CHIROPRACTIC DIPLOMATIC CORPS

Chiropractic availability and equal access for all

Chiropractic Global Professional Strategy

CHIROPRACTIC DIPLOMATIC CORPS

Global Professional Strategy for Chiropractic

Chiropractic GPS: *"Revealing the right coordinates for professional development."*

www.ChiropracticDiplomatic.com

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Introduction

Planting, cultivating and improving the quality of the harvest

In 1895 the world saw the beginning of a healthcare profession that based its existence on a simple principle: *"Vertebral subluxations interfere with health."* This original idea, or *"original seed"* as I prefer to call it, is the basic foundation of the chiropractic premise of health and disease. The century that followed saw this seed take roots and grow into an established profession that leads the drugless healthcare practitioners in North America. The actual practice of chiropractic in the USA has changed quite a bit over the years as the profession began to introduce adjunctive or complimentary procedures in fitness, nutrition and advanced diagnostic methods in radiology, orthopedics and neurology. In fact, one could say that there is a hybrid form of chiropractic that now exists in the USA in serving the needs of its communities.

There are now chiropractors in 123 countries all over the world where most (74) have only one chiropractor for every hundred thousand to ten million people. Here, the profession is in its infancy where a hand full of doctors has the responsibility of developing the profession in their country. This publication is dedicated to these pioneers.

The development of chiropractic is influenced by its cultural environment. What elements form the cultural soil found in each country? The country's history, economy, folklore, value systems and other characteristics of that population; existing healthcare providers, both traditional medicine and Western medicine; and most importantly, the humanitarian attitudes reflected in their laws. So, one could say that some soils would be unsuitable to nurture the chiropractic seed while other soils could sustain the growth of the chiropractic seed. The higher the quality of the soil, the more chiropractic will thrive.

Incidentally, it would be a grave error to attempt to transplant the proverbial hybrid practices that exist today in the USA into countries with drastically different cultural or social values. The best way to honor and respect the true potential that can come from bringing chiropractic to all parts of the world is to guarantee that only the "original seed" is being planted, the one given to us by DD Palmer, allowing the soil that nurtures to represent the elements of that society and protecting the essence of chiropractic for these patients.

Lest we forget the lessons that history teaches us, we must learn what we can from the past and, since we are talking about a world full of diversity, respect and honor our differences.

Something as simple as the subluxation correction based concept for wellness care is the most powerful truth we can share with the entire world. Until chiropractic is taught in every major language and a school in every country with over 2 million people there will always be the need for chiropractic pioneers. These DCs are the individual seeds while institutions that are established to teach chiropractic will survive better if planted as saplings and are cultivated with great care and support. These seeds and saplings will grow into a strong organism capable of producing a higher quality harvest over time.

UNIVERSAL VARIABLES

TOP FOUR

1. Size of the Middle Class
2. Humanitarian rights
3. Traditional healers
4. Education & Language

"Things are the way they are because of the way things are."

Size of a country's Middle Class

Practices that start in third world countries generally price themselves similar to other specialists in the area and primarily attract the middle class who can afford these fees. This explains in part why the number of DCs has remained small and no great effort is extended to attract more doctors to that city. Often a two-tiered fee schedule is offered in order to also provide care to the low income working class that find their way into the practice.

During the past 75 years there has been a very slow increase in the number of permanent practices established in third world countries and only small to moderate increases in the growth of chiropractic in non-English speaking countries. Typically what happens is that a foreigner will become exposed to chiropractic due to travels to the USA for business purposes or just to visit family that has emigrated there. They decide to become a chiropractor and usually prefer to come to the USA to get their degree. Not everyone can afford to do this so the number of foreign students has also remained relatively small because of the $ barriers.

Upon returning to their countries, after paying top dollar for their education, they set up practice. Even though there may be lower overhead and low staffing costs, the cost of foreign education prices the services too high to provide access to the average citizen of their country with the practice mostly serving the wealthy and business owners, foreigners working there and other working people with above average salaries that comprise the growing middle class.

How do we estimate how many DCs a particular population can support? This is being estimated by taking the Gross Domestic Product (GDP) representing the average annual income per individual from a country and, comparing it to what exists in the USA, we can extrapolate the percent of that population who can actually afford chiropractic care in today's economy.

Another consideration, which can be attributed to greater percentages of middle class, is the higher tax base they produce in developed countries. These taxes help to fund many social health related benefits that increase access to chiropractic care; such as workers compensation benefits and other government funded health services that form a 'safety net' giving the financially disadvantaged greater access for medical and chiropractic care as well.

Finally, it seems that the economic evolution of a country, where the majority falls into the middle class, is the proof-in-fact of many underlying accomplishments in human rights, workers' rights, higher education and political maturity. These social standards reflect a society that, as a whole, is no longer struggling to meet basic or survival needs; now they have interests for a greater quality of life. This is where chiropractic excels in meeting the demand for wellness care that arises from a population that is more interested in longevity and a higher quality of life.

Humanitarian treatment by governments toward their own citizens

Favorable: A democratic society favors strong humanitarian policies by providing the best opportunity for people to influence their government into meeting their family and economic needs. Societies who have provisions for the well being of all their citizens offer better opportunities for chiropractic to thrive.

Improving: Many developing countries and benevolent authoritarian governments have recognized the importance of implementing stronger human rights policies. This is reflected by the passing of laws that protect civil rights and the rights of its citizens to make private decisions about their personal lives, including their choice of healthcare. As these countries implement financial policies that comply with the "golden straightjacket" standards, their economic growth will begin to meet the tax base objectives of countries with the higher quality of life. This is a complex process that eventually intertwines all governmental ministries. In the absence of a legal infrastructure reflecting the changes towards social improvement there is rhetoric but little substance behind the claims of humanitarian rights.

Lacking: It is not surprising to see the absence of chiropractors where the countries have a history of war, ethnic and civil unrest, gross humanitarian violations and absolute poverty. Post-colonial countries have the better infrastructures reflecting healthy humanitarian policies. Post-communist countries may take years before they can build a safe and economically thriving society. Ancient world empires such as China and Persia show promise for future opportunities that will favor chiropractic development. Africa and Asia have such large populations where chiropractic will remain unavailable until the end of this century. The fertile ground needed to cultivate and establish the chiropractic profession must be adequately fertilized by elements that maintain a peaceful and productive nation.

Socio-cultural aspects of integrating chiropractic with traditional healthcare structures

Traditional medicine is a term that describes the type and nature of healthcare that has evolved in most countries over a period of centuries and in the absence of Western medicine. In the USA, Canada and Australia, these traditional methods of healthcare were present in the aboriginal populations when the English first colonized them. History shows how the colonization process stripped these and other countries from access to the folk medicine and other natural methods of healing that were previously available from the local natives. In a sense, chiropractic grew out of the American demand for natural healing in an environment devoid of traditional medicine. However, this was not largely the case in most other countries and today there exists more than just remnants of these healing methods. What have the majority of the world's countries done in absence of an established chiropractic presence? They relied on the traditional healing ways of their ancestors.

There is no question that chiropractic needs to make special consideration of the existing traditional healers found in most countries. We find a larger presence of traditional healing practitioners when there is a smaller presence of Medical Doctors. The *bone-setters and*

herbalists of Eastern Europe, the *medicine-men* of Africa, the *hilots* of the Philippines, the *curanderos* of Latin America, the *acupuncturists* of China and the *aruvedists* of India remain in service to their people, even as Imperial Western medicine became present in their respective countries. Why have they continued to prevail? The answer is simple: Economics! Western medicine is the most expensive form of healthcare in the world and continues to follow that trend. Since most people in developing countries have little money, they see their traditional healers who can provide healthcare at a reasonable fee. Western physician attitudes toward the local healers may be somewhat accepting and it has been reported that families have been encouraged to take the patient to a local healer; unfortunately, this occurs only after the patient's money runs out and without a formal referral of course. Hopefully, this scenario would not be repeated by chiropractors.

