

Credentialing CAM providers



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Having biases seems to be a fundamental human trait. We have biases about almost everything. It is a constant battle to try to control our biases. In science one often goes to extreme measures to remove the bias of subjects and researchers. This is done with blinding and control. The purpose of the experimental design is to as effectively as possible remove bias from the study. In some studies one cannot systematically avoid bias but one must be aware of the possibility of bias affecting a study or one's writing and be vigilant for its appearance.

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Eisenberg et al.¹ have shown what I believe to be their bias in their paper detailing the credentialing of complementary and alternative medical providers (CAM). Eisenberg and colleagues (3 of whom are MDs) deal with this topic in a way that I believe is consistent with their status as the majority health care providers. The biases or arrogance with which the majority deals with a minority is often completely transparent to the members of the majority. Even if they are trying to be dispassionate and unbiased, the bias can be glaring to the minority.

The most blatant bias in Eisenberg's¹ paper would probably be obvious to any of the regular readers of this journal. It is easy to say that it is an issue that I would have been aware of given my past residence in Canada and my research collaboration with two Canadians.^{2,3} But suffice it to say that at the least my awareness of Eisenberg's bias is heightened by whom I am writing this commentary for, a Canadian chiropractic journal. It must be apparent now that the bias I am referring to is that their paper covers credentialing of CAM providers in the United States only, but does not say this anywhere in the abstract or paper. I suppose one could assume that it is a given that the paper is about the credentialing of CAM providers in the States because it appears in the official journal of the American College of Physicians and American Society of Internal Medicine. However a Medline search of Annals of Internal Medicine showed that of 18864 articles, 134 are by Canadians or about Canada is some way. So this journal while rarely publishing papers by or about Canadians does do so rarely.

In the first paragraph Eisenberg et al.'s bias or should I said their medical superiority complex shines through clearly. They say, "Legislative recognition trumps medical recognition: State legislature can license providers and thereby grant citizens access to certain therapies, even if scientific debate has not concluded in favor of those modalities." To me this is the most troubling statement in the whole paper for the implication here is two fold:

- 1 That the medical profession has some quasi-official authority to determine what is good and what is bad in health care. The fact that some legislatures have bypassed seeking the medical professions approval and have granted licensure to CAM providers was wrong or improper.
- 2 That the medical profession attained its exalted position of a licensed profession by divine right rather than through legislative recognition.

The medical profession does not hold any official authority to determine what is good or bad in health care. They have for years tried to obtain this kind of monopolistic control seeking to eliminate the chiropractic profession and others.⁴ In Eisenberg et al. the sentiment that legislation or freedom of choice trumps medical opinion is restated five times. So while the medical profession may not have earned official authority they certainly talk as if they should.

Licensure for medicine and for CAM providers was as a result of legislation. While we live in the era of evidence based practice, I am certain that the legislation authorizing the practice of medicine in most western countries was enacted before there was any research into the efficacy of any medical procedures. Depending on the jurisdiction and the profession this is also the case for CAM providers. I teach and practice in Connecticut where chiropractors first got licensure in 1917⁵ and the medical profession only received their legislative mandate 14 years earlier (personal communication, Joseph C. Keating, Jr., PhD, 3/4/03). I am certain that the Connecticut legislature was not convinced that medicine should be licensed because of a compelling body of literature demonstrating the clinical effectiveness and safety of the methods used in 1893.

To be evenhanded, when specifically discussing the credentialing of chiropractors, Eisenberg et al. are fairer. They note that the date of the first chiropractic license (in the US) was 1904 in Illinois. There is a discussion of the CCE (US) and its status with the US government. As well they note that standards for education and testing that have been established by the Federation of Chiropractic Licensing Boards and the use of the National Board of Chiropractic Examiners certification examinations. It is noted that an obstacle to uniform credentialing of chiropractors in health care organizations is the lack of uniformity of scope of practice from jurisdiction to jurisdiction.

There is a significant discussion about the variability of practice from jurisdiction to jurisdiction. This is, of course, not only a concern to those looking for uniformity in credentialing but also for those being credentialed. I have been licensed in three states and there are dramatic differences between the scope of practice and even the titles I can use in each of these states.

