An Initial Report of the International Chiropractors Association's Ad-Hoc Committee On the Standards, Policies, By-Laws and Practices Of the Council on Chiropractic Education

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A Report requested by:

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An examination of the Standards, Policies, Procedures and By-laws in light of the changes of January 2011 in the Standards of the Council on Chiropractic Education

The International Chiropractors Association (ICA) has been a long-standing supporter of the goals of the Council on Chiropractic Education (CCE). The ICA has also been a critic of the CCE over the years and the Association has voiced these concerns to the agency as well as to other constituents of the CCE (http://members.chiropractic.org/viewer.aspx?PageID=209).

Most recently the ICA has filed a formal complaint about the activities of a program accredited by the CCE and provided written comments and oral testimony before the National Advisory Committee on Institutional Quality and Integrity (NACIQI) expressing the importance of the CCE to the chiropractic profession as well as the concerns held by the Association about the agency.

Subsequent to the NACIQI hearings the ICA has called for dialogue between the Association and the CCE. The CCE has responded to these calls from the ICA as well as from other constituent groups and movement appears to be underway that will lead to an honest, frank and open discussion of the concerns of the ICA and other groups with the structure, design, emphasis and activities of the CCE.

For this to be a meaningful discussion all parties, including the ICA must articulate the nature and extent of the concerns held with respect to the CCE. The following report is an attempt to provide clear, concise and constructive feedback to the CCE about the agency.

We respectfully offer this input as a stimulus to more extensive and detailed discussion with the CCE as well as with other constituent groups expressing their concerns.

The ICA sees problems with the CCE on many levels ranging from procedural matters, policy matters and elements of the Standards to a series of operating assumptions that underlie the activity of the Council on Chiropractic Education. While matters of procedure or policy can easily be addressed and corrected the greater concern for the ICA lies with the *Standards* themselves, how they are applied and the *a priori* assumptions that undergird them.

Foundational Concerns

1. The CCE and its philosophic stance

The CCE has for decades asserted that it does not represent a particular philosophy of chiropractic or a particular approach to the practice of chiropractic. These assertions notwithstanding the agency does, in fact, skew its activities to support one approach to the concept of chiropractic as a health discipline and to the application of the discipline in a patient setting.

This is not a new notion. It has been expressed repeatedly over time. The response of the agency has been like someone trying to speak to a deaf person by raising their voice and eventually shouting at the hearing impaired! When this concern is raised the standard response is "The CCE does not reflect a philosophy of chiropractic". Saying so, saying so very often and saying so louder and louder does not change the facts of the situation. The CCE does represent a given practice orientation and a given conceptual approach to the concept of chiropractic as a discipline. It does so at the peril of programs not supporting that perspective.

The net effect of the CCE not acknowledging the differing perspectives in the profession and within the educational community is the stalemate that the agency finds itself in at this moment. A problem cannot be corrected or addressed until it is acknowledged. The ongoing denial in the context of this matter has perpetuated and magnified the problem.

2. Control through committee appointments and site team membership

While the ICA agrees that the CCE has not articulated this philosophic perspective in a policy statement or a procedural manual it has affected the same through its site visitation team construction, the membership on key committees, the self-sustaining nature of the board of directors, the election processes and the force

and power of its authority being reinforced in state statute and board of examiner regulations across the country.

Much like the political process in the United States, the party that controls the House of Representatives controls the majority of committee appointments, controls the agenda of the body and even controls whose office is where in the House office buildings. These are the rewards of political victory. This is not however, how institutional and programmatic accreditation policy should be developed, implemented and applied.

The CCE does not need to formally dictate a given philosophic position if it can accomplish the same through the ability to control appointments, the agenda and the conduct of the organization.

An analysis of the institutional representation among the leadership of the CCE over the past thirty years shows a clear and undeniable pattern in support of a group of institutions characterized by their liberal practice orientation and their tendency to de-emphasize chiropractic thought and application in favor of a traditional medical orientation.

