A New Massage Therapy Licensing Examination:
We Need Clear Goals, Transparency, & Public Accountability

Keith Eric Grant, PhD, NCTMB

First ABMP Massage Therapy Examination Discussion Meeting
11-12 May 2005, Denver CO

Fortunately, you can win trust. And you put your finger on the best way: transparency. Transparency just means you tell the truth in a way that people can verify. Say what's true and honest, then let people check it out for themselves. Did you make a mistake? Admit it and people will still trust you. Cover it up, especially when everyone knows you did it, and you'll destroy any chance that people will believe your word is good. — Stever Robbins[1]

I have a tendency to state the obvious. Indulging that tendency, the obvious is that ABMP has gathered us together both because there is a recognized demand for a widely usable massage therapy licensing exam and because there are recognized difficulties with what is currently offered. As a consequence of this confluence of need and difficulty, we have a rare opportunity to foster an approach to massage regulation with greater transparency of goals, greater focus on public benefit, and greater public accountability than has previously existed. However, to pursue this opportunity shall require that we forego vague generalities and be specific and clear in our outcomes and methods. Given my background in the hard science of physics, my tendency to identify specific problems, to craft specific solutions, and to want measurable and well-defined outcomes is even stronger than my tendency to state the obvious. That rigor plays freely in the meta-examination below. Along the path to a new exam, we can learn a lot from recent writings on outcome-based medical education. As an example and start, consider the term 'standards'. It will undoubtedly emerge within our discussions and this term implies a lot. We should carefully consider what Wojtczak and Schwarz wrote in *Medical Teacher* before bringing the term into play.

The term 'standard' means different things to the different people, and often is used interchangeably with 'objectives', 'outcomes' and 'goals'. Sometimes the word is used as a synonym for doing better in some nonspecific way such as "we should improve our standards", or "the standards are too low". The dictionary definition of 'standard' refers to "something set up and established by authority, custom or general consent as a model, example or rule for the measure of quantity, weight, extent, value, or quality". 'Standard' is also defined as a "criterion, gauge, yardstick, and touchstone" by which judgments or decisions may be made. Thus, the word 'standard' refers simultaneously to both 'model and example' and 'criterion or yardstick' for determining how well one's performance approximates the designed model. Thus, a standard is both a goal (what should be done) and a measure of progress toward that goal (how well it was done). Therefore to be meaningful, a standard should offer a realistic prospect of evaluation to measure whether anyone actually meets it. Without that, it has no practical value.[2]

---

[1] Robbins, Stever: **The Keys to Building Trust**, *Working Knowledge*, Harvard Business School, 20 December 2004, <http://hbswk.hbs.edu/item.jhtml?id=4553&t=srobbins>

[2] Wojtczak, Andrzej, and M. Roy Schwarz: 2000. **Minimum Essential Requirements and Standards in Medical Education**, *Medical Teacher*, 22(6), 555-559, <http://www.iime.org/documents/vs.htm>

Goals and Standards

Given that a standard implies a measure, it is both fair and pertinent to ask 'of what specifically?' If we are performing a measurement of the outcomes of massage education as to effects on practice, then it is natural to assume that specific desired outcomes have been defined and documented and, in the context of a licensing exam, to ask about the evidence base for the need of those outcomes and the measured effectiveness of their implementation. As we shall see below, it is not a minor issue for even a state to intrude without cause on the freedom of occupation and commerce. If our course is based on the need for specific outcomes of education, we are not without tools. The Association for Medical Education in Europe (AMEE) has put together a number of guides to outcome-based education and assessment that are either available directly through the AMEE[3] or through their publication in the journal Medical Teacher[4]. In particular, I have found Guide 14 by Harden et al.[5] and Guide 25 by Shumway and Harden[6] to be applicable. Together they constitute an introduction to outcome-based education and as thorough discussion of assessment to determine resulting competence. The Accreditation Council for Graduate Medical Education (ACGME) also has created a context and discussion of outcome-based training that may be helpful[7]. The Institute for International Medical Education (IIME) has a collection of documents on creating 'minimum essential requirements' for education[8]. As an addition aid to our discussion, the appendix of this document contains a table of guidelines for creating guidelines. This is a slight adaptation of a table of guidelines for creating clinical practice guidelines[9]. Epstein and Hundert, in a 2002 paper in the Journal of the American Medical Association, also address the question of defining and assessing professional competence[10]. A paper by Yedidia et al. (also in JAMA) looks at the effects of communication training on medical student performance[11].

