GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 1722/8815

Professional Conduct Committee Hearing

DECISION

Case of: Emanuele Vanoli

Committee: Sue Ware (Lay Chair)
Andrew Howard (Lay)
Jim Hurden (Osteopath)

Legal Assessor: Helen Gower

Representation for Council: Neelam Gomersall

Representation for Osteopath: Emanuele Vanoli was present but not represented

Clerk to the Committee: Sajnee Padhiar (2 June 2026)
Laura Manners (3 June 2026)

Date of Hearing: 2-3 June 2026

Summary of Decision:

The Committee found Allegation 2(a) proved and the remainder of the Allegation not proved.
Allegation 2(a) did not amount to unacceptable professional conduct.

Allegation and Facts

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

1. *From 10 November 2023 to a date unknown in 2024 (Treatment Period), the Registrant treated Patient A on multiple occasions.*
2. *During the Treatment Period, the Registrant:*
   a) *was present at Patient A's therapist sessions with Therapist B;*
   b) *shared Patient A's osteopathy records with Therapist B, without the consent of Patient A.*

3. *The Registrant's conduct as set out at particular 2 in its entirety was:*
   a. *inappropriate;*
   b. *a breach of professional boundaries.*

Preliminary issues:

1. In accordance with Rule 6 of the General Osteopathic (Professional Conduct Committee)(Procedure) Rules Order of Council 2000 ("the Rules"), the Committee considered whether there was any reason why any member of this Committee would not be eligible to hear this case. The Committee decided that there was no such reason.

2. The Committee noted that the Council had provided an Italian translator, to provide assistance, if required, for Patient A, when giving their evidence.

Background:

3. Ms Gomersall referred the Committee to the GOsC skeleton argument and outlined the background as follows.

4. The Registrant is a registered Osteopath.

5. On 18 February 2025 Patient A made a complaint to the General Osteopathic Council (GOsC) concerning the Registrant.

6. Patient A's complaint referred to an apparent referral from the Registrant to a "teacher", "Therapist B" who could help Patient A "psychologically". Patient A reported that Therapist B treated him in the Registrant's studio.

Patient A complained that the Registrant gave "all" his private information to Therapist B.

7. On 19 February 2025, Patient A completed a concerns and declarations form in which he described Therapist B treating him in the Registrant's studio "*most of the times with [the Registrant's] presence*". Patient A stated that the Registrant gave all his private and sensitive information to Therapist B without any approval by him *"not even verbal*".

8. Patient A provided further detail of his complaint in correspondence with GOsC on 21 February 2025. Patient A confirmed that the Registrant was "*playing by the rule [sic] of only assistant"* in his sessions with Therapist B and was "*co-operating sometimes depending the situation, expressing his opinion or his personal experience to the moment".*

9. Patient A clarified that the information provided by the Registrant to Therapist B included his "*Spanish number identification, date of birth, home address, personal health notes, personal event notes and every information that he needed to treat [him] better".*

The hearing:

10. The Allegation was read and the Registrant made no admissions.

11. The Committee was provided with a hearing bundle which included Patient A's initial complaint, concerns and declaration form, and correspondence with GOsC. The bundle also included two witness statements from Patient A dated 27 May 2025 and 19 November 2025, a log of WhatsApp messages complete with English translation, the Registrant's written response to Patient A's complaint, and the Registrant's clinician notes for Patient A.

12. As summarised in the GOsC skeleton argument, Patient A's first witness statement states:

i. From 10 November 2023 he had approximately 3-5 appointments with the Registrant all of which took place at the Registrant's studio at a cost of 60 Euros an hour.

ii. The Registrant initially took a lot of information from Patient A and was aware that Patient A was having personal difficulties including stress at work and relationship problems.

iii. At Patient A's last appointment with the Registrant, the Registrant informed Patient A that Therapist B could assist him and it would cost 120 Euros per hour to which Patient A agreed.

iv. Patient A's first session with Therapist B took place at the Registrant's studio in the Registrant's presence.

v. During the first session the Registrant showed Therapist B Patient A's medical file, and Patient A told Therapist B about his issues and how they were causing him stress.

vi. The Registrant acted as an observer in the first session but would engage with his opinions and ideas at certain points.

vii. The Registrant stated that he was learning from Therapist B and it was a good opportunity for him, and suggested that he was doing Patient A a favour by referring him to Therapist B.

viii. Patient A paid 120 Euros at the conclusion of his first session with Therapist B and was later contacted by Therapist B by telephone who asked Patient A for a further payment of 120 Euros to pay for the Registrant's presence.

ix. Patient A and his family attended subsequent sessions with Therapist B at which the Registrant was present.

13. As summarised in the GOsC skeleton argument, Patient A's second witness statement states, in respect of his first session with Therapist B:

i. The medical file showed to Therapist B had his personal details displayed at the top of the page, including his first name and other identifying personal information, and the notes reflected specific information previously disclosed to the Registrant such as chest pain, shoulder discomfort, smoking status, and personal stressors relating to work and relationships.

ii. The Registrant placed the medical file on the treatment room desk within Therapist B's reach, opened it, verbally summarised its contents and positioned it in such a way that Therapist B could read it directly.

iii. Patient A did not provide written consent, nor did he recall giving explicit verbal consent, for his notes to be shared with a third party.

iv. Although Patient A felt uncomfortable during the session, he did not interrupt or challenge the process at the time as he did not feel able to question the conduct of the Registrant mid-session.

14. The Registrant's written response states in summary:

i. He treated Patient A on one occasion on 10 November 2023 for which he was paid 60 Euros.

ii. He shadowed Patient A's subsequent treatments with Therapist B with the express consent of Patient A on three occasions. He had received treatment from Therapist B. Therapist B had offered to let him shadow treatments if he had any difficult cases to bring him. Therapist B told him he was keen to pass on his knowledge before retiring.

iii. At Patient A's first session with Therapist B, he had Patient A's notes out in case they were needed to answer questions or present the case to Therapist B, however Therapist B wished to conduct his own interview and did not ask for any information.

iv. Therapist B had no access to Patient A's notes directly.

v. He did not share Patient A's personal details without Patient A's consent.

vi. He had shared Therapist B's contact details with Patient A, not the other way around.

vii. Patient A and Therapist B started to communicate directly.

viii. Patient A shared much more in depth personal and sensitive information with Therapist B than he had previously shared which did not suggest that Patient A had any particular sensitivity to having his clinical notes out on the desk.

ix. He had no financial interest when referring Patient A to Therapist B and at no point was there mention of him being paid an extra 120 Euros to account for his presence in the first session.

x. Patient A was required to pay an extra 120 Euros for the first session because it lasted two hours instead of one.

xi. He had no reason to suspect that there were any problems with Patient A's treatment or that he had any issues with his relationship with Therapist B which continued independently of him.

xii. On 9 August he received a threatening message from Patient A regarding his willingness to thank him "in person" for pushing him in the hands of Therapist B to which he did not reply.

15. Patient A gave evidence on affirmation and confirmed that the contents of his witness statements were true. In answer to questions from Ms Gomersall Patient A said that he was unsure whether he had seen the Registrant alone for a treatment session after the first session on 10 November 2023. He said that he thought that the purpose of the referral to Therapist B was to provide him with "mental support".

16. In answer to questions from the Legal Assessor based on the Registrant's written response, Patient A agreed there were three occasions when the Registrant shadowed the treatment sessions with Therapist B, and that he was in agreement that this shadowing could take place.

17. In answer to questions from the Panel, Patient A said that he had provided details of his personal life to Therapist B, particularly about his personal relationship and his childhood. In relation to the Registrant's clinical notes, he said that there was a file on the desk in full view of Therapist B so that Therapist B could check information and look at it.

18. The Registrant gave evidence on oath and provided his comments on the content of the GOsC skeleton argument. He invited the Committee to consider the proximity in time between Patient A's complaint to the GOsC and the messages he received from Patient A relating to the problem that had arisen in the relationship between Patient A and Therapist B.

19. The Registrant said that his clinical notes were placed on the desk for his personal reference in case there were any questions arising during the consultation. He told the Committee that his clinical notes do not include Patient A's address or his Spanish ID number, and that the notes he has provided are his complete records for Patient A. The Registrant also told the Committee that Therapist B does not speak any English and that he was asked to assist with translation when Therapist B held a treatment session

with Patient A's wife. The Registrant, however, acknowledged that Patient A might have seen things differently.

20. The Registrant said that his usual practice was that when he booked a patient for a shadowing session, he would verbally confirm with them that they were content with this arrangement. He said that there were cases where his patients had not been content for shadowing to take place. The Registrant believed that Patient A was comfortable with the arrangement and that Patient A had booked his wife in for a treatment session, with Therapist B, specifically asking the Registrant to be present at that session.

21. The Registrant stated that he had no doubt that Therapist B was an Osteopath and that he was acting within the scope of his practice when shadowing Therapist B and that this included offering his opinions and ideas. He said that it is usual practice, as part of shadowing to ask questions and offer opinions.

22. The Registrant pointed out that when referring Patient A to Therapist B he had not provided personal information to Therapist B, but had provided Therapist B's contact information to Patient A. This was confirmed by the WhatsApp messages.

23. In response to questions from Ms Gomersall the Registrant confirmed that he is an experienced Osteopath and that he has now been practising for twelve years. He said that in his first session with Patient A he was aware that Patient A was experiencing stress at work, but was not aware of his personal difficulties.

24. The Registrant was asked about the purpose of his referral to Therapist B, and said that this was because Therapist B was more skilled than he was and that he thought Therapist B could do more for Patient A than he was able to do. He did not agree that he had introduced Therapist B as a Psychologist, and said that he was an experienced Osteopath. The Registrant denied that the referral was primarily for his own benefit for learning purposes, and said that he believed that the referral was primarily in the interests of Patient A. He accepted that Patient A may have interpreted the referral as being an opportunity for the Registrant to learn from Therapist B.

25. The Registrant was asked whether the sessions with Therapist B were focused on Patient A's relationship issues. The Registrant said that these were not discussed in detail in the first session, but in the last session there was a more in depth discussion on these matters.

26. The Registrant was asked whether Patient A had agreed to the shadowing and the Registrant said that there was verbal consent and this was his routine practice. This probably took place in a telephone conversation prior to the first session with Therapist B.

27. The Registrant accepted that his clinical notes which were open on his desk might have been within reach of Therapist B. The notes were there for him to answer questions if asked and he did not deliberately position the file in a way that Therapist B could read them. He did not recall verbally summarising the case to Therapist B, that it was not uncommon that he would "present" a case when shadowing, and this is something that he would usually do. The Registrant accepted that he had not had a conversation with Patient A explaining that he could decline to disclose his records to Therapist B. The Registrant was asked about written consent, and said that he thought that verbal consent was sufficient within the context of shadowing and that he was not sharing information apart from the presentation of the case.

28. The Committee heard submissions from Ms Gomersall on behalf of the GOsC and from the Registrant. It accepted the advice of the Legal Assessor.

29. The Committee reminded itself that the burden of proving the facts is on the Council alone, and that the standard of proof is the civil standard, namely the balance of probabilities.

Allegation 1 – not proved

From 10 November 2023 to a date unknown in 2024 (Treatment Period), the Registrant treated Patient A on multiple occasions.

30. The Committee found there was no reliable evidence that the Registrant had treated Patient A on more than a single occasion on 10 November 2023. The Committee gave weight to the contemporaneous evidence. The

WhatsApp messages and the Registrant's clinical notes were consistent with the Registrant's evidence that he treated Patient A on a single occasion on 10 November 2023, before Patient A was referred to Therapist B approximately one month later.

31. Although Patient A referred in his witness statement to multiple occasions when he was treated by the Registrant, when answering questions from Ms Gomersall he was unsure whether there were any treatment sessions with the Registrant alone following the session on 10 November 2023.

32. There was evidence before the Committee that the Registrant had attended subsequent treatment sessions between Patient A and Therapist B, but the Registrant was not the treating Osteopath in these sessions. The Registrant's role was not entirely passive during these sessions. He was asking questions and offering his opinion. This would be the expected and common practice for an Osteopath who is shadowing another Osteopath as a learning experience, and there was no evidence that the Registrant was treating Patient A during the shadowing sessions.

33. Accordingly, the Committee found Allegation 1 not proved.

<u>Allegation 2(a) – proved</u>

2. During the Treatment Period, the Registrant:

a) was present at Patient A's therapist sessions with Therapist B

34. The Panel noted that the "Treatment period" is defined in Allegation 1 as "10 November 2023 to a date unknown in 2024".

35. The evidence before the Committee is consistent that the Registrant was present at three of Patient A's sessions with Therapist B. In his written

response and his oral evidence the Registrant confirmed that he was present at treatment sessions and that this was in a shadowing or learning role. The Registrant's evidence is consistent with the evidence of Patient A, in relation to the Registrant's presence at three treatment sessions with Therapist B.

36. The Panel therefore found Allegation 2a) proved.

Allegation 2(b) not proved

2. During the Treatment Period, the Registrant:

b) shared Patient A's osteopathy records with Therapist B, without the consent of Patient A

37. This Allegation relates to the first treatment session between Patient A and Therapist B, which was attended by the Registrant in an observing or shadowing role. The Registrant accepts that he had Patient A's osteopathy notes open on his desk during this session, but he does not accept that these were "shared" with Therapist B.

38. Patient A told the Committee that the osteopathy notes were on the desk and that Therapist B had the opportunity to look at them. He also said that Therapist B had picked up the file to read it. In his second witness statement he stated that the Registrant had positioned the file so that Therapist B could read it.

39. The Committee considered this evidence, but it found the Registrant's account to be consistent, plausible, and reliable. The Registrant's recollection of the position of the one page clinical record was clear, it was face-up, but not in direct line of sight of Therapist B. The Registrant knew that Therapist B was not a native English speaker, and it was therefore unlikely that he would have chosen to position his clinical notes, written in English, for Therapist B to glance at and absorb during a treatment session. The Committee also accepted that the Registrant had provided a cogent and credible reason for the presence of the osteopathy notes during the treatment session. The Committee found it plausible that the Registrant might need to refer to the notes to answer a question posed by Therapist

B or to provide pertinent information between professionals. This would be expected of an Osteopath, and the Registrant might have been criticised if he had relied on his memory rather than his notes to answer any questions. The Registrant had no reason to show the notes to Therapist B. His normal practice would be to provide an oral summary of the case to the treating Osteopath following a referral.

40. The Committee also noted that the Registrant had been careful in his referral to Therapist B not to provide Patient A's contact details. The WhatsApp messages confirmed that he had provided Therapist B's details to Patient A, who had chosen to take up this option.

41. For these reasons, the Panel preferred the evidence of the Registrant to that of Patient A, and found that the Registrant had not shared his osteopathy notes with Therapist B.

42. Accordingly, the Committee found Allegation 2b) not proved.

Allegation 3 not proved

3. The Registrant's conduct as set out at particular 2 in its entirety was:

a. inappropriate;

b. a breach of professional boundaries.

43. In his oral evidence to the Committee Patient A accepted that he had agreed to the Registrant being present. He understood that this was a learning experience for the Registrant. He continued to book sessions with Therapist B, knowing that the Registrant would be present. The Committee noted that Patient A made no complaint and raised no concerns about the Registrant's attendance at any of the treatment sessions with Therapist B. While acknowledging Patient A's vulnerabilities, the Committee noted from the WhatsApp messages that the relationship between Patient A and the Registrant appeared to be good up to the point that dispute arose between Patient A and Therapist B. The Committee was satisfied that Patient A had agreed to the arrangement at the outset and the Registrant had no reason to believe that he was not content for it to continue.

44. In her submissions Ms Gomersall referred the Committee to the Osteopathic Practice Standards B2 and D2. Standard B2 requires Osteopaths to recognise and work within the limits of your training and competence. Standard D2 states that Osteopaths must establish and maintain clear boundaries with patients, and must not abuse their professional standing and the position of trust that they have as an osteopath.

45. The Committee did not consider that the Registrant had acted in breach of Standard B2 or D2 when he was present at Therapist B's treatment sessions in an observing and learning role. The shadowing of more experienced practitioners is common and expected practice for Osteopaths, including those who are experienced practitioners. A theme in the GOsC Continuing Professional Development Scheme is the need to address professional isolation by fostering a culture of peer support and creating collaborative learning environments. The Committee noted from the WhatsApp messages that the Registrant described Therapist B to Patient A as his "mentor". It is not expected that, whilst shadowing a mentor, osteopaths are merely to sit and observe; interaction that enhances the osteopath's learning experience is a vital component of such peer to peer development.

46. There is also an expectation that Osteopaths take a person-centred approach to care to enhance the quality of care and outcomes for patients and it is therefore appropriate for an osteopath to consider psychological stressors. Standard D10 requires osteopaths to consider the contributions of other health and care professionals, to optimise patient care and this includes (at 1.4) "*working collaboratively with other healthcare providers to optimise patient care, where such approaches are appropriate and available*".

47. The Committee therefore found that the GOsC has not proved that the Registrant's presence at the treatment sessions with Therapist B was inappropriate or a breach of professional boundaries.

Determination on Unacceptable Professional Conduct

48. The Committee next considered whether the fact it had found proved amounted to conduct falling short of the standard required of a registered

Osteopath, namely whether it amounted to unacceptable professional conduct ("UPC"). The Committee took into account the submissions of Ms Gomersall.

49. Having considered the Committee's full reasons for its determination on the facts, Ms Gomersall submitted that the Committee should proceed to the next stage of considering UPC, but made no further submissions.

50. The Registrant made no further submissions at this stage.

51. The Committee accepted the advice of the Legal Assessor. It bore in mind that there is no standard of proof to be applied at this stage and that the consideration as to whether the threshold for UPC has been reached is a matter of its professional judgment. The Committee took into account the guidance of Mr Justice Irwin in *Spencer v The General Osteopathic Council [2012] EWHC 3147 (Admin)* in which it was stated that a finding of UPC implies "*moral blameworthiness and a degree of opprobrium.*"

52. In its decision on Allegation 3 the Committee concluded that the Registrant's conduct in Allegation 3 did not amount to a breach of the Osteopathic Practice Standards. In the Committee's judgment the Registrant's conduct would not be regarded as deplorable by fellow practitioners, nor would it be described as morally blameworthy. The Committee concluded that the Registrant's conduct in Allegation 2(a) did not amount to UPC.

53. The Allegation is therefore not well founded.