Globalizing Chiropractic Schools, Part I - By Michel Tetrault, DC

- Begin with the end in mind. (Steven Covey)

Chiropractic education is at a turning point in its history. As a follow-up to the conference on Philosophy in Chiropractic Education in November 2000, the International community has been planning an equally important conference: **WFC/ACC Conference on Clinical Education — São Paulo, Brazil, October 26-29, 2002**. Core Curriculum contents will be discussed and debated seeking agreement on what should be the core clinical skills in chiropractic education for today's students world-wide, that will set the foundation for International Standards on Chiropractic Education and the private practicing DCs need to make their voices to be heard. The following 2 Part article is designed to inform and inspire you to actively engage and participate in this process.

In the advent of globalizing the chiropractic education process, it is paramount we first understand that our profession is able to qualify Doctors of Chiropractic (DC) under an accredited chiropractic program which permits students to satisfy internship requirements in an on-campus clinical setting concomitant with completion of their formal education. This is particularly important for the new schools that are added to an established university such as the new school in Mexico. Countries that are actively pursuing the establishment of a chiropractic program that meets International standards are: Argentina, Costa Rica, Egypt, Hong Kong, India, Italy, Japan, Malaysia, Netherlands, Peru, Philippines, Portugal, Spain, Sweden, Taiwan, and Thailand.

However, if a course of study in chiropractic does not produce a chiropractor who grasps the principle of increased vivification as a result of the adjustment, he will be more inclined to follow preceding chiropractors who have assumed the mantle of a "fixer" or cricks, backaches and strains. Such a practitioner will eagerly embrace the notion of full-body treatment and non-legend drugs. The end result of this scenario is a "rudderless" doctor of chiropractic, inclined to embrace whatever may recommend itself to him.

This would also severely compromise any effort to establish legislative authority for chiropractic in these developing countries. What appeals to the law makers is the addition of a new and viable profession, unique and distinct, clear in its service mission and not one that merely tries to duplicate services already provided by other existing licensed health care professionals.

From the patient's perspective, they want a doctor to perform according to their highest skills in whatever discipline of health care they seek services. A chiropractor who takes 100 hours in acupuncture does not an acupuncturist make; no more than 100 hours in manipulation by a Physical Therapist or Medical Doctor qualify him to perform chiropractic. Lawmakers and patients alike want and are entitled to access the expert who is most qualified to deliver that particular service. For the correction of spinal subluxations and to experience better overall health from that adjustment, the patients prefer the DC because of the unique education and level of skill that education process produces. That is the outcome of beginning with the end in mind: a chiropractor who can adjust the spine and deliver that unique service to mankind. Everything else is supplemental or supportive to that end and new schools must place this premise first and foremost. After a century of refining great techniques our new schools have many options available.

Chiropractors have provided a service needed by all mankind - a need that has never been so comprehensively met before in history. Immediate attention by all levels of the profession is needed to carefully scrutinize what a chiropractic curriculum should be as we approach this time in our history when we will soon see a proliferation of International DC programs. The basic sciences, presented from a viewpoint of interrelationship and master control, combined with a thorough presentation of the clinical sciences, will only serve to yield a chiropractor who is first a chiropractor - a chiropractor who understands the philosophical underpinnings of his profession, who knows how his beliefs differ from the medical profession; one who is proud of the difference.

The field and the colleges must come to grips with what and where we are. We, as a profession, have been authorized to legally function upon the basis of our philosophical approach to health and sickness. Our legislative niche has been delegated to us, not as a replacement for or a variety of medicine, but rather as a new science based on a new idea of service and a new method in the care and management as a specific area of the body that may and usually does affect the entire body. Yet, it is the recognition and understanding of his philosophic, professional and legal parameters that allows the chiropractor to maintain his role as a primary health care provider.

Chiropractic exists today as a separate and distinct profession, as does dentistry, optometry, and podiatry, each having a legal basis upon which to function as an exception to the various medical practice acts throughout the country and throughout the world.

The New Zealand Report of 1979 expresses our uniqueness very well: "The chiropractors differential diagnosis is not aimed at identifying the patients disorder so that a specific treatment for the disorder may be prescribed, but instead is aimed at determining whether spinal manual therapy should be undertaken at all, and whether the patient should be encouraged to take medical advice." The report summarizes the reason for our care by stating: "by treating that malfunction, the chiropractor expects the patient's general condition to improve, and the specific condition of which the patient complained may be relieved..."