An alternative theory of a massage examination's purpose that I have heard advanced by a staunch advocate of massage licensing is that a massage licensing exam has little to do with

---

[3] AMEE, <http://www.amee.org/guides/titles.html#guides>

[4] Medical Teacher e-Journal, <http://www.tandf.co.uk/journals/titles/0142159X.asp>

[5] Harden, R. M., J. R. Crosby & M. H. Davis, 1999: AMEE Guide No. 14: **Outcome-based education Part 1 — An introduction to outcome-based education**. *Medical Teacher*, 21(1), 7-14.

[6] Shumway, JM, and RM Harden, 2003: AMEE Guide No. 25: **The assessment of learning outcomes for the competent and reflective physician**. *Medical Teacher*, 25(6), 569-584.

[7] ACGME, 2001: ***Outcome Project — General Competencies***. Accreditation Council for Graduate Medical Education, Accessed May 2005. <http://www.acgme.org/outcome/comp/compFull.asp>

[8] Institute for International Medical Education (IIME), <http://www.iime.org/>.

[9] Field, Marilyn J. and Kathleen N. Lohr, 1990: ***Clinical Practice Guidelines: Directions for a New Program***, National Academy Press, <http://books.nap.edu/catalog/1626.html>

[10] Epstein, Ronald M. and Edward M. Hundert, 2002: Defining and Assessing Professional Competence. Journal of the American Medical Association, 287(2), 226-235.

[11] Yedidia, Michael J., PhD; Colleen C. Gillespie, PhD; Elizabeth Kachur, PhD; Mark D. Schwartz, MD; Judith Ockene, PhD; Amy E. Chepaitis, MBA; Clint W. Snyder, PhD; Aaron Lazare, MD; Mack Lipkin, Jr, MD, 2003: Effect of Communications Training on Medical Student Performance, Journal of the American Medical Association, 290, 1157-1165.

well-defined outcomes of education and the evidence-based need for those outcomes but is simply a regulatory expedient. From this viewpoint, the implementation of the exam is primarily to verify that the former student had sufficient funds and time to attend classes and remained alert for a reasonable fraction of them. Coupled with this is the implicit test that the attended school was supplying the necessary stream of facts for the student to later pass the exam and obtain licensure. The ability of the student to organize the remembered facts and carry them into actual practice is only incidentally relevant. The purpose of the exam is defined to be an extra regulatory hurdle to entry to practice. If this is the case, then it seems appropriate that we be honest about our goals and methods, open about where and how we draw the line, and clear about our underlying assumptions on why we believe this to be effective. Would assumptions, for example, that are akin to gentrification of massage, from a blue-collar skill to a white-collar career, or that largely eliminate those not fluent in English lead to necessary and valid state interventions? Ultimately, those we regulate and those we test deserve honesty, clarity, and specificity in our stated goals and outcomes. Their time, their money, and their potential for careers and businesses deserve our respect, whether they intend to practice massage full-time or part-time and whether they are starting on their first career or changing careers amid other job, family, and community responsibilities. We should attribute unto education what is based on needs of practice and unto regulatory expediency what remains.

Legal Background of Occupational Regulation

I have alluded to or assumed above a lot of background that I have yet to deliver. There are several of the issues deserve our awareness. First, it is a reminder of our task to consider the legal basis for occupational regulation by the individual states. While a private organization, outside of any legal requirement, is free to promote a profession largely as it wishes, a state licensing organization has a different mandate.