Chiropractic does not hold the same attitudes of the medical practitioners in regards to traditional healers. In The USA and Canada there was no other alternative to medicine except chiropractic but it is quite another story where traditional disciplines have survived and thrive. In contrast with the more apprentice-type training of the traditional healers the level and depth of formal academic training received in chiropractic is significantly advanced. As developing countries evolve economically, the growing middle class begins to cast away the less trained practitioners and naturally demand greater accountability from their doctors. At present in these countries the only choice for a high academically trained primary healthcare professional is a medical doctor. So we can see how the chiropractic profession is perfectly positioned to take the leadership role in providing the natural, drugless, wellness care preferred by the increasingly more sophisticated populations. This can be taken one step further.

Chiropractors have a greater respect and philosophical common ground with the traditional practitioners. This begs for a more thorough investigation. An excellent example is the study of the Filipino *hilots* by John O'Malley, DC, PhC from 1992-1996. His thesis has meticulously detailed the folklore and techniques of these traditional healers who continue to serve their communities today. This study was distributed to the hand full of DCs now in practice in the Philippines, to aid in their understanding of the roles played by the *hilots* and to foster respect for them. This type of study needs to be repeated in all counties where there are traditional healers.

There is a special role that can be taken by the chiropractor in these communities that places the DC as a pivotal player in healthcare relations, being comfortable in both camps of natural healers and formal education. This role is that of the patient advocate. As people become more familiar with the benefits of chiropractic and better understand the chiropractic mission, it comes as a natural development for the DC to be placed in that role.

In planning for the seeding of chiropractic in new countries there must be considerations made to build healthy relationships with these traditional healers. Firstly, there is the need to study and to better understand the premises, the actual practices of the healers. Then, to promote mutual respect between practitioners, with guidelines for referrals in situations that best serve the patients' needs. Caution is urged to avoid holding an attitude of superiority toward the traditional practitioners. It would be a grave error on the part of chiropractors to assume the Imperial role played by the medical doctors who have preceded them on this topic. Case in point regarding the Philippine Hilot. When the PMA labelled Hilots quacks it dishonored them and discouraged the next generations from claiming their traditional role; to the degree that as the active Hilots pass away and the next generation not replacing them, in effect this is nearly obliterating traditional healers in the Philippines. A shameful outcome!

Lastly, maintaining cooperative relationships with these traditional healers will attract many to the chiropractic profession that could well result in the introduction of creative hybrid techniques that would benefit chiropractic patients worldwide. Integrating chiropractic with traditional healthcare structures can bring harmony between the healthcare disciplines; strengthen chiropractic and create greater possibilities for future chiropractic patients, as chiropractic itself evolve through global exposure and experiences.

Language issues in the potential education of future chiropractors

English: The graduate programs found in English speaking countries represent the current international standards in chiropractic education and more. The need here is to continue to enhance the teaching technologies to meet the future needs for qualified chiropractors in developed countries. Current and future financial conditions place these schools within the highest probability for engaging in continuous, high quality research programs. This is placed in contrast with the struggling nature of the newer schools in developing countries that may not be able to significantly contribute to the overall research efforts in the up coming decades. Distance learning developments may assist in providing quality teaching tools for the newer schools who cannot afford the investment for high quality experienced faculty.

Non-English: At present the student population in non-English countries represents less than 5% of the global enrollment. The challenge here is to make that number go up to 30% when there are chiropractic schools in every region on Earth; then up towards to 60% when chiropractic is taught in every major language and country where populations exceed two million. **Primary difficulties identified are:** the shortage of qualified chiropractic faculty who are fluent in the main language of the country; also, the expectations from institutions within developing countries that the Western schools will bankroll their program. We can expect economics to factor heavily with the nature of the relationships that develop in pursuit of global planting of chiropractic schools. Additional planning considerations will be required to adequately address the challenges involving the integration of chiropractic within University systems where they have been graduating medical doctors for decades or longer. The contrast of teaching a wellness-based curriculum in an institution that is more familiar with the object-based premise of western medicine raises concerns regarding the culture necessary to properly prepare the student DC for a practice that is more geared toward vitalistic issues and a wellness focus in healthcare delivery.

Miscellaneous: The size or geographical location of a country may adversely affect the viability of developing a school there. Poor humanitarian policies of certain governments and seemingly insurmountable economic realities may postpone the introduction of a chiropractic school for a very long time. Although it is recommended that a school be planted as early as possible, it is expected that a certain number of DCs will have to be in full time practice for a number of years before a critical mass is created whereby the school option evolves naturally, as was the case in the USA. However, the number of active practicing chiropractors in a country may not even be a factor when there are prevailing opportunities that arise when selective relationships facilitate the early planting of a chiropractic program. We have seen this happen when a law is passed where there are few DCs but a personal relationship opens doors favorable to establishing the profession in its infancy.

MEASURING GROWTH

CRITERIA

1. Doctors in Practice
2. Legal authority
3. Organization
4. Students

"Rating the levels of International growth in chiropractic."

RATING CHIROPRACTIC

One hundred years ago chiropractic was in the pioneer stages of development in the United States. There was no legal recognition of this new profession and there were only a small number of graduates in practice. This history is currently repeating itself in dozens of countries throughout the world.

What can be learned about the growing stages experienced in the USA?

1. Without schools the numbers remained small and schools usually preceded laws.
2. In each state, a critical mass of DCs was reached before enough momentum could produce a regulatory law in their State.
3. State Associations became more sophisticated over time to support a growing profession and the needs of the DC members.
4. Schools began to participate in research proportionately to their size and the curriculums evolved over time as well.

Can we also learn what should NOT be repeated?

1. There was no uniformity in defining the legal scope of practice.
2. Some Associations & State Boards promoted a "protectionist" policy that tended to be discriminatory and restrict growth.
3. Research was a low priority of institutions and private practitioners.

So what is the current state of affairs in the growth of chiropractic in the International arena? At the turn of the 21st century there are only three countries where the profession is fully established with legal protection and can practice the full measure of the training. These are: the USA, Canada and Australia. There are next some 20 or so countries with enough DCs to reach most population areas, but there is yet much to be done before the profession can claim to be fully established. The remaining 90 plus countries, where there is only one DC for greater than 100,000 people, we see the pioneering doctors struggling at creating a foundation for the profession.

Regardless of the growth achieved, all countries with DCs are at some point along the developmental path for the profession. This grading system is offered to help countries keep score of their progress. It is hoped that a continuously progressive & introspective profession can accelerate the rate of growth by sharing experiences, solutions and organizational structures; including both the wins and the losses encountered along the pathway.

Let us look at the four separate criteria used in the grading system. Firstly, it is important to develop a valuable assessment tool that remains simple yet can effectively and accurately identify each country's place on the road of development. A scale of zero to ten (0-10) is used with the USA and Canada having a rating of 10. Pioneer countries rate from 0.5 to 4.9, Advancing rate from 5.0 to 8.9 and Established rate at 9 and 10 on the scale of 10.

The four categories are:

1.	Total # of DCs in permanent practice.	R= 3.0
2.	Level of legal recognition by the government.	R= 2.0
3.	Organizational levels of the national Associations.	R= 2.0
4.	Total student enrollment in the country.	R= 3.0
		Total=10.0

1. Number of Chiropractors

Chiropractic is a healthcare service that is delivered by a trained and competent chiropractor to a given population of patients. Obviously, the more doctors there are in practice, the more the profession becomes established. The ratings are as follows:

3.0 One DC for every 10,000 people or less
2.0 One DC for every 10,000 to 50,000 people
1.0 One DC for every 50,000 to 100,000 people
0.5 One DC for greater than 100,000 people

2. Level Of Legal Recognition

Chiropractors meet International standards of education that is reflected in the scope of practice that is actually permitted by law. Scope of practice varies from country to country and even State to State, reflecting the official capacity and professional recognition of chiropractic by the government.

