



Department of Commerce
Office of Professional Licensure Review

2026 Periodic Review

Chiropractic Physicians

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Executive Summary

Background

Chiropractic Physicians (DCs), or chiropractors, are licensed health care professionals whose focus is the musculoskeletal system, particularly the spine. DCs take a non-surgical, non-pharmacological approach to care, emphasizing spinal manipulation, rehabilitation, and other physiological therapies. There is no single approach to chiropractic education and training. As a result, DCs practice according to their philosophical approach. Practitioners with traditional training focus largely on manipulation and adjustment, whereas practitioners with a more recent approach incorporate other therapies and rehabilitative procedures.

Every state in the U.S. licenses DCs. The requirements for licensure are largely uniform across the nation. The scope of practice, however, varies more significantly across states. Although most states' scope includes the core of chiropractic practice, states differ on whether they allow DCs to perform other adjunctive therapies or practices and with what training. Utah's scope of practice is relatively broad compared to most states.

Regulatory Model Recommendation: Continue to license DCs

- DCs use manual therapies, some of which involve physical force that, in rare cases, may result in serious bodily injury and require immediate medical intervention.
- Chiropractic care occurs in a private setting where the patient may be in various states of undress. This setting presents the risk of ethical and sexual misconduct.
- DCs operate with a high level of independence and little oversight outside of licensure.

Recommended Regulatory Adjustments:

- *Grant DOPL citation authority for licensed chiropractic physicians to provide the Division of Professional Licensing (DOPL) with more tools for holding licensees accountable*
- *Adopt additional practice requirements and unprofessional conduct provisions to address sexual misconduct:*
 - DOPL data shows DCs have a relatively higher rate of substantiated complaints, and a higher proportion of complaints related to sexual misconduct.
 - These measures are aimed at strengthening professional practices and patient protections while minimizing burdens on the many ethical practitioners in Utah.

Additional Recommendations:

- *Better align the profession-specific and universal endorsement pathways*

Other Considerations:

- OPLR considered, but ultimately decided against making formal recommendations related to joint injection therapy.

Context

Consistent with its legislative mandate, the Office of Professional Licensure Review (OPLR) reviewed Utah's regulatory laws for chiropractors. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners and the state¹

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), academic literature, health workforce data, as well as laws and policies in other states. OPLR also conducted interviews with practitioners, industry representatives, business owners, employers, educators, and other subject matter experts. See [Appendix 1.1](#) for more information.

Background

Profession Overview

Chiropractic physicians (DCs), or chiropractors, are licensed healthcare professionals concerned with the assessment, diagnosis, treatment, and prevention of disorders of the muscles, bones, and joints, particularly the spine, and the effects of these disorders on the nervous system and on general health.² DCs take a non-surgical, medication-free approach to care, emphasizing spinal manipulation and adjustment, rehabilitative procedures, therapeutic exercise, patient education and self-efficacy (i.e., providing guidance on diet, sleep, and stress management), and other adjunctive physiological therapies (e.g., massage, acupuncture).

There is no single approach to chiropractic education and training. Traditional chiropractic philosophy is rooted in the idea that the human body possesses an innate ability to self-regulate and heal, and that misalignments in the spine hinder that ability, necessitating treatment that aligns the spinal column to reduce pain and promote healing.³ However, more recent chiropractic approaches diverge from this traditional belief. They use a whole-person approach (body, mind, and lifestyle) that treats musculoskeletal and neuro-musculoskeletal conditions through a combination of manual therapy, exercise prescription, education, and interdisciplinary collaboration.⁴

As a result, DCs practice according to their philosophical approach. Practitioners who ascribe to the traditional view focus largely on manipulation and adjustment, whereas practitioners with a more recent approach often use other therapies and rehabilitative procedures.

¹ Utah Code § 13-1b

² World Federation of Chiropractic, "What Is Chiropractic."

³ Taking Charge of Your Wellbeing, "Philosophy of Chiropractic."

⁴ Leboeuf-Yde et al., "One Big Unhappy Family."

DCs primarily treat neuromusculoskeletal issues. The most commonly managed conditions include acute low back pain and muscle strain, acute neck pain, spinal subluxation/joint dysfunction, and other chronic pain (e.g., pelvic, thoracic, myofascial, neck).⁵ Chiropractic treatment has been shown to moderately manage pain and improve function for patients with acute back and neck pain.⁶ It may also effectively treat persistent headaches in some people.⁷ DCs treat patients of all ages, but most commonly treat adults aged 18–65.⁸

DCs commonly operate as sole practitioners working in outpatient single- or multi-DC offices.⁹

Profession in Utah

There are approximately 1,100 licensed chiropractic physicians in Utah.¹⁰ To become licensed as a chiropractic physician in the state, an individual must: 1) complete two years of general study in a college or university, 2) earn a degree of doctor of chiropractic from a chiropractic college or university accredited by the Council on Chiropractic Education (CCE), 3) pass parts I–IV of the board exams, as well as the physiotherapy exam, administered by the National Board of Chiropractic Examiners (NBCE), and 4) pass the Utah Chiropractic Law and Rules exam. Doctor of Chiropractic programs accredited by CCE typically take three to four years to complete¹¹ and only admit students who have previously completed at least ninety semester hours (approximately three years) of learning at an accredited institution of higher education.¹²

Utah law also provides an endorsement pathway for chiropractors licensed in another state who have actively practiced for at least two years immediately before applying.

