GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 1649/9744

Professional Conduct Committee Hearing

DECISION

Case of:	Chen Chen
Committee:	Andrew Harvey (Chair) Sue Ware (Lay) Tom Bedford (Osteopath)
Legal Assessor:	Tim Grey (5 & 7 - 9 December) Jon Whitfield (6 December)
Representation for Council:	Christopher Gillespie
Representation for Osteopath:	Sapandeep Singh Maini-Thompson
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	5 - 9 December 2022

Summary of Decision:

The Committee found Paragraphs 1, 3(d) and 4 proved upon the Registrant's admission.

The Committee found Paragraphs 2 and 5 proved in their entirety.

The Committee found Paragraphs 3 (a) - (c) and (e) not proved.

The Committee determined that the facts found proved amounted to Unacceptable Professional Conduct ('UPC')

The Committee determined to impose an order of conditions for a period of 8 months.

Allegation (as amended)

The allegation is that you, Mr. Chen (the Registrant) has been guilty of unacceptable professional conduct, contrary to section 20(1)(a) of the Osteopaths Act 1993, in that:

1. On 30 July 2020 Patient A attended an osteopathy appointment with you ("the Appointment")

2. During the appointment you
   a. Performed excessive and/or forceful treatment on Patient A's back
   b. Treated Patient A by performing:
      i. spinal manipulation
      ii. acupuncture which comprised of electrical stimulation
      iii. the use of an inversion table

3. During the appointment you in relation to the treatments set out at paragraph 2 above:
   a. failed to provide Patient A with information about the treatment
   b. failed to provide Patient A with sufficient information about the treatment before performing the treatment in 2a and 2b
   c. failed to obtain valid consent from Patient A before performing each treatment
   d. failed to include details of each treatment performed in Patient A's clinical notes
   e. failed to refer Patient A for further investigation.

4. Following the treatment provided by you as described at paragraph 2 above, within the same day, Patient A:
   a. experienced symptoms including:
      i. numbness in their saddle area
      ii. leg muscle twitching
      iii. lack of sensation from the waist down
      iv. difficulty urinating

   b. was diagnosed with 'Cauda Equina Syndrome'
   c. underwent a laminectomy and discectomy surgery.

5. Your treatment as set out in paragraph 2 was
   a. Inappropriate
   b. Not Clinically justified

Preliminary Matters:

Application to Amend the Allegation

1. At the outset of proceedings, Mr. Gillespie on behalf of the Council, made an application, pursuant to Rule 24 of the Rules, to amend the Allegation in the terms set out above. He submitted that the amendment was both necessary and desirable in order to ensure clarity in the Allegation. The proposed amendments more adequately and fully reflected the nature of the referred matters, without materially altering the nature and scope of the case.

2. On behalf of the Registrant Mr. Maini-Thompson did not object to the application to amend.

3. The Committee received and accepted the advice of the Legal Assessor. It was advised that its power to make such an amendment was governed by Rule 24 of the Rules. The Committee thereby had a discretion to amend the Allegation at any time if, having heard submissions and received legal advice, it considered that an amendment could be made without injustice.

4. The Committee carefully considered whether the proposed amendments might lead to any unfairness to the Registrant. Having done so, it concluded that the amendments as sought by the Council could be made without injustice and were both necessary and desirable to properly reflect the nature of the case and in order for the Committee in exercising its case management functions to effectively and expeditiously consider all matters referred to it by the Investigating Committee.

Decision:

Background

5. On 30 July 2020, the Complainant who had been suffering from back pain and had been unable to secure an appointment with his usual osteopath booked an appointment with the Registrant who was able to see him that day.

6. Patient A's account was that the Registrant's treatment was rough and included spinal manipulation, acupuncture that involved electrical stimulation and, finally, the use of an inversion table. Patient A asserted that none of these techniques were properly explained to him and that he did not give valid consent to them. The Registrant denied that any of these treatments took place and that he provided gentle treatment explaining what he was doing at all times.

7. Following the appointment, Patient A developed a number of symptoms including numbness in the saddle area, leg muscle twitching, lack of sensation from the waist down and difficulty in passing urine. He was admitted to hospital where he underwent an urgent laminectomy and discectomy for cauda equina syndrome.

8. Both the Council and the Registrant instructed experts. The experts were agreed on most of the issues in the case. In particular, that if Patient A's evidence was right, then the treatment provided by the Registrant was inappropriate and not clinically justified. Conversely, if the Registrant's evidence was right, then the treatment was both appropriate and clinically justified. There remained a disagreement between the two experts as to the need for Patient A to be referred for further investigation.

9. Patient A wrote to the Registrant with a letter of complaint dated 31 December 2021. In that complaint, Patient A alleged that the clinical notes with which he had been provided were inaccurate in that there was no record of the treatments he said had occurred and that no discussion had taken place about those treatments. Patient A thereafter formally complained to the Council on 2 February 2022.