The power of the individual states in the U.S. to enforce occupational regulation was set forth in the 1889 Supreme Court decision of Dent vs. West Virginia[12]. This decision decided the constitutional balance between the 14th amendment restriction that "*No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law, nor deny any person within its jurisdiction the equal protection of the laws*" and the power of states to enforce laws that protect the public from the results of incompetence and malfeasance. The court specified both the rights of the states to intervene and the reasons for such intervention.

The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud. As one means to this end it has been the practice of different states, from time immemorial, to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely; their possession being generally ascertained upon an examination of parties by competent persons, or inferred from a certificate to them in the form of a diploma or license from an institution established for instruction on the

[12] U.S. Supreme Court, 1889: ***Dent vs. West Virginia***, 129 U.S. 114. <http://caselaw.lp.findlaw.com/scripts/getcase.pl?navby=case&court=us&vol=129&page=114>

subjects, scientific and otherwise, with which such pursuits have to deal. The nature and extent of the qualifications required must depend primarily upon the judgment of the state as to their necessity.

Subsequent state sunrise laws have often determined that the harm to be remedied must be apparent, not remote, and that the form of regulation should be minimal to the need. Inherent in such regulations are considerations of an imbalance of knowledge leading to poor consumer choice, severity and magnitude of initial harm, and lack of other sufficient remedies. Cox and Foster note that regulation can have unintended collateral effects, producing decreases in availability of services or increases in prices that lead consumers to forego professional services[13]. They cite a study in which licensing of electricians led to more "do it yourself" efforts at wiring and a resultant increase in electrocutions. This example motivates the need to assess collateral as well as direct effects of regulation in balancing public policy and formulating an examination for wide use. Robert Fellmeth of the Center for Public Interest Law has written an excellent presentation of a theory of regulation[14]. Fellmeth basically sees the state exercise of prior restraint on an occupation as necessitated by a likelihood of irreparable harm. He also allows for external costs and market flaws that may change the normal picture. As will be advanced below, these latter considerations are pertinent to massage regulation.

The Issue of Harm

Protection of the public via the licensing of massage is frequently mentioned yet, in general, lacks clarity. The evidence base for recurring patterns of significant physical harm from the practice of massage is extremely weak. Two separate reviews of medical literature were published in peer-reviewed journals in 2003, one review done by Edzard Ernst[15] and one by myself[16]. The reviews found 12-15 incidents achieving medical notability occurring over more than forty years. Ernst provided a suitable conclusion for both reviews, *"Massage is not entirely risk free. However, serious adverse events are probably true rarities".* Ernst's conclusion is independently supported by two other separate sources. A 1998 paper by Studdert et al. reviewed massage liability insurance statistics over three years in the 1990's[17]. Claims were made against about 0.18% of those insured. Paid claims were on the order of 0.08% with the average payment being about $6300. About 6% of claims made were for physical injuries above minor. Finally, the British Columbia Health Professions Council included massage in a major scope of practice review within a model based on shared scopes of practice[18] and a

---

[13] Cox, Carolyn and Susan Foster, 1990: ***The Costs and Benefits of Occupational Regulation***, Bureau of Economics, U.S. Federal Trade Commission. <http://www.ramblemuse.com/articles/cox_foster.pdf>

[14] Fellmeth, Robert C., 1985: A Theory of Regulation: A Platform for State Regulatory Reform, Center for Public Interest Law, San Diego, <http://www.cpil.org/download/A_Theory_of_Regulation.pdf>.

[15] Ernst E, 2003: The safety of massage therapy. ***Rheumatology***, 42 (9), 1101–1106.

[16] Grant KE, 2003b: Massage safety: injuries reported in Medline relating to the practice of therapeutic massage — 1965–2003. ***Journal of Bodywork and Movement Therapies***, 7(4), 207-212.