Official recognition of chiropractic, when present, also varies significantly from country to country. In Japan and Taiwan, for example, the government has not granted legal status; instead, a "tolerance" posture is adopted as long as the services are not dangerous to the people. In other countries where "common laws" prevail, such as Ireland and Singapore, a DC can practice their profession or trade as long as all usual residence & business laws are followed. Still other countries have begun to register all non-MDs under newly enacted Complementary & Alternative Medicine (CAM) legislation where chiropractic is often included merely by name or with a very limited scope definition. Finally, there are other countries where the legislative has passed a separate bill that grants the profession limited status under the law. Unfortunately, there is great diversity in these rulings and several stages of upgrading the law becomes necessary.

The rating for a country's legal status is as follows:

2.0 Full scope and legal protection
- primary doctor with scope as taught in schools

1.5 Legislated law with limited scope of practice
- under MD referral, unable to x-ray or no access to labs

1.0 Included in C.A.M. or Common Law
- no protection or recognition of DC title

0.5 Only permitted to practice under commercial laws
- barred from x-ray or lab services

3. National Organization

As the number of practicing DCs increases in a country there is a natural desire to organize. Creating a formal association can be viewed as the first official step in locally establishing the profession. What are the main reasons for having a National Association?

1. Establishing a formal presence in the country.
2. Supportive to the group as they deem necessary.
3. Represent the DCs in speaking to government when seeking legal recognition and registration guidelines.
4. Guide the steps for starting a local DC school.
5. Continued education and other membership benefits.
6. Public relations liaison for chiropractic in their country.
7. Advocate for greater patient access to government, labor and insurance.
8. International representation.

Rating the effectiveness of the activities of the National Association reflects a degree of professional development and its ability to foster growth and stability.

2.0 Full benefits with multi-level representation.
1.5 Public Relations programs in full force.
1.0 Multiple committees in action.
0.5 Just started. Basic organization.

4. Total Student Enrollment

As the world becomes interested in chiropractic there has been an increase in the number of foreign students at USA schools as well as an increase in the number of schools outside the USA. Once a country can grant its own people a DC degree it follows a rapid professional development. In fact, until chiropractic education is available locally, the services have to be an imported technology. This is a costlier situation and seriously slows the growth of the profession.

In some ways, chiropractic cannot really be seriously considered an official profession or certainly become an integral part of the country's culture until it is taught there. In cases when the country is too small or traditions have it that other professions also have to be educated abroad, it would then follow suit for chiropractic as well. When you think about it, how can the government and its people rely on the profession in the future if it cannot replace its practitioners and observe the natural market place effects as it exerts its influences?

Rating the value of local chiropractic training in the establishment of the profession is as follows:

3.0	above 700 students
2.0	from 300 to 700 students
1.0	from 100 to 299 students
0.5	up to 99 students

Why use a rating system?

As each country begins to take a serious look at firmly establishing the chiropractic profession locally there is a lack of guidelines for the leaders to turn to. Each country is left up to their own devices to find its way into cultivating a stronger profession. If you take a moment to think this through from a patient's point of view it becomes apparent that some populations are then victims of circumstances or blessed by the presence of compassionate doctors.

Helping to study, analyze and produce thoughtful and useful guidelines that offer structural and practical suggestions is what advocates and consultants do. Hopefully this information will fall upon the minds and hearts of motivated individuals who can make a difference and act according to their conscience. After all, rating progress means the focus is on progress.

1	2	3	4	5	6	7	8	9	10
PIONEER				ADVANCING				ESTABLISHED	

1.	DC Ratio:	1 : <10,000	(3.0)	
		1 : >10K & <50K	(2.0)	
		1 : >50K & <100K	(1.0)	
		1 : > 100,000	(0.5)	v.1= _____
2.	Chiropractic Law:	Full recognition	(2.0)	
		Legislated w/limits	(1.5)	
		C.A.M. inclusion	(1.0)	
		Under commercial laws	(0.5)	v. 2= _____
3.	National Assoc.:	Advanced Organization	(2.0)	
		Public Education	(1.5)	
		Intermediate services	(1.0)	
		Basic org. startup	(0.5)	v. 3= _____
4.	School Enrollment	over 700 students	(3.0)	
		300 to 699 "	(2.0)	
		100 to 299 "	(1.0)	
		up to 99 students	(0.5)	v. 4=_____

COUNTRY STATUS & STRATEGY

FOUR STAGES

1. Established
2. Advancing
3. Pioneer
4. Unsuitable

"Current trends for Chiropractic's growth."

Countries where the chiropractic profession is more established are faced with entirely separate issues from those challenges that confront third world countries where the profession is in a pioneer stage. In Canada and the USA, the issues are about providing equal access to chiropractic care for all citizens. In countries like Costa Rica and Thailand, the profession is in its infancy; the issue of equal access is overshadowed by the need of simply having enough doctors available to reach all parts of the county. In the other countries, where chiropractic has been available for years, it is more an issue of growth and stability for the profession. Still, today the greatest percent of countries have a zero chiropractic presence where complex issues need to be monitored for future opportunities before we see the beginning of chiropractic there. In developing the categories that follow, information from the ICA, WFC, CIA and United Nations sources were used.

Established

1. **Availability Ratio** is one DC per 10,000 or less. That's 1: <10,000

   Only in the United States, Canada, Australia, New Zealand, Liechtenstein*, Cayman Islands* and the British Virgin Islands* (*These very small countries are nearly saturated with DCs.)

2. **State of Chiropractic described.**

   a. Laws: There are established laws that provide for licensure requirements and protection of professional status. Multi-tiered license registration procedures.
   b. Usage: An estimated 8% - 12% of the population sees a DC annually.
   c. Education: Formal 4-5 year chiropractic program following 2-4 years pre-chiropractic university classes. (Colleges: 18 in USA, 2 in Canada, 4 in Australia)

3. **Plans for reaching the next level.**

   a. Continued professional development in the building of a legacy.
   b. Increased utilization.
   c. Universal access to all citizens.
   d. Sponsorship of International efforts.

4. **Goals.**

   a. Develop new research paradigms that can strengthen the validity of spinal care in wellness and provide support for national education programs.
   b. Double the chiropractic utilization levels of the population.
   c. Build stronger partnerships with chiropractic patient groups.
   d. Generously support the new pioneers of the profession.
   e. Continue to monitor organized medicine's efforts to monopolize the healthcare industry all-the-while developing support for patient universal access to chiropractic that is equally regarded in the primary provider roll.

Advancing

1. **Availability Ratio** is 1:>10,000 & <100,000
   Bermuda, Cyprus, Denmark, El Salvador, Fiji, Guam, Hong Kong Iceland, Ireland, Jamaica, Namibia, Netherlands, New Caledonia, Norway, Panama, Puerto Rico, St. Kitts & Nevis, Singapore, South Africa, Sweden, Switzerland, Trinidad & Tobago, United Kingdom, US-Virgin Islands, Zimbabwe.

2. **State of Chiropractic described.**

Foremost, increase public education about chiropractic!

   a. Laws: Formal laws provide for simple licensure requirements but may not provide full protection of professional status as found in established countries.
   b. Usage: Generally these countries have progressed to this utilization level because of their smaller size or because of their ability to provide a local chiropractic education.
   c. Education: There are now three chiropractic schools of varying sizes in England, two in South Africa and one in France, Denmark and New Zealand that meet the Int'l standard for a chiropractic degree.

3. **Plans for reaching the next level.**

   a. First and foremost is to increase public education about chiropractic. More patients produce more students, then more chiropractors for a stronger profession.
   b. Develop and implement a strong student recruitment strategy to increase rapidly the number of practicing DCs.
   c. Develop a structured research program that enhances the wellness capabilities of the chiropractic paradigm, ideally through the local schools.
   d. Strengthen the chiropractic profession through a variety of professional and patient advocate organizations. i.e.: Assure equal access to chiropractic care through private and government insurances and programs.
   e. Correct any inaccuracies within the laws that regulate chiropractic.

