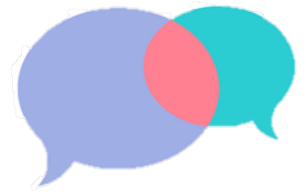
General Chiropractic Council



What we learned from the March Blog

The Registrar's "food for thought" blog post was written to kick-start a wider discussion about the GCC Code as we develop the standards within it for consideration at the June Council meeting.

By the nature of being a regulator the GCC tends to hear complaints and requests that "something must be done". We do not get to hear of the thousands of positive interactions with patients that we know are happening every day.

The blog post drew on evidence from the scoping review that we published last year; from our insights further to concerns raised by patients; and from evidence gathered in our monthly registrant Pulse Survey[1].

In March we sought engagement with some important issues. There were around 450 responses from a wide variety of viewpoints – with most respondents feeling the suggestions made went "too far" in overstepping our remit and role. We did not intend the blog to cause distress or anxiety, but we recognise it had an unsettling effect for some within the profession, and we acknowledged this in the April newsletter.

The following six briefing sheets aim to explain:

- the concerns and themes that led to each of the questions in the blog;
- what we learned from the responses;
- and how our thinking has evolved.

The complaints and comments are not verbatim, but are representative of the types of comments we regularly receive.

Finally, we recognise the diversity of practise within the chiropractic profession, and our priority is to ensure that patients experience professional, safe and appropriate care from whichever chiropractor they see.

GCC April 2024

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[1] The Pulse Survey is sent to a sample of around 10% of registrants as the first item in the monthly newsletter each month. It began in November 2023 and asks for feedback on the registrants' confidence in the GCC to carry out core duties, as well as an open text box for comments about the profession and the GCC.

Open Plan Clinics and High Volume Practice

We received comments such as:

From patients:	From chiropractors:
My 73-year-old mum had to get changed behind a curtain in the corner, into an open-backed gown which left her pants and bra showing. He told us that sessions will last up to 40 mins but he finished her session in under 2 minutes while he was seeing another patient beside us in the same room. He excused this by saying “your mum is old so I need to go easy”. It cost 43 pounds for those 2 minutes – and he demanded I book a series of further sessions.	I’m struggling to work in a clinic that expects each patient that walks through the door to be booked in twice a week for 4 weeks then once a week for 6 weeks then fortnightly for 4 sessions, that's 20 appointments including a new patient appointment and report of findings appointment, regardless of what they walk in the door with. There isn't another clinic to move to and I'm scared to start out on my own, after 5 years I'm thinking about leaving the profession.

That explored themes such as:

Multiple patients being treated at once; consent; privacy; dignity; high volume clinics

So, in the blog we asked:

Are open plan treatment rooms with several patients being treated at once, compatible with modern expectations of consent and privacy with care centred around the patient?

What we learned from the blog responses:

Support for open plan clinics is widespread (though we lack evidence on how widely it is practised). It is clear to us that open-plan can be provided in a thoughtful patient-centred way – and indeed while there is little evidence on either open or closed practise there may be some benefits to open plan such as:

- Patients acting as unofficial chaperones for patients and chiropractors
- A supportive group atmosphere

Our concerns need to be focused on the risks around ensuring privacy, confidentiality, and patient dignity. Registrants were concerned about the risk of a loss of patient focus in “high volume, high turnover” clinics. There are perceptions the open plan approach is sometimes aligned to business, rather than patient-focused, reasons.

We are now keen to explore further:

- The clinical model and patient experience of “high volume” clinics in more detail to ensure that the new Code continues to protect patients.
- How do the standards around confidentiality, privacy and patient dignity ensure that all clinics (including open plan and closed room) meet the expectations of patients and the public?
- Do the frameworks and safeguards highlighted by registrants (active offering of private rooms, undressed (gown etc) appointments in private) need to be put into the Code so that patients are clearer on what to expect?
- Many chiropractors explained in their response how they communicated their practice to new patients in order to set their expectations. Should there be a basic level of explanation that all chiropractors should offer?
- How can the Code ensure that the clinician is given appropriate time to treat each patient?

