GCC Code consultation

Feedback report

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community research

Bringing the voices of communities into the heart of organisations

Contents

1. Executive summary

1.1 Introduction

The GCC Code encompasses both Standards of Proficiency and Standards of Conduct and Practice for chiropractors. Following engagement with the sector, the GCC has now drafted a new version of the Code and launched a formal consultation on the content which ended on the 27th September 2024.

In total, 121 responses were received in response to the online survey; the majority of which were registered chiropractors. The online survey was supplemented by a series of events, including events convened in partnership with the Professional Associations and discussion sessions with specific audiences, including Professional Associations, Educationalists, the Royal College of Chiropractors and those involved in Fitness to Practise proceedings.

1.2 Summary of feedback

The drafting of a revised Code was largely welcomed, in light of changing societal trends, technology and patient expectations since the previous iteration. There were perceived to be few gaps in the content and the expansion of specific areas, namely safety and equality, diversity and inclusion were, by some, felt to be very positive. The other Healthcare Regulators who responded to the consultation were largely positive about the changes to the draft Code, commenting that they are in tune with current developments in the sector and their own revised guidance. They particularly praised the focus on a patient-centred approach.

For each Principle, survey respondents were asked *'to what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to this Principle?*. Overall there were high levels of agreement with this statement for all Principles. Lowest levels of agreement were for Principles D and H (with 78% and 80% agreeing respectively).

The draft Code was felt to be more aspirational in tone than earlier versions. This resonated with some, particularly where it dovetailed with content in the Education Standards. However, this change was also felt to be problematic by some. There was some confusion about what registrants are now expected to do and what they should do in an ideal world or if possible. This ambiguity was specifically highlighted by those involved in Fitness to Practise proceedings who felt that it would cause issues with associated decision making.

If all the Standards are something that chiropractors *must* do, then there was significant concern about the sheer volume of requirements and the shift away from minimum standards (and linked to this, the lack of distinction between those Standards that are really important and those that are just desirable). Comments about this aspect of the draft Code were made in relation to all of the Principles, but

particularly focussed on the new Principle H '*Foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice*'. Practical challenges in relation to meeting these standards were flagged, particularly for those registrants working in different settings and relating to the feasibility of collaboration with other professionals.

Some respondents suggested that their concerns would be ameliorated by greater clarity over the key standards registrants '*must*' meet, combined with a reduction in the number of these mandatory Standards i.e. more Standards being designated as those which registrants '*should*' meet or the inclusion of qualifying phrases, such as 'where appropriate'.

There was some concern expressed that the revisions to the Code represent a narrowing of the scope of practice and/or greater prescription in terms of how things are done. This was particularly the case in relation to Principle D '*Provide a good standard of clinical care and professional practice*'. Some felt that this perceived prescription could be detrimental to patient care and could potentially result in an increased number of Fitness to Practise cases (potentially as a result of malicious complaints). The use of the term 'evidence-based' throughout the draft Code served to reinforce this sentiment as it suggested that clinical recommendations must be backed up by published scientific papers rather than evidenced by experience of clinical practice.

There was also some call for greater clarification of specific requirements in relation to the reporting of safety incidents, concerns about colleagues and safeguarding issues. Linked to this, there was some uncertainty about how the draft Code links with employment law (and other legislation, for example that relating to advertising and promotion).

Finally, there was some commentary about the acknowledgement in the Code of the responsibilities of patients (as well as chiropractors) and greater clarity about expectations of chiropractors when ceasing treatment.

2. Introduction

2.1 Purpose of the report

The GCC will respond to the feedback received as part of the formal consultation in the form of a report setting out the consideration given to representations received and any further changes or revisions made to the revised draft Code as a result.

The purpose of this report is to summarise the main feedback received. This analysis and reporting has been conducted by Community Research, an independent research company.

2.2 The consultation

The GCC Code encompasses both Standards of Proficiency and Standards of Conduct and Practice for chiropractors. The GCC last consulted on the Code in 2015, with the Code coming into effect in 2016. Following engagement with the sector, the GCC has now drafted a new version of the Code and launched a formal consultation on the content which ended on the 27th September 2024.

In total, 121 responses were received in response to the online survey; the majority of which were registered chiropractors. Further details on the demographics of respondents are provided in Appendix 5.2. Ten of the 121 responses received were from membership bodies, companies, organisations and charities. A list of those who responded is provided in Appendix 5.1.

The online survey was supplemented by a series of events. Three consultation events for registrants were convened in partnership with the Professional Associations and seven discussion sessions were convened with specific audiences, including Professional Associations, Educationalists, the Royal College of Chiropractors (RCC) and those involved in Fitness to Practise (FTP) proceedings (Expert Witnesses and the chairs of the Investigating Committee (IC) and Professional Conduct Committee (PCC)).

2.3 About the analysis

Responses to the survey were coded as to whether they were a positive, negative or actionable comment. This coding was completed by the GCC and reviewed by Community Research.

By their very nature, public consultations are not necessarily representative of the general population. As they are open access, any individual or organisation can submit their views and those who have an interest in (and who have the capacity to respond) are more likely to participate in a consultation than those who do not. For this reason, the approach to consultation analysis tends to be qualitative rather than quantitative – we are interested in the range of views held and who said what, rather than focusing on the number of responses. The main aim of the analysis is to

explore areas of agreement and disagreement and the reasons given. We have, however, conducted some frequency analysis in order to understand the volume of views and the characteristics of the people with particular opinions.

In terms of the survey responses, it should be noted that not all respondents answered every question and not all responses related to the question asked. Some responses related to other consultation questions and some to issues not explicitly asked in the consultation.

Some of the percentages shown in the charts do not sum to 100% because of rounding.

Some responses included detailed information. It is not possible for us to include this detail in a thematic report of this nature (but the full information is being reviewed by the GCC).

2.4 About the report

This report is structured to provide a thematic overview of the feedback. Views of those who responded to the open access consultation (who are self-selecting and called 'respondents') are distinguished from those who participated in more structured stakeholder engagement events (who are called 'attendees').

Throughout the report, quotes have been included to illustrate particular viewpoints. It is important to remember that the views expressed do not always represent the views of all those who participated in that specific event. The attendees have been aggregated with the exception of the RCC who gave explicit permission to be identified. Quotation attributions by stakeholder type in relation to survey responses are those selected by the individual themselves when completing the survey.

3. Key themes

3.1 Positive feedback

There was positivity about the overall approach to the drafting of the new draft Code and the amount of work and engagement with the sector that has gone into its development. It was commented that the revised Code is long overdue given societal and technological changes since 2016. The renaming of the Code to the Code of Professional Practice was also well received.

> The Royal College of Chiropractors congratulates the GCC on the quality of the work that has contributed to the production of the proposed new Code and the thoroughness of the process it has used to consult on the document…We believe the new Standards incorporated into the proposed new Code will contribute significantly to improvements in the safety and quality of care provided by GCC-registered chiropractors.
>
> Survey response from the RCC

> The updated code represents an appropriate and well written update of the existing one, reflecting changes within healthcare generally, regulation, and issues affecting the profession, with the aim of enhancing patient care.
>
> Healthcare Regulator

The extended coverage of the draft Code was welcomed by some, with specific praise for elements of the new Principle B on Safety and the strengthening of equality, diversity and inclusion (EDI) requirements.

> I think back at the original Code and you look at this Code and you think of the all the elements that are now a part of that in terms of EDI, you know confidentiality information, you know information and data protection, etcetera, all those sorts of things are now part of that framework….So absolutely, it's raising the bar, to be honest.
>
> Educationalist session

> The [named Healthcare Regulator] is supportive of the changes to these standards. This Principle is focused on specific patient safety processes and more specific than the [named Healthcare Regulator] standards which are outcomes focused.
>
> Healthcare Regulator

The strengthened links with the Education Standards were singled out for approval at the Educationalist event.

> I think the fact that these Standards map and sync very nicely with the Educational Standards as well is really strong, and both documents I think can

> be seen to be to protect the public…so you're seeing that continuum from education into professional practice.
>
> Educationalist event

The use of the shared values and links to patient feedback and engagement were welcomed.

The provision of a mapping document where changes can be seen at a glance was felt to be helpful, particularly highlighting those areas which have been strengthened. Although it was noted that this could helpfully also include any specific points that are no longer in the Code.

> And I particularly like…the mapping document where we could compare across the codes. It's really, really helpful and shows areas where you strengthened the code, some of the newer areas that have come in.
>
> RCC event

3.2 Focus on patient-centred care

The explicit focus on putting patients' interests first was praised by the RCC and a number of the other Healthcare Regulators.

> It is good to see the move towards explicit patient-centred requirements, as well as requirements for registrants to be more proactive. These include requiring registrants to:
>
> - ask what matters to the patient (A2),
> - actively look for signs of abuse in children and vulnerable adults (A8),
> - actively identify and control risks (B3),
> - raise concerns about unfair or discriminatory behaviour by others (C12), and
> - to take action in response to inappropriate behaviour, particularly the explicit reference to inappropriate behaviour towards colleagues, as well as towards patients (H5).
>
> Healthcare Regulator

> The [named Healthcare Regulator] welcomes the patient centric updates to the Principles and the inclusion of wellbeing outside of more narrow definitions of health. The focus on actions rather than attitudes is in line with the [named Healthcare Regulator's] own updates to our standards of conduct, performance and ethics.
>
> Healthcare Regulator

3.3 Minimum standards or aspirational approach

A point raised extensively in the consultation feedback related to the intention behind the Code and whether it aims to set basic, minimum standards that chiropractors must adhere to or it is aiming to be more aspirational. This was

compounded by some confusion over the use of language, specifically 'must' and 'should' as discussed Section 3.4.

It was queried whether a chiropractor, by not meeting these (higher) standards, could be sanctioned if the Code is aspirational and that this has implications for future Fitness to Practise processes.

> I always think every point, every line, should be a question. You know, what's the Fitness to Practise question on the back of that issue?
>
> Professional Association event

> To a large extent the new Code is not setting a minimum standard for registrants to meet but is rather aspirational in nature which is unreasonable and likely unachievable by the average registrant.
>
> Survey response from Individual Chiropractor

> I think it is not clear sometimes what the threshold is for a breach of the Code. Some Standards are very clear and prescriptive. Others seem to be straying into minor issues which in and of themselves would be unlikely to reach the threshold for unprofessional conduct.
>
> Survey response from Educationalist

It was mooted that the Code is not the best place to think about best practice and the more aspirational 'gold standard' (which could be done in education or by the RCC).

> This particular point with A8 is that we are being expected to, I think, go beyond what is our scope of practise, what is our training, and I don't think the right approach…Okay, we are putting it into educational institutions, we want to build this skillset within the profession, that's from the bottom up; that makes sense. Right? But then top down, that means that every chiropractor is then held to this standard which they may not be trained or skilled to do.
>
> Individual involved in FTP proceedings (at event)

> So, with the nature of regulation as it is currently accurately identified above is to set the minimum acceptable standards, the essentials, however we feel like the general proposed Code that follows contradicts this intention by going above and beyond the minimum regulatory requirements, straying a little bit too far maybe into best practice and gold standard
>
> Professional Associations event

There was a call for the GCC to consider the impact of the changes to the Code as a whole and ensure that they are not placing too much burden on chiropractors, particularly those working in single practice. It was felt that the communication of requirements in relation to the Code is key.

> It does cut out the low standard chiropractor that actually causes us concern. That's what it does. It helps with that and it gives you the Standards for it. I just would be very conscious of that middle level chiropractor who is working on their own and this gives them an extra burden that maybe causes them some concern, and how that is communicated to them…It's a standard that they should be meeting anyway rather than a burden, if you understand me.
>
> Individual involved in FTP proceedings

Linked to this, others also called for the draft Code to be stress tested considering the impact on those working in different settings and circumstances.

There was some mention that the Code is longer than previous versions and there is some perceived duplication across Standards.

