GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 1735/3315

Professional Conduct Committee Hearing

DECISION

Case of:	**Alexander Malkani**
Committee:	Ms Ormerod (Chair) Ms Harvier (Lay) Ms Easter (Osteopath)
Legal Assessor:	Jon Whitfield KC
Representation for Council:	Mr MacDonald
Representation for Osteopath:	Mr Corre
Clerk to the Committee:	Sajinee Padhiar
Date of Hearing:	10, 11, 12, 13, 16, 19, 20 June 2025

Summary of Decision:

Case Number

The Committee found proved
Allegation 1, 2, 3, 4a, 4c, 5a (in part), 5b (in part), 6

The Committee found not proved
Allegation 4b

UPC: Found proved in respect of Allegations 3, 4a, 4c, 5a (in part), 5b (in part) and 6

Sanction: Conditions of Practice Order, 12 months. (To be reviewed)

Allegation 1735/3315

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

1. Patient A attended ~~two~~ appointments with the Registrant on 27 March 2023 (Appointment 1) and 4 April 2023 (Appointment 2).
   Admitted. Found proved

2. During Appointment 1 and~~/or~~ Appointment 2, the Registrant applied spinal manipulation treatment techniques to Patient A's cervical and~~/or~~ lumbar spine areas (the Treatment).
   Admitted. Found proved

3. At Appointment 1 and/or Appointment 2, the Registrant failed to obtain valid consent before carrying out the Treatment
   Denied. Found proved in relation to Appointment 1 and Appointment 2

4. At Appointment 1 and/or Appointment 2, the Registrant failed to conduct an adequate osteopathic evaluation of Patient A, in that he:

   a. failed to undertake an appropriate clinical assessment of Patient A;
   Denied. Found proved in relation to Appointment 1 and Appointment 2

   b. failed to consider that severe spinal degeneration may have been present in Patient A's spine;
   Denied. Found not proved

   c. failed to adequately assess Patient A's lower limbs for neurological deficit, motor power loss and/or sensory deficit.
   Denied. Found proved in relation to Appointment 1 and Appointment 2

5. The Registrant's conduct as set out in paragraph 2 was:

   a. contraindicated; and/or
   Denied. Found proved in relation to the lumbar spine in relation to Appointment 1 and Appointment 2. Found not proved in relation to the cervical spine in respect of both appointments.

   b. not clinically justified.
   Denied. Found proved in relation to the lumbar spine in relation to Appointment 1 and Appointment 2. Found not proved in relation to the cervical spine in respect of both appointments.

6. The Registrant's conduct as set out in paragraph 4 was inappropriate.
   Denied. Found proved in relation to Allegation 4a and 4c in respect of Appointment 1 and Appointment 2. Found not proved in relation to Allegation 4b.

Preliminary Matters:

1. Allegation one and Allegation two were slightly amended as set out above to clarify the facts admitted in the case. This was done with the agreement of Mr MacDonald and Mr Corre and following advice from the Legal Assessor.

Summary & Opening

2. Mr MacDonald read the Allegation into the record. Mr Corre advised that Allegations 1 and 2 were admitted but all remaining allegations were denied.

3. Mr MacDonald referred the Committee to the written documentation and outlined the case in brief. He said that Patient A saw the Registrant for treatment during which he did not tell her what he was going to do, nor did he provide information as to the risks involved. She described him as "a man of few words". Mr MacDonald referred to the Registrant's notes and said there was one reference to consent at the first appointment but this was not explained further and there was no such note for the second appointment. He said it was the Registrant's case that he would have explained what osteopathic treatment was and then asked Patient A if she agreed. He then made a record of this. The expert evidence was that valid consent required an explanation of the reason for the treatment, the nature of the treatment, the benefits, risks and any alternatives to the treatment proposed. Mr MacDonald said that if Patient A's account was accepted the Registrant did not obtain valid consent. It was the opinion of Mr McClune (the expert called on behalf of the GOSC) that this would fall far short of the relevant standard. Mr MacDonald said that in his initial written response to the allegation the Registrant provided no explanation of why the treatment was pursued or the key risks involved. This was expanded upon in his witness statement and it would be a matter for the Committee to determine what he explained to Patient A and if there was valid consent. Mr MacDonald said there was nothing recorded regarding consent in the second appointment.

4. Concerning the osteopathic evaluation, Mr MacDonald said there was no issue regarding the case history and what the case largely concerned was whether the Registrant had sufficiently acted upon and completed an assessment of Patient A's neurological symptoms. He said that degenerative changes in Patient A's thoracic and lumbar spine were subsequently discovered via MRI scan and were such that they were likely to be present at appointments one and two. Patient A was recorded as having had symptoms of pins and needles, pain, her leg gave way and she had a long standing urinary urgency. These all supported the conclusion that the degenerative changes were likely to be present at the time of the consultations.

5. Mr MacDonald said that regarding appointment one the case history appeared to be acceptable but there was no assessment of Patient A's motor power or the symptoms in her lower limbs to consider radiculopathy. It was Mr McClune's

view that the symptoms should have led the Registrant to undertake an assessment of strength loss and sensory deficit by way of tests such as the straight leg raise test. Further, it was Mr McClune's view that a working diagnosis should have concluded that the symptoms were the result of degenerative changes in the spine. No such working diagnosis was recorded in the Registrant's case notes. Mr MacDonald asserted that the Registrant went on to perform manipulation that was contraindicated by a number of factors and a clinical examination insufficient to exclude radiculopathy.

6. Regarding the second appointment Mr MacDonald said that other than an inquiry as to whether Patient A felt better, there was no record of assessment at all. He said that the Registrant and Mr Butler (the expert called on the Registrant's behalf) provided their views on muscle tests and pinprick tests. Mr MacDonald said that the Registrant asserted that he did recognise Patient A's potential for spinal degeneration and this was why he did not aim treatment at her thoracic spine but to date the Registrant had not referred to any explanation of the neurological symptoms. Mr MacDonald commented that Mr Butler suggested an explanation of symptoms was necessary but due to the absence of detail in the Registrant's notes he could not say what more could or should have been done by the Registrant. It was Mr Butler's opinion that it may be no further testing was required. Mr MacDonald said it was the GOsC's case that further inquiry was required including the straight leg raise and an exploration of the symptoms given in the history, and the picture was not sufficiently clear for the Registrant to dispense with such further investigation. This he said was why the osteopathic investigation was alleged to be inappropriate at both appointments.

7. Regarding spinal manipulation Mr MacDonald said that Patient A described the manoeuvres and the force used in both appointments. He said that it was not disputed that techniques including HVT (High Velocity Thrust) were used on the cervical and lumbar spine but it was the Registrant's case that given the thoracic spine was avoided the use of HVT was not contraindicated. It was the GOsC's case that given Patient A's age, the finding of a very rigid spine and neurological symptoms that were not adequately explored, spinal manipulation was indeed contraindicated. The fact that such manipulation was at the cervical and lumbar levels made no difference. Mr MacDonald said that the Registrant claimed he used minimal force but Patient A's description was not consistent with that. He said that both experts agreed that the contraindications were relative and the question was the weight to give to those when deciding whether to proceed with HVT.

8. Mr MacDonald said that Patient A did subsequently deteriorate and there was a diagnosis following an MRI scan but he said that whilst it is possible the Registrant's treatment caused deterioration that was not capable of proof. The Committee was not being asked to determine that fact. It was the GOsC's case simply that the Registrant's actions created a risk to Patient A.

Evidence

Evidence for the GOsC

9. Patient A was sworn and then shown her witness statement. She confirmed that the contents were true. Mr MacDonald then asked some supplementary questions. Patient A said that when she was on the treatment table lying on her side the Registrant rocked her about and then he used some force to try and ease her back but it remained rigid. She said the Registrant did this several times during which he told her to relax, which she said she did. Patient A confirmed that she was on her side when he did this manoeuvre to her mid spine, he used both hands but she was not sure whether he had one hand on her shoulder and one hand further down her body. She described a short sharp movement with both of his hands on her body. She said it felt like quite a lot of force was used on her lower back and the same extent of force was used when manipulating her upper spine and neck. She said that she did not immediately experience symptoms.

10. Patient A agreed that she attended a second appointment on the 4th April 2023 and said the Registrant performed the same manipulation three or four times with no success. He used the same amount of force as in appointment one. She said that she did not experience any symptoms prior to May 2023. She said she attended the Registrant's practice because she had pain, stiffness and aching. She confirmed that she worked in an office and that sitting at a desk all day made her symptoms worse. She denied experiencing any tingling sensations or stiffness in her feet before the appointments. She confirmed that she had never had to go to her GP regarding her back. She said that the GP had not mentioned what they thought had caused the onset of the tingling sensation and stiffness in her feet before she consulted her GP in May 2023.

11. When describing the appointments Patient A said that she did not feel the Registrant recorded very much of a medical history. She spoke of her experience at a massage during which a long form had been filled out and she contrasted that with the Registrant who she did not feel took very much information and did not fill in such a long form or any disclaimer. Patient A said she was not given any information on the risks of the treatment and she did not think that the Registrant told her he would be manipulating her. She re-stated that she was on her side at which time the Registrant told her to relax. He did not say anything else before going on to manipulate her. This happened during both appointments and she described him as "a man of very few words".

12. Patient A was referred to a record of her initial complaint and she said that it was a correct note of what she said. In this she described a deep thrusting movement to her upper back and neck which was repeated in her middle and lower back. Patient A was taken to a diagram referred to as image B and asked to indicate where she was treated. Regarding her upper back and neck Patient A utilised the grid overlaid on the diagram and indicated H1 to 4 (neck to between shoulder blades) was where she was touched and manipulated using

the deep thrusting movement. She then indicated the same further down at H8-11 (below shoulder blades to mid and lower back). She described the same movement with no difference. Again she described lying on her side with gentle rocks and then the deep thrusts using his arms on her body. She said he pulled her back vigorously or very hard. She said that she did not recall work on her lower back rather she recalled work on her mid and upper back and her neck. She did not think work was done on the hip area. She described the level of force as high or very strong and occurring three times. On a scale of one to ten she said it felt like 8 and it was the same in each area. She said that the treatment at the second appointment was in the same areas and with the same levels of force.

13. Patient A said that the Registrant did not tell her what he was going to do. She said there was no explanation at any appointment, he did not tell her why he was doing what he was doing or what he was going to do, there was no explanation of the risks, no explanation of the possibility of discomfort, worsening symptoms, damage to neurological structures or blood vessels. Regarding an explanation of the risk of stroke she said; 'definitely not'. Patient A was then taken to her second witness statement and further comments. She said she was commenting upon the Registrant's response and what she said in her statement and comments were true to the best of her belief.

14. Mr Corre then asked questions in cross examination. Patient A confirmed that she first met the Registrant some 10 years ago when he successfully treated her neck. She said that she had not seen her GP or any other medical person about her back. She had seen someone regarding arthritis in her knee, she had never had an X-ray to her spine, she did have fibromyalgia and saw a doctor and had been prescribed painkillers.

15. Patient A agreed that she had spoken to someone at the GOsC on 5th April 2024 regarding the first appointment on 27th March 2023. She had referred to tingling which developed into pins and needles. She said that it was not difficult to distinguish between the two, tingling was delicate pins and needles was more severe. She denied telling the Registrant that she had experienced pins and needles in her left leg but thought she had said she experienced pain in her neck and back. She did not specifically recall saying her lower back. She said that she did not say anything about pins and needles at the appointment because she did not develop the sensation until May 2023, which was after the treatment had taken place. She described her back as aching and stiff and attributed some of that to sitting at a desk as part of her employment.

16. When asked about the first appointment, Patient A said she did not recall the Registrant testing her reflexes or tapping her knees. She agreed that she was taking medication for high blood pressure and said that she had pain in her knee from osteoarthritis and was awaiting a knee replacement. Patient A confirmed that she had an emergency operation on her back in February 2024 but denied this had affected her memory of events as related in her complaint in June 2024. She reaffirmed that she did not recall the Registrant explaining

the nature of osteopathic treatment nor did she recall him explaining the manipulation of soft tissue or bones, stretching of muscles, manipulation or mobilisation of joints or HVT. She did not recall any explanation or description of treatment. Regarding her headaches she said that these may have been related to her neck and that was why her neck was treated. She confirmed that after the first appointment she experienced some relief in her upper back and neck. Patient A said she did not recall the Registrant inquiring whether she was happy for him to proceed with treatment. She confirmed she was lying on her left hand side and thought the Registrant stood behind her when he treated her. She said that his thrusting of her body did not feel gentle. It was suggested that the Registrant did not treat her middle back but she did not believe that to be true. She confirmed he treated her middle back. She did not agree that it was difficult to recall the exact location of the treatment.