DCs must renew their license with the Utah Division of Professional Licensing (DOPL) every two years, which requires completing forty hours of continuing education.¹³

The scope of practice for DCs in Utah is broad, enabling both traditional and broader forms of practice. It includes taking X-rays, ordering other diagnostic imaging, administration of physical agents and topically applied medicinal agents, wound debridement/care, and rehabilitative therapies such as joint manipulation, exercises and splinting. DCs may also provide acupuncture and injection therapy with additional training. DCs' scope contains some important exclusions, such as prescribing beyond certain topical agents, performing incisive surgery, and practicing obstetrics.¹⁴

⁵ National Board of Chiropractic Examiners, *Practice Analysis of Chiropractic 2025*, 21.

⁶ Paige et al., "Spinal Manipulative Therapy."

⁷ Lynge et al., "Chiropractic Manipulation versus Sham Manipulation."

⁸ National Board of Chiropractic Examiners, *Practice Analysis*, 78.

⁹ National Board of Chiropractic Examiners, *Practice Analysis*, 73.

¹⁰ DOPL Licensing Data, Accessed January 13, 2026. 85% of licensees have an address in Utah.

¹¹ The CCE requires programs to be 4,200 hours, 1,000 of which must be in patient care settings.

¹² Council on Chiropractic Education, *CCE Accreditation Standards*.

¹³ Utah Code R156-73-303a. Licensees providing acupuncture services must complete 10 hours related to acupuncture.

¹⁴ Utah Code § 58-73-601. DOPL has also taken action on complaints about DCs treating behavioral health disorders.

Approaches in Other Jurisdictions

Every state in the U.S. licenses DCs. The requirements for licensure are largely uniform across the nation. Although education standards differ somewhat, every state requires applicants to pass the NBCE I–IV board exams,¹⁵ functionally requiring all applicants to meet, at a minimum, the education requirements set by CCE to sit for the exam (described above). Thirty-four states, including Utah, require applicants to pass at least one additional exam beyond board exam parts I–IV.¹⁶

DC scope of practice varies more significantly across states.¹⁷ Although most states' scope includes the core of chiropractic practice (e.g., ordering X-rays, adjustment/manipulation, therapeutic exercise), states differ on whether they allow DCs to perform other adjunctive therapies or practices and with what training. Utah's scope of practice is relatively broad compared to most states. For example, a number of states require additional training for physiotherapy modalities, while Utah does not. Not all states allow DCs to perform acupuncture, injection therapy, or dry needling, though many do. Only three states (ID, NM, OR) allow DCs to perform advanced activities if those DCs meet certain training requirements. These activities may include the administration of specific prescription drug products, prescription of certain medications (e.g., NSAIDs, steroids, lidocaine), obstetrics or minor surgery.

Regulatory Model Assessment & Recommendation

Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g., license, registry, no regulation), OPLR developed a framework that incorporates its statutory review criteria.¹⁸ Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See [Appendix 2.1](#) for more information.

Recommendation

OPLR recommends that licensure is an appropriate form of regulation for chiropractic physicians. Significant considerations for this recommendation include the potential for harm

¹⁵ A few states, such as Utah and New York, may allow an applicant to take the SPEC exam in place of the NBCE III exam. Both are administered by the NBCE. OPLR Policy Scan; see [Appendix 1.2](#).

¹⁶ These states all require the NBCE's physiotherapy exam, 2 of which additionally require the NBCE's acupuncture exam. Federation of Chiropractic Licensing Boards, Education and Testing.

¹⁷ It is difficult to precisely compare scope across states. Many states stay "silent" on many issues, making it unclear whether or not a licensed individual could practice that act. Therefore, OPLR focused on states which give DCs explicit authority to perform certain activities.

¹⁸ Among other criteria, OPLR is required to evaluate "whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" and consider "potentially less burdensome alternatives to the... existing regulation". Utah Code § 13-1b-302(1), (10).

inherent in the practice of chiropractic, patient and setting factors, the prevalence of sole practice, and the limited nature of other forms of oversight.¹⁹

Potential for harm

The practice of chiropractic involves the use of joint and spinal manipulation, which requires the application of physical force to thrust a joint past its normal range of motion. Poor or untrained performance of this scope may exacerbate a patient's current injury or disability or cause new, sometimes severe, injury. Spinal manipulation in particular has been linked to spinal cord injuries and vertebral artery dissection, which causes strokes.²⁰ Although rare among educated and trained chiropractors,²¹ adverse events require immediate medical attention and can result in death.²²

The potential for harm inherent in chiropractic is exacerbated by the downstream implications of poor or untrained care. Worsening, or causing, a neuromusculoskeletal disorder may necessitate further medical interventions. Additionally, failing to refer a patient to another provider (for conditions such as cancer, respiratory or cardiovascular disease or infection) may enable disease development that ultimately cannot be reversed.

The setting in which chiropractic care takes place also exacerbates the potential for harm. Care occurs in a one-on-one setting. It consists of frequent, sustained, and sometimes intimate hands-on physical touch of patients who may be in various states of undress. This environment creates an opportunity for sexual harm that does not exist in most other healthcare professions.

Related Harm Factors

DCs operate with a high level of independence and little oversight outside of state licensure through DOPL. Over half of DCs report working as sole proprietors, and approximately 80% report working in solo private practice or multi-DC offices.²³ There is little oversight from employers as a result.

Cash/private payment is the most common reimbursement method for chiropractic care (approximately 40% of all reimbursement), limiting oversight by insurance payers.²⁴ Consumer oversight mitigates some risk, as individuals may choose their practitioner based on reviews or word of mouth. However, consumer oversight of chiropractic does not mitigate the risk of harm enough to consider deregulation.

¹⁹ This is not a comprehensive list of all factors. Please see [Appendix 2.2](#) for more information on OPLR's analysis of the potential for harm related to chiropractic.

²⁰ Ernst, "Adverse Effects of Spinal Manipulation."

²¹ Aleyadeh et al., "Cervical Artery Dissection"; Daniels et al., "Adverse Events among Older Adults."