[17] Studdert DM, Eisenberg DM, Miller FH, Curto DA, Kaptchuk TJ, Brennan TA 1998 Medical malpractice implications of alternative medicine. ***Journal of the American Medical Association*** 280: 1610-1615

[18] BCHPC, 2004: ***Shared Scope of Practice Model Working Paper***. British Columbia Health Professions Council. <http://www.healthservices.gov.bc.ca/leg/hpc/review/shascope.html>

specific list of reserved acts (BCHPC, 2001, 2004). The conclusions relevant to massage were that "*the Council has seen no evidence that massage therapy carries with it such a sufficient risk of harm to warrant making any portion of its practice a reserved act*"[19].

Even if we consider the above to be inconclusive and preliminary, there is still the need to collect observations into an evidence base of recurring patterns of injury. If we don't understand specific mechanisms of injury and their likelihood, then we are ill-equipped to implement and monitor the effectiveness of changes in training and clinical protocols designed to be remedies. As an example, the five core functions of the Department of Entergy's Integrated Safety Management (ISM) protocol include defining the specific scope of work, analyzing the hazards within the defined work, developing training and protocols to control hazards, working within the controls, and providing continuous feedback and improvement based on results in practice[20]. This is a protocol developed to include situations in which ignorance of hazards can easily lead to serious injury or death. In contrast, a recent article by Mitchell Batavia notes considerable disagreement, disarray, and lack of references for massage contraindications — a situation not conducive to a process such as ISM and indicative of work yet to be done by the profession[21].

Because of the lack of data indicative of high likelihood of significant harm from the practice of massage, current legislative efforts to create state regulation of massage in California are not being justified on the basis of such physical harm. Sufficient justification for regulations was made to the Joint Committee on Boards, Commissions, & Consumer Protection based on the need for oversight to protect the consumer from harms of malfeasance and from indirect harms of lessened service availability following from variable and at times onerous local regulations. It is here that Fellmeth's concept of regulation addressing a market flaw seems to fit[22]. Lack of state regulation implies local regulation rather than lack of regulation. Thus state regulation has the potential to create a freer market for the consumer than would otherwise exist.

Looking at the regulation of massage from the perspective advanced by Fellmeth also raises questions of where the limit of government involvement should be drawn in regulating massage. The medical profession has both licensing and board certification beyond licensing. The American Board of Medical Specialties (ABMS) has 24 member boards certifying in 36 specialties and 88 subspecialties. The states interface with these boards only to the extent that they forbid a doctor to claim that they are "board certified" apart from the ABMS system of certifications. The impetus for a specialist to be board certified follows from referral

---

[19] BCHPC, 2001: ***Post-Hearing Update of Preliminary Report: Massage Therapists***. British Columbia Health Professions Council. <http://www.healthservices.gov.bc.ca/leg/hpc/review/part-i/update-massage.html>

[20] USDOE, Guiding Principles / Core Functions of Integrated Safety Management, U.S. Department of Energy, accessed May 2005, <http://www.eh.doe.gov/ism/principles.html#c3>

[21] Batavia, Mitchell, 2004 Contraindications for therapeutic massage: do sources agree? ***Journal of Bodywork and Movement Therapies***. 8(1), 48-57.

[22] 14, above

and facility use requirements rather than state law. Two paragraphs from a publication of the ABMS capture the essence of this situation[23].

Licensure, the legal privilege to practice medicine, is governed by state law and is not designed to recognize the knowledge and skills of a trained specialist.

The intent of the certification process, as defined by the member boards of the American Board of Medical Specialties, is to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality patient care in that specialty.

Clearly, verification of advanced competencies does not, of necessity, require direct government intervention when there are other restraining forces, such as referral and facility use requirements. A model similar to that of the ABMS may be highly applicable to the inclusion of massage within the U.S. heath care system. Such a system of certifications provides a more specific and flexible approach than the 3000 hour "all or nothing" title-act approach used in British Columbia to fold massage practitioners into the health care system. A licensing exam does not have to include all possible practices to be sufficient for entry use but can aim at providing a basic level of public protection as per medical licensing.

Public Accountability, Supervision, and Anti-Trust

Returning to consideration of why a new exam is needed, let me also turn to consideration of the NCTMB exam currently being required, by 26 states. As a state-mandated exam, the NCTMB has a number of serious problems that would not be an issue for voluntary use.

Licensing of occupations is, as pointed out above, the legal prerogative of the individual states. The states can carry out this function of regulation, except for certain situations, given a 'rational basis' that it serves a public benefit. Court decisions have given the states wide latitude in the interpretation of public benefit and allowance that it is generally sufficient that a rational basis exists, independent of actual legislative intent[24]. The more limited situations are where a 'suspect classification' for discrimination is targeted by regulation, either explicitly or in application, moving justification of regulation under the more stringent test of 'strict scrutiny' that requires a compelling public need. Clearly, licensing is a state action in either case. As such, the 'state immunity doctrine' allows a state regulatory board to set rules in the public interest that would otherwise violate the Sherman anti-trust act. A state can delegate some of its actions to a private organization while maintaining the umbrella of state action immunity only if the purpose is "*one clearly articulated and affirmatively expressed as state policy*" and under "the requirement that the policy be '*actively supervised*' by the

---

[23] ABMS, 2002: ***Which Specialist for You? American Board of Medical Specialties***, <http://www.abms.org/Downloads/Which%20Med%20Spec.pdf>

[24] e.g., Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985) <http://laws.findlaw.com/us/473/432.html> and Appeal from The United States District Court for The Western District Of Oklahoma (D. Ct. No. CIV-01-445-F) <http://laws.findlaw.com/10th/036014.html>

State itself[25]. The potential for anti-trust action from privatization is not just theoretical. The American Bar Association, for example, signed a consent agreement on its school accreditation process after being sued by the anti-trust division of the Department of Justice[26]. The Council on Licensure, Enforcement and Regulation (CLEAR) has available resource briefs on the issue of privatization and state action immunity for licensing boards[27] and accreditation bodies[28]. Such delegation of state actions to private agencies and the effects on public accountability is an area of active legal concern. Fordham University sponsored a symposium in February 2001 that was published in the June 2001 issue of the *Fordham Urban Law Journal*[29]. The University of California at Los Angeles held a symposium in 2002 that was published in the August 2002 issue of the *UCLA Law Review*[30]. One consensus seems to be that a state can delegate responsibilities for required functions but not the final accountability.

As was summarized in the call for this meeting, there is a feeling that the NCTMB board has not fulfilled the responsibilities expected of a private agency to which a state responsibility, i.e. partially determining eligibility for licensing, has been delegated by many states. Notable in terms of the above discussion is that NCTMB prerequisite changes to go into effect this July were done without the level of notification, requests for input, and review that would be expected of a public function. If challenged, this could leave such responsibility for review in the laps of the mandating states. Other problems with lack of service orientation (i.e. responsiveness) and with the board nomination and election process were also noted. Equally troubling has been that NCTMB sponsored a 'massage safety week' and lent its name to the bottom of a number of syndicated news reports alluding to the dangers of massage. As noted above, such a stance is in direct conflict with the medical literature and with insurance rates. A likely result of such news reports would be to scare some potential clients into feeling it is simplest to avoid massage if its use is not absolutely necessary. It also should be noted that nothing in the NCTMB process is defined specifically enough to guarantee competency. A multiple choice exam can only test the ability to recognize remembered information, not the insight to put it into practice or the kinesthetic skills to implement it.

The current run of problems with and experienced by NCTMB is, however, not the focus of my main concern with NCTMB. These are merely the symptoms of a greater underlying problem — the NCTMB has no line of functional public accountability and was never

---

[25] California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97 (1980) <http://laws.findlaw.com/us/445/97.html>

[26] U.S. vs. American Bar Association, 95-1211 <http://www.usdoj.gov/atr/cases/americ1.htm>

[27] Meredyth Smith Andrus, 1998: ***State Licensing Boards and the Limits of State Action Immunity***, <http://www.clearhq.org/resbriefs.htm>