If one examines the institutional affiliation of the officers of the agency, and of the committee leadership and committee composition driving the agency, a strong emphasis in favor of a subset as identified above emerges. If this same analysis is extended to members of the site visitation team pool a similar shift in emphasis in favor of one perspective again emerges.

Anyone experienced in organizational behavior understands the power of appointment and the power of the committee chair. Through these means power and control of the direction and emphasis of the CCE has been consolidated and handed down from administration to administration within the organization.

The key committee appointments in areas related to procedures, policies and standards of the agency have allowed this perpetuation of a specific orientation

absent an organizational decision to accomplish the same. Therefore when key proposals about the agency have come forward over the years they have come through the filter of the favored institutions carrying their emphases and orientation as well as their philosophic position on the profession.

If the orientation of evaluators leans in a given direction, and the orientation of the Council members leans in a given direction then the only hope for a program or institution to be successful in smoothly moving through the accreditation process is to lean in that direction.

The involvement of faculty and administrators of accredited programs and institutions in the accrediting process by participating as site team members is a valuable opportunity for personal development and is an important opportunity for institutional development as well.

Over the past thirty years the participation of selected, one might even say favored institutions, has concentrated this knowledge and experience among the institutional subset noted above furthering the gap between these institutions and the remainder of the institutions.

A stunning example of this distortion in the accreditation process was experienced at Life University from 1975 through 2000 where not a single faculty member or administrator from the largest accredited program in the history of the profession was seen fit to be chosen to participate as a peer reviewer of CCE accredited or applicant institutions. This selective avoidance of Life University faculty served to promote isolation, alienation and harm to the Doctor of Chiropractic program at Life University and ultimately to the university as a whole.

The difference in emphasis and orientation in the agency have been amplified over the years by a practice of sending persons holding a polar opposite view of the profession and the emphasis its education and clinical application should have on site teams to institutions. Several institutions report to the ICA that they have

been essentially harassed by the practice of the agency of sending persons known to be contrary to the views of an institution to that institution to serve as evaluators and judges. Aside from sending a message that lacks any form of professional respect the practice is a chilling reminder to the institution or program that disagrees with officialdom who has the power and how it will be used.

3. A failure to evaluate the core of chiropractic skills and the hegemonic control of curricula

A key clinical question on many campuses is the orientation essentially required by CCE with respect to chiropractic care, the determination of the need for that care and the appropriateness of the circumstances under which that care is provided.

There has been an absolute omission on the part of the CCE with respect to the evaluation of the most central element of the care provided by the Doctor of Chiropractic, the spinal adjustment. This is a matter of grave concern for the ICA. Senior chiropractic program administrators from across the country report to the ICA that in the course of their careers, with some involving several institutions, there has never been the development of a concern or even a helpful suggestion by a site visitation team regarding the instruction in chiropractic technique or in the delivery of the adjustment in the clinical setting.

It is an axiom that we measure that which we value. The absence of any attention on the part of the CCE with respect to the “signature gesture” of the Doctor of Chiropractic is an appalling abdication of responsibility on the part of the CCE. It further sends a message to the faculty and staff of every program as to what is valuable, meaningful and critical and what is not. CCE has, by its behavior, clearly stated that the chiropractic adjustment is irrelevant in chiropractic education.

In one area that approximates the concern about adjusting skills the CCE has imposed its will, reflecting that of the previously discussed subset, on institutions

regardless of the institution's clinical emphasis. This involves the use of spinal x-ray imaging for any application beyond fracture, tumor or infection. In this area the over-representation of radiologists among the CCE leadership has constrained institutions and programs beyond any level justified by safety and compromised the ability of institutions and programs to adequately present certain x-ray oriented technique systems. The compelling of institutions and programs to abandon time-tested clinical procedures involving radiological services is a disservice to the profession, the program and the student. Again the composition of the leadership group is allowed to determine key elements of professional behavior about which there is legitimate controversy.