The text states that the "reason for treatment is" "to correct spinal malfunctions so that the body's own recuperative forces can work unimpeded..." The Commission concludes that: "the chiropractor occupies a unique position as a spinal specialist.

To emphasize the significance of a philosophical base, consider if you will, two students of economics, with each being equally intelligent, dedicated and motivated. Each studies the principles of economics and the laws of supply and demand. Upon graduation day they emerge, one as a capitalist, the other as a socialist - the lectures were the same and the textbooks were the same. The difference arose from the philosophic base upon each placed the building blocks of his science.

Similarly, two students may study the basic sciences. Again, both of equal intelligence, dedication and motivation. One chooses to align himself with the philosophy of the medical practitioner, which is aimed at diagnosing all variety of human disease and then treating them with whatever remedies man or science can discover. An allopath's philosophy centers around the specific diagnosis and the treatment of illness, regardless of the method. The medical practitioner may utilize the natural forces of air, light, and water and herbs, as in homeopathy or naturopathy, or he may utilize *materia medica* because, in his view of allopathic medicine, all agents are designed for the treatment of disease.

The other chooses the chiropractic philosophic system of health care, a legalized exception to the medical practice act.

The hard reality in beginning with the question of philosophy is a devastating one. We either continue in the marketplace as a separate, distinct and non-duplicating philosophy, art and science, or we approach the path of duplicating existing services as limited, "drugless physicians" constantly seeking to expand our background to gain esteem, dignity, and acceptance - ultimately losing legality as did the naturopaths.

As ludicrous as this may sound, the fact remains that many chiropractors do not hesitate to diagnose and attempt to treat conditions other than those which are biomechanical and neuromuscular in nature, which are within the chiropractic scope of practice as defined by the CCE and the various state legislatures.

Schools of dentistry, optometry, podiatry and chiropractic provide an education, which in some areas is quantitatively and qualitatively similar to that provided osteopaths and allopaths. Even though all health care professionals may share limited commonalities within their individual educational curricula, their profession is by design and intent separate and distinct, affording a generalist or specialized education.

Dentists, podiatrists and optometrists do not perform broad body diagnosis, seek to treat the whole body or add competencies to their practice not provided for by the emphasis in their specialized education and accepted area of professional expertise. If you were to visit a dentist who began to diagnose and treat conditions outside of the dental scope of practice, you would probably take issue with their attempt to treat anything outside the mouth... and change dentist, quickly.

Chiropractic education institutions have never been in a position where they enjoyed the luxury of surplus instructional time. Operating within the time constraints we now experience demands dedication and professionalism to qualify a chiropractor eminently in his specialized field. To think we could qualify graduates to diagnose and treat the whole body, given the amount of classroom instruction and the length and nature of the clinical experience they now receive is beyond belief. What we do - and we do well - is give the chiropractic student a solid understanding and experience with the osseous structure, particularly the spine, and how that relationship with the nervous system affects the restoration and preservation of health. This is a far cry from diagnosing with eminent qualifications all diseases throughout the entire body and treating them with various treatment procedures.

Claiming our own

Next, let us compare the extent of clinical internship between chiropractic and allopathic education formats and how the actual framework of this experience determines what areas of the body the practitioner becomes qualified to treat and the foundation for the laws devised for professional license.

Standards of the Council on Chiropractic Education (CCE) establish the area of eminent qualification and eminent domain of the chiropractor: "skeletal biomechanical and subluxation evaluation" and general screening of the patient for referral and consultation.

The following extracts address CCE positions/ policies:

Diagnosis:
"With respect to diagnosis, it is the position of the CCE that appropriate evaluative procedures must be undertaken by the chiropractic physician prior to initiation of patient care. There must be proper and necessary examination procedures including recording of patient and family history, presenting complaint, subjective symptoms, objective findings and skeletal biomechanical and subluxation evaluation."

Chiropractic care and patient management:
"The following categories constitute acceptable avenues for patient care when in accordance with chiropractic physician's clinical judgment. He/she is expected to render care in accordance with the patient's need, and in the public interest."

