decisive manner; and

(j) discuss potential immediate or delayed reactions or responses to the chiropractic adjustment or manipulation.

i. Emergency Care

Doctors of chiropractic may encounter clinical situations - within and outside the office setting - that require immediate attention, and must develop the ability to identify an emergency or life-threatening situation and apply the necessary care or procedures.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the responsibility to provide emergency care procedures; and

(b) recognize the need for a prompt critical appraisal and response to an emergency situation.

(2) Knowledge

The student must demonstrate an ability to:

(a) recognize an emergency or life-threatening situation;

(b) understand current emergency care and first aid procedures, equipment and instruments;

(c) monitor the effect of emergency care on the patient;

(d) understand the legal implications associated with providing emergency care; and

(e) determine the availability of local emergency care resources and select the appropriate services.

(3) Skills

The student must demonstrate an ability to:

(a) utilize emergency care procedures and equipment effectively in providing first aid and basic cardiac life support;

(b) remain calm, reassure and communicate with the patient, and elicit additional help, as needed;

(c) recognize the need for assistance in an emergency situation and effectively communicate and collaborate with other health care professionals; and

(d) perform appropriate reporting, recording and follow-up procedures.

j. Case Follow-Up and Review

Case follow-up and review involves monitoring the clinical status of the patient and modifying the care plan as new clinical information becomes available. Doctors of chiropractic evaluate patient progress by conducting follow-up examinations, and seek help from clinical consultants when needed.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the need to monitor the patient's response to care and modify the care plan, consult with, or refer to another health care provider when indicated;

(b) recognize and respond to patient concerns and apprehension that may result from proposed changes in a care plan or the need for referral or collaborative care; and

(c) appreciate the benefits of appropriate consultation and/or referral in the management of the patient, and be considerate of patient questions regarding second opinions and alternative forms of care.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand how and when to re-evaluate the patient's clinical status to obtain current information;

(b) recognize the need to modify the care plan consistent with current clinical information;

(c) identify referral needs, and how to communicate them to patients; and

(d) evaluate the patient's response to care by identifying appropriate outcomes.

(3) Skills

The student must demonstrate an ability to:

(a) monitor patient's clinical status during and after completion of the health care regimen through follow-up and review appropriate to the patient's health status;

(b) record data relevant to case management decisions in an organized manner;

(c) communicate appropriately when referring to other health care providers; and

(d) conduct a relevant and competent re-evaluation of the patient.

k. Record-Keeping

Record-keeping is that element of case management in which proper documentation of the patient's evaluation, diagnosis, clinical care and other transactions are recorded, accurately maintained and appropriately reported.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the need to ensure that all records relevant to the patient's care and management contain legible, accurate, complete and current information;

(b) recognize the patient's right to privacy and ensure that information from the record is released only upon legal and/or written authorization;

(c) be willing to respond to requests for patient records, or information from patient records, in an adequate and timely manner;

(d) recognize the need to ensure patient record security and confidentiality;

(e) be sensitive to the interests that patients may have in accessing their records, and follow accepted legal guidelines when it is deemed necessary to provide or withhold specific information regarding the patient; and

(f) recognize the need to keep abreast of current trends and technologies for record-keeping, communications and data transfer.

(2) Knowledge

The student must demonstrate an ability to:

(a) be aware of and follow accepted procedures and protocols when requesting patient records or information from other health care providers or agencies;

(b) know what elements of the record must be released to the patient, or other health care providers or agencies, and those elements that can be legally withheld;

(c) know and understand those elements essential to the patient record including demographic data, clinical findings and patient care information, financial transactions, reports, correspondence and communications;

(d) be aware of accepted methods and legal requirements for record maintenance, storage and security;

(e) be aware of the need to provide a key with records if abbreviations or

symbols are used; and

(f) use accepted coding systems for diagnosis and clinical procedures.

(3) Skills

The student must demonstrate an ability to:

(a) construct the patient record in a manner that is accurate, legible, complete and current, and is neither inflammatory, prejudicial nor degrading to the patient;

(b) enter clinical findings, diagnosis or initial clinical impressions, identity of the doctor and other care providers, care plans, progress notes, and follow-up evaluations in a manner that is legible, accurate, organized and reflects the clinical decision-making process; and

(c) generate clear, concise, and professional narrative reports and correspondence in a timely manner.

