

An open letter to the profession from the Council on Chiropractic Education (CCE)

November 22, 2011

Over the past year the chiropractic profession has witnessed a series of attacks on the Council on Chiropractic Education (CCE), the agency responsible for the accreditation of educational programs leading to the doctor of chiropractic degree. These attacks, many of which have been coordinated by a few outspoken but ill-informed individuals, have mischaracterized the CCE as being unrepresentative of the profession, unresponsive to criticism, and promoting an erosion of the values and practices of the chiropractic profession. This cacophony has focused lately on attempting to block the CCE's re-recognition by the US Department of Education (USDE), a routine process that each accrediting agency undergoes every five years. As the elected chair of the Council, I take pride in the accomplishments of the agency over the past few years and would like to take this opportunity to address some of the misconceptions, misunderstandings, and factual distortions that have been expressed in various newsletters, blogs, social media outlets, and in correspondence sent directly to the USDE. I appreciate the passion that permeates our profession, the tremendous strides that chiropractic has made in the face of adversity from outside forces, the wonderful progress that our educational institutions have made over the past few decades, and the tenuous nature of our practice rights. Although the vocal and printed opposition to the CCE bothers me, I can also understand why our practitioners and patients quickly became defensive when they perceived a possible threat. I hope that this letter will help the readers become better informed about the CCE and its actions, to dispel some of the concerns about the impact of the CCE on the profession, and identify how the CCE could work better with its constituents to avoid future misunderstandings. As CCE representatives have done at several recent conferences and professional meetings, I will address the most common myths and misconceptions about the CCE.

I'll start by providing some background information on the CCE and some context on the accreditation process. We need to remember that the CCE is an accrediting agency, and the primary purpose of every accrediting agency is to assure and improve the quality of its institutions and academic programs. CCE is not involved in professional regulation, lobbying, establishment of public policy or guidelines, or the development of professional standards of care. The USDE authorizes CCE to accredit educational programs leading to the doctor of chiropractic degree. Federal regulations (34 CFR Part 602) stipulate that each accrediting agency undergo a formal renewal of its recognition by the USDE every five years. The CCE was last reviewed in 2006; hence it is undergoing a routine renewal process this year (2011). Contrary to some recent statements on blogs, this USDE review has not been triggered by complaints or a vocal outcry. The CCE submitted its petition for re-recognition earlier this year and is scheduled for its appearance at the December meeting of the National Advisory Committee on Institutional Quality and Integrity (NACIQI), the body that makes recommendations to the Secretary of Education on the recognition of accrediting agencies. Recent activity of NACIQI indicates that only about 20% of accrediting agencies manage to navigate through the renewal process unscathed, whereas the others are required to make additional reports. As such, it is most likely that the CCE will be asked to submit one or more supplemental reports over the next year. It is important to recognize that the USDE and the Advisory Committee focus on agency compliance with the 34 CFR 602 regulations and do not get involved in intra-professional disputes, such as scope of practice, the lexicon of a profession, or philosophical differences.

The USDE also requires accrediting agencies to periodically review and revise their accrediting standards. The CCE has a formal policy on this process and began a comprehensive review of the Standards several years ago. Much of this work was delegated to a Standards Review Task Force. As part of this process, two drafts of revised standards were circulated for public comment in 2009 and 2010. It is probable that some of the fears expressed by certain elements of the profession were triggered by these drafts. Unfortunately, many of the concerns were addressed by the Task Force and the Council in the final versions, but went unnoticed. I'm confident that many of the authors of anti-CCE letters over the past several months would have toned their comments down after a careful reading of the final published 2012 Standards. I'll address some of the changes between drafts in the discussion on myths below.