Financial Inducements, Long Payment Plans and Special Offers

We received comments such as:

From patients:	From chiropractors:
I am writing as a concerned primary care clinician on behalf of a patient, to highlight some extremely dangerous practices going on at a chain of clinics, culminating in a serious negligence case against one of the chiropractors working there involving their treatment of our cancer patient….He was seen by multiple times (approx. 7 sessions over 3 weeks)….He was put under significant coercion and duress to buy an extremely expensive (multiple £1000) package of treatments that he couldn't afford without clear justification, having to fight hard for pay as you go for appointments. Each appointment was then performed to his surprise in a group environment with approx. 5 patients in the same room and a couple of chiropractors….	There are numerous 'volume' clinics like this where patients are subjected to full-spine 'marketing' X-rays as soon as they walk in, are told they must pre-pay £1000 to have any treatment, and are then treated for 2-3 minutes every week, without any increase in interval between visits, and I'm not aware of the GCC taking any regulatory action against these. The holistic ethos offered by chiropractors should be differentiated from medical & physiotherapy care. I do not think that American style Practice Building Techniques, which are promoted by corporate clinic groups, are useful to newly qualified practitioners. The use of enhanced pay by increasing sales performance (ie number of treatments) should be discouraged.

That explored themes such as:

Conflicts of interest between the patient and chiropractor.
Are financial inducements appropriate if the patient is not seeking to resolve a specific ailment?

So, in the blog we asked:

Are financial inducements offered to patients, such as online discount vouchers and free initial consultations that lead to lengthy packages of care. a conflict of interest too far?

What we learned from the blog responses:

Chiropractic is a business and must be financially sustainable.

While some chiropractors view upfront financial plans as coercive, unethical and leading to overtreatment, others felt that they can make care more accessible. There were multiple examples of safeguards such as pay-as-you-go; and refund policies for unused care. The question was also asked whether it is ethical to offer a financial plan that is longer than a clinical care plan.

Special offers were seen as less of a problem than financial packages, but the inclusion of x-rays within special offers was seen by some as having significant risks.

Many suggested a much clearer separation in language and delivery between the proposed clinical care plan (see next question), and a financial plan.

We are now keen to explore further:

- Should the Code clearly separate and define clinical care plans and financial plans?
- Should there be an approach to financial plans that are longer than care plans (either in the Code or in associated guidance)?
- Would it be useful to highlight business regulations in the Code (in the same way that the current code highlights the ASA) to signal expectations of financial plans?

Long Treatment Plans

We received comments such as:

From patients:	From chiropractors:
After the X-ray I was diagnosed with severe arthritis and told my spine was like that of an 80 year old. The recommendation was 6 months of visits, 3 to 4 times every week. I started the treatment but the way my neck was cracked each time was making the pain worse. I eventually stopped going, and visited a different chiropractor who was able to reassure me that I don't have arthritis and I don't require anything like that number of treatments.	I struggle to cope with members of the profession who provide excessive treatment programs and/or non-effective types of treatments, this draws the professional reputation down, but I don't know how the GCC can do anything about this, so probably a pointless comment.

That explored themes such as:

Does the current Code allow for care outside of acute clinical necessity – such as maintenance, elective care and non-evidence-based care? What safeguards are in place to prevent abuse of the patient/chiropractor power imbalance?

So, in the blog we asked:

Is there a place for lengthy packages of care at all? Where treatments extend for a long time should there be more prescriptive requirements for the review, with the patient being an equal partner in that review?

What we learned from the blog responses:

There was more agreement on the importance of patient involvement in personalised care plans than most other areas of discussion. There were calls for the GCC to define the frequency of care plan reviews.

Most told us that care plans should be tailored to individual patient needs rather than offering generic packages that do not suit everyone; and the length and frequency of care should be based on relevant research, clinical experience, and ongoing assessment of the patient's condition.

Most emphasised the importance of patient autonomy and informed decision-making, stating that patients should be fully informed about their care plans, including the rationale behind them, and have the freedom to choose whether to proceed with care. This includes regular reviews and discussions about the progress of their treatment.

