GENERAL CHIROPRACTIC COUNCIL EDUCATION COMMITTEE
REVIEW OF THE DEGREE RECOGNITION CRITERIA
REPORT ON THE OUTCOMES OF THE CONSULTATION

1. Background

The Review of Degree Recognition Criteria formally began in September 2009. Prior to that date, the Education Committee had noted issues for consideration for the review during its ongoing discussions.

The review proceeded through the following stages with the active involvement of the Education Committee throughout:

1. analysis and interpretation of developments in:
   a. the requirements for pre-registration education and training of other regulated healthcare professionals in the UK
   b. educational developments within the European Union
   c. the accreditation criteria from other worldwide chiropractic jurisdictions.

2. preparation of draft revised criteria for consultation with key stakeholders

3. consultation with current education providers, students, professional associations, College of Chiropractors, public and patient representatives and other interested parties (such as possible future education providers, other healthcare regulators) on the draft proposals

4. analysis of the outcomes of the consultation, preparation of the report and recommendations for changes to the criteria.

The Education Committee considered the report of the consultation and the proposed changes to the Degree Recognition Criteria at its meeting on 13 April 2010. This report forms the overview of the analysis and recommendations for changes to the criteria that have been agreed by the Committee and are recommended to the Council.

At stage 2 and 4, the wording of the criteria has been checked by the Word Centre to ensure that Plain English is being used.

The Council is asked to:

1. **receive the report of the consultation and the revised Degree Recognition Criteria as advised by the Education Committee**

2. **decide whether the proposed revised version of the Degree Recognition Criteria should be accepted.**

2. Overview of the consultation

The consultation ran from 6 January – 10 March 2010. The consultation pack – the consultation version of the Revised Degree Recognition Criteria, an explanatory letter and a response form - were sent to an invited list of stakeholders. The response form set out a number of specific questions for consideration related to the proposed major changes to the Degree Recognition Criteria. It also gave room for respondents to provide feedback on any

other of the criteria and guidance that they wished and offer any overview comments. The response form is given in Appendix 1.

Invites were sent to:

- current providers of undergraduate chiropractic education
- student associations of the current education providers
- professional associations
- College of Chiropractors
- public and patient representatives
- other education providers that may have an interest in providing undergraduate chiropractic education in the future
- other healthcare regulators through the Education Inter-Regulators Group
- Councils on Chiropractic Education International (includes European Council on Chiropractic Education).

Responses
16 responses were received, all of them organisational responses. In addition an individual comment was received from a member of the Education Committee. An informal meeting was offered by, and held with, the General Medical Council and advice was sought from the Quality Assurance Agency in relation to research levels within degree programmes. There was a very good response from all categories of respondent, particularly those in the chiropractic community. Appendix 2 shows the names of all respondents.

Analysis
The information received from the different respondents was collated using the consultation response form as the basis. Once all of the comments had been collated, they were considered together to determine any further changes that might need to be made the Degree Recognition Criteria and issues for further consideration by the Education Committee.

3. Main findings of the consultation

3.1 Overview

Overall respondents welcomed the proposed changes that had been proposed to the Degree Recognition Criteria and believed them to be consistent with the wider education context in which UK chiropractic education is placed.

The majority of respondents focused their comments on the specific questions noting they had little, or nothing, else on which they wished to pass comment.

The sections below take each of the specific issues that were raised in the consultation in turn before considering any further issues and proposals that were raised when general comments were made.

3.2 Inclusion of philosophy of chiropractic in the programme outcomes

The first specific question that was asked in the consultation was relation to whether or not the philosophy of chiropractic should be deleted as a requirement for students as it is in the extant criteria (ie from criterion 4a). The two reasons that were given for the proposal were that this requirement was not contained in any other accreditation criteria in worldwide chiropractic and there was difficulty in providing guidance as to what exactly would be required in this area.

Is this correct? What about Australia, N, Zealand Canada, Barcelona etc?

There were divergent views as to the appropriateness of including a requirement for understanding the philosophy of chiropractic or not. Five respondents (two chiropractic education providers, another education provider, a chiropractic professional organisation and a healthcare regulatory body) were in favour of philosophy being deleted from the criteria. The reasons included: consistency with other worldwide chiropractic accreditation systems; the new wording being sufficiently comprehensive as it stood to cover the principles and historical context of the development of the profession; and the fact that although the subject would no doubt be interesting, it could not be deemed necessary for safe and competent practice. However one of these education providers noted students should understand what constitutes a standard philosophical framework (although it was not clear from the response whether they felt that this should be added to the guidance or the criteria). The professional organisation stated that the new wording would be sufficient provided that the spectrum of chiropractic care that is taught to undergraduate students is consistent with the guidance related to programme outcome 4(a) which sets out the spectrum of different models used in chiropractic care.