10. In correspondence with the Council the Registrant denied any wrongdoing. He asserted that Patient A's description of the consultation was inaccurate. Specifically that the Registrant explained that he did not use acupuncture or an inversion table. He diagnosed Patient A with a lumbar disc herniation at L4/5 and L5/S1, which he treated with gentle soft tissue massage, joint articulation and manual traction. He explained what he was doing and the Complainant was happy to proceed.

Evidence

11. The Committee received witness statements from Patient A and the Registrant, and expert reports from Mr. Tim McClune, instructed by the Council, and Mr. Devan Rajendran instructed on behalf of the Registrant. The Committee heard oral evidence from all four witnesses.

12. Patient A adopted his witness statement and described attending the appointment with the Registrant whilst suffering from acute pain in his lower back and right shoulder. He explained the nature of the appointment, in particular identifying the Registrant taking a medical history, conducting an examination and thereafter treating him. He explained he found the treatment to be painful, and that after initial pressure had been applied to his lower back,

the Registrant began using acupuncture. He connected the acupuncture needles to some wires and then performed electro-acupuncture ('EA'). Patient A described this as causing pulses of pain. Patient A then explained that the Registrant took him to a different room towards the front of the property where he used an inversion table to tip Patient A, so that his head was facing the floor, from a horizontal starting position.

13. In his oral evidence Mr. McClune confirmed that he and Mr. Rajendran were in agreement that the vast majority of the issues in the case depended upon which account the Committee preferred, whether that was Patient A's version of events or that of the Registrant. The issue upon which they disagreed was the need to refer Patient A for an MRI scan. Mr. McClune considered that with numbness in his right foot and pain in his left leg, there was sufficient need for an MRI before treatment to rule out any serious pathology. He considered such was necessary regardless of the negative results obtained by the Registrant in his neurological examination of Patient A. In so saying he opined that the involvement of both sides showing some neurological symptoms meant that there was a chance of neurological involvement and damage that required imaging to investigate.

14. Mr. Rajendran gave oral evidence and confirmed the area of disagreement between him and Mr. McClune. He explained that in view of the negative results from the neurological examination the Registrant had carried out and the nature of Patient A's symptoms, a referral for an MRI was not required. In particular, he noted that although there was pain in the left leg there was no pain in the right leg, and the numbness was confined to Patient A's right foot. He therefore opined that a significant body of osteopaths would consider it reasonable for the Registrant to have continued to treat Patient A without referring for an MRI, given he had conducted a combination of neurological tests.

15. The Registrant gave evidence. He explained that when he treated Patient A he was less than three years qualified and it was during the pandemic. The Registrant explained that he set up his clinic at home in 2018. He described the layout. He described Patient A phoning at around 11am on 30 July 2020 and asking for a consultation that afternoon when he would not normally be working. Patient A said he was in a great deal of pain and he persuaded the Registrant see him. He said that Patient A had 'tried everybody' but no-one could help so he agreed to assist. Patient A showed typical signs of a patient with lower back pain. Thereafter the Registrant explained how the appointment proceeded. First he took a medical history from Patient A. During that consultation Patient A told the Registrant that 12 years previously he had an operation on his back at the Fitzwilliam Hospital but he was unable to provide any detail. The Registrant asked him to bring these details and any MRI scans

to the next appointment. Patient A explained he had been in pain for two months but he had not seen anyone during that time. Patient A told him he had seen a consultant but did not disclose seeing any other healthcare practitioners. Thereafter the Registrant described the neurological and general examinations he undertook, explaining that he was seeking to discount the possibility of cauda equina syndrome.

16. Regarding the treatment on the day, the Registrant reiterated that he had a conversation with Patient A in which he suggested he may benefit from soft tissue work. He explained the risks and benefits in lay terms. This he did, it involved gentle massage and articulation to lengthen the back muscles. At the conclusion of the appointment the Registrant was under the impression that Patient A felt better and he booked another appointment. Whilst accepting he did have experience in using acupuncture, the Registrant denied using acupuncture on Patient A and denied using inversion therapy or an inversion table with Patient A.

Submissions of the Parties

17. On behalf of the Council, Mr. Gillespie submitted that the case for the Registrant must be that Patient A had opportunistically made up the story of EA and inversion therapy which he had described in credible detail. The alternative was that the Registrant was not telling the truth. He said it was not the Council's case that the Registrant caused injury to Patient A but the Registrant may well have thought that he had done so at an early stage. He said this was not a case of unreliable memory or the fallibility of recollection. Either Patient A was attached to an EA machine, or he was not. There was no scope for misremembering. Likewise there was no scope for misremembering being strapped to a table and being turned upside down so his head was near the floor. This was not faulty memory or 'enhanced' recollection. It happened or it did not. He invited the panel to look at the alternative accounts.

18. Mr. Gillespie suggested that Patient A was a credible witness who made appropriate concessions when he did not remember matters. He said the treatment was more physical and stronger than previous treatment. He gave a detailed account of EA, how it worked and what he was told. It followed, so Mr. Gillespie submitted, that according to the Registrant, Patient A made up the evidence about the needles, electricity, sensations, the Registrant's comments about turning up the current, breathing and so on. Equally the detailed account of lying on the inversion table, strapped ankles, rotating, the sensations, the conversation were, on the Registrant's account made up.

19. Mr. Gillespie noted that no one had suggested Patient A's descriptions were inaccurate. The treatments as described were therefore accurate accounts of treatment of that type. Mr. Gillespie posed the question 'how was Patient A to come by these descriptions?' He contended it must be the Registrant's case that Patient A had seen the needles and equipment and worked out what they were and what to say when it didn't happen. He suggested the Panel contrast Patient A's appropriate concessions with the Registrant's combative, dismissive attitude and not answering questions.

20. Mr. Gillespie went on to make submissions regarding the patient notes. He submitted that a good example of the Registrant's combative approach was line one of the notes, which he suggested, was clearly one line describing chronic pain. He suggested the Registrant's description was not credible and his answers regarding the notes were wholly unsatisfactory, in addition to which only half the notes were present. He said boxes 6 – 10 had not been disclosed but what made no sense at all were the Registrant's answers regarding the last page. The form was detailed and structured with a history and testing, ending with the patient feeling better but, there was no note of the treatment. This made no sense at all, "of all the things to leave out".

21. Mr. Gillespie further submitted that the Registrant had claimed the treatment was included in the checks which was not in accordance with the structure of the document and did not explain why the treatment section was missing and none of the three treatments the Registrant said he did were recorded. He queried the use of the form if the fourth page was for a tutor to sign. He said there was a crucial element missing regarding a line about risks and benefits. He submitted the notes were awkward for the Registrant and his answers were unsatisfactory. Overall Mr. Gillespie submitted there were real concerns about the notes.

22. Mr. Gillespie further submitted that the Registrant had concerns about what had occurred and that was why he was not telling the truth. Patient A had brought a civil claim but this had petered out so he therefore had no motive for lying. The Registrant's case was that Patient A had gleaned information, worked out what the inversion table and EA were and was making up a story from this scant information.

23. Regarding the issue of treatment and referral, Mr. Gillespie submitted this was slightly different to the rest of the case. Two rival expert contentions had been arrived at based upon the information available to the Registrant. He submitted the Registrant had not followed the NICE guidance and being early on in his career he did not know what he was looking for. He said the general presentation indicated he should not have treated Patient A at all. The rest of the case rested on who was to be believed and he said the Panel should prefer

the credible coherent account of Patient A, and therefore fined the outstanding elements of the Allegation proved.

24. Mr. Maini-Thompson on behalf of the Registrant, submitted there were challenges in the narrative conflict between the Registrant and Patient A. Nonetheless he submitted there were reasons why the Registrant should be believed and factors to suggest Patient A could not be relied upon. He reminded the Panel that the Registrant was entitled to be believed because of his good character. There was nothing to suggest he was dishonest. He had offered clear and cogent details of the day and had substantiated the chronology. He said the Registrant had described being contacted by an anxious Patient A and he had accommodated him. He conducted a 'meticulous' examination which included multiple tests. This led to a diagnosis of disc-herniation. Mr. Maini-Thompson submitted that the Registrant had informed Patient A he could not do intrusive treatment because he did not have Patient A's medical records so he asked for these and then undertook gentle massage with the full verbal consent of Patient A provided in a running dialogue.

25. Mr. Maini-Thompson queried whether there may have been some 'labelling' issues when Patient A described tucking his knees toward his chest at the tail end of the examination or start of the treatment. This he submitted was ambiguous and suggested Patient A had elided the examination and the treatment. He suggested Patient A may have a confused recollection of events blurring the boundaries in the sequence. Mr. Maini-Thompson further submitted that the Registrant had not used EA or inversion, first, because they were not clinically justified, and second, because there was insufficient time to perform these separate modes of treatment.

26. Regarding the MRI scan Mr. Maini-Thompson submitted that Mr. Rajendran's opinion should be preferred for two reasons. First, the Registrant performed multiple neurological tests and could do no more. Second, the literature was to the effect that the tests performed, whilst not guaranteed, but when applied together, produced a broadly reliable result. Regarding the checks for cauda equina syndrome Mr. Maini-Thompson submitted that the Registrant did what was reasonable and concluded a referral was not justified. This was after a comprehensive testing regime. This was to be contrasted with Mr. McClune's approach which was rigid, made with the benefit of hindsight and would result in an over-cautious approach and multiple referrals to the NHS contrary to an evidence based approach.

27. Mr. Maini-Thompson submitted that from the outset the Registrant had admitted his notes of the treatment were not full notes. The Council's case was that there was a deliberate obfuscation but, the simpler explanation which he commended to the panel was that the treatment was a natural extension of

the assessment. The Registrant did not think there was a particular need to record this in a separate section of the form. As to the allegedly suspicious gaps in the form he suggested this suspicion was mitigated by the Registrant's otherwise clear and detailed notes as presented. Patient A confirmed the tests and these were fully recorded by the Registrant.

28. Mr. Maini-Thompson submitted that the absence of the previous treating osteopath from the notes reflected the fact Patient A had not told the Registrant about him and had not been entirely honest in his approach. Whilst Mr. Maini-Thompson conceded that the hospital notes concerning Patient A's subsequent admission should be treated with some caution, it was notable and suspicious he submitted, that there was no mention of violent osteopathic treatment. In addition he submitted that if it had been so violent and painful why had Patient A booked an immediate second appointment?