4. Primary Care Chiropractic Physician Mandate

Perhaps the most contentious aspect related to this part of the discussion involves when a chiropractic adjustment should be provided. The prevailing perspective is that chiropractic care is an appropriate "treatment" for acute and chronic neck problems, low back problems and certain types of headache. Others in the profession see the chiropractic adjustment as an appropriate response to these situations but they also see it as an appropriate intervention absent the presence of pain or overt dysfunction intended to normalize joint motion and the attendant ramifications of this dysfunction. The controversy over this basis for the provision of care in chiropractic is important as it serves to shape the thinking of students and future chiropractors about the delivery of chiropractic care.

While the CCE has defaulted on its responsibility and authority to evaluate the technique curricula of chiropractic programs it holds an absolute stranglehold on the perspective, the philosophy, a chiropractic program must have by requiring total and complete acceptance of the *Standards for Chiropractic Programs and Institutions* as pre-requisites for accreditation and as an ongoing requirement for reaffirmation of accreditation. There is simply no room for variance or disagreement on the part of an institution or program. This type of autocratic

regulation is inconsistent with sound educational efforts and is far beyond being appropriate as a criterion to be eligible to apply for accreditation.

An example of a mandate about which there is considerable disagreement among the accredited programs involves the concept in the Standards of “primary care chiropractic physician”. Institutions MUST ascribe to providing chiropractic education leading to the training of chiropractic students as primary care providers. The fact that the agency fails to define a “primary care chiropractic physician ” and combined with the realization that there are a wide range of definitions of the term “primary care physician” from various agencies and authorities makes the matter nearly nonsensical.

In light of the perspectives expressed above the CCE asserts the appropriateness of the position with circular reasoning that because all CCE accredited programs attest to providing “primary care physician” education they must promote this viewpoint. If the accredited programs don’t agree to this statement they are ineligible for accreditation. This circular argument is used by former CCE executive position holders as justification for everything from the expansion of state scopes of practice to testimony in professional liability settings asserting that the practice of chiropractic is the practice of primary care medicine.

The Standards, Overview

The “Mission Statement” of the Standards (page vi) asserts that one of its missions is “serving as a unifying body for the profession”. The CCE functions as anything but a unifying body. Having been referred to as part of a “cartel” during recent federal hearings the CCE has served to create division and discord in the ranks of chiropractic education as well as in the practicing community. Addressing the issues delineated above will go a long way to rectifying this situation as will addressing the elements that follow.

The “Preface” to the Standards (page 9) references chiropractic education leading to “competent practice as a primary care chiropractic physician.” As this term is not defined in the Standards and as this is not a commonly used or understood phrase in chiropractic practice the opportunity for confusion and misapplication of the concept is readily appreciated.

> Action needed: The CCE must define “primary care chiropractic physician”. This definition must appreciate that “primary medical care” and “primary health care” are not synonymous. The lack of definition related to all of these terms has created a slippery slope for the profession. It has also created an environment where senior chiropractic educators and former CCE leaders are misrepresenting “primary medical care” and “primary health care“ as being one in the same.

The term “primary health care” is also referenced in the Preface. The glossary of the Standards does provide a definition of this term. The problem with the definition provided is that it is non-distinguishing in its language. The term is defined on page 25 as follows:

> “Care that is provided by a health care professional in the patient’s first contact within a health care system that includes an examination and evaluation, diagnosis and health management. A Doctor of Chiropractic practicing primary health care is competent and qualified to provide

> independent, quality, patient-focused care to individuals of all ages and genders by: 1) providing direct access, portal of entry care that does not require a referral from another source; 2) establishing a partnership relationship with continuity of care for each individual patient; 3) evaluating a patient and independently establishing a diagnosis or diagnoses; and, 4) managing the patient's health care and integrating health care services including treatment, recommendations for self-care, referral, and/or co-management."