Two further respondents (a student society and a chiropractic professional organisation) felt that an understanding of philosophy would be helpful but placed caveats on the extent of this. One felt it was useful in relation to both how chiropractors view their professional background from a historical standpoint but this should not be allowed to constrain future developments. The other stated that it would be helpful for students to understand philosophy as the study of the theoretical basis of knowledge and experience which fosters the development of appropriate attitudes and ethical approaches, and that this would be consistent with many other healthcare professions. However there was concern that the 'philosophy of chiropractic' was not used to indoctrinate students with a particular set of beliefs.

The remaining eight respondents strongly disagreed with the proposal that the philosophy of chiropractic should be deleted from the programme outcomes, a number of whom questioned whether there were any grounds for this being proposed. Three of the seven responses had a high degree of similar content. The arguments put forward for retaining philosophy in the programme outcomes included:

- it being one of the three parts of chiropractic - science, art and philosophy - and hence of vital importance to the undergraduate chiropractic curriculum (science explaining what chiropractors do, art being what is done, and philosophy the reason for doing what is done)

- concerns that philosophy was being confused with dogma and fears that after graduation students who were not taught philosophy would be more susceptible to dogma and evangelism

- recommendation from a World Federation of Chiropractic symposium in 2000 when 34/36 colleges agreed that philosophy be taught as an intellectual discipline, and that it be taught in a way that helps students understand their role as chiropractors within healthcare; and the inclusion in the proposed new European (CEN) Chiropractic Standards as part of the agreed undergraduate chiropractic core competencies of. At that meeting there was broad consensus from virtually all of the chiropractic colleges in the world about the importance of philosophy in the undergraduate chiropractic curriculum

- references to a study by Pollentier and Langworthy in 2006 which states that 76% of the profession considered chiropractic philosophy to be an important and integral part of chiropractic[1]

- the role of philosophy in encouraging students to question, consider, explore ideas, develop critical thinking and address ethical dilemmas

- the philosophy of chiropractic giving students a grounding from which to understand where chiropractors fit alongside the philosophy of medicine and healthcare and in distinguishing it from other manipulative professions

- the assertion that whilst philosophy might not be relevant to a medical school it is vital to chiropractic education.

Whilst the issue of philosophy not being included currently in other extant worldwide accreditation standards was not directly addressed, one of the student associations noted that from their meetings with other students from across the world they are aware that other colleges teach philosophy. A professional organisation suggested that this was a great opportunity for the GCC to lead the way forward worldwide spearheading the importance and distinctions of chiropractic.

BCA ?

It was noted that schools of philosophical thought that are relevant to chiropractic including, amongst others, holism, vitalism, therapeutic conservatism and critical rationalism. Another respondent proposed that further time should be spent articulating what the philosophy of chiropractic included so that it could be included in the guidance.

3.3 Use of credit ratings to specify programme level and length

A specific question was asked in relation to the use of credit rating to specify programme level and length in contrast to the specification of time in hours (including specific requirements on directed study time) that was used previously. The question was as follows:

> *Given current practice in higher education, do you agree that it is appropriate to specify the level and length of the course with reference to its credit rating rather than using a time specification? Please explain the reason for your answer. (see criterion 11)*

All respondents except one agreed to a move to using credits rather than specifying the minimum student study time. The common reason for this being appropriate related to this being common practice in higher education and hence the consistency and equivalency with other programmes that this would provide. One of the healthcare regulatory bodies noted that they did not use credit ratings but focused only on outcomes ie graduates meeting the Standard of Proficiency. They noted however that the QAA Benchmark statement for the profession suggested that the level would be either a Bachelors or Masters, but there was still a Diploma qualification awarded at one institution as a fall-back position should graduates not attain Bachelors or Masters level.

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[1] Pollentier A and Langworthy J, 2006, The scope of chiropractic practice: A survey of chiropractors in the UK in Clinical Chiropractic (2007) 10, 147 – 155. This one-shot postal questionnaire was sent to 490 randomly selected chiropractors on the GCC register and asked their views on chiropractic beliefs and philosophy, the benefit of chiropractic intervention in paediatric, adolescent and adult conditions and its relationship with the NHS. The response rate was 54% (ie 263/490) and was based on 52 questions on 5 point Likert scales where individuals were asked to rate their level of agreement with certain statements.

Whilst there is overall support for a move to credit rating and the credits referred to in the proposal, a few respondents questioned whether it was wise to solely rely on credits as the measure of level and length. This was due to the Bologna agreement using time in addition to credits to define the length of a programme as this gives clearer direction as to requirements and consistency with other healthcare professions. Specifically the issue was raised as to whether there should be a set time given for the final clinic period / clinical practice so that further consistency was achieved with other healthcare professions in the UK.