29. Mr. Maini-Thompson concluded by submitting that Patient A had been inconsistent and weight should not be given to his account. As such he submitted the outstanding elements of the Allegation should be found not proved.

Determination on the Facts

30. The Committee received and accepted the advice of the Legal Assessor. The Committee was advised that the Council bears the burden of proof throughout and the standard of proof is the civil standard namely the balance of probabilities. The Committee was further advised that in assessing the evidence it was entitled to draw inferences, that is it was entitled to come to common sense conclusions based upon the evidence, but that it should not speculate on the evidence. The Committee was advised that it had heard evidence from a number of witnesses including two expert witnesses. It should assess all the witness evidence in the same fair-minded way. Simply because evidence was given by an expert it did not mean the Committee was bound to accept it. It should assess that evidence in the same manner as any other evidence in the case, bearing in mind that expert evidence is entitled to contain opinion.

31. The Committee was also advised as to how it should treat the Registrant's previous good character in assessing both his credibility and propensity.

32. Where the Council alleged that the Registrant had "failed" that connoted a culpable failing. The Council would therefore have to prove that there was duty upon the Registrant to do or to not do something and that he had failed in that duty.

33. The Committee was advised that the terms "inappropriate" and "clinically justified," whilst similar were distinct and should be considered separately. Just because something is not clinically justified it does not mean it is necessarily inappropriate but it may be indicative of that fact.

Paragraph 1 - Admitted and Proved

34. The Registrant admitted Paragraph 1 of the Allegation at the outset of proceedings. Pursuant to Rule 27(1) of the General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ('the Rules') the Committee found Paragraph 1 proved.

Paragraph 2(a) - Proved

35. The Committee took careful account of the evidence it had heard from Patient A. It noted that Patient A described his previous knowledge and treatment by other osteopaths, and that the treatment provided to him by the Registrant was more forceful than he had ever experienced. Patient A had described lying on his side and the application of a lot of downward pressure.

36. The Committee noted that there was a degree of agreement between Patient A and the Registrant in so far as the level of pain Patient A presented with. Both agreed it was significant with Patient A describing it as at 8 out of 10.

37. The Committee noted that the Registrant did not accept using forceful treatment and that he had explained he used only gentle massage to relieve Patient A's pain.

38. There was clear and direct conflict in the evidence of the two witnesses. In resolving that conflict the Committee noted that the technique reported by Patient A was a technique consistent with forceful manipulation. It was therefore an account that in Patient A's written and oral evidence presented as both reliable and credible.

39. The Registrant's evidence, whilst clear did nothing to explain how the techniques reported by Patient A and consistent with forceful treatment were anything other. The Committee didn't doubt that the Registrant had administered some gentle massage, but on the basis of the evidence before it, the Committee concluded that the Registrant's treatment went further and did involve forceful treatment.

40. Given Patient A's presentation as being in significant, acute pain, the Committee concluded that in the circumstances the treatment administered was also excessive.

41. The Committee therefore concluded that on the balance of probabilities Paragraph 2(a) was found proved.

Paragraph 2(b)(i) - Proved

42. The Committee noted that the evidence Patient A gave regarding the initial treatment provided was consistent with forceful treatment. It was also consistent with spinal manipulation. Having preferred Patient A's account of the early part of the treatment provided, the Committee considered it was more likely than not that the Registrant had begun with some gentle massage and soft tissue treatment as he described in his written and oral evidence, but had then gone on to perform spinal manipulation.

43. The Committee therefore found Paragraph 2(b)(i) proved on the balance of probabilities.

Paragraph 2(b)(ii) - Proved

44. The Committee noted that the evidence of both Patient A and the Registrant was that the equipment for providing EA and inversion therapy was in the various rooms described by Patient A.

45. It noted Patient A's account of how EA was applied and how it felt, but that he had never before had that treatment, although he had had non electro acupuncture. The Committee noted the account given by Patient A of how such treatment was administered was not challenged. Patient A had given detailed evidence about how a box with protruding wires had been attached to acupuncture needles, where the box had been, the levels of electric current he was going to have administered and the pain it caused him.

46. The Committee took careful account of the Registrant's evidence that such treatment whilst something he could do was not something he would have considered in Patient A's case, and that he did not administer such treatment to Patient A.

47. The Committee determined that Patient A's account in this regard was detailed, credible and the accuracy of his account of the provision of such treatment had been unchallenged. Given Patient A had never before had such a treatment it

was difficult to account for how he would know the technique for administering EA if the Registrant had not provided it.

48. The Committee considered that presented with a patient with acute pain, the Registrant, having tried spinal manipulation, and being trained in EA was likely to have sought to help Patient A by the provision of alternative treatment modalities.

49. The Committee determined that in an effort to help Patient A it was more likely than not that the Registrant had performed EA.

50. The Committee therefore determined that on the balance of probabilities Paragraph 2(b)(ii) was proved.

Paragraph 2(b)(iii) - Proved

51. The Committee noted the evidence from Patient A, and his description of the inversion table. It considered his description was one consistent with him having seen the table being used, rather than simply having seen it in situ in the waiting room. His description of the technique involved in inversion therapy was unchallenged. Patient A had never before had inversion therapy and as with EA there was no explanation as to how he would have been able to provide a clear and unchallenged account of the performance of such a technique unless the Registrant had indeed performed it.

52. The Committee took careful account of the Registrant's evidence and noted that in his general practice the Registrant used inversion therapy for those patients suffering with "low back spasms." It noted that the Registrant denied using the technique in Patient A's case. However, taking account of Patient A's accurate account of how the treatment is performed, and of the Registrant's use of the technique on occasion to treat "low back spasms," the Committee determined that it was more likely than not that the Registrant had performed inversion therapy on Patient A.

53. The Committee therefore determined that on the balance of probabilities Paragraph 2(b(iii) was proved.

Paragraph 3(a) - Not Proved

54. Both Patient A and the Registrant explained that during treatment the Registrant was providing a narrative or 'running commentary' on what he was doing. The Committee determined that on the basis of the undisputed evidence

the Registrant had provided Patient with some information about the treatment.

55. The Committee therefore found Paragraph 3(a) not proved.

Paragraph 3(b) - Not Proved

56. The Committee noted that Patient A's evidence was that the Registrant had told him what was going to happen but had not set out the risks and benefits at the very start of treatment. However, Patient A was provided with some information such that he was able to follow instructions to move into certain positions and to undertake certain movements.

57. The Committee were only helped to a limited extent by the Registrant's evidence in this regard, given he explained his usual practice as what he would have done, rather than being able to provide an independent recollection of this particular occasion. Notwithstanding that difficulty the Committee considered that Patient A had been provided with sufficient information to understand what he needed to do and that the techniques would be used to provide him with some relief.

58. In the Committee's judgment before commencing treatment this represented Patient A receiving sufficient information about the treatment to be performed.

59. The Committee therefore found Paragraph 3(b) not proved.

Paragraph 3(c)

60. The Committee noted the definition of valid consent at A4 of the Osteopathic Practise Standards 2019 ('OPS'). In particular the Committee noted that for valid consent to be obtained Patient A had to be given sufficient information to enable him to be considered an "appropriately informed person."

61. The Committee noted that Patient A's evidence whilst definite in some regards was equivocal as to the nature of the information he was provided by the Registrant. He accepted the Registrant had provided a narrative during treatment but that he could not recall if he had been told about the risks and benefits of particular modalities of treatment.

62. There was therefore no definitive evidence that Patient A had not been fully informed as part of the Registrant's narrative. The Committee accepted that it was more likely than not that full information was therefore given to Patient A during the course of the treatment rather than before. However, the Committee

further noted that point 7 of Standard A4 of the OPS specifically anticipated a circumstance in which simultaneous examination and treatment can take place whilst information is provided to patients. That can only occur in specific circumstances such that it requires the osteopath to cease his treatment if it goes outside the agreed plan.

63. On the basis of the evidence before it the Committee concluded the Council had failed to satisfy the burden of proof it bore. The Committee could not say it was more likely than not that the Registrant had not ensured Patient A was appropriately informed for the purposes of giving valid consent, and that he had not conducted the consent process in the manner anticipated within point 7 of Standard A4. That conclusion was supported by the Registrant's actions in relation to the inversion therapy. When Patient A had objected to it continuing, the Registrant had ceased treatment immediately as envisaged in point 7.

64. Bearing in mind the burden of proving the case is on the Council, the Committee determined that it had failed to discharge that burden in relation to Paragraph 3(c) and that therefore it was not proved.

Paragraph 3(d) - Admitted and Found Proved

65. The Registrant admitted Paragraph 3(d) of the Allegation at the outset of proceedings. Pursuant to Rule 27(1) of the General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ('the Rules') the Committee found Paragraph 3(d) proved.

66. The Committee noted the submissions made by the Council that the records had been withheld, amended or otherwise redacted to remove elements inconsistent with the Registrant's case. The Committee determined there was no evidence to support such submissions and that the natural inference was that the Registrant's note taking system was at fault, rather than any deliberate attempt to cover up treatment performed.

Paragraph 3(e) - Not Proved

67. The Committee carefully considered the evidence of the two expert witnesses, as well as the Registrant's evidence. The Committee noted Mr. McClune's view that there was an imperative to refer for an MRI to rule out cauda equina syndrome, where there might have been neurological involvement in both Patient A's left side and right side, regardless of the examinations the Registrant had done.

68. Mr. McClune's view did not alter by reason of the low incidence of cauda equina syndrome, or by reason of the fact the NICE material was not accorded the status of Guidance.

69. The Committee noted Dr. Rajendran's view that the testing along with the low level involvement of neurological symptoms on the right side did not trigger any absolute requirement to refer. Rather it was an assessment taking account of the evidence before him that the Registrant was required to make, and that a reasonable body of osteopathic opinion would not have referred.