²² Tavakoli, Britt, and Agarwal, "Vertebral Artery Dissection."

²³ National Board of Chiropractic Examiners, *Practice Analysis*, 73.

²⁴ National Board of Chiropractic Examiners, *Practice Analysis*, 77.

Regulatory Model Adjustments & Recommendations

Framework

After determining an appropriate regulatory model, OPLR's framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see [Appendix 3.1](#)).

Safety Issues

OPLR found concerning levels and patterns of harm among the chiropractic profession in Utah. OPLR's analysis of DOPL complaint data found that chiropractic physicians have among the highest substantiated complaint rates of all healthcare professions.²⁵ While this represented only 73 complaints between 2017 and 2024 in a profession of ~1,100 licensees, ~30% of complaints, representing 20 cases investigated and closed during this timeframe, were related to sexual misconduct, some of which resulted in severe harm.²⁶ This represents the highest rate of sexual misconduct complaints of all non-behavioral healthcare professions regulated by DOPL, including massage therapists.²⁷ All chiropractic sexual misconduct complaints were filed against distinct licensees, and 15 of the cases were non-consensual. Of the 20 cases, OPLR determined that one or two may have been accidental and 5 involved inappropriate comments rather than touch. However, OPLR also found 6 cases of sexual battery or assault against multiple patients, 4 of which resulted in criminal conviction and a prison sentence.

OPLR's complaint analysis also uncovered a degree of alleged financial harm, although not at the same frequency as sexual misconduct. OPLR could not make cross-profession comparisons about fraud and therefore could not contextualize the potential degree of this issue. Of note, four substantiated complaints followed a similar pattern of elderly patients signing up for prepaid chiropractic treatment plans at very high prices, without these patients fully understanding the contract, or even receiving services in some cases.

OPLR did not find any other concerning complaint patterns. Many of the remaining complaints alleged relatively minor issues, such as DCs using an incorrect title or advertising a practice that is outside their scope of practice.²⁸

²⁵ Between 2017 and 2024, there were 5.1 substantiated complaints per 100 chiropractic physicians. While rates are not directly comparable and there are only ~1,100 chiropractic physician licensees in Utah, the complaint rates for professions such as physicians (MDs and DOs), nurse practitioners and physical therapists are materially lower.

²⁶ 20 complaints were related to sexual misconduct of 70 complaints read. There were 73 total complaints, but OPLR was unable to access 3 of them.

²⁷ Although massage therapists and physicians had an overall higher number of sexual misconduct complaints across the same time period, the number per practitioner for DCs is over two times that of massage therapists and over 10x that of physicians. See [Appendix 3.2](#) for more information on this analysis.

²⁸ One complaint alleged physical harm, but it was minor and temporary in nature.

Access Issues

Available evidence suggests that access to chiropractic services is sufficient in Utah, although reliable data on the size of the employed workforce is limited.²⁹ The Health Resources and Services Administration (HRSA) provides an estimate for the demand of chiropractic services in Utah, and licensing data suggests that the number of DCs working in Utah meets, or potentially exceeds, that demand.³⁰ Between 2014 and 2024, the number of licensed DCs in Utah grew 2.4% on an annualized basis.³¹ This is slightly above the 1.8% annualized growth in the Utah population over the same time period but below the rate for other healthcare professions reviewed by OPLR, such as physical therapists (4.6%) and osteopathic physicians (12.4%).³² However, the number of licensed DCs per capita in Utah (3.2 per 10,000) aligns with the national median (3.0) and national average (3.1), suggesting that Utah's supply of practitioners aligns with the rest of the U.S.³³

Stakeholders agreed that the supply of DCs is likely sufficient, but that patients may face barriers to access due to insurance constraints.³⁴ OPLR's preliminary research into this issue confirms that DCs are not reimbursed at the same rate or frequency as some other healthcare professions, such as physicians. For example, Medicare covers only one type of service,³⁵ Utah Medicaid does not reimburse any chiropractic services for non-pregnant adults,³⁶ and DCs may be reimbursed less than physicians for the same billing codes.³⁷ As mentioned earlier in this report, cash/private payment is generally the largest source of income for DCs.³⁸

There are barriers to individuals interested in pursuing a career as a chiropractic physician, primarily from the location and cost of education programs. This challenge is similar to other areas of healthcare. There are only 19 accredited chiropractic programs in the U.S., with none in Utah.³⁹ Average tuition for chiropractic programs is roughly \$145,000, and the programs

²⁹ The Federal Bureau of Labor Statistics (BLS), and the Utah Department of Workforce Services (DWS) use employment surveys to estimate the size of the chiropractic workforce, but the accuracy is likely affected by the prevalence of DCs working in solo/private practice. HRSA uses BLS data as only one of its inputs for estimating supply.

³⁰ HRSA estimates that Utah needs 860 DC FTEs in 2026, which is met by the number of licensees in Utah that have an in-state address (940). However, licensing estimates are an imperfect proxy for FTEs, as it is possible that some currently licensed practitioners are not practicing or are practicing part-time. Health Resources and Services Administration, "Workforce Projections."

³¹ DOPL Licensee Data. See [Appendix 3.4](#).

³² OPLR used the annual Utah population estimates from the IBIS Query Builder using Kem C. Gardner Policy Institute Population Estimates. Growth rates for other healthcare professions are based on DOPL licensee data. Utah Department of Health and Human Services, "Population Estimates Query Module."

³³ OPLR filled in missing 2024 data from the FLCB's licensure statistics from the FLCB's licensure statistics with 2022 estimates in the instances where the 2022 estimates were distinct from the 2021 estimates. Delaware, Iowa, Michigan, and Vermont were excluded from OPLR's analysis due to a lack of any recent data. Per capita estimates used 2024 Census population data from 2024. Federation of Chiropractic Licensing Boards, U.S. Licensure Statistics.