Spinal adjusting	**Adjunctive Physical Procedures**
Manipulation	Nutritional and Psychological Counseling
a) Spinal	First Aid and Emergency Procedures
b) Articular	Supportive Procedures
c) Soft Tissue	Patient Education
	Consultation and/or Referral

Spinal adjusting is described as including both manual joint and soft tissue components. Adjunctive procedures are used preparatory to or subsequent to the chiropractic adjustment that mainly include lifestyle changes advised by the chiropractor to the patient.

Adjunctive Therapy:
"The educational process should be a reinforcement of the validity of the basic principles of chiropractic and an encouragement to the student to apply those principles in his or her clinical programs with emphasis given to the detection and correction of the vertebral subluxation. Adjunctive procedures are to be considered ancillary and used if required preparatory to or subsequent to the chiropractic manipulative procedure." *Make particular note that the physical procedures are not allopathic or treatment of diseases or conditions, they are ancillary, complimentary or preparatory to the chiropractic adjustment.*

Internships:
Patients expect and are entitled to a certain level of clinical expertise from their health care providers. They can do this because the educational programs have been consistent in the specialized clinical internships that apply to the respective disciplines. In dentistry and optometry as well as chiropractic, the clinical experience is incorporated concomitant with their academic studies in preparation to graduation and limited to their area of specialization. The allopath's educational preparation, on the other hand, fully supports broad body diagnosis and treatment. It is structured to eminently qualify him in the above areas by virtue of curriculum content and the "serves" he performs during two years of postgraduate internship.

A "serve" is a specifically designed training sequence to acquaint the student with the particular body area or function that its design specifies. The various serves collectively cover all areas of the body and all treatment procedures known to science below the specialist level. The intern spends a certain amount of time in each serve with practical hands-on experience studying the conditions and treatment procedures associated with the serve. The electives and non-electives include: bio-statistics, cardiology, EENT, emergency medicine, family practice, intensive care, internal medicine, nephrology, neurosurgery, nutritional medicine, OB-GYN, opthalmology, orthopedics, psychiatry, radiology and surgery. The end result of academic preparation and clinic internship by the allopath is a generalist with low-level whole body qualifications.

Some of the above "serves" may be addressed in the chiropractic college curriculum but are done so within an academic rather than clinical setting, designed to acquaint the student rather than qualifying him for a given competency. There can be no question that the depth of the educational experience of the allopath accords him, not the chiropractor, eminent qualification in the area of full-body diagnosis and treatment. In the like manner, the MD does not have eminent qualifications to practice chiropractic.

Chiropractic alone understands how to achieve vivification and enhanced homeostasis without recourse to chemicals or artificial intervention. We are afforded the unique opportunity to observe in a clinical setting the results of the adjustment as it manifests itself in increased vivification, an opportunity no other health care profession enjoys. It is this aspect of training, which is wholly missing in the clinical experience of the allopath, thus fostering and perpetuating doubt and mistrust in chiropractic and what it can accomplish when applied properly. In like manner, the lack of emphasis on this aspect by certain chiropractic colleges only encourages the chiropractor to use more treatments; a predictable response when one does not know the effect the adjustment has on vivification and homeostasis.

The chiropractor's clinical serve experience has provided him with extensive opportunities to observe the effect of the vivification process on healing and the restoration and preservation of health. In a clinical setting, we can observe the short and long-term effects of the adjustment as it releases vivification and homeostasis. We may observe these effects as they apply to manifestations of dysfunctions through increased vivification as the result of the chiropractic adjustment. No other health profession has grasped this principle; it is virtually unknown outside of chiropractic.

The chiropractic profession is gradually beginning to expand its ability to educate chiropractors in an increasing number of countries. There is a need for an organized effort to package an exportable educational product that complies with the legitimate and established professional standards. This subject will be covered in greater depth in the following parts of this article series.

What can you do to help? A good place to start is to be active in your Alumni Association, but even if you are not, contact your Alma Mata and find out who they are sending to the WFC/ACC conference. Express interest for input - ask the school to state their position on subjects that you feel are important to include in this International dialogue. Engage in deeper discussions if you are not satisfied with their reply and even consider attending the conference this October in Brazil yourself. (For details of the conference go to www.wfc.org)

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Globalizing Chiropractic Schools, Part II - By Michel Tetrault, DC

- Thinking things through.