In the third line of the statement cited above there is reference to "A Doctor of Chiropractic". If "A Medical Doctor" or "An Osteopath" or "An Advanced Practice Nurse Practitioner" was substituted for "A Doctor of Chiropractic" the definition would apply equally well. Therefore there is nothing contained in this definition that provides any guidance as to what is unique, different or special about the approach of the chiropractor. The statement is not definitional in a meaningful sense. If this was the intention of the authors then it means the practice of primary health care by a chiropractor, medical doctor or osteopath would be the same.

The ICA finds this to be one of the most troubling aspects of the Standards, that is, the desire to homogenize health care and to lose any and all defining characteristics of the practice of chiropractic.

> Action needed: The definition of "primary health care" as expressed in the glossary of the CCE Standards must be modified to be definitional of the chiropractic experience in health care and the intentional ambiguity created by the exiting language must be clarified.

It is ironic that the CCE would conjure up its own terms and its own definitions and rely so heavily upon them. This, in contrast to council members rejecting the term "subluxation," in part because it is defined differently elsewhere. Why is it acceptable for the CCE to have its view of "primary health care" and stand in contrast to the rest of health care when others in chiropractic seeking to use a

deeply entrenched historic and legally significant term are denied the right to differ from orthodoxy?

The “Preface” of the Standards goes on to detail a series of requirements for chiropractic graduates including:

> • Assess and document a patient's health status, needs, concerns and conditions.
>
> • Formulate the clinical diagnosis(es).
>
> • Develop a goal-oriented case management plan that includes treatment, prognosis, risk, lifestyle counseling, and any necessary referrals for identified diagnoses and health problems.
>
> • Follow best practices in the management of health concerns and coordinate care with other health care providers as necessary.
>
> • Promote health, wellness and disease prevention by assessing health indicators and by providing general and public health information directed at improving quality of life.
>
> • Serve as competent, caring, patient-centered and ethical healthcare professionals and maintain appropriate doctor/patient relationships.
>
> • Understand and comply with laws and regulations governing the practice of chiropractic in the applicable jurisdiction.

A review of these requirements does not reveal anything inconsistent with an approach to the practice of chiropractic where the spinal adjustment is provided as a matter of health maintenance or as a form of lifestyle enhancement absent a pain syndrome or other overt dysfunction. Yet this is consistently objected to and rejected by CCE site team members as being inappropriate and inconsistent with the Standards. The ICA hopes the CCE could live out its required institutional expectation and its intent as expressed in the Foreword:

> "The processes of accreditation are intended to encourage innovation and advancement in educational delivery. Accreditation requirements focus on student learning outcomes that prepare DCP graduates to serve as competent, caring, patient-centered and ethical primary health care professionals."
>
> Action needed: Clear, concise and direct language regarding the appropriateness of the term subluxation as an acceptable diagnosis is required in the Standards and/or related documents. In addition the potential for chiropractic care to address a range of circumstances from overt pain and dysfunction syndromes to quality of life implications must be clearly articulated.

The Standards of the CCE present elements of concern for the ICA from a structural standpoint as well as from a content standpoint.

Structural Concerns

The movement of all clinical competencies from the Standards, which require a two-thirds affirmative vote to amend, to the policies of the CCE, which require a simple majority to amend, is of concern for the ICA. Further the removal of quantitative requirements for the performance of specified clinical tasks from the Standards as well as from the policies of the CCE is a further concern.

This change in approach to documenting clinical skills development when combined with the absence of attention from CCE site visitation teams on the technique curricula of chiropractic programs creates a very troubling circumstance. The presence of quantitative as well as qualitative requirements in terms of chiropractic care delivery, especially as it relates to spinal adjusting are essential to the development of future doctors of chiropractic. Competency in performing a task can be demonstrated following a limited number of experiences but the movement toward skill mastery requires cycles of repeated performance, feedback, improvement and re-application of the skill. With the de-

emphasis of the Standards and policies of the CCE on the “signature gesture” of the chiropractor, the spinal adjustment, there is the very real potential for a further deterioration of the adjusting skills of the next generation of chiropractors.

