Workgroup Meeting Notice

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Interpretive Statement
The Washington Medical Commission (commission) is developing an interpretive statement regarding RCW 18.71.011, RCW 18.57.001(4), and RCW 18.25.005.

The commission is developing this interpretive statement to address the practice of physicians performing musculoskeletal physical examination.

Proposed Interpretive Statement Meeting
The Commission will conduct an open public meeting on Friday, February 14, 2020 beginning at 10:00 am:

In person
Department of Health
Town Center 2 - Room 167
111 Israel Road SE
Tumwater, WA 98501
(360) 236-2397 (security desk)

Via GoToMeeting
https://global.gotomeeting.com/join/432650909
Please note, we are unable to accept comments via VOIP at this time. If you would like to comment, please use the chat function in the GoToMeeting platform or call in via phone.

Via phone
Dial: 1 (646) 749-3122
Access Code: 432-650-909

The purpose of this meeting will be to collaborate with stakeholders, Commissioners, and members of the public in developing the language in the interpretive statement. Interested parties, stakeholders, and the general public are invited to participate in these workgroup meetings to provide comments on draft language.

For more information or to provide written comments prior to the meeting, please contact Amelia Boyd, Program Manager, at (360) 236-2727 or by email at amelia.boyd@wmc.wa.gov.

Attachments:
Original Draft Interpretive Statement
Proposed Draft Interpretive Statement
Letter from the Chiropractic Quality Assurance Commission

Original Draft Interpretive Statement

Department of Health
Washington Medical Commission

Interpretive Statement

Title:	Allopathic Physicians Scope of Practice Relating to Osteopathic Manipulative Therapy	INS2019-0X
References:	RCW 18.71.011; 18.57.001(4); 18.25.005	
Contact:	Washington Medical Commission	
Phone:	(360) 236-2750 E-mail: medical.commission@wmc.wa.gov	
Effective Date:		
Approved By:		

The Washington Medical Commission (Commission) interprets RCW 18.71.011, RCW 18.57.001(4) and RCW 18.25.005 to permit an allopathic physician to perform a musculoskeletal physical examination, regardless of the anatomy being examined, and to perform any treatment of a patient's back or spine, including osteopathic manipulative therapy, so long as it does not involve manual adjustment of the spine that would be considered the practice of chiropractic.

RCW 18.71.011 defines the practice of allopathic medicine:

> A person is practicing medicine if he or she does one or more of the following:
>
> (1) Offers or undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
>
> (2) Administers or prescribes drugs or medicinal preparations to be used by any other person;
>
> (3) Severs or penetrates the tissues of human beings;
>
> (4) Uses on cards, books, papers, signs, or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor of medicine," "physician," "surgeon," "m.d.," or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005.

RCW 18.57.001(4) describes the scope of practice of an osteopathic physician as follows:

> (4) "Osteopathic medicine and surgery" means the use of any and all methods in the treatment of disease, injuries, deformities, and all other physical and mental conditions in and of human beings, including the use of osteopathic manipulative therapy; ….

RCW 18.25.005 defines the scope of chiropractic practice. It provides, in part:

> "Chiropractic" defined.
>
> (1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
>
> (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments and extremity manipulation. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity.
>
> …
>
> (5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine.

It is clear from the above statutes that only osteopathic physicians and chiropractors can perform manual adjustment of the spine. Allopathic physicians are specifically excluded. The Commission understands there is uncertainty about what other procedures involving the spine that allopathic physicians can legally perform. The Commission wishes to clarify this issue.

Allopathic physicians frequently evaluate and treat patients for back pain. Standard treatment involves a diagnostic physical examination that includes assessing the patient's ability to sit, stand, walk and lift their legs, as well as having the patient rate their pain and describe how they are functioning with the pain. The physical examination typically also includes palpating the patient's back, including the spine, to help determine the area of the pain. All of this is done to properly diagnose the cause of the pain, decide if additional testing is required, and determine an appropriate plan of treatment. Treatment can include physical therapy, exercise, medication,

and, in some cases, surgery. This treatment may involve manual adjustment of the spine, but it is the practice of medicine and is not considered the practice of chiropractic.