³⁴ OPLR Stakeholder Series.

³⁵ Medicare covers manual manipulation of the spine only, not any other services or tests a chiropractor orders. Medicare.gov, "Coverage for Chiropractic Services."

³⁶ *Utah Department of Health, Utah Medicaid Provider Manual*.

³⁷ "Reimbursement Research."

³⁸ National Board of Chiropractic Examiners, *Practice Analysis*, 77.

³⁹ National Board of Chiropractic Examiners, *Practice Analysis*, 17.

require approximately 3.5 years of full-time study to complete.⁴⁰ Education debt could be difficult to pay down. A recent survey on the return on educational investment for DCs found that respondents graduate with ~\$180,000 in debt, currently hold \$230,000 in debt, and earn an average income of \$100,000. Over half (53%) of respondents disagreed that chiropractic training provided a positive ROI.⁴¹ The profession is aging, suggesting that younger licensees are not entering the chiropractic workforce at a replacement rate, although OPLR cannot confirm that. In 2016, the median age of licensees was 46, and 25% of licensees were above the age of 55. Currently, the median age of licensees is 51, and ~40% of licensees are above the age of 55.⁴² Despite this, an industry stakeholder associated with the chiropractic colleges expressed little concern about chiropractic program enrollment, stating that 2025 was the first year in which there was a slight overall decline in enrollment.⁴³

Discussion

The relatively disproportionate theme of sexual misconduct in DOPL substantiated complaints is OPLR's main concern from its review of safety and access considerations. Utah does not have overly burdensome requirements for licensure relative to other states and the state's scope of practice for DCs is already broad. Access appears generally adequate and licensing policy cannot address barriers presented by limitations on chiropractic reimbursement.

To mitigate potential risks of sexual misconduct, OPLR recommends strengthening DOPL enforcement mechanisms and adding a combination of standard patient disclosure, consent, and practitioner conduct requirements. These recommendations, and examples, are described below.

Recommendation 1: Grant DOPL citation authority for licensed chiropractic physicians

Under DOPL's umbrella statute, DOPL may cite and fine any profession, including DCs, for a small subset of actions (e.g., practicing without a license), but for all other actions, a profession's practice act must specify if and when a citation and fine can be issued.⁴⁴ Currently, Utah's Chiropractic Physician Practice Act does not give DOPL authority to issue a citation and administrative fine to DCs for any acts of unprofessional conduct. In contrast, DOPL can cite and fine many other (but not all) healthcare and related professions for profession-specific violations of their respective practice acts.⁴⁵

⁴⁰ Tuition estimates pulled from program websites.

⁴¹ The reported median income was much lower at \$76,000. However, income may be underestimated, as women were overrepresented in the survey and tend to earn lower salaries. Income estimates for DCs are generally reported as low and are difficult to rely on. The chiropractic practice analysis report estimates the average DC income in Utah as \$75,000. Data USA reports an average income of \$100,000. Schut, Cupler, and Coleman, "Student Loan Burden." Utah Department of Workforce Services, "Utah Economic Data Viewer."

⁴² DOPL Licensing Data.

⁴³ OPLR Stakeholder Series.

⁴⁴ See Utah Code § 58-1-502(2).

⁴⁵ DOPL can cite and issue fines for profession-specific violations to: physicians (MDs and DOs), pharmacists and pharmacy technicians, nurses and advanced practice nurses, naturopathic physicians, and massage therapists. Similar to DCs, this DOPL authority is not included in the practice acts of: behavioral health practitioners, physical therapists, physician assistants and optometrists.

OPLR recommends expanding DOPL's authority to cite and fine chiropractic physicians. This provides DOPL with more tools to address instances of patient harm. Currently, DOPL may either issue DCs a letter of concern (public reprimand), or take action against an individual's license (probation or revocation). There are instances when a letter of concern may not provide enough of a disincentive (letters of concern largely help in cases where misconduct was not purposeful), but taking an action against a license may be inappropriate or impossible. Many of the more serious sexual misconduct cases OPLR reviewed involved behavior that escalated. DOPL citation and fining authority may hold licensees accountable for inappropriate behavior before it escalates to more severe patient harm. It may be particularly effective for the chiropractic profession, as many providers are sole practitioners in private practice and may feel the financial impact more strongly than practitioners in larger practice settings.

In addition, OPLR recommends considering a dedicated chiropractic education and enforcement fund. Allocating administrative fines to this fund could support more effective oversight by DOPL and compliance efforts within the chiropractic industry.

Recommendation 2: Adopt additional practice requirements and unprofessional conduct provisions to address sexual misconduct

OPLR recommends a combination of patient disclosure, patient consent and practitioner practices to address sexual misconduct.

Examples, informed by adjacent professions and other states' requirements, are outlined below:

a) Written patient consent for certain activities:

Example: Receive informed, specific, written consent for "Examining or treating the anus, breast tissue, or genitalia of a patient, with or without clothing."

OPLR read multiple sexual misconduct complaints alleging inappropriate touching of the breast and pelvic areas, and in these cases, the patient was unaware that the examination/treatment was going to occur until they were in the room with their provider. This requirement ensures clarity for patients and accountability for licensees, even in instances when this behavior may be clinically appropriate.

b) Chaperone requirements

Example: Require licensees to ensure patients understand their right to request a chaperone prior to an appointment. If a chaperone is desired and cannot be provided, this must be disclosed to the patient and the patient must be made aware that they can bring their own chaperone.

This may help reduce the opportunity for practitioners to engage in misconduct and does not impose a financial burden on practitioners to provide a chaperone.