4. **Goals.**

   a. Professional development through an upgraded registration process that requires post-graduate continued education for re-licensing.
   b. Outline and implement a national education program to recruit more students into the profession that also serves to raise the awareness of the benefits of care for the general public.
   c. Increased and improved relations with the government to keep upgrading the laws until they reach the level of established countries like the USA.
   d. Research programs to include studies of indigenous or traditional healers and efforts to integrate suitable candidates into chiropractic.
   e. Monitor organized medicine's efforts to monopolize the healthcare industry all-the-while increasing equal opportunities for patient access to chiropractic.

Pioneer

1. **Availability Ratio** is one DC for greater than 100,000 people.

   In Argentina, Austria, Bahamas, Bahrain, Barbados, Belarus, Belgium*, Belize, Bolivia*, Botswana, Brazil, Brunei, Chile, China, Columbia, Congo, Costa Rica*, Croatia, Czech Republic, Dominican Republic, Ecuador, Egypt, El Salvador, Estonia, Ethiopia, Fiji, Finland*, France, Germany, Ghana, Greece, Guatemala, Honduras, Hungary, Iceland, India, Indonesia, Iran*, Israel, Italy, Japan, Jordan, Kenya, Kuwait, Latvia, Lebanon, Libya, Lithuania, Macau, Malaysia, Malta, Mauritius, Mexico*, Moldova, Montenegro, Morocco, Mozambique, Nicaragua, Nigeria, Oman, Palestine, Pakistan, Papa-New Guinea, Peru, Philippines, Poland, Portugal, Qatar, Reunion Island, Romania, Russian Federation, Saudi Arabia*, Serbia, Slovakia, Slovenia, South Korea, Spain, Sri Lanka, Sudan, Tahiti, Taiwan, Thailand, Tonga, Turkey, Turks & Caicos Inslands, Uganda, Ukraine, United Arab Emirates*, Uruguay and Venezuela*, Vietnam, Zambia and Zimbabwe*. (*law)

2. **State of Chiropractic described.**

   a. Laws: There is no law or a relatively new law in place with others getting close to that reality. Some additional work is still needed to elevate the basic legal status of the profession, such as access to x-ray and diagnostic labs, etc.

Increase the number of practicing chiropractors. Nothing is more important!

   b. Usage: Developing countries with a less than 15% middle-class population will only see at best 2% - 3% of the population until the county's socio-economic profile evolves, even with adequate legal protection. Typically there is only a small % that can afford to pay for a specialist. The marketplace weeds out ineffective doctors and builds support for the solid practitioners who maintain a good reputation. Post-industrialized countries, where over 50% of the population are in the middle-class, only need larger numbers of DCs to increase patient utilization similar to established country levels.

   c. Education: There is no school and little opportunity to start one at present, except Brazil, Japan, Mexico and South Korea that now have schools. There is also no research being conducted while still in a survival mode. The economic disparity of many of these countries requires that a chiropractic school be established within their university system allowing the average college student access to a formal chiropractic degree, such as Costa Rica. This is a very important undertaking needed at this level of professional status.

3. **Plans for reaching the next level.**

   a. Increase the # of suitable practicing DCs, period. Nothing is more important!
   b. Locate practices in financial districts, in the newer malls or near the clusters of growing middle-class suburbs. Home offices may often be an ideal location on a major commercial avenue.
   c. Immediately install a National Association that is totally inclusive. Be united, really!
   d. Support high profile humanitarian missions through coordination with foreign national DCs or NGO's with the expressed intention of recruiting the next generation of chiropractors from the attention received. Stay in close touch with all students who go abroad to get their DC degree and create opportunities however possible for them to return. It will be much easier to attract students when there is a local school.
   e. Create a structure that will attract visiting DCs to move to your country to establish permanent practices, like short term missions, and keep healthy professional relations. Continue to import suitable DCs until local graduate numbers increase to 50 per year.

If not already done, begin directing the Association to put a plan into action that will establish a chiropractic school as soon as possible. Recruit heavily to increase the DC student enrollment and use NGOs to recruit both faculty and students.

4. **Goals:**
   a. To increase the number of qualified DCs at all cost. The fastest way to do that is to have a local school and graduate lots of new local DCs. Until then, attract as many foreign DCs as possible to increase the awareness of chiropractic that is the only way to interest many people into the profession.
   b. Then simply deliver good care, stay profitable and make friends with leaders of allied health professions and other people of influence who can open doors, make introductions and advise on the state of affairs as they are done in that country.
   c. Select a leader, support him and be alert for opportunities to implement the above steps. Regular monthly meetings of the National Association will build affinity and greatly speed up the development of the pioneering profession. Specific goals will depend on the opportunities available and the individual talents of the pioneering DCs in permanent practice there who are willing to represent the profession.
   d. Mutual respect will avoid most of the pitfalls seen in countries with a few DCs.

Unsuitable

1. **Countries in this category number about 140.** They are without any legal chiropractors and the environment is either inaccessible, unfavorable financially or simply too hostile socio-politically to foster confidence in any rational chiropractor's mind to establish a permanent practice there. The exception would be some one with a strong personal affinity for that country, like family.
   Afganistan, Albania, Algeria, American Samoa*, Andorra, Angola, Anguilla, Antigua and Barbuda, Armenia, Aruba*, Azerbaijan, Baker Island, Bangladesh, Bassas da India, Benin, Bhutan, Bosnia and Herzegovina, Bulgaria, Burma, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Christmas Island, Clipperton Island, Cocos (Keeling) Islands, Comoros, Congo, Cook Islands*, Djibouti, Dominica, Equatorial Guinea, Eritrea, Europa Island, Falkland Islands*, Faroe Islands, French Guiana, Gabon*, Gambia, The Gaza Strip, Georgia, Gibraltar*, Glorioso Islands, Greenland*, Grenada*, Guadeloupe, Guernsey, Guinea, Guinea-Bissau, Haiti, Heard Island and McDonald Islands, Holy See (Vatican City), Howland Island, Iraq, Jan Mayen, Jarvis Island, Jersey, Johnston Atoll, Juan de Nova Island, Kazakhstan, Kiribati, Korea-North, Kyrgyzstan, Laos, Lesotho, Liberia, Luxembourg*, Macedonia, Madagascar, Malawi, Maldives, Mali·Malta, Isle of Man, Marshall Islands, Martinique*, Mauritania, Mayotte, Federated States of Micronesia, Midway Islands, Monaco*, Mongolia, Montserrat, Mozambique, Nauru, Navassa Island, Nepal, Netherlands Antilles, Niger, Niue, Norfolk Island, Northern Mariana Islands, Palau, Palmyra Atoll, Paracel Islands, Paraguay, Pitcairn Islands, Rwanda, Saint Helena, Saint Lucia, Saint Pierre and Miquelon, Saint Vincent and the Grenadines*, Samoa*, San Marino, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Solomon Islands, Somalia, South Georgia and the South Sandwich Islands, Spratly Islands, Sudan, Suriname, Svalbard, Swaziland, Syria, Tajikistan, Tanzania, Timor-East, Togo, Tokelau, Tonga, Tromelin Island, Tunisia, Turkmenistan, Tuvalu, Uzbekistan, Vanuatu, Wake Island, Wallis and Futuna, West Bank, Western Sahara, Yemen, Zaire, Zambia. (*in waiting) (T=140)

2. **State of Chiropractic** does not exist for many reasons in these countries. The most compelling reason is the lack of economic opportunities within the country or worse, because of the oppressive government policies toward its own citizens. War, civil unrest and high percentages of absolute poverty are not fertile grounds to attract DCs to establish a permanent practice.

3. **Plans for reaching the next level** are tabled until the socio-economic problems of the country are adequately resolved and it is safe to live and work as a professional. Today, 10% of these countries, like the Cook Islands, Luxembourg, Monaco and others, are quite capable of supporting chiropractors. It will be interesting to see what it takes to bring chiropractic to these countries of fertile opportunities. No goals considered at this level.