I. The Doctor-Patient Relationship

The nature of the relationship between the doctor and the patient has an important influence on the process and outcome of chiropractic care. Doctors of chiropractic are expected to respond to their patients' needs and provide care in an atmosphere of trust and confidence. Accordingly, doctors of chiropractic must be compassionate, sensitive to the biopsychosocial needs, recognize the importance of good communication skills, and consider the patient to be their partner in the care process.

(1) Attitudes

The student must demonstrate an ability to:

(a) recognize the importance of developing and maintaining professional attitudes and behavior within and outside the office setting;

(b) appreciate the importance of developing a professional relationship with the patient based on trust, confidence, respect, and confidentiality;

(c) recognize and accept the importance and seriousness of the role that doctors of chiropractic have in the care of patients;

(d) be aware of and be willing to respond to the needs, concerns and fears that patients may have relative to their health complaints and problems;

(e) appreciate the importance of compassion, empathy and touch as vital components of healing and factors that influence the outcome of care;

(f) recognize the importance of both the doctor and patient working together as partners in promoting optimum health;

(g) recognize and accept the inherent vulnerability of patients because of the perception of authority that patients attach to care-givers;

(h) recognize the important and frequent role physical contact has within many chiropractic clinical services; and

(i) appreciate and respect the protective boundaries patients secure over their physical and emotional being.

(2) Knowledge

The student must demonstrate an ability to:

(a) recognize the need to appropriately manage patients who may develop unrealistic expectations of and a dependency on chiropractic care;

(b) appreciate and be willing to adapt to the cultural, social, religious, gender and age differences that may exist between the doctor and his or her patients;

(c) know what patient care and office procedures can be employed that will reduce potential risk and professional liability.

(d) recognize the importance of open communication and the need to properly and adequately inform the patient of potential or proposed care;

(e) understand the appropriateness of obtaining informed consent from the patient prior to initiating clinical care; and

(f) recognize the need to establish and maintain appropriate boundaries in doctor-patient interactions which ensure physical and emotional safety.

(3) Skills

The student must demonstrate an ability to:

(a) develop and exhibit behavior and a communication style that project a professional image and enhance the doctor-patient relationship;

(b) use effective and appropriate methods of touch and other non-verbal communication techniques; and

(c) use appropriate techniques that may be employed when managing a patient who exhibits inappropriate behavior.

m. Professional Issues

Health care providers have an obligation to the patients they serve, and to society, to provide competent and effective care, and to do so in a professional manner. Doctors of chiropractic must exhibit ethical values and behaviors, recognize their responsibility to first serve the patient, and to follow sound business practices. It is important that doctors of chiropractic maintain

knowledge and clinical skills through continuing education, and be able to access, understand and critically evaluate the research literature.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the importance of supporting and participating in professional activities and organizations;

(b) recognize the need to support and participate in the activities and affairs of the community;

(c) acknowledge the societal obligation of the profession to produce research, and appreciate the importance of research in education, clinical practice and to the growth of the profession;

(d) have a desire and an ability to critically evaluate new and current knowledge;

(e) exhibit ethical attitudes regarding the provision of patient care services, fees, financial arrangements, billing practices and collection procedures; and

(f) identify and acknowledge an obligation to refrain from illegal and unethical patient care and practice management procedures.

(2) Knowledge

The student must demonstrate an ability to:

(a) be aware of and comply with, the professional reporting requirements and procedures of commercial, federal, state and local agencies;

(b) understand the need to maintain a breadth and depth of knowledge and skills necessary for the practice of chiropractic through continuing education;

(c) identify community health care and social service agencies that can assist in meeting patient needs;

(d) know patient care and office procedures which can be employed to reduce potential risk and professional liability;

(e) be aware of the types, policy limits and coverage levels available for professional liability insurance;

(f) develop a knowledge of ethical practice development strategies including marketing, community demographics, and patient management techniques; and

(g) understand the need to follow sound business practices including those involving leases, loans, purchasing, selection of consultants and advisors,

financial management, and personnel.

(3) Skills

The student must demonstrate an ability to:

(a) critically review clinical research literature;

(b) develop effective patient rapport by employing oral and written communication skills, and appropriate care procedures; and

(c) use personal computers and other business and communication technologies.