In terms of how this should be captured in the criteria, it was suggested that the proposed consultation wording of criterion 12 would in fact give sufficient guidance on time as it stated the length of time that is normally needed to complete the programme.

In relation the description of the level of degree programme, one respondent suggested that criterion 11 should be modified to state: 'The course must be at a minimum of an honours degree or integrated masters degree …' as this would provide an indication of the lowest level of degree that is expected, whilst not being restrictive to other possible models in the future, such as the 3+2 model which is referred to in the Bologna agreement. This would require similar editing of the guidance.

Two respondents (one chiropractic professional organisation and the other from another profession) proposed that it would be helpful to make specific mention that the length of degree programmes can be tailored dependent on the starting point of student's knowledge and skills ie some form of accreditation of prior learning can be accommodated.

UCA response

3.4 Level of undergraduate research project

The amended criteria that were the subject of the consultation proposed that the undergraduate research project should be at the same level as the final degree classification. Respondents to the consultation were asked a specific question about this proposed change.

The vast majority of the respondents agreed with the proposal that the undergraduate research project should be at the same level as the final degree classification as this is consistent with normal higher education practice and that it was inconsistent to have a research project credited at another level.

Two respondents (a current education provider and a chiropractic professional organisation) disagreed with this proposal. The professional organisation believed that there should be flexibility as some projects may not reach Masters level. However this appeared to be contradicted in the next statement which raised the question as to whether this was not already a general requirement for Masters programmes to have research projects of the equivalent level.

The education provider suggested alternative wording both for the level and the nature of the research project. In doing this they questioned however whether such a specification was a matter for the recognition of a chiropractic degree by the GCC but rather was more related to the validation of the degree programme by the validating university. The questioning by this provider of this criterion reflects the advice given by the Quality Assurance Agency (QAA) and the informal discussions with one of the healthcare regulators, both of whom questioned the rationale for having a specific requirement on how the programme outcomes related to research and evaluation knowledge and skills (criterion 5) are assessed when no such requirements are made for any other programme outcomes. The QAA also queried why this

was specified by a healthcare regulatory body as it would normally be the responsibility of the awarding body (ie university) and would also be subject to their own assessment regulations for validation. The QAA emphasised the importance of having confidence in the specification of the programme outcomes in this area.

3.5 Removal of requirement for students to repeat whole years if any component is failed

The extant version of the Degree Recognition Criteria, as did the one which preceded it, required that students who failed any of the degree components after a resit repeated the full diet of modules for the year (criterion 16). The proposal in the consultation version of the criteria was that this requirement should be deleted as it was inconsistent with current educational approaches and was inequitable to individuals who were forced to retake modules that they had already achieved.

All respondents except for one felt that this specific requirement should be deleted although it was emphasised that it would be necessary to ensure that all students passed all of the modules and that they were competent at the point of graduation, particularly for those modules focused on clinical chiropractic. Not having to repeat whole years would bring chiropractic education in line with other healthcare programmes and higher education practice for modular programmes. It was noted that assessment must be non-compensatory ie that in passing brilliantly in one domain (such as knowledge) it is not possible to compensate for failing in another (such as skills or professionalism).

The current education providers noted that universities are likely to have their own specific requirements about the number of modules (linked to credits) that could be failed and/or retaken in any one year, but it is for the validating institution to determine this.

The respondent who did not wholly support this proposal believed that there should be an exception in the case of students who fail critical vocational modules required for progression to the subsequent year, such as failing clinical examination prior to progression to the in-clinic year.

3.6 Removal of requirement for students to assess and care for a specific number of patients

The consultation version proposed that there should not be a requirement related to the number of patients that students need to assess and care for during the clinic period as a clearer specification of the outcomes for the clinic period, and the relationship of this to the programme outcomes, would be sufficient to ensure that students are fit to practice. A move to not stating specific numbers of patients that students have to assess and care for would be inconsistent with the other jurisdictions of worldwide chiropractic education, except for the CCEI[2]. However the 2009 consultation document from the CCE proposed a different approach through removing the numerical requirements for clinical cases in students' final practice year and emphasising the link to fulfilment of the competence requirements. This proposed move by the CEE appears compatible with a competence-based approach to chiropractic education and parallels the discussions that have taken place over recent months within the GCC.

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[2] CCEI - The Councils on Chiropractic Education International; CCE - The Council on Chiropractic Education (USA)

All of the respondents, except for one chiropractic professional organisation, agreed with this proposal. There were a number of reasons given for this being an appropriate way forward which included:

- the requirement for specific numbers of patients can lead students to number chasing rather than learning from their clinical practice and focus on the development of competence
- some students may have seen the required number of patients and still not be fully competent or confident
- students develop and achieve competence at different rates
- a required minimum number of patients may lead to allegations of encouraging or promoting over-treatment or unnecessary treatment
- it is the institutions' responsibility to ensure that students successfully meet the learning outcomes and are considered safe and competent at the point of graduation
- this would move chiropractic education programmes closer to other health care programmes
- outcome led criteria as specified in criterion 19 and other programme mechanisms (such as assessment requirements) are sufficient to ensure students are fit to practise at the point of graduation.