> Action needed: The quantitative clinical requirements previously expressed in the Standards must be returned to the Standards

An additional structural concern on the part of the ICA is not so much with respect to the language of the Standards it is with respect to the lens through which site team members understand, interpret, apply and use the Standards to evaluate educational offerings. This is a perspective consistent with elements of the Foundational Concerns previously expressed.

Content Concerns

The concerns of the ICA with respect to the Standards lie primarily in what it NOT reflected in the current Standards in contrast to previous editions of the document.

Specifically the deletion of the phrase “without the use of drugs and surgery” represents a sea-change in perspective for the entire profession. This omission serves to eliminate a key characteristic of the profession and causes the Standards to be a document that is consistent with chiropractic practice realities across the country and around the world.

> Action needed: The ICA sees the return of this language as a non-negotiable matter.

Similarly the deletion of any reference in the Standards to the term “subluxation” is matter of grave concern for the ICA. The token reference to the term “subluxation” in the Meta-competencies defined in a policy statement external to the standards does little if anything to ameliorate the devastating impact of this change on the future of the profession.

Action needed: Again the ICA sees the return of appropriate references to the term “subluxation” in the Standards as a non-negotiable matter.

If one appreciates the structural concern regarding quantitative requirements for clinical procedures then our content concerns can be easily understood. The ICA is strongly supportive of the return of quantitative and qualitative clinical skills development markers to the Standards. This is important not only from and educational point of view but also from the perspective of what the requirement says about the importance of the skills from the agency’s perspective.

Similarly the role of chiropractic care in the form of maintenance care or wellness care needs to be entertained in the context of the Standards. The present perspective of chiropractic care only being appropriate in the presence of overt pain and dysfunction circumstances is unacceptable to the ICA. From the ICA perspective this is the equivalent of waiting for a dental problem to become painful or to result in functional impairment before it is addressed. The foolishness of this dental analogy is obvious and to the ICA the foolishness of not providing chiropractic care in the absence of pain and overt dysfunction is equally foolish.

Action needed: Clear, concise and direct language regarding the appropriateness of the term subluxation as an acceptable diagnosis is required in the Standards and related documents. In addition the potential for chiropractic care to address a range of circumstances from overt pain and dysfunction syndromes to quality of life implications must be clearly articulated.

The Policies of the CCE

Policy 3, Meta Competency 3 Health Promotion and Disease Prevention, Required Components

The ICA is concerned that the following requirement is inconsistent with the realities of chiropractic practice in 2012:

> "C. Coordinating health improvement strategies with other health care professionals"

The ICA agrees that this is a good and reasonable goal to be sought. The ICA is however of the viewpoint that this is rarely the case in chiropractic practice in 2012. Coordination such as required above calls for the active participation of other providers with the chiropractor and his/her participation with them in return. As desirable as this may be it cannot be accomplished by one of the parties involved and requires the agreement and support of all parties. As a "required outcome" this is an unreasonable expectation.

> Action needed: Amend the existing language as follows: "C. Coordinating health improvement strategies with other health care professionals <u>when opportunities for such mutual collaboration exist</u>"

Meta-Competency 3 Health Promotion and Disease Prevention, Required Components and Desired Outcomes as related to the following statements:

> "D. Identifying public health issues relevant to patients." (Required component)
>
> "2) Explanation of health risk factors, leading health indicators and public health issues to patients" (Desired outcomes)

The ICA has concerns about the extent of this required component and the related desired outcome. There are many public health issues that are within the purview of the Doctor of Chiropractic such as the use of automobile seatbelts,

bicycle helmets, smoking cessation and the like. There are additional public health measures such as immunization recommendation that are beyond the scope of practice of a chiropractor anyplace in the United States. If this meta-competency envisions the chiropractic student being required to enter discussions with patients about immunization recommendations then the ICA is very, very concerned that this is an unacceptable required component of the patient experience under chiropractic care.