NATIONAL ASSOCIATION

"Organizational support for the enhanced structuring of a National Association."

As chiropractic celebrated its first Centennial in 1996 the profession was fully established in only three countries: USA, Canada and Australia. One vital aspect of reaching this distinction relied heavily on the presence of sophisticated National Associations.

Certainly, in the early days of the profession in these countries, the degree of such a complex organizational structure was not needed, nor possible, and for a variety of reasons: a small number of DCs and no legislative recognition or protection. These three countries have gradually increased the sophistication of their national and regional (state/province) organizations that could effectively represent the growing needs of the profession in their local areas.

Today, there are another two-dozen countries at some stage of professional development with their National Associations and yet another 90 countries that are more accurately classified within the Pioneer stage in the development of the chiropractic profession - much like it was in the first decades of the profession in the early 1900's.

A POSTULATE: Recognizing the challenges faced by individual DCs who find themselves pioneering the chiropractic profession in their homeland or in a foreign country of residence; and, recognizing the lack of formal organizational guidance available to help structure and official organization that can serve as the National Chiropractic Association in that country; and, recognizing the needs of the people who can benefit from a well established chiropractic profession in their country; and, looking at the current framework of International organizations in chiropractic and the mandate, by default, that each country is pretty well left to its own devices to build the chiropractic profession therein; whereby, acknowledging that structural guidance and other consulting services are needed by the profession; and, finding these needs can be addressed by the technical information available through the Chiropractic Diplomatic Corps' volunteers; this organization is engaging the chiropractic community to enter into discussions on creating strategy for resourcing a formal working model in structuring a National Association.

Working from a simple model there are three stages of professional development offered: pioneer, advancing and established, each with its own unique needs. Without going into the details of each stage (comprising enough material that covers a separate article) common sense tells us that there are different issues at each level of development that take precedence. For example Finland and Costa Rica, each with about 30 DCs, can hardly undertake the financing of a TV or radio public relations program like we see done in many American states. In fact, they only have acquired official legislation with their governments in the past years. So, it takes time to build an effective association and to bear fruits.

In itemizing the different functions of a State or National Association we find six (6) primary divisions:

1. Executive	2. Membership	3. Services/benefits
4. Administrative	5. Public Relations	6. Legislative

A well-run association helps to support the needs of the individual practitioner; protect the profession as it encourages ongoing professional growth; increase market share in the healthcare industry. Even though each chiropractor builds their practice using a variety of acceptable marketing methods, the role of public relations falls squarely on the National Association. The possible range of member benefits increases as the organization grows in size, influence and leadership. A sample organizational structure may look like this:

EXECUTIVE	MEMBERSHIP	BENEFITS
Leadership training	Tied to licensing	Practice building
Regular meetings	Student inclusion	Student recruitment
Multi-year goals	Committees as needed	Annual seminars
By-Law adoption	School recruitment	Family support
Official representation	Student recruitment	Chiropractic Assistants
ADMINISTRATIVE	**PUBLIC RELATIONS**	**LEGISLATIVE**
Budget and Dues	PR materials/ scope	Model Law
Local corporate sponsors	Sports event tie-ins	Lobbying tips
Operating designs S M L	Humanitarian Mission Co-op	By-Laws sourcing

In addition there are resources available from the World Federation of Chiropractors (WFC), the International Chiropractic Association (ICA), the Federation of Licensing Boards (FCLB), the International Council on Chiropractic Education (ICCE), and a growing list of NGOs (non-government organizations) active with International programs such as Life International, the Chiropractic Diplomatic Corps and several Mission groups.

Country associations that have attained some degree of legal protection have different needs than those Pioneer chiropractors that may still not have a formally working association. In part, it is the lack of an organized presence or working structure that hinders the ability to acquire legal recognition. At present there is no standard for these pioneer DCs to turn to. As members of the WFC, they have representation at the WHO (World Health Organization), some assistance if they actually take the time to request information on legal definitions, and then only good wishes to help them get their house in order.

It is pretty well left up to the individuals to get their local act together. That may be fine if one or two of these DCs have leadership skills. Somehow, it seems practical to help by offering structural models that can facilitate the development of a National Association in the early years. History shows up that failure to establish a formal organization only opens the door to struggling growth and the usual polarization we see within the profession plus the additional cultural separation between the Native vs the Imported DCs.

To these ends the following listing is offered with a variety of suggested ideas and objectives for each respective stage of professional growth to demonstrate the relative needs.

PIONEER STAGE ISSUES:

- Getting the National Association organized, using standard By-Laws adapted to their laws.
- Recruiting 100% of the few DCs into membership - being totally inclusive.
- Holding regular monthly meetings and set up 5 or 6 committees as needs dictate.
- Initiating legal recognition efforts with local government.
- Begin sending a representative to International conferences to help build DC numbers.
- Set up a "Student Abroad Support" program to assure the new DC will return home.
- Coordinating with humanitarian mission groups to maximize benefits to all concerned.
- Initiate local university prospects then seek foreign school partnership.
- Develop policies on Public Relations efforts and actively work to see 2% of the population.
- Put together a bulletin or newsletter as the number of DCs grows.

ADVANCING STAGE ISSUES:

- Finalize law effort to include formal Registration Protocols.
- Coordinate national PR programs thru magazine articles and sports (goal is now 10%)
- Start a chiropractic school that meets the full International Curriculum standards.
- Upgrade any defects in law for DCs into Primary Provider and full legal protection.
- Establish a broad complement of committees that address all local issues.
- Publish a regular newsletter or periodical filled with articles of local professional interest.
- Hold an Annual Conference with continuing education programs.
- Raise funds for research and identify studies of local interest.
- Increase participation in International representation.

ESTABLISHED STAGE ISSUES:

- Equal access as healthcare providers - government, Insurance, laws, etc.
- Advanced research agendas.
- Advanced public relations with the goal to see 25% pf the population.
- Generously support International programs; increase humanitarian missions.
- Export education curriculums and expand distance-learning capabilities.
- Create innovations for professional development.

As much as one wishes to respect the sovereignty of each country there are *de facto* standards necessary to ensure one unified profession with certain unique elements. Creating and offering a model structure to guide the organizational development for a National Association can only produce a smoother and more effective outcome for the growth of the profession in new countries. An interesting aspect of the suggested model topics is that this clearly places the responsibility with the established countries to sponsor and mentor International growth. The challenge is to offer assistance and support while still respecting the autonomy of the pioneer DC as they integrate the chiropractic profession within their county's laws and cultures.

It has been estimated that there currently exists the need for over 320,000 chiropractors in today's global marketplace. There are presently just around 100,000 DCs in the world reaching less than 30% of the people who can afford care today and leaving 70% unserved. Perhaps some effort to help with organizational assistance is not such a far-fetched idea after all at this time and there is room to expand the contents of this chapter with input from several pioneer DCs wishing to share in this effort.

International Education

"Thinking things through to preserve a unique culture."

1. ***Begin with the end in mind.*** *(Steven Covey)*

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. Countries that are actively pursuing the establishment of a chiropractic program that meets International standards are: Argentina, China, Hong Kong, West AfricaIndia, Italy, Netherlands, Norway, Peru, Philippines, Portugal, 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 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.

In the Part II, we will 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.

2. *Claiming our own*

Standards of the Council on Chiropractic Education (CCE) establish the area of eminent qualification 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

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.*

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.