Of the respondents who agreed with the removal of the requirements relating to patient numbers in the clinic period, one of the current chiropractic education providers suggested that there should be more specific guidance on new patient visits and case mix as these are particularly important to student learning and development. Related to this point, another chiropractic education provider proposed that each institution should be required to demonstrate how they plan to expose students to a diversity of learning and clinical experience to meet the degree requirements to ensure competency at the end of the programme. This should allow for flexibility in the approach to the clinical training of student clinicians but require a minimum level of patient management to develop clinical problem solving and physical assessment skills. One of the chiropractic professional organisations suggested that where an institution has a significantly large number of students falling below the 40 new patients guideline before graduation, then explanations for this happening should be sought.

One of the healthcare regulators noted that their focus is on students meeting the outcomes of the programme but they do have specific requirements for the clinic period including: a dedicated clinic facility with appropriate provision for the discussion of patient cases, a clinical supervision ratio of one tutor to a maximum of five students being supervised while interacting directly with their patients at any point in time, clinic practice learning in the clinical environment of no less than 1,000 hours, and a mix of patient presentations and ensuring continuity of care. This particular regulator also make a requirement on a minimum of 50 new patients for each student during their clinic experience where the student is taking the main responsibility for the patient's care.

The one respondent who did not agree with the removal of this requirement (a chiropractic professional organisation) stated that "students are poorly prepared to actually manage patients and should have to reach targets in their clinical year. It is vital that students gain confidence adjusting patients and seeing a large number as a student helps this." Concern was expressed that by removing specific requirements for patient numbers in the clinic year, subjectivity would be introduced so a numerical guide should be used to protect students.

3.7 The clinical opportunities to be used in the final clinic period

The consultation document noted that criteria 20 – 21 have been rewritten to allow for different forms of clinical opportunities to be used in the final clinic period. This is because a comparison between the GCC's and other jurisdictions of worldwide chiropractic education showed that the GCC currently has stricter requirements for on-site clinic facilities with private rooms for assessment and treatment than the other jurisdictions, who appear to allow the use of other facilities (eg community-based health centres / practices). This suggests that a possible move to considering placements within UK chiropractic education would not be inconsistent with chiropractic education elsewhere. It would also have the potential benefit of encouraging other education providers in the UK to offer chiropractic programmes.

A specific question was asked on whether the criteria were sufficiently robust to ensure that students are fit to practise when they graduate. The rewritten criteria are:

> *The school must ensure that, during the clinic period, each student has the opportunity to assess and provide chiropractic care for a sufficient number of different patients while also ensuring that patients receive continuity of care.*
>
> *The school must have policies and procedures to ensure the effective governance of the clinic period and the effective supervision of students.*

There was overall support for this proposal with respondents suggesting that students should be exposed to as many different types of clinical practice as possible as this would produce more rounded practitioners and that awarding institutions should be given the latitude to decide what additional clinical opportunities will enhance the student learning experience. It was also noted that these criteria allow for innovation, development and flexibility by different higher education institutions whilst still ensuring that outcomes are met.

In order to strengthen these criteria it was stated that:

- the points under 'guidance' needed to be consistently applied within recognition processes and followed and supported by institutions (a chiropractic education provider)
- the need for there to be clarity that there is monitoring by "a chiropractic community, with the ethos becoming part of the practice, not just the skill base" (a chiropractic professional organisation)
- reference should be made as to how institutions might manage clinical experience if teaching is undertaken by those employed by other organisations (higher education body)
- quality assurance of the clinical environment and the teaching and clinical expertise of those involved at all levels (a healthcare regulator).

3.8 The competence of individuals undertaking summative assessments

The consultation version of the Degree Recognition Criteria included a new criterion relating to the competence of those making summative assessments of students' achievement (criterion 35). The proposed criterion stated:

> *People involved in assessing students' achievement of learning outcomes must be competent to assess the learning outcomes concerned using the assessment methods specified.*

A specific question was asked relating to whether this criterion was sufficient as a requirement, or whether there should be additional requirements/guidance such as how assessor competence would be assessed.

There were mixed responses to this issue.

Nine of the respondents (from different respondent groups) stated that the criterion was sufficient as it stands and did not require additional requirements or guidance. It was noted that the requirement would be consistent with other healthcare professions and higher education institution processes should be relied upon to assure assessor competence. However one of the respondents noted that if this were to be tightened up, it would be essential to ensure that the wide range of people who might contribute to assessment, such as peers, professions other than chiropractic, and patients or carers, should not be forgotten.