6. Optional Clinical Competencies Required in the Curriculum Including Didactic and Laboratory Components in Non-Adjustive Therapeutic Procedures.

Chiropractic care may include the use of procedures and modalities other than the adjustment and manipulation, which may be employed for the purpose of case management, rehabilitation, or wellness care.

(1) Attitudes

The student must demonstrate an ability to:

(a) appreciate the need to explain what will be done when administering therapies, discuss risks, and recognize the potential for patient apprehension and concern;

(b) be aware of the need to accommodate patient privacy and modesty in the course of administering therapies; and

(c) be aware of the need to reassess and modify therapy procedures appropriate to the needs of the patient.

(2) Knowledge

The student must demonstrate an ability to:

(a) understand the principles, physiological effects, and application of various therapeutic procedures common to the practice of chiropractic;

(b) recognize the clinical indications and rationale for selecting a particular therapeutic procedure;

(c) understand the selection and use of equipment and instruments necessary to administer therapeutic procedures; and

(d) recognize the contraindications, and potential complications, of therapeutic procedures.

(3) Skills

The student must demonstrate an ability to:

(a) select and apply appropriate therapeutic instruments or procedures;

(b) explain effectively the clinical benefits and communicate necessary information to the patient concerning the application of therapeutic procedures;

(c) modify the application of therapeutic procedures consistent with the patient's physical and clinical status;

(d) record accurately appropriate information relative to the use of therapeutic procedures; and

(e) discuss potential immediate or delayed reactions or responses to therapeutic procedures.

I. Research and Other Scholarly Activity

1. Purpose Statement

The DCP must establish objectives for and conduct research and scholarly activities that support its mission and goals. When there is more than one (1) campus, there must be active research opportunities and efforts at each campus site.

2. Policies/Procedures

The DCP must have and follow written policies regarding the conduct of research and scholarly activities, to include protection of human and animal subjects.

All DCPs and institutions using animal subjects must comply with the federal standards specified in the Animal Welfare Act (Public Law 89-544, 1966, as amended, (P. L. 91-469 and P. L. 94-279) 7 U.S.C. section 2131 et seq. Implementing regulations are published in the Code of Federal Regulations (CFR), Title 9, Subchapter A. Parts 1, 2, 3 and 4, and are administered by the U.S. Department of Agriculture).

3. Inputs

The DCP must provide appropriate financial, faculty, physical, and administrative resources for the conduct of research and scholarly activities.

4. Outcomes

The DCP must compile evidence regarding the extent to which the research and scholarly activity outcomes meet stated research and scholarly activity objectives

J. Service

1. Purpose Statement

The DCP must establish objectives for and provide service activities, beyond the chiropractic services to patients required of all interns that support its mission and goals.

2. Policies/Procedures

   The DCP must have and follow written policies regarding the provision of services.

3. Inputs

   The DCP must provide appropriate financial, faculty, physical and administrative resources for the conduct of services.

4. Outcomes

   The DCP must compile evidence regarding the extent to which service outcomes meet the stated service objectives.

## IV. Requirements for Institutional Status

Review toward continued award of institutional status is provided by the COA upon specific request from solitary purpose chiropractic institutions offering only the doctor of chiropractic degree program (DCP) that have not otherwise achieved institutional accreditation status with a nationally recognized accrediting agency. (CCE no longer accepts application for such status unless the institution held such status before 2002) The DCP must be in compliance with the DCP accreditation requirements of these *Standards* (Section 2, II) and be currently accredited by the COA, and must request review for institutional status when applying for reaffirmation of accreditation. The institution must be in compliance with the specific requirements identified and addressed below in this section of the *Standards* in order to be awarded continued institutional status.

A. Mission and Scope of Service, Self-Assessment and Planning

1. The institution must have a statement of mission adopted by its governing board, and stating that it is an institution of higher education offering only the Doctor of Chiropractic degree; however, the institution also may have educational, research, and service activities other than those within the DCP.

2. The statement of institutional mission must be consistent with the statement of mission of the program leading to the Doctor of Chiropractic degree, and provide for activities in education, research and service.

3. The institution must seek and maintain accreditation of its DCP by the CCE.

4. Institutional self-assessment and planning requirements for institutional accreditation must be consistent with those described for DCP accreditation.

B. Authorization

1. The institution must be incorporated within the United States as a not-for-profit corporation.

2. The institution must hold appropriate legal authorization to grant the Doctor of Chiropractic degree.

3. The institution must meet all legal requirements to conduct its business as an institution of higher education in all jurisdictions in which it operates.

C. Governance

1. The institution must have established a governing board which has legal authority for the institution.

2. The governing board must act in agreement with the following requirements:

   a. The governing board must be composed of representatives of both the chiropractic profession and the public;

   b. No member of the board may serve in any administrative or teaching position at the institution, except for occasional service without compensation; and

   c. No member of the governing board may use board membership for personal or private gain or advantage to the board member, to members of the board member's family, or to any business in which the board member has a substantial interest.

3. The governing board must have adopted bylaws whereby it establishes and periodically reviews the basic policies under which the institution operates. These policies must address at least the following areas of operation:

   a. Conduct of governing board business.

   b. Administration, faculty and staff.

   c. Facilities, learning resources and finance.

   d. Students and student services.

   e. Management, control, and conduct of the academic program, including all courses for credit as well as seminars and other noncredit offerings.

   f. Public disclosure.

   g. Service.

   h. Research.

   i. Academic resources.

   j. Admissions requirements.

   k. Assessment of instructional outcomes and student academic achievement.

D. Administration

1. The governing board must designate a person not a member of the governing board as the Chief Executive Officer of the institution, responsible for the administration of policies adopted by the governing board.

2. The Chief Executive Officer must hold educational credentials and have experience appropriate for the principal administrative officer of an institution of higher education offering the Doctor of Chiropractic degree.

3. Additional administrative staff holding appropriate credentials and having appropriate experience must be appointed by the Chief Executive Officer or by the governing board as specified in the bylaws of the institution.

E. Student Services

1. The institution must establish appropriate admissions requirements and procedures for each educational activity or program to which students are admitted.

2. The institution must provide appropriate learning resources support services for each educational activity to which students are admitted.

3. If the institution participates in activities affected by Title IV of the Higher Education Act of 1965 as amended it must maintain compliance with its program responsibilities, including but not limited to:

   a. Administrative and fiscal standards.

   b. Record-keeping and disclosure requirements.

   c. Default prevention measures, which must include the maintenance of a Federal Family Education Loan Cohort Default Rate that is beneath the threshold established by the United States Secretary of Education.

F. Financial Resources

The institution must have its financial statements audited by a certified public accountant annually.

1. The financial statements of the institution must demonstrate the appropriate allocation and use of financial resources in the support of the activities of the institution.

2. The financial statements and practices of the institution must demonstrate that the institution has adequate financial resources to operate for a reasonable period of time in light of its obligations to admitted students and the ability to graduate its most recent entering class.

G. Public Disclosure

1. In addition to the public disclosure items required to be published for DCPs, the

institution must publish in official documents available to the public at least the following:

a. The institutional statement of mission.

b. The educational activities conducted by the institution.

c. A description of admissions requirements, attendance requirements, and graduation requirements for each educational activity.

d. The accredited status of the institution with the CCE and all other accrediting bodies with which it is affiliated.

2. The institution must make available upon request information that accurately describes its financial condition.

## Appendix I
## Historical Development of the Council on Chiropractic Education

The importance of quality education was recognized early in the chiropractic profession. Voluntary efforts to improve chiropractic education were undertaken as early as 1935 when a Committee on Educational Standards (CES) was created by the Nat'l Chiropractic Assoc (NCA).

During the years between 1935 and 1940, various national chiropractic associations such as the NCA; the Chiropractic Health Bureau (CHB); and the Council on State Chiropractic Examining Boards (CSCEB) supported the improvement of chiropractic education with both funds and human power. Years later the NCA became the American Chiropractic Association (ACA) and the Chiropractic Health Bureau became the International Chiropractors Association (ICA).

In 1938 the CES and CSCEB merged into a new CES. Under the direction of this committee the first institution self-study questionnaire was sent to all 37 chiropractic institutions actively engaged in chiropractic education in the United States.

In 1939 the CES completed work on educational criteria, which were presented for approval of the chiropractic institutions. Funds were subsequently appropriated by the NCA to employ an inspector to visit the applicant institutions and evaluate their programs against their self studies and the educational criteria. In 1941 the CES issued its first list of institutions with status; the list contained twelve provisionally approved institutions.

