A dichotomy in the accreditation process for chiropractic education

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As a practitioner first, an educator second, and a college administrator third, I have been an advocate for stringent standards for chiropractic education and practice for all of my professional life. I was fortunate to have graduated from the Canadian Memorial Chiropractic College (CMCC), which began its educational program under the guidance of Dr. John Nugent and the National Chiropractic Association's [later the American Chiropractic Association (ACA)], Committee on Education. Today, CMCC is fully accredited by the Council on Chiropractic Education CCE (Canada), with reciprocity by the CCE (USA), and the Australasia CCE with all of the international mobility rights that reciprocity provides.

Between 1945 to 1949, the academic program at the CMCC was a remarkable integration of basic science, chiropractic science and clinical science, which was above average for most colleges of that period. Although the college was founded on the scientific principles laid down by D.D. Palmer, there was no cultist homage to his memory. Philosophy and principles were taught, but in balance with what was the major objective of the college – to educate a responsible chiropractic practitioner, capable of providing patients with quality chiropractic health care, based on clinical skills which included not only diagnostic and quality chiropractic care, but also clinical judgment to make appropriate referrals. The CMCC continues with that same basic objective to this day, with the assurance that as new scientific clinical information becomes available the curriculum will reflect the new discovery.

But today, I have great concern for the presence of a second USA chiropractic accrediting agency, the Straight Chiropractic Academic Standards Association (SCASA), with an educational and practice philosophy that defies intelligent understanding, not to mention the threat that agency's policies pose for the public consumers of chiropractic care. I will define my concerns in the second half of this paper.

I have had the privilege of representing two quality chiropractic colleges before the Council on Chiropractic Education, (CCE,USA); CMCC, 1969–1976, and the WSCC, 1977–1986. It was my good fortune to participate in the development of the Educational Standards for Chiropractic Colleges, Guidelines To Interpret the Standards,[1] and the ever changing By-Laws.[2] In 1975, the CCE earned recognition as the sole accreditation agency for chiropractic education by the United States, Department of Health Education and Welfare (HEW) (now the United States, Department of Education). What a remarkable achievement for a Doctor of Chiropractic to be identified as:

> "a physician whose purpose is to help meet the health needs of the public as a member of the healing arts. He/she gives particular attention to the relationship of the structural and neurological aspects of the body and is educated in the basic and clinical sciences as well as in related health subjects. Chiropractic science concerns itself with the relationship between structure (primarily the spine), and the function (primarily coordinated by the nervous system), of the human body as that relationship may effect the restoration and preservation of health.
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> "The purpose of his/her professional education is to prepare the doctor of chiropractic as a **primary health care provider. As a portal of entry to the health care system, the doctor of chiropractic must be well educated to diagnose, to provide care, and to consult with, or refer to, other health care providers**." (emphasis added)[3]

In 1978, the CCE (Canada) was chartered by the Canadian government, and granted reciprocity with the CCE (USA) in 1982. And so, throughout the United States and Canada, the profession had earned the right to expect quality education and research from the accredited chiropractic colleges. That quality of education was to provide the professional product as noted in the above paragraph. Although the 1990 revised Standards are

* The views presented here are those of the author and do not necessarily represent the views of any association or organization the author is associated with; nor do they represent the views of the CCA, JCCA, editorial board or the editors.

not intended to prevent colleges from being "distinctive" relative to their local environments, they are required to acknowledge, that a "major purpose of accreditation – the assurance of quality – requires that all of these distinctive institutions adhere to a set of minimum standards of quality of chiropractic education that apply to all chiropractic institutions seeking accreditation . . ." It is appropriate to review, briefly, what some of those clinically directed standards include. (Emphasis to follow has been added.)

All institutional clinics must establish a mechanism to:

- assure quality care;
- develop a COMPREHENSIVE patient's case history to include appropriate emphasis on all elements appropriate to the patient's entering COMPLAINT AND HEALTH STATUS;
- develop objective data through conduct of a PHYSICAL EXAMINATION appropriate to the health status of the patient;
- perform and/or order, and INTERPRET appropriate imaging examinations;
- perform and/or order and INTERPRET appropriate clinical laboratory examinations;
- perform and/or order and INTERPRET other relevant procedures indicated by the clinical status of the patient;
- integrate data in a manner that facilitates identification of the pathophysiologic mechanism(s) responsible for the patient's complaint(s) and DIAGNOSIS/CLINICAL IMPRESSION:
- REFER PATIENTS WHEN CLINICALLY INDICATED for consultation, continued study or other care;
- identify and initiate the APPROPRIATE health care regimen;
- perform chiropactic adjustment and/or manipulations;
- monitor patient's CLINICAL STATUS DURING AND AFTER completion of the health care regimen through follow-up and review appropriate to the patient's health status; and
- keep appropriate records of patient's EVALUATION AND CASE MANAGEMENT.