Three of the respondents (one chiropractic professional organisation, an education provider and another healthcare regulator) agreed with the requirement but felt that more specific information - in the form of criteria or guidance was also required such as: initial recognition of assessors followed by regular (mandatory) updates, the achievement of an appropriate teaching/assessing qualification or the development of specific guidelines on how to assess assessors' competence.

Two respondents (chiropractic professional organisations) did not directly answer the question noting that: *"Anyone who is involved in teaching will also need to be involved in assessing. Anyone who is involved in assessing students will need to be competent to assess. We are confident that each institution will have mechanisms in place to ensure this."* One of these respondents added that: *"all assessors should spend some time in clinical practice to understand the challenges meeting undergraduates and new graduates as they settle into clinical practice"*.

One respondent (a current provider) noted that it would be appropriate for there to be further guidance on this point but then noted that institutions should already have mechanisms in place through quality assurance mechanisms. Questions were also raised as to why the focus was on summative assessment as all assessment was equal value in the learning.

3.9 Detailed comments on the introductory text

The following points were raised for consideration in the introductory text to the Degree Recognition Criteria ie information on the statutory powers of the GCC; the content, structure and format of the document; links to other quality assurance systems; and the recognition process. The comments received are considered below following the structure of the document.

Statutory powers of the GCC

1. A current chiropractic education provider queried the accuracy of the second paragraph stating that the GCC "... make sure that graduates of initial chiropractic degree programmes have demonstrated they can meet all the requirements set out in the GCC's Code of Practice and Standard of Proficiency for the Competent and Safe Practice of Chiropractic". This was because whilst the GCC can make sure that the chiropractic degree programmes meet the requirements set out in the criteria for recognition of degrees, it evaluates the institution and programme of study, not individual graduates. It was suggested that the wording be amended to, for example: "... make sure that graduates of initial chiropractic degree programmes are able to meet ....etc".

2. A professional organisation sought clarification as to what is meant by 'ensuring the development of the profession', which suggests that, perhaps, the wording is unclear.

Content, structure and format of this document

3. A higher education organisation suggested that the words 'higher education' should be removed from the definition of 'School' as this would relate better to the definition of 'institution' and recognises the potential for flexibility in provision arrangements / partnerships which are encouraged and recognised by the QAA.

Recognition process

4. Two regulatory bodies wondered whether the GCC had considered conjoint validation with the HEI's approval/validation processes, one noting that 'this is theoretically less burdensome on the HEI'.

5. One regulatory body suggested that the approval panel was rather 'top heavy' and raised the question as to whether patients, carers and students should be included on the panel.

6. One regulatory body noted that they separated the Visitors who undertake the visit from the decision makers on Education Committee, Council and the Privy Council but aside from that, their process is very similar to the GCC process as described.

3.10 Points made on the recognition criteria related to content

The following points were raised for consideration in relation to the content of the document. These have been set out against the structure of the document.

General criteria on content – introductory statements

1. A higher education organisation recommended that para 2 in the introduction should include the term 'professionalism' or 'professional behaviour'.

2. One of the regulatory bodies noted that it is helpful to have an explicit mapping between the programme outcomes and the Standard of Proficiency as this is helpful to students and shows how all of the different standards fit together.[3]

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[3] This is already done in the detailed guidance notes for the GCC Degree Recognition Criteria.

Programme outcomes relating to the knowledge and skills that form the basis of chiropractic (criterion 4)

3. One of the current chiropractic education providers queried the use of the term 'vertebral subluxation' in the guidance relating to criterion 4 as this is both a contentious concept both within and outside the chiropractic profession, difficult to quantify and define, and historical in nature and unproven.

Programme outcomes relating to research and evaluation knowledge and skills (criterion 5)

4. It was suggested that 'relevant to chiropractic' should be deleted from Criterion 5(c).

5. It was proposed that 'diagnostic studies' should be added to the guidance for criterion 5 following 'case-control studies'.

Programme outcomes relating to assessment knowledge and skills (criterion 6)

6. It was proposed that the guidance for criterion 6(a) should be changed to '…whether the patient is taking nutritional supplements, herbal or homeopathic remedies).' And similarly for criterion 6(l).

7. It was proposed that the guidance for criterion 6(l) should be re-worded to: 'Students need to have an appropriate understanding how prescription…might affect patients.'

Programme outcomes relating to the knowledge and skills needed for chiropractic care (criterion 7)

8. It was proposed that 'dry-needling and acupuncture techniques' should be added to bullet points in the guidance for criterion 7(a) following the 'exercise and rehabilitation' bullet.