In 1947 the Council on Education was formed by institutional representatives and members of the CES. On August 4, 1947, this Council received the approval and support of the House of Delegates of the NCA.

From 1941 to 1961 the Council continued to strengthen chiropractic education. Many of the weaker institutions were merged with other institutions to create stronger academic programs. A number of the grossly substandard institutions were closed. By 1961, the number of institutions had been reduced to ten.

In 1964 the NCA merged with other groups to form the ACA which continued to support the Council on Education. In 1971 the Council on Chiropractic Education (CCE) was incorporated as an autonomous national organization and continues to function as such.

In 1952 the Council on Education made initial contact with the United States Office of Education (later to become the United States Department of Education [USDE]) with an official application for recognition being filed in 1959.

Suggestions for strengthening academics and procedures were received and implemented, and in 1969 an unofficial filing of materials with the USDE resulted in further suggestions for change.

On August 16, 1972, CCE filed a formal application and on August 26, 1974, CCE was first listed as a Nationally Recognized Accrediting Agency by the U.S. Commissioner of Education. CCE recognition was extended on December 11, 1975, for a period of three years; on June 29, 1979, for a period of three years; on November 18, 1982, for a period of four years; and on September 28, 1987, for a period of two years and later extended for two additional years to September 18, 1991. In 1992, CCE was awarded continued recognition until 1997, and, again in 1997 until 2001. The U.S. Secretary of Education has now recognized CCE for a period of five years, until 2006.

The CCE was also accepted as a member of the Council of Specialized Accrediting Agencies in 1975.

On July 1, 1976, the New York State Education Department began accepting the status decisions of the CCE Commission on Accreditation (COA), thus discontinuing its policy of independent evaluation of chiropractic institutions outside the state of New York.

On October 13, 1976, the CCE was granted initial recognition by the Council on Postsecondary Accreditation (COPA) for a period of five years for the accreditation of educational programs leading to the doctor of chiropractic degree; on April 14, 1982, for a period of five years; and on April 17, 1987, for a period of five years. In 1992, the CCE was granted continued recognition by the Council on Recognition of Postsecondary Education (CORPA) for a five-year period to 1997, and, in 1997, until 2002, and is now recognized by the successor, Council on Higher Education Accreditation (CHEA).

In keeping with the CCE policy on American-Foreign Cooperation in Accreditation of Chiropractic Institutions, the CCE (USA) announced the establishment of full reciprocal agreements with the CCE (Canada) on March 26, 1982, with the Australian CCE (ACCE) on February 2, 1986, and with the European Council on Chiropractic Education (ECCE) on January 23, 1993. These reciprocal agreements hinged respectively upon an award of status by the Commission on Accreditation of the CCE (Canada) to a Canadian chiropractic institution, an award of status by the Commission on Accreditation of the ACCE to an Australian chiropractic institution, and an award of status by the Commission on Accreditation of the ECCE to a European chiropractic institution. The practice of forming such recriprocal agreements was ended by action of the CCE Board of Directors in January 2002.

During 1986-87 the CCE USA undertook a major program to review and revise the *Educational Standards for Chiropractic Institutions (Standards),* subsequently renamed the *Standards for Chiropractic Programs/institutions.* A random sample of more than 500 persons from CCE's various publics were asked to critique the *Standards.*

These findings, plus those of a concurrent study examining the validity and reliability of the purposes, *Standards* and the accreditation process, supported the mission and operational aspects of the CCE.

In 1987-89 the CCE continued the *Standards* review process in response to impending substantive changes in postsecondary education and accreditation recognition requirements. The USDE and the COPA revised their provisions and procedures governing recognition of accrediting bodies to require that program review assess outcomes as well as resources.

In 1990, the CCE approved major revision of its *Standards*; the revision focused on the development of an accreditation program that assesses chiropractic institutional effectiveness and outcomes.

In 1995, the CCE again approved major revisions of its *Standards*, in order to maintain compliance with the provisions added to the Higher Education Act of 1965 (HEA) by the Higher Education Amendments of 1992, and the Higher Education Technical Amendments of 1993.