Responses pointed to elective reasons for care (variously referred to as "maintenance", "performance" or "wellness") which leads us to question whether explaining elective care in terms better suited to acute cases reduces the patient's ability to provide informed consent.

We are now keen to explore further:

- Does choosing to undertake elective care move the patient's role closer to that of a customer or consumer? Does the Code need to reflect this?
- Can the Code ensure that treatment is bespoke and tailored to individual patient needs at every appointment?
- How can the need for bespoke treatment be balanced with the needs of patients (and practitioners) who "know what works for them".

Chiropractic Within Wider Healthcare

We received comments such as:

From patients:	From chiropractors:
Despite his warm words on the website about the close relationship he would have with my existing doctor, he did nothing but bad-mouth doctors throughout my entire appointment.	I would like to see closer links with the NHS, with more GPs confident to recommend and/ or refer to chiropractors. This is probably part of a wider issue of our perception by the public and their lack of knowledge of recent quality research on what we are able to safely treat. It would be great to see more awareness of how much we have to offer.
When I mentioned my gynaecologist had referred me to see an orthopaedic specialist, the chiropractor said: "I don't know why you are bothering – you are my patient now".	I'm optimistic that if we remain true to our uniqueness within healthcare we will continue to be high-quality healthcare providers who are easily accessible in a time of high demand for healthcare. I'm certain that there is a serious possibility of us trying to belong and be liked by the NHS and losing our individuality in the process.

That explored themes such as:

The relationship between the chiropractor and the wider healthcare system. Chiropractic availability on the NHS. Is chiropractic complementary to, or instead of, other healthcare? The relationship between the chiropractor and their immediate colleagues.

So, in the blog we asked:

We know that patients expect the practitioner to be connected with the wider health and care system so they are signposted to the most appropriate professional: should there be a presumption that chiropractors will write to GPs following each contact with a patient, with a copy sent to the patient?

What we learned from the blog responses:

This question failed to generate the hoped for wider discussion of the position of the chiropractic profession within the wider health and care environment. We were left in no doubt the suggestion of more regular communication with GPs was considered unworkable and inappropriate.

A key theme was the increasingly fractured nature of the UK healthcare system – with many patients no longer having a named GP but being assigned to a practice.

Wider acceptance by the healthcare profession was touched upon – with many saying that doctors did not trust the profession, and some preferring a complementary therapy label suggesting "mainstream" healthcare didn't appreciate what chiropractic had to offer, or that patients had sought out chiropractic treatment as an alternative to the medical model of the NHS.

While some in the profession favour allied health professional status and closer integration with mainstream healthcare, some are very much against it.

We are now keen to explore further:

- How can patients be assured that details of their care are shared appropriately with other health and care professionals as necessary?
- When the NHS looks to the patient as an expert in their own conditions and care, how can patients be provided with knowledge of their condition and treatment to advocate for themselves?
- Where chiropractors are working within a wider team and supervising roles that are not regulated (for instance chiropractic assistants), what responsibilities (if any) does the chiropractor have over the training and actions of those individuals?

Vulnerability of patients; boundaries and chaperones

We received comments such as:

<table>
<tr><th>From patients:</th><th>From chiropractors:</th></tr>
<tr><td>I had to disclose what I do for a job to highlight how I gained my neck injury. He asked me inappropriate questions about my job including how much money I make, and whatnot.</td><td rowspan="3">In the 20+ years I have been a chiropractor my job has changed significantly. Daily I face patients seeking our care as they have nowhere else to turn to. Last week I had:
a patient who is suicidal, whose GP will only offer them a telephone consultation.
a patient with Parkinson’s whose wife wants him in a care home and his children want him to stay at home with carers. He discussed his anxiety about this, rather than his sore neck.
a patient who found her daughter self-harming but can’t get CAMS help and is now sleeping on the floor outside her child’s door to prevent another incident.
a patient whose husband has been diagnosed with multiple cancers and whilst he can get counselling, there is no emotional support for her, so her issues were laid at my door.</td></tr>
<tr><td>He said I'm too big for my skeleton and told me to lose weight and skip meals! I am 5ft8, size 12, I also have a history of anorexia. He patted my stomach telling me to lose all that weight! He did the same to my fiancé. We are going through fertility treatment which causes weight gain.</td></tr>
<tr><td>He kept pulling down the top of my pants which triggered my anxiety as I have been through assault in the past. I was unable to complain as my anxiety was high. I went home and cried.</td></tr>
</table>

That explored themes such as:

To what extent should a chiropractor consider the wider vulnerability of patients? Privacy; Opportunities for inappropriate relationships or attachment between chiropractors and patients (in both directions).