> Action needed: Clarification of this language through the inclusion of specific examples and through inclusion of direct statements in site team training materials that this reference does not extend to matters that are outside of the scope of practice of a chiropractor.

Policy 4, Confidentiality of Council Actions

Most stakeholders respect the fact that in handling sensitive matters directly associated with the review and assessment of individual institutions that there is a need for a strict application of confidentiality. However, an accrediting agency, acting as a para-regulator, should appropriately balance that need with the stakeholders' expectation for operating transparency on matters unrelated to accreditation decisions. The CCE continues to apply Policy 4 to almost all aspects of their operations. Minutes of open meetings do not accurately reflect actual proceedings and some committees operate in almost complete secrecy with no accountability to stakeholders. The lack of operational transparency has resulted in an organization that is unresponsive and unaccountable to the stakeholders that the agency is expected to serve.

> Action needed: The CCE must provide greater access to the internal processes of its activities, not including the deliberative process of accreditation award or reaffirmation, to allow an appropriate level of confidence to develop within the profession.

Policy 10, The Academy of Site Team Visitors

The ICA is particularly concerned with this policy and the practices of the CCE with respect to the Academy of Site Team Visitors. The selection of persons to serve as members of the Academy holds great potential for bias and discrimination of various perspectives in the profession to be institutionalized within the CCE process. ICA is concerned that over the years the members of this pool of visitors have been selected based on the criteria of the policy as well as on the orientation of the candidate to the practice of chiropractic.

ICA is aware of persons who meet all qualifications of Policy 10, who have proven track records of dedicated service on various levels in the profession who have been consistently passed over in the selection process. Those that have been selected are consistent with a given political, professional and philosophic orientation in chiropractic and their selection must be interpreted as a means of controlling the hegemony of the powers that be within the CCE.

> Action needed: The Academy of Site Team Visitors must reflect a broader cross-section of the profession and must be required to seek out new team members to balance the perspectives of the Academy members. Due to the protracted and prolonged imbalance of representation in the Site Team Academy an “affirmative action” plan should be initiated to actively recruit practitioners representing a more conservative practice approach to the practice of chiropractic and efforts must be made to then utilize these persons on site team visits.

Policy 11

As expressed in the Foundational Concerns previously related the composition of site team members and the assignment of personnel to serve on these teams is another method that appears to be used to affect a given emphasis and direction with respect to the practice of chiropractic that is inconsistent with broad based professional representation and mutual respect.

Policy 11 notes the following:

> "The CCE Council Chair, working in coordination with the Council Site Team Academy Committee Chair and the CCE Administrative Staff, selects team members from the current Academy of Site Team Visitors roster. Selection is based upon academic and professional experience; area(s) of expertise; previous team experience, and past performance. Every effort is made to avoid selection of individuals with known conflicts of interest. (Reference: CCE Policy 18, Conflict of Interest)."

The ICA is concerned that these are not the only criteria that have been used to assign site team members and that these criteria are incomplete as presented.

Several programs have reported to the ICA the assignment of visitors who are diametrically opposed to the perspectives of the program being evaluated. It has also been reported that these same persons are used time and time again with the institution. From the perspective of the ICA this practices serves to create an atmosphere of concern and even hostility that is unproductive and inconsistent with the goals of sound accreditation practice.

The accreditation process needs hard, sometime blunt and direct feedback to programs. Objectivity must be an essential element of the process. The ICA appreciates these realities. At the same time the ICA does not understand the value of placing polar opposites in this process.

While an institution has the ability to object to a given person as a site team member such an objection must be based on grounds other than the professional perspective of the proposed evaluator. Consideration of the problems this can create must be addressed by CCE.

> Action needed: The ICA proposes a system that involves two clinicians on site team visits, one person appointed by the process outlined above and

the other left to the choice of the program from full roster roster of potential candidates. There is no reason such a procedure would serve to compromise the evaluation process and it may very well serve to increase the fairness, or at least the perceived fairness, from the programmatic perspective.