Myth #1: *“CCE is forcing the chiropractic profession into the practice of medicine by accrediting the DCM degree”*. This oft-stated concern about the CCE and a “Doctor of Chiropractic Medicine Degree (DCM)” is simply not based on fact. The CCE is not authorized by the USDE to accredit a Doctor of Chiropractic Medicine degree. The CCE only accredits programs leading to the DC degree. The CCE has never accredited a DCM degree, has never been asked to accredit a DCM degree, and has no plans to ask for USDE authorization to accredit a DCM degree. So how did this myth get started? This was most likely the result of one institution (National University of Health Sciences) deciding several years ago to adopt the use of the term “chiropractic medicine”. This is a polarizing phrase to many in our profession, but it is also in common use in the literature as well as in statutes. NUHS presently only awards a D.C. degree, and the CCE accredits the program that leads to that degree. NUHS refers in its publications to the name of its program as a “Doctor of Chiropractic Medicine” program. When the CCE inquired of USDE about the naming of programs by institutions, the USDE informed the CCE that an institution had latitude in naming its degree program as long as it only awarded the degree that CCE was authorized to accredit (i.e., the D.C. degree), and as long as CCE used the same standards for accreditation as it used for other D.C. degree programs. This could become confusing to some visitors to the CCE website, so we revised our practices and now only list locations where accredited DC degree programs exist, and not the names of those programs (see http://cce-usa.org/Accredited_Doctor_Chiro.html). Completely removed from the issue over the naming of D.C. programs in our accredited institutions, Draft #2 of the revised Standards contained the following statement: *“This document presents the process and requirements for The Council on Chiropractic Education (CCE) accreditation of Doctor of Chiropractic degree programs (DCPs) or their equivalent (as determined by CCE)”*. Unfortunately, those in the profession who were philosophically opposed to the DCM concept interpreted this statement as a covert attempt to sneak in the DCM degree as an “equivalent” degree. This is far from the truth. The CCE Articles of Incorporation and Bylaws had been modified in 2009 because of a number of inquiries from international chiropractic programs regarding the possibility of obtaining CCE accreditation. It is quite common outside the USA for health professional programs, such as in chiropractic, to award academic degrees, such as a master of science, rather than a professional doctorate. The change proposed by the Task Force was made to accommodate this difference in international professional degree programs and the degrees awarded. After feedback was received on Draft #2, the Task Force acted to reassure that the intent was to address international chiropractic programs and not create a loophole for a DCM degree in the US. This is what the final version states: *““This document presents the process and requirements for The Council on Chiropractic Education (CCE) accreditation of Doctor of Chiropractic degree programs (DCPs), and equivalent (as determined by CCE) chiropractic educational programs offered outside the United States.”*

Myth #2: *“The Standards no longer require chiropractic colleges to teach core principles and practices of chiropractic.”* This myth most likely got triggered by Draft #1 of the revised Standards in which the curricular required subjects lumped “principles and practice of chiropractic” into a generic topic area. We received a fair amount of input on this issue following the public commentary periods. This was remedied in the final 2012 Standards by creating an entirely new section in the required curricular subjects section entitled: “Foundations – principles, practices, philosophy and history of chiropractic”.

Thus, no program can be accredited if the curriculum does not contain these required subject areas. This is further enforced by the mandatory competencies students must demonstrate in chiropractic technique.

Myth #3: “CCE has removed all mention of subluxation from the Standards and students no longer have to know how to assess for subluxation”. This again was most likely triggered by early drafts of the revised Standards. It’s also possible that the concern is based on a misunderstanding of the relationship of the Standards to associated policies. CCE Policy #3 (Meta-competencies and Guidelines) replaced the rather cumbersome clinical competencies section of the 2007 Standards. The 2012 Standards specifically reference Policy #3, stating: “*The mandatory meta-competencies and their required components and outcomes, plus recommended sources and types of evidence used to demonstrate student achievement of the meta-competencies and evidentiary guidelines for assessment, are cited in CCE Policy 3*” (emphasis added). Thus, the Standards document and the meta-competencies are intimately linked, and again a program cannot become accredited unless its students demonstrate achievement of the meta-competencies. In early drafts of the revised Standards, the term “subluxation” was mentioned in the Foreword, stating, “...*Each individual DCP chooses how to incorporate chiropractic principles and practices, such as spinal subluxation, into the course of study according to its educational mission*”. However, inasmuch as accreditation decisions were unlikely to be based on something in the Foreword, eventually the Council opted to remove this section and rely instead upon emphasis of this issue in the required meta-competencies. Between the three drafts and the final 2012 Standards, subluxation received considerable attention by the Task Force and the Council. Despite its historical legacy in the profession, a number of educational programs and practitioners have opted to use other terms, such as joint fixation or joint dysfunction. Even the Association of Chiropractic Colleges (ACC) has not reached a unified definition or specific criteria for subluxation, despite its own task force addressing this issue. The 2012 Standards opted to use a combination phrase, “subluxation/neuro-biomechanical dysfunction” in the meta-competencies as a compromise. The meta-competency on diagnosis and assessment has this requirement for students: “*Performing case-appropriate physical examinations that include evaluations of body regions and organ systems, including the spine and any subluxation/neuro-biomechanical dysfunction, that assist the clinician in developing the clinical diagnosis(es)*”.