In 1996, the CCE approved major revisions of the Clinical Competency Document. This document is now a section of the *Standards*, not an appendix.
Since 1996, CCE has continued to take seriously its commitment to ensure that the *Standards* for

the accreditation of DCPs are adequate and effective measures for assessment of quality, and relevant to the requirements and expectations of the chiropractic profession and to the protection of the public. Specific revisions of the *Standards* have taken place from time to time, particularly with regard to requirements for admission to the programs and clinical aspects of the curriculum. In this regard, the CCE Board of Directors has approved a specific and systematic program for review of the *Standards* and the accreditation process. This program insures regular and thorough reconsideration, and improvements where necessary.

In January 1999, the CCE Board of Directors voted to change the organizational structure and makeup of the components of CCE. The Board of Directors is now composed of thirteen individuals, seven from the accredited chiropractic programs/institutions, four practicing chiropractors from the field and two individuals from the general public. The Board of Directors establishes the *Standards*, elects the members of the Commission on Accreditation (COA), and conducts the general business of CCE through its Executive Committee and the Executive Vice President.

The COA is now a completely separate body composed of eleven individuals, five from the accredited chiropractic programs, four practicing chiropractors from the field and two individuals from the general public. The COA is responsible for implementation of the CCE *Standards* in its deliberations and decisions on all matters pertaining to the accreditation of programs/institutions.

Initially named the CCE Council, The CCE Corporation was given responsibility for election of the Board of Directors and approval of the CCE *Bylaws*. This body was composed of representatives from each of the accredited programs.

In the year 2000, the CCE Board of Directors conducted an extensive review of proposed revisions of the *Standards*, involving participation by all entities in CCE and interested outside parties. Major revisions of the *Standards* resulted from this activity.

Along with another major revision of the CCE *Standards* in January 2001, the CCE Board of Directors moved to support the formation of and appropriate funding for development of the Councils on Chiropractic Education International (CCEI) to support and insure the promotion of high quality in accreditation of chiropractic education worldwide.

After an extensive process of revision, the CCE/COA were determined by the United States Secretary of Education, to be in full compliance with federal requirements, resulting in a five (5) year renewal of recognition through December 2006 with no concerns. During 2001 the COA imposed a public sanction of probation on a CCE-accredited program.

In 2002, the CCE Commission on Accreditation instituted processes to enhance consistency in application of requirements and in reporting on site team visits, and revised the COA Manual to include examples that illustrate compliance with the CCE *Standards* and assist programs in understanding CCE accreditation requirements.

After recommendations from the Board of Directors and COA, the then members of the CCE "Corporation" dissolved with the understanding that the CCE Board of Directors would assume any responsibilities formerly had by that entity. Also in 2002, the COA decided not to reaffirm the accreditation of a program previously placed on probation. In that same year, after recommendations from the Board of Directors and the COA, the entity known as the CCE Corporation" dissolved itself with the understanding that the CCE Board of Directors would assume any responsibilities formerly held by that entity.

# Appendix II

## History of Clinical Competencies for DCPs

In July, 1981, the Council on Chiropractic Education (CCE) initiated an effort to identify those minimal clinical competencies requisite to entrance into the chiropractic profession. An ad hoc task force was appointed consisting of members representing CCE member DCPs, as well as professional and regulatory organizations. The work of the task force was completed and the clinical competencies were adopted by the CCE in 1984.

A second task force was appointed in 1994 and a third task force worked in 1999-2000 for the purpose of revising the clinical competencies. The most recent set of competencies more closely reflect changes that have occurred in chiropractic education since they were first implemented by the CCE, and are more consistent with the primary care role of the doctor of chiropractic.

The competencies address the minimal acceptable clinical criteria necessary to the conduct of the competent practice of chiropractic. They are not intended to limit the skill level attained through didactic course work and clinical experiences. Rather, they identify the knowledge, skills and attitudes expected of the primary care doctor of chiropractic. This skill level is implicit in the first professional degree awarded by a college holding status with the COA of the CCE. These competencies also do not reflect the mastery of clinical skills acquired through extensive practice experience; rather, they represent those minimal skills a candidate must demonstrate upon completion of the educational program with resident clinical experience in a status-holding institution.

The clinical competencies detail many of the responsibilities of the doctor of chiropractic broadly described in Section 2.1. Requirements for Accreditation of these *Standards for Chiropractic Programs and Institutions*. However, they are not intended to establish a universal standard of chiropractic care and application of these competencies must be consistent with the regulations governing the practice of chiropractic in the jurisdiction to which they are applied.