In addition to the above qualitative standards for clinical education, the following quantitative standards must be demonstrated, such that each degree candidate:

- performed at least twenty-five (25) CLINICAL EXAMINATIONS to include case history, physical and neuromusculoskeletal examinations, each leading to a DIAGNOSIS, DIAGNOSTIC CONCLUSION, OR CLINICAL IMPRESSION:
- performed/interpreted at least twenty-five (25) area RADIOGRAPHIC [DIAGNOSTIC IMAGING] EXAMINATIONS WITH WRITTEN REPORTS OF FINDINGS:
- INTERPRETED CLINICAL LABORATORY TESTS appropriate for a chiropractic practice setting to include at least twenty-five (25) URINALYSES, twenty (20) HEMATOLOGY procedures such as blood counts and ten (10) CLINICAL CHEMISTRY. MICROBIOLOGY OR IMMUNOLOGY procedures or profiles on human blood and/or other body fluids; and
- performed chiropractic adjustments and/or manipulations on at least TWO HUNDRED AND FIFTY (250) PATIENT CARE ENCOUNTERS.

The forgoing clinical competency standards are based on a 47 page definitive companion document to the standards titled, *CLINICAL COMPETENCY DOCUMENT*, which was adopted in October, 1984.[4] In the introduction to this document the following paragraph appears:

> "The clinical competencies delineated herein address the minimal acceptable clinical criteria necessary to the conduct of a competent practice of chiropractic. They are not intended to limit the skill level attained through the resident clinical experience; rather, they identify the various cognitive, affective, and psychomotor skills expected of the non-specialist, primary contact, Doctor of Chiropractic that are implicit in the first professional degree award by a college holding status with the Council on Chiropractic Accreditation. These competencies do not reflect the mastery of clinical skills acquired through extensive practice experience; rather they represent those minimal skills a candidate should demonstrate when presenting for licensure after completing the educational program with resident clinical experience in a status-holding institution."[5]

Unquestionably, graduates meet the clinical competency standards, which reflects each graduates dedication to quality education. However, my concern as noted earlier, is the standards for chiropractic education advocated by the Straight Chiropractic Academic Standards Association (SCASA). Since SCASA does not have any recognition as an accrediting agency in Canada at this time, many Canadian chiropractors may not be aware of the dichotomy that exists between, what I refer to as scientific based chiropractic education, as represented by CCE, and metaphysical dogma based chiropractic education, as represented by SCASA. But why should we, the chiropractic profession in Canada, have concern for an accreditation agency that does not have any provincial approval? Unfortunately, at the time of this writing, one province, Newfoundland, does not have a chiropractic statute, and so is open to graduates of the only SCASA colleges, Sherman Straight Chiropractic College and Pennsylvania Straight Chiropractic College. It is my experience and opinion, that not only would Newfoundland suffer, but the entire country could face a demand by SCASA to be approved by other provincial boards, not to mention the divisiveness that demand would create.

What is SCASA?

The Straight Chiropractic Academic Standards Association is a splinter group which formed in the middle 1970's, after Sherman Chiropractic College was denied Correspondent Candidate status with the CCE (USA). Since that time it and the Sherman College have launched several court attempts to challenge the CCE's status as an accrediting agency. The courts have dismissed all of the charges and allegations from this splinter group. However, in 1988 the SCASA was successful in being granted a limited Department of Education (DOE) status. A letter to

SCASA from the secretary of the DOE states, "For a period of two years from the date of this letter (August 30, 1988), I shall list the association as a nationally recognized accreditation agency for the accreditation and preaccreditation only with regards to one of your two preaccreditation statuses, (candidacy) OF STRAIGHT CHIROPRACTIC EDUCATION."[6] This is in contrast to the unlimited status granted the CCE in September, 1987, "as a national recognized accreditation agency for the accreditation of education programs leading to the D.C. degree."[7] The circumstances[a] surrounding this unusual action in favour of SCASA is the subject of much concern within the USA accreditation community, which is expected to argue vociferously against renewal of the SCASA's limited authority. The fact that a few US states will allow SCASA college graduates to seek licensure, is based on those statutes which allow graduates from colleges accredited by a United States DOE approved accrediting agency to be candidates. By not specifying CCE as that agency as most jurisdictions do, a few states had no other choice but to allow this straight chiropractic aberration. I do not know if this possibility exists in Canada or not, and so we should be alert. Our Canadian profession is too small and too fragile to allow this kind of internecine war to develop and consume our limited resources.