So, although the final Standards document itself does not contain the word “subluxation”, the required coursework includes the foundations for chiropractic principles and practice, and the required meta-competencies require students to be proficient in the detection of subluxation/neuro-biomechanical dysfunction”. A justified argument can be made that the meta-competencies appear in policy form, and can thus be modified without public input by the Council. Although theoretically true, it is rather unlikely that this would happen.

Myth #4: “CCE no longer requires students to be able to adjust. There’s no difference in the accrediting standards for chiropractic or any other health profession.” Again, this myth is not based on fact. The 2012 Standards require students to learn chiropractic adjusting technique and to perform adjustments. Draft #1 of the revised Standards referred to required course subjects to include “*spinal adjustive techniques...and extremities manipulation*”. The associated Draft #1 meta-competencies only alluded to adjusting by inference: “*Provide care appropriate for diagnosis, including treatment, co-treatment or referral*”. However, after receiving feedback, this was eventually changed in the meta-competencies to state: “*Provide appropriate chiropractic adjustments and/or manipulation procedures, passive and active care*” and “*Assess the need for and deliver chiropractic adjustment/manipulation, passive and active care.*” Someone recently argued that by using “adjustment/manipulation” a program might teach only manipulation and not specific chiropractic adjusting. This is an argument in semantics that is not based in reality. Many in our profession use the terms adjustment and manipulation interchangeably. All of our chiropractic institutions are currently accredited under the 2007 Standards which used also used the

phrase “chiropractic adjustment or manipulation” throughout the document. Not one of our institutions has stopped training students how to perform a chiropractic adjustment.

Regarding our uniqueness as a profession, the CCE is the only accrediting agency that has Standards requiring instruction in the foundations of chiropractic (including principles, practice, philosophy and history), determination of the presence of subluxation/ neuro-biomechanical dysfunction, and the application of spinal and extremity adjusting and manipulation

Myth #5: “CCE is forcing colleges to teach students how to prescribe medicine. CCE is changing the profession into Medicine.” This is simply not true. Neither the 2007 nor the 2012 Standards include any mention of prescriptive medications or pharmacology in required or elective courses or meta-competencies. Draft #3 (and Final Standards) added as a required component of the curriculum, “toxicology”. Many DCPs see this as an opportunity to include instruction on the adverse health effects of medications. This same subject appeared in former editions of the Standards. At the same time, the Standards are not intended to limit what is taught in the chiropractic programs. Some may choose to include acupuncture, applied kinesiology, the use of orthotics, or even pharmacology, whereas others may not. The Standards set the minimum requirements and expectations. What a DCP decides to teach in addition to those minimums is a matter of institutional preference, as long as it is in conformance with its mission.

Related to this is the concern over the elimination of the phrase “without the use of drugs and surgery.” Many agree that this has been an important part of the history of the profession and helped establish its uniqueness. Yet times have changed and we now find that some states allow DCs to perform minor surgery, use local anesthetics, administer certain medications, or administer IV or IM nutrients. Similar legislation is up for consideration in several other states. The Task Force went back to its principle on not wanting to establish limits on programs and felt that keeping the disputed phrase in the document might lead a program to feel it was in violation of the Standards if it taught, for example, minor surgery. The 2012 Standards removed the entire “Purpose of Chiropractic Education” section, including the “without the use of drugs or surgery” phrase because the Purpose section was redundant with much of the rest of the revised Standards. So it is true the phrase on drugs and surgery is no longer in the Standards, but it is also true that it contributed nothing to the accreditation process. The 2012 Standards also allow a DCP to not teach these topics, if including them would be counter to the programmatic mission of the institution.