Example recommendation: Require the automatic imposition of a chaperone requirement for patients of DCs who are facing pending criminal or administrative proceedings involving sex offenses or sexual misconduct.

This is something the California Board of Chiropractic Examiners recommended after its 2026 sunset review.

c) Unprofessional conduct standards regarding proper draping procedures

Example: As with massage therapy, include failure to properly drape a patient as an unprofessional conduct standard for DCs.

While there is language in rule concerning unprofessional conduct that broadly addresses “engaging in sexual contact with a patient,”⁴⁶ OPLR recommends more specific guidelines on draping procedures. This holds licensees accountable for standards that are common in adjacent professions, such as massage. It provides DOPL with an avenue to address misconduct situations at a lower level of severity, which may reduce the potential for escalation of misconduct.

Some other states have adopted this approach. For example, Arizona prohibits intentional viewing of a completely or partially disrobed patient in the course of an examination or treatment if the viewing is not related to the patient's complaint, diagnoses, or treatment under current practice standards. Maine prohibits disrobing, draping practices, or touching of the patient's clothing that reflect a lack of respect for the patient's privacy; watching a patient dress or undress, instead of providing privacy for disrobing. This includes not providing a gown when requiring someone to disrobe.

d) Patient intake form requirements

Example: Provide information during patient intake on a patient's rights to: (i) disrobe in privacy and to that individual's comfort level; (ii) be draped properly, (iii) ask questions; (iv) identify areas of the body that individual would like the licensee to avoid; (v) modify the treatment; (vi) stop treatment. Patient information should include disclosure about when disrobement is necessary and to what degree.⁴⁷

DOPL may need to post example forms to ensure standardization across practitioners.

⁴⁶ Utah Admin. Code R156-73-501.

⁴⁷ Other states, such as Arizona, North Dakota, and Maine, include language in their rule about proper disrobing practices.

e) Mandatory continuing education requirements on sexual misconduct and fraud

Example: Require continuing education every renewal period on ethics training that covers both sexual misconduct and fraud.

Currently, there is no mandatory ethics or compliance continuing education (CE) requirement for chiropractic licensure. Other healthcare professions already require one.⁴⁸ The intent of the CE requirement is to reinforce best practices for clinical documentation, obtaining explicit informed consent, and maintaining professional boundaries, particularly when performing manual therapies on sensitive areas. Additionally, training in billing compliance, accurate coding, and documentation standards could mitigate inadvertent fraud.

f) Signage requirements

Example: Post, in a publicly accessible area (e.g., reception area or treatment room, website, patient intake forms), signage that includes: 1) A notice with DOPL contact information and how and where to issue complaints, and 2) Accepted ethical guidelines on what to expect when receiving chiropractic treatment and what constitutes a boundary violation.

OPLR reviewed multiple complaints wherein a patient allowed certain activities to occur because they believed it was necessary for treatment, only to find out later that the practitioner's behavior was inappropriate. This approach would educate patients on what is appropriate and where to submit a complaint if something happens, although OPLR acknowledges that it also places a burden on ethical practitioners.

To implement this approach if it were adopted, DOPL could post example signage on its website for licensees to print and post in a noticeable area, similar to the massage profession.

Additional Recommendations

Better align the profession-specific and universal endorsement pathways

One avenue to licensure in Utah for chiropractic physicians from other U.S. states is through a profession-specific endorsement pathway. Among other requirements, applicants must demonstrate they have worked under an DC license for at least two years immediately prior to their application.⁴⁹

In 2020, the Utah Legislature approved a universal endorsement framework within DOPL, which allows out-of-state applicants to obtain licensure in Utah with at least one year of work in a similar scope of practice on a license that is in good standing.⁵⁰

⁴⁸ In Utah, physical therapists and occupational therapists have mandated ethics CEs. The hands-on nature of their work is similar to Chiropractors. Other health care professions, like nursing and physicians, very often require ethics training in their CE training as well.

⁴⁹ Utah Code § 58-73-302.

⁵⁰ Utah Code § 58-1-302

OPLR recommends evaluating these pathways and bringing them into alignment as appropriate, for example, by removing the two-year requirement. This recommendation is consistent with other healthcare professions OPLR reviewed in 2026 (e.g., physicians, naturopathic physicians, dentists and dental hygienists, and pharmacists).

Other Considerations

Intra-Articular (Joint) Injection Therapy

OPLR considered a recommendation to allow DCs to practice joint injection therapy while also specifying the training requirements necessary to perform it. Ultimately, OPLR does not recommend allowing DCs to practice this type of injection therapy at this time, due to concerns regarding DCs' ability to treat complications, division within the chiropractic profession, and lack of standardized training.

Injection therapy involves the subcutaneous, intramuscular, and intradermal injection of sterile substances "to stimulate meridians, acupuncture points, ashi points, motor points, trigger points and other nonspecific points throughout the body."⁵¹ Injection therapy is used in chiropractic practice to treat painful knots in myofascial tissue and stimulate cellular repair.⁵²

Currently, injection therapy practiced by DCs is limited to subcutaneous or intramuscular administration,⁵³ which excludes intra-articular (joint) injection.

Permitting DCs to perform intra-articular injections could enhance patient convenience and continuity of care, allowing patients to manage joint health without needing a referral to a medical specialist. Further, formally expanding the scope while establishing strict training requirements would create a structured, regulated framework for safe practice.

However, intra-articular injections carry greater clinical risks than other injections, specifically regarding joint infection and sterile technique. Should complications arise, DCs may lack the emergency medical training or specialized supplies necessary to manage them. Additionally, there is currently a lack of standardized, nationally accredited training programs dedicated to joint injection therapy for DCs. This educational gap is compounded by division within the chiropractic profession itself; traditional practitioners contend that invasive procedures diverge from the core philosophy of non-invasive, hands-on spinal care.