The confusion may arise because the legal scope of practice for osteopathic physicians, RCW 18.57.001(4), permits osteopathic physicians to perform osteopathic manipulative therapy (OMT). The osteopathic practice act does not define OMT. According to the American Osteopathic Association, OMT "is a set of hands-on techniques used by osteopathic physicians (DOs) to diagnose, treat, and prevent illness or injury. Using OMT, a DO moves a patient's muscles and joints using techniques that include stretching, gentle pressure and resistance." OMT involves much more than a manual adjustment of the spine.

The Commission is cognizant of the increasing blurring of the distinction between allopathic and osteopathic physicians. Osteopathic physicians and allopathic physicians are training in the same residency programs on an increasing basis. In 2020 accreditation for allopathic and osteopathic residencies will transition from two separate accreditation systems into a single accreditation system with the Accreditation Council for Graduate Medical Education. In these residencies, osteopathic physicians are teaching allopathic physicians to perform OMT as they have been for years. The Commission supports any physician doing what he or she has been trained to do. This may include OMT depending upon the training and experience of the physician.

The Commission interprets RCW 18.71.011, RCW 18.57.001(4) and RCW 18.25.005 to permit an allopathic physician to perform a musculoskeletal physical examination, regardless of the anatomy being examined, and to perform any treatment of a patient's back or spine, including osteopathic manipulative therapy, so long as it does not involve manual adjustment of the spine that would be considered the practice of chiropractic. Manipulation of the spine that is incidental to the treatment of the patient is not considered the practice of chiropractic.

Proposed Draft Interpretive Statement

The Washington Medical Commission (Commission) interprets RCW 18.71.011, RCW 18.57.001(4) and RCW 18.25.005 together, in contemporary context, to permit an allopathic physician to perform a musculoskeletal physical examination, regardless of the anatomy being examined, and to perform any treatment of a patient's back or spine, including osteopathic manipulative therapy (OMT), so long as the treatment does not involve treatment techniques that would be considered the practice of chiropractic, or the physician being viewed or designated as practicing chiropractic.

RCW 18.71.011 defines the practice of allopathic medicine:[1]

> A person is practicing medicine if he or she does one or more of the following:
> (1) Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
> (2) Administers or prescribes drugs or medicinal preparations to be used by any other person;
> (3) Severs or penetrates the tissues of human beings;
> (4) Uses on cards, books, papers, signs' or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor of medicine," "physician," "surgeon," "m.d.," or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005.

RCW 18.57.001(4) defines the scope of practice of an osteopathic physician as follows:[2]

> (4) "Osteopathic medicine and surgery" means the use of any and all methods in the treatment of disease, injuries, deformities, and all other physical and mental conditions in and of human beings, including the use of osteopathic manipulative therapy….

RCW 18.25.005 defines the scope of chiropractic practice.[3] It provides, in part:

> "Chiropractic" defined.
> (1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.
> (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments and extremity manipulation. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological

[1] New section added to chapter 18.71 RCW in 1975
[2] New section added to chapter 18.57 RCW in 1979
[3] New section added to chapter 18.25 RCW in 1974

therapeutic procedures as traction and light but does not include procedures involving the application of sound, diathermy, or electricity.

…….

(5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine.