17. Patient A was taken to her statement and she confirmed that the description of her first and second treatments were the same. She said at the time of the statement she probably remembered more than she did today. She said that what was written in her statement was middle and lower back. Mr Corre took Patient A to a further diagram (Diagram A) and suggested that the Registrant only treated her cervical spine and lumbar spine not the thoracic spine. Patient A did not agree.

18. When asked about her employment Patient A said that she worked in an office and spent a lot of time in her chair. She did not expect to have immediate relief from her symptoms although this would have been nice. She confirmed that some 10 years previously she had experienced immediate relief and so did expect to have some immediate relief and expected to hear a cracking sound. She reiterated that she perceived the thrusts as hard. She confirmed that she felt a release in her upper back and neck, but the middle part of her back did not crack or release. She confirmed this was set out in her statement and she described the treatment as lasting about 10 minutes. Following the first appointment she said the Registrant asked her to come back in a week. She agreed to do so because at the time she believed more treatment would be helpful.

19. When asked about the second appointment on the 4th April 2023 she said she did not recall the Registrant asking her about any changes since the last appointment. It was put to her that she had said the headaches were better and so were the pins and needles. She said she did not recall pins and needles. Patient A said that the Registrant did not reassess her at the second. He treated her upper, middle and lower back and again treated her middle back. She said that the Registrant had told her about some exercises and described what she should do. She said that she absolutely did not agree that a third party such as a physiotherapist had described exercises and she vividly remembered him telling her this. She confirmed that she was not in pain after the second appointment.

20. Patient A denied seeing the Registrant at a third appointment on the 13th April 2023. She said that she had mentioned her neck to the Registrant some 10 years ago. She thought that she had gone to see him about her leg however she did not recall the details. She said that she only saw him twice in 2023 regarding her neck and back. She could not remember the details of the appointment 10 years previously it may have been about her hip but she could not confirm this. She said that she had had a heel lift on her left hand side but that had not been prescribed by the Registrant, rather it had been by NHS orthotics.

21. Mr Corre suggested that Patient A had seen the Registrant for a third appointment during which he reassessed her, asked her about changes and she had said that her headaches were much better. She confirmed that her headaches were much better and that her lower back was sore and stiff but not severe nor was it a shooting pain. However she said that she did not attend such an appointment rather the Registrant did the same thing on two occasions. She did not recall the Registrant suggesting that she see a GP if her symptoms did not settle. Mr Corre took Patient A to the bundle and the reference to the third consultation on 13th April but Patient A said that she did not recall this.

22. Patient A was taken to documents in the bundle including her response to the Registrant's comments on her allegation. She confirmed in her response and in her evidence today that she did not suffer from sciatica or pins and needles in her left leg, or pain in her left buttock at the time of the consultation. She said that these symptoms must be notes from a previous appointment she had with the Registrant going back several years. She referred to treatment and a consultation with the Registrant following use of the heel raise as provided by her orthotist to treat her pelvis which had been tilted. She said that her fibromyalgia did not cause pain in her spine or legs rather it was in her hands arms and shoulders. She agreed it was a muscular pain all over similar to that when suffering from flu she said it did not affect her memory. Regarding the second treatment Patient A said she did not recall the Registrant checking the way she stood nor did he ask her to bend or turn around or turn on her side she did not recall any of that. She clarified this to say that it could have happened but she did not now recall it. She again said that the note of her original complaint was likely to be more reliable.

23. In answer to questions from the Committee Patient A said that she did not recall any massage treatment. She thought that she moved on the treatment couch but did not recall the Registrant being in front of her. She denied lying on her back and said that she was on her side all the time. She could not now recall his position, whether he was behind her back or her head she confirmed that she lay on her left hand side and that she did not recall any massage. Patient A recalled a rocking motion prior to the thrust and she said that the Registrant's hands were fixed in one place but she could not now recall where that was. She did not recall him stretching her tissue as part of the treatment. She reaffirmed that the issue of pins and needles and her left leg giving way was not dealt with in her consultations with the Registrant in 2023 and she

really did not know where that detail had come from. She recalled saying that she had a stiff neck and stiff sore spine. Patient A was asked 'how could the Registrant have recorded these things if she did not say it?' and she replied that she most certainly did not say this and did not say that she had pain in her left buttock. When asked if these symptoms were described in a previous visit she thought this was the case. She said that she had a pelvic problem but she could no longer recall when she had attended for that but it could have been as long ago as 10 years. Patient A said they did not discuss her previous appointments nor did the Registrant ask her how she had been in the 10 years since he had last seen her.

24. In further cross examination Patient A confirmed that she did not remember lying on her back with the Registrant treating her neck. She then conceded that it could have happened in this way but she did not remember it. She referred to her statements and the documents and said she did not now remember the position she was in. She re-stated that she did not mention anything to do with pins and needles since that was a reference to her pelvis some years ago. She said that she did not believe the notes were taken or kept correctly because from her own recollection they were incorrect. She confirmed that her GP's details had been correctly recorded. She again said she did not understand how pins and needles could have been recorded by the Registrant because she did not have them in March 2023. She had used an orthotic wedge in her left shoe which had corrected her hip problem so there were no pins and needles in 2023.

25. Regarding stretching her neck muscles, back muscles and fibres, she did not remember this. She confirmed that she had told him that she had a pain in her neck and in her periscapular area. Regarding the problem in her knee, she said she was awaiting a replacement but she denied that he had treated or stretched the muscles in her right leg. She said she did not remember this. It was put to her that the Registrant had done a great deal of soft tissue treatment and she said it might have happened but she did not remember. When asked by the Chair how things have been left after the second appointment, Patient A said that she did not think it had been helpful but she had been given exercises to do and she thought fair enough that might help but he did not suggest another appointment.

26. In further re-examination Patient A said she saw notes made at the time but did not see the detail. She saw a card being written on and put in a box. She did not read what had been written. She said that today was the first time she had seen the handwritten notes and the first time she had seen the typed notes.

27. Mr McClune was then called to give evidence. He adopted his report dated the 8th of July 2024 and stated that it was true to the best of his knowledge and belief. Having listened to Patient A's evidence he said that he had no changes to make to his report. Mr McClune was also shown the joint expert report and he said that he adopted this in respect of his conclusions. Mr McClune was then taken through some of his conclusions. He said that at paragraph eight of his

report he had commented that the Registrant provided no evidence of a diagnosis or treatment plan or even a working diagnosis. He expressed the view that a working diagnosis played a part in consent since part of what an osteopath does is to explain what they have found after the examination and case history, outline the possible causes or treatments that may be used to deal with those issues and outline what the risks are. He said that the consenting process started with a working diagnosis and what the osteopath may do. He conceded that the working diagnosis may have a degree of uncertainty but it was part of the process of providing an idea of what might be happening to a patient based upon what the osteopath had been told and what they had found. He agreed that the working diagnosis might change over time over weeks or months depending upon the evidence and the response to treatment.

28. Regarding Patient A undergoing an MRI scan some months after the consultations he confirmed that this found she suffered from severe degenerative changes to her thoracic and lumbar spine. He described compression of the spinal cord at T11-12 and L2-3, L3-4 where the spinal canal narrowed, and corda-equina at the tail end of the spine where the spinal cord was again compressed and narrowed. He said that T 11/12 is at the base of the thoracic section of the spine. He said T1 was at the base of the neck and T12 at the waistline. He said that the degeneration such as was clear on the MRI was likely to have occurred over a number of years and was likely to have been present at the osteopathic appointments. He said that the use of force could aggravate such degeneration. When asked why, Mr McClune said that force at the lower lumbar spine could have some physical effect on the upper lumbar and the thoracic areas. He described the spinal column as being connected in that the spinal cord runs through the canal from the neck to the lower end and there is connection through tissue and muscle overlap. He described the spine moving at the individual level but also as one gross structure hence force at one level could affect another level. He said that the amount of force, the position and technique used all affected a patient's experience of where the manipulation was felt.

29. Regarding the question of whether Patient A had symptoms or signs that should have alerted the Registrant of her spinal degeneration Mr McClune was referred to paragraph 26 and 28 of his report. He said that these symptoms gave rise to the potential for a left side radiculopathy which is a compression of the nerve root where the nerve comes out from the nerve root canal. This could be caused by for example compression or inflammation and may result in pins and needles, pain, power loss, numbness or any of these. Mr McClune observed that the case notes suggested Patient A had pins and needles in her left leg and the leg also gave way which may indicated power loss. These appeared to have been described by Patient A. Whilst he agreed that that could be a variety of reasons for these symptoms, they suggested that something was happening because the leg was not supporting the body. When asked of the importance of this he said there were symptoms suggestive of something happening at the nerve root. That could for example be a disc prolapse. It was not just an issue of a muscle being stiff or tight and therefore a degree of caution was required.

He agreed that symptoms may be of varying degrees and that the potential required testing of muscle power and sensory deficit in accordance with the NICE guidelines. He conceded that the NICE guidelines were the gold standard but then queried how low could the bar (of competence) go. It was his view that there should have been some sensory touch examination of Patient A's leg to see if she could feel this and that a muscle resistance test was simple and quick and would test the L1-2 part of her spine. He said this quick test may indicate whether it was a nerve issue or a muscle power issue and the difficulty was that if you did not do this test you would not know.

30. When asked about the straight leg raise test Mr McClune said that the Registrant appeared to consider the potential for radiculopathy and a straight leg raise test would illustrate how bad that was since it would demonstrate how well the nerves moved. He said it was a simple test and because Patient A did not appear to clarify her experience of symptoms the test may suggest that the nerve was prevented from moving. He said it gave the idea of whether there was potential pressure on the sciatic nerve. Mr McClune was then taken to the NICE guidelines within the bundle which he commented upon. He said these were broad and authored to provide guidelines for different practitioners. He confirmed that it provided guidance when an osteopath suspected sciatica or lumbar radiculopathy.

31. Mr McClune was asked to comment upon the Registrant's notes of his examination and said that there was no note of muscle power, sensory deficit or straight leg testing. When asked why this needed to be done he said that if Patient A had discussed pins and needles, and her leg giving way, the Registrant would want to find evidence as to whether this was caused by neural compression so one looked for signs of nerve conduction problems. This would bring you to a different place as compared to muscle stiffness or back stiffness since it suggested there were degenerative changes or perhaps a disc prolapse or something more sinister. He said that these three tests may well give results to suggest the back was normal or they may be indeterminate or suggestive of mild nerve compression, which was unimportant but, if the Registrant did none of the tests, he would not know. He said that these tests may inform caution or confidence and the risks or lack of risks around a compression of nerves.

32. Mr McClune observed that he had confirmed the case notes did not raise any red flags but suggested a decreased range of movement in the patient's lower thoracic spine which was said to be very rigid. He regarded this as unusual and suggestive of a significant loss of mobility in the lower thoracic spine. His conclusion was that the working diagnosis should probably have concluded the symptoms were the result of degenerative changes in the lower thoracic and lumbar spine areas however the clinical examination was not adequate to assess the likelihood or the extent of radiculopathy. In other words the neurological examination was too limited and could not rule out this risk. He said that he had come to this conclusion because of a combination of the patient's age, chronic history of lower back pain, which was progressively worsening, the absence of traumatic injury or cause, there were symptoms of

leg nerve compression and Patient A had a very rigid thoracic spine. He said that all of this was pretty strong evidence the spine was not moving or functioning as expected. It was not simply a muscular cause. It was his view that the symptoms meant that manipulation should not have been used, it was contraindicated. That was his conclusion based on the evidence. He said that a very rigid spine was not typical in a 64 year old and suggested something significant was happening. He said that the lumbar spine may have an effect on the lower thoracic spine so one would want to be cautious. He said that regarding the pins and needles and the leg giving way, without testing this the Registrant would not know the cause. An examination might confirm the complaint. He said all of these features raised alarm bells and the Registrant would want to be careful with this patient.

33. When asked if it was acceptable to use an HVT only in the area of the lower lumbar spine and not the upper lumbar or thoracic areas Mr McClune said that an osteopath can focus treatment and manipulate the body to isolate the areas of the spine but it was very hard to eliminate movement at the thoracic from the lumbar area. He said it could be reduced but it was very difficult to eliminate completely. He said that Patient A's description of lying on her side and a rocking motion before the thrust was typical of a lumbar manipulation technique which he then described. He confirmed that a patient would experience a rocking movement and then a thrusting movement. He said there was a scale of both force and speed in the use of an HVT and that one can manipulate with speed but without force, focussing on one level to isolate the manipulation. However, he said that a lumbar roll (ie manipulation of the lumbar spine) always involved thoracic movement and that the roll will start always two or three joints above the one that was being manipulated. He said that a very focused low force thrust would feel quite mild and might feel like slight pressure and a slight twist to the back.

34. When asked about his conclusions Mr McClune said that there was no evidence of a re-evaluation by the Registrant at the follow up consultations. He said that the notes did not show there to be a revaluation but said this could be because it was not noted down. Such re-evaluation may be quite short, asking a patient how they felt, reassessing, palpating and repeating neurological tests etc but it was in effect asking questions and a physical re-assessment to some degree although the latter could be quite brief.

35. When asked about the degree of failing he considered to be present, Mr McClune said that if the Registrant failed to obtain valid consent that fell far below the standard expected. He said that the osteopathic standards set out what was required to obtain valid consent and that a lack of such consent could lead to criminal cases and serious unprofessional conduct. Regarding the lack of neurological examinations he again asked the question 'how low can the bar be set?' He said that once Patient A had confirmed those symptoms the Registrant should have tested for sensory or motor deficit. He said omitting the testing fell below the standard. He said that in a case where it was likely there was a low risk of harm it fell just below the standard. Where there was evidence

of a serious clinical effect that would be further below the standard. He said that such matters were difficult for experts to assess and said that it was difficult to assess seriousness in one specific failing. Mr McClune said that if spinal manipulation was contraindicated then he would place his view as this being below the standard expected. He said it was a single clinical failing in a case where relative contraindication suggested it was just below that line.

36. Mr McClune said that a red flag indicated a clinical and serious matter such as a serious health complaint or infection. Relative contraindication was a judgement that the osteopath had to make.

Evidence for the Registrant

37. The Registrant took the oath and provided details of his qualifications and experience. He explained that he is an osteopath working within the Orchard Medical Centre where he has been for some 10 years. The Registrant agreed that assessing patients is different for each patient and he had developed his own method of doing so. Concerning the cervical spine he explained that he would ask a patient to stand and rotate their head, then move it backwards and forwards. Similarly he would investigate the thoracic spine and the lumbar spine by asking a patient to rotate and bend from side to side. He said he would perform reflex testing with a patient lying on their back and if he considered it necessary he would do strength testing and pinprick testing but it depended on the presenting symptoms. He would ask a patient what their symptoms were, whether there were any causes or trauma, what exacerbated the symptoms, any injury and also make a general inquiry about their health. He would then go on to explain what osteopathy involved and the side effects. Thereafter he would examine the patient passively with them lying on their back checking the joints passively but he would probably not give a diagnosis. Rather he said he would provide some treatment and then sit with the patient and discuss their case. He said he would provide treatment, reassess a patient and then sit with them to discuss his findings, perhaps a diagnosis and the expected number of treatment appointments.

38. In terms of explaining osteopathy the Registrant said he would explain how he may work on muscles, stretching tissue, work with muscle energy and resistance, work on joints and explain processes like HVT. He would then ask the patient if they were happy for him to proceed. This is what he would do with every patient and then he would write down 'consent given' as he had in this case. Regarding neck manipulation he said that if he decided this was needed he would speak of the side effects of this but also say that it was controversial. Again if the patient said they were happy he would go ahead.

39. The Registrant explained that he first treated Patient A some ten years before but he did not have his records of this since he kept these for about seven or eight years and then destroyed them. He had no recollection of what the previous treatment was for nor did he have any recollection of the consultations being considered by the Committee and was totally reliant on his notes.

40. Turning to the consultations and treatment in this case the Registrant said that he noted that Patient A had sciatic pain but he did not diagnose sciatica. Looking at his notes he confirmed Patient A was experiencing pain in her lower back intermittently but it was getting worse, she had pins and needles in her left leg and this leg also gave way, she had pain in her right knee, pain in her left buttock, and she had seen her GP who had given her painkillers. He then said he took notes of her general health and these were set out in his written notes. He then explained that he examined Patient A. Referring to her dorsal (thoracic) spine he described this as having decreased mobility and being very rigid. He said that he would have asked Patient A to move actively and then he would do a passive test and if there was no movement in a joint he would mark this as rigid. The Registrant said the treatment was as per his notes and that Patient A consented to this.

41. Concerning HVT the Registrant said that he noted her dorsal spine was rigid but he criticised Mr McClune's opinion stating that he had missed the fact that patient had hypoflexia. He went on to say that hypoflexia meant Patient A had no reflexes. This indicated to him that she may have nerve damage, peripheral neuropathy, muscular dystrophy, an under active thyroid or ALF - all of these required further testing by her GP whom he said she should contact. He said he did not give a diagnosis because her lack of reflexes suggested a number of conditions and it required blood tests to confirm. He said that he thought he could help with Patient A's fibromyalgia and the pain in her buttock or leg by careful manipulation of the lumbosacral area in her spine. He said that she did obtain some muscular relief. He explained that Patient A would have been lying on her left hand side facing him, he would do the rocking motion she described so that he could find the correct joint and then deploy a gentle thrust. He said there was no harm in using HVT and the force involved was no more than one may exert on oneself 'turning in bed'. He said that HVT could properly be given in the absence of absolute contraindicators such as something like cancer or trauma. He said an HVT was safe and used extensively in osteopathy. He said the HVT used in this case could not be done from behind as Patient A described, indeed there was no such technique that he knew of.

42. The Registrant said that he formulated a treatment plan but did not provide a diagnosis because he could not do as this required further medical tests. Instead he thought he could help with Patient A's headaches which was most likely caused by some joints doing too much work. He performed periscapular stretching with Patient A lying on her stomach and this provided some relief to her. Concerning not giving a diagnosis, he said it would have been the same as his findings namely that in the lumbar spine L1 and L2 joints were overworking and the periscapular region was fibrotic. He said this was his diagnosis if one wished to call it that. He said he treated the cervical and the lumbar spine he did not touch the thoracic spine because of the lack of reflexes. He explained that he thought the T11 and T12 joints in the thoracic spine would likely be causing the urinary problems that Patient A complained of. He said it could also be L1 to L2 or a protective muscle spasm. He said he suspected T11-T12 and

L1-L2 so he did no treatment at these areas rather he only treated the lumbar sacral area. He went on to say that he treated Patient A's muscles, buttock and quadriceps because he thought this might help her right knee.

43. Concerning HVT the Registrant said he was always gentle and used no force, at least no more than 'turning in bed'. He said this was low amplitude and low leverage, he did not use long levers but went to specific joints and used low force. He said the results were that Patient A's headaches were better, the fibrotic tissues were better and the left leg symptoms were reduced. He said she still had pain in her back and her right knee.

44. Concerning the second appointment on the 4th April the Registrant said he would have told her that he can help her cervical area and the fibrotic tissues but she needed to go to the GP because of the lack of reflexes. He had said this after the first appointment. He may have said he could help the pins and needles but they would have to see. He said that Patient A had reported things were better following the second treatment hence he asked her to return for a third treatment on 13th April 2023.

45. Regarding the second appointment the Registrant said that he asked all patients how they feel after treatment and she had said she felt better for two to three days but then the leg symptoms returned. Whilst the pain in her back was no better, her neck had improved. The Registrant said that symptoms often return and then one repeats treatment. Concerning reassessment he said that this was 'an osteopathic given'. He said he would reassess both actively and passively and again this was 'a given'. Regarding the issue of consent he said that Patient A agreed that he asked her if it was OK to continue with the HVT and she confirmed that it was. In addition he described what treatment occurred in the first appointment. Since this had been beneficial he repeated it. He said in the third treatment Patient A would have told him how she felt after the second treatment.

46. Turning to that third treatment, the Registrant said that Patient A's memory was not as it should be. He said that he had noted her appointment and made a record of it and also the senior receptionist at the Orchard Medical Centre had confirmed that a booking was made. The Registrant explained that the treatment to Patient A's lower back was to try and improve things for her. He said that he had noted Patient A's response to his question as to how she was. He then said he would have performed an assessment and then go on to treat her. He said that at no time did Patient A say she felt worse indeed she always felt improvement. He reiterated that he would have told Patient A that she needed to see her GP since her back was still hurting. He then said her lack of reflexes was the reason she needed to see her GP. He said that he would have told her to do this at the earlier appointment although he accepted that that did not appear in his notes. It was pointed out to him that Patient A described him as a man of few words but he said that he would have sat down with her and explained and told her to go and see her GP because her back was no better. Regarding the issue of spinal degeneration he said that he had

considered this and commented that you don't practise for 40 years and then not recognise spinal degeneration, one would be a poor osteopath if one did this.

47. Looking at the areas of Patient A's back, the Registrant said he assumed that he suspected something was wrong in those areas where no treatment was deployed. He said this supported his view that he had considered spinal degeneration. He said that he had obviously considered radiculopathy but there were 'far more important things going on that needed attention and, HVT would help these'. When asked about other symptoms he said he had never come across a patient suffering from numbness who had not reported this to him. He said that he had considered that radiculopathy was likely to be in the upper lumbar area since this was hyper-mobile. He reiterated that he had considered alternative diagnoses such as a spinal stenosis or muscular protection. He said that he had not undertaken a sensory or neurological assessment because the reflex test showed she had no reflexes. He said that if Patient A had been in pain, performing a straight leg raise would prove nothing. Likewise a strength test would prove nothing. It was his view that with no meaningful result there was no point in doing the test. By way of example he said if he were to stress Patient A's knee she would get a pain in the buttock. She already felt pain there so he thought she would not use her whole strength. As such the motor power test would be meaningless.

48. Mr MacDonald then asked questions in cross examination. The Registrant agreed that he took notes as the consultation proceeded and it was during the history taking that he provided advice 'as to what osteopathy involved'. He said a patient would then consent to move to the assessment and he would then write 'consent given'. This was after he had given his 'blurb'. He said that after the assessment if he considered he needed to use HVT on a patient's cervical spine [specifically] he would then explain the complications of that. He agreed that he generally made a note of this and he should have done in respect of Patient A but conceded that he had not. He said that he thought he would have advised Patient A to see her GP at their first appointment because that is what he would normally do [in the circumstances]. He said that he normally had a chat at the end of an appointment but this may go on for some time and he did not record all of this. Rather he only put information on the small cards that he held in his treating room, he did not have a filing cabinet for large paper records. He said that he would have told patient A to see her GP at the first appointment because of his findings regarding her reflexes. He said that one can ask a patient to see a GP and they sometimes forget so he always reminded them at the end of any sequence of sessions.

49. Regarding Patient A's reflexes and the term hypoflexia, the Registrant said this was when there was no response to for example hitting a tendon with a treatment hammer. He outlined a number of potentially serious medical causes and said it was important that blood tests and an MRI scan or similar were conducted. He was asked why he would treat Patient A's spine if he thought she may have an injury or condition that required blood tests or an MRI. The

Registrant said that Patient A had headaches and a fibrotic thoracic spine but in the meantime he thought he could help by releasing the joints in her lower neck and stretching various tissues. He said he thought he would have said the GP needs to do further tests but he would try to help with the pain in her left buttock, pins needles, and the pain in her right knee. He agreed that Patient A could have a serious condition and he said he would need to be very careful in applying force to the spine. He reiterated that the force he used was no more than turning in bed, he was very gentle. He agreed that Patient A may experience this as being forceful but it was not.

50. The Registrant said that it was obvious that Patient A had a difficulty in her lower thoracic or upper lumbar spine and this was indicated by her urinary difficulties over many years. When taken to his notes regarding Patient A's reflexes he said that his note was these were difficult to elicit which indicated to him that he was not getting a reaction. Regarding the term decreased and equal he felt that this meant that the reaction was equally decreased, either way it needed to be investigated. He said he could not swear to referring patient A to her GP at the first appointment but it would have been normal for him to do so. He said that he had done so following the third appointment where he had noted that she should see her GP if she had not improved. He then reiterated that it was her lack of reflexes had made him suggest she should see the GP. He said that the notes made perfect sense to him.

51. Concerning the issue of consent, the Registrant was shown his written comment at Bundle A62 where he said that he understood it was suggested he had not obtained Patient A's consent. He said it was his policy to explain that osteopathic treatment involved manipulation, massage, stretching, articulation and HVT work. He would then ask a patient if they were happy to go ahead with osteopathic treatment. If they did (and most did so) he would then note that consent had been given in the case history. He said he would again ask the patient if they were OK with him using HVT thrust work before doing so. He could see no reason why he would not follow that procedure with Patient A. In addition to what was written the Registrant said he would speak to a patient about the risk associated with cervical HVT if after his assessment he was going to work on their neck. He said this is what he would do with most patients. The Registrant said that he did not tell patients what he was going to do, rather having obtained what he called their consent (to osteopathic treatment in general) he would then go on to give specific treatment and then afterwards sit down and discuss what he had done and any further treatment programme. He expressly said that the explanation of why he was treating a patient would come after the treatment had occurred.