70. The Committee agreed with Mr. Rajendran's assessment. It was clear that there was a requirement for the Registrant to consider neurological involvement, and to assess that neurology. Both experts agreed the Registrant had done so assiduously and in detail. Neither could recommend an alternative or additional test the Registrant could have performed to identify neurological issues. It was clear from the Registrant's history of referring patients with suspected cauda equina syndrome that he was both aware and ready to refer as he considered it necessary.

71. In light of the evidence before him including the results of his examinations of Patient A's presenting symptoms, the Committee concluded that a reasonable body of osteopathic opinion would have concluded there was no requirement to refer Patient A for an MRI. The Registrant was therefore not under a duty to refer Patient A in the circumstances known to him at the time, and that he therefore cannot have been said to have failed in that duty. Accordingly, the Committee found Paragraph 3(e) not proved.

Paragraph 4 - Proved

72. The Registrant admitted Paragraph 4 of the Allegation at the outset of proceedings. Pursuant to Rule 27(1) of the General Osteopathic Council (Professional Conduct Committee) (Procedure) Rules Order of Council 2000 ('the Rules') the Committee found Paragraph 4 proved.

Paragraph 5(a) - Proved

73. The Committee first considered whether the Registrant's use of spinal manipulation was inappropriate. It concluded that it was a treatment administered with force, in circumstances where the patient had an involved history including spinal surgery twelve years before.

74. The Committee next considered whether EA and inversion therapy were inappropriate. The Committee noted the NICE Guidelines for sciatica appended to Mr. McClune's report. Both acupuncture and traction (inversion therapy) were not to be offered for the management of lower back pain.

75. The Committee also noted that the Registrant conceded that had he used those modalities they would have been inappropriate.

76. The Committee also noted Mr. Rajendran's evidence within his expert report, that acupuncture was not necessarily contra-indicated in the treatment of lower back pain.

77. Taking the evidence before it in the round, the Committee determined that the NICE Guidelines were clear that treating lower back pain with acupuncture or traction (inversion therapy) was not to be offered and was thereby inappropriate.

78. The Committee therefore found Paragraph 5(a) proved.

Paragraph 5(b) - Proved

79. The Committee carefully considered whether performing spinal manipulation was clinically justified. It considered that given the acute pain Patient A presented with anything other than gentle massage and soft tissue work was likely to cause significant discomfort possibly additional pain to Patient A. That accorded with the evidence Patient A had given, and demonstrated that spinal manipulation was, in the circumstances not clinically justified.

80. In light of the NICE Guidelines that acupuncture and traction (inversion therapy) are not to be offered for management of lower back pain, the Committee determined they could not have been clinically justified in Patient A's case.

81. The Committee therefore found Paragraph 5(b) proved.

Unacceptable Professional Conduct ("UPC") & Sanction

82. In light of the prevailing timetable, having canvassed the views of both parties and of the Legal Assessor, the Committee determined to deal with the issues of UPC and sanction in a single stage. It therefore invited both parties to provide submissions on both elements.

Submissions of the Parties

83. Mr. Gillespie submitted that assessing UPC was primarily a backward looking task, in which the Committee needed to assess the seriousness of the conduct found proved. He noted that not every falling short of the standards would amount to UPC, but that those that were serious enough to be worthy of the moral opprobrium associated with a finding of UPC should necessarily attract such a finding.

84. In relation to the treatment failings found proved by the Committee, Mr. Gillespie submitted they represented forceful, excessive treatment, and treatment that was both inappropriate and not clinically justified. The use of EA and inversion therapy was against NICE Guidelines, and although this was a single patient the treatment ran the risk of causing Patient A harm. As a matter of fact it did cause Patient A discomfort and pain at the time. The Registrant's conduct raised serious issues in the sense that the treatment was simply wrong for this patient. Patient A had presented with significant lower back pain. The treatment performed wouldn't have made his condition any better and might have made it worse. It was, he submitted, a solid foundation for a finding of UPC.

85. In so saying Mr. Gillespie submitted the Registrant's conduct in this regard amounted to a serious falling short of Standard C1 of the OPS 2019.

86. Mr. Gillespie further submitted that the failures in clinical note taking reflected in Paragraph 3(d) also amounted to UPC. He accepted that not every note keeping failure would amount to UPC, but that the Registrant's failing was particularly egregious, because what was missed off was everything that had triggered the Council's investigation and proceedings, specifically the treatment that was provided. He further submitted it represented a breach of Standard C2 of the OPS. In so submitting Mr. Gillespie accepted that if specific advice was given, omitting it from the notes would not on its own amount to UPC but that the failure to record treatment was serious and negated the point of record keeping. The whole point of records was that one should be able to look at the contemporaneous documentation and understand what went on in the room at the time.

87. Mr. Gillespie went further and submitted that, had both parties agreed about what had happened in the room, the record-keeping failings may not have amounted to UPC. However, because that was fundamental in this case it was particularly egregious.