The Commission has become cognizant of the increasingly blurred distinction between allopathic and osteopathic physicians in recent years. Allopathic physicians and osteopathic physicians are training together in residency programs on an increasing basis, effectively amalgamating their respective philosophies. In 2020, accreditation for allopathic and osteopathic residencies will transition from two separate accreditation systems to a single system under the Accreditation Council for Graduate Medical Education (ACGME). Especially in the field of sports medicine, continuing medical education presentations that teach osteopathic manipulative therapy (OMT) techniques to mixed allopathic and osteopathic audiences are increasingly common. Thus, in contemporary medical practice, many allopathic physicians have received instruction and become proficient in OMT techniques, while most osteopathic physicians base significant portions of their practice on allopathic philosophies. This evolution of practice is of distinct benefit to patients, and should be encouraged, but it gives the impression of being in conflict with the relatively outdated and conflicting statutory definitions cited above. Each of the practices referred to in the above statutes employ techniques of physical examination and treatment that are common to, or resemble, those used in the other two, and appropriate use of these should not be a source of contention. The Commission believes that a licensed allopathic physician and surgeon (and a licensed osteopathic physician and surgeon or chiropractor) should be entitled to exercise any skills and techniques in the examination and treatment of patients for which the physician has been appropriately trained and which the physician can perform safely with competence.

The Commission notes the very broad language in the statutory definition of osteopathic medicine and surgery and believes that such language accurately reflects the current practice of allopathic medicine and surgery as well. The Commission further notes the dates of adoption of the statutory definitions for allopathic, osteopathic and chiropractic practice cited above, concludes that they are outdated and in conflict with much of current practice, and respectfully urges the legislature to review them at its earliest convenience to bring them into conformity with present-day practice and each other.

November 14, 2019

Alden W. Roberts, MD, Chair
Washington Medical Commission
111 Israel Road SE
Tumwater, WA 98501

Dear Dr. Roberts,

The Chiropractic Quality Assurance Commission (CQAC) is in receipt of the Washington Medical Commission's (WMC) draft interpretive statement titled "Allopathic Physicians Scope of Practice Relating to Osteopathic Manipulative Therapy, INS2019-0X" (Interpretive Statement). The CQAC has significant concerns with this Interpretive Statement.

The draft Interpretive Statement does not comply with statute. Specifically, the Interpretive Statement does not comply with RCW 18.71.011 and RCW 18.25.055. To illustrate, the Interpretive Statement provides that treatment by an allopathic physician may "involve manual adjustment of the spine" and "osteopathic manipulative therapy." The CQAC interprets these statements to be in conflict with relevant statutory provisions that prevent an allopathic physician from "adjustment by hand or any articulation of the spine" and from "engag[ing] in the practice of chiropractic" (*see* RCW 18.25.005(5) and RCW 18.71.011(4)).

While the CQAC understands there is an "increasing blurring of the distinction between allopathic and osteopathic physicians", and that the WMC "supports any physician doing what he or she has been trained to do," this does not allow an allopathic physician to engage in conduct that is prohibited by statute. As a result, the CQAC respectfully requests the WMC decline to adopt the Interpretive Statement.

Kind Regards,

David Folweiler, D.C.,
Chiropractic Quality Assurance Commission, Chair

From: Kevin Ware
To: Boyd, Amelia (WMC)
Cc: Drake, Tracie L (DOH)
Subject: OMT
Date: Monday, February 10, 2020 3:35:08 PM

Ms Boyd

I am a member of the Washington State DO licensure Board and will try to attend via phone the Wed 2/14 meeting on the above topic. In the event I am unable to make the call, or do not have an opportunity to express my opinion, I am listing it below. You are free to quote me.

In the main DO trained physicians, including myself as a member of the DO board, feel that US health care would be better served if ALL physicians (regardless of degree MD or DO, who were interested and trained in the subject), performed manual medicine, including using various common manipulative treatments in which no one school really holds a "patent".

In 40 years of practice in Washington State I have found that MD colleagues who for whatever reason had a real professional interest in manual medicine were often more skilled and adept at manipulative treatment modalities than I was. Same is true for some physical therapist.

In addition in many of the National level AAFP CME courses I have attended over the past 20+ years, hands on courses on manipulation put on by DOs for their fellow FP MD colleagues were standing room only. Which is how it should be.