9. The rewritten criterion 7 relating to evidence-based care was praised by an education provider.

Programme outcomes relating to communication with patients and other healthcare professionals (criterion 8)

10. It was noted by a regulatory body that the programme outcomes relating to communication with patients and other healthcare professionals are appropriate and consistent with other healthcare degree programmes.

11. The user-carer criterion (8) was praised by an education provider..

Programme outcomes relating to the knowledge and skills needed to be an independent primary care practitioner (criterion 9)

12. An individual raised the question as to whether learning to start and run a practice should be a mandatory part of chiropractic training.

Programme outcomes - the knowledge and skills needed for professional accountability and the protection of patients (criterion 10)

13. A regulatory body noted that whilst the programme outcomes require the recognition of issues, there does not appear to be a requirement to act on them. It was noted that other healthcare programme outcomes require students to self-regulate; report any health issues, cautions/convictions which occur after the initial CRB check, and to declare fitness to practise on an annual basis. And that there is also an expectation that programme providers have a process for students to escalate any concerns they may have about others.

14. The programme outcomes related to accountability and protection of patients in criterion 10 were praised by an education provider.

3.11 Points made on the recognition criteria related to the nature of the degree programme and programme providers

The following points were raised for consideration in relation to the nature of the degree programme and programme providers. These have been set out against the structure of the document.

An education provider noted that the changes proposed in the consultation document brought the GCC criteria closer to QAA and HEI norms. It is assumed that this means that this will be more likely to make other education providers interested in offering a chiropractic undergraduate degree programme.

Level and length of course (criteria 11 – 12)

1. A chiropractic professional organisation asked for greater clarification to be given as to what is meant in criterion 11 as to the meaning of 'directed study' ie does it include formal contact hours. This is because, whilst there is support for self-directed learning as an important route to development, there is a need for sufficient formal contact hours with appropriate individuals for practical training, mentoring and guided physical skill development in manual based chiropractic practise.

2. A regulatory body raised the question as to whether the Scottish credit rating should be included within the criterion to be inclusive.

ok - agreed

Teaching and learning methods (criterion 13)

3. It was noted by a professional organisation that the use of multi modal approaches to learning is not specifically discussed and needs to be addressed due to the use of distance learning.

4. A higher education organisation recommended that there should be greater use of 'patient involvement' and/or 'involving users and carers' in areas other than criterion 13 as patients can provide substantial insight in a wide variety of areas from admissions to curriculum design[4].

Assessment methods and regulations (criteria 14 - 16)

5. A regulatory body applauded the inclusion of patients and carers in the assessment of students and agreed that all learning outcomes must be assessed.

Programme structure (criterion 17)

6. A current chiropractic education provider noted that whilst criterion 17 c states that the final year of the degree programme must have a substantial period of clinical practice, this may prove be restrictive to future curricular developments. It was suggested that this should be changed to: "the degree programme must comprise a substantial period….etc."

7. It was noted by a regulatory body that the programme structure appeared to be appropriate for autonomous practice.

Clinical experience and practice (criteria 18 - 22)

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[4] Note – the involvement of patients and carers is included in teaching and learning, assessment and also programme design and delivery.

8. One of the education providers noted that there was a typo in the guidance for criterion 19 where the final bullet point stated that there were links to criterion 15. This should have read to criterion 35.

9. There was concern about criterion 22 from four respondents (a current education provider, a chiropractic professional organisation, a higher education organisation and a regulatory body). It was queried why this had been included as a criterion rather than guidance as whilst institutions might encourage students to do extra curricular activities, this is, and should not be, enforced or monitored. It was also questioned as to whether this represents good practice as students would benefit from having holidays.

10. It was proposed that in criteria 20 – 21 reference should be made as to how institutions might manage the clinical experience, where teaching is undertaken by those employed by other organisations.

Programme planning and review (criteria 23 - 26)

11. It was proposed by a higher education organisation that the guidance in criterion 26 should make specific reference to training/trained external examiners (ie this being part of their 'effective use'). This would reflect the on-going national debate about the quality of the external examining system and the extent to which schools are responsible for training examiners.

12. It was suggested by a higher education organisation that reference should be made to 'quality enhancement' in order to give further scope for continuous improvements to the student learning experience.

Staff (criteria 31 - 37)

13. The exact meaning and focus of criterion 32 was raised ie as it specifically refers to 'academic staff', is it correct to presume that this refers specifically to academic staff for a reason, and therefore it is not appropriate to amend it to, for example, 'academic and clinical staff' or 'academic staff and practice educators'.

14. A regulatory body noted, in relation to criterion 36, the requirement that at least one faculty member should be a chiropractor at the same level as Head of School. They noted that they did not this specifically, although it is assumed that their registrants will be involved in educational delivery to the appropriate level. They would not expect there to be a professionally registered person at the same level as the head of school necessarily as professional heads can be distinct from administrative heads and at a lower level.