So, in the blog we asked:

Should there be unequivocal rules around the use of chaperones covering a wider cohort of patients?

What we learned from the blog responses:

Many recognise the importance of chaperones in certain situations, although patient-centred decision-making and professional judgment in deciding when chaperones are needed was advised. There was a recognition of the role in protecting the practitioner from complaints or patient advances; as well as protecting the patient.

The difficulty of providing chaperones when working alone is a concern, but there was recognition that some procedures (particularly intimate ones) should always require the offer of a chaperone.

Guidance was sought on the role of chaperone in more detail – are a patient’s family or friends appropriate? How should staff be trained as chaperones? Is another patient appropriate? How should a chaperone speak up if they are concerned?

The questions of wider vulnerability (other than sexual predation) and the power and information imbalance between chiropractor and patient requires further exploration.

We are now keen to explore further:

- How can the Code emphasise that patients by their circumstance are often vulnerable, with the right checks and balances put in place to protect their interests?
- How can this be done without undermining the patient’s right to privacy?
- What further support and research can be done into burnout and support for chiropractors?

Scope of practice, standards of proficiency and adjunctive therapies

We received comments such as:

From patients:	From chiropractors:
How long should a TENS unit be left on? He left the room and was gone for a while – it started to get painful and I called out but nobody heard me. I stood up to try and turn it off myself and he rushed back in and tore the pads off my back. It felt like sunburn.	I had a prospective patient call requesting a 'ring dinger' like they had seen on Tik Tok. When I told them I didn't do that they asked if I could recommend anyone who did.
She did acupuncture through my jeans. I thought it was a bit weird at the time but only when I got home and saw the tiny holes in the butt of my jeans did I think about how unsanitary it was.	I came across a Chiropractor at a conference selling a laser to use on children's brains. How is this ethical or even possible in Regulated Healthcare? There is so much bizarre and irrational treatment being offered.
During the last part of my appointment, he tried out a new technique without warning. He shone a light in my eyes and watched how my eyes followed his finger – like an optician. When I got to the car I could still see the lights in front of my eyes – I wasn't sure if I was safe to drive.	It is confusing for patients to go to 10 different chiropractors and get 10 different experiences/ approaches to their care. One of my patients recommended some kind of document that would allow new patients to understand each approach.

That explored themes such as:

Is there a need for a scope of practice that formally defines chiropractic?
Is there a need for a clearer position regarding adjunctive therapies?

So, in the blog we asked:

Are patients clear about the competence of their chiropractor to carry out activities that are not universally used by all chiropractors – techniques such as dry needling, cupping, therapeutic ultrasound and laser treatments?

What we learned from the blog responses:

It is difficult to define what is "chiropractic" and what is an adjunctive therapy. Chiropractors are encouraged to continue their professional development and training to expand their skills and competencies. This often involves undertaking additional courses and certifications in specific modalities as part of their ongoing education, and this must be encouraged.

Patients assume that those who offer additional treatments are appropriately trained and competent in those techniques, and chiropractors are reassured that the insurance companies offer protection by requiring proof of training and competence before covering these therapies.

A chiropractor is highly unlikely to use a therapy that they do not believe will benefit the patient. Nevertheless, there are some tools and modalities available that have the potential to cause harm (to both patient and practitioner) if used inappropriately. It is not clear that patients or chiropractors always understand that adjunctive therapies are also regulated by the GCC – with certain dispensations in law allowing them to practise techniques based only on their GCC registration.

We are now keen to explore further:

- In response to the question above (10 treatments from 10 chiropractors): How can the profession ensure that the patient knows what to expect from the chiropractor when they first see them?
- Does the Code have a role to play in this?