It has also been my experience that techniques used by various skilled practitioners in this area (DC vs DO vs PT vs MD) differ primarily in name only. That is there is nothing truly unique about "osteopathic" or "chiropractic" manipulative treatment that I have not seen other competent practitioners of manual medicine use.

I think that for the most part this is an outdated and semantic debate, with some aspects perhaps being self serving to different professional groups. For DO medical school graduates the time has long passed wherein "spinal manipulation" was considered something that was or should be considered their exclusive domain.

Manual medicine or manipulative treatment is not a "cure all" by any means, but the public would be better served if these therapeutic modalities were accepted and their use open to all appropriately skilled and interested physicians, regardless of professional degree, DO or MD.

Regards,

Kevin E. Ware, DO/AAFP

Sent from my iPhone

Improvement of health care delivery to minimize disruptions is another important area that requires more research.[1] Power outages during extreme heat can create dangerous situations in which patients may lose access to cooling equipment or electricity-dependent medical supplies at home. Hospitals must rely on backup generators that may power only certain aspects of operation, resulting in technological complications and turning normally high-tech hospitals into limited-resource environments. Recently, nearly 250 hospitals were affected by the intentional power outages in California, undertaken to reduce the risk of wildfires. Many of the events that expose us to the effects of climate change can also result in supply-chain disruptions like those that have caused shortages of intravenous saline.[1] Such disruptions further hinder clinicians' ability to provide care, and they present a significant opportunity to proactively prepare instead of reflexively reacting to each individual crisis.

Despite the irony, I often describe our current knowledge of the health effects of climate crisis as an iceberg. Though we see a peak above the water's surface, there is much more to fear from the larger mass beneath — the effects that we haven't yet identified. For example, rising temperatures were recently linked to increasing bacterial resistance to antibiotics.[5] The full health implications of the climate crisis may be far more immense and insidious than we have so far imagined. Although dedicated climate and health research is needed, this gap can be addressed more rapidly by adding a climate-change lens to existing lines of research.

Transitioning from theoretical discussions to practical applications will require multidisciplinary collaboration and sharing of best practices. We will need to learn from health professionals and systems that have already been facing dynamic climate threats that will increasingly affect other regions. Collaboration is the driving force behind the Climate Crisis and Clinical Practice initiative that is being launched in Boston on February 13, 2020, with the first of what we, the organizers, hope will be numerous symposia held throughout the United States and elsewhere. The initiative aims to highlight this critical need and provide an online forum to promote conversation. Although ultimately the best medicine for the climate crisis is preventive — the urgent reduction of greenhouse gases — we cannot ignore the myriad ways in which our patients' health is already being harmed and our responsibility to improve our practice.

Disclosure forms provided by the author are available at NEJM.org.

From the Department of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School, and the Center for Climate, Health, and the Global Environment, Harvard T.H. Chan School of Public Health, Boston, and the Harvard Global Health Institute, Cambridge — all in Massachusetts.

1. Salas RN, Solomon CG. The climate crisis — health and care delivery. N Engl J Med 2019;381(8):e13.
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4. Hoye WL, Mogalian EM, Myrdal PB. Effects of extreme temperatures on drug delivery of albuterol sulfate hydrofluoroalkane inhalation aerosols. Am J Health Syst Pharm 2005;62:2271-7.
5. MacFadden DR, McGough SF, Fisman D, Santillana M, Brownstein JS. Antibiotic resistance increases with local temperature. Nat Clim Chang 2018;8:510-4.

DOI: 10.1056/NEJMp2000331

Modernizing Scope-of-Practice Regulations — Time to Prioritize Patients

Bianca K. Frogner, Ph.D., Erin P. Fraher, Ph.D., M.P.P., Joanne Spetz, Ph.D., Patricia Pittman, Ph.D., Jean Moore, Dr.P.H., Angela J. Beck, Ph.D., M.P.H., David Armstrong, Ph.D., and Peter I. Buerhaus, Ph.D., R.N.