PARIS 2001 - Representatives of several countries, during their Country Reports at the WFC Congress, stated that there is some preliminary work being done in their country toward the eventual establishment a chiropractic school. This indicates that the time has indeed come to prepare more resources for this growing list of countries planning on starting a new school. In order to place some relevance in this effort, it makes sense to evaluate the population and economic indicators for the possible number of schools a country can support; build a database that includes the names of the prospective universities and the mentor institution(s) affiliations within the already established schools; and, address the challenges of supplying enough teachers to meet the growing demand and growth in the number of schools. In addition, some consideration be allowed for the unique specifics of each country's educational laws that may require modifications in the early stages of establishing a chiropractic curriculum, as seen in Brazil during the latter part of the 90's.

Developing models that can estimate the demand and viability of chiropractic schools in new countries presents two possible directions. One is based on comparing chiropractic with the allied healthcare professions of similar levels of education, such as Dentistry or Optometry. The other relies on the population and economics within each country. In fact it may require either or both to arrive at reliable values.

To compare the number of other First Professional Degree institutions and calculate for example the ratio of Chiropractic to Dentistry schools it is best to look in countries like America, Canada and Australia, where the chiropractic profession is well established. There are 55 DDS schools to 17 DC schools in America and 9 DDS to 2 DC schools in Canada. Looking at the dental schools of both countries there are 6 times less dental schools in Canada than the US suggesting that Canada should have 3 chiropractic schools. If British Columbia ever gets its act together, the matching ratio of schools would be accurate. Now, it remains to be seen whether that ratio of 3 DDS to 1 DC school can translate into other countries with different socioeconomic realities.

In another article, this author has illustrated how the size of a country's middle-class dictates the number of DCs that country can support. When considering this, the financial approach of estimating if a country can support a school may be more valid. This is accomplished by multiplying, for a country like the USA or Australia, the total population with the gross domestic product per individual (GDP) and dividing that

number by the number of schools to come up with working denominator: *POP x GDP ÷ DC school = X*. This approach was taken for each of the countries where there are practicing DCs today with the results listed below. Only in the established countries were both methods required.

The number in brackets () is the estimated total of schools for that country.

Established Countries:			
USA	17 Schools (18 needed)	Doctor of Chiropractic Degree	
(First Professional Degree ratio model estimates 18 US schools while the POP x GDP ÷ DC school = X model suggests 43 possible schools. Perhaps the US population distribution supports larger sized schools?)			
Australia	3 Schools (3)	BSc Degree	
Canada	2 Schools (3)	DC Degree	

Advancing Countries:			
England	3 Schools (9 needed)	Batchelor of Science in Chiropractic Degree	
South Africa	2 Schools (2)	Masters in Chiropractic Degree (?)	
New Zealand	1 School (1)	Doctor of Chiropractic Degree	
Denmark	1 School (1)	Masters in Clinical Bio-Mechanics Degree (?)	

Pioneer Countries:						
Brazil	2 Schools	(7)	DC Degree	Costa Rica	1 School (1)	DC Degree
France	1 School	(9)	DC Degree	Japan	1 School (19)	
Korea	1 School	(4)	DC Degree	Mexico	1 School (5)	DC Degree

Hopefuls: (11 out of 26 total)							
Argentina	2	Iran	2	Italy	8	Malaysia*	1
Peru*	1	Philippines*	2	Portugal	1	Spain	4
Sweden	1	Taiwan*	2	Thailand	2	*discussions underway	

Eventuals: (87 total)							
Austria	1	Belgium	2	Chile	1	China	25 est.
Czech Republic	1	Egypt	1	Finland	1	Germany	12
Greece	1	Hong Kong	1	India	25 est.	Israel	1
Morocco	1	Netherlands	2	Norway	1	Poland	2
Russia	4	Saudi Arabia	1	Singapore	1	Switzerland	1
Turkey	1	Venezuela	1				

The current global snapshot creates the following projections:

A total of 195 possible schools in 46 countries and in 30 languages, so far that have DCs.

- 36 schools in 7 languages are established out of a possible 82 in these 13 countries.
- 11 new countries are currently at some level of negotiation.