CCE Policy 18

Conflict of interest is often a matter of perception. This policy of the CCE addresses conflict of interest from the position of the person acting on behalf of the CCE. It does not however address any issues of conflict of interest as perceived by the program under review/evaluation. As detailed in the discussion of Policy 11 there are many issues from the view of the program that serve to reduce the sense of fairness of the site visitation and review process.

Action needed: Policy 18 must be expanded to provide a stronger appreciation for the view of the program being evaluated/reviewed and must engage matters of perceived conflict of interest from this perspective.

Policy 18, Observers, c. Site Team Observers

It has been related to the ICA that the prohibition of involvement of site team observers in “deliberations, decision-making, report writing or consensus process of the site team” is poorly and unevenly applied. Steps must be taken to assure that this policy is strictly enforced and observers not be allowed to formally or informally influence the site team process.

As an element of transparency it is the view of the ICA that the CCE should consistently and routinely disclose the composition of site teams by membership and affiliation. The current practice of keeping the identity of site team members a matter between the agency and the program feeds the suspicions that the Academy of Site Team Visitors is being used for reasons beyond the evaluation of programs.

Action needed: CCE must enforce its policy that observers are observers and they are not active participants in the evaluation process, the debate about compliance within the team process nor are they involved in the write-up of the team findings.

Policy 29 CCE Election Processes

The CCE election processes represent another method of directional control of the agency by a subset of well-positioned persons within the CCE. While nomination is open and at-large the ballot development process by the Council Development Committee (CDC) serves as an "election before the election" to assure that only persons consistent with the orientation of the leadership have the opportunity to make it to the final ballot.

The impact of limiting candidates for positions within the CCE to those judged suitable beyond the stated criteria by the CDC is magnified by the requirement that an elector must vote for seats open as expressed in the following statement:

> "The number of votes cast by an elector must equal the number of contested seats or the entire ballot cast by that elector is invalid."

Why? If someone chooses to vote at a national election for the presidential candidate but not for the senatorial candidate this does not invalidate the presidential vote. In CCE elections failure to vote for all open seats invalidates the ballot. This is another method of inappropriate control over the election process and the election outcomes.

> Action needed: Eliminate the following requirement; "The number of votes cast by an elector must equal the number of contested seats or the entire ballot cast by that elector is invalid."

The ICA appreciates that persons are needed with certain talents at certain times in the activity of the CCE. This perspective however is too widely applied and serves as the justification for the "election before the election".

Action needed: Delete the following sentence from Policy 29, 2. “The Council Development Committee will review and compare the qualified nominees toward formation of a slate of candidates for each open seat.”

Policy 56 NBCE Performance Disclosures, Thresholds and Outcomes

The ICA is concerned that the application of the threshold requirements of Policy 56 is inconsistent with the statement of CCE Principles and Processes of Accreditation which states the following:

> ”This reflects a recognition that DCPs exist in different environments. These environments are distinguished by such differing factors as jurisdictional regulations, *demands placed on the profession in the areas served by the DCPs, and the diversity of student populations”* (Emphasis added)

A number of DCPs are based in areas where the level of English as a second language is far higher than the national norm. In addition in these areas the population patterns are strongly influenced by first or second generation residents of the United States that do not have a family history or tradition of professional school experience.

The blanket application of this policy serves to harm the institutions that are serving these emerging and assimilating population components. A modification of this policy is in order in the environments where a program has a higher than usual ESL student population and/or a higher than usual first or second generation U.S. residency background.

A criticism of the chiropractic profession is that it is an exceedingly “white” profession. The CCE has an obligation to make allowances for programs that are seeking to alter this reality and who are seeking to more appropriately reflect the nature of the populations served in their geographic region.