3. *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 63 DDS schools to 18 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	18 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. However, the US colleges can support larger student capacities.)							
Australia	4 Schools	(4)	BSc Degree				
Canada	2 Schools	(3)	DC Degree				
Advancing Countries:							
England	2 Schools	(9 needed)	Batchelor of Science in Chiropractic Degree				
South Africa	2 Schools	(2)	Masters Degree in Chiropractic				
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	Sweden	1 School	(1)	DC
France	2 School	(9)	DC Degree	Malaysia	1 School	(1)	
Korea	1 School	(4)	DC Degree	Mexico	2 School	(5)	DC
Japan	2 School	(19)	DC Degree	Spain	2 School	(3)	DC

Hopefuls:							
Argentina	2	Iran	2	Italy*	8	Malaysia*	1
Peru	1	Philippines*	2	Portugal*	1	Spain*	4
Costa Rica	1	Taiwan*	2	Thailand	2	Switzerland*	1
Chile	1	Netherlands*	2	Norway	1	*in discussion	
Eventuals:							
Austria	1	Belgium	2	China est.	25		
Czech Republic	1	Egypt	1	Finland	1	Germany	12
Greece	1	Hong Kong	1	India estimated	25	Israel	1
Russia*	4	Saudi Arabia	1	Singapore	1	Indonesia*	3
Morocco	1	Poland	2	Turkey	1	Venezuela	1

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 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 had programs in Korea and Japan with additional consultations with Malaysia, Philippines and Thailand but did not prevail. RMIT has yet to realize 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, under Dr. Guy Riekeman's leadership, is undertaking the development of a resource center that can provide specific consultative instruments for foreign schools that can take existing chiropractic college administrative roles for adaptation into a university based system. The role of a Clinic director, the Dean of Students, a Technique or Philosophy teacher for example, with specific application for chiropractic students, can be exported for use by the newer schools. There is definitely a need for this information but it is a shame that the profession has not been able to produce a single entity that can provide the whole package needed to import a chiropractic education program.

Life University, considered by many to be the "Harvard of Chiropractic," stood as the only institution with the potential to create multiple partnerships on multiple fronts. However, Dr. Sid Williams' primary humanitarian focus on serving the poorer nations did start up his creative, human and financial resources to become that institution of total dedication to the global installation of chiropractic schools. Reality is that it will require a partnership of several collaborating advanced institutions to create the right blend to secure a uniform curriculum and provide the staff and expertise to formulate and implement a global institution model; or we may see the birth of a multi-national institution stepping in to fill this role.

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 - subject of the following part of this series.

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.

4. Curriculum Designs - *Expanding the model.*

In the preceding articles, 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. There are presently 45 DC schools taught in 16 countries that are established but leaving far more regions and countries unable to supply their country with enough chiropractors. Still we see that 15 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? This article discusses 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. The real issue today is where will they find qualified faculty to teach.

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 be "grand-fathered," for example.

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 to reach high national board passing scores but sacrificed the training of various 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 http://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.

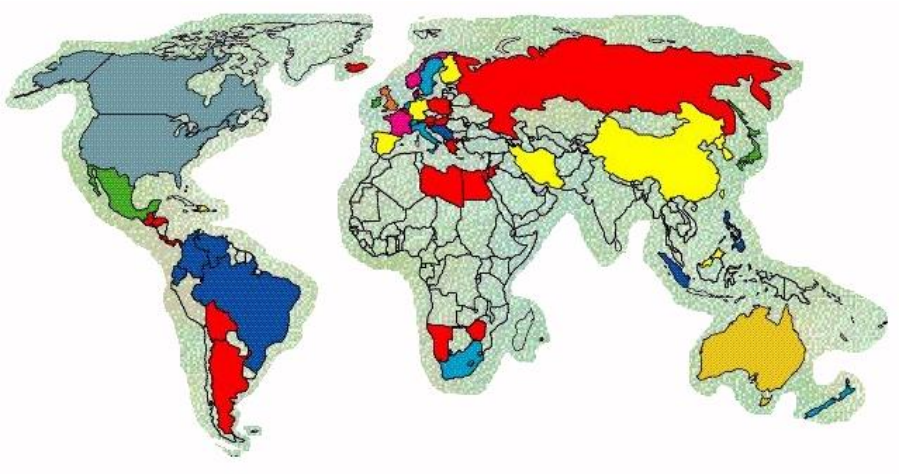
As the new schools open in many different countries, prospective chiropractic students shall be accepted into a chiropractic program based on the country's existing matriculation levels afforded other health care professions with similar exceptions to the medical practice, such as dentistry, optometry 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 10% of the people with adequate income to afford care; and a general population that knows little to nothing about chiropractic; and worse yet - 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. 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.*



Non-chiropractor Actors

"What role can non-chiropractor stakeholders play in chiropractic's Int'l expansion?"

Immigration and constitutional law policies vary some from country to country and there are some laws that are not cross-border friendly for a chiropractor who wishes to establish a chiropractic practice in another country, one where he or she is not a citizen. This has created several hybrid scenarios that have evolved as the chiropractor is looking to work within the local laws to get their clinic opened.

This has begun to happen more and more over the last 20 years. Some have very favorable outcomes with normal practices growing stable over the years. Some not so favorable seen with excessive turnover of associates for a variety of reasons; such as poor business practices, questionable business practices, illegal business practices just to generalize. So the question remains: *"Is this a good thing or a bad thing?"*

What specific types of alliances or partnerships are seen today?

1) A businessman or businesswoman sets up a chiropractic clinic and hires 1+ associates.
2) A businessman or businesswoman partners with a chiropractor to open a clinic.
3) A corporation is formed between the citizen and the chiropractor to open a clinic.
4) An existing business like a spa hires a chiropractor as an employee and chiropractic is an additional service in that business.
5) The chiropractor's spouse, who is a citizen and the reason why the practice located there.
6) A chiropractor in one country that sets up satellite clinics in neighboring countries; legal set up will vary by country where any of the above may apply.
7) A patient of a local chiropractor entices the associate (a foreigner) to open their own clinic in a neighboring community and engages in either of the above scenarios.
8) A patient takes over an existing chiropractic office left behind by a transient chiropractor and recruits their own associate(s).

These types of developments are clearly a necessary part of chiropractic's International development. Most chiropractors would find it dubious to work for a non-chiropractor but even in the countries where the profession is fully developed, DCs work for MDs all the time; or are hired by corporations, HMOs, etc. Although the best long-term practice development is expected to come from chiropractors opening their private practices, in what-ever country they can do so legally, partnering with local actors has become necessary in many countries.

The question isn't whether this should be allowed. The right question is how to guide this process; how to even encourage this, under proper ethical and professional guidelines. There are basic business and fundamental concepts that need to be considered for this to work properly, regardless of the country in question.

1) Acquire the legal right to live and work in the country: work visa, alien registration card.
2) Meet local health authority licensing / registration requirements
    a) Acquire a chiropractic license to practice, if available.
    b) Most pioneer countries have no law that licenses chiropractors, so an alternative health classification may have been determined for permission to treat the public.
    c) Department of Health may accept foreign certification of the chiropractic training.
        i) Copy of Diploma with translation in local language certified by their embassy
        ii) Active license where chiropractic is fully regulated. (translations also)
3) Meet local commercial business requirements
    a) Business license (city, other)
    b) Tax registration (federal)
    c) Labor law compliance (proper contracting)

4) Proper contracting between the company and the chiropractor
   a) Term of agreement length
   b) Compensation agreement detailed
   c) Meet local contracting laws
   d) Addressing for any leave of absences
   e) Termination clause for cause and how to maintain coverage in the transition.

As much as there is a formal process required to properly set up a chiropractic clinic, the key element will always be the mutual trust and respect between the chiropractor and their partner. Realities of starting up a chiropractic clinic in a country that is relatively unaware of the profession at all will have a different start up experience than in the country where the chiropractor took their training. Reasonable expectations on what to expect and how to promote the chiropractic services is an ongoing learning process between the owner, the staff and the chiropractor, as they engage the community and the growing chiropractic family.

Reported Abuses

There are wide-spread reports of abuse that are endured by the associate chiropractor working abroad that we hope to minimize by somehow, always include the non-chiropractor clinic owners in the association activities. Some have had their passport unreasonably withheld to prevent them from leaving. Some have contracts changed on them after starting to work reducing the agreed compensation. Some experience harsh personal treatment by the owners. Associates have been unduly influenced to teach chiropractic methods to non-chiropractors.

There are also reports of abuses conducted by chiropractic associates so there is plenty of blame to be placed across the board: associates leaving without notice and without a replacement to care for existing patients; associates moving down the street taking patient records with them; associates just plain being lazy and unproductive, late and uncooperative.

In conclusion, it will be impossible to control all the things that are and will be taking place in the majority of countries where the chiropractic profession remains in its early or pioneer years. It would be unwise to take a negative outlook on the role of non-chiropractor actors who have an equally vested interest in participating in the advancement of the chiropractic profession in their country, one that can significantly impact their future, the future of their families and of the country at large, because chiropractic matters and it matters to them.

There are several stakeholders that will be engaged in the formal development of chiropractic where there is yet so little advancement in law or local chiropractic education; and in particular, so few chiropractors and clinics to serve the country's population. It will take more than just the relatively few chiropractors and willing clinic owners but several community players as well.

The Chiropractic Diplomatic Corps supports the development of patient associations in pioneer countries. There is an 80 year history in Europe of the Pro-Chiropractic Europe group. They have recently changed their name to the Chiropractic Patient Federation of Europe and their website is http://www.prochiropractic.org. They have inspired the development of a sister group in Asia named the Chiropractic Patient Federation Asia – Philippines and their website is http://www.chiropractic.org.ph.

HUMANITARIAN MISSIONS

TOPICS

- Mission Objectives
- Patient needs
- Profession's needs
- Local DC involvement
- Long-term conversion

"Guidelines for an updated model of structuring chiropractic missions."

It is true today that people do seek out "experiential vacations" that occasionally may become a "transformational" experience. *Chiropractic Ecotourism,* to coin an expression, may well define travel related activities that combine a vacation to a foreign country with a humanitarian activity. These missions are value driven experiences that bring great personal gratification for the participating Doctors of Chiropractic.

Short-term humanitarian missions are increasing in both the number of countries served and in the frequency of events in each country. There are two main groups of participants: secular and non-secular. Although motivation may vary from group to group, the common thread is purely humanitarian. People living ordinary lives with only the occasional extra-ordinary experiences that bring fulfillment and satisfaction are finding themselves attracted to experiences that have the potential to "transform" their lives. Transformational experiences sought by the religious participants help them reach a closer experience and relationship with God through service to the needy. Transformational experiences sought by individuals help nurture their humanitarian tendencies and possibly also are opportunities to get closer to God.

Short-term humanitarian missions offer both physical and emotional experiences that provoke serious introspection in re-evaluating one's "purpose in life" or one's sense of placement in their community. For chiropractors, as in other healthcare and service oriented disciplines, the desired outcome of donating one's time and money to participate in these missions is also to renew their dedication to the "reasons why they became a chiropractor in the first place." In all cases we see successful outcomes.

Since we have seen more of these missions as we enter the 21st Century it is safe to assume that primary mission goals are being achieved. The question today is: "Do these goals serve the greater good?" What are some of the primary mission objectives?

1. To reach more prospective religious converts through healthcare services.
2. To renew a practitioner's motivation in their profession by donating their services to the needy.
3. To acquire an appreciation for how good life really is at home after experiencing first hand the world's poverty.
4. To increase awareness of the benefits of chiropractic care.
5. To participate in the healing of people without financial gain. (Humanitarian service)
6. To get away for a vacation that has greater personal satisfaction.
7. To visit new places and become exposed to different cultures.

As you can see, existing short-term missions are successful in achieving these personal objectives, but the questions of lasting benefit to the people served and the chiropractic profession as a whole also needs to be raised. Do short-term missions really help the intended target population? How can these missions be designed to produce a greater benefit to the establishment of the profession; which ultimately translates into more and better care for the patients?

It is always heartwarming to hear the reports from mission doctors about their renewal in the simple, beauty of chiropractic and, in particular, about some of the spectacular and miraculous results received by some of the individuals following their first chiropractic adjustment, especially the children. As doctors we have learned to personally appreciate the value of

lifetime chiropractic care so it must be heartbreaking for the participating doctors to leave a population without care once the mission is over. Short-term missions are just that... of short duration. What can be done to raise the outcome of missions to create more regular access to care? In answering these questions, several inspired DCs have attempted to create a network of some sort where a number of doctors could rotate into a permanent clinic location. They are finding this goal very difficult to accomplish and have to settle for scattered return trips with often, small groups, and admittedly, a hard task that is financially and emotionally depleting.

Reaching across borders, oceans, great distances and cultural differences presents many challenges. It takes resources and reserves of money, people, time and opportunities. We will likely continue to see an increase in foreign missions. How can these dedicated DCs meet the demands of today's mission needs? Networking and sharing experiences and resources is a good place to start. Adopting an updated mission structure is the next step to take, one that addresses the deficiencies of older models and also takes partial responsibility to be a stakeholder in the establishment of the profession of chiropractic in the target countries.

Today's researchers and businessmen and women have learned the value of "outcome based" designs for their work. If we really want to bring chiropractic to other countries it will require designing a mission structure that places patients' needs first, the professional needs second and personal needs third. Since we've already established that personal needs are being met, let's look at the other two areas: patients and the profession.

Patients' needs are pretty simple: They want access to a doctor when they need one. A doctor who is affordable and who is willing to become a part of their community. It's really no different than what patients expect of their doctors where chiropractic is already established.

The profession needs six things from short-term chiropractic missions:

1. Attract qualified doctors who may become permanent additions to the country's roster. Let the DCs know that they are welcome to come back and become a part of the pioneer effort in that country.
2. Attract prospective students to the profession from the attention and PR produced by the event. Schedule regular "special student sessions" at local universities or have people return after the day's clinic hours for a student talk.
3. Local DCs need to be included in the planning stages and their clinic advertised to the patients who are treated by the mission team. (So patients will have a place to continue care.)
4. Respect the authority of the local DCs and tap into their contacts but mostly use the "dignitary" status of the mission to further the cause of establishing the profession in a more formal or official capacity.
5. Only bring licensed doctors to treat people and be fully documented at all times. The only exception is when a DC school structures a clinic environment within the mission group and even then, only senior interns who qualify and actually receive school clinic credits.
6. Make the mission a series of highly publicized events in each location. High profile events reach more people and have the best results across the board.

Humanitarian missions have left many of the existing practicing DCs with mixed feelings. If we are to extend the concept of outcome oriented activities, there could be special consideration made for the doctors who are pioneering chiropractic in the developing countries targeted by mission groups. Chiropractic is only regulated or officially recognized in about 30 countries. These are largely "northern countries" with an advanced post-industrialized economy. In the other 70 countries, where chiropractic is not legislated, there is nothing to stop anyone from misrepresenting themselves as chiropractors. This is why mission participants need to be documented.

Understandably, pioneer DCs may not feel entirely comfortable with receiving too much attention since they actually live with the fear or the risk of sanctions by the local government should a chiropractic mission group create undesirable results. Always include the leadership of the existing DCs in any activities where chiropractic services are being delivered to the local population. They may have no interest in participating in the mission or it's planning; being tied up with their own practice and families. Or, just the opposite, they can be a valuable ally and a primary contact. Either way, they are entitled to be notified and invited well in advance.

MODEL INTERNATIONAL LAW

INGREDIENTS

"Opening the dialogue for a consensus on a model chiropractic law."

Attempting to establish some version of a single model law for chiropractic has not only been difficult but, in truth, it is impossible. The legal and legislative variables from country to country virtually make the task impossible. However true that may have been to those who have attempted to create such a model law in the past, there still remains the need to develop "something useful" to guide those countries emerging into chiropractic.

What questions can be asked towards establishing a framework for such an endeavor?

- "What are the key components required for a full scope of chiropractic?"
- "What have we learned from current and previous laws that can be carried forward?"
- "Can we identify the main sub-classifications of the different legal structures that are found in this world and develop variations that serve each particular situation without compromising the long-term outcomes that protect both the patients and the profession?"

These questions indicate that it is possible, after adequately probing into the different legal systems for the commonalities therein, to identify a framework that can be used in the development of a comprehensive "building-block model" instead of trying to develop a "one-model-fits-all" International model law.