It is generally held that the development of competency cannot be accomplished within the resident clinical experience alone. The integration of those pre-clinical sciences basic to chiropractic practice with courses in the clinical disciplines is necessarily prerequisite to a clinical experience in which these competencies may be appropriately demonstrated. Furthermore, the nature of the competencies may require assessment methods unique to their particular domains. For example, knowledge might best be assessed with written instruments, attitudes evaluated by repeated observation during the clinical experience and technical skills by practical demonstration. The competencies serve only to delineate the knowledge, skills and attitudes expected of the graduate and are not intended to prescribe a method of instruction or specify the manner in which chiropractic students should be evaluated.

## Appendix III

## Glossary

**Case types** = In this context, "case types" represents a list of diagnostic entities (e.g., lumbar disc herniation, hypertension), patient presentations (e.g., woman with fatigue, patient over 50 with insidious low back pain, patient with radiating arm pain and nerve root deficits), and/or subluxation or joint dysfunction patterns (e.g., T4 syndrome, Maigne's syndrome, upper cervical joint dysfunction causing cervicogenic headache) which will represent the intended training domain of the clinical training phase of the DCP.

**Competency evaluation** = Any of a variety of methods used to assess students' knowledge, skills and attitudes, with the goals of providing feedback to enhance the educational process, rating performance, and determining the appropriateness of progression in the clinical phase of the DCP.

**Diagnosis** = An expert opinion based upon the reasoned judgment of the doctor of chiropractic to identify the nature and cause of the patient's subjective complaints and objective findings, which directs clinical care and case management decisions. The diagnostic process is an essential component of chiropractic care and includes the integration and synthesis of all available information obtained from appropriate history, examination findings, laboratory, imaging, and other evaluations, resulting in a recorded opinion of the patient's health problem(s) and status.

At times, there may be insufficient or inconclusive information to render a final diagnosis; however, the initial diagnostic impression should guide the doctor of chiropractic in decisions about further diagnostic evaluation, referral, or initiation of patient care. The diagnosis may be modified during the course of case management as a result of further evaluation, acquisition of additional information, changes in subjective complaints and objective findings, or clinical responses to chiropractic care.

Final diagnostic conclusions may be contingent upon information that is not immediately accessible to the doctor of chiropractic, including results obtained from specialized diagnostic procedures, reports from other health care providers or facilities, data derived from clinical observation, or other knowledge from third party sources.

**Educational outcomes** = Indicators of the quality of instructional effectiveness.

**Health promotion** = Maintenance of neurobiomechanical integrity inclusive of subluxation prevention, and general strategies to enhance quality of life and prevent disease, trauma, and illness. This includes aspects of ergonomics, psychosocial support, exercise, diet, nutrition and life style counseling, and health screening.

**Information technology** = The means for the search for and retrieval of information from electronic sources such as CD ROM, WEB-based information services, and computerized information and patient information storage sites.

**May** = Indicates a condition allowable within the *Standards*.

**Must** = Indicates a condition mandatory for accreditation by CCE.

**Patient review policies** = A mechanism to systematically review and effectively deal with patient complaints and reported incidents.

**Portal of entry** = The opportunity for the doctor of chiropractic to be the first contact a patient may make with a provider to seek health care information and/or services.

**Primary Care Chiropractic Physician** = An individual who serves as a point for direct access to health care delivery, the doctor of chiropractic's responsibilities include: (1) patient's history; (2) completion and/or interpretation of physical examination and specialized diagnostic procedures; (3) assessment of the patient's general health status and resulting diagnosis; (4) provision of chiropractic care and/or consultation with continuity in the co-management, or referral to other health care providers; and (5) development of sustained health care partnership with patients.

**Quality Standards** = Quality standards shall mean each of the standards set forth in Section 2 of the Standards for Doctor of Chiropractic Programs and Requirements for Institutional Status. CCE expects compliance with these Standards.

**Requirements** = Signifies a set of conditions that must be met as one of the requirements for CCE accreditation to be awarded.

**Should** = Indicates a condition that is desirable but not mandatory for accreditation by CCE.

# 資料８

# 12

# Contraindications and Complications

## Chapter Outline