In the matter of Section 22 of the Chiropractors Act 1994 ("the Act")

and

The General Chiropractic Council (Professional Conduct Committee) Rules 2000 ("the Rules")

and

The consideration of an allegation by the Professional Conduct Committee

NOTICE OF FINDING BY THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL CHIROPRACTIC COUNCIL

Name of Respondent:	**Lorraine Le Mare**
Address of Respondent:	**Apartment 25** **33 Osiers Road** **London** **SW18 1NL**
Registration Number of Respondent:	**04626**

On 13-21 January 2020 and 1-4 February 2021, the Professional Conduct Committee ("the Committee") of the General Chiropractic Council met to consider the following allegation against you, referred to it by the Investigating Committee in accordance with Section 20(12)(b)(ii) of the Chiropractors Act 1994 ("the Act"):

THE ALLEGATION:

That being a registered chiropractor you are guilty of unacceptable professional conduct.

General Chiropractic Council

PARTICULARS OF THE ALLEGATION:

That, being a registered chiropractor, you are guilty of unacceptable professional conduct in that:

1. At all material times you practised as a chiropractor at Sensus Health and Wellness, 60 Walham Grove, London SW6 1QR ('the clinic')

2. You had consultations with Patient A at the clinic on or around 16 February 2018 ('the first consultation'), 26 February 2018 ('the second consultation') and 2 March 2018 ('the third consultation').

3. You performed spinal manipulative therapy on Patient A on the second and/or third consultations.

4. In respect of the treatment referred to in 3 above you failed to provide an adequate standard of care to Patient A in that:

    a) You were aware that Patient A suffered from a connective tissue disorder and/or hypermobility;

    b) Spinal manipulative therapy was contraindicated in light of Patient A's connective tissue disorder and/or hypermobility;

    c) You failed to obtain informed consent for the treatment;

    d) You failed to respect Patient A's preference not to have spinal manipulative therapy on her neck.

5. At the third appointment Patient A told you that (or words to the effect that) following treatment given by you at the second appointment:

    a) She had sat in the clinic's reception because she felt starry eyed;

    b) She had a bad reaction to her lower pelvic area;

    c) She did not sleep well;

    d) She had had diarrhoea;

    e) She had pain in her hips and pelvis for almost a week;

    f) She had pain in the right side of her neck going up to her temple.

6. During a telephone call on or about 8 March 2018:

    a) Patient A told you that (or words to the effect that) following the third appointment she had experienced:

i. Ringing in her ear;

ii. Pain and/or blurriness in her eye.

b) You told Patient A that (or words to the effect that):

i. She should give it a week to let her neck get better;

ii. After a week she should return to the clinic for further treatment.

7. In light of all or any of the matters set out in 5 and/or 6 above you failed to act appropriately in that:

a) You gave Patient A spinal manipulative therapy at the third appointment;

b) You failed to review your plan or treatment for Patient A;

c) You failed to re-examine Patient A and/or invite her to come in to the clinic for a re-assessment;

d) You failed to undertake any or any sufficiently prompt investigation in respect of Patient A's reported symptoms and/or recommend that such an investigation be undertaken;

e) You continued to treat Patient A and/or recommended that she have further treatment without conducting a review or any investigations.

AMENDED ALLEGATION

That, being a registered chiropractor, you are guilty of unacceptable professional conduct in that:

1. At all material times you practised as a chiropractor at Sensus Health and Wellness, 60 Walham Grove, London SW6 1 QR ('the clinic')

2. You had consultations with Patient A at the clinic on or around 16 February 2018 ('the first consultation'), 26 February 2018 ('the second consultation') and 2 March 2018 ('the third consultation').

3. You performed spinal manipulative therapy on Patient A on the first, second and/or third consultations.

4. At the first, second and/or third consultations you failed to provide an appropriate standard of care to Patient A in that you performed spinal manipulative therapy which was contraindicated due to her suffering a connective tissue disorder giving rise to general hypermobility.

5. At the third consultation you failed to provide an appropriate standard of care to Patient A after she had informed you of adverse symptoms following her previous treatment in that:

   a) You treated her without adequate re-examination;
   b) You treated her without adequately reviewing her plan of care.

6. Following a telephone call on 8 March 2018 when Patient A reported further adverse symptoms you failed to provide an adequate standard of care in that:
   a) You did not offer to re-assess and/or refer Patient A;
   b) You did not offer to investigate Patient A's reported symptoms;
   c) You offered reassurance to the effect that this was "all McTimoney" without having further assessed Patient A.

7. You failed to obtain informed consent for the treatment provided to Patient A in that:

   a) You commenced treatment at the first consultation without having adequately informed Patient A of the findings of your assessment;
   b) You commenced treatment without adequately explaining the risks and benefits of treatment;
   c) You did not adequately explain the risks of spinal manipulative therapy, including the use of the McTimoney Toggle Technique, in view of her suffering from a connective tissue disorder giving rise to general hypermobility.

General Chiropractic Council

DECISION

1. The Professional Conduct Committee (the Committee) convened to consider an Allegation of Unacceptable Professional Conduct against Miss Lorraine Le Mare. Mr Orpin-Massey appeared on behalf of the General Chiropractic Council (the GCC). Miss Le Mare attended and was represented by Mr Goldring.

Application to amend

2. At the outset of the hearing Mr Orpin-Massey made an application to amend the Allegation. He informed the Committee that the amendments were to provide greater clarity and simplicity to charges by grouping them more clearly in chronological order and theme. He said there was no new territory covered in the proposed amendments and the Registrant would not be prejudiced by them. Mr Goldring, on behalf of the Registrant, did not object to the proposed amendments.

3. The Committee considered the application with care and accepted the advice of the Legal Assessor. The Committee took into account the lack of objection by Miss Le Mare and the fact that the amendments were to clarify matters and not to alter the seriousness of the case against the Registrant. In all the circumstances the Committee was satisfied that the requested amendments were desirable and would cause no injustice to Miss Le Mare. The Committee therefore allowed all the amendments requested and as reflected above.

4. Following further discussion with the GCC's expert Chiropractor witness, Mr Richard Brown, Mr Orpin-Massey applied to amend heads of charge 4 and 7(c) to read, *"suffering a connective tissue disorder giving rise to generalised hypermobility"* from "suffering a connective tissue disorder and/or hypermobility." Again, this was to provide clarity and was not opposed by Miss Le Mare.

5. The Committee agreed that this was a helpful amendment that would indeed provide greater clarity. It noted the lack of any opposition from the Registrant and was satisfied that to allow the amendment would not cause any injustice. The application was, therefore, granted.

Admissions

6. Following the amendments to the Allegation, Mr Goldring, on behalf of Miss Le Mare, indicated that heads of charge 1 and 2 were admitted. The Chair therefore announced that those facts were found proved. Mr Goldring also indicated that head of charge 3 was admitted, but only on the basis that the Registrant did not take Patient A's joints past their physiological range of motion. The Chair indicated that in light of the caveat it was safer to treat this head of charge as not admitted at this stage, but that the Committee would in no way hold that against the Registrant if, in fact, it was later to be found proved.

Application for Patient A to give evidence via live televisual link

7. Mr Orpin-Massey indicated to the Committee that an application had been made in advance of the hearing for the evidence of Patient A to be given by live televisual link. He said the application had not been opposed by the Defence and had been granted. However, due to Patient A being unwell and the time difference between the UK and Vancouver in Canada, where Patient A was residing, it would not be possible to reach her evidence until 2pm on Tuesday 14 January 2020.

Background

8. Miss Le Mare qualified as a chiropractor in October 2017, having completed a four-year full-time Masters course in chiropractic at the McTimoney College in Abingdon, Oxfordshire. Before deciding to train as a chiropractor, Miss Le Mare had been a chartered surveyor for many years.

9. In November 2017 Miss Le Mare started work as an associate chiropractor at the Sensus Health and Wellbeing clinic ("the Clinic") in Fulham. The manager of the Clinic was a chiropractor of around 20 years experience. At the time of these allegations Miss Le Mare had only been in full time practice for some three months.

10. Patient A is a lady from Canada who was 35 years old at the time she visited the Clinic and was treated by Miss Le Mare. She has a professional background in marketing, and at

the time of her treatment had been completing a one-year full-time Masters course in London. Her medical history is somewhat complicated. In brief:

- She had seen a chiropractor in Canada, when she was a child, for back pain and scoliosis. The last time she saw that chiropractor was in 2016, as an adult;
- She had seen an osteopath in 2011 and 2012;
- She was informed by a physiotherapist around the same time that she had a condition called hypermobility;
- She was told in 2014, by a geneticist, that she may have a condition called Ehlers-Danlos syndrome ("EDS"), which is a specific condition, associated with a more pronounced form of hypermobility;
- She had seen an acupuncturist in 2016 for back pain;
- She had pains in her pelvic floor from May 2017, for which she had seen a gynaecologist in London;
- She saw a physiotherapist in September 2017, who performed an internal physiotherapy technique to help her with the pelvic floor pains.

11. This same physiotherapist recommended that Patient A see a chiropractor who might be able to help her with her lower back, and may be able to help with her pelvic floor issues. Patient A consequently arranged to see Miss Le Mare. The first appointment was on 16 February 2018. Patient A saw Miss Le Mare for a total of three appointments in February and March 2018. What happened in those appointments was to some extent disputed between Patient A and Miss Le Mare.

12. Patient A said she attended for treatment for her pelvic floor issues. She said she told Miss Le Mare about her prior history and that she had a *"connective tissue disorder and hypermobility."* Patent A said she mentioned to Miss Le Mare EDS and that this also caused swelling of her hands and neck stiffness. However, at the time of seeing Miss Le Mare Patient A had been advised, by geneticists at University College London Hospital ("UCLH"), that she did not meet the diagnostic criteria for EDS. She had been under the care of UCLH and was being treated for a diagnosis of Hypermobility Spectrum Disorder ("HSD").

13. The first appointment was mostly taken up with taking a history from Patient A and considering the treatment plan. There were some pelvic adjustments towards the end of the treatment. Patient A said she advised Miss Le Mare that she preferred Activator treatment as she had benefited from it previously and felt it was safe for her. Patient A said Miss Le

Mare told her that she used Diversified Technique, however Patient A said that she did not wish that treatment to be used on her neck, but she was content to consent to it being used on her lower back, if it would help her. In response to this Patient A said that Miss Le Mare told her she wanted to perform neck treatment and that she proposed using a technique called McTimoney Toggle Recoil, assuring her that it was safe and gentle. Patient A stated that on that basis she would consent to treatment of her neck using that technique. There was no neck treatment at the first appointment.

14. Diversified technique is a method of spinal manipulation used by chiropractors which uses levers to create tension in a joint and is commonly associated with joint cavitation (joint clicking or popping). It utilises high velocity, low amplitude thrusts to a joint with the intention of restoring normal joint mobility. This is to be distinguished from McTimoney Toggle Recoil technique, which, while also involving the application of a high velocity, low amplitude thrust, is generally considered a lighter, less forceful technique.

15. Patient A remembered signing a consent form that explained the risk of stroke, but she did not remember being advised of any other risks of care and was led to believe that there were no risks associated with McTimoney treatment.

16. At the second appointment, on 26 February 2018, time was spent completing the patient assessment before treatment was provided to both the pelvis/lower back and then the upper back and neck for the first time. Patient A described the technique used on her neck as being like a hammer hitting a nail, with Miss Le Mare placing one hand on the neck before striking the contact hand with the other hand.

17. At the third and final appointment, on 2 March 2018, further treatment was provided to the pelvis, lower back and then the upper back/neck again.

18. After the appointments Patient A was unhappy with the way that she had been treated by Miss Le Mare in a number of respects and made a relatively detailed statement of complaint to the GCC on 19 March 2018. She alleged that she suffered serious physical symptoms following her treatment, and believed that she should never have been adjusted in the way she was given her hypermobility.

19. This was investigated, evidence was gathered, and the expert opinion of Richard Brown, an experienced chiropractor, was sought. This led to charges being formulated, which essentially fit into the following categories.

20. First, it was alleged by the Council that in the course of one or more of the three consultations Miss Le Mare performed spinal manipulative therapy ("SMT") on Patient A, which was contraindicated because of Patient A's hypermobility. Mr Brown stated that, in his expert opinion, where hypermobility is present SMT is contraindicated and he cited World Health Organisation ("WHO") guidance to that effect.

21. Miss Le Mare's position was that whilst she did perform SMT on Patient A, in accordance with her understanding of the chiropractic definition of SMT, she did not take the joints beyond their physiological range of motion and therefore this did not come within the WHO definition of SMT. Furthermore, Miss Le Mare believed that McTimoney SMT was not a contra-indication, provided one proceeded with care. To this end she only carried out very gentle manipulations.

22. Secondly, it was alleged that by the time of the third appointment Patient A had told Miss Le Mare that she had troubling adverse symptoms following the first two appointments, including diarrhoea, and pain in the right side of her neck going up to her temple, but that this did not cause Miss Le Mare to stop and take stock. Instead, she continued with treatment without an adequate re-examination and without reviewing her plan of care.

23. Miss Le Mare denied this allegation and there was a factual dispute as to what she had been told by the third appointment, which impacted on the allegation about what she should have done at that stage.

24. Thirdly, it was alleged that after a telephone call Patient A made to the Clinic on 8 March 2018, where Patient A reported further, more serious adverse symptoms, including numbness, Miss Le Mare did not offer to re-assess Patient A, or to investigate Patient A's reported symptoms, and simply said that this was *"all McTimoney"* by way of an inadequate response to what she was being told.

25. Miss Le Mare denied this allegation and maintained that she did make an offer for Patient A to come back into the clinic to be seen by way of an appropriate follow up.

26. Finally, it was alleged that Miss Le Mare failed to obtain informed consent from Patient A because she commenced treatment without having adequately told her of the findings of her assessment, without adequately explaining the risks and benefits of the treatment, and in particular not adequately explaining the risks of SMT, including the McTimoney toggle technique, in view of Patient A suffering from hypermobility.

27. It was Miss Le Mare's position that she did obtain informed consent over the course of the first and second consultation.

Half-time submission of no case to answer on Particular 7(a)

28. At the conclusion of the case for the GCC, Mr Goldring made a submission that there was no case to answer in respect of Particular 7(a), namely that Miss Le Mare had failed to obtain informed consent for the treatment she provided to Patient A, in that she commenced treatment at the first consultation without having adequately informed Patient A of the findings of her assessment. Mr Goldring said that at the first consultation the treatment provided only related to Patient A's pelvis. He said he had asked Mr Brown, *"If the only treatment at the first consultation was an adjustment to the pelvis, would this be satisfied if she told her that her pelvis was misaligned?"* Mr Brown said that yes it would. Mr Goldring said that in her evidence Patient A had said that Miss Le Mare had told her that her *"hips were off"*. Mr Goldring asked Patient A if it was possible Miss Le Mare had told her that her hips were misaligned, but Patient A could not remember if that was what was said.

29. Mr Goldring submitted that, in light of the evidence of Mr Brown and Patient A, there was no evidence that at the time Miss Le Mare commenced treatment at the first consultation she had not adequately informed Patient A of the findings of her assessment.

30. In response, Mr Orpin-Massey submitted that there is evidence to support Particular 7(a). He said that the application made by Mr Goldring focussed too narrowly on the physical examination. However, an assessment must, he argued, include taking a case history as well, which is part of the process. Mr Orpin-Massey said that the Registrant commenced

treatment without adequately informing Patient A of the findings of her assessment, which must, at the first consultation, have included (even on the Registrant's case) the knowledge of hypermobility. He said that the Council observed that as an informed consent charge, it was necessary, before any treatment commenced at the first appointment with a patient with general hypermobility, for the Registrant to do a holistic assessment and inform the patient of her findings. Mr Orpin-Massey said that the adjustments to the pelvis carried some risk because the patient was hypermobile and those specific risks should have been set out in any findings discussion.

31. Mr Goldring said there was no allegation to suggest Miss Le Mare's history taking was inadequate and that Particular 7(a) was specific about what the Registrant had communicated to the patient and he invited the Committee to focus on that. He said the explanation of risks were covered in Particular 7(b).

32. The Committee considered the application with care and accepted the advice of the Legal Assessor. The Committee noted that the stem of this charge related to the provision of informed consent. There was undisputed evidence to support the fact that Patient A received treatment to her pelvis at the first appointment. With reference to what she was told, the evidence of Patient A was that she remembered being told something about the hips, although not whether they were misaligned. The Committee was satisfied that there was evidence to support the Council's case that the adjustment to the pelvis on the first appointment was, in accordance with WHO guidelines, a form of spinal manipulative therapy, whether it was using a diversified technique or a McTimoney adjustment. Mr Brown's evidence, based on the WHO guidelines, was that SMT is absolutely contra-indicted in a patient suffering with general hypermobility. It was known by the Registrant at that first appointment that Patient A was hypermobile as this is recorded in both the medical history and the examination completed on 16 February 2018. Furthermore, in the examination record Miss Le Mare has recorded a differential diagnosis of "Ehlers Danlos", which is a connective tissue disorder. On her own account (Defence bundle pages 44 and 45) these entries were made on the first appointment, so she was aware that Patient A was both hypermobile and possibly suffering from EDS.

33. In light of this evidence, the Committee considered that, if Mr Brown's analysis of the WHO guidance is right, then in order to give informed consent, Patient A would need to have been told that, in accordance with the WHO guidelines, the treatment she was about to give was absolutely contra-indicated. The evidence so far adduced suggests that the treatment

provided by Miss Le Mare to Patient A's pelvis did amount to SMT and that SMT is absolutely contra-indicated. There is no evidence at this stage that Miss Le Mare informed Patient A of this. Accordingly, there is, on one view, evidence to suggest that the information given to Patient A was inadequate and that therefore any consent she gave was not fully informed. On that basis it could be possible to find Particular 7(a) proved on the balance of probabilities and the Committee therefore rejects Mr Goldring's application to dismiss 7(a).

34. The Committee noted that whether or not SMT was absolutely contra-indicated is a live issue in this case and its ultimate findings would depend on its assessment of the whole of evidence, including any adduced on behalf of the Registrant, which it had yet to hear.

35. Following on from the half-time submission, Miss Le Mare gave evidence, as did the expert chiropractor, Kevin Grant, instructed on her behalf. The Defence also relied on the statement of Professor Cunliffe, Principal of the McTimoney College of Chiropractic.

36. Before the Defence formally closed their case, it was apparent that there was insufficient time to complete the case and accordingly it was adjourned, with a view to recommencing on 27 April 2020. Thereafter, all hearings were postponed due to the outbreak of COVID-19.

Resumed hearing 1 February 2021

37. The case resumed in February 2021. The same parties were present, with Mr Orpin-Massey appearing on behalf of the GCC and Mr Goldring on behalf of Miss Le Mare. The hearing was conducted remotely using the Microsoft Teams platform due to the ongoing restrictions on physical hearings due to the pandemic.

38. Mr Goldring made reference to a second statement from Professor Cunliffe and that her evidence was now agreed evidence, which Mr Orpin-Massey confirmed. Mr Goldring then formally closed the case on behalf of Miss Le Mare. Both parties had provided written closing submissions, which they did not feel the need to expand upon orally.

Decision on facts

39. The Committee considered with care all the evidence, both oral and written, together with the submissions made by the parties. The Committee accepted the advice of the Legal

Assessor and bore in mind that it was for the GCC to prove its case and to do so on the balance of probabilities.

40. The Committee first considered each witness's credibility and reliability.

41. The Committee considered Patient A to be a credible witness who provided an oral account largely consistent with her original email complaint to the GCC and her written statement. It was clear that she knew her condition well, and, in the Committee's view, made a complaint in good faith following what she felt was a negative care experience with the Registrant. There was no suggestion that she was being vexatious or malicious in her complaint. Overall, the Committee considered Patient A to be a credible and reliable witness, whilst recognising some limitations of her oral evidence due to the passage of time and her inability to remember a number of details.

42. The Committee noted that Mr Brown was a very experienced and knowledgeable chiropractor who had given evidence in many fitness to practise hearings. However, the Committee considered it noteworthy that he was not, as he acknowledged and made clear, a McTimoney practitioner and thus in some respects his assistance was constrained by his specific lack of knowledge about McTimoney techniques. He came under significant pressure during cross-examination, in particular in relation to correspondence disclosed between himself and the GCC. That correspondence indicated that he had taken it upon himself to carry out some limited investigation of the case by visiting the GCC and Miss Le Mare's clinic website. The document in question contained comment and some opinion on the facts, which were exclusively within the Committee's purview. However, the criticism that he also highlighted potential questions for cross-examination of both factual and expert witnesses was, in the Committee's view, somewhat unfair since experts are often relied on for precisely that purpose. The Committee also had in mind that the document in question was not, or ever intended to be, part of his report for these proceedings. It is fair to say Mr Brown was embarrassed by his correspondence with the GCC and expressly referred to his fuller and more balanced expert report in which he identified evidence favourable to Miss Le Mare and in which he was clear when expressing his expert opinion and clear when matters were for the Committee to decide. The Committee also considered Mr Brown to be somewhat dogmatic in his rigid adherence to the WHO guidelines and this did little to assist the Committee, which considered there to be some ambiguity within those guidelines.

43. The Committee considered Miss Le Mare, who whilst clearly nervous was generally open, honest, and consistent throughout much of her evidence, although her evidence was, on

occasion, confusing and, on one significant point (highlighted below), simply not credible. She did make some appropriate concessions when she accepted that she could have done better, but was firm and convincing on the points that she recalled clearly. The Committee noted her good character (and the reference from Mr Porter) and whilst, at the relevant time, she had only been a registered chiropractor for a short time, she did have the benefit of a successful 25 year career without complaint as a chartered surveyor, which is also a regulated profession. The Committee's over-riding impression was of a confident but inexperienced practitioner, who was very new to practice and who had been presented with a patient suffering from particularly challenging health issues.

44. Mr Grant gave evidence on behalf of Miss Le Mare. He is an experienced Chiropractor with the benefit, for the purposes of this case, of being a McTimoney practitioner. He was articulate and able to provide helpful layman's analogies. He was also helpful in his interpretation of McTimoney techniques. However, the Committee considered his forceful defence of McTimoney chiropractic cast some doubt on his impartiality. In particular, the Committee found somewhat implausible his refusal to accept there was any risk at all in McTimoney techniques being used on a patient with hypermobility.

45. Professor Cunliffe, Principal of the McTimoney College of Chiropractic, provided two written statements that were unchallenged by the parties and thus treated as agreed evidence by the Committee.

46. The Committee then considered each of the Particulars contained within the Allegation.

1. **At all material times you practised as a chiropractor at Sensus Health and Wellness, 60 Walham Grove, London SW6 1 QR ('the clinic').**

47. This was admitted and found proved.

2. **You had consultations with Patient A at the clinic on or around 16 February 2018 ('the first consultation'), 26 February 2018 ('the second consultation') and 2 March 2018 ('the third consultation').**

48. This was admitted and found proved.

3. **You performed spinal manipulative therapy on Patient A on the first, second and/or third consultations.**

49. This was admitted by Miss Le Mare, but only on the basis of SMT being in accordance with the chiropractic definition and not WHO guidelines. That is to say, Miss Le Mare admitted she had performed SMT on Patient A at all three appointments but not that she had at any time taken a joint beyond its physiological range of motion. As mentioned above, because the admission was qualified, the Committee considered the appropriate course was to treat it as not admitted and for it to reach its own conclusion based on the evidence.

50. Having heard all the evidence, the Committee was satisfied that Miss Le Mare had performed SMT at all three appointments and that it was not necessary at this stage to decide what that meant in terms of any guidelines, or indeed the precise nature of the SMT, since this would be dealt with in Particular 4.

4. At the first, second and/or third consultations you failed to provide an appropriate standard of care to Patient A in that you performed spinal manipulative therapy which was contraindicated due to her suffering a connective tissue disorder giving rise to general hypermobility.

51. Given its findings in relation to Particular 3 above, the question for the Committee with Particular 4 was whether or not any of the SMT provided by Miss Le Mare to Patient A was absolutely contra-indicated. If it was then she would have failed to provide an appropriate standard of care as alleged. It was common ground between the parties that Patient A suffered from hypermobility and that she had informed Miss Le Mare of that fact when first they met.

52. The GCC's case was essentially reliant on the WHO guidelines on safety and basic training in chiropractic, published in 2005. The guidance states:

In order to facilitate qualified and safe practice of chiropractic as well as to protect the public and patients, the objectives of these guidelines are:

• to provide minimum requirements for chiropractic education
• to serve as a reference for national authorities in establishing an examination and licensing system for the qualified practice of chiropractic
• to review contraindications in order to minimise the risk of accidents and to advise on the management of complications occurring during treatment and to

53. The guidance has a glossary which defines spinal manipulative therapy (SMT) as follows:

> *Includes all procedures where the hands or mechanical devices are used to mobilise, adjust, manipulate, apply traction, massage, stimulate or otherwise influence the spine and paraspinal tissues with the aim of influencing the patient s health.*

54. Under the heading, 'Part 2: Guidelines on safety of chiropractic', the guidance goes on to state:

> *When employed skilfully and appropriately, chiropractic care is safe and effective for the prevention and management of a number of health problems. There are, however, known risks and contraindications to manual and other treatment protocols used in chiropractic practice.*

55. Then, under the heading 'Contraindications to spinal manipulative therapy', the guidance states:

> *Spinal manipulative therapy is the primary therapeutic procedure used by chiropractors, and because spinal manipulation involves the forceful passive movement of the joint beyond its active limit of motion, chiropractors must identify the risk factors that contraindicate manipulation or mobilisation.*
>
> *Contraindications to spinal manipulative therapy range from a non-indication for such an intervention, where manipulation or mobilisation may do no good, but should cause no harm, to an absolute contraindication, where manipulation or mobilisation could be life-threatening.*

56. One of the conditions listed under the heading 'Absolute contraindications to spinal manipulative therapy' is 'congenital, generalised hypermobility.' As stated above, there was no dispute that this was the condition Patient A presented with and that Miss Le Mare was aware of this. Thus, relying on the WHO guidelines cited above, the GCC, via their expert Mr Brown, submitted that all SMT was absolutely contraindicated for Patient A. Mr Brown said that all types of SMT, to a greater or lesser extent involve the application of force and it is this application of force that makes SMT contraindicated in conditions where connective

tissues are compromised and individuals are more prone to dislocation and injury. He referred the Committee to the definition of SMT in the glossary.

57. Miss Le Mare said that in her view hypermobility was just a relative contraindication to McTimoney SMT, not an absolute and that she was able to adjust with care, as taught at the McTimoney College of Chiropractic. She therefore considered it was appropriate to use McTimoney SMT that did not take the joint beyond its active range of motion and that this amounted to adjustment with the extra care needed for a patient with hypermobility.

58. Mr Grant also said that hypermobility was a relative contraindication for McTimoney treatment, not an absolute. He emphasised that McTimoney was a safer option than other forms of SMT. With reference to the WHO guidelines, Mr Grant pointed out that they describe SMT as *"forceful passive movements of the joint beyond its active limit of motion."* This, he said, excluded McTimoney adjustments because they do not take a joint beyond its active limit of motion.

59. The Committee noted the ambiguity within the WHO guidelines and the conflict between the definition of SMT, as contained within the glossary, and that recorded under the specific heading 'Contraindications to spinal manipulative therapy'. The glossary is drafted in very broad terms and includes, for example, massage, and relates generally to the entire 49 page document. Section 2 of the WHO Guidelines, headed 'Contraindication to Spinal Manipulative Therapy' includes the two paragraphs recited above, which provide a narrower description of SMT. These two paragraphs are the opening paragraphs of that section and can be read as specific to, and setting the context for, what then follows in this section. The Committee, therefore, on a common sense approach, concluded that it was this narrow description of SMT that was relevant when considering contraindications to SMT and not the wider definition in the glossary.

60. There is a clear distinction to be drawn between McTimoney adjustments - which, the Committee was informed by Miss Le Mare and Mr Grant, do not take a joint beyond its active limit of motion - and diversified adjustments (of which 'Carver' adjustments are one type) - and which do take a joint past its active limit of motion. In light of its approach to the WHO guidelines, referred to above, the Committee was not satisfied, on the balance of probabilities, that McTimoney SMT is absolutely contraindicated for patients with hypermobility.

61. Professor Cunliffe's evidence was that hypermobility falls under the section entitled 'Extra Care' within the Care Guidelines for students at the McTimoney College, which states:

> *Some conditions call for extra-gentle management as the body may be very fragile. It is very important for these people to rest as soon as possible after care. For example:*
>
> *HYPERMOBILITY: Adjust with care – joints may be lax due to hypermobility. Be conservative with mobilisations and recommend a suitable strengthening programme where appropriate.*

62. In other words, treating patients with hypermobility using McTimoney adjustments is not absolutely contraindicated, but that extra care has to be taken when carrying out such adjustments. The Committee thus proceeded on the basis that if Miss Le Mare had performed McTimoney adjustments to Patient A, then those adjustments did not come within the WHO guidelines and were not, therefore, absolutely contraindicated. If, on the other hand, the Committee concluded that Miss Le Mare performed any diversified adjustments on Patient A, then these would be absolutely contraindicated.

63. Patient A said she told Miss Le Mare that she suffered from a connective tissue disorder and hypermobility. She added that she said she had been diagnosed with EDS. She accepted that at the time she saw Miss Le Mare she had been advised that she did not meet the diagnostic criteria for EDS, but maintained this was because the criteria had changed, rather than her condition. This was supported by a letter dated 25 April 2017 from a Consultant Clinical Geneticist at Imperial College London who, on writing to Patient A, stated, *"You do not fulfil the **new** diagnostic criteria for hypermobility Ehlers Danlos Syndrome."*

64. The Patient Medical History taken from Patient A when she attended the clinic, recorded that *"Pt is Hypermobile"*, with a differential diagnosis recorded as *"Ehlers Danlos"*. In the Report of findings, Miss Le Mare recorded, *"Pt is Hypermobile, although restricted in lumbar region. Diagnosed previously with Ehlers Danlos."*

65. The Committee was thus satisfied that at the time of seeing Patient A and of carrying out treatment, Miss Le Mare was aware that she was hypermobile and, by the second appointment had, according to Patient A, previously been diagnosed with EDS. Her medical records support the assertion that she has 'generalised' rather than 'localised' hypermobility. It was not disputed that hypermobility is a connective tissue disorder.

66. The Committee next considered the three appointments attended by Patient A, namely 16 February 2018, 26 February 2018 and 2 March 2018. In her statement when dealing with the first appointment, Patient A recalled Miss Le Mare doing a *"very small adjustment to my pelvic/hip area"*. She described it cracking something. In her second statement, Patient A elaborated on this adjustment describing her position, namely on her back, which accorded with the word *"sup"* (supine) recorded in Miss Le Mare's notes. Patient A described this procedure as being a *"mini small adjustment"* and *"insignificant"*. From this description, and that given by Miss Le Mare, the Committee concluded it more likely than not to have been a McTimoney style technique that was carried out rather than a diversified type technique. This was further supported by the evidence of Mr Brown, who said that a diversified adjustment of the pelvis would not normally be performed with the patient in the supine position. The Committee also noted Miss Le Mare's response to the 'cracking' where she said, *"It is not often but it does happen that a small audible cavitation is experienced when carrying out the McTimoney pelvic rotation adjustment which I administered together with the torsion adjustment as per my adjusting notes."*

67. At the second appointment, however, Miss Le Mare's adjustment would appear to have been different. Patient A recalled Miss Le Mare telling her she would be *"continuing"* the pelvic adjustments from appointment one, but described a different position, putting one leg over the other to do what the patient described as the *"diversified technique".* She also recalled an adjustment to the pubic bone and hip but was unable to recall how this was done. Miss Le Mare denied that the patient was ever put in this position as a precursor to a diversified treatment. She believed that the patient may have been confusing the adjustment with a test for range of motion. In her statement she also said, *"I recall I did a very much modified carver on her upper thoracics. I put this as Upper Carver – nar (No audible release), which technically was incorrect. To me that meant that I put no thrust behind the adjustment as otherwise it would have been a diversified HVLA adjustment, which was contraindicated. In this instance the carver was more akin to a gentle tissue pull to try and release some of*

the upper back musculature, which was my intention in doing this. With hindsight it would have been more technically correct to record this as tissue pull with my hands in the Carver position, instead of my shorthand note."

68. The Council's case was that, in accordance with the Registrant's own records from that appointment, it was clear that on that occasion Miss Le Mare performed a 'Carver' adjustment on Patient A's thoracic spine. If that was right then even Miss Le Mare would accept that such an adjustment was absolutely contraindicated. However, notwithstanding what was recorded in the notes, Miss Le Mare said she did not carry out a 'Carver' adjustment and that this was mis-recorded. In her statement she said, *"The only time I used an adapted diversified adjustment was for her upper thoracics during the 2nd appointment. This was a very gentle Carver, because I did not put any thrust behind it. … I was mindful in choosing this modified technique to help with spinal misalignment as she was hypermobile and that any diversified adjustment was absolutely contraindicated."*

69. The chiropractic note included the detail *"Upper Carver - nar"* (no audible release) which, the Committee considered, was entirely consistent with a 'Carver' having been applied. As referred to above, a 'Carver' adjustment is one that would take the joint beyond its active limit of motion and would, therefore, be covered by the WHO guidelines as an absolute contraindication. Miss Le Mare said she had carried out a *"modified Carver"* or *"pseudo Carver"*, akin to a gentle *"tissue pull"* to try and release some of the upper back musculature. The Committee noted that not only was 'tissue pull' not recorded but also that a 'tissue pull' would not be expected to produce any sort of audible release and therefore to record 'nar' would be entirely otiose. The Committee did not find the suggestion plausible that one might record 'nar' to serve as a reminder that a Carver technique was not performed.

70. The Committee noted that at the second appointment Miss Le Mare treated three different areas, namely the neck, pelvis and thoracic spine. From the description provided by Patient A, together with the chiropractic notes and Miss Le Mare's evidence, the Committee was satisfied that, apart from the 'Carver' adjustment referred to above, the other adjustments were provided using McTimoney techniques and were not, for the reasons already given, absolutely contraindicated. That said, the Committee was cognisant of the need to take extra care when manipulating the upper neck, which is particularly vulnerable. The Committee also noted from Mr Grant that the 'TTR' [Toggle Torque Recoil] at 'C1' was an adjustment associated with more force, with Patient A describing Miss Le Mare performing a toggle recoil on her neck which felt like a *"mini karate chop"*. However, in accordance with

the evidence given by Mr Grant, the Committee accepted that this adjustment would not have taken the joint beyond its active limit of motion.

71. Accordingly, the Committee was persuaded, on the balance of probabilities, that at the second appointment, on 26 February 2018, Miss Le Mare performed a diversified adjustment to Patient A and that this was absolutely contraindicated. In reaching this decision the Committee also noted from Professor Cunliffe's evidence that a 'Carver arch' is taught at the McTimoney College, but that it should be carried out between T9 and T12, or in other words, the lower thoracic spine. However, Miss Le Mare performed it, according to her notes, in the upper thoracic, which would be T1 to T6. Thus, not only did she perform an adjustment that was contraindicated, she also performed it in the wrong area, according to the teaching at the McTimoney College.

72. At the third and last appointment, on 2 March 2018, Patient A recalled the treatment being the *"same as last time"* with increased amounts of toggle recoils to the neck but a lighter adjustment to the pelvis. She did not, however, describe anything that sounded like a 'Carver' adjustment on this occasion and there was nothing in the notes to suggest otherwise. The Committee was not, therefore, persuaded that any adjustments carried out on the last appointment were anything other than McTimoney adjustments and that accordingly they were not absolutely contraindicated.

73. In conclusion, the Committee found Particular 4 proved, but on the limited basis that Miss Le Mare performed a single diversified adjustment at the second appointment, which was absolutely contraindicated, as alleged. All other adjustments at the second appointment and at the first and third appointments the Committee was satisfied were McTimoney adjustments and not, for the reasons given above, absolutely contraindicated.

5. At the third consultation you failed to provide an appropriate standard of care to Patient A after she had informed you of adverse symptoms following her previous treatment in that:

a) You treated her without adequate re-examination;
b) You treated her without adequately reviewing her plan of care.

74. The Committee had first to decide what Patient A had passed on to Miss Le Mare about any adverse symptoms she had suffered following the second appointment. In her first statement Patient A described her reaction after the second appointment. She said her

symptoms included diarrhoea, poor sleep, pain in her hips and pelvis for a week and pain in the right side of her neck going up to her temple. Patient A said that at the appointment on 2 March 2018 she told the Registrant about these symptoms and that the pain was progressively easing. In her oral evidence Patient A was asked about these symptoms and in particular the diarrhoea. Her evidence is chief was that she thought *"it was definitely the treatment"* that caused her diarrhoea as she had not eaten anything that would cause that.

75. Patient A was cross-examined in light of an entry in a letter dated 2 March 2017 from a Consultant Clinical Geneticist at Imperial College Hospital, which stated, *"Her irritable bowel syndrome was worse in childhood and this has improved with age but she still gets diarrhoea about twice a week."* In response to that she said, *"Yes. You know what, I must have just really not recalled it, because I don't even recall this now, or, like I said, I don't know how those were read to me. I don't recall any of that portion and filling it out, and it is not my handwriting, so I don't know. I wouldn't purposely say no I don't have something if I have it. That doesn't make any sense."* The Committee noted Patient A had not mentioned diarrhoea in her first complaint to the GCC and the expert evidence that diarrhoea would be an unlikely side-effect from chiropractic treatment.

76. Miss Le Mare accepted that Patient A reported pelvic pain and poor sleep as a result, but not that she had mentioned diarrhoea, or pain radiating up in her neck to her temple. Her notes record, *"Pelvic Pain and right shoulder tenderness".* No other symptoms were recorded.

77. Both Mr Brown and Mr Grant agreed that if the Committee accepted the evidence of Miss Le Mare then there would be no need to re-examine and review the plan of care and Particular 5 would fail. If, however, the Committee accepted the account given by Patient A, then Mr Brown was of the opinion that there would have been a need to re-examine and to review the plan of care.

78. Mr Grant's expert opinion was that no additional chiropractic reassessment was necessary after only two appointments, with potentially no new symptoms being reported.

79. The Committee could see no reason or rational explanation for why Miss Le Mare would record some reported symptoms and not others. By contrast, the Committee noted, when following the subsequent phone call with Patient A (see Particular 6 below), Miss Le Mare made a detailed list of the matters passed on to her. Given its reservations about Patient

A's ability to always recall detail the Committee could not be satisfied, on the balance of probabilities, that Patient A reported more symptoms than those recorded by Miss Le Mare.

80. In light of that conclusion, and given the agreed position of the experts, the Committee found Particular 5, in its entirety, not proved.

6. Following a telephone call on 8 March 2018 when Patient A reported further adverse symptoms you failed to provide an adequate standard of care in that:

a) You did not offer to re-assess and/or refer Patient A;
b) You did not offer to investigate Patient A's reported symptoms;
c) You offered reassurance to the effect that this was "all McTimoney" without having further assessed Patient A.

81. Allegation 6 related to a telephone call that took place on 8 March 2018, in which the Council say that Patient A reported further adverse and serious symptoms, which, for similar reasons to allegation 5, should have caused Miss Le Mare to take stock, offer to re-assess or refer Patient A, and offer to investigate her symptoms. Instead, it is said, she appeared to take an attitude that *"this was all McTimoney"* by way of reassurance.

82. In her notes Miss Le Mare recorded the various symptoms reported to her by Patient A and then said the appointment booked for the following day would be cancelled to *"let* [Patient A's] *system settle down."* Later Miss Le Mare called Patient A again and offered to see her at the practice, but Patient A said in her view this was only for reassurance, rather than re-examination or investigation.

83. Mr Brown said in light of the symptoms passed on by Patient A, Miss Le Mare should have offered to re-assess or refer Patient A and should also have offered to investigate her reported symptoms.

84. Mr Grant consider Miss Le Mare's responses to the call from Patient A to be reasonable in all the circumstances.

85. Miss Le Mare's evidence on this encounter was consistent with her notes, as well as her written statement and during cross-examination. She said that she called Patient A on 8 March 2018 when she returned from holiday at 9:05am and that it was agreed between

them that the appointment for the following day would be cancelled partly because the patient didn't want to come in and also because the Registrant advised to see if things settled down. This was consistent with the patient's account that she wanted to see what happened and was not comfortable at that stage to continue treatment. Miss Le Mare denied the patient reporting any blurriness in her eyes.

86. It was put to Patient A that it was agreed during that call on 8 March, that the Registrant said she would call back to check up on the patient the following day. Patient A initially said *"possibly, yes"* followed by *"I do not recall it"* followed by *"I do not know I am trying to remember now".* In the interim Miss Le Mare spoke to her manager and it was decided that they should ask Patient A to come in anyway. Rather than waiting until the following day, as originally planned, Miss Le Mare called Patient A back on the same day (8 March) and left a message. This was also confirmed as *"likely"* by Patient A in her evidence. The following day, Miss Le Mare called Patient A again to see if she had received her message from the previous day, which the patient denied she had. Miss Le Mare was clear that during this call she had suggested to Patient A that she come back in to see her colleague. Patient A recalled this discussion, but her account was that she was being asked to come back in and *"keep things going and moving"*.

87. The suggestion she come back in to the clinic was supported by the fact that Patient A agreed that she rang the clinic back in the afternoon of the 9 March to try and arrange the appointment she had been offered. It would appear however that the appointment time of 2pm, which Patient A described as *"odd"* was not suitable and that was the end of the matter. Thereafter, Patient A did not return to the clinic. Patient A maintained that her understanding was that any further appointment was simply to reassure her and that it would not involve any kind of assessment. The Committee noted that this assumption may well have arisen as a result of a conversation Patient A had with the receptionist rather than with Miss Le Mare. Patient A said, *"I was talking to the receptionist at this point, I could hear the head chiropractor in the background but he wouldn't speak to me. I told them that I had ringing in my ears and a neck spasm and eye blurriness and the receptionist said I could come in for reassurance. I asked if someone wanted to re-examine me. The receptionist just repeated I could go in for reassurance. I tried to book a slot but it was impossible as the slots were at very odd times."*

88. The Committee was satisfied from the sequence of events on 8 and 9 March that Miss Le Mare was encouraging Patient A to come back into the clinic to be seen and called her three

times in 24 hours to try to arrange this. The appointment that was finally offered was not convenient to Patient A, so she decided not to return.

89. The Committee noted that this Particular alleged a failure to offer and yet Miss Le Mare did offer to see Patient A at the practice, an offer which Patient A did not ultimately take up. On the evidence the Committee could not be satisfied, on the balance of probabilities, that this offer was just for reassurance and would not have involved more, had Patient A followed it through. The Committee noted that on this basis the experts agreed that Miss Le Mare's actions were appropriate.

90. In such circumstances the Committee was not persuaded that there had been a failure to provide adequate care and found this Particular, in its entirety, not proved.

7. You failed to obtain informed consent for the treatment provided to Patient A in that:

a) You commenced treatment at the first consultation without having adequately informed Patient A of the findings of your assessment;

b) You commenced treatment without adequately explaining the risks and benefits of treatment;

c) You did not adequately explain the risks of spinal manipulative therapy, including the use of the McTimoney Toggle Technique, in view of her suffering from a connective tissue disorder giving rise to general hypermobility.

91. It was the Council's case that Miss Le Mare could not seek consent for treatment that was contraindicated and that, accordingly, when she heard what Patient A had to say about hypermobility that should have put a stop to her trying to treat the patient with SMT.

92. Mr Orpin-Massey said that because of Patient A's generalised hypermobility the Council say there should have been a proper assessment completed at the first appointment, and the finding relayed to the patient. He said Miss Le Mare undertook SMT to the pelvis at the first appointment with two adjustments at a time that both her report of finding document and her physical assessments were incomplete. He submitted she completed these over two appointments, possibly due to pressure of time, and possibly due to pressure to adjust in the first appointment.

93. Although the Committee found Particular 4 proved, it was only in relation to the treatment at the second appointment. The allegation of a lack of consent in Particular 7(a) related to the first treatment only. In light of its decision that Miss Le Mare's SMT treatment on the first appointment was not absolutely contraindicated, it followed that there was not an obligation on Miss Le Mare to have informed Patient A that the treatment was absolutely contraindicated. In her statement, Patient A agreed that at the first appointment, Miss Le Mare told her that her hips were "off". Patient A also accepted in cross-examination that she was shown a spinal model before treatment and that Miss Le Mare may have described it as a *"pelvic misalignment"*.

94. Mr Brown, in his evidence, confirmed that if Patient A was provided with the information above, that would satisfy him for the purposes of consent in Particular 7(a), subject of course to the caveat that the Committee did not find the treatment an absolute contraindication.

95. In her statement Patient A said *"I have been asked if Dr Le Mare discussed the risks and benefits of treatment with me. Before treatment, I was asked to sign a form in the waiting room by reception which I recall said there was a small chance of a stroke. Other than this she did not explain risks, only benefits and I was led to believe that there were no risks from her McTimoney technique. She told me that McTimoney was gentle and that there was no risk to my neck as that was my main concern due to my connective tissue disorder and also because I wouldn't like to risk a stroke by having something done to my neck that could cause it, which is also why I do not like anyone doing a diversify neck adjustment to me. Dr Le Mare did a demonstration of the toggle recoil technique on my shoulder before she commenced treatment. It felt like a little tap on my shoulder. It did not feel like this subsequently on my neck (she did not do a neck adjustment on the first treatment though, I am referring to the future ones)."*

96. At the first appointment on 16 February 2018, Patient A signed a consent to treatment form. However, it was recognised by all parties that consent is very much an ongoing process and no one suggested that by signing that form Patient A was giving consent to all treatment, whatever the treatment might be. For consent to be informed a Patient has to be advised of the risks and benefits of any particular course of proposed treatment and to provide their consent accordingly. Such consent can be written, oral or, in some instances, inferred.

97. In Particular 7(a) the alleged failure to obtain informed consent was based on Miss Le Mare commencing treatment at the first appointment without having adequately informed Patient A of the findings of her assessment. Miss Le Mare said:

> *"Following the examination/testing to Patient A s pelvis, I considered what we had discussed together with my findings and told to her that my opinion was that she had pelvic misalignment. As we had agreed to use McTimoney adjustments on her pelvis, I proceeded to inform her of some of the risks of Chiropractic including the (rare) chance of stroke (in the case of neck adjustments), feeling achy or even worse, stiffness and tiredness. I also mentioned that sometimes pelvic adjustments may have an effect on a woman s menstruation, but this is likely with regular care than irregular treatment. Having already palpated her hips I asked if she were happy for me to proceed with adjusting to which she confirmed she was. I noted this as VCO (Verbal Consent Obtained) in my Adjustment notes and carried out two McTimoney adjustments (as per my adjustment notes) being for Left Posterior Rotation and Left Superior Torsion."*

98. The Committee noted that there was no evidence to contradict Miss Le Mare's account. It also noted that at the first appointment time was pressing and that the first 40 minutes of the hour long appointment had been taken up with history taking. Miss Le Mare then proceeded to do some very gentle adjustments to Patient A's pelvis, which was Patient A's main concern. In such circumstances the Committee did not consider Miss Le Mare's actions to be unreasonable and that it was harsh to criticise her for not finishing her assessment and report of findings. The Committee noted that Mr Goldring's half-time submission on Particular 7(a) was unsuccessful on the basis that at that stage the Committee had not heard sufficient evidence to be able to form a view about whether the SMT provided at the first appointment was absolutely contraindicated. The Committee has now made that decision and found that it was not. The Committee was satisfied that Miss Le Mare had provided sufficient information to Patient A in order for Patient A to be able to provide informed consent to the treatment she received on that day, notwithstanding the fact that she had not completed her assessment and report of findings. Accordingly, the Committee found Particular 7(a) not proved.

99. It was also the Council's case that treatment was commenced at both the first appointment (pelvic adjustments) and second appointment (upper back and neck adjustments) without an adequate conversation having been had about risks and benefits of the treatment.

100. The Committee was of the view that Particulars 7(b) and 7(c) very much overlapped and accordingly considered them together. The questions for the Committee were whether the risks and benefits were adequately explained in order for Patient A to be able to give informed consent; and whether the risks of SMT were adequately explained in view of Patient A's hypermobility.

101. Particular 7(b) was not limited to the first appointment and given the Committee's finding that at the second appointment Miss Le Mare did carry out a diversified technique that was absolutely contraindicated, then it had been incumbent one her to explain the risks of that treatment before carrying it out. Furthermore, at the second and third appointments Miss Le Mare carried out a 'TTR' at 'C1' which, as noted above, is a particularly vulnerable area and thus the importance of explaining the risks was increased.

102. As a starting point, the Committee considered the GCC's own guidance on consent, which states:

> *When explaining risks, you must provide the patient with clear, accurate and up-to-date information about the risks of the proposed treatment and the risks of any reasonable alternative options, in a way that the patient can understand. You must discuss risks that occur often, those that are serious even if very unlikely and those that a patient is likely to think are important. You must encourage patients to ask questions, so that you can understand whether they have particular concerns that may influence their decision and you must answer honestly.*

103. Both experts agreed that the upper cervical spine is most vulnerable and that Miss Le Mare could have used other, more gentle, techniques. TTR uses a downward force so the risks of harm are increased. Although Mr Grant maintained little force was used when carrying out TTR, the Committee noted from a research paper referred to by both experts (Colloca *et a*l, 2009) that the forces involved were not insignificant. Mr Grant also recognised that there was bound to be some variability in the amount of force used from practitioner to practitioner, but he added there was no way to measure this.

104. From Patient A's evidence, and the records, there appears to have been little explanation of risk in terms of providing McTimoney treatment to a patient with Hypermobility. If anything,

there was a suggestion that this technique was being used because it was without risk. Given that the McTimoney Guidelines state that Hypermobility is a relative contraindication, there is an assumption that there are at least some risks associated with treatment, and that there would be an expectation to discuss this with the patient. This is most relevant to the upper cervical spine where the McTimoney TTR technique was used, which, as stated above, is acknowledged by the experts as being the most vulnerable area, and mentioned in the McTimoney Guidelines with reference to *"not adjusting atlas or axis in circumstances with ligament laxity"*. According to Mr Grant, the forces used in the TTR technique are greater than other techniques (for example the 'strike' technique). Given this choice of technique, there was an obligation on Miss Le Mare to discuss the risks and alternative approaches with Patient A.

105. With reference to the 'Carver' diversified adjustment carried out on the second occasion, as stated above this was absolutely contraindicated and so should not have been performed. That said, the same applies as mentioned above, and Miss Le Mare should have discussed the risks of such treatment for a patient with hypermobility and the alternatives to such treatment. There was no evidence that she had done so.

106. Accordingly, the Committee found Particulars 7(b) and 7(c) proved in relation to the 'TTR' to 'C1' carried out on the second and third appointments and the 'Carver' adjustment performed on the second appointment only.

UNACCEPTABLE PROFESSIONAL CONDUCT

107. Having found a number of the facts proved, the Committee next considered whether Miss Le Mare was guilty of Unacceptable Professional Conduct ("UPC"), which is conduct falling short of the standard required of a registered Chiropractor. The Committee took into account the submissions made by both parties, together with all the evidence and accepted the advice of the Legal Assessor.

108. For the purposes of UPC, the pertinent facts found proved were the provision of a diversified adjustment at the second appointment that was absolutely contraindicated (Particular 4) and the failure to obtain informed consent for that adjustment and the TTR adjustments at C1 performed at the second and third appointments (Particulars 7(b) and 7(c)).

109. The Committee found there to be breaches of the following parts of The Code, Standards of conduct, performance and ethics for chiropractors ("The Code"), effective from 30 June 2016:

C You must uphold the high standards of the chiropractic profession by delivering safe and competent care to each patient.

C5 You must select and apply appropriate evidence-based care which meets the preferences of the patient at that time.

E Patient consent must be voluntary and informed. It is your duty to ensure the patient has all the necessary information and support they need in order to give it.

E1 You must share with the patient accurate, relevant and clear information to enable the patient to make informed decisions about their health needs and relevant care options.

E2 You must obtain and record consent from a patient prior to starting their care and for the plan of care.

F1 You must explore care options, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge.

110. The Committee also had in mind the GCC's own guidance on consent, which states:

When explaining risks, you must provide the patient with clear, accurate and up-to-date information about the risks of the proposed treatment and the risks of any reasonable alternative options, in a way that the patient can understand. You must discuss risks that occur often, those that are serious even if very unlikely and those that a patient is likely to think are important. You must encourage patients to ask questions, so that you

can understand whether they have particular concerns that may influence their decision and you must answer honestly.

111. In its findings on the facts, the Committee referred to Miss Le Mare's inexperience at the relevant time, having only recently qualified as a chiropractor, and the fact that she was faced, so early on in her career, with a patient with particularly challenging health issues. However, she was familiar with the WHO guidelines and, in the knowledge that Patient A suffered from hypermobility, Miss Le Mare should have taken particular care to avoid using a technique that was absolutely contraindicated. Her use of the diversified 'Carver' technique presented a risk of harm to Patient A. If Miss Le Mare was in any doubt about what techniques she could and could not use or had any concerns about the implications of a patient suffering from hypermobility, then she should have sought advice.

112. Mr Goldring, in his submissions, posited two possible different scenarios. He said that either Miss Le Mare deliberately carried out a technique she knew to be absolutely contraindicated or that, notwithstanding her clear note, written in red ink at the top of Patient A's records "No Diversified neck/Back adjustments, hypermobile" she forgot and did such an adjustment anyway. Mr Goldring said that Miss Le Mare maintained she had not done a diversified adjustment, so he could not say which approach the Committee should take, but he urged them to take the more favourable to Miss Le Mare.

113. The Committee, however, considered there to be a third explanation. The Committee accepted Miss Le Mare's evidence that she would never have wanted to hurt Patient A. It did not believe she acted in a malicious, or cavalier way or that she exhibited any attitudinal problems. Rather, the Committee considered that at the time of the 'Carver' adjustment, Miss Le Mare was not paying sufficient attention to what she was doing. She overlooked her own instruction, to the extent of even recording it in her notes, and went ahead and provided a diversified adjustment. The Committee was in no doubt that she was trying to do her best in difficult circumstances, but she went further than she should have done, without realising it at the time. It was fortunate that no actual harm was caused as a result, but there was certainly the potential for harm, hence the WHO guidance which states such adjustments are absolutely contraindicated.

114. With reference to the 'Carver' adjustment the Committee accepts that this was one adjustment to one patient on one occasion, with no actual harm caused. However, Miss Le Mare was aware of the WHO guidelines and the McTimoney guidance about the extra care

needed with patients who were hypermobile. To act contrary to those guidelines was, in the Committee's view, serious. That action was aggravated by Miss Le Mare's failure to obtain informed consent. The process of seeking informed consent is fundamental to respecting patients' rights to be involved in decisions about their treatment and therefore fundamental to everything a chiropractor does. Acting without informed consent is likely to always be considered serious. In this case the lack of informed consent was not restricted to the 'Carver' adjustment, but went further because of Miss Le Mare's failure to fully explain the risks and benefits of her treatment to Patient A's neck.

115. Miss Le Mare was aware that Patient A was particularly concerned about her neck and any treatment given to it. She would have been aware that the neck is particularly vulnerable, due to the close proximity to important arteries and the spinal cord. That vulnerability is exacerbated in a patient suffering from hypermobility. Thus, whilst the McTimoney SMT she performed to the neck was not absolutely contraindicated it was nonetheless, in accordance with McTimoney teaching, relatively contraindicated and it was incumbent on Miss Le Mare in such circumstances to ensure that she fully informed Patient A of the risks involved with her proposed treatment and also to explain about any possible alternatives. This duty should have been recognised as being all the more important, given the knowledge of the concerns that Patient A had about any treatment to her neck.

116. Taking Miss Le Mare's conduct as a whole, as found proved, the Committee considered her conduct to have fallen far short of that which is expected of a registered chiropractor and that it crossed the threshold of unacceptable professional conduct.

SANCTION

117. On deciding the appropriate and proportionate sanction, the Committee took into account all the evidence and material provided, together with the submissions made by Mr Goldring and those made by Mr Orpin-Massey.

118. In determining the appropriate sanction the Committee accepted the advice of the Legal Assessor and considered the Guidance on Sanctions issued by the Council. The Committee was cognisant of the fact that the purpose of sanctions is not to punish but to protect the public, maintain public confidence in the profession and maintain proper standards of

conduct. The Committee considered the sanctions in ascending order starting with the least restrictive and concluding with the minimum sanction that it considered necessary for the protection of members of the public. Protection of the public includes the need to uphold proper standards of conduct and performance within the chiropractic profession and also maintaining public confidence in the profession of chiropractic and the GCC as its regulator.

119. Mr Orpin-Massy said to the Committee that it was not the GCC's practice to make a bid for any particular sanction, but nevertheless it was thought an admonishment or conditions of practice would be the appropriate sanction in this case and it was clear much would depend on the view the Committee took of Miss Le Mare's insight.

120. In his submissions to the Committee on the question of sanction, Mr Goldring said that Miss Le Mare was in a difficult position because of her denial of the matters now found proved. However, he said this did not mean she lacked insight. He said that Miss Le Mare respected and accepted the decision of the Committee, but was upset by it. Mr Goldring referred the Committee to the case of GMC v Awan [2020] EWHC 1553 (Admin), in which the Judge said:

> *"I think that it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding, and add very little, if anything, to the principal allegations of culpability to be determined."*

121. Mr Goldring said that Miss Le Mare was very sorry that Patient A had been through this ordeal, but reminded the Committee of its findings at UPC, namely that her actions were well intentioned, she had not acted in a cavalier way and had been trying to do her best in very difficult circumstances. He reminded the Committee of some of what Miss Le Mare had said in her Personal Statement for these proceedings, namely:

> *"The allegations made against me have upset me deeply. I am truly sorry that Patient A suffered any pain to Patient A as she describes. I take it very personally that to her I have come across as 'a danger' to people. I do not believe that her view about this is correct."*

"Since the day of the phone conversation that I should be reported to the GCC, I changed the way I practiced by ensuring all my adjustments were noted explicitly in the listing sheet and over expanded upon any written discussion on a patient's symptoms especially following treatment."

"I have ensured that I am more explicit in the way I state the Report of Findings and phase certain things in order to eliminate any potential ambiguity during an appointment and am asking more if the patient understands what I am saying and doing before and after obtaining consents." [sic]

122. Mr Goldring submitted that this did show evidence of insight and also that Miss Le Mare had shown insight during the hearing by making concessions where appropriate and acknowledging the things she could have done better.

123. With reference to what Miss Le Mare had been doing since these matters arose, Mr Goldring said that she had worked for another six months at the Clinic, but was unhappy with some of the practices pursued and, after unsuccessfully attempting to negotiate some changes in procedures (such as implementing a complaints procedure), therefore had decided to leave. In 2019 she was unable to work as a chiropractor for personal reasons and in 2020 the COVID-19 pandemic meant that finding work was difficult. Accordingly she had returned to working as a Chartered Surveyor. However she was keen to return to practising as a Chiropractor.

124. Mr Goldring then provided a quote from Miss Le Mare, including:

I am very aware due to the time lapse since last being in clinic (Oct 18) I have to regain my confidence and skill sets. To do this, I will be undertaking private revision and when possible asking to observe in clinics and also seeking to have private tuition for technique building again. I have decided to stick with McTimoney certainly in the meantime. The private tuition and revision will of course be supplemented with CPD and other online learning to ensure that I am ready to enter the clinic environment."

"I went into Chiropractic to help people. I am very saddened to hear the panel s decision. I feel very saddened to think that the patient felt unduly treated by me in

this way and am sincerely sorry to think that I could have been the cause of some of her issues. It certainly was not my intention. Since the commencement of the claim it has been 2.5 years, a lengthy term for anyone s name to be seen by all on the GCC website. I have had to live with this, it has been a sentence in itself and it hasn't sat lightly. Indeed the fear of having any sanctions etc on record for the rest of my working life is something that I will never come to terms with. I consider myself to be a conscientious person but feel that my world has fallen apart.

Going forward I will be choosing very carefully which clinic I apply to. I will ensure that I myself am clearer in my verbal communication with clients and ensure that the process of History taking, examination/Assessment, