation of this chapter may result in disciplinary action against the license holder or the registration holder under Health Occupations Article, Title 3, Annotated Code of Maryland.

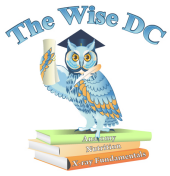


10.43.20 Massage Therapy – Continuing Education Requirements

Authority: Health Occupations Article, §§3-205 and 3-5A-02, Annotated Code of Maryland
.01 Required Continuing Education Hours.
A. By October of each renewal year, beginning in October, 2004, certificate and registration holders shall satisfactorily complete a minimum of 24 hours within the previous 24 months as follows:
(1) 3 hours in professional ethics or jurisprudence;
(2) 3 hours in communicable disease education which includes AIDS/HIV; and
(3) 18 hours in massage-related courses as approved by the Board.
B. In addition to the requirements of §A of this regulation, at the time of renewal, a certificate or a registration holder shall possess a certification of qualification in cardiopulminary resuscitation (CPR).
.02 Approval of Continuing Education Programs.
A. The Board shall approve credit for the following:
(1) Courses approved by the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB);
(2) Courses offered by Maryland schools accredited by the Maryland Higher Education Commission (MHEC); or
(3) Courses determined by the Board to meet professional standards and educational needs for certified massage therapists and registered massage practitioners.
B. The Board shall approve as having met all requirements, certificate and registration holders who have a current, valid NCBTMB certification, provided the cited hours in the specified curriculum in Regulation .01 of this chapter are met.
C. The Board may approve for renewal credit a program or course consisting of one or more of the following subjects in live, audio, or electronic mode:
(1) Risk management;
(2) Professions ethics and jurisprudence;
(3) Client and patient relationships and professional boundaries;
(4) Massage therapy theory, technique, or practice;
(5) Massage therapy contraindications;
(6) First aid and cardiopulminary resuscitation; or
(7) Any other course or program determined by the Board to meet the professional and educational requirements of the certificate and registration holders.
.03 Exemptions.
A. Individuals issued initial certification or registration within 12 months of the renewal date are exempt from the continuing education requirements in Regulation .01 of this chapter for the first renewal cycle.
B. Certificate or registration holders with documented hardships, and seeking an exemption, waiver, or extension from the continuing education requirements in Regulation .01 of this chapter, shall petition the Board in writing at least 90 days before the renewal date.
C. The Board shall review the petition for an exemption, waiver, or extension and respond in writing to the certificate or registration holder.
.04 Board Procedures.
A. A program or institution seeking Board approval shall submit the following in writing at least 90 days before the starting date of the program or course:
(1) Title, location, and date of program or course;
(2) If electronically administered, website, database, or system used;
(3) Credit hours requested;
(4) Names and professional and educational qualifications of instructors;



(5) Name of attendance certifying officer and method of certification;
(6) Required texts or course books used;
(7) Program or course syllabus; and
(8) List of any sponsor of the program or course.
B. The Board shall notify the requestor in writing of the Board's decision to approve or disapprove a program or course.
C. The Board shall conduct a biennial audit of continuing education, and shall notify audited certificate and registration holders by mail that the audited certificate and registration holders shall produce satisfactory evidence of completion of the continuing education requirements.
D. Certificate and registration holders shall maintain accurate records, including continuing education course certifications, and if audited, shall present this documentation upon request to the Board.[xxvii]



Part IV - Cultural Competency

Introduction

In 1999, the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health (OMH) first proposed national standards for culturally and linguistically appropriate services (CLAS) as a means to correct inequities that exist in the provision of health care (Federal Register 64(240), 70042–70044). The standards were developed on the basis of an analytical review of key laws, regulations, contracts, and standards used by federal and state agencies and other national organizations, with input from a national advisory committee of policymakers, health care providers, and researchers. Open public hearings also were held to obtain input from communities throughout the nation. The standards represent the first national standards for cultural competence in health care. The 14 standards are comprised of guidelines (standards 1–3, and 8–14) and mandates (standards 4–7) for all recipients of federal funds. They follow three general themes: Culturally Competent Care (standards 1–3), Language Access Services (standards 4–7), and Organizational Supports (standards 8–14) (Box 1). The final CLAS standards were issued in the Federal Register on December 22, 2000, (Federal Register 65(247), 80865–80879), and the final report, "National Standards for Culturally and Linguistically Appropriate Services in Health Care," was published in March 2001 (See Box 1).

A second phase of the CLAS initiative, "Developing a Research Agenda for Cultural Competence in Health Care," is currently being prepared for dissemination. The main goal of the Cultural Competence Research Agenda Project is to produce and disseminate a working research agenda on the relationship between CLAS interventions and health outcomes. The research agenda was developed after conducting a literature review on cultural competence interventions, convening a Research Advisory Committee, and soliciting public comments (Fortier & Bishop, forthcoming).

These national initiatives reflect a recognition that culture and language are central to the delivery of health services. It is essential for physicians to be sensitive to cultural and linguistic factors while providing health care to people from diverse backgrounds, particularly minority groups. One of the requirements for implementing culturally competent health care is teaching physicians how to practice it. There have been many efforts across the country to develop formal and informal curricula for teaching cultural competence in service delivery settings. These efforts have been largely isolated, with each institution or organization developing its own discrete curricula independently. Up to this point, no standardized curriculum for cultural competence has been developed. The development of the CLAS standards by the Office of Minority Health was the first attempt to unify efforts in defining and implementing culturally and linguistically appropriate services. The OMH has now contracted the

Box 1: National Standards for Culturally and Linguistically Appropriate Services (CLAS)

1.Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health belief and practices and preferred language.

2.Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3.Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4.Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5.Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6.Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).

7.Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8.Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9.Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

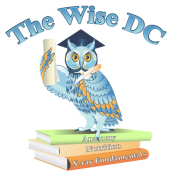
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/ consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Source: Federal Register 65(247), 80865–80879.



American Institutes for Research (AIR) to carry out the first national effort to design and assess Cultural Competence Curriculum Modules to teach cultural competence to family physicians.

DEFINITION OF "CULTURAL COMPETENCE"

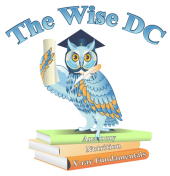
Early work that shaped today's understanding of cultural competence in health care was largely in the field of medical anthropology (Harwood, 1981; Kleinman, 1980; Kleinman et al., 1978; Pfifferling, 1980). These anthropologists have applied the observational methods of anthropology to medicine, examining the dynamics of the physician-patient relationship within the context of medical culture and exploring the interactions between culture, health beliefs and health behavior. They have described the traditional culture of Western medicine as being disease-oriented, focusing on biological concepts and processes, and largely discounting the importance of cultural and psychosocial factors to health (Harwood, 1981; Pfifferling, 1980).

The concept of "cultural competence" has been applied to many fields of service delivery. For the purposes of this report, we adopt the definition of cultural and linguistic competence used in the CLAS standards, which was adapted from a definition developed in the mental health field (Federal Register 65(247)):

> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Based on Cross, Bazron, Dennis, & Issacs, 1989)

It is important to point out that in our definition of cultural competence, the social groups influencing a person's culture and self-identity include not only race, ethnicity, and religion but also gender, sexual orientation, age, disability, and socio-economic status. The culture of linguistic groups is also an important domain of culture to include. Linguistic minorities include not only people with limited English proficiency (LEP), but also people with low literacy skills and the hearing impaired. Although this report primarily focuses on issues of cultural competence that pertain specifically to ethnicity and race, it is our intention that the issues concerning culturally competent care addressed in this environmental scan and in the Cultural Competence Curriculum Modules that are subsequently developed will encompass a broad definition of culture and include these less often mentioned social groups.

Cultural competence can be viewed in relation to general competence in professional medical practice as an integrated aspect of overall competence. A recent article generated a definition of professional competence intended to be inclusive of all important domains of competence. According to



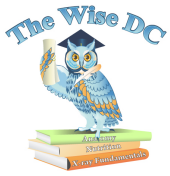
the definition, competence is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” (Epstein & Hundert, 2002, p. 226). This definition of encompasses certain aspects of overall professional competence that were found to be underemphasized by Western medical culture, including interpersonal skills, lifelong learning, and integration of core knowledge into clinical practice (Epstein & Hundert, 2002). Many of these aspects are also central aspects of cultural competence. The implication is that cultural competence is part of a central set of professional competencies, rather than an isolated aspect of medical care with limited relevancy.

In addition to defining cultural competence as essential to professional competence in general, cultural competence can be defined in terms of the power dynamics in medicine as well as society at large. The need for cultural competence arises from the inherent power differential in the physician-patient relationship (Tervalon & Murray-Garcia, 1998). Ethnicity and social status are inextricably linked (Harwood, 1981), and social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large. Therefore, the goal of cultural competence training in health care should be to guide physicians in bringing these power imbalances into check. This process, consisting of ongoing self-reflection and self-critique, requires humility. In fact, the concept of “cultural competence” may be better described as “cultural humility” (Tervalon & Murray-Garcia, 1998).

It is important to make one other distinction regarding the definition of cultural competence. According to a comprehensive report, “Cultural competence is usually broken down conceptually into linguistic competence and cultural competence, even though true cultural competence recognizes language and culture as inseparable” (Fortier, 1999, para.1). However, in certain instances it is useful to conceive of them as separate competencies. In this scan, we consider linguistic competence as an integral aspect of cultural competence, but for practical reasons and better understanding, we discuss linguistic competence separately when appropriate.

PURPOSE

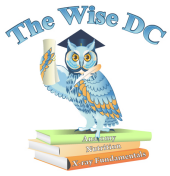
The purpose of this report is to synthesize the information from our environmental scan on the concepts, policies, and teaching practices regarding culturally competent health care and to inform the National Project Advisory Committee (NPAC) on this subject. The committee will convene to advise on the development of Cultural Competence Curriculum Modules (CCCMs) to teach culturally and linguistically appropriate health services to family physicians. The CLAS standards developed by OMH and summarized in Box 1 will serve as the starting point for this initiative. The 14 standards are directed primarily at health care organizations and represent a comprehensive set of recommendations and



mandates for implementing culturally and linguistically appropriate services at all levels of the organization. Individual providers are encouraged to use the standards to make their practices more culturally and linguistically accessible (Federal Register 65(247), 80865–80879). We first provide a context and rationale for cultural competence by discussing relevant health policy and research issues that support the need for culturally competent health care and training. After discussing the issues from this perspective, we discuss concepts of cultural competence and training practices as they pertain to the three major CLAS themes. Since the family physician is the subject of this project, we use the CLAS standards as the framework, but examine them as they apply specifically to the education of physicians on this subject. For our purposes, we discuss the three main themes of the CLAS standards as follows:

1) **Culturally Competent Care** refers mainly to the family physician-patient relationship and the delivery of culturally competent care by individual physicians.
2) **Language Access Services** focus on the family physician's role in ensuring appropriate language access services to every patient.
3) **Organizational Supports** focus on the family physician's functioning as part of a health care team within an organization. Although family physicians work in a variety of settings, the family physician is a central figure influencing the cultural competence of the staff and the organization as a whole. Given this role, knowledge of the issues concerning the implementation of culturally competent services at the organizational level increases the physician's capacity to enhance institutional change.

Even though we will discuss them separately, it is important to note that these three themes are interdependent. Naturally, culturally competent care is not authentic if it does not include language access services for people with limited English proficiency and if it is not supported by the organization at large. Similarly, language access services will not be effective if they are not delivered in a culturally appropriate manner, and culturally competent care will not be provided on an ongoing basis if organizational supports are not in place. The three themes are ultimately parts of the interrelated and overall construct of cultural competence.



CONTEXT AND RATIONALE FOR CULTURAL COMPETENCE CURRICULA IN HEALTH CARE

There are many reasons why it is important for family physicians to learn to practice culturally competent care. In this section, our purpose is to provide a context that illustrates the critical need for cultural competence curricula from the perspective of health-related research and the laws and policies that govern the delivery of health care services to an increasingly diverse U.S. population. This section is divided into two subsections; the first describes the importance of cultural competence in three major health research contexts, and the second offers an overview of the laws and policies that shape culturally competent practice and provides some examples of the ways they are implemented.

THE IMPORTANCE OF CULTURAL COMPETENCE IN THREE RESEARCH CONTEXTS

Research and writing on cultural competence are relatively new in the literature. In this section we relate the need for cultural competence to the context of three major areas of health services research and policy: health disparities, access to health care, and quality of care (specifically the aspects of patient safety and patient centeredness).

RACIAL AND ETHNIC HEALTH DISPARITIES

The long-standing problem of racial and ethnic health disparities is well documented and well known in health and policy arenas (DHHS, 2001; Geiger, 2001; Lillie-Blanton, Martinez, & Salganicoff, 2001; NIH, n.d.; Rutledge, 2001; Stapleton, 2001). Despite improvement in overall health for the majority of Americans, the burden of health disparities continues to disproportionately affect minority populations. Recent studies reveal that good health is connected with an individual's socio-economic status, environmental factors, ethnicity, and gender. In response to staggering disparities, a number of major initiatives to improve the health of minority populations have been implemented (DHHS, 2001). Healthy People 2010 establishes a public health agenda with the elimination of health disparities as one of its two overarching goals. Its other major goal is to improve health. The focus for disparity reduction is on six key areas shown to affect racial and ethnic groups differently at all life stages: infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and child and adult immunizations (DHHS, 2001).

For example, according to the National Institutes for Health (NIH), infant mortality rates among Blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for Blacks, whose infant death

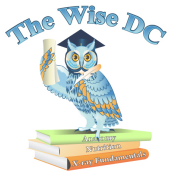
rate (14.2 per 1,000 in 1996) is nearly two and a half times that of White infants (6.0 per 1,000 in 1996). The overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group, which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995. Paralleling the death rate, the incidence rate for lung cancer in Black men is about 50 percent higher than in White men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with White men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do Whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than White women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer (NIH, n.d.). An increasingly large, consistent body of research indicates that racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services (Geiger, 2001; Lillie-Blanton et al., 2001; Rutledge, 2001).

The complexity of issues surrounding health disparities makes it hard to research causal factors. Causes have been attributed to a variety of factors including socio-economic status, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the scarcity of effective prevention programs tailored to the needs of specific communities (Satcher, 2001); shortages of health professionals in urban areas where minority populations are high (American Medical Student Association, 2001); patients' mistrust of the health care system (Coleman-Miller, 2000); perceived discrimination (Krieger, 1999); poor communication between physician and patient (Vermeire et al., 2001; Woloshin et al., 1995); and lack of cultural sensitivity and cultural competence on the part of physicians and other health care workers (Rutledge et al., 2001; Geiger, 2001; Canto, Allison, & Kiefe, 2000).

Even though a direct link between racial and ethnic health disparities and the lack of culturally competent care has not been empirically demonstrated, the provision of culturally competent services can potentially improve health by increasing the understanding between physicians and patients and potentially increasing the adherence to treatment (Vermeire et al., 2001). Culturally competent services have the potential to increase the quality of health care so that it is delivered in the context of each patient's cultural beliefs and practices and those of his or her family and community.

ACCESS TO HEALTH CARE: CULTURAL BARRIERS TO ACCESS

Barriers in access to health care are economic, geographic, social, and cultural (Office on Women's Health, 2000). These types of barriers encompass a wide variety of specific impeding factors; however, much of the literature on access to health care focuses on access to health insurance. Data on health insurance coverage indicates that every major minority group has significantly less access to health care insurance than Whites do (Brown, Ojeda, Wyn, & Levan, 2000). A major reason for these disparities in access is that minorities have higher rates of poverty, but racial and ethnic disparities in insurance



coverage persist among people of the same income level. Even for people with similar health insurance coverage, disparities include differences in the source of primary care (Lillie-Blanton et al., 2001; Commonwealth Fund, n.d.) and patient-reported experiences with health providers (Commonwealth Fund, n.d.). These examples accentuate the fact that social, cultural, and language barriers to access outside of insurance coverage are numerous.

Barriers in access to health care also include cultural and linguistic differences. Cultural and linguistic differences can be present within groups of the same race and ethnicity and thus are significant because both language and culture affect health in many ways. These intraethnic variations include the individual's level of acculturation, which depends on citizenship and refugee status, the circumstances of immigration; and the length of time the family has lived in the United States. These differences affect individual health practices and the ability to navigate the American health system. Fear may be a powerful barrier for groups who are illegal immigrants. History can have a tremendous influence on creating barriers of mistrust toward physicians and hospitals for minority groups who have historically experienced racism, as the legacy of the Tuskegee University experiment demonstrates. The study, funded by the U.S. government, observed Black men with syphilis in order to study long-term complications of the disease while allowing the study participants to believe that they were being treated. Intergenerational transmission of health care experiences and attitudes based on stories of such extreme discrimination are very powerful influences (Coleman-Miller, 2000).

Even when language barriers are reduced through interpretation services, other cultural barriers can hinder effective communication and produce negative effects. Patients are less likely to comply with treatment if they do not understand it (Coleman-Miller, 2000; Woloshin et al., 1995) or have conflicting health beliefs (Coleman-Miller, 2000; Vermeire et al., 2001). Strategies to increase access to health insurance are important and necessary to decrease disparities in access owing to economic reasons, but the means to decreasing cultural and language barriers lies in the provision of culturally and linguistically appropriate services to increase understanding and improve quality of care.

QUALITY OF CARE RESEARCH: PATIENT SAFETY, PATIENT CENTEREDNESS, AND CULTURAL COMPETENCE

In today's changing health care environment, physicians and health care organizations are under increasing pressure to ensure quality of care for their patients. It is important for all practitioners and organizations to understand that providing culturally competent services is essential to quality care. Recently, the Institute of Medicine (IOM) convened a national committee of experts to develop a framework for a National Health Care Quality Report on the quality of health care in the United States (IOM, 2001). According to the framework, health care quality consists of four components: safety,

effectiveness, patient centeredness, and timeliness. Two of these components, safety and patient centeredness, can be used to illustrate the necessity of cultural competence to quality care.

The IOM report refers to patient safety as "avoiding injuries to patients from care that is intended to help them" (IOM, 2001, p. 44). Lack of culturally competent care can result in a patient's misunderstanding of the treatment plan and harm to the patient. For example, a patient may not take a medication correctly due to a miscommunication, compromising the patient's safety. So, the physician must be able to communicate treatment plans effectively to patients with limited English proficiency or of diverse cultural backgrounds through culturally and linguistically appropriate services.

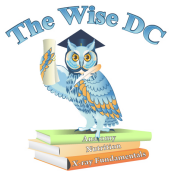
The relationship between the clinician and the patient is central to patient-centered care. Patient-centered care is based on a partnership of practitioners, patients, and their families and takes into account the patient's needs and preferences (IOM, 2001, p. 50). Patient centeredness is "furthered when patients receive information in their own language, when the clinicians have greater awareness of potential communication difficulties, and most importantly, when care is provided taking into account the context of the patient's cultural beliefs and practices" (Hurtado et al., 2001, p. 52). A competent physician must be aware of the role of cultural health beliefs and practices in a person's health seeking behavior and be able to negotiate treatment options appropriately and in a culturally sensitive way. As the population becomes increasingly diverse, culturally competent health care practitioners, bilingual practitioners, and language access services are becoming a requirement for high quality care (Chin, 2000).

POLICIES AND LAWS PROMOTING CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

This subsection provides an overview of the laws and policies that influence culturally and linguistically appropriate services. We briefly discuss Title VI of the Civil Rights Act of 1964; Medicare and Medicaid policies; accreditation standards for health care organizations and medical schools; and policies, activities and resources of professional organizations and consumer advocate and minority interest groups

FEDERAL AND STATE LAWS

Title VI of the Civil Rights Act of 1964 states that "no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination" under any federally supported program (Civil Rights Act of 1964). The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) extends this protection to language, viewing inadequate interpretation as a form of discrimination. DHHS-funded health programs are required to provide patients with limited English proficiency access to services equal



to that of English speakers. Programs that do not comply risk losing all federal funds. However, the regulation is vague and is difficult to comply with and enforce. On August 30, 2000, OCR issued a Policy Guidance to provide clarity and guidance to physicians and other recipients of federal funds on the regulation as it applies to LEP patients. According to the Policy Guidance (Federal Register 65(169), p. 52772):

> The key to providing meaningful access for LEP persons is to ensure that the relevant circumstances of the LEP person's situation can be effectively communicated to the service provider and the LEP person is able to understand the services and benefits available and is able to receive [them] in a timely manner.

In the section on Language Access Services, we discuss this issue further.

The Minority Health and Health Disparities Research and Education Act became effective on October 1, 2000, establishing the National Center on Minority Health and Health Disparities to facilitate the work of the National Institutes of Health (NIH) to address and reduce health disparities.

In recognizing the importance of language access services, many states have also enacted laws that require providers to offer language assistance to LEP persons in many health care and other service settings. In fact, at least 26 states and the District of Columbia have enacted legislation requiring some form of language assistance (OCR, 2000). A few state laws, such as those passed in California, Massachusetts, and New York, give specific guidance to health care providers regarding what they must do to meet the regulation. Other states' legislation, such as that in Illinois, note the importance of translation services, but do not specify what services must be offered. Many states have tied language access laws to specific categories of health services, with some of the most stringent requirements being those for mental health and long-term-care services (Perkins et al., 1998).

At least 18 states have enacted laws that make English the official state language. Although many of these laws are purely symbolic, and even the strictest of these laws include exceptions for law enforcement and public health activities, state agencies may interpret public health exceptions broadly or narrowly (Perkins et al., 1998). Because of state English-only laws, agencies that receive federal funding may not realize that they are required to provide language access services to non-English speakers.

MEDICARE AND MEDICAID POLICIES

Medicare is the federal health insurance program that covers people over age 65, people with permanent kidney failure, and certain other disabled people of any age. Although Medicare policies consider bilingual services reimbursable costs for hospital overhead rates, no explicit billing for interpreter services is allowed. The provision to pay for any outpatient interpreter services virtually does not exist (Woloshin et al., 1995).

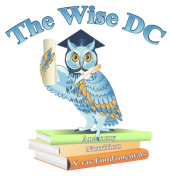
Medicaid is a cooperative federal and state medical assistance program, and policies vary among the states. Medicaid provides services to indigent aged, blind, and disabled people; poor families with children; and poor children and adolescents (Perkins et al., 1998). Typically, hospitals are reimbursed for patient care according to the diagnosis and are not reimbursed specifically for interpreter services. In fact, most states do not have legislation that deals explicitly with interpreter services, and states that do typically have problems of vagueness and a lack of funding (Woloshin et al., 1995).

In recognizing the need to improve the provision of health care services to minorities, a growing number of states have begun requiring that health plans meet the linguistic needs of non-English-speaking enrollees under their Medicaid managed care contracting provisions. Under these provisions, nearly three-quarters of all states require plans and providers to make written materials available in other languages; close to half require language interpreter services for clinical and administrative encounters; and nearly two-thirds of all Medicaid managed care contracts have some cultural competence requirements that are non-language specific (Coye & Alvarez, 1999).

States' approaches to ensuring culturally competent services to Medicaid beneficiaries vary widely, primarily as a result of differences among states' demographics and health care delivery systems. In California, all Medicaid (Medi-Cal) recipients are enrolled in managed care plans. All of these plans provide cultural competence training for member services personnel. The state and most health plans offer education to providers on the appropriate use of linguistic services (Coye & Alvarez, 1999). Several programs are also interested in providing more detailed educational programs for other staff and contracted health care providers.

Both California and Oregon have a concentration criterion as part of their Medicaid contracting requirements for providing linguistic services to certain language groups. In California, linguistic services must be provided in areas that either meet a threshold standard of 3,000 beneficiaries per language group or meet concentration standards. Concentration standards are defined as 1,000 beneficiaries of a specific language group in a single zip code or 1,500 in two contiguous zip codes. In Oregon, the criterion is defined at the provider level. A physician who is selected by at least 35 members of a single ethnic group must provide linguistic services. Few contractual requirements exist. Translation and interpreter costs are included as administrative costs in capitation rates (Coye & Alvarez, 1999).

In an increasingly complex political environment, physicians should be aware of the complicated issues and problems surrounding Medicare and Medicaid policies. They should be aware of the potential benefits of policies that support culturally competent care that certain states have implemented.



ACCREDITATION STANDARDS FOR HEALTH CARE ORGANIZATIONS AND MEDICAL SCHOOLS

In addition to federal and state laws, accrediting organizations influence standards regarding cultural competence for health care organizations and medical schools. New standards have been implemented by the Liaison Committee on Medical Education (LCME), which mandated higher standards for curricular material in cultural competence for medical schools than were in place before (LCME, 2001a).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits hospitals and other health care institutions such as behavioral health care facilities and home care agencies (JCAHO, n.d.). JCAHO standards require hospitals to employ policies that provide the means for effective communication for each client served. For example, on admission, patients must be informed of their rights in a manner that they can understand (Perkins et al., 1998).

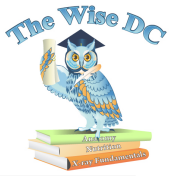
The National Committee for Quality Assurance (NCQA) accredits managed care organizations in primary health and behavioral health (NCQA, 2001). NCQA's accreditation standards call for managed care organizations to be able to provide materials in languages of major non-English speaking populations that make up at least 10 percent of the membership.

The Accreditation Council for Graduate Medical Education's (ACGME) requirements for family practice ensure that residency programs teach residents to assess and understand the specific health needs of the community in which they work (ACGME, 1997). Clearly, in today's increasingly diverse communities, training programs must prepare physicians to care for people of diverse cultures.

The Liaison Committee on Medical Education's (LCME) new accreditation standards for 2001 include a specific requirement for cultural competence. The accreditation handbook states (LCME, 2001a, p. 19):

> The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.

This new requirement is evidence that the importance of patient-centered care, the influence of both culture and gender on health care needs, and the need to teach concepts of culturally competent care are becoming increasingly recognized. We discuss examples of curricula that address this requirement in the section on Curricula and Training.



PROFESSIONAL ORGANIZATIONS

Many professional organizations in different areas of health have instituted policies that promote culturally competent practices. The Society for Teachers of Family Medicine (Like, Steiner, & Rubel, 1996), the American Psychological Association (1990), the American Medical Association (1999), the National Association of Social Workers (2001), the American Academy of Pediatrics (Committee on Pediatric Workforce, 1999), the American Medical Women's Association, the Association of American Medical Colleges, the National Medical Association, the American Academy of Family Physicians, and the National Alliance for Hispanic Health are a few examples of organizations that have policies, research and initiatives or that provide training in cultural competence (American Medial Association, 1999; Horowitz, Davis, Palermo, & Vladeck, 2000). The American Medical Association's *Cultural Competence Compendium* (1999) provides comprehensive information on policies, publications, educational programs, and relevant activities of physician associations, medical specialty groups, and state medical societies.

Several organizations have instituted guidelines or standards in cultural competence for their memberships. For example, the American Academy of Family Physicians (AAFP) issued cultural proficiency guidelines for preparing information or continuing medical education programs (AAFP, 2001). A policy statement issued by the American Academy of Pediatrics on culturally effective pediatric care, education, and training issues defines "culturally effective health care" and other terms related to cultural competence and describes the importance of training in cultural competence in medical school, residency, and continuing medical education (Committee on Pediatric Workforce, 1999). Other professional organizations have issued guidelines on providing culturally competent services for their membership. The APA's "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" provides general principles that give suggestions for psychologists working with diverse populations (APA, 1990). A publication of the National Association of Social Workers, "Standards for Cultural Competence in Social Work Practice," presents and interprets 10 standards that address the need for definition, support, and encouragement of a social work practice that prompts cultural competence among all social workers (NASW, 2001).

The Association of American Medical Colleges (AAMC) surveyed medical schools for information on established programs in cultural competence and identified needs (AAMC, 1998), and the organization's Task Force on Cultural Competence was instrumental in developing and supporting the new standard on cultural diversity that was recently implemented by the Liaison Committee on Medical Evaluation (AMA, 1999; LCME, 2001a). Other professional organizations also support projects and initiatives that promote cultural competence. The American Public Health Association's "Alternative and

Complementary Health Practices" special primary interest group sponsors sessions at the annual meeting that focus on topics such as using cross-cultural communication and synthesizing alternative and complementary health practices into Western medical practice (AMA, 1999). The National Hispanic Medical Association has a Cultural Competence Project that includes a medical education curriculum survey, a speakers' list, and policy reports and programs for medical schools (AMA, 1999).

Some professional organizations have developed their own curricular materials, such as the Society for Teachers of Family Medicine and the National Alliance for Hispanic Health. In 1996, the Society for Teachers of Family Medicine published curricular guidelines, developed over a decade, that are designed to introduce cultural competence into residency training and graduate medical education (Like et al., 1996). The National Alliance for Hispanic Health has developed resources for delivering culturally competent services to Latinos, such as "A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics" (National Alliance for Hispanic Health, 2000). The Administration on Aging has also produced an introductory guidebook that addresses culturally competent care for elderly minority population (DHHS Administration on Aging, 2001).

Professional organizations have developed and continue to develop policies, guidelines, and resources that encourage their memberships to learn and continue learning to provide effective culturally competent health care. They are important vehicles for promoting and training their members to be culturally competent health care providers.

SECTION IV: THREE THEMES OF THE CLAS STANDARDS

he contexts of health care research and policies and laws guiding health care practices, the rationale for a physician to enhance his or her cultural competence through training is evident. In the next three sections we discuss the three major themes of culturally and linguistically appropriate services (CLAS) as they apply to family physicians. For each of the three main themes of the CLAS standards—culturally competent care, language access services, and organizational supports—we present the main concepts drawn from the information we gathered and synthesized, and we include examples. More detailed examples of the materials we collected are included in appendices where indicated.

CULTURALLY COMPETENT CARE

The theme of culturally competent care is addressed by the first three CLAS standards (see Box 1), and for the purpose of this report refers to the culturally competent services delivered by individual physicians. Many of the materials reviewed for this section provide conceptual frameworks and key aspects of culturally competent care that can be used in developing curricula for training physicians and

other health care practitioners. The main themes of culturally competent care are discussed in this section. A review of curricular matters focusing on relevant aspects of pedagogy is provided in the last section of this paper.

The resources gathered for this section represent the majority of the information we collected and were found mainly in journals and web sites. Summaries of some of these cultural competence frameworks or approaches are given in Appendix B. After reviewing the materials we gathered on culturally competent care, we saw five themes emerge: a patient-centered focus; effective physician-patient communication; balance fact-centered and attitude/skill-centered approaches to acquiring cultural competence; the acquisition of cultural competence as a developmental process; and understanding alternative sources of care.

PATIENT-CENTERED FOCUS

In the information we reviewed, most conceptual frameworks of cultural competence emphasized the patient (and family when appropriate) as the focus of attention, rather than the person's cultural group characteristics or the disease (Carrillo et al., 1999; Leininger, 1978; Shapiro & Lenahan, 1996). This idea marks a departure from the traditional medical model that focuses on treating a disease rather than the whole patient. These frameworks tend to take a holistic approach, emphasizing the cultural and social influences on a person's health and health beliefs. This scenario empowers the patient as the "expert" of his or her unique illness experience (Tervalon & Murray-Garcia, 1998). An important concept to patient centeredness is the distinction between disease and illness.

The difference between "disease" and "illness" is an important distinction. Disease refers to the malfunctioning of physiological and psychological processes, whereas illness refers to the psychosocial meaning and experience of the perceived disease for the individual, the family, and those associated with the individual (Kleinman, Eisenberg, & Good, 1978). Individuals seek health care because of their experience of illness, so it is important for physicians to recognize that a patient's experience with illness may vary from their professional interpretation of the disease and may be influenced by cultural and social factors (Blue, 2000). In response to a particular illness episode, an individual forms an explanatory model that encompasses his or her own beliefs about the course of the sickness, such as its origin, severity, treatment, and expected recovery (Kleinman, 1980). The goal of medical interviewing techniques is to "elicit" the patient's explanatory model of his or her sickness. This focus on the patient's perspective marks a shift from a disease perspective to a more holistic perspective that sees the patient as a whole person and not just as an organ system or a disease. A culturally competent physician must address both the disease and the illness. Examples of patient-centered approaches follow.

Carrillo, Green, and Betancourt (1999) warn against a categorical approach to teaching cultural competence that focuses on specific characteristics of certain groups of people. Instead, they emphasize a

patient-based approach to cross-cultural curricula that focuses on differences between individual patients rather than between groups or cultures. One of the five major content areas focuses on determining the patient's social context. The curriculum they have developed combines medical interviewing techniques with the sociocultural and ethnographic tools of medical anthropology. A summary of the content areas of the five modules can be found in Appendix B, and a thorough description of this curriculum is given in the Curricula and Training section.

Leininger's Sunrise Model suggests that the patient's worldview and social structure are important areas of assessment and that the Western medical model fails to explore cultural patterns of illness. The Sunrise Model provides nine domains that practitioners can use to assess patients in order to provide comprehensive and culturally sensitive care. Leininger's nine domains are presented in Appendix B (Leininger, 1978).

As part of their solution-oriented approach to cross-cultural training for family practice residents, Shapiro and Lenahan use inductive models for learning about cultural differences as one of their basic strategies (Shapiro & Lenahan, 1996). An inductive model focuses on the patient and his or her family as the center of analysis rather than on some generalized theory.

Another patient focused approach to teaching cultural competence is to focus on the patient's family unit. Marvel and colleagues' (1993) approach to teaching concepts of culture focuses on the family system. The model uses the family as its basis for identifying and understanding cultural influences that affect health, and negotiating a treatment plan. The relationship between a patient centered approach and culturally competent care is intertwined. Culturally competent health interventions require a patient-centered focus, and conversely a patient-centered approach implies culturally competent interventions.

Box 2: Berlin & Fowkes' LEARN Model

- **Listen** with sympathy and understanding to the patient's perception of the problem.
- **Explain** your perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities.
- **Recommend** treatment.
- **Negotiate** agreement. *Source:*

Berlin & Fowkes, 1983

EFFECTIVE PHYSICIAN-PATIENT COMMUNICATION

Effective communication is essential for the physician-patient relationship to be successful. A majority of resources reviewed focus on enhancing the communication skills of the physician or the clinician. Important concepts related to communication include interviewing techniques, eliciting the explanatory model, and negotiation of treatment.

Many frameworks for cultural competence curricula emphasize the importance of learning communication skills as part of the core intercultural skills required for culturally competent care (Kristal et al., 1983; Bobo et al., 1991; Levin, Like & Gottlieb, 2000; Scott, 1997; Stuart & Lieberman, 1993). These frameworks stress the use of communication for eliciting the patient's understanding of his or her

culture and establishing rapport. Campinha-Bacote's construct of "cultural skill," which is one of five interdependent constructs that make up cultural competence in her model, depends on effective communication (Campinha-Bacote, 1999). Cultural skill is the ability to collect relevant cultural data regarding clients' health through a culturally sensitive approach to interviewing clients.

Several interviewing and communication strategies are cited in the literature as important techniques for culturally competent clinical practice. Kleinman and colleagues (1978) developed a set of patient-centered interviewing questions for eliciting a patient's explanatory model, such as "What do you think has caused your problem?" and "How does it affect your life?" Berlin and Fowkes' LEARN model consists of the five guidelines for cross-cultural encounters listed in Box 2. Stuart and Lieberman's (1993) BATHE model is a mnemonic that suggests useful questions for eliciting a patient's psychosocial context. ETHNIC is a framework that guides culturally competent clinicians to communicate effectively throughout the physician-patient encounter (Levin et al., 2000). Details of the BATHE and ETHNIC models are given in Appendix B.

Berlin and Fowkes and Carrillo and colleagues agree that negotiation is an essential component to treatment. Negotiation of explanatory models involves acknowledging and negotiating across belief systems (Carrillo et al., 1999). The treatment plan should be the result of a partnership in decision making between physician and patient (Berlin & Fowkes, 1983).

BALANCING FACT-CENTERED AND ATTITUDE/SKILL-CENTERED APPROACHES TO ACQUIRING CULTURAL COMPETENCE

Approaches to acquiring cultural competence can be categorized as fact-centered or attitude/skill-centered approaches. The fact-centered approach enhances cultural competence by teaching clinicians cultural information about specific ethnic groups. Although it has practical applications, a solely fact-centered approach risks presenting patients as racial stereotypes. An individual has far more cultural influences than any handbook or course can teach, and it may not be possible for physicians to learn about the particularities of all the various cultural and ethnic groups they serve. However, culture-specific knowledge, such as an ethnic group's historical context, cultural concepts of illness and disease, health-seeking behaviors, health-oriented data and disease patterns, etc., may be helpful in certain situations (Fisher, 1996; Harwood, 1981). Cultural competence resources that use a fact-centered approach usually emphasize the importance of recognizing intra-group variation, warn against ethnic stereotyping, and may be presented as a "first step" to learning culturally competent care (Fisher, 1996, p. xx).

The attitude/skill-centered approach represents a universal approach to cultural competence that enhances communication skills and emphasizes the particular sociocultural context of individuals. Although some cultural competence frameworks fall into one category or another, most emphasize the need for achieving a balance of the two approaches. Many frameworks of cultural competence have the

goal of balancing specific cultural facts and knowledge pertaining to health beliefs of specific cultures with acquiring sound skills and general knowledge of physician-patient interaction that applies to all patient encounters (Bobo et al., 1991; Kristal et al., 1983; Scott, 1997). An example of balancing fact- and attitude/skill-centered approaches to acquiring cultural competence is discussed in more depth in the Curricula and Training section.

ACQUISITION OF CULTURAL COMPETENCE AS A DEVELOPMENTAL PROCESS

Most of the conceptual frameworks we reviewed present cultural competence and sensitivity as an ongoing process of learning, reflecting and developing concepts, skills, attitudes, experiences, knowledge, or specific competencies (Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1999; Cross et al., 1989; Borkan & Neher, 1991; Tervalon & Murray-Garcia, 1998). These developmental models describe cultural competence as consisting of levels or stages that build on each other as cultural competence develops, rather than as a competence that is achieved after attaining any one particular goal, such as passing a course or completing a training module. In other words, developing cultural competence requires more than just passive learning; it requires a deliberate process of thinking through, reflecting, and progressing on the part of the trainee. Campinha-Bacote (1999) encourages health care providers to focus on cultural competence as more of a journey than an ultimate goal. Her model of cultural competence is made up of five interdependent constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. See Appendix B for a more detailed description.