Policy 64 Complaints

The handling of complaints by stakeholders with a different perspective has been an issue for years. Despite citations from the Department of Education in 2005 and 2006, Policy 64 continues to be used to delay addressing well documented issues against "favored" institutions. Recently, following a formal complaint against one such institution, the CCE used the "informal process" as an excuse to delay responding and then assumed a role of a mediator rather than an objective enforcer of the CCE standards. During the most recent review, CCE was once again cited for non-compliance with the Secretary's criteria for handling complaints. Eventually, after taking very limited action, the CCE used a flawed "Appeal Process" to justify the validity of their original decisions. An objective review of the recent behavior of this agency can lead to no other conclusion that the governance structure combined with a lack of checks and balances has created an environment where the rules are written, policed, and judged under the direction of a common Executive Committee with no independent source of remedy other than the Department of Education.

> Action needed: Modification of the current complaint processes with particular attention to providing a framework to the "informal process" associated with complaint resolution.

By-Laws of the CCE

Article IV, 4.01 Membership

This clause should be revisited and the reference to Cleveland College of Chiropractic, Los Angeles removed.

Article VI, 6.03 Nomination and Election (b)

The by-law being referenced states as follows:

> "(b) Councilors shall serve staggered three (3) year terms and may serve for three (3) consecutive terms."

It is appreciated by the ICA that the term limits noted above became effective in the not too distant past. As a result there are members of the Council who presently exceed these limitations. While one may back up on the technical aspect of the clock running from the date of implementation of the requirement it would be more appropriate for members who have exceeded the spirit of the requirement to resign from the Council.

> Action needed: The spirit and intent of this by-law should be applied to all Council members without regard to when service to the Council began or when the by-law was adopted.

This section of the by-laws further states:

> "Councilors who have served three (3) consecutive three (3) year terms may stand for re-election following a three (3) year absence from the Council."

It is the opinion of the ICA that three consecutive terms or a total of three terms over any period of time is the maximum period that any person should be able to serve on the Council. The loosely worded nature of this provision of the by-laws

with the use of the word “consecutive” allows for life time involvement of a person on the Council with intermittent gaps in service every nine years. Is the profession so lacking in talent that persons needed to be called upon in this unlimited and unending manner?

> Action needed: Modify the following by-law: “Councilors who have served three (3) consecutive three (3) year terms may stand for re-election following a three (3) year absence from the Council.” With the following amendment: “Councilors who have served three (3) ~~consecutive~~ three (3) year terms may <u>not</u> stand for re-election ~~following a three (3) year absence from the Council~~.”

Article VI, 6.03 Nomination and Election (c)

As to the seven positions set forth in Category 1, Section 6.02(a), election to the Council shall be by majority vote of all Members. As to the remaining positions in Categories 2, 3, and 4, set forth in Section 6.02, election to the Council shall be by majority vote of all Councilors.

The ICA questions an election process that by its very nature creates a self perpetuating Council with no opportunity for reform.

> Action needed: The ICA calls for a new election process which would involve a variety of some stakeholder groups in a manner that would ensure that those elected to the Council were representative of the different viewpoints within the profession.

Article VII-Governance, Section 7.06 Conduct of Meetings

The by-laws of the CCE do not call for, require or even permit a period of public comment at public meeting of the CCE. The ICA has not done an exhaustive review of Arizona law but based on experience with non-profit laws in other states the opportunity for public comment is rather widely viewed as a matter of

organizational best practices to assure input for the constituencies served by the agency or government entity in question.

> Action needed: The ICA calls for such a provision for public comment to be included in the conduct of meetings of the CCE for all public meetings.

Article VIII-Officers and Administrative Staff, Section 8.07 Council Standing Committees

The ICA questions the current committee organizational procedures where the chair is elected by the Council but other members are selected by the Chair of the Council with affirmation by the full Council. It would seem to be a more streamlined and efficient process to have the Council fill all committee seats directly.

Concern has been expressed that the Council committee structure has been used to direct the emphasis and orientation of the CCE. This is perceived to be accomplished through the power of the chair to appoint committee members of his/her choosing as outlined in this portion of the by-laws.

> Action needed: The Council would be better served by a more democratic and transparent process of committee appointments that omits the intermediate role of the chair in selecting committee members.