Consequently, OPLR recommends revisiting this issue once standardized postgraduate training frameworks are established, clear patient need is demonstrated, and robust clinical evidence supports the efficacy of joint injections within chiropractic practice.

⁵¹ Washington State Department of Health, "Point Injection Therapy."

⁵² Cleveland Clinic, "What Is Prolotherapy?"; Cleveland Clinic, "Trigger Point Injections."

⁵³ This is despite provisions in rule allowing DCs to perform clinical acupuncture after meeting certain requirements. See Utah Admin. Code R156-73-601.

Additional approaches to address DOPL complaint issues

OPLR also considered, but rejected, some additional approaches to addressing the fraud and sexual misconduct themes discussed above in DOPL substantiated complaints against DCs.

One approach is setting requirements for prepaid treatment plans to address potential fraud involving elderly patients. Texas is an example state that has specific provisions on this topic.⁵⁴ OPLR chose not to recommend this approach because there is not enough evidence that fraud through prepaid treatment plans is either unique to DCs, or occurring frequently. DOPL can already take action on these kinds of matters through the Chiropractic Physician Practice Act.⁵⁵ The Consumer Sales Practices Act (CSPA), administered by the Utah Division of Consumer Protection (DCP), is another avenue for redress.

Some states have very strict approaches to addressing sexual misconduct in the chiropractic profession. For example, Colorado requires licensees (DCs as well as other healthcare and mental health practitioners) to provide a sexual misconduct disclosure statement to patients.⁵⁶ OPLR first recommends the approaches outlined above before considering this more burdensome alternative.

Rule Review

In accordance with Utah Code § 13-1b-203(5), OPLR conducted an in-depth review of DOPL's chiropractic physician rules, found in Utah Admin. Code R156-73.

The rule review covered potential rule changes needed to:

1. address specific rules that may be overly burdensome (e.g., for individuals seeking to practice a profession or given the potential risk to public safety from a profession) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language, and correct references to statute or other rules; or
4. support OPLR's recommendations

OPLR's review of R156-73 found:

1. A few potentially burdensome rules
 - a. R156-73-303b defines the organizations that can offer CEs. DOPL could possibly expand accepted CE providers, for example by including any accredited institution of higher education, or CEs from other industry organizations if they are relevant to the practice of chiropractic.

⁵⁴ Texas Admin Code 75.7.

⁵⁵ See UCA 58-73-501: (7) through (10).

⁵⁶ See C.R.S. § 12-30-115.

2. No rules misaligned with statutory language.
3. Using DOPL's newly rewritten R156-73, OPLR found this incorrect reference to statute:
 - a. R156-73-501(11) refers to Utah Code § 58-37-102(e)(ii), which should refer to Utah Code § 58-37-101(1)(e)(ii).
4. New rules will need to be written to support OPLR's recommendations addressing sexual misconduct, injection therapy training requirements, and additional ethics CE hours.

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1. Context

1.1 General Research Methodology

OPLR's methodology combines qualitative and quantitative methods with stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Division of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., DWS, BLS) as well as relevant industry associations (FCLB, ACA)
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah and other state governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings

1.2 Chiropractic Policy Scan

To better understand the regulatory environment for naturopathic physicians, OPLR conducted a review of state occupational regulation in the U.S., which made use of industry resources and NotebookLM, Westlaw Advantage's AI Jurisdictional Survey tool, and resources from the FCLB. Results of the policy scans were used to both understand the regulatory landscape as well as inform recommendations.

OPLR used the Education and Testing (U.S.) document from the Federation of Chiropractic Licensing Boards (FCLB) to map the requirements for licensure across all 50 states.⁵⁷ This document includes information on requirements for pre-professional education, program accreditation, and examinations. OPLR did not independently validate these results.

OPLR then utilized Google's NotebookLM tool to engage in an in-depth review of 21 states to understand the scope of practice, practice requirements, regulatory citation/fining authority, and sexual misconduct provisions in a sample of U.S. states.⁵⁸ These results helped shape OPLR's initial research and primarily informed conclusions about the scope of practice.

OPLR's sample consisted of Western states and states that appeared to have either a broader or more restrictive scope of practice.⁵⁹ A few states were also included at random. OPLR analysts then downloaded the statute and administrative rules governing chiropractic regulation

⁵⁷ Federation of Chiropractic Licensing Boards, Education and Testing.

⁵⁸ The states included were: AL, AZ, CA, CO, FL, HI, ID, IL, KS, MI, MO, NH, NJ, NV, NM, OK, OR, TX, UT, WA, and WY.

⁵⁹ OPLR leveraged Gemini's deep research function to identify which states likely had the broadest or most restrictive scopes of practice.

in each state (pulled from each state's websites) and uploaded them to NotebookLM as source material. After prompting the AI tool, OPLR analysts validated the results by periodically checking that the sources included in the response matched the language of the statute and/or rule linked.

The following prompts were used:

- Provide me with the chiropractic scope of practice for each state in the sources
- For each state, what activities require a chiropractor to complete extra training or certification to legally practice?
- For each state in the sources, what are chiropractors explicitly not allowed to do?
- For each of the states in the sources, provide any provisions regarding sexual misconduct

OPLR used Westlaw's AI tool to conduct a more comprehensive, 50-state scan of chiropractic regulation. OPLR analysts validated by checking each source cited by Westlaw's AI tool and checking against the results of the earlier NotebookLM results. The validated sources were used to map the national policy landscape, find patterns in regulation, make cross-state comparisons, and discover outliers. Westlaw's AI tool was relied upon for research regarding specific policies, such as injection therapy, acupuncture, and sexual misconduct provisions.