Examples of developmental models of cultural competence include Cross and colleagues' (1989) developmental continuum ranging from "cultural destructiveness" to "cultural proficiency." To articulate the continuum, the model characterizes six points along the range. Similarly, Culhane-Pera and colleagues' (1997) developmental model consists of five levels of cultural competence, ranging from level 1, "no insight about the influence of culture on medical care," to level 5, "integration of attention to culture into all areas of professional life." Borkan and Neher (1991) present a model with seven stages from "ethnocentric" to "ethnosensitive" that emphasizes the progression from stage to stage. For example, the stage of "superiority," which is characterized by negative stereotyping, is followed by "minimization," in which the trainee has learned to value similarities between cultural groups, accepts that no one group is superior, but tends to over-generalize this notion, minimizing the importance of cultural differences.

In contrast, other approaches to cultural competence focus on methods and guidelines for practicing culturally competent care in certain multicultural situations (Carrillo et al., 1999; Pachter, 1994; Shapiro & Lenahan, 1996). These frameworks present a more methodological approach aimed at practical applications and may not emphasize the developmental nature of cultural competence acquisition. For example, Shapiro and Lenahan's (1996) solution-oriented approach identifies general strategies that can be applied in cross-cultural situations. However, such methodological guidelines for

addressing cultural competence may also be interpreted as important multicultural experiences that further the development of cultural competence.

Two important aspects to learning cultural competence further articulate the idea that it is a personal process of developing one's own cultural sensitivity and proficiency. The literature emphasizes self-reflection of one's own cultural identity and cultural beliefs, and the importance of experiences with cross-cultural encounters, as important to developing cultural competence. Cultural competence frameworks that cite self-reflection as a key element explain the importance of exploring one's own cultural and family values and influences (Campinha-Bacote, 1999; Marvel, Grow, & Morphew, 1993) and exploring one's own biases or prejudices (Campinha-Bacote, 1999; Carrillo et al., 1999; Ohmans, 1996). Frameworks that emphasized the need for experience with cross-cultural clinical encounters noted that such experience is important for a variety of reasons. Through repeated interactions with diverse groups, providers have the opportunity to learn to deal adequately with and become comfortable with a variety of issues and scenarios (Campinha-Bacote, 1999; Lurie & Yergan, 1990); to prevent stereotyping through repeated interactions with diverse people from similar cultural groups (Campinha-Bacote 1999); or to achieve empathy or a sense of patients' essential values through cultural experiences (Carrillo et al., 1999; Lurie & Yergan, 1990). Tervalon and Murray-Garcia (1998) describe cultural competence as a commitment and active engagement in a lifelong process of self-reflection and self-critique, requiring humility.

For individuals who are beginning to learn to provide culturally competent care, presenting cultural competence as a developmental process that involves self-reflection and cross-cultural experience may be an important framework for learning.

UNDERSTANDING ALTERNATIVE SOURCES OF CARE

Many of the conceptual frameworks regarding culturally competent care explicitly emphasize the importance for physicians to recognize that patients may use alternative sources of health care and that their health care seeking behavior is influenced by culture (Pachter, 1994; Blue, 2000; Brach & Fraser, 2000; Cohen & Goode, 1999). That is, an important aspect of culturally competent care is an awareness that the Western health care system is only one among multiple sources of health information and resources from which people gain knowledge about health and receive health care. Traditional or folk models of health care differ from the Western biomedical model in that explanations for illness may include such factors as injuries, environmental factors, interpersonal conflicts, witchcraft, hexes, or spirits. In addition, traditional or folk health practices or remedies include herbal remedies, acupuncture, massage, prayer rituals, and the use of traditional healers or practitioners such as curanderos, shamans, and herbalists (Fortier & Bishop, forthcoming).

Spector (2000) points out that traditional health beliefs and practices should not be confused with

alternative medicine, which has been rapidly gaining in popularity. Traditional methods of health care differ from alternative medicine in that they are based on traditional beliefs and practices that are integral to a person's culture.

The foundation for today's understanding of traditional health care is anthropology. In 1980, Kleinman conceptualized multiple source health care sectors. According to Kleinman, the folk health care sector is a non-professional, specialist sector that may be based on secular or sacred beliefs and practices, or both. It also may overlap with the professional or popular health sectors. Kleinman's model emphasizes that culture plays a major role in influencing a patient's experience of and interaction with popular and folk health care sectors (Blue, 2000; Kleinman, 1980).

Most of the literature on traditional and folk health care describes traditional health models and practices and articulates that culturally competent care should attempt to coordinate alternative systems and practices with conventional approaches to care (Fortier & Bishop, forthcoming). For example, Spector's health traditions model uses a holistic concept of health, exploring traditional methods of maintaining, protecting, and restoring health. Traditional methods are based on the knowledge and understanding of health-related resources from within a given person's ethnoreligious cultural heritage (Spector, 2000). Similarly, Leininger's Sunrise model of nine domains that influence health status includes "health and life care rituals and rites of passage to maintain health" and "folk and professional health-illness systems used" (Leininger, 1978).

In terms of coordinating alternative care with conventional approaches, an example is Pachter's (1994) guidelines for addressing clinical issues surrounding folk beliefs in a culturally sensitive way, which include

- becoming aware of the commonly held medical beliefs and behaviors in the patients' community;
- assessing the likelihood of a particular patient or family acting on these beliefs during a specific illness episode; and
- arriving at a way to successfully negotiate between the two belief systems.

An understanding of the clinical issues surrounding folk health provides the physician with a framework to develop a therapeutic plan within the context of the patient's cultural system, which may increase patient compliance.

Culturally competent care is dependent on the ability to understand and communicate. For many who do not speak English, communication can be a major barrier to health care. The next section focuses on the issues related to creating language access services for LEP patients.

LANGUAGE ACCESS SERVICES

A main tenet of anthropology is that language is the most important aspect of culture because it

is the primary way that a culture is transmitted. This notion holds true in health care settings. The medical interview is the physician's most powerful tool (Woloshin et al., 1995). But millions of U.S. residents throughout the country do not have proficient English speaking and reading skills. Providing language access services in health care settings to people with limited English proficiency is the second theme of the CLAS standards. Standards 4 through 7 (see Box 1) represent the set of CLAS standards that are federal mandates, not just recommendations, for providing appropriate language access services for LEP patients so that they can have equal access to health care services. The standards support Title VI regulations mandating that every federally funded service provider ensures adequate language access services. Providing linguistically appropriate services entails overcoming difficult challenges with a shortage of qualified medical interpreters available and a lack of resources for interpretation and translation services.

In this section, we address issues related to the physician's role in ensuring appropriate linguistic services people with limited English proficiency. A large body of information on language access exists, and much of the information we found pertains to Title VI and related laws and policies. Even though we did not find information specific to services for the hearing impaired and people with limited literacy skills, we acknowledge that addressing the language access needs for all people is essential to providing culturally and linguistically appropriate services. Using information from the sources we reviewed on language access services, we discuss these prominent themes: appropriate interpretation services, the training of physicians to work with interpreters, the lack of resources for language access services, and language access strategies.

APPROPRIATE INTERPRETATION SERVICES

Appropriate interpretation services are essential to providing good health care. In the previous section, we discussed communication as a core aspect of the physician-patient relationship. Language barriers can hinder communication, often resulting in misdiagnoses, over-testing, poor compliance, patient dissatisfaction, and poor health outcomes, especially when complaints, questions, or psychosocial concerns cannot be effectively addressed (Woloshin et al., 1995; Jackson, 2001; Haffner, 1992; Fortier, 1999). In fact, according to two studies, 20 to 25% of patients who change physicians decide to switch because they are dissatisfied with physician-patient communication (Jackson, 2001). Inadequate interpretation can also raise ethical dilemmas because it puts client confidentiality at risk and can prevent truly informed consent (Woloshin et al., 1995; Haffner, 1992). Lack of informed consent or failure to convey treatment instructions because of language barriers may even result in liability and malpractice claims (Goode et al., 2000). The majority of information on interpreter services emphasizes the need for professional, qualified interpreters and warns of the risk of using inappropriate ones.

According to Woloshin and colleagues (1995), there are three suboptimal mechanisms for

communication between patients and clinicians where translation is involved: 1) using the patient's own limited language skills; 2) relying on the English language skills of family or friends accompanying the patient; or 3) or using ad hoc interpreters, such as other patients in the waiting room or employees who are not professional interpreters. All of these mechanisms have the potential for errors in communication that could have negative health care effects. In caring for people with limited English proficiency, the preferred form of communication is using a bilingual physician who is fluent in the patient's preferred language. In fact, the literature shows a preference for language-concordant encounters, or encounters where the physician and patient speak the same language, because language concordance can eliminate many of the problems associated with language barriers (Fortier & Bishop, forthcoming). Of course, physicians who are not truly bilingual will likely lack the language skills necessary to effectively communicate with LEP patients. Family, friends, and ad hoc interpreters usually lack the health care knowledge, understanding of medical terminology, and interpretation skills to effectively carry out this function. Placing them in this role can jeopardize informed consent, that is, the ability of patients to make informed decisions about their own health care.

The development of clear standards for medical interpreter training and certification is an important step to ensuring appropriate use of interpreters. Most of the materials reviewed call for the implementation of standard training or certification for interpreters in cross-cultural medical interpretation (Woloshin et al., 1995; Fortier, 1999; Goode et al., 2000; Haffner, 1992). However, agreement about appropriate interpreter roles and a lack of interpreter standards have been ongoing problems. For this reason, it is especially important for organizations to have clear standards for interpreter roles that are understood and agreed on internally (Fortier, 1999).

In Minnesota and Massachusetts, statewide medical interpreter initiatives have developed standards and provide workshops to train interpreters to meet these standards. The Minnesota Interpreter Standards Advisory Committee developed recommendations for professional standards that include core competencies and professional ethics standards for health care interpretation. Core competencies include such skills as adequately introducing and explaining one's role to both the physician and patient at the first meeting; positioning oneself to best facilitate communication in the least disruptive, most respectful way; reflecting the style and vocabulary of the speaker; remaining neutral in times of conflict; and addressing culturally based miscommunication by providing relevant cultural information when necessary (Minnesota Interpreter Standards Advisory Committee, 1998).

Minnesota's standards were adapted from standards developed by the Massachusetts Medical Interpreter Association (MMIA) and the Education Development Center in 1995. In 1998, the National Council on Interpretation in Health Care endorsed the standards. The MMIA's standards of practice were based on the premise that an interpreter must go beyond proficiency in interpretation to an understanding of the nuances and hidden sociocultural issues involved with interpreting across cultures. Harvard Pilgrim

Health Care has an interpreter training program that provides both clinical and non-clinical interpreters at several health center sites. It has policies that encourage pre-scheduling of appointment with interpreters and recommend that providers allot an extra 15 minutes for initial appointments with LEP patients (Fortier, 1999).

TRAINING PHYSICIANS TO WORK WITH INTERPRETERS

Interactions between non-English speaking patients seeking care and physicians who do not speak their language are not just *bilingual*, but *bicultural* as well (Scott, 1997). The nature of the interaction is complicated and has many implications. To be effective, the physician must understand the interpreter's role and how to interact with both the interpreter and the patient when communicating through an interpreter (Fortier, 1999; Ohmans, 1996). Physicians should understand what constitutes an appropriate interpreter. As mentioned above, if an interpreter is necessary, a professional one is preferred, or at minimum, a person with a biomedical background. Also, the physician should not assume that a bilingual person wants to speak in his or her native language. Finally, debriefing with the translator after a session is also crucial to understanding potential intercultural misinterpretations (Scott, 1997).

One example of a program that trains physicians to work with interpreters is at the Asian Health Services of Oakland. The program has developed and distributes provider training for working with interpreters that includes understanding provider responsibilities for communication, interpreter role and skills, ethics, liability, and negotiation of basic cultural issues (Fortier, 1999). The Cross Cultural Health Care Program provides training programs for physicians who are concerned about working with interpreters. The Program's "Guidelines for Providing Health Care Services through an Interpreter" answers general questions about working with interpreters such as "how do you decide if you need an interpreter?" "how do you choose an interpreter?" and "how do you work effectively through an interpreter?" (The Cross Cultural Health Care Program [CCHCP], n.d.). Examples of guidelines for working through an interpreter include (CCHCP, n.d.):

- During the medical interview, speak directly to the patient, not to the interpreter.
- Assume that, and insist that, everything you say, everything the patient says and everything that family members say is interpreted.
- Be aware that many concepts you express have no linguistic, or often even conceptual, equivalent in other languages. The interpreter may have to paint word pictures of many terms you use; this may take longer than your original speech.
- Encourage the interpreter to ask questions and alert you about potential cultural misunderstandings that may come up. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.

- Be patient. Providing care across a language barrier takes time. However, the time spent up front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings down the line.