52. It was put to the Registrant that since his conversation regarding osteopathy in general happened at the end of the history but before examination had occurred (a matter he agreed with), at that point he had no idea as to what treatment he was going to give. The treatment would be informed by the examination. The Registrant agreed with this to some extent and said a patient's symptoms told him something but he agreed he could not tell Patient

A exactly what he was going to do at the point he had his conversation with her. He reiterated that if he was going to thrust the cervical spine he would have told her of these risks. He agreed that he would not and indeed did not explain that osteopathic treatment may cause discomfort. He would have mentioned damage to structures. In terms of a reaction to treatment he said he would have covered that in the earlier consent. He said that every time he thrust a joint he asked patients if they were happy for him to go ahead. It was put to him that there was no value in asking a patient if they were OK unless a procedure had been explained to them. The Registrant responded that he did explain the risk involved. He agreed that his initial written response (referred to in Patient A's evidence) did not mention a reaction to treatment but he said he always described side effects. The Registrant agreed that explaining risks was key to consent, he had done lots of courses on that and was well aware of this but he conceded that he had missed this in his written response.

53. Mr MacDonald again suggested that it was the Registrant's case that he explained the treatment he used and why he used it after the treatment had occurred. The Registrant responded that he explained osteopathic treatment in general and they consented to it and nothing more needed to be done he said it did not matter if he did so before or after it had occurred. He clarified that he obtained consent after he had given the general picture of what osteopathy involved which included a description of the repertoire of techniques used by osteopaths. The Registrant said of course he gave those sorts of explanations to Patient A and queried why Mr MacDonald suggested he did not. Mr MacDonald put to the Registrant that Patient A said he did not explain to her and his note of consent given was written before he knew what he was going to use by way of treatment. The Registrant said this was not the case because he explained osteopathy involved soft tissue treatment etc and then he asked for consent. He asked if patients were happy for him to go ahead if he was going to treat the cervical area and he would go over that in particular. He said he could see nothing wrong with his approach but he had obviously missed out the reaction to treatment in his written response.

54. Regarding the issue of a diagnosis the Registrant said that he had stated his findings in his notes which was that a cervical joint was doing all the work and this finding was his osteopathic diagnosis. It was put to the Registrant that his note of the second consultation did not have a record of consent. He responded that Patient A's own statement was to the effect that he asked both before and after performing the manipulation. He agreed that his note of the second appointment did not make reference to consent. The Registrant said that Patient A had already given her consent to treatment. She had done it once and he didn't think he had to write it down every time. However, he reiterated that he would have inquired if Patient A had improved or deteriorated if she was OK with him treating her. It was put to the Registrant that there was no note of any testing or assessment in the second and third appointments. He said that there was a brief history taking in which he noted the answers he then assessed and then treated Patient A. He conceded that the notes did not illustrate this but he said it was a given that one always tested before and after

treatment but if the result was the same there was little point in making a note. He rarely made a note unless there was a specific change. Concerning examination in general he said he did not do strength or pinprick or leg raise tests on Patient A. He said that the reflex tests he carried out were to her arms and legs but his notes did not show whether he had carried out a Babinski test. He thought he had probably not done so. He reiterated that he did not do motor power tests for the reasons he'd already discussed.

55. The Registrant said that he elicited Patient A had suffered from low back pain for a long time, it was deteriorating, she had pins and needles in her left leg, and this had given way. He said these all indicated a possible neurological cause. He agreed that a left lumbar radiculopathy was one possible cause but he felt all the evidence pointed to the upper lumbar or lower thoracic area. When asked if he investigated her neurological symptoms he said that he had decided that she needed to see her GP and he would try to help her back. He had concluded her difficulty was in the upper lumbar and lower thoracic area and he would manipulate the lower sacral area to see if this helped. Having done so he said that Patient A felt some improvement. He reiterated there is no point in muscle testing, touch testing or pinprick testing particularly if there is no complaint of numbness. He said that he did not use the straight leg test even if a patient had pain down their leg. Whilst it might prove there was a trapped nerve at L4 or L5 it would prove nothing else. He felt that the fact Patient A had no reflexes, urinary incontinence for some years and had a hinge point at L1 – L2 told him this was the area he needed to concentrate on. He said that his treatment was aimed at reducing her muscle spasm and he would not say that it was to get better (ie cure her).

56. When asked how he had investigated Patient A's new illogical symptoms the Registrant said that he had already explained why he did not do this. It was put to him that the pinprick and leg raise tests are classic investigations of such symptoms. He said that they were irrelevant if there were more serious issues. It was put to the Registrant that there was no way of knowing whether the tests would be helpful unless he tried. He reiterated that a patient with a leg pain during the strength test would provide a confused picture. He said that if a practitioner was experienced and knew what response they were likely to get or not, they can choose to do the tests or not. The Registrant said from his experience he concluded that such tests would be misleading and would not be helpful. He agreed they might only take a few minutes but he reiterated he had explained why he did not do them.

57. When asked whether he had considered Patient A’s spinal degeneration the Registrant said that he had recognised this because she was 64, had worsening low back pain, sensory or motor symptoms in her left leg, no reflexes, significant reduced mobility in her lower thoracic spine and a general reduction in movement in the cervical and lumbar spine. He said all of these symptoms suggested he should proceed with caution. He said he did not agree that they were all relative contraindications to spinal manipulation. He said that Patient A’s thoracic spine and upper lumbar spine had a hinge point and he would not

touch that however her lower lumbar spine could be manipulated and she had in fact felt considerably better after the treatment. He said it was some weeks later that she had deteriorated. He reiterated he had not manipulated her thoracic spine or her upper lumbar spine he had merely dealt with her lower lumbar sacral area and there was no contraindication to thrusting this. He said that he had done some soft tissue work because of her muscle spasm.

58. The Registrant reiterated that HVT could be given carefully with no contraindication unless there was something like an accident or cancer or similar red flags. He said that without the red flags one can always do HVT if careful and in an area where there was no danger of exacerbating an existing condition. He stated that in his view there were no relative contraindications and the HVT did not exacerbate Patient A's symptoms rather it made them better. The Registrant described HVT as being quick and to a specific area which he had tried to relax beforehand to get past muscular control. He again described the stress on the back as being no more than when turning in bed. He said that asking Patient A to do some form of exercise would have exacerbated her condition. It was put to the Registrant that manipulation of her cervical and lumbar spine when he was aware of the contraindicators risked aggravating Patient A's spinal condition. He responded that this was not the case since he had stated there were no red flags. In his view there was no harm in manipulating Patient A's lower lumbar spine. It was put to him that this was riskier when he had not properly investigated her neurological symptoms and he responded that Patient A had felt better after the HVT.

59. The Registrant was asked if he felt that Patient A's neurological symptoms were coming from her thoracic spine and he said this was not his opinion. Rather he thought it was muscle spasm in that area and the upper lumbar spine and this had put stress on her lower joint. He said his thoughts were that she had an upper lumbar problem and muscle spasm. He said he had explained why he had not done the neurological testing and he maintained it would have given him no further useful information. The Registrant was taken to the NICE Guidelines (National Institute for Health and Care Excellence) which refer to various symptoms under the headings "Sciatica (lumbar radiculopathy)" and "When should I suspect sciatica?". He said there was no such thing as sciatica rather there was sciatic pain that can be caused by a number of things. He said sciatica was not a diagnosis it was a symptom of something else and he had considered Patient A's upper lumbar area. He said that he disagreed with the NICE guidelines and how they applied generally, as well as to Patient A.

60. Mr Corre then read the statements of Caroline Higgins the receptionist at the medical centre who confirmed Patient A had an appointment booked on 13th April 2023.

61. Mr Butler was then called to give his expert opinion on matters. He was sworn and outlined his expertise and confirmed that he was aware of his duty of impartiality. He confirmed the contents of his report as being true to the best of his knowledge and belief and he acknowledged the joint statement made

with Mr McClune. Mr Corre then took Mr Butler through HVT and some other techniques used by osteopaths including massage, stretching and some short rapid movements used to move or unlock joints and to encourage movements and reduce tension. Mr Butler described these and the use of an osteopath's hands as the hallmarks of osteopathy. He described HVT as a method by which a joint may be prepositioned to isolate it and then a high velocity but low amplitude thrust (quick but small thrust) is used in order to try and separate the joint surfaces and improve motion. He agreed that HVT may have negative connotations because a patient may feel aftereffects such as aching. He said there may also be long term effects but these were poorly understood. He said that the hallmark techniques discussed were used by many (a significant body of) osteopaths and were part of osteopathic training.

62. Regarding consent, Mr Butler said that this was an essential prerequisite to treatment. He described different ways of gaining consent. One way was to take a history then go on to examine a patient then discuss both the oral information and physical findings and then for the osteopath to state what they thought was the difficulty, what treatment might assist, the pros and cons of this, the benefits and the risks and then ask a patient whether together they should continue. He said the other more classical method of gaining consent, used particularly by those who qualified longer ago, was to take a case history and then to examine and treat a patient in a continuing process. Such osteopaths blended their examination and treatment. He referred to the osteopathic standard A4.7 which allowed for this blended approach.

63. Turning to a consideration of the Registrant's notes of the consultations, Mr Butler said the Registrant had carried out competent and wide-ranging of assessment of Patient A's body. He said the case history was adequate and there was a wide-ranging account of her past medical history. He said the difficulty he experienced in assessing the records was that they were so lacking in focus or granularity, for example where the left leg had given way or where the pins needles were, that he had to limit his analysis and that meant limiting his analysis of what further tests should have been used by the Registrant. Mr Butler said he did not know any more than that Patient A experienced tingling. This may have been caused by nerves, blockage of blood flow or be a musculoskeletal problem but he could not determine from the notes what or where the tingling was. He could not determine the source of the problem from the notes.

64. Regarding the issue of severe spinal degeneration, Mr Butler said that all human beings degenerate with age to some degree however sometimes one came across a patient that was unusual. He said it was not always necessary to refer them for an MRI since an osteopath can infer a lot from the function of the body, by asking questions, touching, passive examination, moving, palpating and asking a patient whether they felt discomfort and so forth to find out more about the structure of their body. He said degeneration was age, gene, gravity and time related but it was a matter of degree and sometimes such degeneration may be peculiar. In looking at the notes he said it appeared to be

that the Registrant had some reason not to treat Patient A's spine and he opined there was something peculiar about it. He said this was something that he inferred this from the notes. He described osteopaths as often trying to get a stuck joint moving and, from the notes, there appeared to be something that prevented or stopped treatment of patient age thoracic spine. He said the notes did not record treatment to Patient A's low thoracic spine or to the upper lumbar spine, only to the lower lumbar spine and, from this, he inferred that something inhibited treatment of the thoracic area. He described the spine as being similar to a bicycle chain with fused links meaning other links work excessively. With permission, an osteopath would try to unstick the links. That had not been done according to the Registrant's notes.

65. Regarding neurological testing he said that his opinion may be different to others and may be different to Mr McClune's. He felt that history taking was the key hub of gaining information - asking a patient how they felt, was there anything wrong and if so where. He said he tended to believe patients and be guided by what they said. Regarding the neurological deficit and motor power testing he said that a neurological examination was only necessary if there was a neurological question to be answered. He said that one undertook clinical examination depending on what the history had thrown up and reiterated that one can examine by history taking and then ask more directed questions to get more detailed information. If all that came back normal, there was no reason to examine physically unless there was reason to disbelieve the patient or something else had arisen. He commented that the Registrant had said motor power testing was not appropriate but he did not know what the Registrant had found at the time. He noted that Patient A had limited hip function and that could cause the leg to give way but he did not know what the Registrant's findings were on the day. He said that the Registrant could not recall what he had evaluated and did not now know what Patient A had said, nor whether there was a neurological cause for the leg giving way rather than the range of things it may be. Mr Butler's view was that without this detail he could not place the onus on the Registrant for not undertaking a motor examination.