[28] Susan Dorn and Kristin Becker, 1997: ***Legal Update: Current Issues Affecting Accrediting Bodies***, <http://www.clearhq.org/97-2.htm>

[29] Redefining the Public Sector: Accountability and Democracy in the Era of Privatization, 2 February 2001, <http://law.fordham.edu/ihtml/eventitem.ihtml?id=679&template=st> and <http://law.fordham.edu/publications/contents.ihtml?pubID=400&issueID=62>

[30] New Forms of Governance: Ceding Power to Private Actors, 2002: UCLA Law Review, 49, <http://www1.law.ucla.edu/~lawreview/back.html>

structured to be suitable for mandating by the states. The NCTMB is approved as a certifying agency by the National Organization for Competency Assurance (NOCA) and their accrediting arm, the National Commission for Certifying Agencies (NCCA)[31]. NOCA is a nonprofit, nongovernmental organization. The NCCA standards document, until the latest revision effective in January 2005 was explicitly for voluntary certification. The introduction to this prior document, dated 2/9/95, stated:

The National Commission for Certifying Agencies (NCCA) is an independent organization which has identified the essential components of a national certification program and determines if certification organizations meet established standards based on those essential components. The NCCA Standards for Accreditation are standards for voluntary certification organizations.

While the latest document makes clear that NCCA is recognizing a wider scope of certifying agencies and purposes, that recognition still stops short of NCCA having a code of ethics for certifying agencies, providing active oversight, and requiring notification and review processes typical of what is required of public agencies. Although NCCA is expanding its allowable structure for certifying agencies beyond nonprofits to include governmental agencies and for-profit organizations, it does not appear to have a code of ethics for board conduct nor an established complaint process. In short, NCCA was set up only to guide the structural development framework for a certification, independent of content and lacking an active oversight process. Accreditation by NCCA is not the direct state supervision required for state action immunity.

We thus come to the bottom line of this meeting. There is a considerable need for an exam process that is supervised and accountable to public agencies, has the mandate to test in the public interest, and that understands the level for proposal and review appropriate for state actions, even when delegated. We need clear goals, transparency, and public accountability

Quis custodiet ipsos custodes? (Who shall guard us against the guardians?) — Juvenal

[31] National Organization for Competency Assurance, <http://www.noca.org/>

Appendix A: Guidelines for Creating Guidelines

Various organizations in medical education have been increasingly been defining the needs for specific training in terms of the outcome skills, knowledge, and abilities of the practitioners produced (ACGME, 2001; Harden et al., 1999; Wojtczak and Schwarz, 2000). These outcomes should also be coupled with appropriate means for their assessment (Epstein and Hundert, 2002; Shumway and Harden, 2003). Outcomes can include not only technical skills, but also interpersonal competencies (Epstein and Hundert, 2002; Yedidia et al., 2003).

Such methods apply best to massage therapy, when applied to subpractices well-defined in techniques and setting. Table 1 suggests a number of attributes likely to be of high value in creating outcome-based guidelines for training.

Table 1: Attributes of guidelines for effective practice. From Grant(2003a), as adapted from guidelines for creating clinical practice guidelines presented in Field and Lohr (1990).

Attribute	Discussion
Validity	Compliance with a guideline should clearly improve the effectiveness of early practice by those entering a subpractice of massage.
Reliability/Reproducibility	The evidence and process used should lead to essentially the same guidelines if produced by multiple independent groups of experts.
Applicability	Guidelines should be specific to the needs of each subpractice.
Flexibility	Guidelines should identify expected exceptions to the recommendations.
Clarity	Guidelines should use unambiguous language, define terms precisely, and use logical, easy-to-follow modes of presentation.
Multidisciplinary process	Guidelines should be developed by a process that includes participation by representatives of key affected groups.
Scheduled Review	Guidelines should include planned reviews to review new field experience or changing professional consensus.
Documentation	The procedures followed in developing guidelines, the participants involved, the evidence used, the assumptions and rationales accepted, and the analytic methods employed should be meticulously documented and described.