Ongoing payment reforms are pressing health systems to reorganize delivery of care to achieve greater value, improve access, integrate patient care among settings, advance population health, and address social determinants of health. Many organizations are experimenting with new ways of unleashing their workforce's potential by using telehealth and various forms of digital technology and developing team- and community-based delivery models. Such approaches require reconfiguring of provider roles, but states and health care organizations often place restrictions on health professionals' scope of practice that limit their flexibility.[1]

These restrictions are inefficient, increase costs, and reduce access to care. As leaders of public and private research centers

who interact with and study the U.S. health workforce, we believe it's time to revise the country's antiquated patchwork of laws that restrict the health system's ability to innovate. We should improve our approach to regulating health professionals' scope of practice so that regulations better serve the needs of patients, rather than protect turf in the battles among health professions.

State licensure boards determine which health care practitioners are licensed, the requirements for obtaining licensure, and what services various practitioners can provide. As a result, the services performed by members of the same health profession may vary widely among states. An additional layer of regulation occurs at the health care organization level, where privileges are determined by medical-staffing committees and other leadership bodies. Policymakers are increasingly recognizing that differences in state laws and in the ways in which organizations deploy their workforces aren't based on evidence regarding quality of care or safety. Rather, state laws and organizational policies are informed by lobbying by professional associations that jockey to impose their self-interested views.[2,3]

There are two major consequences associated with restricting the scope of practice of qualified and competent workers who have been trained to safely and efficiently provide services: skills aren't used to their full extent, and workers aren't employed in innovative ways to meet health care needs. The status quo is unproductive, wasteful, and costly. Psychiatric pharmacists, for example, could help offset the shortage of psychiatrists by providing medication-management services. In addition, many states don't allow these practitioners to prescribe buprenorphine, despite the need for more trained clinicians to mitigate the opioid epidemic. Dental therapists provide routine preventive and restorative oral health care services, including preparation and filling of cavities. Although dental therapists or equivalent practitioners augment the capacity of the oral health workforce in at least 50 countries and a vast body of evidence supports the safety and effectiveness of this approach, professional dentists' organizations continue to oppose legislation to authorize dental therapists to practice in the United States. Similarly, home care aides, who provide assistance with activities of daily living for millions of frail older adults and younger people living with disabilities, are subject to regulations that reduce their ability to meet clients' care needs. In many states, licensed nurses are prohibited from delegating various tasks to aides, including administration of routine medications. We are unaware of evidence that such restrictions protect patient safety. On the contrary, there is growing evidence that expanded delegation benefits patients.

Traditional workforce-planning approaches have imposed similar constraints by trying to identify the "right" number of each type of health professional needed in the future. Most health workforce models have taken a silo-based approach that assumes that each health profession has an exclusive and fixed scope of practice. Contemporary workforce-planning models have begun to transition away from these profession-centered approaches toward population-based approaches that start with different questions: What are the population's health care needs? And how might fully enabled teams of providers meet these needs?[4] Such an approach requires shifting from a focus on provider shortages to a recognition that health professions have scopes of practice that overlap and can, if regulation allows, adapt depending on patients' health care needs and on other members of the care team.[4] New workforce models for behavioral health needs, for example, could include social workers and community health workers in addition to psychiatrists, psychiatric nurse practitioners, and physician assistants.