Although our review of materials for this section did not uncover many resources for training physicians and other staff to work with interpreters; however, the importance of such training was mentioned frequently.

LACK OF RESOURCES FOR LANGUAGE ACCESS SERVICES REQUIREMENTS

Even though language access services are currently the only culturally competent services required by law, the enforcement of Title VI faces significant barriers owing to a lack of federal and state reimbursement policies that support interpretation. Even though they recognize language access services as necessary, many doctors are frustrated by the expense required to implement them. Some policy analysts are worried that owing to these requirements, private practice physicians enrolled in Medicaid and Medicare will decrease in numbers, making it harder for many minority patients to obtain quality care (Landers, 2000).

Only two states, Washington and Oregon, have created a separate billing code for interpretation. In Oregon, translation and interpreter costs are included as administrative costs in capitation rates (Woloshin et al., 1995). Many states have also enacted provisions that encourage or require both state agencies and their contractors to provide language appropriate services to LEP patients. In California, the Dymally-Alatorre Bilingual Services Act imposes direct obligations on state and local agencies to provide appropriate translation services, such as translated materials and sufficient numbers of bilingual persons on staff (Perkins et al., 1998). Examples of these types of services that states have developed are discussed in the Language Access section below.

Physicians must be aware of the particular state laws and other policies that determine whether and how interpreter services can be billed. Physicians and health care organizations should promote direct reimbursement or capitation differentials for interpreter services by health plans and government agencies, as well as support research on interpreter services cost and the appropriate calculation of reimbursement/capitation levels (Fortier, 1999).

Besides cost, another reason some physicians may resist providing language access services for their patients is a lack of awareness of the range of services that are available or of potential alternatives.

LANGUAGE ACCESS STRATEGIES

Health care organizations may employ a wide variety of language access strategies, some of which highly effective. However, the majority of health care practice settings (community health centers, hospitals, clinics, managed care organizations, and individual practitioners) do not employ such model strategies, relying on inefficient, ad hoc approaches (Fortier, 1999). Model language access services are often created in isolation to serve a particular need of a particular community. The result is a lack of

shared knowledge about more cost-effective options than hiring full-time, professional interpreters. There is clearly a need for disseminating information on models and best practices for providing language access services. This section explores some innovative and successful strategies.

In August 2000, the Office for Civil Rights (OCR) acknowledged the need for clarification and issued a Policy Guidance in response to widespread confusion about how to meet Title VI requirements (*Federal Register* 65 (169), 52762–774). The Guidance includes examples of promising practices, which are given in Box 2.

We found several examples of the use of the language access strategies. Many communities, especially ones with large cultural and linguistic populations, can use local resources. Some communities have programs that recruit, train, and certify medical interpreters from the bilingual community at large (Woloshin et al., 1995). For example, the University of Minnesota's Department of Linguistics runs a community interpreter program that recruits bilingual individuals for 150 hours of technical training, and Hunter College in New York City recruits and trains local college students as medical interpreters in exchange for scholarships or academic credit (Woloshin et al., 1995).

A similar strategy is to recruit bilingual hospital staff internally to serve as interpreters after they undergo training and certification. At facilities where demand is greatest, Kaiser Permanente of Southern California offers a pay incentive for bilingual staff who pass a proficiency exam to serve as interpreters (Fortier, 1999).

Community interpreter banks hold promise for many areas as a way to offer a wide variety of languages to many providers at competitive rates. It is a shared resource that allows many providers to access interpreters, especially from small language groups. As a response to language discrimination complaints, Seattle area hospitals initiated the Hospital Interpreter Program in the late 1980s. University-based programs, immigrant services agencies, health departments, and community clinics have initiated similar community interpreter banks. Although setting up these complex programs may take considerable resources and effort, community interpreter banks could offer the most cost-effective solution in certain areas (Fortier, 1999).

Some physicians and hospitals have filled the need for interpreters in less frequently heard languages by using telephone services as an alternative to full-time or contracted interpreters. These telephone services can be considerably less expensive (Jacob, 2001). For example, Logansport Memorial Hospital in Logansport, Indiana, treats many patients who speak Vietnamese, Bosnian, or Spanish and uses telephone interpreter services every day. Kaiser Permanente's medical center in Panorama City, California, has used both on-site interpreters and telephone language interpretation services for 20 years. Phones are installed in examining rooms, and doctors are trained to use phone interpreter services (Jacob, 2001).

A number of simpler interventions can also improve access to health services for LEP patients.

For example, using multilingual materials in the facility to inform patients about interpreter services is a way to reach LEP patients. In Hennepin County, Minnesota, the Metropolitan Health Plan is a public HMO with the Hennepin County Medical Center as its flagship facility. The plan added translated patient forms, patient education material, and audiovisual programs to the hospital's interpreter program (Fortier, 1999).

Another simple intervention is to provide staff and patients with bilingual phrase sheets for common expressions, words, and questions to help patients reach the appropriate service areas and to create a more welcome environment for LEP persons (Woloshin et al., 1995).

A final idea for a simple intervention is to give patients access to bilingual telephone operators for asking questions or making appointments (Woloshin et al., 1995). Blue Cross of California has established community resource centers to provide specialized member services in communities where service populations do not meet the state criteria for required services. The centers' staff is representative of the ethnic and linguistic demographics of the communities they serve and deal with member services, appointment scheduling, intake needs assessments. They also emphasize preventive services and prenatal care (Coye & Alvarez, 1999).

To improve overall linguistic access through language access strategies, it is important to promote awareness of and dissemination of technical information, case studies, and summaries of model programs and strategies of bilingual/interpreter services programs. It is also important to promote information sharing on best practices and lessons learned.

Language access services that serve particular language groups and meet a particular need in the community or service area are likely to be a challenge to develop and implement. Organizations that serve multi-linguistic populations have the challenge of implementing even more extensive linguistic services. However, ideally these language services are just one part of a health care organization's overall plan to increase cultural competence. In the next section, we discuss the main themes associated with implementing cultural competence, including language access services, at the organizational level.

Box 3: Office for Civil Rights' Promising Practices for Language Access Strategies

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  which the provider and the patient communicate using wireless remote headsets while a trained competent interpreter, located in a separate site, provides simultaneous interpreting services to the provider and the patient. The interpreter can be miles away. This reduces delays in the delivery of language assistance, since the interpreter does not have to travel to the medical facility.

- providers have created community language banks that train, hire, and dispatch competent interpreters to participating organizations, reducing the need to have on-staff interpreters for low-demand languages. These language banks are frequently non-profit and charge reasonable rates.

- Interpreter Services and Translation." This office tests and certifies all in-house and contract interpreters; provides agency-wide support for form translation, client mailing, publications, and other written materials into non-English languages; and monitors the policies of the agency and its vendors that affect LEP persons.

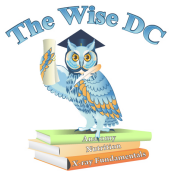
- interpreters to help immigrants and other LEP persons navigate the county health and social service systems. The project uses community outreach workers to work with LEP clients and can be used by employees in solving cultural and language issues. A multicultural advisory committee helps keep the county in touch with community needs.

- Interpreter." They are intended to facilitate basic communication between patients and staff to increase the comfort level of LEP persons as they wait for services.

- documents online. The documents can be retrieved as needed.

- requirements, and the availability of free language assistance in appropriate languages by a) posting signs and placards with this information in public places such as grocery stores, bus shelters and subway stations; b) putting notices in newspapers and on radio and television stations that serve LEP groups; c) placing flyers and signs in the offices of community-based organizations that serve large populations of LEP persons; and d) establishing information lines in appropriate languages.

Source: OCR Policy Guidance (Federal Register, 65 (169), 52762–774) (Summarized.)



ORGANIZATIONAL SUPPORTS

The third theme of the CLAS standards is organizational supports for cultural and linguistic competence. This aspect is addressed in standards 8 through 14. The recommendations in these standards are extensive. They cover many issues related to developing and implementing cultural and linguistic competence at the organizational level, including strategic planning, self-assessment and evaluation, management information systems, community partnering, complaint/grievance structures, and notification of the public. This section focuses on the core concepts of organizational supports that are necessary to foster the physician's capacity to facilitate change and enhance cultural competence in his or her clinic or health care organization.

In the social structure of the health care organization, the physician is hierarchically in a position to exert a lot of influence on the "institution's patient care, processes, and outcomes" (Rutledge 2001, p. 317). Even though the physician's role within an organization varies greatly depending on the setting, learning about the role of organizational policies and procedures in supporting culturally competent care is an important aspect of any physician's training. The family physician is largely responsible for whether or not an atmosphere of cultural competence is established among the staff, and he or she may be solely responsible for the cultural competence of the whole health care organization.

For health care organizations, implementing culturally competent policies and procedures is very complex—practically, politically, and programmatically (Rutledge, 2001). Like cultural competence training approaches, cross cultural health programs and initiatives at the organizational level often fall into one of two categories: programs that focus on specific population groups and/or health conditions and programs that address overall organizational cultural competence. Generally, it is easier to develop organizational programs targeted at specific groups than to achieve multiethnic cultural competence (Fortier, 1999). In this section, we primarily address issues related to developing and implementing overall organizational cultural competence.

Although there is a great deal of overlap, we have attempted to focus this report on information regarding cultural competence that is targeted toward physicians rather than administrators. For example, organizational assessment tools and handbooks on organizational cultural competence undoubtedly contain information that is useful for physicians but are not targeted at physicians.

The materials we reviewed on organizational supports were largely drawn from journal articles, web sites, and other online resources. They were often in the form of guidelines or recommendations for implementing cultural competence. Some material was from federal agencies. Several of the comprehensive sets of guidelines, key elements, or recommendations we refer to in this section are summarized in Appendix B. The main topics relevant to organizational support that emerged from the

materials reviewed are: the need for a strong commitment to cultural competence at every level of the organization; the importance of community involvement; the recruitment of minority and community health workers; training and professional development; and organizational assessment.

STRONG COMMITMENT TO CULTURAL COMPETENCE AT EVERY LEVEL OF THE ORGANIZATION

One of the major aspects stressed in the materials reviewed is that a strong commitment to cultural competence at every level of the organization is essential to successfully supporting culturally competent care (Fortier, 1999; Rutledge, 2001; Siegel, 1998; Goode, 1999). In fact, some have stated that a true commitment and dedication to cultural competence at every level is the most important factor to successful implementation. According to Rutledge and colleagues, "The key ingredient in this effort is ensuring that the governing bodies and executive management are absolutely committed to the journey and the destination" (2001, p. 323). Some have noted that it is important for the commitment to cultural competence to penetrate every aspect of the organization, including its policies and plans.

An organization's commitment to cultural competence in all its departments and activities should be stated in its mission statement (Goode, 1999). It is also important for all stakeholders of an organization to understand and be committed to a vision that articulates culturally competent values. The organization's policies and everyday operating procedures should reflect the principle of cultural competence (Rutledge, 2001). An effective diversity or culturally competent plan infuses cultural competence into every aspect of the organization so that it becomes part of the operating culture of the system.

However, the reality is that health care policy is generally lacking in the area of cultural competence. The National Center for Cultural Competence (NCCC) has documented policy as the most underdeveloped area at the programmatic level after observing cultural competence initiatives that serve children with special health care needs and their families. They determined that many health care initiatives lack the policies, structures, and planning procedures that support culturally competent practices (Cohen & Goode, 1999). Implementing cultural competence is an incredible challenge, and the commitment must begin at the top in order to be a serious and authentic goal for staff and clients throughout the organization (Siegel, 1998). Thus, a committed leadership is a first key to achieving a culturally competent organization.

THE IMPORTANCE OF COMMUNITY INVOLVEMENT

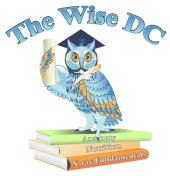
A main theme emphasized in the literature on organizational supports is the importance of community involvement. Community involvement can refer to involving community members or family members in clinical encounters or in the planning and implementation of programs. A main assumption of

either paradigm is that through community involvement, families or communities can identify cultural issues essential to health care, which can then be more effectively addressed (Fortier & Bishop, forthcoming). Although individual physicians may find that some organizational aspects are not relevant to them; they should have a general understanding of the importance of community involvement in terms of both culturally competent clinical encounters and health care programming in order to thoroughly understand culturally competent care. For example, on the level of the clinical encounter, physicians should be aware that some minority groups believe that family and/or community members should be involved in health care decisions; therefore involving them may be crucial to care (Brach & Fraser, 2000).

On the level of program planning and implementation, a majority of the literature states that organizations should solicit input from consumers and the community representatives for planning policies and programs and for gaining information about their needs (BPHC, n.d.; Coye & Alvarez, 1999; Goode, 1999; Siegel, 1998). Two ways to ensure community participation are to convene committees or advisory boards that include representatives from the community and to partner with community-based providers and traditional healers. Building networks of community informants can be a useful resource for developing a knowledge of diverse groups in the community (Goode, 1999).