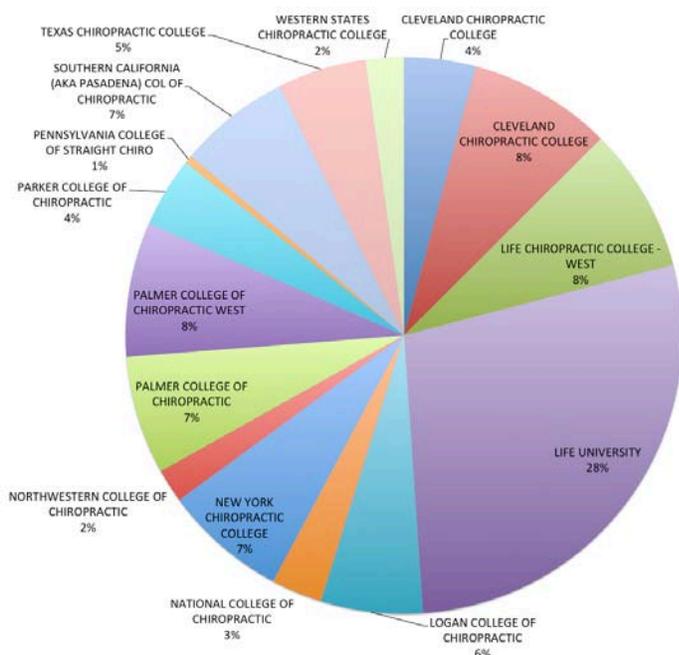
Myth #6: “CCE is responsible for 53% of student loans going into default. This is because the colleges teach medicine instead of chiropractic”. This myth appears to be based on very old data from the now defunct HEAL loan program. The Health Education Assistance Loans were only issued from 1978 – 1998. At the height of the HEAL loan defaults, there were about 1,600 health care professionals in default. Of these, DC’s accounted for about 53%. But, 53% of total defaults is a far cry from 53% of DCs with HEAL loans. Consider that total chiropractic college enrollment during the late ‘90s averaged about 15,000, with roughly 3750 graduates each year. The HEAL program ran for 20 years and during that time, tens of thousands of DCs got loans and graduated. If we look at current data on HEAL loan defaults, we find there are only about 500 chiropractors in default, with the actual number varying depending on payment status (<http://www.defaulteddocs.dhhs.gov/discipline.asp>). Chiropractors still account for the bulk of the HEAL loan defaults:

DC	507	52%	Psychology	27	3%
Dentistry	193	20%	Optometry	18	2%
MD	114	12%	Pharmacy	14	1%
Podiatry	65	7%	Other	3	0%
DO	28	3%	Total defaults	969	100%

There were many causes of the HEAL loan default problem back then, including a mismatch between graduation dates at some colleges and the eligibility dates for taking the National Boards. Attempting to attribute this multifactorial failure on the CCE or on a “medical philosophy” is inappropriate. When one looks at the data on these defaulting doctors, it seems that the bulk of these graduated from institutions with a philosophy well distanced from the medical model, as shown below:

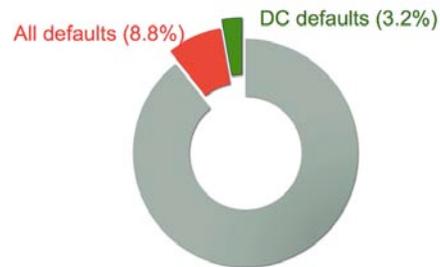
Life University	28%
Palmer (2 locations)	15%
Cleveland (2 locations)	12%
Life Chiropractic College West	8%
Southern Cal (Pasadena)	7%
New York Chiropractic College	7%

Here’s a more detailed depiction of the HEAL loan defaults by school:



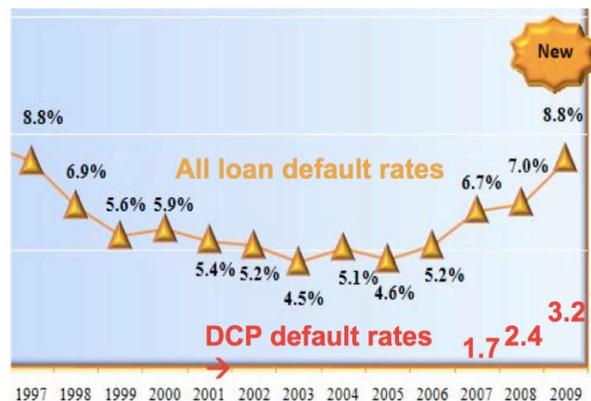
Again, this is not an attempt to establish a causal relationship between philosophy and loan default, but rather to simply dispel the myth that the CCE was responsible for chiropractors being in default on these loans.