66. Regarding the strength deficit testing he said this again depended upon what the Registrant found on the day. He said it may be that Patient A had given a sufficiently clear account for the Registrant to come to the conclusion that he did not need to deploy a deficit test. Regarding radiculopathy he said that this was the entrapment of a nerve and it could include nerves other than the spinal nerve. He gave examples and said any of these could cause the tingling or the pins and needles or it could have been from a lack of blood flow. He said that radiculopathy is one form of nerve compression which the Registrant had introduced but, he could not say Patient A had radiculopathy from looking at the notes. He commented that Patient A said she had previous hip trouble, arthritis in her right knee and other problems that could cause the hip to be flexed by muscle spasm or indeed the arthritis itself. All of this could set the scene for the nerve at the front of the groin being compressed or the circulation being restricted. On the evidence he concluded that it was reasonable to consider that radiculopathy was present and the Registrant said he had thought

of this but he, Mr Butler, could not confirm this from the notes. Mr Butler said the notes were all he had because the recollection of both the Registrant and Patient A was poor and he could not say that she was more likely to have radiculopathy than anything else. He was strengthened in this view when looking at the NICE guidelines.

67. In cross examination Mr Butler said the presentation of Patient A was of deterioration with no trauma, left leg pins and needles and giving way and he did not know why. He agreed that there were sensory and motor abnormalities and radiculopathy was one possible cause. He described this as coming from a pinch in the lumbar or possibly the sacral spine. Mr Butler was taken to images in the bundle and described different parts of the body sending or receiving nerve signals to and from different parts of the spine. He said that the Registrant's notes did not give precision as to where Patient A felt pins and needles, or why the leg gave way and this greatly limited his ability to diagnose the cause. He agreed that a problem with the blood supply may result in more generalised symptoms but if it was a spinal or nerve related issue it would be more localised.

68. When asked about the notes Mr Butler said that if the lack of detail in the notes was because Patient A's symptoms were not explored by the Registrant then that would have limited the Registrant's ability to determine the cause of those symptoms. He said that if this was the case the evaluation would not be sufficient. Regarding the need for assessment and evaluation and the question of neurology, Mr Butler said the first part was in the history. If there was an abnormality or uncertainty about the history that could be tested and analysed by examination. He agreed that a history of pins and needles and a leg giving way showed that something was abnormal and he felt that this should first be clarified through the history. He said that if the notes provided by the Registrant reflected the limit of his analysis, this analysis was insufficient.

69. Mr Butler said that if Patient A was correct in her denial of any lower limb symptoms then there was no onus on the Registrant to do any further testing. He regarded testing as asking more questions or going on to a physical examination and he meant testing of the hypothesis of a cause for Patient A's symptoms. He reiterated that if the notes were correct and there were pins and needles and a leg giving way these were possible neurological symptoms and some form of testing was required. Mr Butler said the Registrant did a form of testing namely the reflex test and he then decided to continue with treatment. Mr Butler considered this to be reasonable. However, he agreed that if the Registrant had only taken note of where Patient A had said she experienced pins and needles and he did not explore this further that would be insufficient. Likewise if the leg giving way was not explored further that was insufficient. He said the problem was it was difficult to know if the Registrant carried out the reflex tests because of what Patient A had said. Mr Butler reiterated that the examination would be insufficient if the Registrant had not explored what was contained in his notes. Testing the reflexes would not have been sufficient on their own. He said that muscle power testing might be clarified in the case

history and if it was not then one had to go on to explore that by examination. For him it was a question of trying to find the source of what was generating the symptoms. The question was therefore did the Registrant sufficiently inquire of Patient A to come up with a working hypothesis. He described the case history as a patient's own diagnosis from within and it was valuable and should not be downgraded. He agreed that it was helpful to compare the account with objective testing. He also agreed that pain can interfere with motor testing but one could nonetheless ask if that or any other tests were hurting. He said that his point was that if there was sufficient information provided by the history and the examination one may have sufficient to have a working hypothesis if it was not sufficient then one needed to continue to test further.

70. When asked about the NICE guidelines and lumbar radiculopathy, Mr Butler said that not all symptoms had to be present to suspect radiculopathy but the more symptoms there were the more compelling was the likelihood. He noted that the NICE guidelines did not mention the oral history from the patient but mentioned low back pain and tingling which would have to be mapped onto the nerve maps of the body. He said that the NICE guidelines started with pain and then looked at necessary and distinct feelings in the dermatome and then the question of weaknesses and reflex changes. He described the practitioner as trying to see the distribution of the nerve pain and then analyse that distribution to try and link the dysfunction to the hypothesis of damage. Mr Butler described a particular area of the lumbar or sacral spine as affecting a particular area of the leg. When taken to the straight leg test and the recommendation of its use by NICE he said that he did not disagree with the NICE guidelines rather they were limited by the breadth of people to whom they were addressed. A practitioner had to interpret some of those shortcomings. He said that the straight leg test was progressively less useful in older patients. He said that 64 years of age was mature not old. He said that it was possible to infer that the Registrant had decided that Patient A suffered from thoracic degeneration and it was difficult to tell if a straight leg test would be helpful. For patients aged under 40 the straight leg test was reliable but beyond that it could become less reliable. Mr Butler conceded that based on the notes alone there was insufficient explanation of the pins and needles and the leg giving way. He reiterated that the problem was from the notes he did not know beyond reflexes what if any testing was done and what they showed.

71. Concerning the use of HVT Mr Butler said that its use was not justified in the upper lumbar and thoracic spine and, from the notes, this had not been done. However in the upper thoracic spine it was justified in helping Patient A's neck and/or headaches. Mr Butler said that the Registrant had found lower lumbar restriction and was justified in the use of HVT if it could be kept there. He said there was some degree of rotation to the thoracic spine but the Registrant said in his evidence that he was subtle and used low force and was very specific. Mr Butler then explained the use of long levers as referring to twisting the body. He said the Registrant said he used his hands locally and applied leverage locally. He agreed with Mr McClune that the spread of force or leverage was

possible but it was conceivable that if the Registrant acted locally and used high speed to reduce the force he could limit the effect on the upper lumbar or lower thoracic spine. However he conceded that the risk of spread of force was always present. He said that Patient A had severe degeneration (discovered subsequently) and on balance she had it at the time of the treatment. He said it appeared the Registrant had inferred such degeneration was present and it would feel like the back was welded as a block rather than behaving like a bicycle chain. He concluded that the Registrant appeared to have decided not to influence that area of the back through hands on treatment and this suggested he had found something that meant he should not treat that area.

72. Mr Butler said that Patient A's age, low back pain without traumatic cause, sensory issues, possible reduced reflexes, reduced mobility, and general issues in the lumbar spine were all relative contraindications to HVT. He did not agree that proceeding with HVT to any area was very risky rather he thought that if the damaged segments of the spine were removed from the process and the Registrant used sufficiently specific technique he may have kept the force sufficiently local to where he was acting. It was suggested that the Registrant might have exacerbated the degeneration but Mr Butler rejected this referring to Patient A's response which appeared to be that she had responded well with her neck, upper thoracic spine and lower limbs feeling better [albeit this was temporary]. He said that it did not appear that the Registrant had done any harm which suggested he had kept to the local area that he was treating.

73. Mr Butler said in his view there were no absolute contraindications, rather there were relative contraindications and that a practitioner may proceed with care to avoid collateral damage. He agreed that the contraindications of the upper lumbar spine meant that no reasonable practitioner would treat that area. However he said that the risk was increased if there was not a proper exploration of the symptoms. Mr Butler then said that some practitioners examine, treat, correct, assess and repeat the process and there were some elements of that from what the Registrant had said was his practice. Conversely there were elements of the Registrant's practice that were linear which was his own preference. Either way he said that one had to have sufficient information of quality to test a hypothesis before treating. He agreed that the possibility of a radiculopathy raised the issue of problems in the lumbar spine because it was often associated with disc damage which increased the hazards when treating the lumbar spine.

74. In response to questions from the panel Mr Butler said ideally one would expect any further information sought or elicited from Patient A to have been recorded in the notes. For example he said it would have been an obvious question to ask Patient A about her right knee. The problem he said was, was it not in the notes because it was not written down or because the questions were never asked. He said that an arthritic knee could affect weight bearing and posture and he would expect a reasonable osteopath to explore these problems. He did not know whether it was explored/not explored or whether an exploration was simply not noted down. Regarding neck manipulation Mr Butler said that it can

be done with very little force but if the upper thoracic and neck were manipulated at the same time that might require more force. He said it was difficult to know what was done. He said that people were usually more sensitive to work done on the neck compared to lower down the spine although some felt otherwise. He confirmed that there was no reference to the Registrant suggesting Patient A see her GP after the first or second appointments. He said that Patient A's description of the use of force sounded like a factual difference between her and the Registrant and was a matter for the committee to decide.

75. Mr Corre and Mr MacDonald stated that it was an agreed fact that the Registrant had no previous findings of UPC.

Submissions of the Parties

76. Both Mr MacDonald and Mr Corre provided written submissions regarding the facts.

77. Mr MacDonald submitted that the case he presented at the beginning had not changed. Regarding Allegation 3 and the lack of consent, he said that Patient A was adamant the nature of any treatment, why it was used and the risks involved were not explained to her. He observed that she was an honest witness who made concessions about what she did not recall. Regarding consent she did not say it was something she could not recall she said it did not happen and in particular regarding the risk of injury to her neck she said no definitely not. He said that the experts were in agreement that for consent to be valid the Registrant would have to explain what he was going to do, why he was going to do it, what the problem to be solved was, what the risks were, so the patient could make an informed decision weighing up the risks and the benefit. He observed that imperfect though Patient A's memory was, the Registrant's own case supported her point of view. This was because the point at which he recorded that she had given consent was not a point at which valid consent can be taken. It was before any examination had taken place. He said that the Registrant could not have told Patient A what he was going to do or why he was doing it since at the time he says he got valid consent he had not decided anything supported by an examination.

78. Mr MacDonald said that the Registrant's approach was not supported by Mr Butler's reference to the mingling of examination and treatment because that is not the approach the Registrant said he took. Rather his approach was to take a history then obtain what he considered to be consent then do an examination and then go on to treatment. He said that is exactly what the notes showed and, the problem for the Registrant was the time at which he wrote 'consent given' was before the examination. Thus when he wrote this his note had no value. It did not reflect any record of what he was doing why he was doing it or what the risks were. Mr MacDonald said there was no position in law to take a general consent as the Registrant spoke of. He said that one could now understand why Patient A said the Registrant asked a few questions and

then went on to treat. He said that it was only when prompted by questions in cross examination that the Registrant said he would have explained what he was doing in the initial conversation. However, he did not say this in his first written response and his belated suggestion that he would have discussed risks in osteopathic treatment with no specifics held very little weight. Mr MacDonald submitted that on balance Allegation 3 was proved.

79. Regarding Allegation 4 Mr MacDonald said the Registrant's position was 'he knew testing would not achieve anything and he disagreed with anyone who said anything else and that included NICE. Mr MacDonald said that was not a reasonable approach to osteopathic investigation. He said that Allegation 4 was interlinked with Allegation 2 and because where there were relative contraindications it was all the more important to conduct an investigation regarding the neurological symptoms. He submitted that both experts say the symptoms should have been explored but they differ regarding the usefulness of the tests. Mr MacDonald submitted that the symptoms were not explored. He said there was some detail in the oral history and some detail in the examination but as regards the neurological symptoms there was only a note that they existed [according to the history]. There was nothing to suggest that these had been explored further. Mr MacDonald was not saying 'because it was not written down it was not done' but rather he contrasted those areas where pertinent details were noted with the lack of detail concerning the neurological symptoms. He said in these circumstances it was reasonable to infer that there was no detail in the note because there was no questioning and was no neurological testing. He observed that it was the Registrant's opinion that the problem was in Patient A's upper lumbar or lower thoracic spine and so he would avoid these areas and testing would achieve nothing. However, both experts held the view that there was insufficient explanation of the potential neurological signs that were present. He reiterated that the pins and needles and the leg giving way gave rise to the possibility of a radiculopathy and there was no evidence this had been explored. In the circumstances he said that this was an inadequate osteopathic investigation and insufficient investigation or assessment of the motor symptoms.

80. Regarding Allegation 4b Mr MacDonald conceded that the Registrant said he did appreciate spinal degeneration may be present and that was potentially supported by his avoidance of the thoracic and upper lumbar spine but all of this was more reason to not do the HVT which he did.

81. Mr MacDonald then submitted Allegation 2 was admitted and that Allegation 5A was that such treatment was contraindicated and not clinically justified. He said that these tended to stand together. He said that Mr McClune had fairly observed that it was a matter for the Registrant's own judgement. He said that both experts said the unintentional risk of spread of force to other areas of the spine existed and the closer to the area of the lower thoracic and upper lumbar the higher the risk. Both experts agreed that they could infer that severe degeneration was present. He said that it was Mr McClune's opinion that given Patient A's age, low back pain which was worsening, the lack of trauma, sensory

and motor symptoms in her lower limbs which were not adequately explored, the possibility of reduced or no reflexes, the significant reduced spinal mobility in the lower thoracic which was an unusual finding, and the general spinal dysfunction in the cervical and lumbar all these factors overwhelmingly led to the conclusion that a spinal manipulation was risky. Mr MacDonald said that the fact that Patient A did not immediately suffer adverse effects was not persuasive since defective treatment may not cause problems and appropriate treatment can cause problems.

82. Mr MacDonald confirmed that it was not the GOsC's case that the Registrant has caused problems for Patient A. Although this might be the case, he could not prove it on the balance of probabilities. He said that he was not in a position to say that Patient A's response showed there was an unjustified risk but the Committee could take account of the consistency of Patient A's description of the force. Mr MacDonald said that even Mr Butler had conceded that if there was the possibility of a lumbar radiculopathy and this had not been sufficiently explored, it was riskier to treat the lumbar spine.

83. In conclusion Mr MacDonald said that it was the GOsC's case that Patient A's symptoms were not sufficiently explored and therefore the risks associated with HVT were not justified. He said that the Registrant had come close to saying that you can always use HVT provided there are no red flag absolute contraindicators. He said that was not the view of either expert and the fact that the Registrant disagrees with NICE, which is an authoritative source, suggested he was not willing to accept his practice was in any way not a sensible one.

84. In his submission Mr Corre observed that there were a number of issues to resolve. This included the conflict of evidence between Patient A and the Registrant, the notes and the evidence of the third appointment. He said that some of this may be of importance in assessing the credibility of Patient A. In addition he said that the burden of proof was particularly important and in this case there was some similarity with a Victorian 'locked room mystery' in which no one really knows what happened. He said that Patient A had said if it was not in her statement then it did not happen but then changed and said it may have happened but she had forgotten.

85. Regarding the issue of consent Mr Corre said it was possible that there was more than one form of consent and the Committee should allow for the diversity of senior practitioners whose approach may vary from their junior practitioners. He referred the committee to the OPS paragraph A4.7 which specifically referred to the simultaneous use of examination and treatment. He said that the Registrant had stated it was his practice to explain what osteopathy involved. He then said that perhaps the Registrant had been overconfident in obtaining consent and he had done a number of courses but it would be very odd for a practitioner as experienced as the Registrant not to have obtained consent.

86. Regarding the question of the clinical evaluation, Mr Corre said that one had to distinguish the evaluation itself from the notes. He said that the notes may be evidence of evaluation but they lacked detail and this was referred to by Mr Butler on a number of occasions. He said that it will be a matter for the Committee to decide what actually happened regarding the notes. He said that they do not tell everything that the Committee ought to know but they were evidence that the Registrant had carried out a reasonable case history and from that it was possible to infer that he had undertaken an appropriate clinical assessment. He observed that although the Registrant had recorded pain in the right knee he had not said what the cause was but then neither did Patient A's medical professional. He submitted that it should not be held against the Registrant that he had not identified the knee was affected by osteoarthritis.

87. Concerning the presence of spinal degeneration, Mr Corre said that the evidence was the Registrant had considered this and that is why he did not treat Patient A's thoracic spine. Something told him to stay away from that area but it did not follow that he should not manipulate the spine at all. As for the issue of testing for neurological deficit, motor deficit or sensory deficit, he said that the Registrant had said Patient A had no reflexes but this had been underplayed in his notes. His evidence was this could not be explored further by the Committee because there is not sufficient detail of the location of the symptoms and his answer to the neurological testing was not to perform them unless there was a neurological question to answer. He said the same regarding the motor testing which may give a false result he would not carry them out if they did so.

88. Regarding the use of HVT Mr Corre said this was not absolutely contraindicated and Patient A's description of the force as she felt it and where she felt it was subjective. He suggested that where the Registrant had disagreed with the NICE guidelines under pressure of cross examination it was important to note that they were written for a number of professionals and there was a hierarchy in the guidance concerning allegations 4a and 4c. He said that it was important to note the words 'appropriate' and 'adequate'. Finally he observed that the burden of proving the case remained on the GOsC and reminded the Committee that the Registrant was a practitioner of good character

Advice

89. The Committee accepted the advice of the Legal Assessor. It recognised that the burden of proving the case was upon the GOsC and the standard of proof was on the balance of probability. It understood the importance of consent and it understood that it may draw inferences as to facts and/or states of mind from facts found proved. It understood the term contraindications and how this applied in this case. It recognised that the Registrant was a man of good character and entitled to full consideration of this fact.

Determination on the Facts

90. The Committee was clear from the outset that it was not being asked to consider any causal link between the treatments she received and her subsequent deterioration. Rather the allegations arise out of the expectations incumbent on any reasonable osteopath presented with the symptoms reported to the Registrant.

Allegation 1

Patient A attended ~~two~~ appointments with the Registrant on 27 March 2023 (Appointment 1) and 4 April 2023 (Appointment 2).
Admitted. Found proved

Allegation 2

During Appointment 1 and~~/or~~ Appointment 2, the Registrant applied spinal manipulation treatment techniques to Patient A's cervical and~~/or~~ lumbar spine areas (the Treatment).
Admitted. Found proved

Allegation 3

At Appointment 1 and/or Appointment 2, the Registrant failed to obtain valid consent before carrying out the Treatment
Denied. Found proved in relation to Appointment 1 and Appointment 2

91. Having considered the guidance set out in the Osteopathic Practice Standards (OPS), the evidence from both experts and the submissions of counsel, the Committee determined that to obtain valid ("informed") consent a Registrant must, as a minimum, explain to a patient his/her findings from the history taking and physical examination, outline his/her proposed course of treatment and the alternatives (which may include no treatment at all) and explain the risks and benefits of treatment or lack of treatment. It must be done at such pace and in such detail as enables each patient to make the decision alongside a Registrant to proceed with or reject any proposed treatment/procedure. It may be done in a linear fashion or as a blended process but the onus remained on a Registrant to ensure all this occurred.

92. Turning to the facts of this case, it was Patient A's account that none of the above took place at either of the two consultations set out in the allegations. It was the Registrant's account that his practice is to explain in general terms what osteopathic treatment may involve. He called this his "spiel". Having gone through this spiel he would ask a patient if they consented. He explained that although he had no memory of this case that is what he would have done and that is why he had written "consent given" in his clinical notes. If he subsequently considered HVT should be used on the neck he would additionally outline the specific risk of this and seek consent. Once the treatment had

concluded he would then sit with a patient and explain what he thought was occurring to them and why he had used certain techniques.

93. In light of his evidence, it is the Registrant's own case that he purported to obtain informed consent before he conducted a physical examination of Patient A, before he explained his findings, which if any osteopathic techniques he might deploy and before the risks or benefits of these were explained. Consent required all of this information to have been imparted to and understood by Patient A for her consent to be informed. The Registrant's explanation of the process made it clear that it had not happened in this way. This accorded with Patient A's recollection and with the comment made by both experts who acknowledged that the term "consent obtained" appeared in the notes but the issue was what interaction had taken place before that was written. What the Registrant described was in effect no more than Patient A agreeing to proceed with the consultation. It did not amount to her informed consent to physical treatment of her body.

94. The committee next considered whether the Registrant had nonetheless corrected this deficit and obtained valid consent through a continuous process of examination, explanation and treatment as is the practice of some osteopaths. Such practice was commented upon by Mr Butler and the Committee noted that it is within the ambit of the OPS (see OPS 4.7). Again, Patient A's account did not support such a process taking place and nor did the Registrant describe this to be part of his practise. He did say that he would specifically ask a patient if they consented to HVT but he gave little detail regarding this. Patient A said this amounted to the Registrant asking her if it was OK to proceed but she flatly rejected the suggestion that the risks and benefits were explained to her. Whilst the Registrant says he explained and asked for permission to proceed regarding the use of HVT, he could provide no detail of this either from memory or from the notes. There was no evidence in the clinical notes to support the conclusion that the Registrant had in some way 'cured' the existing lack of consent by fully explaining the process, the reasons for it, the risks and benefits or alternatives. This continued lack of a basis for consent was again made clear by the Registrant's own description of his practice to explain the specifics of what techniques or treatment he had done at the end of a consultation and before the examination.

95. For the reasons set out above the Committee concluded on the balance of probabilities that the Registrant did not obtain informed/valid consent from Patient A before he commenced the treatment and he did not cure this initial defect by way of an ongoing discursive process.

Allegation 4

At Appointment 1 and/or Appointment 2, the Registrant failed to conduct an adequate osteopathic evaluation of Patient A, in that he:

a. failed to undertake an appropriate clinical assessment of Patient A;

Denied. Found proved in relation to Appointment 1 and Appointment 2

96. The Committee noted Mr MacDonald's assertion that there is some overlap between this allegation and Allegation 4(c) which alleges a specific failure in the clinical assessment.

97. The Committee considered that in this case an adequate osteopathic examination consisted of the history taking followed by a physical examination.

98. Patient A claimed that there was little if any history taking. However, the Registrant's contemporaneous clinical notes suggest that an initial history was taken with details of general health and some aspects of the symptoms complained of by Patient A. This was undertaken at the first appointment. Both experts regarded this part of the evaluation as adequate and, to that extent the Committee agreed. In addition the Registrant's record of his hands-on examination of Patient A in appointment one supported the conclusion that this part of the evaluation was adequate to the extent that it evidenced that the Registrant had assessed Patient A in a number of ways across a number of areas of her body.

99. However, the Committee also noted the comments made by Mr McClune and Mr Butler regarding some of the specifics necessitated by Patient A's presentation. Mr McClune was critical of the Registrant's overall clinical assessment since it did not involve further oral or physical investigation of Patient A's neurological symptoms by way of the tests as alleged in allegation 4(c). He was of the view that such inquiry and such tests may have provided the Registrant with additional information and enable him to better judge which areas of Patient A's back to avoid. Mr Butler was less critical of the absence of the tests provided there was a full oral inquiry into the symptoms complained of which could enable the Registrant to judge where to avoid. It was the combined expert view that such inquiry (per Mr Butler) or such inquiry plus tests (per Mr McClune) was necessary for the Registrant to understand the potential/probable source of Patient A's neurological symptoms and avoid areas of potential risk. These symptoms included pins and needles, the collapse of her left leg and pain in her left buttock. Both experts agreed that it was possible these symptoms may be the result of a trapped nerve, muscle spasm or Patient A's body compensating for the weakness in her right knee.

100. On the evidence, the Committee concluded that beyond the reflex test, the Registrant did not undertake further neurological examination, indeed he considered they would be of little use. It was Mr McClune's opinion that, this might be correct but, unless the Registrant tried, he would not know. The implication of this is that the Registrant denied himself an opportunity to gain information. As to the more extensive inquiry that could in Mr Butler's opinion render the physical tests unnecessary, there was no evidence of such further inquiry. Patient A's memory of events was that there was no detailed inquiry.

The Registrant's notes did not support a detailed inquiry having taken place and nor did his oral evidence.

101. The Committee was of the view that the Registrant was faced with a 64 year old woman with an unusually stiff back and a number of symptoms that indicated a potential neurological problem. Furthermore, whilst the generality of the Registrant's history taking and physical examination were adequate, the specific investigation of Patient A's neurological symptoms whether by physical testing or extended oral inquiry were insufficient in this case. As such the Committee concluded that the Registrant did not undertake an adequate clinical assessment at the first appointment.

102. Turning to the second appointment, beyond the short note supporting the occurrence of an inquiry by the Registrant as to Patient A's cervical spine, shoulders and her left leg, there was no evidence of the tests and/or the inquiry that Mr McClune and Mr Butler regarded as being necessary. Once again neither Patient A's evidence nor the Registrant's evidence supported the conclusion that such tests or detailed inquiry occurred. As such the Committee concluded that the Registrant did not undertake an adequate clinical assessment at the second appointment.

b. failed to consider that severe spinal degeneration may have been present in Patient A's spine;
Denied. Found not proved

103. The Committee noted that the Registrant had observed Patient A had a very rigid thoracic spine, a hyper-mobile upper lumbar joint ("hinge") and experienced potential neurological symptoms. He had recorded these in his notes and confirmed this in his evidence. He stated that he was clearly aware of the potential for spinal degeneration. He further opined that this must have informed his decision not to directly treat Patient A's thoracic spine but only treat her cervical and lower lumbar spine. Both experts agreed that the Registrant appeared to have avoided the thoracic spine and they too considered that he appeared to have a reason to do so even though there was no explicit recognition of this in the notes.

104. The Committee noted that the GOsC all but conceded this allegation and, whilst it may be that the Registrant did not have a diagnosis, the Committee was satisfied that he did appear to avoid the thoracic area. That being the case it was a reasonable inference to draw that he had considered the possible presence of spinal degeneration and had not failed to do so as alleged.

c. failed to adequately assess Patient A's lower limbs for neurological deficit, motor power loss and/or sensory deficit.
Denied. Found proved in relation to both Appointment 1 and Appointment 2

105. The Committee adopted the reasoning set out above with reference to allegation 4(a). The Registrant was faced with a 64 year old patient with an unusually stiff back who complained of neurological symptoms. These had the potential to evidence that Patient A suffered from lumbar radiculopathy. It was, in the view of the Committee, the combined evidence of the experts that in these circumstances the Registrant ought either to have undertaken the tests that he accepts he did not do (tests for neurological deficit, motor power loss, sensory deficit) or he should have undertaken extensive oral inquiry to obtain further information to justify his conclusion that these tests would have been of no assistance.

106. The Registrant rejected the need for such tests beyond the reflex test that he undertook. He did not suggest in his evidence that he undertook the sort of oral examination referred to by Mr Butler which may replace such tests. Patient A's evidence was that he did not. The Committee rejected the Registrant's suggestion that such tests would have been of no benefit or otherwise misleading. Rather it preferred the exploratory approach supported by Mr McClune. These were simple, quick tests that may have resulted in a positive or negative response from Patient A. Such response may have assisted the Registrant but, unless he tried he would not know. The Registrant effectively denied himself the opportunity of gathering information and, he persisted in his view that he was right to do so. Even while rejecting this approach, he did not remedy that denial of physical information by way of additional oral information of the type described by Mr Butler.

107. The Committee noted that at page B-345 the Registrant is reported to assert that he always undertakes basic motor power and reflex tests to obtain a baseline of information. He appears not to have done so as regards the motor-power test on either occasion.

108. Having considered Patient A's presenting complaint and symptoms and reviewed the evidence of the appointments and the views of the experts, the Committee concluded that the tests or the alternative history taking referred to above should have been undertaken. The Committee concluded that on balance of probabilities they were not and as such the Registrant failed to adequately assess Patient A's lower limbs as alleged during both appointments.

Allegation 5

The Registrant's conduct as set out in paragraph 2 was:

a. contraindicated; and/or
Denied. Found proved in relation to the lumbar spine in respect of Appointment 1 and Appointment 2. Found not proved in relation to the cervical spine in respect of both appointments.

109. The Committee noted that there are at least two forms of contraindication referred to in this case, red flag contraindicators and relative

contraindicators. According to Mr McClune and Mr Butler red flag contraindicators are in the main serious medical conditions which determine that particular forms of treatment should not be used. Relative contraindicators refer to conditions that may bar particular forms of treatment or render them inadvisable but the use of such treatment is a judgement for each osteopath to make.

110. The neurological symptoms complained of by Patient A such as pins and needles, her leg giving way, pain in her buttock, chronic and worsening low back pain with no traumatic cause and a particularly stiff spine were in the opinion of both experts all relative contraindicators as regards HVT. It was the Registrant's evidence that these were not contraindicators, or that he considered such contraindicators to mean that he could proceed with caution and in his view it was always fine to do so. It was notable that the Registrant flatly rejected the usefulness of the NICE guidelines regarding safety in practice when considering HVT and the possibility of lumbar radiculopathy.

111. Whilst neither expert rejected the use of HVT, Mr McClune considered that the Registrant should have undertaken further physical examination of Patient A prior to its use and, by not doing so the Registrant put Patient A at risk. Mr Butler's position was more nuanced in that he considered use of HVT did not require additional physical examination provided a sufficiently detailed oral history had been taken to determine the cause of Patient A's symptoms and HVT was applied with care and precision.

112. When considering the contraindications the Committee noted that the evidence suggested these related to a condition, whether radiculopathy or otherwise, in the lower part of Patient A's back, that is her lower thoracic spine or lumbar spine. There was not the same weight of contraindications directly related to Patient A's cervical spine (neck area) although she had a very stiff thoracic spine (mid-spine). Whilst Mr McClune was cautious in his approach to the question of whether one area of the back could be isolated from the effect of manipulation in another area, he limited the extent of spread to two or three vertebrae. This 'spread' of force, likened to the links in a chain being twisted, did not appear to be such as to run from Patient A's cervical spine to her lower thoracic/lumbar spine which is from where Patient's symptoms appeared to emanate. However, this would be a greater risk factor when applying manipulation to the lumbar spine with the potential for upward transmission as Patient A reported was her experience.

113. Concerning the use of HVT on Patient A's cervical spine, the Committee concluded that there was not the same weight of relative contraindications from the symptoms Patient A reported. The Committee next considered the use of HVT on Patient A's lumbar spine.

114. Having considered all the evidence the Committee was of the view that the Registrant did use HVT when it was contraindicated as regards Patient A's lower thoracic and lumbar spine since he had neither undertaken the tests

preferred by Mr McClune nor obtained the extra detail in the oral history which Mr Butler suggested may render the physical tests unnecessary. This was the case in respect of both consultations.

115. It appeared to be the Registrant's view that HVT is always safe if one proceeds cautiously even in the face of the numerous contraindicators evident from Patient A's symptoms. He appeared disinclined to undertake the tests advocated by Mr McClune believing them to be of little value. That is not a stance with which the Committee agrees since the Registrant would not know the value of the tests until he tried. Both experts suggest further investigation of the contraindicators was required before proceeding and the evidence from Patient A and the Registrant supported the conclusion that he did not do this.

b. not clinically justified.
Denied. Found proved in relation to the lumbar spine in respect of Appointment 1 and Appointment 2. Found not proved in relation to the cervical spine in respect of both appointments.

116. The Committee considered that treatment is not clinically justified when it is not in a patient's best interests and/or the potential for benefit is outweighed by the potential for risk from the treatment.

117. It was conceded by Mr MacDonald that the GOsC cannot prove a causal link between the Registrant's treatment of Patient A and the subsequent deterioration of her back. The Committee considered that to be an appropriate concession to make. His case was that the use of HVT in the absence of sufficient investigation was not clinically justified since until the contraindications were adequately investigated the use of HVT placed Patient A at unknown risk. Mr Corre argued that the use of HVT was justified since it was clear from Patient A that the symptoms in her neck and lower back were reduced for a period of time.

118. The Committee adopted the reasoning in respect of Allegation 5a above as regards the use of HVT on Patient A's cervical spine. There was insufficient evidence from which to conclude that it was not clinically justified. It is a commonly deployed technique and the Registrant had a reasonable clinical basis for its use to alleviate Patient A's symptoms.

119. Turning then to the use of HVT on Patient A's lumbar spine, the Committee concluded that this was not clinically justified.

120. The Committee has already found that the Registrant did not sufficiently investigate the symptoms of which Patient A complained. Until he did so the use of HVT was contraindicated because he was not fully able to weigh up the contraindications and the risks of treatment. With inadequate investigation, the reason(s) for and risk(s) associated with those contraindications were uncertain and as such should not have been undertaken by the Registrant. This is all the more important in a case where the Committee has concluded that Patient A

had not been provided with sufficient explanation of the risks to give her informed consent.

Allegation 6

The Registrant's conduct as set out in paragraph 4 was inappropriate.
Denied. Found proved in respect of Allegation 4a and 4c in respect of Appointment 1 and Appointment 2.
Found not proved in respect of Allegation 4b.

121. The Committee accepted the advice of the Legal Assessor that 'inappropriate' is a word in common usage intended to criticise something as unsuitable, ill-chosen or unacceptable. In this case the Committee has already concluded that the Registrant failed to conduct an adequate osteopathic evaluation of Patient A (Allegation 4a) and failed to adequately assess Patient A's lower limbs for neurological deficit, motor power loss and/or sensory deficit (Allegation 4b). The former is the basis for considering treatment at all. In the absence of a very detailed history, the latter was the basis for considering use of a specific technique deployed by the Registrant when treating Patient A.

122. The Committee determined that it was unacceptable for the Registrant not to conduct the evaluation and assessment referred to since, as stated, these were necessary to provide the information required by the Registrant to advise and then treat Patient A safely.

Proceeding in Absence

123. Following the conclusion of the facts stage of the hearing Mr Corre advised that the Registrant would not be in further attendance in person. The Committee advised that it had the discretion to continue in his absence and invited the parties to address this when the hearing resumed.

124. Mr MacDonald reminded the Committee that the Professional Conduct Committee Procedure Rules permit a hearing in the absence of a Registrant provided certain criteria are met. He invited the Committee to proceed on the basis that the Registrant was aware of the proceedings and had voluntarily absented himself. He was however represented by Counsel and no prejudice would arise from his non-attendance.

125. Mr Corre provided a short written submission and observed that the Registrant was seeing patients in clinic and consented to being present through Mr Corre attending on his behalf. He did not seek to adjourn the case but observed that no adverse inference should be drawn from the fact the Registrant was absent.

126. The Committee accepted the advice of the Legal Assessor which included reference to the overarching objective, whether the Registrant was absent by choice or force of circumstance, the fact that he was represented and did not

seek an adjournment and the ultimate question of whether the Committee was satisfied that it could continue to ensure the hearing was fair in the absence of the Registrant.

127. The Committee determined that it could continue to hold a fair hearing in the absence of the Registrant and concluded that the hearing should continue in his absence.

128. In coming to the above conclusion the Committee noted that the Registrant was aware that the hearing could continue in his absence and he did not seek an adjournment. The Committee accepted the submission of both Counsel that the Registrant had chosen to attend not in person but rather through his instructed advocate. He was quite entitled to do so. Having been advised that neither advocate intended to call further evidence but intended to rely on submissions, the Committee was satisfied that there was no prejudice to the Registrant (or the public) in his non-attendance. The Committee noted that the Registrant had participated in the regulatory process to date and attended all days of the fact-finding process. It could not and would not draw any adverse inference from his non-attendance.

Unacceptable Professional Conduct (UPC)

Submissions

129. Mr MacDonald relied upon his written submissions in which he indicated that the Registrant's conduct included actions which breached a number of the professional standards expected of a registered osteopath (the OPS) which he outlined. He conceded that such breaches did not require a finding of UPC but were indicative of this. He submitted that the Registrant's conduct as found proved during the fact-finding stage of the case fell short of expected standards, was serious and did amount to UPC. He set out what he submitted were a number of breaches of the OPS in Standard A (Communication and Patient Partnership) and Standard C (Safety & Quality in Practice) and Standard D (Professionalism).

130. Mr Corre also relied upon his short written submissions in which he set out the relevant test to be applied. In oral submissions he stated that he had no detailed submissions on the findings themselves but reminded the Committee that a breach of the OPS did not of itself give rise to UPC, this was a matter for the Committee's own judgement. He submitted that each allegation should be considered separately.

131. When asked whether it was the Registrant's case that the facts found proved did amount to UPC Mr Corre said that he did not seek to go behind the findings of fact but it remained the Registrant's case that he obtained valid consent, he conducted an appropriate osteopathic evaluation and, applied properly and carefully, the use of HVT did not fall below the standards expected.

Decision on UPC

132. The Committee accepted the advice of the Legal Assessor which included that UPC comprised of conduct that was serious and fell below the standards expected, breaches of the OPS may indicate UPC but did not determine this, the Committee may take account of expert opinion but it was a matter for the Committee's own judgement. It then went on to consider the issue of UPC in light of its previous findings of fact.

133. The Committee carefully considered the submissions made by both representatives and took note of the fact that the Registrant has no previous regulatory findings against him. It accepted the general proposition that the Registrant's actions were driven by an intention to provide treatment to Patient A and alleviate her symptoms. However, the Committee regarded the Registrant's failings as sufficiently serious to be described as UPC. Whilst the matters complained of occurred over a short period of time, they occurred in two consultations and the Registrant's failings were spread across a number of areas of his practice. In addition, the Registrant asserted (and continues to assert) that the inappropriate method he used in purporting to obtain consent was his standard practice. Thus, there was at the time, evidence of a serious systemic failure in his practice.

134. Regarding Allegation 3 and consent, the Committee noted that the OPS Standard A4 is mandatory in its language – a registrant "***must*** *[Committee's emphasise] receive valid consent for all aspects of examination and treatment"*. Clause 1 thereof reiterates that consent is a "*fundamental part of [a registrant's] practice and is both an ethical and legal requirement*."

135. In its findings of fact the Committee has already determined that the Registrant's approach is erroneous. Whilst he may feel he has a patient's agreement to continue; his approach specifically excludes him obtaining informed consent to the techniques he deploys. This was clear from his own evidence and from Patient A's lack of understanding. It is not sufficient for the Registrant to obtain a general agreement to the use of such treatment or techniques as he considers appropriate. Rather the expected approach to obtaining informed consent is to take a patient along a therapeutic journey by tayloring the discussion to the patient's needs, explaining the risks and benefits of the specific treatment (if any) such that they make the decision with the osteopath's advice on what individual techniques or treatment to accept. Whilst the Registrant did make some enquiry of Patient A during his treatment of her, the initial process of a general explanation and discussion was insufficient. There was no adequate discussion of the risk in treating the lumbar region nor apparently were options offered. The Committee was satisfied that OPS Standards A1, A2, A3 were breached. The Registrant did not adapt his standard approach to the individual (Patient A), he did not work in partnership with her, he did not give her the information she needed to make an informed choice regarding the specific treatment used.

136. Given the fundamental need for consent to be obtained the Committee was satisfied that the Registrant's failure was serious and does amount to UPC.

137. Turning to Allegation 4 and the failure to undertake an adequate osteopathic examination or assess Patient A's lower limbs, the Committee again noted that whilst these occurred over a short period of time, there were two specific failings on two occasions. The Committee has already found that the Registrant's initial case history was adequate however, its findings reflect the need to do more in this case due to Patient A's presenting symptoms. These symptoms indicated a risk of a serious underlying lower back pathology.

138. The Committee considered the expert evidence which was to the effect that either the Registrant should have made more detailed inquiry of Patient A concerning her potential neurological symptoms, or he should have undertaken a series of specific tests regarding those symptoms. He did neither. The Registrant thereby deprived himself of information which may have enabled him to better assess risk and better evaluate the safety of treatment. The Committee accepted the submission that this failure breached OPS Standard C1 and in particular C1.1 and C1.2. These require the Registrant to conduct an osteopathic evaluation in order to deliver safe treatment, taking account of the patient's case history, presentation and individual needs.

139. The Committee determined that the Registrant's failings, repeated on at least two occasions, were serious and amounted to UPC whilst acknowledging that the GOsC conceded it could not and did not seek to prove harm was caused to Patient A. This case is about risk of harm and not harm itself.

140. Having concluded that the Registrant put Patient A at risk through the failings found regarding Allegation 4. The Committee concluded that such conduct was inappropriate (Allegation 6) and sufficiently serious to amount to UPC.

141. Turning finally to Allegation 5 and the use of HVT (Allegation 2) when it was contraindicated and not clinically justified. The Committee noted and accepted the proposition that HVT itself is a widely used technique. However, it is not HVT itself that is criticised, rather it is the use of HVT given the weight of the relative contraindications and the lack of clinical justification because of this.

142. The Committee noted the Registrant's case that he had considered the possibility of a potential radiculopathy and/or spinal degeneration. It was his case that it was nonetheless safe to use HVT. Indeed he appeared to consider the use of HVT to be safe in all cases save where there were absolute (red flag) contraindicators. In adopting this approach the Registrant did not pause sufficiently to investigate the symptoms further but went ahead in spite of the contraindications. In so doing he potentially deprived himself of further evidence to evaluate safety.

143. In coming to the above conclusion the Committee accepted the submission that the Registrant's approach breached OPS Standards C1, C1.4.2 and C4 since he did not develop or adapt his approach to the needs of Patient A or seek the best evidence rather he ploughed on which placed Patient A at risk. Whilst again the Committee accepts that no provable harm resulted, the Registrant's actions raised that risk and to do so was a serious failing amounting to UPC.

144. In coming to the above conclusions the Committee was of the view that such failings either individually or when considered together are capable of adversely affecting public confidence in the profession. As such the Registrant's conduct was in breach of OPS Standard D7.

Sanctions

Submissions

145. Mr MacDonald adopted his written submissions and reminded the Committee that the purpose of sanction is not to punish the Registrant but to protect the public. He submitted that the Committee should consider any aggravating and mitigating factors within the case. Regarding mitigating factors he said that the Registrant was of good character and there had been no complaint since these matters had come to light. As to aggravating features Mr MacDonald submitted that the fact the Registrant had refused to apologise or accept mistakes was one such. He also alluded to the risk of harm albeit this had already been assessed as part of the seriousness of the case resulting in a finding of UPC. He submitted there was no evidence of insight or of any steps to avoid repetition.

146. Mr MacDonald's written submissions then set out observations on each of the available sanctions in ascending order of gravity. He submitted that Admonishment would not meet the gravity of the case nor protect the public due to the Registrant's lack of insight. Regarding a Conditions of Practice Order he conceded that the areas of concern in the Registrant's practice had been identified but submitted that they were serious and wide ranging. He again raised the concern of a lack of insight, the potential for an attitudinal problem to be present and noted the Registrant's refusal to accept he had done anything wrong. He submitted that Conditions would be a matter for the Committee to consider and it should look carefully at whether conditions could be formulated and whether the Registrant would adhere and respond to them.

147. Concerning suspension, Mr MacDonald submitted that the Registrant's failings were serious but not incompatible with practice provided there was a realistic prospect of remediation. That depended to a large extent on the Registrant's attitude and capacity to remediate which had as yet not been demonstrated. Finally concerning Removal from the Register, Mr MacDonald observed that this was reserved for the most serious cases where there had

been harm or a risk of harm. He submitted that the latter was engaged. In addition he submitted that an assessment of the Registrant's insight and capacity to remediate was important.

148. In short oral submissions Mr MacDonald observed that there was some evidence of CPD and remediation. Some of this learning predated the allegations and neither they nor the more recent training events appeared to have altered the Registrant's view of the correctness of his own practice.

149. Mr Corre referred to his written submissions and amplified them in oral submissions. In the round he submitted that a Conditions of Practice Order was appropriate and proportionate. He submitted that the Registrant's failings had been identified and that these could be met by further training. He submitted this would protect the public. He conceded that the registrant's insight was limited in that he disputed the factual findings but this did not preclude the imposition of such an order but may itself be a reason for its imposition. He submitted that the learning from a Conditions of Practice Order could be tested and evaluated by way of a reflective statement by the Registrant.

150. In answer to questions Mr Corre confirmed that the more severe sanctions of Suspension or Removal from the Register would have a financial impact upon the Registrant. He advised that the Registrant had instructed him that he was willing to undertake further training should that be a condition of his continued practice.

151. In addition a number of testimonials regarding the Registrant and evidence of CPD undertaken by him were submitted for consideration by the Committee.

Decision of the Committee on sanction

152. The Committee determined that the appropriate level of sanction was a Conditions of Practice Order of twelve months duration with review.

153. In coming to the above conclusion the Committee considered the Hearings and Sanctions Guidance (HSG) produced by the GOsC, the submissions by both advocates and it accepted the advice of the legal assessor. The latter included consideration of the overarching objective, the order in which sanction should be considered and issues such as good character, insight, remediation and/or the capacity to gain insight or to remediate.

154. Concerning aggravating and mitigating factors, the Committee first looked at mitigating factors. The Committee concluded that the Registrant's good character over a number of years of practice was such a factor and, to a lesser extent, the fact that there had been no complaints since those raised by Patient A. The Committee also noted that the Registrant had in the past demonstrated a willingness to undertake CPD or learning opportunities. Some of these appeared to be both recent and relevant to the allegations, however

it was questionable how much he had actually learned from them. Finally the Committee noted that the Registrant caused no provable harm, rather it was a question of risk. Concerning aggravating features the Committee was concerned by the Registrant's refusal to accept the mistakes identified in his practice or to recognise the potential for harm. It also noted that he appeared to be somewhat dismissive of Patient A's evidence and her concerns.

155. Concerning the issue of insight, which goes to the issue of continued risk, the Committee had observed the Registrant during the hearing and had heard from Mr Corre as to the Registrant's view regarding the conduct found proved.

156. The Committee took account of the fact that the Registrant has engaged in CPD courses in relevant areas but as stated above this was balanced by the fact that there was no evidence from which to conclude he had altered or improved his practice.

157. Considering the above, an important question for the Committee was whether the Registrant was unwilling or unable to remediate the faults found proved. His otherwise good character and the complimentary testimonials shed some light onto this and the issue of risk. The feedback was not provided by professional colleagues and did not appear to be written in the knowledge of the allegations.

158. Drawing the above factors together the Committee concluded they gave the overall picture of a registrant who lacked insight, was overconfident, rebuffed challenge and appeared to be set in his ways. Despite this he had engaged in CPD and, following Mr Corre's submissions, the Committee was not satisfied that he was entirely closed to remediation even though this had not occurred to date. In this regard it noted that the Registrant has no previous adverse findings over a long history in practice and, this case did not fall into the category of cases such as sexual offences or dishonesty where the seriousness and type of conduct meant that remediation was all but excluded.

159. Having come to the above conclusions the committee next considered the appropriate sanction in order of ascending gravity, taking account of the factors set out in the HSG.

160. The Committee first considered the question of whether admonishing the Registrant was an appropriate and sufficient sanction. It concluded that it was not. In coming to this conclusion the Committee noted that despite the Registrant's otherwise good character, this case involved a risk of harm and the Registrant had not yet demonstrated insight into that risk. Whilst the allegations related to one patient it was the Registrant's case that the method by which he purported to gain consent (and which the Committee found to be wanting) was his usual practice and it continued to date. Furthermore he had made it clear that he did not accept the criticism of his practice nor had he learned from relevant CPD or taken any rehabilitative steps to date.

161. The Committee next considered a Conditions of Practice Order and, despite the concerns outlined above, it was not satisfied that the Registrant could not or would not remediate. Whilst he had not done so to date, he had undertaken CPD and Mr Corre, on the Registrant's behalf, specifically asserted that the Registrant was open to further learning opportunities and supervision which could be provided through the imposition of a Conditions of Practice Order. Whilst the Committee recognised the force in Mr MacDonald's submission that the Registrant's failings covered more than one area of practice, it also regarded them as discrete and capable of being addressed. There was also some force to Mr Corre's assertion that the fault(s) in cases involving senior practitioners such as the Registrant often revolve around long-established styles of practice and modes of communication that require challenge, training and support.

162. Overall the Committee determined that the Conditions of Practice Order should focus upon challenging, training and supporting the Registrant in the following matters:

Gaining informed consent.

Improving history taking and the proper consideration of relative contraindications by neurological assessment techniques in order to formulate an appropriate treatment in cases where neurological symptoms are or may be present.

Those standards in the OPS referred to in this determination as having been breached.

The Committee was satisfied that such an order could and should protect the public and enable the Registrant to practise safely.

163. Having determined that a Conditions of Practice Order was at first consideration an appropriate and sufficient sanction, the Committee nonetheless looked at the factors that may yet indicate suspension or removal from the register are appropriate. The Committee concluded that whilst such orders would protect the public for a shorter or longer period of time, their effect upon the Registrant would be unduly punitive. In addition they would deprive the public of a registrant who had served the public for many years and who, subject to remediation, may yet do so.

Conditions of Practice Order

164. This Order shall be of twelve months duration during which the Registrant shall:

(a) Engage and fund a supervisor (details to be provided to GOsC and approved by it within 14 days) with whom he shall develop an appropriate Personal Development Plan to include in-person training on the above mentioned matters (see paragraph 162 above).

(b) Report to his supervisor after each course and provide copies of completion certificates to demonstrate the learning and the fact that he has put such learning into practise.

(c) Meet with his supervisor for a minimum of 2 hours per month (such meeting may be in person or remotely as the supervisor considers appropriate) to discuss a sample of cases and case-notes picked at random by the supervisor taking account of the learning identified as required.

(d) Arrange for his supervisor to attend and observe the Registrant in consultation at least once every 3 months to ensure the training undertaken has in fact been implemented.

(e) Provide a reflective statement together with any supporting documentation for any review hearing.

(f) Arrange for his supervisor to provide a report for any review hearing.

165. This Order shall be reviewed before its expiry at such time and date of which the Registrant shall be informed. The Review Committee may then make such order as it deems necessary (if any) in accordance with the overarching objective.

166. The above Conditions were provided to the parties in draft form for their comments in accordance with the GOsC's Informal Procedure for Consultation with the Parties on Draft Conditions. Neither Mr Corre nor Mr MacDonald had any comment to make and the Order was thus made final.