Students (criteria 38 - 41)

15. A regulatory body raised the question as to whether Welsh should be accepted as an alternative language to English as it is an official UK language.

16. A regulatory body queried the reason for criterion 40 requiring schools to submit outcomes of FTP cases to the GCC and wondered what action was taken as a result. They do not require this at present.

17. Layout problems were noted in this section.

No comments were received on the following sections:

- Institution (criteria 27 - 28)
- Resources (criteria 29 - 30)
- Research (criteria 42 - 43) except for layout problems being noted.

- The appendices – except that they appeared to be useful and accurate.

3.12 Further comments

Few additional comments were received in the 'other comments' section. Where they were made, they thanked the Council for involvement in the consultation (a student society, another regulatory body and a higher education organisation), emphasised support for the amendments made, noted that the criteria compared favourably with other healthcare professions (patient group), noted that the document was well set out and easy to understand, and applauded the Council for its use of plain English.

4. Conclusions and recommendations

Given the outcomes of the consultation described in the previous sections, it can be concluded that the vast majority of the proposals made in the consultation version of the Degree Recognition Criteria had the broad acceptance of respondents to the consultation.

The Education Committee gave consideration to a number of specific aspects in the report and the Degree Recognition Criteria and its recommendations are set out below.

The Education Committee agreed and recommends to Council that:

1. the philosophy of chiropractic should be deleted from criterion 4(a) based on the reasons outlined in the consultation document. In addition the guidance relating to criterion 4(a) should be improved so that it does not include specific references to particular chiropractic approaches as chiropractors are required to provide evidence-based chiropractic care.

2. a new programme outcome should be introduced in criterion 10 relating to the 'professional accountability and the protection of patients' focusing on the need for students to self-regulate their own practice and raise any concerns of poor practice (ie a fitness to practise related outcome)

3. credit ratings should be used to specify programme level and length in contrast to the specification of time in hours which is used in the extant criterion. In addition it should allow for different models of degrees to emerge consistent with UK and European frameworks. (criterion 11)

4. the specific criterion related to the research project in the extant degree criteria (no: 15) should be deleted consistent with the advice from the Quality Assurance Agency that this is normally a matter for the validating institution to decide in the context of the programme outcomes that have been set (ie criterion 5)

5. the requirement that students who failed any of the degree components after a resit must repeat the full diet of modules for the year should be deleted from the criteria (criterion 16 in the extant version of the Criteria)

6. student learning in clinical practice should be encouraged throughout the chiropractic degree programme as this will support student learning and the development of practice (slight modification of wording to criterion 17c)

7. the requirement that students need to assess and care for a set number of patients during the clinic period should be deleted as a clearer specification of the outcomes for the clinic

period, and the relationship of this to the programme outcomes, has been introduced to ensure that students are fit to practice (criterion 19). Guidance should focus on the normal expectation for students assessing new patients.

8. criterion 22 in the consultation version of the criteria should be deleted as it related to the encouragement that providers could give to students in relation to their extra-curricular activities and is not a requirement of the degree programme

9. the criteria should be broadened to allow for different forms of clinical opportunities to be used in the final clinic period ie not just provided within a student clinic based in the college (criterion 30)

10. criterion 34 should be broadened to include the following statement "all staff involved in student teaching and assessment must be competent in enabling students to learn effectively and assessing student achievement". This would then negate the need for a separate criterion related to the summative assessment of students as considered in the consultation.

The detailed recommendations for change have been made in the accompanying post-consultation version of the Degree Recognition Criteria so that the Council can see the proposed full version of the document.

The Council is asked to decide whether the proposed revised version of the Degree Recognition Criteria should be accepted.

LM 02/05/10

APPENDIX 1 CONSULTATION RESPONSE FORM

QUESTION	YOUR RESPONSE
SECTION A: INFORMATION ABOUT YOU	
Name	
Are you responding on behalf of an organisation?	Yes / No If yes, please state which organisation your response is for.
Address	
Email address	
Telephone number	
SECTION B: SPECIFIC CONSULTATION QUESTIONS *Please identify in the relevant box your responses to these specific consultation questions*	
1 Are you in agreement that it is appropriate to delete the requirement for students to understand the philosophy of chiropractic (in the criterion 4c) as it is not currently required in any of the other worldwide chiropractic jurisdictions? If not, please explain why the philosophy of chiropractic should be included and what exactly would be meant by reference to it.	
2 Given current practice in higher education, do you agree that it is appropriate to specify the level and length of the course with reference to its credit rating rather than using a time specification?	