What about today’s loan programs and the default rate of chiropractic graduates? The federal government regularly reports data on the most recent three years of defaults in current loan programs (FFEL and Direct Loan). The chart to the right shows the September 12, 2011 report data. Whereas there is currently an 8.8% default rate nationwide on student loans, defaults from chiropractic students are only about 3.2%.



(<http://www2.ed.gov/offices/OSFAP/defaultmanagement/cdr.html>).

This rate of roughly one third of that of other students has been fairly consistent. In the adjacent chart of the nationwide trend for student loans over the past decade, I've superimposed the chiropractic loan default rates for the past three years (the federal government only makes available the last three years on its website). One should reasonably conclude that the profession's current loan default rate is not alarmingly high.



Myth #7: “The CCE is part of an evil cartel, along with the NBCE and FCLB, and doesn’t reflect the profession or different philosophies.” This myth combines a variety of misconceptions and some old information. Obviously the CCE includes the NBCE and the FCLB among its stakeholders, as there is a need to keep abreast of the impact of chiropractic education programs’ curricula and changes in the licensing exam process and the state licensing boards. But there is no appointment by the NBCE or the FCLB of membership on the Council, nor is there any financial relationship between those entities and the CCE. The “cartel” statement appears to have originated from a quote during the 2006 NACIQI hearing at which time there was discussion about the accreditation status of one institution. So let’s look at the makeup of the Council and its Standards Review Task Force. The CCE structure was significantly changed in 2009 when the Bylaws were revised and approved by a supermajority of the member programs (i.e., the college presidents). The former Board of Directors was merged with the former Commission on Accreditation, forming a new 24 person Council. The number of program chief executive officers allowed on the Council was capped at three, thereby reducing the influence of these powerful persons on accreditation matters and the inherent conflicts of interest. Presently, there are two CEOs on the Council, one from Life University and one from Southern California University of Health Sciences. In addition, there are institutional representatives from Life-West (2), Palmer, Logan, Cleveland, Texas, Western States (2) and Northwestern. There are five public members from fields of higher education, regional accreditation, law and finance. There are eight field practitioners who are not working at a chiropractic institution; these include graduates of Palmer, Logan, LACC, and National. One can reasonably conclude that the background of the D.C. Councilors represents a fairly wide spectrum of philosophies and institutions and that no one philosophy predominates. What has been particularly rewarding to me is that every single accreditation decision that has been reached over the past several years has been by consensus (i.e., no dissenting members). Similarly, the 2012 Standards were approved by a unanimous vote of the Council. The Standards Review Task Force also included a broad representation of the profession. The Task Force, roughly 20 members – varying slightly over the several years, included the CCE president and past president, the Commission chair, employees with expertise in clinics, academics, finance and administration from several chiropractic institutions (Life University, Life West, Northwestern, Texas, Sherman, Palmer, Western States, Logan and New York), experienced site team evaluators, some current or past officers/leaders from the ICA, ACA, FCLB, and FCER, a vice president from a large university, and a former USDE staff member. Again, this task force operated by a consensus model.

The process of nomination and election of CCE Councilors is specified in the CCE Bylaws and Policies. These documents are available on the CCE website (<http://cce-usa.org>). Each fall, the Council puts out a call for nominees to fill any vacancies. Category 1 Councilors (the category of seven full-time employees from chiropractic programs) are elected by a majority vote of the presidents (or delegates). The remainder is voted on by the full Council.