> I just think that sometimes the desire when you're writing a new draft of something, it feels like you need to sort of create more out of it for more clarity, but sometimes more clarity comes from doing less.
>
> Professional Association event

It was questioned whether the changes to the Code are in response to the profession being perceived as 'unsafe' and whether the expansion of the Code is proportionate. Two Professional Associations commented that there is a sense that the introduction to the Code sets a negative tone and some individual chiropractors commented in a similar vein.

> It would perhaps also be welcomed if there was an acknowledgement that the vast majority of chiropractors have met and exceeded Standards within past codes, and this is an evolution of that.
>
> Survey response from Professional Association

> It does seem to make the assumption that chiropractors are unsafe. There are about 40 million chiropractic patient encounters every single year. There is very little that comes out as being chiropractors are unsafe. So the force behind this does seem a bit misplaced to me anyway.
>
> Individual involved in FTP proceedings (at event)

3.4 Clarity over 'must' and 'should'

Attendees at a number of the sessions and some survey respondents felt strongly that the Code could be clearer about what are things that chiropractors must do as opposed to those that they should do, relating back to the overarching point about minimum standards versus aspirations. There was some sense that this aspect was clearer in previous versions of the Code. There was evident concern about this perceived confusion and the implications for how the Code would be used in both Fitness to Practise processes and education.

A Healthcare Regulator's survey response noted that there was strong support in consultation feedback on their standards for the continuing use of '*you must*' and '*you should*'. This was regarded as a well understood signal about the expectations for each specific duty set out in the guidance.

Some of this uncertainty appears to be a result of formatting issues in the version of the Code that was consulted upon[1].

> We must use outcome measures, so we're saying these are 'musts' because for me I wouldn't necessarily, although it's things chiropractors should do, is this the threshold of minimum standards or are these more?
>
> Educationalist event

> Often in Fitness to Practise determinations there are individual Standards that had very specific points. But sometimes it was a more general issue and what you could do is you could go to the introduction of the Principle and it says, right, chiropractors *must* look after patients, or whatever, and that was quite useful…. So some places it's caught, but I'm just worried in a few places that there are things missing from that.
>
> RCC event

> I've written disciplinary civil criminal reports using all four iterations of previous regulatory frameworks, I don't think I could do so using this one because there is no imperative anywhere in any of the Standards. So it doesn't say chiropractors *must*, chiropractors *should*. Some of the statements appear to be aspirational.
>
> Individual involved in FTP proceedings (at event)

If all the Standards are something that chiropractors must do, then there was concern about the sheer volume of requirements and the shift away from minimum standards (and linked to this, the lack of distinction between those Standards that are really important and those that are just desirable). This links back to the debate about which standards are aspirational here.

There were mixed views on whether there is room for 'should' in the Standards or not. Some felt that the inclusion would cause issues but others that it offered a way of distinguishing between Standards that are non-negotiable and those that chiropractors should endeavour to meet (but that they will not be penalised if there is good reason that they cannot).

[1] The overall introduction to the consultation version of the Code does state that all Standards are 'musts', unless otherwise indicated, but this was not identified by some respondents as it was not repeated in the introduction to each Principle..

> I always think the 'musts' is clear, that's what you have to do. I think the 'shoulds' are important in terms of you should be doing this unless you've got a good reason not to. And there might be a jolly good reason not to do something. But if you are putting everything as a 'must', then we are talking about putting people into a situation where there is an FTP situation and there is no defence.
>
> Professional Association event

> You either take out all the 'shoulds' so it's a much smaller Code of 'musts' and you put those 'shoulds' into best practice, and then it's really, really small and clear. Or…you put the 'shoulds' in as 'shoulds'. At the moment it's gold standard and, because there is no 'shoulds', it's all gold standard as a 'must'. So I think either take out the gold standard and have it as a minimum standard, or pile in a load of 'shoulds'. But at the moment it doesn't actually do either.
>
> Professional Association event

There was some discussion about whether the intention is to return to the ethos behind previous Code versions.

> Well it's trying in many ways to do what the 2010 Code used to do. It had a regulatory framework with fairly brief and fundamental Principles, and then it had a separate section that demonstrated how chiropractors could best fulfil these. And I think what it's trying to do is take a fundamental Principle: showing respect, compassion and care for the patient, and then include within the regulation what a chiropractor *must* do as opposed to *might* do or *should aim* to do. And therefore you are bringing it into the UPC framework rather than perhaps separating the fundamental core requirements of a chiropractor and how they can best fulfil these.
>
> Individual involved in FTP proceedings (at event)

3.5 Relationship to other healthcare standards

The other Healthcare Regulators who responded to the consultation were largely positive about the changes to the draft Code, commenting that they are in tune with current developments in the sector and with their own thinking/revisions to their own guidance. This was particularly the case with newer standards introduced in relation to patient-centred care (see Section 3.2), but also relating to registrant proactivity, safety, new technology and EDI.

> We note the proposed ten Principles which feature in the Code (Principles A-J) and we welcome the reflection of the findings of our review of [named own Standards] in the following areas where new standards have been created – Principles A, B, C, D, G & H
>
> Healthcare Regulator

However, it was queried by others whether the GCC was holding chiropractors to higher standards than those required by other healthcare regulators. It was also pointed out by some that, whilst the changes made to healthcare professions' standards more widely should be considered, the Code should not just replicate what is in the guidance of other regulators given the very different nature of chiropractic.

> Of course, if another regulator has brought in a new point to their regulatory code of course the GCC should consider it. It would be foolish not to. But to automatically include it simply because it appears in some other healthcare's regulation and however irrelevant it is to chiropractic; I think is wrong
>
> Individual involved in FTP proceedings (at event)

> There appears to be an inordinate number of Principles to be adhered to, many of which are doubling up on others and are therefore superfluous. More regulation and regulatory principles do not equal better regulation and enhanced patient safety, only more confusion for registrants and patients. When compared to the GMC and GOsC documents, we appear to be overly zealous in our chiropractic regulation and being able to micromanage our registrants in this way will not be conducive to better standards.
>
> Survey response from Professional Association

Linked to this, a general point was made that the Code needs to reflect the fact that chiropractic care is generally a paid for service rather than accessed through the NHS. Those having treatment may see themselves as customers rather than patients and this nuance needs to be considered in the Code.

3.6 Perceived narrowing of scope

There was some concern expressed that the revisions to the Code represent a narrowing of the scope of practice and/or greater prescription in terms of how things are done. Some felt that this could be detrimental to patient care and could potentially result in an increased number of Fitness to Practise cases (potentially as a result of malicious complaints).

> We understand that obviously patients have to be protected but if it gets to that point where we're narrowing the scope to such an extent that actually they're not actually getting what they should be getting, or we're not delivering what we want to deliver in the best interests of the patient, then could that be detrimental to the patient even though we're protecting them.
>
> Professional Association event

> And looking at the new Code, that seems that may almost open up the door to more of that if you just simply don't like the way somebody practises down the street. What reassurance can you give to the registrants that that's not the case or indeed is the case?
>
> Professional Association event

> So we need to be very mindful that, if we have a Code that seems to be placing a massive spike in terms of regulatory obligations, then be ready for the avalanche of complaints that will follow that; not all of which will be justified.
>
> Individual involved in FTP proceedings (at event)

A small number of respondents to the survey expressed concern that the Code was drafted in such a way as to favour those practising certain types of chiropractic care. References to 'evidence-based' care served to reinforce this view (see Section 3.9). A very small number of individual chiropractors indicated that they may consider leaving the profession as a result.

> Myself and other colleagues are suspicious about this Code revision. On the one hand there are many laudable aims and additions to the Current code. On the other hand many of us fear that the sections with regard to 'evidence' are disingenuous, and are included for ulterior motives.
>
> Survey response from Individual Chiropractor

3.7 Legislative requirements

There were a number of comments in relation to how legislative requirements are referenced in the Code typically centred around the following two points:

- A sense that the expectations of chiropractors' knowledge of legislation are onerous and that requirements could be clearer and more specific. There was some strength of feeling about this from the survey responses. It was felt that other healthcare professionals would not be expected to be familiar with the GCC Code.

> It [C3] sort of talks about the fact that we should be knowing about other regulators' codes as well. I just kind of wanted to confirm. I'm getting the flavour from this call that it's kind of a spirit of professional behaviour rather than necessarily the specifics, but that reads very much like you want registrants to read all the other regulators' codes.
>
> Professional Association event

- Some confusion about how Code is linked to the statutory requirements, particularly in relation to employment law and advertising/promotion.

> I believe employees would fall into employment law and is not within the remit if the GCC. I would hope that if a staff member did not adhere to this Principle [E2] that the patient would first seek help from the employer or the chiropractor, who could then investigate and take appropriate action through appropriate employment law.
>
> Survey response from Individual Chiropractor

3.8 Precision of language

There was some praise for the work that has gone into trying to ensure that the new version of the Code is clearer in terms of the expectations of registrants.

> I think it's a vast improvement. There were lots of very wishy-washy comments in the past that are made very specific here. There are comments when we go through it, but in broad terms I think it's a vast, vast improvement.
>
> RCC event

However, there was a call at many of the sessions for greater precision in terms of language and phraseology used.

> If we as a group, are having to thrash this out and have a conversation, about what does that really mean, then the Code needs to be clearer because when we teach it, people go well what if it's this and what if it's that and we can't answer it?
>
> Educationalist event

> I do think an awful lot [in relation to Principle A] of them are frankly waffly. And I'm putting my expert hat on here and thinking, you know, if I'm trying to establish whether there was breach of duty of care for a civil case, if I'm trying to establish whether the actions of a chiropractor fell considerably below the standards expected…There is so many things there that you just can't measure.
>
> Individual involved in FTP proceedings (at event)

There was some debate around the use of the 'evidence-based' in the document and the implications of this for the profession and practice on the ground. This is discussed further in Section 3.9.

There are some specific terms like 'thorough case history', 'complex health and social circumstances', 'near misses', 'concerning behaviour' and 'emotional' boundaries that were felt to be open to interpretation. There was a call for the glossary to be reviewed to check that it is comprehensive.

> "A near miss is an event that almost causes harm or damage but doesn't fully happen." I mean a more woolly phrase one couldn't ask for, could we?...Almost causes harm. What's harm? What's damage? It didn't fully happen. It's so ephemeral. It's fodder for the lawyers, isn't it, not for the chiropractor?
>
> Professional Association event

Interestingly, at the Expert Witness session there was a point of view that sometimes it can be useful to use terminology that allows for some interpretation. The example of 'thorough' case history was given at D1.

> Can we just head back into 'thorough' because I picked up on 'thorough' too. I thought to myself that was very black and white. It had absolutely no grey to it. I would prefer to see something along the lines of 'close' because 'close' in its definition actually means careful and thorough.
>
> Individual involved in FTP proceedings (at event)

3.9 Use of the term 'evidence-based'

There was some debate at many of the sessions and in the survey responses around the use of the 'evidence-based' in the document and the implications of this for the profession and practice on the ground i.e. does it mean clinical recommendations must be backed up by published papers or can they be evidenced by experience in clinical practice and substantiated using outcome measures during progress examinations? This was also raised in relation to advertising standards which is discussed more in Section 3.10.

> I think the issue there is that you've got those definitions of evidence that make so much sense and they're all based on Sackett. So the idea essentially is that you've got the best available evidence, the patient's needs and wishes, and your skills and experience, and I think everybody would completely subscribe to that from a patient-safety perspective. But then, on the back of that, you've got the acceptable quality of evidence side that suggests that there needs to be, you know, meta-analysis or RCTs. Well that then negates clinic audits or clinical reflection, or what you see in your practice or what you find that works really well for certain patients within your practice. And certainly that then stifles practise. And it's those little bits of definition, which

> from an academic perspective again I think we are all behind, we want to do the best we can do, but actually practically that is a concern.
>
> Professional Association event

> There is a lot of reference to evidence-based, you know, guidelines without being specific. It sets the tone that we are using invalid and poor examination techniques. I mean it doesn't seem to be referencing practitioner experience. Because earlier in the document it seems to minimise practitioner experience. So it's repeated multiple times. So I'm just wondering what the intent is on that.
>
> Individual involved in FTP proceedings (at event)

> Evidence-based is used multiple times within the document and Principle D. However, the tone is that Chiropractic practice inherently lacks evidence which is not the case in the true meaning of the statement. There needs to be explicit acknowledgement as in the existing Code that practitioner and patient preference is part of evidence-based care.
>
> Survey response from Professional Association

Two Professional Associations suggested the use of the term 'evidence-informed' as the base expectation for registrants. It was felt that this allows for the use of evidence to be part of the Standard, but also acknowledges there is a lack of breadth and depth in chiropractic evidence due to the relatively young age of the profession.