Regulators can change the ways in which scope-of-practice regulations are created and revised by making decisions on the basis of evidence regarding quality and safety, rather than the objections raised by other health professions. Strategies for increasing the use of evidence in decisions about scope of practice include implementing state-based requirements for in-depth policy analysis, issuing "sunrise" reports that document the need for proposed changes, estimating the costs and benefits to the public of such changes, and assessing potential alternatives. When insufficient evidence is available to support a change, demonstration programs such as California's Health Workforce Pilot Project, which permits testing and rigorous evaluation of changes in scopes of practice, may be indicated.[5]

Although each state has the authority to establish scope-of-practice regulations, we believe it's time to standardize evidence-based minimum scopes of practice for health professionals. Greater uniformity would support health professionals' ability to practice to the full extent of their education and training and enhance opportunities for efficient and effective health service delivery that

better meets patients' needs. Uniformity is especially important for the provision of telehealth services, since implementation can be hindered by state scope-of-practice rules that restrict practitioners from working across state lines. Expanded use of interstate licensing compacts would also support more effective and more efficient telehealth service delivery.

Educators in the health professions also have an important role in modernizing scope-of-practice regulations. Traditional programs that educate health professionals in silos reinforce restrictive approaches. We believe it's important to shift to a focus on interprofessional collaboration in practice environments that support continuous learning about how best to serve patients. Interprofessional education can help learners understand the histories, perspectives, and contributions of various professions and better prepare health care professionals to work in teams.

Finally, clinicians can raise questions and challenge their professional associations, state regulatory bodies, insurance companies, and leaders in charge of making decisions about scope of practice in health care delivery organizations. Even in states that permit more expansive scopes of practice, many health care delivery organizations are slow to allow expanded staff privileges in accordance with reforms. Clinical and administrative leaders within health care organizations can discuss the ways in which such restrictions affect efficiency, costs, and the configuration of teams and what changes could be made to better meet patients' needs.

An audio interview with Dr. Frogner is available at NEJM.org

Over the past decade, numerous reforms have been implemented by the federal government and by states to expand health insurance coverage, change payment models, motivate organizations to reconfigure the ways they deliver care, modify eligibility for Medicaid, and better prepare the health workforce for pressing behavioral care, primary care, geriatric care, and community care needs. To realize the potential of these laudable reforms, we believe that states should eliminate overly restrictive scope-of-practice regulations that they impose on the health professions. Doing so would allow us to unlock the full potential of the country's health workforce.

Disclosure forms provided by the authors are available at NEJM.org.

From the Center for Health Workforce Studies and the Department of Family Medicine, School of Medicine, University of Washington, Seattle (B.K.F.); the Carolina Health Workforce Research Center and the Department of Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill (E.P.F.); the Health Workforce Research Center on Long-Term Care and the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, San Francisco (J.S.); the Fitzhugh Mullan Institute for Health Workforce Equity, Milken Institute School of Public Health, George Washington University, Washington, DC (P.P.); the New York Center for Health Workforce Studies (J.M.) and the Workforce Technical Assistance Center (D.A.), University at Albany–SUNY School of Public Health, Rensselaer; the Behavioral Health Workforce Research Center and School of Public Health, University of Michigan, Ann Arbor (A.J.B.); and the Center for Interdisciplinary Health Workforce Studies and the College of Nursing, Montana State University, Bozeman (P.I.B.).

1. Federal Trade Commission. Policy perspectives: competition and the regulation of advanced practice nurses. March 2014 (https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf).
2. McMichael B. The demand for healthcare regulation: the effect of political spending on occupational licensing laws. South Econ J 2017;84:297-316.
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DOI: 10.1056/NEJMp1911077

On Suboptimization — Cadillac Care at the Mecca

Brendan M. Reilly, M.D.

After David had a stent put in his bile duct, the Tumor Board said he needed a Whipple procedure, but 3 weeks later the surgeon hadn't scheduled him, and a friend whose uncle died of pancreatic cancer said David should go to the best place. *When you get on an airplane*, she said, *you want a pilot who does this every day.* So they called three famous cancer centers and interviewed surgeons who do Whipples all the time. David hoped for the place where it doesn't snow, but that guy, when asked about his operative mortality, got huffy and hung up. The second place didn't "target the tumor" as Google recommended, so David favored the place whose surgeon agreed to see him immediately.