The following prompts were used for Westlaw's AI tool:

- Can licensed chiropractors practice injection therapy? If so, what are the requirements? Are there any unprofessional conduct provisions regarding injection therapy?
- In Utah, what professions require specific ethics CE training?

This review does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, errors in data entry, or mistakes made by NotebookLM or Westlaw's AI tool that were not caught by OPLR's manual verification. This is an especially salient issue for specific policy scan prompts that asked whether certain states had adopted a specific policy or not (e.g., the injection therapy question). Many states remain silent on issues of scope, and the Westlaw AI tool will exclude states in which they do not find any relevant information. It is therefore difficult to validate the "non-answers", and it is possible that OPLR may have missed certain states that have adopted specific policies, if Westlaw did not include them. States also take different enforcement approaches regarding "silent" issues; some may consider it out of scope while others might not. Therefore, certain numerical estimates may underestimate the true number of states that have adopted a specific policy. Still, potential bias or measurement error introduced by these limitations likely did not substantially alter any information.

2. Regulatory Model Assessment and Recommendations

2.1 Menu of Regulatory Models

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of OPLR's approach to assessing occupational regulation and evaluating different regulatory models.⁶⁰

2.2 Model Assessment of Chiropractic

The following tables summarize OPLR's analysis of chiropractic according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered particularly determinative in its assessment are highlighted in bold.

Model Assessment of Chiropractic Physicians	
Harm Factors	
Mechanism of Harm	Exacerbating/causing injury (e.g., through manual manipulation, pneumothorax, vertebral artery dissection) or failure to refer
Severity, Permanence, and Likelihood of Harm	High likelihood of moderate to severe injury if untrained; low likelihood of severe injury if trained
Consequence of Error ⁶¹	67
Downstream Impact	High
Consumer & Setting Factors	
Patient Vulnerability	Variable; DCs treat all ages and conditions, although patients are not frequently acute
Frequency of Physical Touch	Frequent. Treatment requires physical touch, and some treatments may require skin-to-skin contact
Frequency of Private Setting	Frequent

⁶⁰ The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://commerce.utah.gov/oplr/about/>

⁶¹ O*Net rates professions on a 100-point scale based on the seriousness of a consequence of making an error. OPLR has not been able to confirm the legitimacy of their methodology, so while this ranking is a consideration, OPLR does not consider it a deciding factor. National Center for O*NET Development, "Consequence of Error."

Information Asymmetry	Moderate to high. It is likely difficult for patients to ascertain the efficacy or competency of a practitioner, given that minor pain is common.
Related factors	
Level of Independence	Structural: High. Very independent as the majority of DCs work in small, independent clinics and ~50% consider themselves sole practitioners Clinical: High. DCs conduct examinations, make diagnoses, determine and implement treatment plans, refer to other practitioners
Patient Choice	High. Patients choose the chiropractor they want to see
Information Availability	Moderate to high. Patients can utilize online or word-of-mouth reviews to make a fairly informed choice about their provider.
Level of Oversight	Employers: Low. Nearly all DCs work for themselves or for small chiropractic clinics Government: Outside of licensure, the Utah Consumer Sales Practice Act (CSPA) or tort law are the only avenues. Low levels of reimbursement mean low payor oversight. <i>Private Bodies:</i> Low

3. Regulatory Model Adjustments & Recommendations

3.1 Possible Adjustments

Please see [this working document](#), OPLR's Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.⁶²

3.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to "investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence".⁶³ Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another

⁶² The document is also available on OPLR's website in the "About OPLR" section, accessible here: <https://oplr.utah.gov/about-oplr/>.

⁶³ Division of Occupational and Professional Licensing, Complaint Handling Process.

agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual's license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) and Salesforce to access closed complaints investigated by DOPL between 2017 and 2024. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR's analysis. DOPL personnel helped code the complaint dispositions as either substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those where a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). 'No jurisdiction' complaints are complaints that may or may not have basis, but DOPL was not able to take action on the case.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

Complaint Case Notes Analysis

To contextualize the relatively high rate of complaints, OPLR downloaded and read case details for 70 of the 73 substantiated complaints filed against licensees from 2017-2024. Case details typically included the investigator's final summarizing notes and a copy of the stipulation, if applicable. Analysts then summarized the nature of each complaint, including whether or not harm occurred, and the severity and nature of harm. Analysts also noted whether the individual practitioner faced criminal charges or if multiple complainants were involved.

OPLR then re-categorized complaints, as DOPL categorizations do not always reflect the specific nature of a complaint. For example, one-third of complaints categorized as "other criminal conduct" and one-fifth of complaints categorized as "ethical misconduct" involved sexual misconduct. OPLR's complaint categories included, in order of most frequent to least frequent: sexual misconduct, fraud/deceptive advertising, title issues, advertising/practicing out of scope, administrative/record, ethical misconduct (non-sexual), failure to attend probation meetings, improper supervision, substance abuse, aiding unlicensed practice, practicing on an expired license, and incompetence/negligence resulting in physical harm.

Special attention was given to the sexual misconduct complaints, as the nature of the complaint and harm inflicted varied significantly. OPLR noted whether the case involved consensual sexual misconduct (including information regarding the existence of grooming behaviors), sexual battery or assault, inappropriate comments only, or possibly unpurposeful grazing (only one complaint fell into this category). Analysts also noted whether the complaint was not validated by DOPL. The unvalidated complaints were those in which DOPL could not determine

whether misconduct actually occurred and closed the case with a letter of concern or verbal warning.

OPLR found that 20 out of 70 complaints involved sexual misconduct.