As Eisenberg terms it, there is a “conundrum” with regards to the status of chiropractors as “primary care providers” (PCP). The problem is the definition of what a PCP is. The Joint Commission on the Accreditation of Healthcare Organizations (JACHO), the major accrediting agency in the US for healthcare organizations, defines PCP, according to Eisenberg et al. as:

An individual “who provides primary care services” (that is “basic health care”) and “manages routine health care needs,” including “referral to a specialist for consultation or continued care”

According to Eisenberg, the American Chiropractic Association defines a chiropractor as “a first-contact gatekeeper” for patients with neuromusculoskeletal conditions in the primary health care system. The issue of whether a chiropractor is a PCP or not seems to be an issue in the US but not in Canada.

The paper then deals with credentialing and licensing of acupuncture, and traditional oriental medicine, naturopathy, massage therapy, homeopathy and “other complementary care providers.” I shall not comment on these other professions.

The crux of the paper is their proposed framework for credentialing CAM providers. To clarify, Eisenberg and colleagues define credentialing as “the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient services in or for a health care organization.” The minimum requirements for credentialing they suggest are: licensure; completion of national certification examination; documentation of completion of required studies and continuing education; and signed statements pertaining to malpractice insurance, history of malpractice and disciplinary action.

For a higher level of quality assurance Eisenberg suggests the following other items to use when credentialing: establishing a minimum number of years in practice, demographic characteristics of the practice and information

about office staffing. Site visits could be used to evaluate patient accessibility; office environment or written materials being distributed; the sale of products; the use of diagnostic or laboratory equipment and appropriate medical record keeping (using random chart reviews). These recommendations are reasonable and in fact would be ones I would suggest if it were up to me to determine credentialing guidelines.

The final suggestion for credentialing is that recommendations from “medical doctors, doctors of osteopathy, other conventional practitioners, and peers are useful to evaluate co-management.” The problem with this suggestion is given the reluctance of many “conventional” practitioners to co-manage cases with CAM providers many outstanding CAM providers may never have had any relationship with any conventional practitioner. This may put some CAM provider attempting to become credentialed in a Catch 22 of not being able to co-manage cases because of having never co-managed a case.

Eisenberg et al. believe that referral to CAM providers may cause an ethical dilemma for physicians because there is an “absence of definitive data regarding documented risks and benefits” of CAM services. This is another biased opinion because a significant portion of conventional services lack these definitive datasets.⁶

There is no question that the evidence based practice revolution is affecting CAM providers as well as conventional providers. However, there is no compelling reason for CAM procedures to be required to have a level of evidence documenting the safety and efficacy of these methods at a higher level than what is required for conventional procedures. Especially, as it appears chiropractors’ decisions to initiate care are as appropriate as medical decisions to initiate care.⁷

In summary, Eisenberg and colleagues present reason-

able guidelines for the credentialing of CAM providers in spite of their biases. It is unfortunate that in the twenty-first century there continues to be bias even in the scientific literature directed at CAM providers. One might expect this of conventional practitioners in private practice but medical scientists should strive for the objective higher-ground.

References

- 1 Eisenberg DM, Cohen MH, Hrbek A, Grayzel J, Van Rompay MI, Cooper RA. Credentialing complementary and alternative medical providers. *Ann Intern Med* 2002; 137(12):965–973.
- 2 Ball KA, Perle SM. Effect of a single manipulation of the tibiotalar (ankle) joint upon lower extremity joint alignment. In: Rosner AL, editor. 2002 International Conference on Spinal Manipulation, 8th Annual Conference on Advancements in Chiropractic, CCCRC Biannual Research Symposium; 2002; Toronto, Ontario, Canada: The Foundation for Chiropractic Education and Research; 2002.
- 3 Perle SM, Kawchuk GN, Perrault T, Adams W. Radiographically determined anatomical location of point of peak pressure during pisiform and hypothenar contact manipulation procedures. In: 2002 International Conference on Spinal Manipulation; 2002; Toronto, ONT, Canada: The Foundation for Chiropractic Education and Research; 2002. p. 20.
- 4 Wilk CA. *Medicine, monopolies, and malice*. Garden City Park, NY: Avery Publishing Group; 1996.
- 5 Wardwell WI. *Chiropractic: history and evolution of a profession*. St. Louis: Mosby-Year Book, Inc.; 1992.
- 6 Booth A. What proportion of healthcare is evidence based? Resource Guide. University of Sheffield, School of Health and Related Research [web page] [cited 2003 Mar 1] Available from: <http://www.shef.ac.uk/~scharr/ir/percent.html>
- 7 Shekelle PG, Coulter I, Hurwitz EL, et al. Congruence between decisions to initiate chiropractic spinal manipulation for low back pain and appropriateness criteria in North America. *Ann Intern Med* 1998; 129(1):9–17.