There are of course many challenges to prepare the necessary resources for these new schools. Partnering with the right institution can have a profound influence on the success or rapid growth of the program. There are schools that have been established with little or no partnering with institutions that represent the full chiropractic product. The results were, let's say, disastrous and there is room for concern that the lone ranger approach may not remain an obsolete practice. Problems continue to arise out of these cases in Japan, Sweden, Denmark and Italy that are very difficult to resolve.

One of the most successful mentorship models observed has been between the Sherman and New Zealand Schools. What can be learned about that example of partnership-in-action? Someday, they may elect to write about their model of cooperation. Palmer College has provided a "bridge-type" of mentorship with the first school to open in Brazil in the '90s. Life University continues to work on a working model for "twinning" with universities of third-world countries, such as in Costa Rica, Peru and is looking at Africa. Northwestern has had their hand in consulting from a distance for several potential foreign schools in Latin America, Mexico in particular. In Asia, RMIT has an ongoing program in Korea and Japan with additional consultations with Malaysia, Philippines and Thailand. RMIT has yet to realized the same positive outcomes as seen from the American mentorship of Latin American schools. Dealing with developing countries has seen many false starts in all continents calling for a more compete resource center to reduce the barriers that have been encountered.

The lack of clear and uniform resources will continue to prevail as long as institutions struggle to just take care of their home base. Stretching abroad with thin resources of faculty and finances makes the effort particularly difficult. Palmer College has continued its logistical support for Fevale, Brazil where faculty comes to Davenport for a 9-month teacher internship program.

Is there a single entity that can provide the whole package needed to import a chiropractic education program? Palmer, Life and Sherman have pledged a continued support for the New Zealand school. Perhaps this is the beginning of an International consortium that can extend beyond the South Pacific. By adding, let's say Cleveland colleges there would be 7 schools pooling their resources to logistically support the newer schools with a "total exportable product."

On the subject of the philosophical focus seen at Palmer and Life, particularly as we see all new schools being developed as a department of an established University, there is the requirement for a clear International Core Curriculum that addresses these University based programs' needs without compromising the outcome and quality of the DC graduate. A thoroughly structured Philosophy content can create the necessary "Chiropractic Culture" needed for the students who are educated in chiropractic within a university system. Again, another point that emphasizes the need for a cohesive and complete exportable program that would be gladly received by both the DCs in the countries attempting to see chiropractic taught there and the universities who are looking into the prospects of adding this new and exciting profession to their institution.

Curriculum Designs - *Expanding the model.*

Earlier, we discussed the growing need for an organized effort in planting chiropractic schools worldwide as well as the value of gathering information to better think things through. A current global snapshot was created to estimate the number of schools needed in each country that resulted with a total of 195 possible schools in 46 countries and taught in some 30 languages. There are presently 36 DC schools taught in 7 languages that are established out of a possible total of 82 in these 13 countries. In addition we see that 11 new countries are currently at some level of negotiation with a nearby university with the hopes of teaching chiropractic in their own country.

Projections suggest that during the first decades of the 21st Century there will be 1-2 new chiropractic schools starting every year and eventually 2-3 new schools annually thereafter until the foreseeable future. Will these schools graduate doctors that are equal to the current practicing DCs? What is being done to preserve the chiropractic heritage yet still allow for progressive developments that come out of technology, research and clinical experiences? Are there enough qualified teachers to fill the positions? Will there be a random implementation of independent schools or can we influence a harmonious strategic development of a global chiropractic education system? Let us discuss these seven key components: university based schools; prerequisites, core courses, preserving subculture in philosophy, Information Technology, faculty shortage and regional accreditation issues.

In the early years, chiropractic was taught by mostly small private institutions. National peer review standards evolved and accrediting bodies were formed to place chiropractic equal to other "First Degree Professional" educational institutions. Since the late 1980's all new schools have been created within university systems and this trend is likely to continue.

Curriculum designs have mostly followed some basic standards but only recently has there been an interest in creating International Standards. In an effort to further encourage International cooperation there are several design elements that invite rational self-critique before casting the curriculum molds to stone. We will discuss some of these elements.

Private institutions have the luxury of setting their own programs and the cost of education has tripled in the last two decades. In an affluent country like the USA there will always be people who can afford to bear these costs. Economics becomes a critical factor in opening the chiropractic profession to other countries. This begins with the cost of educating DCs in these countries. At present only the children of the wealthier families can afford to go abroad for a chiropractic education. There is now the need to see new DC schools start all over the world to reach all the people.