The purpose of convening an advisory committee is to elicit community participation from diverse segments of the community and enlarge the pool of expertise available for program design and activities (Rankin & Kappy, 1993). The role of a committee is to exchange ideas and knowledge about achieving cultural competence in the community (Siegel, 1998). Federally funded community health centers are required to have consumer representatives from the community as 51% of their board representation. Community involvement on such entities is essential to cultural competence. Another mode of community participation is to convene focus groups or special ad hoc committees for specific input on topics such as professional development needs (Goode, 1999). A health center in Arizona drew from the expertise of native peoples and representatives from the community in humanities, education, and arts organizations to contribute to an educational program to heighten the cultural sensitivity of its health care professionals (Rankin & Kappy, 1993).

In some situations, it may be beneficial for physicians to collaborate with traditional healers from the community to negotiate a treatment that best fits with the patient's health beliefs (Pachter, 1994). Similarly, managed care organizations may contract with community-based health centers that provide services to minorities (Coye & Alvarez, 1999). A final important reason for maintaining ties with representatives from the community or with community-based providers is that it can be helpful in assessing the needs of cultural and linguistic minorities in the area. This information can be useful for outreach efforts and for tailoring health services to specific needs (Siegel, 1998; HRSA, 2001a).



THE RECRUITMENT OF MINORITY STAFF AND COMMUNITY HEALTH WORKERS

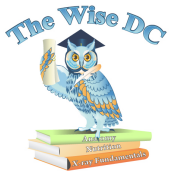
Hiring minority staff to match community demographics is a goal that many health care organizations strive for and struggle with. Minority providers tend to proportionately serve more minority patients than white health care providers (Murray-Garcia, Garcia, Schembri, & Guerra, 2001). Minority physicians have also been shown to communicate better with minority patients. Racial concordance between patient and physician can enhance satisfaction and adherence to treatment (Cooper-Patrick et al., 1999; Saha, Komaromy, Koespsell & Bindman, 1999). For these reasons, the recruitment of bilingual minority physicians and other staff is the primary way linguistic competence and should be a primary goal of health care organizations. Because minority (and especially bilingual) staff are often difficult to find, organizations may try implementing creative recruiting strategies. Some health care organizations have also implemented programs to recruit and train community health workers to support the health care needs of patients (Brach & Fraser, 2000; Coye & Alvarez, 1999).

Some strategies for recruiting and retaining minority group members in health care follow (Brach & Fraser, 2000):

1) creating minority residency or fellowship programs,
2) hiring minority search firms,
3) adapting personnel policy to create a comfortable and welcoming workplace for minority group members,
4) mentoring minority employees by senior executives,
5) tying executive compensation to steps taken to match hiring to community needs,
6) establishing a set of principles for respectful treatment of all people,
7) reviewing fairness of human resource practices and compensation of all staff, and
8) tracking staff satisfaction by racial and ethnic groups.

The increased need for minority and bilingual health care staff has led to increasing programs to recruit community health workers. Community health workers are bicultural and/or bilingual residents of the community and train them as community health workers. Asian Counseling and Referral Services of Seattle, Washington, is a community-based provider that recruits staff from different Asian ethnic groups and trains them in interpretation and basic mental health beliefs and practices of both Asian and American cultures. The trainees then work as co-providers with a licensed mental health professional (Fortier, 1999).

Another program in Seattle, Washington, has developed a model that uses community health workers. The Harborview Medical Center's Community House Calls project, created initially as a demonstration program, developed the interpreter cultural mediator (ICM) model, which uses two kinds



of LEP patient liaisons. Interpreter Cultural Mediators are bicultural, bilingual staff whose responsibilities include medical interpretation, cultural mediation and advocacy, case management, and community outreach. Community Advisors are selected representative of each cultural group served who educate staff about the specific social needs of their communities (Jackson-Carroll et al., 1998). Community health workers can be an important way to create and maintain ties with the community, and to inform health care staff of the health needs of the community.

Although the pool of minority health care workers does not meet the need, and recruitment is difficult, the increased presence of minorities in health care is an important goal.

TRAINING AND PROFESSIONAL DEVELOPMENT

The following section on Curricula and Training focuses on the core components of curricula in cultural competence. This subsection is concerned with the organizational aspect of providing training and opportunities for professional development in cultural competence. Such training for physicians and their staff is essential to providing culturally competent services, and it is important for organizations to support it (OMH, 2000; Brach & Fraser, 2000; Coye & Alvarez, 1999; Goode, 1999). However, organizations are often reluctant to provide organization-wide training because of the cost, the time lost, or the reluctance to face the real problems their organizations may not be addressing (Fortier, 1999). A report from the OMH found that in a study of eight states, most training was spearheaded by minority health entities, rather than the health care organization (OMH, 2000).

Some organizations have recognized the need for staff education and have implemented different modes of training. Organizations may implement cultural competence training as part of new staff orientation, as part of in-service training, or as a separate activity. They can also integrate a multicultural perspective throughout a curriculum or multiple training activities (Brach & Fraser, 2000).

Health care organizations should also set aside a budget each year for professional development through conferences, workshops, colloquia, and seminars on cultural and linguistic topics (Goode, 1999). Other examples of training and resources provided are a medical course in Spanish and an informational clearinghouse (OMH, 2000).

Further information regarding the curricular content for training physicians in cultural competence is given in the next section.

APPENDIX A: MINORITY CONSUMER AND COMMUNITY ADVOCACY GROUPS

Association of Asian Pacific Community Health organization

http://www.aapcho.org

The Black Health Network

http://www.blackhealthnetwork.com/

California's Pan-Ethnic Health Network

http://www.cpehn.org/

The Center for multicultural and multilingual Mental Health Services

http://www.mc-mlmhs.org/

Families USA: The Voice For Health Care Consumers

http://www.familiesusa.org/html/color/color.htm

Hispanic Health Council, Inc.

http://www.hispanichealth.com/hhchome.htm Accessed January 4, 2002.

The National Council for La Raza's Institute For Hispanic Health (IHH)

http://www.nclr.org/policy/health.html

National Multicultural Institute

http://www.nmci.org/

The Native Elder Health Care Resource Center

http://www.uchsc.edu/ai/nehcrc/

OTHER SITES RESEARCHED

Asian and Pacific Islander American Health Forum

http://www.apiahf.org

Association for Multicultural Counseling and Development

http://www.counseling.org

California Rural Indian Health Board

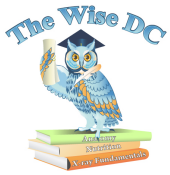
http://www.crihb.org

Center for American Indian Health

http://ih.jhsph.edu/cnah

Centros Para el Control y la Prevencion de Enfermedades

http://www.cdc.gov/spanish



Circles of Care Evaluation Technical Assistance Center

http://www.hsc.colorado.edu/sm/coc

Hispanic Federation

http://www.hispanicfederation.org

National Alliance for Hispanic Health

http://www.hispanichealth.org

National Asian Women's Health Organization

http://www.nawho.org

National Center for American Indian and Alaska Native Mental Health Research

http://www.uchsc.edu/sm/ncaianmhr

National Hispanic Medical Association

http://home.earthlink.net/~nhma

National Indian Health Board (national office)

http://www.nihb.org

National Latina Health Network

NLHN@erols.com

National Minority AIDS Council

http://www.nmac.org

National Native American AIDS Prevention Center

http://www.nnaapc.org

Search Institute

http://www.search-institute.org

APPENDIX B: FRAMEWORKS AND KEY ASPECTS OF CULTURALLY COMPETENT CARE

(BERLIN & FOWKES, 1983)

Berlin and Fowkes' LEARN model is a well-established approach for communication that consists of a set of guidelines for health care providers who serve multicultural populations. The model is intended as a supplement to the history-taking component of a normal structured medical interview. LEARN consists of five guidelines:

- **Listen** with sympathy and understanding to the patient's perception of the problem.
- **Explain** your perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities.
- **Recommend** treatment.
- **Negotiate** agreement.

(BOBO, WOMEODU, & KNOX, 1991)

Learning objectives for cross-cultural training of family medicine residents:

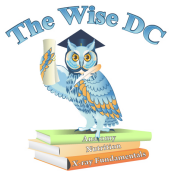
INTERCULTURAL CONCEPTS

- Culture is important in every patient's identity.
- Communication of cultural understanding and respect is essential for establishing rapport and confidence.
- Culture-related stresses and tensions can induce illness.
- Culture-related behaviors (e.g., religion, diet) affect patient's acceptance of and compliance with prescribed therapy.
- Nonverbal and verbal communication may differ from culture to culture.

INTERCULTURAL KNOWLEDGE

Should be specific for each culture represented and includes the following:

- Common dietary habits, foods, and their nutritional components



- Predominant cultural values, health practices, traditional health beliefs

- Family structure—patriarchal vs. matriarchal; nuclear vs. extended; role of individual members
- Effect of religion on health beliefs and practices
- Customs and attitudes surrounding death
- Significance of common verbal and nonverbal communication
- Awareness of the "culture shock" experienced by the very poor and immigrants upon entering modern health centers
- Awareness of prevailing cross-cultural tensions and psychosocial issues

INTERCULTURAL SKILLS

Should be specific for each culture represented and includes the following:

- Communicate an understanding of patient's culture.
- Elicit patient's understanding of patient's culture.
- Recognize culture-related health problems.
- Negotiate a culturally relevant care plan with patient as partner.
- Interpret verbal and nonverbal behaviors in culturally relevant manner.
- Have basic or essential language proficiency.
- Apply principles of clinical epidemiology to common illnesses.

INTERCULTURAL ATTITUDES

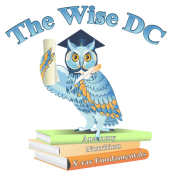
- Recognize importance of patient's cultural background and environment when constructing an approach to an illness.
- Acknowledge patient's role as an active participant in his or her own care.
- Accept responsibility for the patient who has few support systems; avoid the "what can I do?" attitude when facing a patient in abject poverty or with language barriers.

(BORKAN & NEHER, 1991)

Seven stages of a developmental model of ethnosensitivity for family practice training from "ethnocentric" to "ethnosensitive":

- **Fear.** Family physicians may fear a specific group and idea or have a general mistrust of differences. Fear is an incredibly problematic response because it is a powerful motivator. The goal is to decrease or eradicate fear by using basic approaches and understandings.

- **Denial.** In this stage, "culture blindness" or "over-generalization" are displayed. Trainees have little understanding of cultural variation and behave as if cultural differences do not exist. The goal at this stage is to "promote recognition of ethnicities" through fostering the simple awareness of cultural differences. The medical trainee must learn that "everyone has an ethnicity."
- **Superiority.** This stage is characterized by negative stereotyping, which results from "ranking" cultural differences according to one's own culture, or "reversal," which results in denigrating of one's culture as a result of identifying with another group's attitudes, beliefs, and practices to the point of seeing it as superior. The goal at this stage is to promote the recognition of similarities between cultural groups.
- **Minimization.** The trainee acknowledges that cultural differences exist but views them as unimportant compared with similarities. The characteristics of this stage are "reductionism" and "universalism." Reductionism, which most medical training promotes, stresses "biochemistry and pathophysiology models while de-emphasizing the medical effects of personality, family structure, and socio-cultural factors." Universalism is the idea that universal laws and principles of human behavior exist that transcend human differences. At this stage, it is important to stress individual and group differences by stressing bio-psychosocial awareness and by debunking the belief that "common sense" is all that is needed to establish good therapeutic relationships.
- **Relativism.** This stage is characterized by the acceptance of ethnic and cultural differences, but a naiveté regarding actual knowledge of specific differences and their implications on providing care. The goals for this stage are to gain experience through cultural exploration and education and to foster empathy.
- **Empathy.** This stage involves a framework shift to be able to experience events as a patient might. Trainees exhibit "pluralism" when they are able to come outside their own worldview to come to an understanding of the patient's value system and worldview. However, ethical decision making requires more than empathy; it requires an enrichment of cultural experiences.
- **Integration.** The culturally integrated practitioner "stands both inside and outside a culture, having both deep understanding and a critical viewpoint." The integrated physician is able to make ethical decisions through a contextual evaluation of critical cultural and



individual factors. The refinement of cultural integration can continue through fostering integrative skills and multiculturalism.

(Campinha-Bacote, 1999)

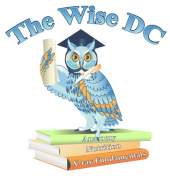
This model presents five interdependent constructs that make up cultural competence.