3.10 Advertising and promotion

Advertising and promotion of services was identified as an area of concern fairly broadly. Clarity over what chiropractors can promote and the guidance that they should adhere to (GCC and/or Advertising Standards Authority (ASA)) were specific issues raised. A Professional Association's response to the survey specifically called for the removed guidance from the 2016 Code to be reinstated to avoid an increase in queries regarding compliance.

> 'Advertising services/promoting your business' is the number one concern from [named Professional Association] members regarding the new Code of Professional Practice. However, much of the guidance from the 2016 version of the code has been removed. The [named Professional Association] suggests that the removed guidance is reinstated to avoid an increase in queries regarding compliance.
>
> Survey response from Professional Association

The relationship between the ASA Standards and the GCC code was also queried at a number of sessions i.e. if chiropractors are not adhering to the GCC Code if they do not follow the ASA code. There were a number of questions that centred around

the perceived divergence of guidance between the ASA and the GCC; specifically a perception that the ASA requires scientific evidence of any claims made in relation to marketing services whereas the GCC has a broader definition of the evidence that they would accept to substantiate claims. This was felt to lead to a potential situation where the GCC would be happy with the content of specific adverts or promotions but they may be in contravention of ASA guidelines or rules.

> The GCC 'allow' us to treat conditions that are not yet 'proven' by science... but the ASA won't like it. Will the GCC support our treatment against the ASA?
>
> Professional Association event

> I think the advertising issue has to almost be spelt out because I think it's such a big issue with registrants that it probably has got to be a bit more specific.
>
> RCC event

Some questions related to what the GCC perceives as suitable evidence for claims, with examples given of whether they can promote treating patients with headaches or whiplash injuries.

> Can I advertise that I can treat whiplash on my clinic website if there is moderate quality evidence for it (e.g. for multimodal care)?
>
> Professional Association event

The use of the word 'verifiable' in C4 was queried as part of the RCC discussions with the concern that it might be too stringent a term in relation to evidence-based practice.

Concerns about being sanctioned for misleading claims was linked to chiropractors being inhibited from marketing their services fully and having a detrimental impact on the business (particularly for newly qualified chiropractors). Clarifications were also asked in relation to the responsibilities of chiropractors who are not themselves responsible for the marketing at a clinic at which they practice

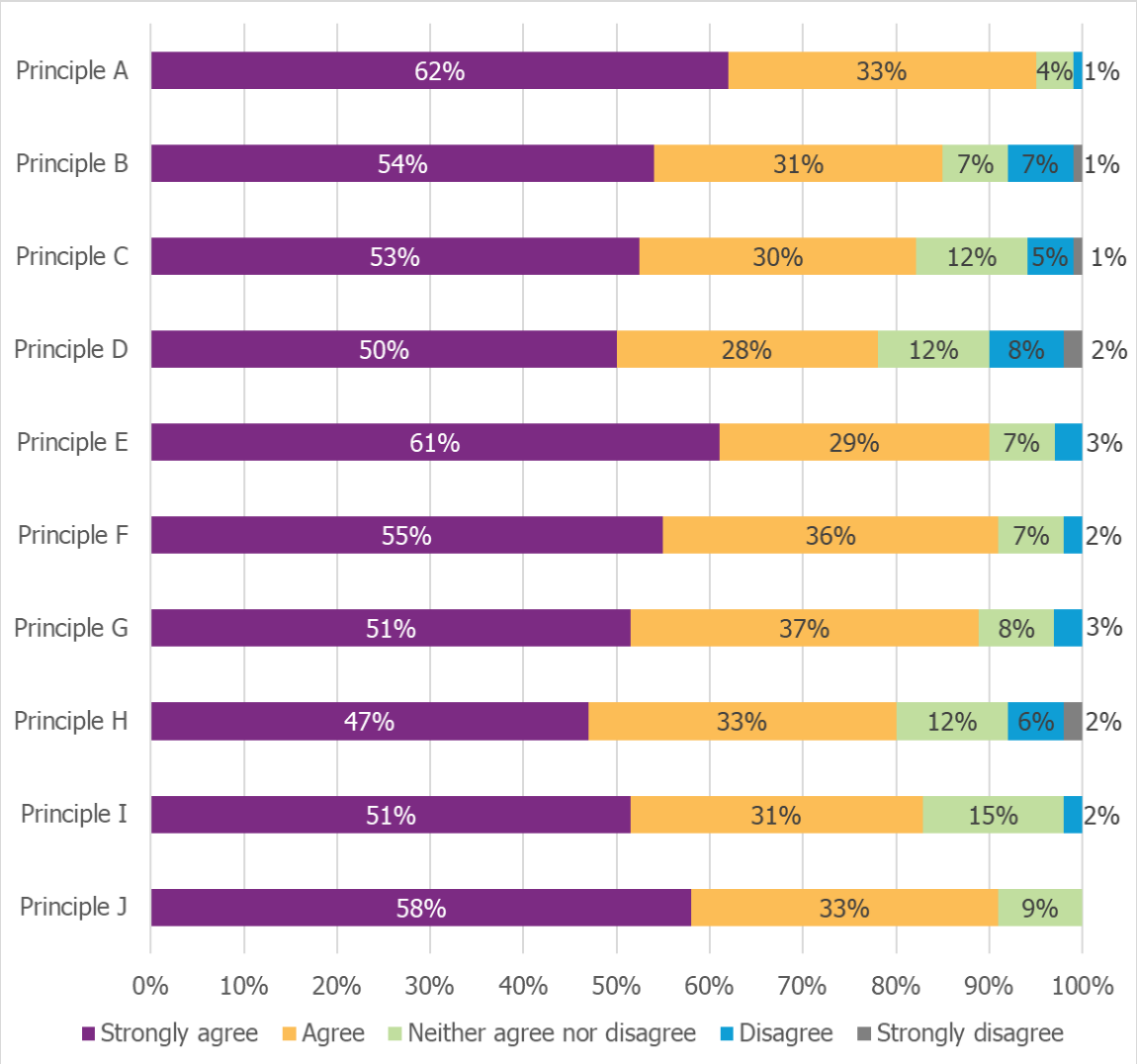
It was also questioned whether the GCC Registrant Guidance on Advertising (2021) remains applicable.

4. Feedback on specific aspects of the Code

4.1 Overall response to Principles

For each Principle, survey respondents were asked *'to what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to this Principle?'*. Overall there were high levels of agreement for all Principles. Lowest levels of agreement were for Principles D and H (with 78% and 80% agreeing respectively). This reflects the debate at the events/discussions which tended to focus on these Principles.

Figure 1 - To what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to each Principle



Base: 121 respondents

More detail on the views on the Principles by stakeholder type is provided in Section 5.3.

The Principles that are earlier in the Code tended to receive more survey comments than those that came later, with most comments centred around Principles B, C and D. Principles F, I and J received comments from fewer than 20 respondents.

Just under half of survey respondents answered the quantitative questions but had no specific comments on detail of the Principles and Standards.

4.2 Principle A – Put the interests of patients first

The patient centred focus of this Principle was welcomed by the RCC and Healthcare Regulators with some noting that updates are in line with other regulators' guidance.

> The RCC welcomes the broadening of Principle A to all aspects of patient interests and the increased emphasis on safety and patient-centredness.
>
> Survey response from the RCC

> This [putting the interests of patients first] is reflected in the proposed review of the Code introducing new standards which demonstrate working in partnership with patients. Standard A3, to engage effectively with the patient through person-centred conversations and interactions and the shared decision-making standard at A4 work with the collaborative standards set out at A5.
>
> Healthcare Regulator

There was also positivity about the broadening of patients' interest to include wellbeing and the requirement for greater proactivity. However, some survey responses, including from a Professional Association, commented that they felt that the Principle should state a patient's *health* interests rather than interests more widely given that this is what chiropractic care is focussed on. There was also commentary about the balance between patient interest and the chiropractors' own interests and wellbeing. It was felt that there should be a better reflection of the reality of practice, consideration of different scenarios and it should be couched in terms of the patient/practitioner relationship.

> Ultimately it must be recognised that chiropractors are humans too and have limitations as to what they can cater for. The Code must consider what is reasonable, proportionate and practical.
>
> Survey response from Individual Chiropractor

Responses highlighted that sometimes patients are not rational in their decision making and that there is a need for chiropractors to help lead, guide and advise.

It was pointed out in survey responses and discussions that A5 '*Collaborate with the patient's family, advocates, carers, healthcare professionals…*' needs to specify that there is a requirement for the patient to consent to this collaboration. It was also queried how chiropractors should prove they are collaborating and whether they

would have the expertise to do so. This Standard generated a relatively large number of comments in the survey.

> It's a very good example of something that is effectively aspirational, being, as you say, a must. So you must collaborate with the patient's family, advocates, carers and healthcare professionals…Well what about if that isn't practical? What about if the patient doesn't want you to?
>
> Individual involved in FTP proceedings (at event)

A6 states '*Respect the patient's privacy, dignity and their right to choose who is in the room when their care is provided'*. It was noted that not all care is provided in a treatment room and that this should also be widened to relate to discussions about care and not just treatment. It was also highlighted that there may be occasions where the chiropractor might want someone else in the room for their own protection but this may conflict with the patients' preferences (and the interpretation of subsequent Standards in the Code). This discussion is linked to that relating to chaperones in Section 4.6.

> It [A6] is phrased very clearly that the patient has a right to choose who is in the room, but later in the Code it suggests there needs to be reasonable discussion as part of determining informed consent.
>
> Survey response from Individual Chiropractor

The vast majority of attendees of one of the Professional Association sessions did not work in open plan clinics. However, there were a number of questions at this session around how 'open plan' treatment would be defined in the Code and what the thinking is around specific guidance/requirements in this respect. This was also queried at RCC discussion:

> I searched for the words 'confidentiality' and 'privacy' and actually didn't find it in many places, and didn't find it obviously in the context of open-plan practice. Now, I don't know whether the GCC is trying to make a point about open plan in this document. I don't think it's made very firmly, to be honest.
>
> RCC event

However, another Professional Association commented that they felt that this Standard has implications for practices that use 'open plan settings'. It was suggested that private spaces should be made available for any discussions, but that registrants should not be expected to change their treatment arrangements and that patients who are not comfortable with this, could seek alternative providers.

The content of A8 in relation to safeguarding children and vulnerable adults was specifically welcomed by a Healthcare Regulator (alongside other Standards which require greater proactivity by registrants; see Section 3.2). A number of individual chiropractors also indicated that the requirement in relation to A8 is in tune the

current education curriculum and responsibilities relating to providing information to individuals. More signposting and guidance in this respect was requested.

However, the Standard was also highlighted as potentially problematic at the Expert Witness session and in responses to the survey. Assessing vulnerability and actively looking for signs of abuse was felt to be outside the scope of many chiropractors' expertise. It was another example of what could potentially be a 'should' rather than a 'must'.

> This Standard [A7] is clearly an evolution of the previous Code; however, we believe its modification and broadening has serious ramifications for a registrant.
>
> Survey response from Professional Association

> A fundamental tenet of the Code is that chiropractors should practise within their knowledge and abilities, and this seems to absolutely fly in the face of that for the majority of graduated chiropractors.
>
> Individual involved in FTP proceedings (at event)

It was also queried what '*local* safeguarding arrangements' are in the context of NHS and care services.

A Professional Association suggested an addition to A2 about outlining treatment options to patients, to expand their understanding outside of chiropractic. Responses from two Professional Associations and discussion at the expert witness session suggested A2 should read 'undue' pressure on a patient as a chiropractor should be advocating a specific course of action or focus on chiropractors, showing leadership in having patients accept their advice.

4.3 Principle B – Ensure safety and quality in clinical practice

In general the introduction of new Principle B was welcomed, in particular by the RCC and Healthcare Regulators.

> The standards at B4 and B6 recognise the importance of supporting the promotion of accessible healthcare and the collection of feedback to evaluate the quality of patient care which contribute to patient safety.
>
> Healthcare Regulator

> We welcome the new principle B around ensuring safe settings for patient care, an aspect which is particularly relevant to chiropractors who will typically be responsible for the treatment setting.
>
> Healthcare Regulator

However, some concerns were expressed about the proportionality of the requirements and the perceived disproportionate burden that it would place on the

profession. This was the view of two Professional Associations and some individual chiropractors who responded to the survey. There was a view that GCC has applied similar Standards to those used by other Healthcare Regulators but that this does not take account of the context and settings of chiropractic care. Other commentators felt that elements of the Principle were ambiguous and called for greater clarity.

> The values that permeate through this Principle are well placed but the execution in several Standards potentially set the bar too high and we feel places reasonable registrants at real risk of complaint.
>
> Survey response from Professional Association

> I question the unreasonable burden placed on a profession that has an excellent safety and customer satisfaction history. We are a small profession with limited resources.
>
> Survey response from Individual Chiropractor

In relation to the new Principle about safety and quality, there were specific questions about [B6] which states that chiropractors should 'apply quality management Principles to continue to improve your practice and service delivery'. More detail was requested about how GCC would see themselves monitoring this and if there are specific expectations in relation to how the practice effects this.

> I wondered if you could give an example of how the regulator would see themselves monitoring that and what that would be? Is there a defined quality tool that is being used there in terms of the management of the practice? And if you could explain how that specifically relates to the safety and care of the patient?
>
> Professional Association event

It was felt that the B6 statement '*collect appropriate feedback, quality and other indicators to evaluate the quality of care of your patients*' should specify quality indicators. It was also suggested by an Educationalist that there could be further guidance on how to collect feedback and that the GCC should ensure that the requirements in this respect aren't too onerous or unfeasible for those working in small practices.

Linked to this, it was also queried what is meant at B5 when there is mention of incident reporting and what is meant by a 'near miss' and 'suitable safety system'. Some asked whether there is an expectation that chiropractors will record very small issues and whether practices will be mandated to use CPiRLS. Others queried if there needs to be a clearer definition of what a 'suitable safety system' actually is i.e. could an email to management or a note to self be sufficient if it led to no specific outcome or prospect of wider learning?

> The RCC welcomes the intention to require registrants to report safety incidents and near misses so that other chiropractors can learn from the collective experience in the best interests of patient safety. However, safety incident reporting systems must be seen as non-threatening, safe places to share experiences for the purpose of risk management/learning only, otherwise they are not trusted. Anonymity is a vital component of this and so it may be unrealistic to REQUIRE incident reporting via a Standard in the Code.
>
> Survey response from the RCC

> If reporting is to be a regulatory requirement, please outline the recommended method, e.g. CPiRLS. Consistency with Standards set by the Royal College of Chiropractors would align expectations across the profession and therefore make it easier for a chiropractor to meet these Standards.
>
> Survey response from Professional Association

At the RCC discussion and in the survey response, it was flagged that specific mention should be made of requirements relating to first aid (at B3 and in Principle I). At the session with Professional Associations, clarification of what 'emergencies' refers to in this context was requested as it could be fairly broad. Two Professional Associations raised an issue with B3 in terms of the requirement to 'control' risks and requested a rethink in terms of what were reasonable expectations of registrants and for examples.

It was mooted that in the title, the word 'quality' should be replaced by 'competency'.

> Yes, I'm saying that competency is more relevant to chiropractic and chiropractors, as opposed to quality which is about a professional standard, which is collaborative.
>
> Individual involved in FTP proceedings (at event)

There was some suggestion in survey responses that this Principle should also recognise the importance of the safety of practitioners (linked to ceasing treatment which is further discussed below).

4.4 Principle C – Act with honesty and integrity and maintain the highest standards of professional and personal conduct

The expansion of this Principle was broadly welcomed by Professional Associations, a Healthcare Regulator and a number of individual chiropractors.

> The standards at C11 - to ensure personal biases, values and beliefs do not detrimentally impact the care provided to patients - and then followed by a duty at C12 - to raise concerns about colleagues if there is a belief that they are treating people unfairly, have discriminated against someone or if their

> personal biases have detrimentally impacted on the care they provide – are an acknowledgement of an awareness in this area which is welcomed.
>
> Healthcare Regulator

However, other individual chiropractors responding to the survey were concerned about its length and level of detail. Again, there were comments about the level of aspiration and some of the perceived onerous expectations on chiropractors i.e. checking that colleagues are registered [C2] particularly for those working in multidisciplinary settings and responsibility to protect others from harm caused by the health, conduct or performance of you or any other regulated healthcare professional [C1]. Some felt that the Code was being written from a standpoint that the profession is not trustworthy and inherently dishonest.

> I feel the Principle is too long with too many Standards. This impacts its accessibility and will be a barrier for chiropractors, students, patients and any other stakeholders to engage with it. Perhaps some Standards could be merged.
>
> Survey response from Individual Chiropractor

C5 on the credibility of health information was welcomed by the RCC and a Healthcare Regulator. The latter felt it may be helpful to clarify that sharing information which is not evidenced based, even when not considered health information, can be damaging to the reputation of the profession. However, others saw this as duplicating C4 and as problematic (linked to the discussion of 'evidence-based in Section 3.9).

> This is probably the biggest bone of contention. A large section of the UK profession feels that this Principle will be used to target chiropractors who offer proper treatment plans with FTP hearings.
>
> Survey response from Individual Chiropractor

Another Healthcare Regulator felt that C4 could also possibly be strengthened further:

> The phrase 'when telling people about your services' may not fully capture the GCC's published position[2] on reviews, testimonials and endorsements. The phrase may be interpreted to mean the requirement only applies to information provided directly by the registrant, when the GCC's blog suggests it also applies to information provided on their behalf.
>
> Survey response from Healthcare Regulator

[2] Reviews, Testimonials and Endorsements - the GCC reminds registrants of their responsibilities | GCC (gcc-uk.org)

'Behave with integrity, act professionally, and honestly, upholding the reputation of the profession and justifying public trust, *in all aspects of your life'* [C6] was felt to be an overreach by some, and potentially result in spurious Fitness to Practise complaints.

It was commented that there is perceived dissonance between the GCC's guidance [C10] and regulatory requirements with Duty of Candour and what you are told by the insurance company when you report a complaint, which is not to offer an apology because it's seen as an admission of guilt.

C14 about concerns about a chiropractor's own fitness to practise could include reference where support is available from and consider adjustments rather than automatically stopping practising.

At the Educationalist session and a number of survey respondents queried whether and how C15 [informing regulator about a dismissal] applies to anyone dismissed by any employer, for example someone dismissed from a university in relation to teaching rather than clinical competence or someone dismissed from an employer because of a personal dispute. It was also questioned how this applies to those who are self-employed and not safe as they wouldn't be dismissed in the same way and whether the duty is on the employee or employer. Finally, it was queried what 'refused membership' means in this context and how the GCC will use this information.

Care and finance plans

At a Professional Association session, there was some concern expressed about clinics that encourage patients to sign up for multiple future treatments at the first session and questions about how this sort of practice would be dealt with in the new version of the Code. Offers such as Groupon in absence of a care plan were also mentioned at Educationalist session. It was felt that this type of selling is detrimental to the profession's reputation as a whole.

> These practices that pressure patients to sign up for 20+ treatments are a disgrace! It is the main complaint about our profession that I hear from GPs!
>
> Professional Association event

As a result some welcomed C9 '*Determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan*' and felt it was an important addition. However, others flagged that it could be perceived negatively externally and have an adverse impact on the reputation of the profession as a whole.

> I think if someone looking at that from other healthcare profession, I think that views us in a very negative light, I don't know it is there. Is there a way to change that or to shape it?

Educationalist event

> This is a welcome evolution from the comments on the registrar's blog earlier this year and we welcome the acknowledgement that financial plans are used and can be beneficial in improving access to care for patients.

Survey response from Professional Association

Whilst there was a call for the Code to be strengthened in this area, it was also pointed out that there does need to be some balance in that any changes do not prevent chiropractors offering discounts or loyalty schemes that would make treatment more affordable and/or adversely affect them as a business.

In response to the survey, some individual chiropractors felt that it was unnecessary to separate conversations about care and payment plans are they are so interrelated. '*Do not offer a financial payment plan that extends beyond the amount of care set out in your initial clinical plan of care for the patient'* was particularly contentious. Some, including a Professional Association, felt change was unnecessary as long as refunds are available.

There was a call for more direct, clearer wording:

> I think what this piece of the Code is trying to say is, look, you shouldn't be getting patients to pay upfront for 100 treatments right at the outset if you don't know how the care is going to progress. I think that's the intent from previous FTP cases. But I just wonder whether the wording needs to be slightly more direct in relation to that, if that's what the intent is.

Individual involved in FTP proceedings (at event)

Ceasing treatment

Issues relating to how to cease treating patients [C13] and how to do this within GCC guidelines were discussed. More detail on how the GCC is intending to approach this was requested.

At a Professional Association session, attendees were asked to respond to a poll question which asked, '*Have you been involved in a situation where you have felt that your safety, or that of a staff member, was at risk from a patient*?' Just under half indicated that this had been the case (with some querying whether female chiropractors were more likely to experience this than male). Some described experiences which had been very upsetting and disturbing.

Concern was expressed about this issue at the session with Professional Associations and in the survey responses from two Professional Associations and some individual chiropractors, with a strong call for clarity that chiropractors could cease treatment if they feel at risk from physical, verbal or sexual harassment and not have to fear being in contravention of the Code. The point was made that GPs are able to cease

treating patients in these circumstances and there could be some learning from how this is handled in the GMC's Standards.

> It's OK to stop treating a patient if you are feeling under threat, it needs to almost have explicit permission in there. I think for our members to feel safe in doing that, it might be like an NHS line that there is zero tolerance against, but I feel that needs to be more explicit.
>
> Professional Associations event

Further clarification of the following was mentioned:

- Who to report the patient to i.e. should the police be involved?
- How the GCC would respond if the chiropractor refused to find an alternative practitioner when halting the provision of treatment (as is stated in C13[3])? It was felt that there could be some circumstances in which they would not wish another practitioner to experience the issues that they had had with the patient.
- If they would be justified in refusing care if the patient is in significant debt to the clinic or if they behave in a racist way (with the suggestion of some qualifiers about this in C11), together with scenarios when it would be acceptable to cease treatment.
- Support with communicating the end of treatment, specifically for those who are concerned about the patient response.

The Code states that chiropractors should '*justify and record your reasons for refusing or discontinuing care for a patient'*. It was mooted that 'support' or 'explain' would be a better term than 'justify' in this instance.

4.5 Principle D – Provide a good standard of clinical care and professional practice

The other Healthcare Regulators were largely positive about the new elements of Principle D.

> We also welcome the tweak to D4 which now refers explicitly to the use of diagnostic imaging…We recognise that the final clause of new D13 (*Support public health initiatives to enhance the health and wellbeing of others*) may come out of the experience of the pandemic, and welcome its inclusion here.
>
> Healthcare Regulator

> We also note the proposed new standards at D13 to D15 regarding clinical care and professional practice, and recognise that the standards are working to the benefit of public health, acknowledging the use of digital technologies in practice enhancement and the use of research in practice.

[3] Explain, in a fair and unbiased way, how they can find other healthcare professionals who could offer care.

Healthcare Regulator

> The [named Healthcare Regulator] welcomes new standards which recognise the role of all health and care professionals to play a role in preventative healthcare and to engage in evidence-based practice.

Healthcare Regulator

Principle D was one area where it was felt by some, including two Professional Associations, that there was too much prescription – that requirements were too onerous and aspirational. There was some feeling from individual survey respondents that this Principle is predicated on a medical model and does not take account of the different types of chiropractic care (and how it differs from other forms of healthcare).

> This Principle as a whole does not reflect chiropractic practice. Many of the Standards are not applicable to chiropractic. It seems like some of the Standards are lifted from a different profession altogether…. If you were catering to only chiropractors who practice completely in a medicalised model, you would be bang-on. But unfortunately, you are not catering to the majority of the profession.

Survey response from Individual Chiropractor

Three Professional Associations and an Educationalist queried the use of 'scope of practice' in the introduction and the latter felt that relevant clinical guidelines are not always available. Linked to the latter point, there was some debate about the use of evidence-based (as per Section 3.9.) Some welcomed the use of the term throughout the Principle. For example, at the Educationalist session, it was questioned whether the wording at D6 'In partnership with the patient' puts too little emphasis on the responsibility of the chiropractor. At D8 '*Do not propose a plan of care that is not justified by a robust, recorded, clinical assessment and reassessment'*, it was queried whether there should be some additional reference to evidence-based. However, others felt that the definition of evidence-based does not take sufficient account of practitioner experience:

> There is very little attention in section D to the importance of basing a good standard of care on valued clinical chiropractic experience and empirical knowledge from case studies in an office and the wider community of chiropractors.

Survey response from Individual Chiropractor

It was mooted that if 'evidence-based' is too narrowly defined, then this could stifle innovation and place too much onus on chiropractors to be abreast of a huge amount of knowledge which was felt to be unrealistic [i.e. at D7 provide evidence-based options provided by other healthcare professionals]. The inclusion of

'expected natural history' was also queried and felt to be problematic by some, including a Professional Association and Educationalist.

Members of another Professional Association raised questions regarding what the GCC would consider an appropriate 'care plan' and it was commented that B6 seems the best opportunity to provide greater clarity.

The requirement to tell the patient if proposed care is not supported by evidence of accepted quality [D6] was also queried, particularly as it was felt that not all patients want all the information about their treatment. The definition of 'accepted' quality was also questioned.

> So I think just based on what you were saying there, what you are expected to say is, "Right, I'm going to do this test now but there is no real evidence to support the outcomes of it." I mean how is that going to pan out in a PCC hearing?
>
> Individual involved in FTP proceedings (at event)

The use of evidence-based outcome measures was flagged as problematic by a number of survey respondents, who tended to see it as an example of the lack of understanding of chiropractic care and unworkable on the ground. Some saw it as a 'gold standard' and aspirational. An Educationalist called for clear guidance and a clear justification for its introduction:

> Given the potential for a significant increase in workload for clinics, it must be justified by an explanation of what problem such a requirement is solving and evidence that outcome measures solve this problem. There must be a clear definition of what outcome measures are permissible and what are not.
>
> Survey response from Educationalist

The RCC welcomed the introduction but felt that 'evidence-based outcomes measures' should read 'validated measures'. It was agreed that this is an important area to consider, that it needs further thought and that chiropractors need clear guidance. Any requirements need to bear in mind the fact that some practitioners will be working on their own in very small businesses. Similar points were also made at the Expert Witness session, particularly as it mentions this should be done 'before commencing care'.

> You could argue that in the Code it should be just a very basic standard, you must measure outcomes objectively. Something simple like that. And then the guidance would expand on best practise in terms of measuring outcomes. To me in the glossary, outcome measure, it reads a bit more like best practise rather than a basic expectation
>
> RCC event

> I think it was the 'agree and document evidence-based outcome measures' that was maybe pushing at a gold standard rather than a standard of a reasonable chiropractor.
>
> Individual involved in FTP proceedings (at event)

D9 specifies '*continuously monitor (and record) the patient's progress…carry out formal reviews at regular intervals*'. It was noted at the Expert Witness session that a formal review is something that is clinically indicated rather than something which should be done by at specified times. It was also flagged that there should be a requirement in the guidance to benchmark against a patient's initial presentation as part of the review.

The introduction to Principle D states that chiropractors are '*expected, as health and care professionals, to engage in interventions that support prevention and health promotion to the benefit of individuals and the population'*. It was queried at the Expert Witness session as to whether this was a reasonable expectation and whether a chiropractor could be sanctioned for not doing this. Similarly, some survey responses, including two Professional Associations, queried the reference at D13 to support public health initiatives, particularly if they are not in line with their beliefs or value system (the example given of Covid-19 vaccinations). However, these additions were welcomed by the RCC and two Healthcare Regulators.

> The RCC welcomes this new Standard which requires engagement with prevention and health promotion interventions and public health initiatives while considering health inequalities.
>
> Survey response from RCC

> In the area of health promotion such as smoking cessation, exercise, dietary advice, etc chiropractors are well placed to discuss this with their patients. However, where the interpretation of this standard provides substantial concern is if we are being encouraged to support public health initiatives that exceed our knowledge. This standard suggests that we would be instructed to do so blindly, even if we may disagree with it on an individual professional, moral, ethical level.
>
> Survey response from Professional Association

The wording of D15 was felt to be ambiguous by some survey respondents. The definition of 'research in practice' at D15 was queried at the Educationalist session. The RCC session suggested that this could be amended to '*when engaging in research, do so ethically and effectively. This may include promoting'*.

Use of technology

It was queried at a number of sessions and by some survey respondents whether there was an absolute requirement for chiropractors to use digital technologies to enhance practice (Introduction to Principle D and D14) or if this was an aspiration. It was felt that this shouldn't be compulsory given the training implications and also that the use of technology isn't always in the best interest of the patient i.e. where risks outweigh the benefits or where used to justify the use of practice-building instruments (e.g. neuraltherm scanners) to enhance practice income. It was suggested that the word 'consider' replaces the requirement to 'use'.

As well as welcoming the change to D4 which now refers explicitly to the use of diagnostic imaging, a Healthcare Regulator also highlighted the need for registrants to consider risks and benefits of using technology.

It was noted that the use of the term 'digital' is ambiguous as to whether, in the context of chiropractic, it means electronic or using the fingers.

The use of the word 'effective' was also challenged – with the suggestion that this should be changed to 'appropriate' as chiropractors can't always guarantee effective care.

There was some discussion about the need to future proof the Code, with the absence of any mention of AI highlighted. It was queried whether there should be specific mention of AI or whether separate guidance was sufficient.

> I was going to suggest was that that maybe the wording needs to reflect the chiropractors' responsibility that as you said, they're not just devolving to AI to do things, they're still responsible for it.
>
> Educationalist event

4.6 Principle E – Establish and maintain clear professional boundaries

The Principle was specifically welcomed by two Professional Associations and Healthcare Regulator.

> [Named Healthcare Regulator] welcomes the updates to these standards and especially the broadened definition of 'relationships' to include interactions with carers.
>
> Healthcare Regulator

Another Professional Association asked for consideration that not all chiropractors work in clinics and some treat sports teams etc. so the Standards need to take this into account.

A number of survey respondents were unclear about the meaning of emotional and financial boundaries and a Professional Association requested further clarification of

the latter. The latter also noted that power imbalances are shifting because of the amount of information available online and other influences.

The inclusion of '*If there is a clinical need for an item of clothing to be adjusted, obtain informed consent from the patient'* at E3 was discussed during the Educationalist session and flagged by a number of survey respondents. It was asked what is the threshold for getting consent (does it depend on what the item of clothing is and how much it is adjusted) and does it need to be recorded?

Use of chaperones

In relation to the guidance in the Code about the use of chaperones, there was some call for the GCC not to be too prescriptive about the requirements in relation to those chiropractors who practice on their own because it may create logistical issues. It was queried whether there is evidence that there are a higher number of complaints in relation to sole workers.

It was also pointed out that it can be difficult for chiropractors to predict when a chaperone may be required in advance of a consultation and that the need for a chaperone during 'intimate examinations' (E4) creates uncertainty as 'intimate' can mean different things to different people.

However, there was some discussion at the Expert Witness session that 'you must, where possible' was not acceptable and that the patient must always be given the option. It was felt that the patient could be offered to come back at another time if the chaperone was not available on that day or for them to be referred to an alternative practitioner. It was noted that the wording around ceasing treatment may need to be reviewed to allow for the latter possibility.

> It says wherever possible offer a chaperone. Does that mean a chiropractor working by themselves without a receptionist who wants to do an intimate examination on a female patient, that isn't possible, so that's fine, just go ahead and do it? I don't think that can be right.
>
> Individual involved in FTP proceedings (at event)

Further advice was requested in relation to best practice about who the chaperone should be i.e. someone linked to the patient or someone independent. In this instance, the chaperone was seen as a means of protecting chiropractors as well as patients (and so the decision whether to have a chaperone is not solely about patient preference).

> I think we agree the need for a chaperone in certain situations, but as sole traders who would you recommend as a chaperone who is a third party (i.e. not a family member or friend of the patient) in order to protect the chiropractor too?
>
> Professional Association event

It was suggested by a Professional Association that instead there is reference to notifying a patient when they book that they may be receiving hands-on treatment in a one-to-one setting so they are welcome to bring a chaperone (as per practice in other health care settings).

4.7 Principle F – Obtain appropriate, informed consent from patients

There were relatively few comments on this Principle in response to the survey or discussions.

It was highlighted that the guidance should be clear about when it is appropriate to ensure informed consent i.e. at which point in the patient journey. Further clarification about GCC requirements in terms of evidencing informed consent was requested at a Professional Association session, particularly whether it is required to get a signature from the patient at every visit. It was felt to be overly burdensome and creating patient dissatisfaction. This was also queried by a survey respondent:

> Clarity on when written or verbal consents are more appropriate. If a patient returns with the same or very similar complaint is implied consent ever acceptable. More detail is needed here in my opinion.
>
> Survey response from Individual Chiropractor

A Professional Association also requested that the GCC consider inclusions regarding AI, digital consent and the use of digital transcribes in addition to 'records'. This would help registrants and would allow for innovation.

It was also asked at a number of sessions if 'informed consent' is the right terminology throughout or if it should be 'valid' consent (as the latter incorporates informed consent, plus other factors such as capacity and its voluntary nature). This was also mentioned by the RCC in its survey response.

One survey respondent queried whether F1 implied the provision of information in foreign languages was expected.

4.8 Principle G – Communicate professionally, properly and effectively

In the survey, there were a few mentions of perceived repetition in places, particularly with Principle F. Some respondents also felt that elements of the Principle were aspirational in nature, for example expecting the registrant to 'use language that promotes patients' health literacy'.

A number of survey respondents queried what 'reasonable steps' to understand and meet the language and communication needs and preferences of the patient [G1] actually meant. A Professional Association felt that the patient could take on more responsibility for their needs in this respect.

There were a few comments about replacing the reference to complaints in G3 with feedback or expressing concerns. It was requested that there is some reference to

frequency in G4 'Communicate effectively with other professionals' (linked back to communication with GPs).

The requirement at G5 to provide information to patients about *everyone* who gives care was read as being providing information on a range of health colleagues working outside the immediate practice and, therefore, too onerous. There was evident confusion about what expectations were in this respect from survey respondents and in discussions.

There was some call for the Code to include guidance relating to clinics making it clear to patients who they are being treated by i.e. if they are seeing osteomyologists or chiropractic assistants (CAs) rather than chiropractors.

> Using the term chiropractic is incredibly misleading when referring to CAs. You regulate it with regards businesses? Why not with CAs?
>
> Professional Association event

The use of the term 'chiropractic assistant' was also flagged as problematic with a Professional Association requesting more stringent guidance on its use.

Two Healthcare Regulators particularly welcomed the inclusion of social media [G6] as did RCC, with the caveat that the latter assume that the Standard is not implying that registrants have to use the internet.