88. In so far as sanction was concerned, Mr. Gillespie made no positive submission as to the appropriate sanction. Rather, he invited the Committee to carefully consider the Hearing and Sanctions Guidance, and in so doing to apply the principle of proportionality. He invited the Commtitee to assess the aggravating and mitigating factors, submitting that of those listed in the Guidance points (c) and (g) were relevant in terms of mitigation, and in terms of aggravation points (e) (h) and potentially (i). He submitted there was no evidence before the Committee of insight or remediation, and no evidence of an apology from the Registrant.

89. On the issue of UPC Mr Maini-Thompson conceded that the Committee's findings in relation to the treatment performed did amount to UPC. However, he submitted that the clinical notes element did not, for two reasons. First, it was a single isolated incident. The Registrant had made admissions to the fact that the notes lacked detail and were lacking in utility for wider purposes.

90. He submitted that the Council's invitation as to how the Committee might find UPC in relation to the notes was "unempirical" and unreasonable, and represented and effort to get dishonesty in "by the back door." Second, he submitted that the legal test for UPC was whether the conduct was worthy of moral opprobrium which he submitted connoted some level of intention. Mr. Maini-Thompson submitted, the Committee was not in a position to make findings of the Registrant's level of intent in note taking failures. It would not be appropriate to find his lack of notes are morally blameworthy or worthy of opprobrium.

91. In addressing the issue of sanction Mr. Maini-Thompson submitted that the Registrant was of previous good character, had practised without incident since March and had provided references and testimonials commending his professionalism.

92. In the circumstances Mr. Maini-Thompson submitted that an order of conditions was appropriate in all the circumstances. On the Registrant's behalf he invited the Committee to impose conditions prohibiting the Registrant form performing EA or inversion therapy and requiring training in note taking and performance of clinical techniques. He submitted that any further sanction of a more serious nature was disproportionate in the circumstances.

The Committee's Findings on UPC and Sanction

93. The Committee received and accepted the advice of the legal assessor. The Committee was advised that the question of UPC was a matter for its own judgment and that there was, as distinct from the fact finding stage, no burden

of proof. The Committee was advised that not every falling short of the standards amounts to UPC. For UPC to be found the act or omissions should be serious: Roylance v GMC [2000] 1 AC 311 & Nandi v GMC [2004] EWHC 2317. The Committee was further advised that in the terms of Spencer v GOsC [2012] EWHC 3147 the allegation should amount to conduct that can be considered deplorable and therefore worthy of the moral opprobrium and the publicity which flows from a finding of UPC.

94. The Committee was further advised of the case of Shaw v GOsC [2015] EWHC 2721 (Admin) in which the Court made it clear that the bar for a finding of UPC was not so high as to make the lowest form of sanction meaningless. For UPC to be found the conduct must be serious but not of such gravity that the lowest powers of sanction would be inappropriate.

95. In relation to sanction, the Committee was reminded that it should have regard to the Guidance published by the Council, and apply the principle of proportionality, weighing the interests of the public with those of the practitioner and taking the minimum action necessary to protect the public and the wider public interest.

96. The Committee was further advised that Sawati v GMC [2022] EWHC 283 (Admin) was a helpful case and authority for the proposition that a Registrant was entitled to robustly defend a case, without an adverse finding about their level of insight, and that the Committee and that the issue of insight should be considered in the round, taking into account all the material the Committee had before it. Admissions were by no means a pre-requisite to establishing insight.

97. The Committee was advised that it should adopt an approach of considering sanctions in ascending order of seriousness beginning with the least draconian and ask whether the sanction it was considering met the need to protect the public and wider public confidence in the profession. If it did not then the Committee should then and only then consider the next sanction in order of seriousness.

98. The Committee first considered whether the facts found proved amounted to UPC. It first addressed the treatment issues identified in Paragraph 2 and 5 of the Allegation. It determined that the treatment was administered in an excessively forceful manner and went beyond the normal parameters of treatment for the pain Patient A was exhibiting. The acute nature of Patient A's presentation meant a conservative approach to treatment had been appropriate, and that the Registrant had failed to give effect to that.

99. The Committee further considered that his choice of treatment was of serious concern, given it was not recommended in the NICE Guidelines that EA or

traction (inversion therapy) be used in the treatment of lower back pain and sciatica.

100. Both the Registrant's decisions on treatment modalities, and his performance of treatment put Patient A at risk of harm and represented a serious falling short of standards, such that it was worthy of the moral opprobrium accompanying a finding of UPC.

101. The Committee next considered whether the Registrant's poor note-taking amounted to UPC. It considered that the note taking was limited and that there were clear and material gaps in the information within the notes. Those gaps represented a breach of Standard C2 of the OPS.

102. The Committee carefully considered whether such a failing was sufficiently serious to cross the threshold of UPC. It noted this was a single patient record, that the appointment had occurred late on a Thursday afternoon (when the Registrant did not normally work) and the Registrant had agreed to treat Patient A at short notice. The Committee accepted that not every omission from clinical notes was serious.