- **Cultural Awareness**—"The deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures." The process includes examining one's own prejudices and biases toward other cultures and exploring ones' own cultural values.
- **Cultural Knowledge**—"The process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures." In addition to knowledge concerning worldviews of different cultures, knowledge regarding specific physical, biological, and physiological variations among ethnic groups is important to the process.
- **Cultural Skill**—"The ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a culturally specific physical assessment." This process involves using a culturally sensitive approach to interviewing clients about their perceptions of the health problem and treatment options.
- **Cultural Encounters**—"The process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds." It is important to prevent stereotyping through repeated direct interactions with clients from diverse cultural groups to "refine or modify one's existing beliefs regarding a cultural group."
- **Cultural Desire**—"The motivation of health care providers to 'want to' engage in the process of cultural competence." Only a genuine desire to work effectively with culturally diverse clients will make a successful culturally competent health care provider. Caring is central to the construct of cultural desire. The goal of the health care provider should be to reflect true caring to the client

(Carrillo, Green, & Betancourt, 1999)

A patient-based approach to cross-cultural curricula, consisting of five content areas:

- **Basic Concepts**—Includes the meaning of "culture" and "disease," the subjective concept of "illness," and the attitudes that are fundamental to a successful cross-cultural encounter— empathy, curiosity, and respect.
- **Core Cultural Issues**—Includes "situations, interactions, and behaviors that have potential for cross-cultural misunderstanding," such as issues of authority, physical contact, communication styles, gender, sexuality, family dynamics issues, among others.



- **Understanding the meaning of the illness**—Encompasses the patient's explanatory model, which is "the patient's understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life." In addition to cultural factors, social factors may shape a person's explanatory model, such as socioeconomic status and education. Another important related aspect is eliciting a patient's explanatory model through specific methods for interviewing.
- **Determining the patient's social context**—Includes socioeconomic status, migration history, social networks, and other factors. Social context is explored through four avenues: "1) control over one's environment (such as financial resources and education), 2) changes in environment (such as migration), 3) literacy and language, and 4) social stressors and support systems."
- **Negotiating across cultures**—Describes cross-cultural negotiation as a skill that is enhanced by the skills and knowledge learned in the previous four modules. Reaching a mutually acceptable agreement consists of six phases: relationship building, agenda setting, assessment, problem clarification, management, and closure. Negotiation skills can be used in addressing both explanatory models and treatment management options.

(CROSS EI AL., 1989)

Developmental continuum ranging from "cultural destructiveness" to "cultural proficiency." The six possible points on the continuum follow:

- **Cultural Destructiveness**—Attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. "A system which adheres to this extreme assumes that one race is superior and should eradicate 'lesser' cultures because of their perceived subhuman position."
- **Cultural Incapacity—**Lack of capacity to help minority clients or communities, remaining extremely biased. Characteristics include "discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients."
- **Cultural Blindness**—Provision of services with the express philosophy of being unbiased, functioning with the belief that all people are equal and the same. Characterized by the erroneous belief that approaches used by the dominant culture are universally applicable, resulting in ethnocentric services that "ignore cultural strengths, encourage assimilation, and blame the victim."

- **Cultural Pre-Competence**—Recognition of weakness in serving minorities and attempt to improve services to a specific population. Characterized by the desire to deliver quality services and a commitment to civil rights, but with a lack of information on the function of culture and its impact on client populations and how to proceed.
- **Cultural Competence**—"Characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations."
- **Cultural Proficiency**—The most advanced point on the continuum is characterized by holding culture in high esteem, always seeking to increase knowledge of culturally competent practice.

(CULHANE-PERA, REIF, EGLI, BAKER, & KASSEKERT, 1997)

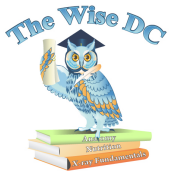
Five levels of cultural competence:

- Level 1—No insight about the influence of culture on medical care
- Level 2—Minimal emphasis on culture in medical setting
- Level 3—Acceptance of the role of cultural beliefs, values, and behaviors on health, disease, and treatments
- Level 4—Incorporation of cultural awareness into daily medical practice
- Level 5—Integration of attention to culture into all areas of professional life Each of the levels has specific objectives for knowledge, skills, and attitudes.

(LEININGER, 1978)

The holistic "sunrise model" presents nine main domains that influence the care and health status of individuals, families, groups, and sociocultural institutions:

- Patterns of lifestyle
- Specific cultural values and norms
- Cultural taboos and myths
- World view and ethnocentric tendencies
- General features that the client perceives as different or similar to other cultures
- Caring behaviors
- Health and life care rituals and rites of passage to maintain health
- Folk and professional health-illness systems used



- Degree of cultural change

(LEVIN, LIKE, & GOTTLIEB, 2000)

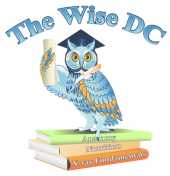
ETHNIC: A framework for culturally competent clinical practice.

E: Explanation	What do you think may be the reason you have these symptoms? What do friends, family, others say about these symptoms? Do you know anyone else who has had this kind of problem? Have you heard about/read/seen it on TV/radio/newspaper? (If patient cannot offer explanation, ask what most concerns them about their problems).
T: Treatment	What kinds of medicines, home remedies or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?
H: Healers	Have you sought any advice from alternative/folk healers, friends or other people (non-doctors) for help with your problems? Tell me about it.
I: Intervention	Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g. foods eaten or avoided in general, and when sick).
C: Collaboration	Collaborate with the patient, family members, other health care team members, healers and community resources.

(LURIE & YERGAN, 1990)

Seven key objectives for learning to deliver care to vulnerable populations:

- **Have direct experience serving as the primary physician for patients from several vulnerable population groups.** Medical residents should be given enough time with patients to adequately deal with different issues and should have the opportunity to serve patients from as many different backgrounds and with as diverse conditions as possible.
- **Become familiar with and sensitive to socio-cultural issues affecting various population groups, particularly those in geographical areas where they are likely to practice.** It is important for residents to learn how to be sensitive to patients' view of medical problems and their treatment, including information about "concepts of illness in different cultures, the



historical relationship between the population under study and the health care system, the nature of the sick role, the roles of the family, society, and religion on illness and health, the use of lay and traditional beliefs and healing methods, and patterns of interaction with the health care community."

- **Explore their own responses to patients who differ from themselves socially and culturally or who have lifestyles or value systems incongruent with their own.** Physicians should be given self-examinations to reflect on their own biases and should learn about the possible implications of these biases.
- **Acquire the skills needed to care most effectively for patients in vulnerable population groups.** These skills include good communication skills, understanding important tenets of communicating through interpreters, and strategies for related health issues such as managing mental illness, chemical dependency, illiteracy, violence, and sexual abuse. Such skills will help them derive satisfaction from caring for such patients.
- **Learn about the unique epidemiologies and presentations of diseases in major population groups in the United States and groups specific to their geographical areas.** Certain diseases have patterns in vulnerable populations. These patterns, as well as the role of poverty in the epidemiology of disease, should be part of the curriculum.
- **Become familiar with major health care financing programs and their effects on access to care and the practice of medicine.** Basic curriculum should cover eligibility criteria and benefits of the Medicare and Medicaid programs as well as information on other major state and local programs.
- **Develop a sense of themselves in relation to society at large.** Medical residents feel dissatisfied when they do not have success with patients. They should learn to set realistic goals for situations dealing with patients with multiple problems.

(MARVEL, GROW, & MORPHEW, 1993)

The core objectives for teaching concepts of culture in a family block rotation follow:

- Conducting a family conference (including conference structure, family dynamics, and negotiating a treatment plan)
- Identifying developmental tasks in the family life cycle (including cultural variations)
- Understanding how one's own cultural and family background influences the doctor-patient relationship
- Understanding basic family systems concepts
- Identifying cultural factors that affect health care

- Recognizing the family role in chemical dependency

(PACHTER, 1994)

Three requirements for a culturally sensitive clinician:

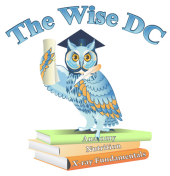
- **Become aware of the commonly held medical beliefs and behaviors in his or her patients' community.** Sources of ethnomedical information can be the patients themselves, office staff who reside in the community, and social science and clinical literature.
- **Assess the likelihood of a particular patient or family acting on these beliefs during a specific illness episode.** The individual's level of acculturation is likely in part responsible for his or her level of adherence to folk beliefs and behaviors. The clinician should be prepared to ask about the patient's thoughts and expectations concerning the course of illness.
- **Arrive at a way to successfully negotiate between the two belief systems.** The type of approach to treatment depends on the potential effects of the patient's belief system on the treatment outcome, as well as the ongoing physician-patient interaction. If possible, the clinician should work with the patient to combine the folk and medical therapies and not attempt to dissuade the patient from the folk beliefs and practices. The collaboration between folk healers and medical practitioners can also be effective in negotiating belief systems.

(SCOTT, 1997)

Practical guidelines for a culturally appropriate approach to health care that can be individualized for each patient:

- Recognize intraethnic variation.
- Recognize ethnic- and culture-bound gender role norms.
- Elicit and understand the patient's concept of the sick episode.
- Identify sources of discrepancy between physician and patient's concept of disease and illness.
- Validate the patient's perspective.
- Provide education and work within the patient's conceptual system.
- Negotiate a "clinical reality" on which patient and physician can base an approach to treatment.
- Validate resolution of the patient's concerns about illness and disease at the end of the encounter.

- When the assistance of a translator is required, encourage the use of the patient's own words.



- Ensure that employees who will serve regularly as translators, but who are not trained in biomedicine, should complete a brief program in cultural sensitivity/competence.
- Provide patients with cards printed with routine requests in English and their native language.
- Consider ethnically and culturally acceptable diets, food preferences, and religious beliefs.

(Shapiro & Lenahan, 1996)

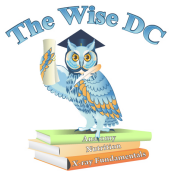
A solution-oriented approach to cross-cultural training for family practice residents, identifying four general strategies:

- **Evidence-based evaluation of cultural information**—Evidence-based research attempts to specify particular cultural constructs that have clear linkages to social behavior, rather than making broad generalizations about cultural differences. Understanding evidence-based research is important for residents to evaluate the quality and integrity of cross-cultural information.
- **Inductive models for learning about cultural differences**—An inductive model focuses on the patient and family, rather than on a theory, as the center of analysis. Information obtained directly from the patient through ethnographic techniques has the greatest importance, whereas general information about the patient's culture is considered, but requires further validation.
- **Narrative approaches**—This refers to building a life-history review of the patient, perhaps over a long period of time, to establish a sense of the patient's essential values, assumptions, and expectations and to communicate respect for the individual.
- **Cultural flexibility—**Residents must develop a flexible patient interaction style in which they learn to adapt between traditional and modern orientations. This involves acknowledging potential differences; for example, patients with a traditional orientation may value a strong family identity and loyalty, whereas a modern orientation may value individual autonomy.

(Stuart & Lieberman, 1993)

BATHE: A useful mnemonic for eliciting the psychosocial context.

B: Background	A simple question. "What is going on in your life?" elicits the context of the patient's visit.



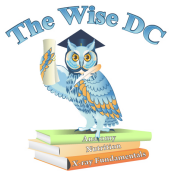
A: Affect	(The feeling state) Asking "How do you feel about what is going on?" or "What is your mood?" allows the patient to report and label the current feeling state.
T: Trouble	"What about the situation troubles you the most?" helps the physician and patient focus, and may bring out the symbolic significance of the illness or event.
H: Handling	"How are you handling that?" gives an assessment of functioning and provides direction for an intervention.
E: Empathy	"That must be very difficult for you" legitimizes the patient's feelings and provides psychological support.

APPENDIX C: GUIDELINES AND KEY ASPECTS OF ORGANIZATIONAL SUPPORTS FOR CULTURALLY COMPETENT CARE

(BRACH & FRASER, 2000)

Nine techniques for cultural competence in health systems most frequently described in cultural competency literature (the authors' explanations are summarized):

- **Interpreter services.** Approaches to interpretation include on-site professional interpreters, ad hoc interpreters (staff members, friends and family members, strangers in the waiting room), and simultaneous remote interpretation with off-site professional interpreters.
- **Recruitment and retention.** Techniques for recruiting and retaining minority group members in health systems include 1) creating minority residency or fellowship programs, 2) hiring minority search firms, 3) adapting personnel policy to create a comfortable and welcoming workplace for minority group members, 4) mentoring minority employees by senior executives, 5) subcontracting with minority health providers, 6) tying executive compensation to steps taken to match hiring to community needs, 7) expanding on traditional affirmative action programs aimed at attracting employees who match the race and ethnicity of the patient populations, 8) establishing a set of principles for the respectful treatment of all people, 9) reviewing the fairness of human resource practices and compensation of all staff, and 10) tracking staff satisfaction by racial and ethnic groups.
- **Training.** Cultural competence training programs aim to increase cultural awareness, knowledge, and skills, leading to changes in staff behavior and patient-staff interactions. Training may be part of undergraduate or graduate medical education, an orientation process for new staff, or in-service training. It can also be a separate activity, either a regularly occurring activity, or a one-time occurrence, or by infusion, which integrates a multicultural perspective throughout a curriculum or training activities.
- **Coordinating with traditional healers.** Many minority Americans use traditional healers while they are seeking biomedical care. Clinicians need to coordinate with these healers as they would with any other care provider to ensure continuity of care and avoid complications owing to incompatible therapies. In addition, coordinating therapies with traditional ones may increase patient compliance.