> The standards at G6 of the Code reflect our guidance in this area [around social media use] and recognise that providing guidance around expectations in this area is an important step in maintaining public trust.
>
> Healthcare Regulator

> The [named Healthcare Regulator] welcomes the amendments to these standards and believes the inclusion of specific standards relating to social media will be especially helpful to registrants and service users.
>
> Healthcare Regulator

A Professional Association requested that '*responsibility for online information, including social media'* should also include personal and professional profiles/ accounts.

There were a number of questions at the events and in survey responses from individual chiropractors relating to expectations of chiropractors' behaviour on social media, particularly whether they are able to express certain opinions, be members of specific groups and like/follow various pages and individuals. This was particularly in relation to the duty to promote public health. A specific question was about whether the chiropractor could be a member of a prayer group/church and whether this would be seen as an issue in relation to inclusivity and diversity.

> I am concerned this Standard may infringe on clinical or academic autonomy and free speech. For example chiropractors and associations promote common messages on manual handing/ posture Principles that are not supported by the current literature or public health initiatives, would these be acceptable?
>
> Survey response from Individual Chiropractor

There was also concern from a Professional Association that this requirement does not impinge upon discussion on closed forums and a call for a collaborative approach to drawing up supplementary guidance in this area.

A survey respondent queried clarification about the responsibility of chiropractors when using a third party for communication or marketing.

4.9 Principle H – Foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

Principle H is a new addition to the Code and, as such, there were a relatively large number of associated comments.

A Healthcare Regulator commented positively about a number of Standards in Principle H in particular:

> The standards at H3 – to foster effective team working - combined with the standard at H4 - to demonstrate leadership - and the standards at H5 - to treat others in the workplace fairly and with respect, are good indicators of the expectations of professional responsibilities towards colleagues.
>
> The bystander requirements in standards H5 and H6 - which create a duty to act when the performance or conduct of colleagues puts others at risk of harm - reflect the new duty created in [own Standards] to take *action* in response to bullying, harassment, discrimination.
>
> We note the standards at H7 regarding contributing to mentoring, teaching and training and the importance of recognising this area of development.
>
> Healthcare Regulator

However, it was highlighted by others that there is some duplication and that the content is adequately covered in other Principles. There was also some strength of feeling that the Standards within this Principle represent an 'overreach' by the GCC and that they are aspirational in nature rather than representing minimum standards. For example, the RCC welcomed the new requirement to collaborate effectively with other health and care professionals, but suggested that it is clarified that collaboration should take place *'where appropriate'*.

Some of the expectations around, for example, teaching and leadership were felt to be voluntary rather than mandatory. There was some confusion about how the Standards relate to established employment law and HR issues.

> There are too many sections here that read like a list of ideals rather than identifiable minimum standards of conduct a chiropractor should be held to.
>
> Survey response from Individual Chiropractor

> Whilst I agree with the aim of creating a safe and supportive environment for all, from the aspect of the regulator I see the boundary to lay at the impact on a patient or patient care only. Amongst work colleagues I would expect this to fall under employment law.
>
> Survey response from Individual Chiropractor

> The Code addresses chiropractors and the manner they relate to staff and employees. Is this not a matter for employment tribunals? This is not related to patients. Creates confusion over who is dealing with it.
>
> Professional Association event

There were a number of responses to the survey from individual chiropractors which requested more emphasis on respecting fellow chiropractors.

> I feel that this Principle is missing something about respect and not 'bad-mouthing' other members of the profession as it looks unprofessional and is stunting the growth of the profession as a whole.
>
> Survey response from Individual Chiropractor

Working with and responsibility for colleagues

The RCC welcomed the inclusion of H7 '*allow your workplace colleagues to meet their regulatory duties*'. They suggested that requirements could be broadened to include training and professional development responsibilities.

> The RCC welcomes this new Standard. We suggest that, in addition to allowing colleagues to meet their regulatory duties (responsibilities?), registrants are also required to allow colleagues to satisfy their training and professional development responsibilities.
>
> Survey response from RCC

However, others queried what exactly is meant by the Standard and were concerned about the implications for different workplace situations.

> For example, what would be the situation in the case where an employer hirers other chiropractors, what would allowing them to meet their regulatory duties look like? And to what extent would be the expectation under the Code?
>
> Professional Association event

An example was given in response to this question of a colleague being unable to meet CPD requirements because of workload and the expectations of the

chiropractor in this scenario. Again, further elucidation of what the requirements were was requested.

> But what if the situation arises that you are unaware that that situation has happened, until such time as that person is unable to complete their CPD? Some practices have many practitioners. Does it then become the responsibility of the other registrant to monitor whether that person is fulfilling their regulatory duties? And, again, my question behind the question is how is that protecting the patient specifically?
>
> Professional Association event

Similar questions were raised in relation to C2 '*Ensure that you, and anyone that has a chiropractic qualification and works with you, is registered'.* It was asked whether this was an individual chiropractor's responsibility or that of the employer. In a previous version of the Code, this was under 'Practice arrangements' section and clearly the employer's responsibility.

> So we're now in a place that, you know, I now have a regulatory responsibility for people who are in my practice, even if I work with them, but they don't work for me.
>
> Educationalist event

At a number of discussions and in survey responses the meaning and intention behind this Standard was queried as it generated some confusion and debate. It was queried if it meant colleagues need to be registered with a regulator even if they are not a chiropractor.

It was queried what exactly the expectations are in relation to H2 '*Delegate tasks or duties only if safe and appropriate to do so'.* A Professional Association expressed concern about delegation to less qualified persons (such as Chiropractic Assistants or similar). Another Professional Association requested clarification about whether this is just within the chiropractic practice and how a registrant would be expected to demonstrate that a person they delegate to is qualified, competent, supervised and supported. They also queried if individual qualified and competent, why they would need to be supervised and supported.

Also, relating to C2, it was asked if being clear with the patient that you are registered means verbal notification or something written.

Reporting others

The expectations outlined in H5 and H6 were broadly welcomed by Healthcare Regulators and RCC.

> The bystander requirements in standards H5 and H6 - which create a duty to act when the performance or conduct of colleagues puts others at risk of harm

> - reflect the new duty created in [named own Standards] to take action in response to bullying, harassment, discrimination.
>
> Healthcare Regulator

However, the duty to act on the '*poor behaviour of others*' in the introduction to Principle H was felt to be challenging by some, particularly in the context of chiropractic care settings where there may be commercial interests at stake. It was flagged that it states 'others' rather than 'chiropractors'.

There was concern at a number of sessions about an increased number of complaints about chiropractors from other practices, 'turf wars' and some debate over how to balance protecting the public versus facilitating spurious concerns. There was a particular issue with Principles C and H in this respect.

> This requirement [H6] could open the floodgates to a whole slew of vexatious complaints. While whistleblowing should be condoned, it is far from certain whether the education of chiropractors in the UK ensures familiarities with the duties, responsibilities and consequences of submitting such concerns. Is there scope for local resolution or is the intent to report all such concerns to the appropriate regulatory body? If the latter, this could create an unsustainable burden on the GCC.
>
> Individual involved in FTP proceedings (at event)

It was suggested that the Code should include a statement similar to what has been included previously about '*you must not unjustly criticise another healthcare professional*'.

> That sort of safety net to that has been taken away and I think something like that needs to be there to counterbalance, if you like, the whistleblowing requirement.
>
> Individual involved in FTP proceedings (at event)

Other issues in relation to H5, H6 and C12 were raised including:

- A request for clearer guidance on what it means to take action/report colleagues.

> It's H5 where it says about taking action. And again, it's like well with who and where? I think the same with H6. So just a bit more clarity on how? Escalate or report and it's like what do you mean, to a colleague?
>
> Professional Association event

- Is a duty to report others, i.e. professionals speaking about other professionals, classed as a complaint to be investigated?
- Is there a mechanism that the GCC could create where you could whistleblow but it wouldn't necessarily trigger a formal complaint?

- At C12 does 'colleagues' mean other chiropractors? Does it mean raise concerns to the regulator, the individual themselves or the Practice Manager?
- Is C12/C14 necessary given content of C1?

Collaboration with other professions

It was commented that requirements in relation to collaboration should not be mandatory. For example, in the introduction to Principle H '*Chiropractors are also required to give professional support to others, where appropriate'*. It was queried who 'others' refers to and what it means by support. A general point was made about expectations in this area for chiropractors working in different settings and whether some of the Standards are not feasible to achieve.

> I think it [Principle H] just requires a bit more thought. I think the concepts of it are good but I read that and thought well, that's great if you're working in a chiropractic college. But outside of that, if you are working independently on your own and the bar is set as we expect you to do this, is it really a failing if they don't want to teach, train and be with their colleagues? If they go, "I don't want a student in the room with me" is that really a failing of them as a professional?
>
> Professional Association event

There was some discussion about H1 '*Enhance the integrated care of the patient by collaborating effectively with other health and care professionals*'. This was felt to be difficult given that not all chiropractors work in multi-disciplinary settings. Some also referenced a perceived reluctance of other professionals to engage with the chiropractic profession and their scepticism of chiropractic treatment (in front of patients).

> This can be extremely problematic when other healthcare professionals (often physios/ doctors) actively discourage chiropractic care.
>
> Survey response from Professional Association

This was described as a 'one-way street' and it was queried whether other professions have a similar Standard in their codes. It was asked why chiropractors must mention other professions when outlining treatment options to prospective patients, when other professionals (specifically GPs) do not have to mention chiropractors. It was suggested by RCC and a Professional Association that '*where appropriate'* could be added to this Standard.

> I think the question here is how can we be held to a standard of collaboration when there is a good chunk of the other people that don't want to collaborate with us?
>
> Professional Association event

> Happy to work with other HCPs but many don't want to work with chiropractors. Is this going to be put in other HCPs' code of conduct and enforced?
>
> Survey response from Individual Chiropractor

It was queried whether the GCC could be doing more to educate other healthcare professionals on the chiropractic profession.

The requirements outlined in H3 '*Foster effective team working and professional interpersonal relationships. When required, support the design, delivery, evaluation, and enhancement of healthcare services, and the integration of patient care within these services*' were also flagged. It was felt that this would not be relevant for many chiropractors working outside of the NHS and some may struggle to see how it applies to them. It was also highlighted those working within the NHS already have additional duties placed upon them through the NHS Constitution.

It was suggested at the RCC discussion that H7 should specify 'regulatory and professional' duties to encompass post registration training. In terms of H4 it was felt that it would be difficult to demonstrate leadership and the use of 'autonomous' in this context was queried.

4.10 Principle I – Maintain, develop and work within your professional knowledge and skills

There were few comments on this area at the discussions and events other than some specific wording points. One query was highlighted at the Expert Witness session as to whether the wording of I4 meant that 'incompetent' educators may be subject to GCC sanction. If this is the case, it was felt to be a new development. Also, it was flagged at the Educationalist and RCC sessions that I7 was felt to be a bit ambiguous.

There were also relatively few survey responses in relation to this Principle. Several survey responses noted that the introduction refers to 'scope of practice' when this is not defined for chiropractors in the Act or Code. They also felt that many of these Standards are more aspirational rather than minimum expectations. This was particularly in relation to I1, I2 and I3.

> This Standard also feels aspirational and appears to be an attempt to bring more of the educational Standards into the code. We again feel this is addressed in other areas of the Code and cannot see how it would be assessable as a standard.
>
> Survey response from Professional Association

A Healthcare Regulator and RCC were broadly positive about the contents of this Principle and particularly welcomed the addition of reflective practice. Two Professional Associations were positive about I5 and I6 in particular.

> The Standards at I1 and I3, which seek to improve patient care through reflective practice and maintaining skills and knowledge to keep up to date with developments affecting professional practice, are also examples of a patient-centred approach in line with putting the interests of patients first.
>
> Survey response from Healthcare Regulator

Several survey responses suggested that requirements in relation to I7 '*Do not allow another person to take on responsibility for the clinical assessment or care of a patient'* should be clarified.