QUESTION	YOUR RESPONSE
Please explain the reason for your answer. (see criterion 11)	
3 Should it be a requirement that the undergraduate research project is at the same level as the final degree classification? (see criterion 15)	
4 Are you in agreement with the removal of the requirement for students to repeat the full diet of modules in a year if they fail any component or resit? If not, please explain why this requirement should be retained. (see criterion 16)	
5 This consultation version of the Degree Recognition Criteria has removed the requirement for students to assess and care for a specific number of patients during the clinic period. Do you agree that rewritten criterion 19, and the programme outcomes set out in criteria 4-10, will be sufficient to ensure that students are fit to practise when they graduate?	
6 Criteria 20 – 21 have been rewritten to allow for different forms of clinical opportunities to be used in the final	

QUESTION	YOUR RESPONSE
clinic period. Are the criteria sufficiently robust to ensure that students are fit to practise when they graduate?	
7 Criterion 35 introduces the requirement for those involved in summative assessment of students against learning outcomes needing to be competent to assess those outcomes. Is this sufficient as a requirement, or should there be additional requirements/guidance here such as how assessor competence would be assessed?	
SECTION C: General consultation questions	Please identify in the relevant box below any aspects of the criteria and guidance that need to be changed and the reasons for this
Section 1: Introduction Includes: • Statutory powers of the GCC • Content, structure and format of the document • Links to other quality assurance systems • Recognition process	
Section 2: Recognition criteria related to content Includes: • General criteria on content (criteria 1 – 3) • Programme outcomes relating to the knowledge and skills that form the basis of chiropractic (criterion 4) • Programme outcomes relating to research and	

QUESTION	YOUR RESPONSE
evaluation knowledge and skills (criterion 5) • Programme outcomes relating to assessment knowledge and skills (criterion 6) • Programme outcomes relating to the knowledge and skills needed for chiropractic care (criterion 7) • Programme outcomes relating to communication with patients and other healthcare professionals (criterion 8) • Programme outcomes relating to the knowledge and skills needed to be an independent primary care practitioner (criterion 9) • Programme outcomes - the knowledge and skills needed for professional accountability and the protection of patients (criterion 10)	
Section 3 Recognition criteria related to the nature of the degree programme and programme providers Includes • Level and length of course (criteria 11 – 12) • Teaching and learning methods (criterion 13) • Assessment methods and regulations (criteria 14 - 16) • Programme structure (criterion 17) • Clinical experience and practice (criteria 18 - 22) • Programme planning and review (criteria 23 - 26) • Institution (criteria 27 -	

QUESTION	YOUR RESPONSE
28) • Resources (criteria 29 - 30) • Staff (criteria 31 - 37) • Students (criteria 38 - 41) • Research (criteria 42 - 43)	
Appendices A Flow chart of recognition process B Specimen programme for a recognition visit C Further information on the Quality Assurance Agency Higher Education Framework and the Scottish Credit and Qualifications Framework D Annual monitoring proforma for each recognised chiropractic degree programme E Submission documentation for recognition of a chiropractic degree programme	
Please add here any other comments you wish to make	

Many thanks for your help with this consultation and with your response.
Please return your form electronically by Wednesday 10 March 2010 to:
Lindsay Mitchell at Lindsay.m@btclick.com

APPENDIX 2 RESPONDENTS TO THE CONSULTATION

Current education providers	1. Anglo-European Chiropractic College - AECC 2. The Trustees of the McTimoney College of Chiropractic - MCC 3. Welsh Institute of Chiropractic - WIOC
Student associations	4. Student Union, MCC 5. WIOC Student Society
Professional associations	6. British Chiropractic Association - BCA 7. McTimoney Chiropractic Association - MCA 8. Scottish Chiropractic Association - SCA 9. United Chiropractic Association UCA
	10. College of Chiropractors
Public and patient representatives	11. College of Chiropractor's Lay Partnership Group *The Chiropractic Patients Association confirmed that they were in agreement with the response of the LPG*
Other interested parties • other education providers that have previously expressed an interest in the work of the GCC • Councils on Chiropractic Education International (includes European Council on Chiropractic Education) • other UK regulators	*Other education providers* 12. University of Cumbria *(The University of Central Lancashire stated that as they had decided not to proceed with the development of a chiropractic degree at the present time, they believed it inappropriate to make a response.)* *Other UK regulators – through the Education Inter-Regulatory Group* 13. Higher Education Academy Subject Centre for Medicine, Dentistry & Veterinary Medicine (responding on behalf of the Higher Education Academy). 14. Nursing and Midwifery Council 15. General Osteopathic Council *An informal meeting was held with the General Medical Council to learn lessons from their recent work on Tomorrow's Doctors*
Members of the GCC Education Committee	16. Alan Breen
Advice sought	*Specific advice was sought from the Quality Assurance Agency on the level of the research project to ensure that final decisions were consistent with QAA requirements.*