Myth #8: “*There are direct financial and political conflicts of interest at the CCE.*” This myth may have emerged from criticisms of the CCE prior to its new structure implemented in 2009. As mentioned before, the old CCE structure had a heavy influence from college presidents. But currently, that just isn’t the case. The CCE has strong policies that it strenuously enforces on conflicts of interest. Policy 18 states, “*Councilors, Academy of Site Team Visitors, Member Representatives, CCE Administrative Office staff; other CCE representatives; and consultants retained by CCE; shall not engage in activities that would result in a conflict of interest, or the appearance of a conflict of interest that would affect their ability to be impartial and objective with their CCE-related duties or that would result in personal gain to themselves.*” Each Councilor must sign a conflict of interest (COI) declaration form at the beginning of each meeting. Any Councilor with a real or perceived COI is recused from deliberations and voting on any accreditation decision. Even if a Councilor doesn’t self-declare a COI, the Chair can recuse a Councilor if there appears to be a COI. As an example, a special meeting of the Council was called in 2011 to discuss the pending closure of a chiropractic college. One Councilor was a current employee of the program and was recused. One Councilor was a current employee of a program that likely would do a teach-out and was recused. Several other Councilors were recused because they worked for DCPs that had announced transfer programs or grants for students affected by the closure. Thus, the final accreditation decision was rendered solely by Councilors with absolutely no personal or institutional investment in the decision. This ensured that the decision was not tainted by even the appearance of a conflict of interest.

Myth #9: “*The voice of the profession was ignored in the recent Standards revision process*”. Actually, the CCE worked very hard to make its Standards revision process visible and receptive to feedback. As is required by USDE regulations, public comment was welcomed during the process, with two drafts of the proposed standards posted in 2009 and 2010 for 60-day public comment periods. Each round of commentary produced considerable input, especially after Draft #2. The CCE and Task Force representative also made presentations at more than a dozen major national/regional/state conferences and meetings, involved work groups from the Association of Chiropractic Colleges, and sought input directly from the chiropractic institutions. The Task Force incorporated many of the suggestions it received at these meetings and from public commentary communications, recognizing that for some topics there were completely opposite points of view. Comments and suggestions for improvement were carefully compiled, tabulated, reviewed, and incorporated into the Standards drafts as deemed appropriate by the Task Force. There were only 28 responses to Draft 1, whereas nearly 4,000 stakeholders responded to Draft 2. With the latter, many responses were verbatim duplications with different signatories. At each meeting of the Task Force or its various subcommittees, the comments were reviewed, reflected upon and debated. Late in 2010 the Task Force submitted a Draft #3 version of the *Standards* to the CCE Council for a final review. Following a lengthy session of deliberation and edits, the Council approved the final version of the Standards at its meeting in January 2011, to be effective January 2012.

During this process, the CCE learned a great deal about how to improve its own practices. Despite our efforts to be inclusive in the Standards revision process, we acknowledge that some groups still feel that they didn’t have access to information. We also are concerned that the major national professional organizations did not appreciate that the CCE was willing to come to their meetings on a regular basis and make presentations or solicit input. For the next revision process, the CCE will be more aggressive in asking to be placed on the agenda of the ACA, ICA and COCSA so that these stakeholders can receive more current and accurate information and provide better feedback. The CCE will also need to develop a better process, including the use of social media and other electronic communications, for regularly updating the profession on CCE matters and responding to concerns or questions posed in various public forums. The CCE has a very small staff, consisting of only five employees, that focuses on assisting

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educational programs and ensuring programmatic compliance with existing standards. However, expansion of external affairs communication is certainly a realistic goal for the organization.

Thank you for taking the time to read through this document. I hope you gained a better understanding of the CCE, its Standards revision process, and the final (2012) Standards for Accreditation. Please take the time to download the 2012 Standards and read through them carefully. I would invite you to help dispel some of the myths that have dominated the press of late and which have been the focus of numerous letters of protest sent to the USDE. The profession relies heavily upon the existence of the CCE and efforts by uninformed persons to derail the CCE's recognition by the USDE or to use the USDE/NACIQI forum to air intra-profession disputes may not reflect well upon the chiropractic profession.

Respectfully,

A handwritten signature in black ink, appearing to read "D. Wickes", with a stylized flourish at the end.

David J. Wickes, M.A., D.C., Chair
Council on Chiropractic Education