4.11 Principle J – Maintain and protect patient information

There were only a small number of comments in relation to the Principle.

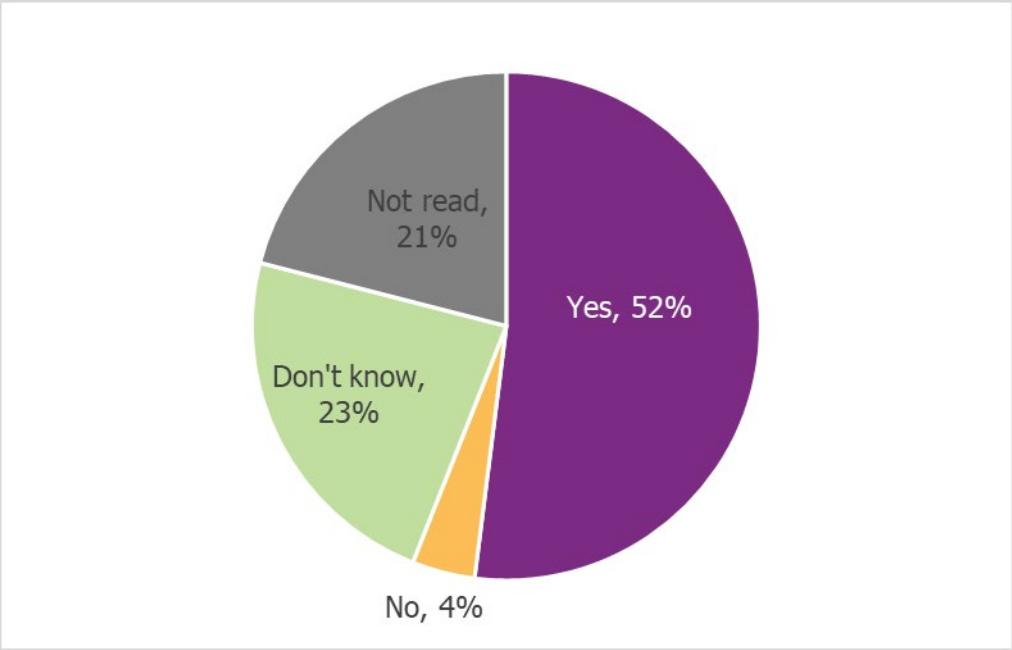
At the RCC session it was noted that the points in relation to the contents of patient records [J3] is crucially important, especially in terms of Fitness to Practise processes. Consideration could be given to adding additional elements that used to be in previous version of the Code [Principal H], including the records you keep must be accurate, reflect the clinical encounter, cover all interactions and must include other factors relevant to the patient's ongoing care including their general health. Clarification of what is meant by 'retrospective' was requested.

Specific requirements in relation to being responsible for data security [J1 & J6] were challenged, particularly as within some settings (NHS and other) there will be named individuals who are data controllers and have responsibility for the practice/department/organisation. It was mooted whether it is also preferable to employ a third party who has more expertise in data security and if Information Commissioner's Office (ICO) Standards are sufficient (rather than GCC in addition). A Professional Association requested some clarification where cloud-based services for storing data are used.

4.12 Equality, diversity and inclusion

The majority of respondents who were able to give an opinion felt that the Equality Impact Assessment accurately describes how the Code could impact on those with protected characteristics.

Figure 2 - Do you think that the Equality Impact Assessment accurately describes how the proposed Code of Professional Practice could impact any individuals or groups with one or more of the protected characteristics defined in the Equality Act 2010



Base: 119 respondents

The RCC welcomed the new Standard [C11] which they felt that, along with Standard C12, helps to uphold the principles of EDI. Some attendees are the Educationalist event were also positive about the inclusion of EDI.

It was mooted by others that perhaps more could be done to ensure that chiropractors see issues of equality, diversity and inclusion as something that they need to actively consider; as well as underlining the difference between equality and equity.

> Could anything be done to strengthen it in terms of making it a positive duty [to take action]…So whether it's something could be done or something in the language to focus not just on the equality side of things, but the equitable side of things as well.
>
> Individual involved in FTP proceedings

This was echoed by the survey responses of two Healthcare Regulators which welcomed strengthened EDI requirements but felt there was perhaps further to go.

> Several of the GCC's Standards touch on these aspects (A7, B4, C11). There may be scope for further strengthening however, to encourage registrants to actively seek to tackle inequalities, and promote equality, diversity and inclusion.
>
> Survey response from Healthcare Regulator

> This Standard [C11] could benefit from more active wording which has been added to other new Standards. For instance 'take action to ensure' your personal biases...
>
> Survey response from Healthcare Regulator

Although it should be noted that there was some discussion about the inclusion of 'bias' throughout the Code:

> I think it is sufficient to talk about personal values and beliefs. I do not believe including biases here adds anything to the statement [C11] or expectation.
>
> Survey response from Educationalist

At the RCC session and in survey responses, including from two Professional Associations, it was also noted that the wording of B4 '*Recognise the importance of promoting accessible healthcare for all patients, and support this in your practice*' is open to misinterpretation – does this mean, support the recognition of it or support accessible healthcare? This point was also highlighted at the session with Expert Witnesses who felt legislation could be referenced. It was noted that accessibility could mean physical accessibility or affordability.

It was commented at the discussions that F1 on consent should explicitly reference 'capacity' and there should be specific mention (and definition) of 'protected characteristics'.

Language requirements

The expectations of chiropractors in providing translators and the associated costs was raised at a Professional Association event and by Expert Witnesses. It was felt that G1 could be seen as implying that chiropractors need to meet patients' language needs.

> How much do I have to provide in terms of language and translation? I cannot be reasonably expected to cater for any and all languages.
>
> Professional Association event

It was queried whether C3 should specify 'local' legislation to cover specific requirements in Wales and whether '*If you practise in Wales, you should consider also making your policies available in the Welsh language'* adequately covers requirements in this area i.e. is it just policies or should it refer to other forms of communication?

> Is it worth having a more generic statement around abiding by the laws of the land as relevant to the region that you're working in, cause otherwise you might end up sort of tying yourself up in knots.
>
> Educationalist event

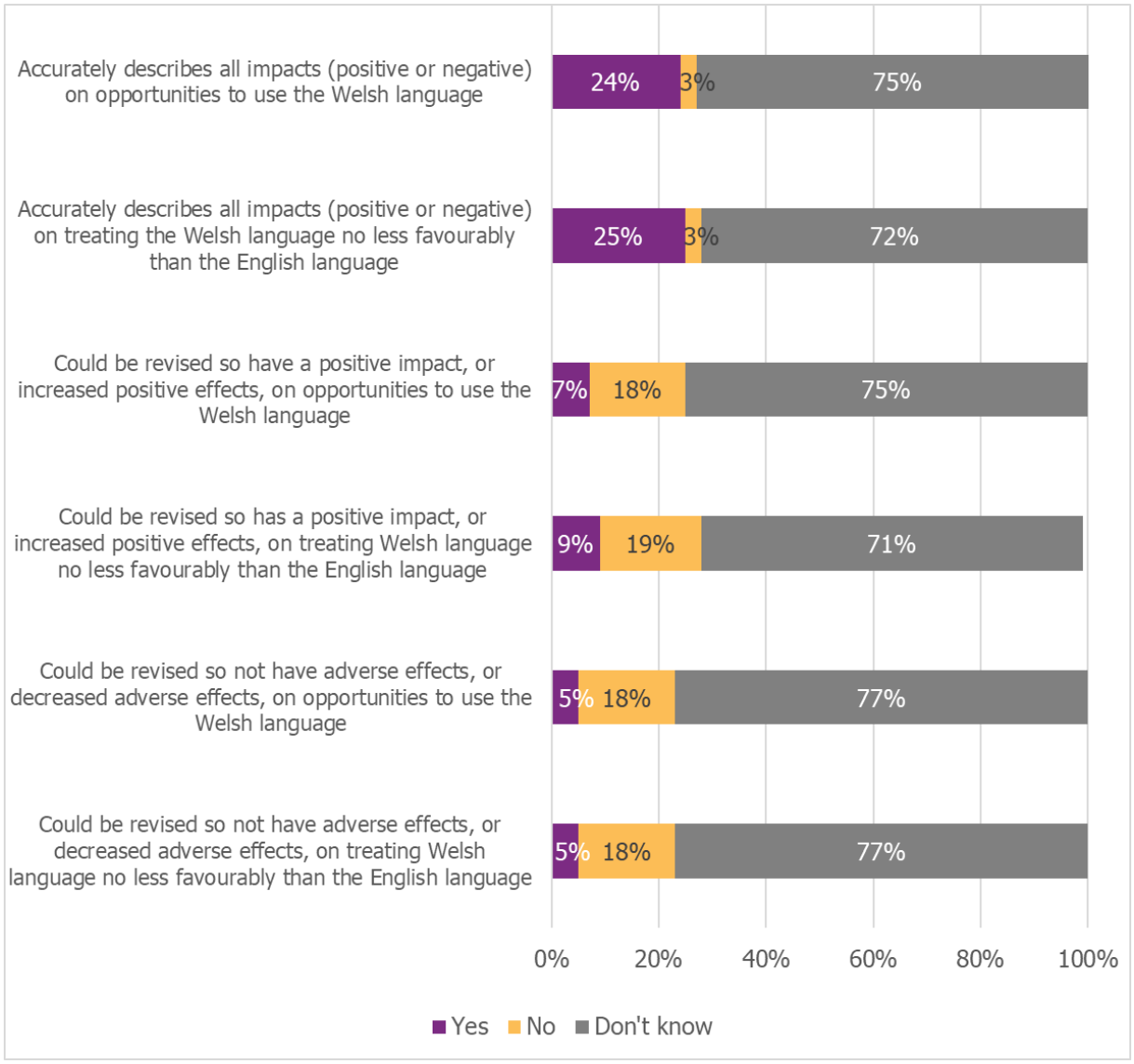
It was also flagged that the Code should also consider requirements in term of the Irish language in light of 2022 legislation[4] and possible future requirements (and possibly make reference to other languages too, for example Gaelic). The latter point was also made by a survey respondent.

Although there were high numbers of respondents who were unable to express an opinion, of the remainder, most were positive about the Equality Impact Assessment in relation to its treatment of the Welsh language.

There was a small amount of negativity from some individual respondents about the need for provision in respect of the Welsh language. An Educationalist welcomed the GCC treating the Welsh language equally in line with The Welsh Language Standards (No. 8) Regulations 2022 but highlighted that requiring registrants to consider it too, potentially imposes an expectation that documents should be provided in Welsh by them. They felt that this may go beyond the regulations imposed on businesses by the Welsh government and result in cost and administrative burden.

[4] Identity and Language Act 2022

Figure 3 - Views on the Equality Impact Assessment document in relation to the Welsh language

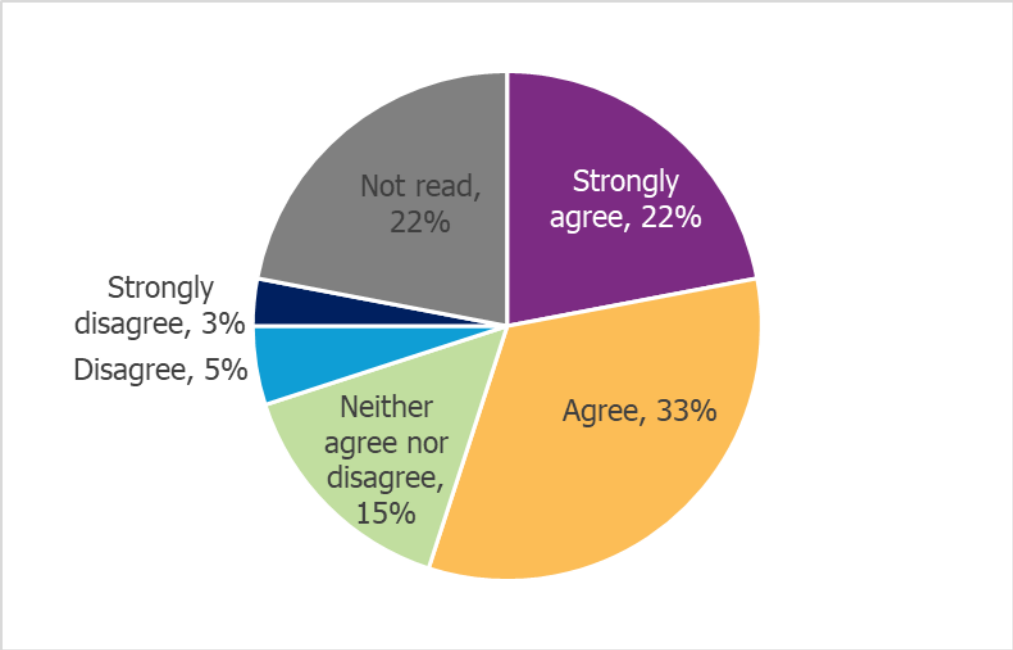


Base: 119 respondents

4.13 Comments on the glossary

In the survey, over half of respondents (55%) say that the definitions within the Glossary cover all of the terms that need to be defined, although a further 37% were neutral or had not read the document.