- 9 complaints involved sexual battery or assault. Four of these resulted in criminal conviction, six involved multiple victims, and two were unvalidated (in one case, DOPL couldn't contact the victim to confirm, but both cases still resulted in a DOPL action, e.g., verbal warning).
- 5 complaints involved inappropriate but consensual sexual relationships. Two involved grooming behaviors by the licensee, and one was unvalidated.
- 5 complaints alleged inappropriate sexual or romantic comments
- 1 complaint involved possible accidental touch

Cross-Profession Sexual Misconduct Complaint Analysis

To compare rates of sexual misconduct complaints across professions, OPLR only utilized complaint data from 2017-2022, as 2023-2024 complaint data was inaccessible for certain professions. For select professions, OPLR used the following complaint data: 1) the total number of substantiated complaints, 2) the total number of substantiated complaints labelled by DOPL as sexual misconduct, and 3) the number of licensees actively licensed between 2017 and 2022.

OPLR used this data to determine the overall complaint rate for each profession, the sexual misconduct complaint rate, and what percent of total complaints were labelled as sexual misconduct.

OPLR relied on existing DOPL categorization to determine the number of sexual misconduct complaints. This categorization does not adequately capture all sexual misconduct complaints, as sexual misconduct complaints can be labelled under other existing categories (e.g., "other criminal conduct", "ethical standards"). Therefore, any estimates provided may underestimate the true number of sexual misconduct complaints.

The following licenses were included and had at least one substantiated sexual misconduct complaint: Chiropractic Physician, Physician/Surgeon, Osteopathic Physician, Massage Therapist, Registered Nurse, Licensed Practical Nurse, Physician Assistant, Radiologic Technologist, Physical Therapist, Dentist and Dental Hygienist (combined estimate) and Nurse Practitioners (APRN, CNM, CRNA).

These subsequent licenses were included, but had no complaints labelled as sexual misconduct: Medical Language Interpreter, Radiologist Assistant, Radiology Practical Technician, Optometrist, Pharmacist, Pharmacy Technician, Naturopathic Physician, Physical Therapy Assistant, Occupational Therapist, Occupational Therapy Assistant, Athletic Trainer, Acupuncturist, Respiratory Therapist, Audiologist, Speech-Language Pathologist, and Hearing Instrument Specialist.

Limitations

There are significant limitations to these analyses, and the information collected should not be interpreted as a precise estimate of harm caused by chiropractors. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported. Additionally, some unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater potential for harm and may generate more complaints.

Furthermore, OPLR had limited access to complaint information. Any detail not included in the investigator's final summary could not be considered here and missing context can lead to incorrect categorizations of the nature of harm.

For these reasons, OPLR uses DOPL complaint data as directionally informative, but typically avoids direct comparisons across professions wherever possible. OPLR did engage in cross-profession comparisons regarding sexual misconduct complaints, however, as it was necessary to contextualize the issue and determine whether chiropractic complaints were an outlier. The results of that analysis should be viewed as directionally informative as well; fine comparisons across professions are unwarranted and unsupported by these data.

3.3 DOPL Licensee Data

OPLR used DOPL licensee data queried in October of 2025 to conduct analyses on the number of licensees per year. The dataset included individuals first licensed after 1970 to those actively licensed as of January 2026. Each row in this dataset is a unique combination of individual and license type and contains information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year.

Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this, but the effect is fairly negligible given OPLR's use of the data to determine trends over time rather than estimate with precision for specific dates.

OPLR also utilized the licensing data to conduct an age analysis. To do this, OPLR found the age of each individual who was active in a given year, according to that year and the birth date on their license. OPLR then grouped the data by year and found descriptive statistics for the

age of licensees actively practicing in each year. Licensees without a birth date or with unreasonably high ages were excluded from the analysis.

4. Stakeholder Outreach

4.1 OPLR Stakeholder Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR's other analysis, to conduct this review and develop recommendations. OPLR engaged with practitioners, industry organizations as well as Utah and other regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders.

Interviews were conducted via video conferencing using semi-structured interview methods; they were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the chiropractic profession, determine potential issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations. OPLR reflected on and synthesized feedback across multiple discussion sessions to develop clear and achievable evidence-based recommendations.

Limitations

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact chiropractic patients, so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be fully representative of the views of all Utahns, DCs, or any other person, group, or population.

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

4.2 Stakeholder Engagement Summary

Stakeholder Engagement Summary	
Government Stakeholders	
Utah Department of Commerce	Ben Baker , Investigator, Division of Professional Licensing Deborah Blackburn , Assistant Division Director, Division of Professional Licensing Daniel Briggs , Investigator, Division of Professional Licensing Jim Garfield , Bureau Manager, Division of Professional Licensing Mark Steinagel , Deputy Commissioner, Department of Commerce, and Director, Division of Professional Licensing
DOPL Board Members	Zachary Manwaring , Chiropractor at Whole Body Healthcare, Division of Professional Licensing Board Member Jon Stucky , Chiropractor at Stucky Chiropractic, Division of Professional Licensing Board Member Larry Vance , Division of Professional Licensing Board Chair, Chiropractor at Highland Chiropractic Clinic
Utah Division of Consumer Protection	Glen Minson , Chief Investigator
Other State Governmental Agencies and/or Members	Evan J. Vickers , Utah Senator, District 28
Industry Stakeholders	
Industry Associations	Erin Axson , Lobbyist and Executive Director of the UCPA Spencer Erickson , Founding Chiropractor at Timpview Chiropractic, President of the UCPA Jeff Metler , Legal Counsel at MHM Law Offices Anne Marie Musnon , Executive Director of the Association of Chiropractic Colleges Jon Schwartzbauer , Executive Director of the FCLB
Subject-Matter Experts	
Academics, Researchers, & Clinicians	Kristina Kill , Founding Chiropractor at Family First Chiropractic & Wellness

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