The difference between CCE (USA, Canada, Australasia) and its 17 colleges, and SCASA and its two colleges is evident in the purpose for the two agencies. All of which is an extension of the philosophical cleavage still evident in our profession. The purpose of CCE has been presented above, with no need to re-state here. SCASA prefers to use the word mission rather than purpose, primarily because their standards are not definitive and rely more on interpretation by the colleges as long as the fundamental philosophy of SCASA is upheld. SCASA is committed to the unique and traditional objectives of straight chiropractic, which may be interpreted as the analysis and correction of subluxations, nothing more nothing less. Straight chiropractors do not diagnosis,[8] do not treat patient complaints, do not refer, and in my opinion, by not doing so, threaten the health safety of their patients. As for research, I am not aware of any quality research emanating from either of the two STRAIGHT colleges.

The irony of the SCASA approach with regards to subluxation is to "analyze" a clinical finding – which is not a disorder[b] – and treat that finding with an adjustment without understanding of the clinical significance. Not only has a definition for subluxation eluded us for nearly 100 years, but so has an understanding of the complex neurobiomechanical physiological mechanisms of subluxation. If a subluxation is adjusted without clinical reason other than, that it is subjectively assumed to be present, one must question what measurable benefits the patient will experience, and whether the patient is obliged to pay for misdirected care. In the absence of appropriate clinical examination, and developing clinical impression, is there a danger of iatrogenic effects?

The courts have ruled, that all primary care providers must arrive at a diagnosis or clinical impression of the patient's complaint before proceeding with treatment, and make a referral to another health care provider, if the patient's complaint is beyond the skill and scope of that provider. To do otherwise invites the consequences of a malpractice lawsuit.

Conclusion

The Canadian chiropractic profession has dedicated itself to quality education since opening the doors of CMCC in 1945. This has been done in the tradition of academic freedom, research, and the absence of cultism and dogma. The college has a remarkable record of examining every aspect of chiropractic principles using the scientific method. One need only read the works of CMCC graduates and faculty members to appreciate the depth of scientific commitment to chiropractic education and practice.

Under no circumstances should the Canadian propensity for compromise be extended to negotiating or even tolerating the limited objectives of SCASA or any other like organization. An organization, that hides behind abstract concepts, and lacks definitive standards may be dangerous. We have worked long and hard for public and legislative recognition by publicly denying the spurious metaphysical philosophy manifest in the doctrine of the SCASA and it's member institutions.

References

1 Standards for chiropractic institutions. Council on Chiropractic Education, West Des Moines, IA; January 1990.
2 Bylaws. Council on Chiropractic Education, West Des Moines, IA; January, 1990.
3 Standards for chiropactic institutions. Council on Chiropractic Education, West Des Moines, IA; January, 1990:V.
4 Clinical competency document. Clinical Quality Assurance Panel, Council on Chiropractic Education, West Des Moines, IA; October, 1984.
5 Clinical competency document. Clinical Quality Assurance Panel, Council on Chiropractic Education, West Des Moines, IA; October, 1984:1.
6 Bennett WJ, Secretary, United States Department of Education. Letter to Moore LG, President, Straight Chiropractic Standards Association, August 30, 1988.
7 Standards for chiropractic institutions, Council on Chiropractic Education, West Des Moines, IA; 3.
8 Williams MC. Letter to LF Cavazos, Secretary, United States Department of Education. October 14, 1988: 21–25.

[a] The circumstances surrounding the granting of accreditation agency status to SCASA is deserving of a special paper with documentation. It was granted against the expert advice of specialists within the Department of Education, and opposed by the Council on Postsecondary Accreditation (COPA). At best it was a political anomaly, and at worst an abomination of cruel proportions.

[b] A subluxation is a clinical finding and not a diagnosis, a condition or a disorder. A subluxation complex can be identified as being concomitant with a recognized clinical entity. A subluxation may be an etiological agent or may be the result of some other problem. It is the chiropractor's responsibility to use clinical judgment to make that differentiation.