Figure 4 - To what extent do you agree or disagree that the definitions within The Glossary cover all the terms that need to be defined within the Code of Professional Practice document



Base: 119 respondents

15 respondents indicated that they felt that there were definitions missing, with 62 saying that there were not and a further 42 unsure.

Issues in relation to the definitions of 'evidence-based' and 'evidence-based practice' were raised – both in relation to the actual phrasing but also what the inclusion of it actually implies in relation to the GCC's view of practise.

> Quality of evidence as defined, suggests more rigid applications of evidence, but this does not sit well with the actual code provisions where there is flexibility with patient discussion, consent and also through giving notes where evidence may not be so helpful to make conclusions.
>
> Survey response from Individual Chiropractor

There were also a number of comments in relation to the absence of a definition of 'adjustment' and a perception that this was a result of the GCC's stance on chiropractic care.

> There is no definition of adjustment; imagine picking up the brochure of a car and it having no specifications about the engine.
>
> Survey response from Individual Chiropractor

A Healthcare Regulator indicated that it may be helpful to include a definition of 'apology' or 'apologising' which explains the aspects that a thorough apology should include and reiterate that it is not an admission of wrongdoing.

It was pointed out that the glossary should seek to explain relevant terms taken from the Code and not include explanations of terms that are not actually used in the Code. One respondent felt that some useful terminology from the 2016 glossary was missing.

Other specific comments on the glossary included:

- Should the definition of 'critical appraisal' including systematically examining facts and information as well are research?
- 'Plan of care' could be expanded to include aims and investigations, types of care, frequency and duration, when it will be reviewed.
- How will 'best interests of the patient' be defined?
- Review how explain 'rationale for care' and check how it is done by Health Education England
- What is meant by 'criminal convictions'
- 'Bias' needs further development with some concern expressed about the use of the word in the Code (although some Healthcare Regulators specifically welcomed additions in relation to this).
- Include a definition of 'valid consent'
- The term 'reasonable' is quite subjective and not covered in the glossary, which could be an issue throughout and something to consider against the level of clarity the Code of Professional Practice provides.
- The definition of 'intimate' may need to broadened to consider cultural differences, bringing out consent. In some cultures, it would be intimate to touch an ankle for example, or to expose the hair.

4.14 Gaps

Few survey respondents indicated that they felt that there are any Standards or minimum expectations of registrants that are missing from the draft Code. The highest numbers (6 and 7 respondents out of the 121 survey respondents) indicated that they thought there were gaps in Principles B and C respectively. Similarly, there were few identified gaps in the Code mentioned at the events and discussions. One specific comment was made about clarity around the role of guidance:

> The only other small comment I put was that it does talk about the role of GCC guidance but I think that could be strengthened. I think that's often misunderstood for chiropractors, for registrants, what is actually the legal status of guidance and I think that could probably be strengthened a bit.
>
> RCC event

The use of the shared values and link to patient feedback/engagement was welcomed but some felt that this could be more explicit. It was highlighted at several sessions and in the survey that the patient expectations section at the start of the current Code should be retained in some form (possibly before the summary table on the Principles and Values) as this is important in setting the tone that the Code is about patients and not the profession.

> Something that I think is missing is the first section of the current Code which is about patient expectations. I thought this was an incredibly positive shift that put patients first, and front and centre in the Code. It may be that this will be added later, but I don't know. And perhaps this is where plain English can be used more fully so that patients understand what is expected.
>
> Survey response from Educationalist

It was mooted that the patient has some responsibility themselves for their care i.e. in choosing the treatment, engaging and being clear about what they want – and that this could be better reflected in the Code. A Professional Association suggested this could be given greater weight throughout as patients' rights are so 'wholly enshrined' in the Code.

4.15 Name, order and flow

The renaming of the Code to the Code of Professional Practice was welcomed.

It was highlighted that the introductions to the Principles are inconsistent – some include descriptive text background, some are statements without requirements, some have expectations and some say 'must' and 'are expected to'. It was also felt to be odd to have these introductions which are aimed at a wider audience and then go directly into Standards which are aimed at chiropractors. It was felt to be unclear that all of the Principles are 'you must' statements.

A Healthcare Regulator commented that they felt that the 'multi-layering' of the concepts of Values, Principles and Standards could create confusion when interpreting the expectations of the Code.

In terms of the Code order, it was suggested that section J on maintaining and protecting patient information should come before section H on collaboration as this is more fundamental.

There was a call for careful consideration about what goes into the Code itself and what is more appropriately dealt with in toolkits etc. Some argue for more content in the guidance; others that more detail should all be in the Code as individuals are unlikely to search multiple documents.

4.16 Accessibility of the document

It was pointed out that the Code needs to be as accessible as possible for public, patients and registrants. A number of suggestions were made at the discussion sessions and events in this respect, including:

- Putting references in where a specific Principle relates to another Principle (it was noted that there is some unavoidable overlap/duplication but it can make it challenging to follow a thread of thought).
- Including a clear summary for patients and considering comprehension of specific language and jargon i.e. would patients understand the term 'patient-centred' or 'quality management Principles'.
- Grammatical issues/clarity of wording.
- Produce a video or animation outlining the key aspects of the Code.
- Consider different language needs.
- Ensuring that the Code can be searched in an interactive way once on the website (in a similar way to how other Healthcare Regulators present their Standards)
- Produce a summary of what the Code means for specific issues, i.e. payment plans, open plan treatment etc.
    - An example was given of the GMC taking a topic such as religious and personal beliefs and bringing together all of the relevant points from their Standards in one place.
- It was suggested that there needs to be a resource available for chiropractors that they can access up-to-date relevant legislation so that they can meet the requirements of C3.

A point about the use of simple terms rather than jargon was made by a survey respondent:

> Healthcare professionals know what 'person centred' conversations are. But I think it is bureaucratic language. I would much rather in plain English it said something like 'talking and listening to patients'.
>
> Survey response from Individual Chiropractor

4.17 Other issues

A number of other issues were raised or questioned including:

- The GCC registration fees were mentioned as being relatively high, particularly for new graduates and sole traders.
- It was asked how the GCC will be 'policing' adherence to the new Code.
- It was stressed that the GCC will need to ensure that the changes to the Code are consistently applied to the Guidelines.
- It was stressed that ideally the Code needs to be a live document with a built-in mechanism to allow for some evolution over time or to give scope to respond

quickly to specific issues, for example a future pandemic and/or specific Fitness to Practise cases, for example those relating to future use of AI.

- There were some positive comments about the engagement and consultation but also some suggestion that the draft Code could have been shared with Professional Associations in advance of the formal consultation.

5. Appendix

5.1 List of organisations who responded

British Chiropractic Association (BCA)

General Medical Council (GMC)

Health and Care Professions Association (HCPC)

General Osteopathic Council (GOsC)

McTimoney Chiropractic Association (MCA)

Professional Standards Authority (PSA)

Royal College of Chiropractors (RCC)

Scottish Chiropractic Association (SCA)

Society for Promoting Chiropractic Education (SPCE)

United Chiropractic Association (UCA)

5.2 Demographic breakdown of responses to the survey[5]

*Table 1 - Number of responses by stakeholder type**

Consultation response – stakeholder type	Number of responses
Registered chiropractor	78
Patient or member of the public	30
Membership body, company, organisation or charity	10
Work at an academic institute carrying out chiropractic education or research	2
Qualified chiropractor (but not registered)	1
Total	**121**

Table 2 - How long chiropractor has been registered

	Number of responses
Under 2 years	3
2 - 5 years	12
5 - 10 years	7
10 - 15 years	9
15 - 20 years	12
Over 20 years	34
Not specified	1
Total	**78**

Table 3 - Survey respondent demographics

	Number of responses
Country	
England	108
Scotland	4
Wales	1
Other	7
Gender	
Male	55
Female	52
Prefer not to say	12
Ethnicity	
White/White British	94
Asian or Asian British	4
Mixed ethnicity	1
Prefer not to say/other	20
Religion	
No religion/belief	43
Christian	42
Muslim	1
Hindu	1
Pagan/spiritual	3
Prefer not to say	29
Disability	
Yes	6
No	97
Prefer not to say	16
Sexual orientation	
Heterosexual	92
Gay man/woman/bi	5
Prefer not to say	22
Age	
20-24	2
25-29	9
30-34	8
35-39	7
40-44	6
45-49	9
50-45	14
55-59	12
60-64	14
65 or over	26
Prefer not to say	12

5.3 Response to Principles by stakeholder type

Table 4 - To what extent do you agree or disagree that the Standards reflect Principle A

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	45	24	-	4	2
Agree	29	6	1	4	-
Neither agree nor disagree	3	-	-	2	-
Disagree	1	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 5 - To what extent do you agree or disagree that the Standards reflect Principle B

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	36	24	-	3	2
Agree	29	5	1	3	-
Neither agree nor disagree	7	1	-	1	-
Disagree	6	-	-	2	-
Strongly disagree	-	-	-	1	-
Total	**78**	**30**	**1**	**10**	**2**

Table 6 - To what extent do you agree or disagree that the Standards reflect Principle C

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	34	25	-	3	2
Agree	29	4	-	3	-
Neither agree nor disagree	9	1	-	4	-
Disagree	5	-	1	-	-
Strongly disagree	1	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 7 - To what extent do you agree or disagree that the Standards reflect Principle D

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	31	26	-	2	2
Agree	29	3	-	2	-
Neither agree nor disagree	10	1	1	2	-

Disagree	6	-	-	4	-
Strongly disagree	2	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 8 - To what extent do you agree or disagree that the Standards reflect Principle E

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	41	26	-	5	2
Agree	28	3	1	3	-
Neither agree nor disagree	5	1	-	2	-
Disagree	4	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 9 - To what extent do you agree or disagree that the Standards reflect Principle F

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	37	23	-	5	2
Agree	34	6	-	3	-
Neither agree nor disagree	6	1	-	2	-
Disagree	1	-	1	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 10 - To what extent do you agree or disagree that the Standards reflect Principle G

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	33	25	-	3	1
Agree	34	4	1	5	1
Neither agree nor disagree	7	1	-	2	-
Disagree	4	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 11 - To what extent do you agree or disagree that the Standards reflect Principle H

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	27	25	-	3	2
Agree	33	4	-	3	-
Neither agree nor disagree	10	1	1	2	-
Disagree	5	-	-	2	-
Strongly disagree	3	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 12 - To what extent do you agree or disagree that the Standards reflect Principle I

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	32	25	-	3	2
Agree	30	4	1	3	-
Neither agree nor disagree	13	1		4	-
Disagree	3	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 13 - To what extent do you agree or disagree that the Standards reflect Principle J

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	37	26	-	5	2
Agree	33	3	1	3	-
Neither agree nor disagree	8	1	-	2	-
Disagree	-	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**