103. However, the Committee considered that of the elements contained in clinical notes the most important was the record of the treatment undertaken during an appointment. It was of profound importance that anyone looking at the records, whether the Registrant himself or any other professional in whatever context, had a clear idea of the treatment administered at a particular consultation. The Registrant's total failure to record such basic information, notwithstanding his defence in the proceedings, represented a serious falling short of the standards and thereby did amount to UPC.

104. The Committee did not consider the Council's submission that the seriousness of the failing was egregious by reason of it "leading" to the proceedings before it. To the contrary, had it embarked on such an assessment the Committee considered this would have been a hindsight assessment of the consequences of the failing, which it considered should not be allowed to affect its assessment of the conduct itself. The fact proceedings had taken place illustrated the fundamental importance of note taking in a clinical setting, but in the circumstances of the case, the Committee determined it could not be considered to make the failing more serious in and of itself.

105. Notwithstanding its rejection of the submission the Committee did determine that the failure in note taking to amount to UPC.

106. Having found UPC proved the Committee next considered what sanction to impose. It first considered the mitigating factors present, and noted the

Registrant's good character, and that no other incidents had been reported since the Registrant treated Patient A. In terms of aggravating factors the Committee noted that the Registrant had not apologised to Patient A and appeared to have shown little or no remorse. However, in oral evidence he had told the Committee he was generally very caring towards his patients, which the Committee accepted.

107. The Committee paid close regard to the References provided on the Registrant's behalf and noted the positive terms in which they were couched.

108. The Committee considered there was extremely limited evidence before it of insight, although it noted that through his counsel, the Registrant had accepted the treatment failings amounted to UPC and had offered to cease using particular treatment modalities altogether. The Committee considered this showed some insight albeit limited, into his own failings and the duty the Registrant owed to the public interest. The Committee was unable to identify any evidence of remediation.

109. The Committee considered that, in light of the nature and extent of the conduct found proved, coupled with the relative lack of remediation and insight in the Registrant's case, that there remained a risk to the public if the Registrant remained in unrestricted practice.

110. The Committee next considered the appropriate sanction, it reminded itself of the need for proportionality, and approached the process looking at the least restrictive form of sanction first.

111. The Committee considered that an admonishment, whilst signalling that the Registrant's conduct was unacceptable, did nothing to address the potential risk the Registrant posed to the public, and was insufficient to uphold public confidence in the profession and declare and maintain standards.

112. The Committee next considered whether conditions of practice could meet the identified need in this case. The Committee concluded that there were conditions that could be formulated and that were relevant, proportionate, workable, measurable and capable of being monitored, and which in turn would meet the Registrant's identified needs and the need to protect the public and the wider public interest.

113. In formulating conditions of practice, the Committee considered the specific risk the Registrant posed to patients and the public. That risk comprised his use of forceful and excessive techniques in inappropriate circumstances, and that his clinical judgment was a risk in so far as it affected his choice of treatment modalities. Further that his note taking was extremely poor to the

point where it did not identify, to subsequent treating clinicians, the nature of treatment performed. That in turn represented a risk to patients, should treatment that had not worked previously be performed again.

114. In order to meet the identified risks the Committee determined that the Registrant's registration should be subject to the following conditions:

1. You must place yourself under the supervision of a registered osteopath. The supervising osteopath must be approved by the GOsC. The supervising osteopath's fees must be paid by you.

2. You must work with your supervisor to formulate a personal development plan, specifically designed to address deficiencies in the following areas:
- *i.* choice of osteopathic treatment modalities;
- *ii.* clinical note taking;
- *iii.* development of spinal manipulation technique.

3. You must ensure that your supervisor reviews no fewer than six sets of your clinical notes, generated in relation to consultations with patients during the currency of these conditions.

4. You must ensure your supervisor observes no fewer than six treatment sessions with patients, involving choices of treatment modalities.

5. You must successfully complete in-person training by attendance at a practical manual therapy course focussing on spinal manipulation.

6. This Order will be reviewed at a hearing before it expires.

7. At the review hearing the Committee will wish to see the following evidence:
- *i.* A report from your supervisor identifying your compliance with conditions 1 - 5 above as measured against the Osteopathic Practice Standards;
- *ii.* A copy of your personal development plan;
- *iii.* Evidence of your training in spinal manipulation.

8. You must provide this evidence to the GOsC at least one month before the date of the review hearing.

9. You will be responsible for the payment of any costs associated with compliance with these conditions.

115. The Committee determined that these conditions shall remain in force for a period of 8 months. Towards the end of that period the Committee directs that a review hearing shall take place.

116. Whilst the Committee considers 8 months is necessary to allow the Registrant time to comply with the terms of his conditional registration, it does note that paragraph 70 of the Hearings and Sanctions Guidance does allow for the period of conditional registration to be reduced, where appropriate. In the Committee's view this envisages allowing the Registrant to apply for an early review should he have complied with the conditions prior to the expiry of the 8 month period.

117. The Committee therefore determined that it was necessary to protect the public and was otherwise in the public interest to impose an order of conditions in the terms set out above for a period of 8 months.

Under section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee's decision.

The Registrant will be notified of the Committee's decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the High Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them, the nature of the Allegations and the steps taken by the Committee in respect of the osteopaths so named.