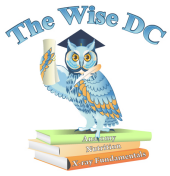


- **Use of community health workers.** Members of minority communities can be used to reach out to other community members as well as to provide direct services such as health education and primary care. They act as liaisons that bring in individuals in need of care, provide cultural linkages, overcome distrust, and contribute to clinician-patient communication, thereby increasing access to care.
- **Culturally competent health promotion.** In an attempt to make health-promotion efforts more culturally competent, culture-specific attitudes and values have been incorporated into messages and materials such as screening tools and public information campaigns.
- **Including family and/or community members.** Some minority groups believe that family members should be involved in health care decision making. Involving families and community members may be crucial in obtaining consent for and adherence to treatment.
- **Immersion into another culture.** Members of one cultural group may develop sensitivity and skills working with another culture by immersing themselves in that culture. It is reported that immersion enables participants to overcome their ethnocentrism, increase their cultural awareness, and integrate cultural beliefs into health care practices.
- **Administrative and organizational accommodations.** A variety of decisions related to clinic locations, hours of operation, network membership, physical environments, and written materials also can affect access to and use of health care. Health systems can make themselves more welcoming and accessible to minority patients.

(Bureau of Primary Health Care, n.d.)

Guidelines for Assessing a Program's Cultural Competence (summarized)

- **Experience or track record of involvement with the target audience.** The organization should have a documented history of positive programmatic involvement with the population or community to be served.
- **Training and staffing.** The staff of the organization should have training in cultural sensitivity and in specific cultural patterns of the community proposed for services. Staff should be identified who are prepared to train and translate the community cultural patterns to other staff members. There should be clear, cultural objectives for staff and for staff development. Emphasis should be placed on staffing the initiative with people who are familiar with, or who are members of, the community to be served.



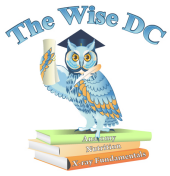
- **Community representation.** The community should be a planned participant in all phases of program design. A community advisory council or board of directors of the organization with decision-making authority should be established with members of the targeted cultural group represented.

- **Language.** If an organization is providing services to a multi-linguistic population, there should be multi-linguistic resources, including skilled bilingual and bicultural translators. Translated printed and audiovisual materials should be provided, and individuals who know the nuances of the language as well as the formal structure should do the translation.
- **Materials.** Audio-visual materials, public service announcements (PSAs), training guides, print materials, and other materials should be culturally appropriate for the community to be served. Pretesting with the target audience should provide feedback from community representatives about the cultural appropriateness of the materials under development.
- **Evaluation.** Evaluation methods and instruments should be consistent with cultural norms of the groups being served. The evaluation instruments chosen should be valid in terms of the culture of specific groups targeted for interventions. The evaluators should be sensitized to and familiar with the culture whenever possible.
- **Implementation.** There should be objective indicators that the organization understands the cultural aspects of the community that will contribute to the program's success and avoid pitfalls.

(COYE & ALVAREZ, 1999)

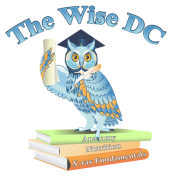
California's Medicaid managed care organization, Medi-Cal, instituted contract requirements for cultural competence that have had a substantial impact on health plan services and operations. The requirements have led to training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. The following are key components from an early review of contract requirements and implementation:

- **Defining criteria for threshold populations.** Because of the great diversity of racial, ethnic, and linguistic groups served by Medi-Cal, plans and providers need a clear definition of the populations and service areas for which specialized services are required. Medi-Cal's threshold and concentration criteria appear to be useful toward this end.



- **Translation of plan materials.** Although the process of state approval is apparently cumbersome, it has spurred health plans to make their member services and health education materials uniformly available in languages appropriate to the needs of their members.
- **Complete access to interpreter services.** By requiring plans to provide 24-hour telephone access and establish protocols for scheduling interpreters when necessary, Medi-Cal has ensured a baseline availability of language services for beneficiaries.

- **Community participation in plan services development.** The establishment of community advisory committees has provided plan members with an organized framework for representing their needs and reviewing plan services. In addition, health plan staff gain insights from their direct interactions with members.
- **Development of training programs.** As plan services directors and provider organizations focus on meeting the needs of specific linguistic and cultural groups, administrators have recognized the need for more staff education, and all plans and provider organizations now have training programs.
- **Use of community health workers.** The implementation of contract requirements has led to increasing experimentation with the use of community health workers. Because of the limited time available between patients and clinical providers in most health care settings today, community health worker programs may offer an effective means of support for the health care management needs of all patients.
- **Use of plan surpluses.** Several Medi-Cal local initiatives reported plan surpluses at the end of their first year, which they allocated in part to community education, risk prevention, and disease management initiatives aimed at non-English speaking populations.
- **Minority physicians and traditional providers.** Medi-Cal policy calls for local initiatives to include traditional providers in their managed care networks. Mainstream plans reported that this process led them to expand their provider networks substantially.
- **Public hospitals and clinics.** The Medi-Cal managed care expansion plan proposed the development of local initiatives largely to ensure public and community hospital participation in managed care at levels adequate for these institutions to continue to receive Medicaid disproportionate share payments. The actual effect of this requirement, however, has been to maintain the availability of multicultural services at these hospitals.

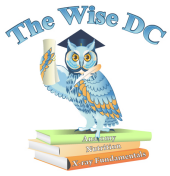


(GOODE, 1999)

The National Center for Cultural Competence of the Georgetown University Child Development Center's checklist for organizations to help them to get started with planning, implementing and evaluating culturally competent service delivery systems in primary health care settings (summarized)

- Convene a cultural competence committee, work group, or task force within your program or organization that includes representation from policy making, administration, practice/services delivery, and consumer levels.

- Ensure that your organization's mission statement commits to cultural competence as an integral component of all its activities.
- Determine the racially, ethnically, culturally, and linguistically diverse groups within the organization's geographic locale. Assess the degree to which these groups are accessing services and their level of satisfaction.
- Determine the percentage of the population that resides in the geographic locale served by your organization affected by the six health disparities identified by HRSA (cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations). Collaborate with consumers, community-based organizations, and informal networks of support to develop approaches for delivering preventive health messages in a culturally and linguistically competent manner.
- Conduct a comprehensive program or organizational cultural competence self-assessment. Determine which instrument(s) and or consultant(s) best match the needs or your organization. Use the self-assessment results to develop a long-term plan incorporating cultural and linguistic competence into all aspects of your organization.
- Conduct an assessment of what organizational personnel perceive as their staff development needs related to the provision of services to racially, ethnically, culturally, and linguistically diverse groups.
- Convene focus groups or use other approaches to solicit consumer input on professional or staff development needs related to the provision of culturally and linguistically competent health care.
- Network and dialogue with other organizations that have begun the journey toward developing, implementing, and evaluating culturally competent service delivery systems.



Adapt processes, policies, and procedures consistent with your organization's needs and encourage mechanisms to share training resources.

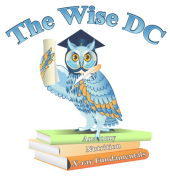
- Aggressively pursue and use available resources from federally and privately funded technical assistance centers that catalog information on cultural and linguistic competence, primary health care, and related issues (e.g., treatment, interventions, how to work with natural healers, outreach approaches, consumer education programs).
- Convene informal forums to engage organization personnel in discussions and activities to explore attitudes, beliefs, and values related to cultural diversity and cultural and linguistic competence.

- Identify and include budgetary expenditures each fiscal year to develop resources and to facilitate professional development through conferences, workshops, colloquia, and seminars on cultural and linguistic competence and other related issues.
- Gather and categorize resource materials related to primary health care and culturally diverse groups for use as references by organization personnel.
- Build and use a network of natural helpers, community informants, and other "experts" who have knowledge of the diverse groups served by your organization.
- Network with advocacy organizations concerned with specific health care, social and economic issues affecting racially, ethnically, culturally, and linguistically diverse communities. Solicit their involvement and input in the design, implementation, and evaluation of primary and community-based health care service delivery initiatives.

(LURIE & YERGAN, 1990)

Organizational goals for supporting training of medical residents to care for "vulnerable populations," whom the authors define as "those patients whom a substantial number of physicians regard as undesirable because they lack a means to pay for medical services, because they have medical problems that are difficult to manage, or because they have characteristics that give them low social status" (p. S27). Included in this definition are minority patients and non-English speakers. Goals for preparing residents to care for vulnerable populations include the presence of the following:

- A commitment to provide ambulatory as well as inpatient care for indigent patients and patients from other vulnerable groups.

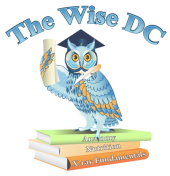


- Adequate physician and non-physician staff to ensure that a satisfactory educational experience is provided for residents learning to care for these populations.
- Ongoing discussion of the ways (financial and other) in which departments and hospitals limit access to care.
- Individuals and institutions that model socially responsible provider behavior and recognition and support of faculty who do advocacy-oriented research on vulnerable population groups.
- A commitment to recruit and support faculty and house staff from racial and ethnic minority groups.
- Explicit learning objectives for teaching about the care of vulnerable populations in the ambulatory setting, and assurances that they are met.

(RUTLEDGE, 2001)

Major elements of an effective diversity or culturally competent plan:

- Acknowledge and accept the importance of delivering culturally competent care by including this principle in the institution's governing documents and adopting it in everyday operations.
- Ensure that all stakeholders—medical staff, employees, and volunteers—understand the institution's mission, vision, and values and how diversity and cultural competency are melded into those beliefs.
- Ensure that executives at the organization buy in and commit to this mission, vision, and values by including them in their individual goals and objectives and relating them to their compensation incentives.
- Address the issue of diversity at the departmental level, which is a precursor to promulgation of policies and value statements throughout the organization.
- Develop or revise policies, procedures, and/or operating principles.
- Carry out a comprehensive orientation of the workforce.
- Appoint an internal steering committee charged with developing a measurable diversity plan, which the board of directors is responsible for adopting. Members of this committee should represent both the clinical support and administrative functions of the institution. The



committee's function can include but is not limited to (summarized):

— conducting environmental assessment in cultural competence;

— establishing a framework for integrating dimensions of cultural competence into all aspects of the organization;

— developing an implementation strategy with timeline;

— developing the orientation/educational process;

— ensuring that policies and operating plan are carried out;

— ensuring that each functional operating unit has an implementation plan; and

— developing accountability measurements.[xxviii]

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[i] http://www.avert.org/historyi.htm
[ii] http://www.avert.org
[iii] http://www.osha-slc.gov/Preamble/Blood_data/BLOOD9.html
[iv] http://janweb.icdi.wvu.edu/kinder/pages/hiv_aids.html
[v] http://www.cdc.gov/mmwr/preview/mmwrhtml/00052722.htm
[vi] http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=treatments-and-drugs
[vii] http://www.hivatis.org/trtgdlns.html#Perinatal
[viii] Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 697.
[ix] Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 411.
[x] Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 769.
[xi] From Forman, S. and Stahl, M.: Medical Legal Issues in Chiropractic, Volume 1, Number 3, pg. 122, Williams and Wilkins, 1990.
[xii] From Vernon, H (ed): Upper Cervical Syndrome: Chiropractic Diagnosis and Treatment; Baltimore, Williams and Wilkins, 1988: 199.
[xiii] National Chiropractic Mutual Insurance Company, Back Talk, Spring 1990.
[xiv] California Civil Code Section 3333.2 (C) (2).
[xv] Webster's New Collegiate Dictionary, G & C Merriam Co., Springfield, Mass, 1976, page 241.
[xvi] Mercy Conference Guidelines, Recommendation 5.51; pg 90, 1993.
[xvii] Mason v. Forgie, Ct. of Q.B. of New Brunswick's Judicial District of St. John, 1984
[xviii] Mason v. Forgie, Ct. of Q.B. of New Brunswick's Judicial District of St. John, 1984
[xix] Tramutola v. Bortone, 304 A.2d 197, (N.J. 1973)..
[xx] From Forman, S and Stahl, M; Medical-Legal Issues in Chiropractic, Volume 1, 1990.
[xxi] Procedure Terminology Manual, PA. Blue Shield, 2000.
[xxii] Medicare Carriers Manual, December 1999, Section 2251.5.
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[xxv] Chiropractic Code Desk Book, 2004.
[xxvi] Procedures Terminology Manual, PA Blue Shield, 2000.
[xxvii] http://dhmh.maryland.gov/chiropractic/SitePages/comar.aspx
[xxviii] American Institutes for Research. (2002). Teaching cultural competence in health care: A review of current concepts, policies and practices. Report prepared for the Office of Minority Health. Washington, DC: Author.