Prerequisites in Canada and the USA have jumped from high school in the 50's to 70's and approaching a full BA or BS degree in the 2000's. Three to four additional years have been added in just the past few decades. How will prerequisites be determined in countries like Egypt and Costa Rica or Hong Kong and Botswana? Certainly not a full college degree! The logical choice is to match the prerequisite standards of the existing professions of dentistry, podiatry, optometry or veterinary schools. This would range from a matriculation right out of high school in some countries to the two years required in many countries today.

In some countries, as was the case in Brazil, it may be necessary to adapt an "interim" course before the full International Standard can be provided. This would be predicated by certain country laws or the high number of non-qualified "so-called-chiropractors" who will likely attempt to be grand fathered in new laws.

Caution needs to be exercised when determining which courses are "core courses" and which are related to Western lifestyles. Competing with other healthcare professions in America has prompted our DC schools to include additional courses that meet the demands of the American stressed-based culture, often sacrificing additional classes in techniques. Some American schools have opted to focus on academic courses and offer minimal diversity in technique programs. What "core courses" need to be included that produces a proficient DC without over-minimizing and without touting one method over another? Beyond core techniques we have also seen the development of hybrid techniques over the past 25 years. There is a trend to move away from purely segmental evaluation and correction toward more neurological and meningeal methods. This may just be a North American trend but other countries are just as likely to develop culturally influenced methods that evolve out of their experiences. An exciting prospect for sure! One that should to be factored into accepted curriculum designs.

Philosophy has been a particularly interesting component of the curriculum process. When 22 out of 32 DC schools convened for the first time in Manila in 1998, to discuss International Education Standards, their first topic of concern for a detailed study was on the Philosophy of Chiropractic. So, two years later in Ft. Lauderdale, Florida the first International conference on Philosophy in Chiropractic Education was held through the WFC. The results were unexpected! It seems that we have been mandated to embrace our "vitalistic roots" as schools re-evaluate their curriculums. Philosophy experts insist that it has something to do with our "raison d'etre" and being "authentic" in our healthcare role. It has been suggested that curriculum designs include a Philosophical basis for each area of study. Not just for technique and clinical sciences but also research, physiology, pathology and other physical sciences.

Then there remains the challenge of training chiropractors in a university system not solely dedicated to the chiropractic profession. Most DCs in practice today have been privileged to receive their education in a private school that exclusively focused on chiropractic. This setting made it easy to maintain a "chiropractic culture" essential in the development of a healer in this discipline. As all new schools and many established schools are university based, DC students receive their basic science courses in a "mixed setting" with students from other health disciplines or science programs. The challenge is to integrate into the learning experience a new model that can recreate this "chiropractic culture" in a manner that maintains harmony with the shared faculty and students of the university. Realizing the value of integrating a Philosophy component in all areas of study can move things in the right direction.

The new frontiers for chiropractic are not found in Western/industrial countries but are occurring in the more recent post-colonial and third world countries. Object based educational models worked well in English speaking and post-industrial societies, even when attempting to train a vitalistic practitioner. Perhaps it is time to create curriculums that are culturally sensitive to societies that have retained a holistic based healthcare mentality as seen in China and India.

Information Technology (I.T.) developments over the past decade are contributing to the potential for expanding chiropractic education, unlike any time in our 100+ year history. Until now, only economically advanced countries could put the resources together to establish a chiropractic school. Today, I.T. systems allow Distance Learning products to be shared internationally and at reasonable costs. This relatively small profession with its limited pool of teaching staff can now share its human resources between schools. Students can be exposed to some of the best teachers in the world to supplement their local faculty through multi-media and Distance Learning technologies.

Today, it is easier to put together a quality education program for chiropractic that can be duplicated and offered worldwide. The biggest barrier to the profession's growth is the lack of chiropractic schools. I.T. brings to classrooms uniformity in training with higher quality and lower costing tools. In establishing International Curriculum Standards we must consider the role Information Technology can play.

There still remains the problem of providing emerging schools with enough qualified teachers. There is a shortage of teachers in chiropractic yet there is no plan to prepare for the future. The availability of face-to-face teachers to staff the growing need for DC faculty is an important issue. Teachers who are experienced in the practice of chiropractic are a valuable resource.

Recruiting this "Faculty Pool" requires sensitivity to both the educational requirements of institutions and the cultural compatibility to the target country. Not all people can adapt to different standards of living but there are teachers with "ex-patriot" qualities who love to live and work in different cultures.

The true benefit that this Faculty Pool can contribute to the profession is to influence greater uniformity of education in meeting the curriculum standards. School start-ups could greatly benefit from an

International Faculty Pool. If you are a qualified teacher with a tolerance or affinity for other cultures, you are invited to register with the Chiropractic Diplomatic Corps at www.ChiropracticDiplomatic.com/register.

Accrediting agencies serve an important role in contributing to the quality of education. Unfortunately, not all countries have chiropractic accrediting agencies. This has resulted in atypical school programs and a poorer quality of education. Without accountability the public remains at risk and DC students are receiving an inferior education for their tuition. Until it is practical to have an accrediting agency in each country that teaches chiropractic, there needs to be at least a regional entity that can establish an early framework to ensure that International Standards are being met by all schools. Creating an International Standard without a regulatory entity to supervise its implementation will not work. Much hope lies in the newly formed International Council on Chiropractic Education (ICCE) late in 2001 to undertake the task of building a network of regional and if needed a CCE for every country where chiropractic will be taught.

To offset a history of random implementation of chiropractic school programs there is a clear mandate to create a strategy for the development of a global chiropractic education system. The educational community has already begun the process with the assistance of the WFC and the cooperation of established chiropractic colleges. Detailed course outlines are being shared and improved through dialogue. There is still the need for financial support and creative input from additional sources such as international consultants and non-government organizations. It will be interesting to see what develops in the coming years as the Curriculum Design process continues.

As the new schools open in many different countries, prospective chiropractic students shall be accepted into a chiropractic program based on the country's existing matriculation levels afforded other health care professions with similar exceptions to the medical practice, such as dentistry, optometry and podiatry; while the chiropractic course length shall range from 4-5 years, the pre-chiropractic education will depend on prevailing standards that are similar to the other allied health first professional degree programs in the respective countries. The educational institution that houses the chiropractic program is likely to teach the basic sciences classrooms with students combined from other healthcare disciplines with special clinical application classes that bridge the course content to the unique professional fields.

In developing countries, where the number of schools is expected to proliferate rapidly, the socio-cultural and economic reality call for an efficient, non-repetitive, traditionally based course of study that equips the new chiropractor to practice in an environment quite different than the greatest majority of today's readers have ever experienced. Countries with a small number of practitioners, rampant poverty and usually little legal protection of the profession, require that the new DC be prepared to duplicate the practice styles and social climates that faced the earlier pioneers in Canada, Australia and the USA: lean and fit with the ability to counter guerrilla tactics of organized medicine without the benefit of a strong long-standing national association, to name one obstacle; a population that has at best 20% of the people with adequate income to afford care; and a general population that knows little to nothing about chiropractic; or worse yet - where there are hundreds or thousands of unqualified people calling themselves chiropractors.

In summarizing this article series, we discussed well-accepted educational values and ideals of the chiropractic profession and what counts as we proliferate educational programs that preserve our uniqueness. We investigated formulas that evaluated the number of institutions we could expect over time and other miscellaneous subjects on prerequisites, university based schools, Information Technology, faculty placement and regional accreditation issues. What is now needed is a universal and exportable curriculum that does the job in today's world; one that has the flexibility to incorporate the cultural gems contributed by genuine values of other traditions in non-allopathic healthcare. It will be interesting to report on this subject after the **WFC/ACC Conference on Clinical Education — São Paulo, Brazil, October 26-29, 2002**. The task is at hand!

Acknowledgement: Throughout this article exerts were taken from several chapters in Dr. Sid Williams' Collected Writings and Letters printed in his 1994 book *Looking Back To See Ahead.*

Dr. Tetrault is the Executive Director of the Chiropractic Diplomatic Corps, a humanitarian NGO (non-government organization) representing chiropractic patient interests worldwide in promoting the increased availability and equal access of chiropractic to the world's populations. The organization's website is **www.ChiropracticDiplomatic.com**