Using common sense as our guide, let's try our hand at answering some of the above questions.

1. ***"What are the key components required for a full scope of chiropractic?"***
   To begin with, title protection is the highest objective while scope is best defined with as few words as possible; leaving the details to be included in the "regulation" work that does not require a return to the legislative body. However, some definitions would be helpful and appropriate in defining key words like chiropractic, subluxation, scope of practice, etc. Now that the WFC has officially adopted the ACC Paradigm, there can be more consistency in defining these terms. Determine the minimum level of requirements that can qualify a candidate for licensure followed by establishing an authority that can ideally administrate this process. Once the public safety and patient rights issues are handled, the profession itself has concerns regarding the intrusion of non-qualified persons claiming equal professional status, as well as protection of chiropractic's title and unique skills in spinal adjustments/ manipulations.

The four components being considered at this juncture are: title protection, definitions, candidate requirements and licensing authority. Further discussion is needed to evaluate additional entries that may apply beyond these first four key components.

2. ***"What have we learned from current and previous laws that can be carried forward?"***
   This area of study is actually the primary resource for any effort that outlines the terms and details used to build a comprehensive "building-block model" for International use. After all, why re-invent the wheel, so to speak? In conducting a mega-study of all the chiropractic laws in the world one could produce viable working lists of primary terminologies and substitute terminologies that can be integrated in formulating a law as they applied to the county-specific issues.

Thirdly, comes a practical question in planning a well-rounded strategy for developing a comprehensive "building-block model" for International use:

3. ***"Can we identify the main sub-classifications of the different legal structures that are found in this world and develop variations that serve each particular situation without compromising the long-term outcomes that protect both the patients and the profession?"***
   There is very little precedent found in chiropractic laws that can reliably be applied to meet every country's legal requirements. It is more reliable for one to study the existing legal framework that has been used to construct regulatory laws for similarly educated at First Professional Degree levels of the allied healthcare professionals in the target county, such as Dentistry, Podiatry and Optometry. Although this may not apply in every instance, much can be learned about observing the nature of the legal framework used in these cases. It is also entirely possible that there exist several unifying qualifiers that can additionally sub-classify a country's legal format with other countries' legal structures. A longwinded way of saying, what worked in Australia can probably apply to England or what applied to Costa Rica may likewise be used in Peru.

It seems that the current consensus regarding a model law liens toward the notion that it is too complex of an issue to even try and formulate guidelines or even a working-in-progress model. Today the default mode is to simply leave it up to the local chiropractor to figure things out and to yell for help, if they choose to do so.

The fact is, Dr. Y in country X is not likely to be the most qualified person to take on this important role. He or she has to overcome significant obstacles just to be there, keep their doors open, support their family all the while trying to educate a population that really does not know anything about chiropractic. What makes the rest of the profession think that these individuals have the leadership skills to get it right? This is not to infer that the local DC is an incompetent bloke. Even if he or she is eminently qualified, it is quite naive for the rest of the profession to impose such a cumbersome responsibility upon a few hard working and otherwise burdened individuals when there is a responsibility from the "powers that be," whomever that may be, to build the infrastructure that supports the task of establishing a completely functional law. All we have to do is look at the myriad of variations that already exist Internationally and how that will require substantial reworking... assuming that the damage can be repaired.

Somehow there is one group of individuals that still remains excluded from the goal defining objectives of the International Chiropractic community. The greatest stakeholders of all are the patients! How do they fit into these discussions when there continues to be this "laissez-faire" attitude that prevails? How do we answer to the patients of countries with inadequate laws or no law at all when they are left to suffer and left with an uncertain future? Even though poor people don't always know how poor they really are, we don't just ignore their needs. Yes, billions of people on this planet have no idea of the benefits of chiropractic care. Do we simply say, so what? They don't know what they are missing anyway? It is good to remember to place their needs into the equation.

A call-to-action does indeed seem in order to create a resource of core information, a reference source. But who do you call? Who de we turn to in requesting assistance in meeting this need? The World Federation of Chiropractors (WFC) has already rejected to undertake this duty. The International Chiropractic Association (ICA) and the World Chiropractic Alliance (WCA) have assembled their version of what a model law should be. Life International, the most active International group at the World Health Organization (WHO) also has created one version of a building-block model law. Lastly, the Federation of Chiropractic Licensing Boards (FCLB) did take a serious look at this issue in the mid 1990's but decided that it was too ominous a task to take on with their limited resources.

STRATEGY - LOGISTICS

RESERVES OF

1.Time

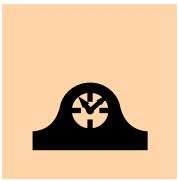
2. Money

3. People

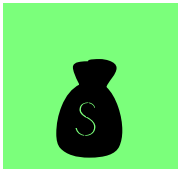
4. Space

5. Opportunities

"Attracting resources for Chiropractic's growth."



There is a lot of *time* that is needed to acquire the necessary data that helps to refine the Global Strategy Formulas. *Time* also to visit countries, build relationships and strengthen the rapport between key individuals within the profession and others of influence in that country, that will increase the trust and the willingness to act on the recommendations that will move things forward. *Time* to implement fund raising programs. *Time* to consult for and to establish chiropractic colleges and recruit for prospective students, the future of the profession in each country. *Time* to recruit DCs into establishing foreign practices. *Time* to attend meetings with International NGOs and developing chiropractic organizations. *Time* to support the lobbying of governments for stronger chiropractic laws. Finally, *time* to maintain personal relationships with family, friends and our Creator. *"Timing is everything."*



Humanitarian organizations and for-profit organizations are needed to raise the money required to start new practices, consult for more college programs, fund humanitarian missions and pay for related travel expenses. Moneys are needed to bring research to smaller countries and to do global studies of select populations that demonstrate chiropractic's wellness premise. The public sector will need money to bring about college programs, to educate the population through public relations programs and develop suitable laws that protect both the patients and the profession that serves them; while the private sector will need money to increase the number of professional practices, the technical components that supply the profession, the costs associated with lobbying efforts and the marketing of their practices. Lest we forget, moneys are needed to provide for International scholarships for the financially disadvantaged as well as formal government student loans to fund chiropractic education in each country. "Money is the fuel for growth."

Chiropractors are needed to establish practices in other countries, to volunteer for humanitarian missions and to serve a role in their National Associations. ***Teachers*** are needed to build the next generation of chiropractic educators that speak languages other than just English. ***Investors*** are needed to support both profit and non-profit entities engaged in the delivery and the expansion of chiropractic services. ***Leaders*** are needed to build the strong organizations and associations that form the infrastructure of the profession. ***Students*** are needed to fill the new schools and become impassioned with the power of chiropractic care when it is delivered to millions of more people with the resulting benefits to their communities. ***Researchers*** that come from within the ranks of chiropractic schools are needed to help build the case for chiropractic as

well as serving to balance the technical growth of the art and science of chiropractic. Last but not least, ***patients*** are needed to pay for and benefit from the competent care of dedicated and well-trained chiropractors, to sponsor chiropractic students, to donate to chiropractic organizations and fund more research; even to volunteer in humanitarian missions, give encouragement to the pioneering DCs and play an active part in supporting the legalization of chiropractic in their communities. *"People are the reason for all this."*

In this day of information technology, it is possible to run an organization or a business from a cyber office. The chiropractic practice does not lend itself well to a cyber clinic so *space* for new practices and facilities to sponsor missionary programs are needed. Suitable locations for the new schools will require enough *space* from Universities that will house and administrate a local chiropractic education program and *Space* for National Associations to conduct continuing education seminars. Sharing *space* in multi-disciplinary clinics will expose more patients to chiropractic care and build better relationships with other healthcare providers.

Building reserves of *opportunities* only develops and increases gradually with more time, more money, more people and more space availability. Building data bases and other information is clearly the most valuable asset for creating more *opportunities* that progressively support the International growth of chiropractic.

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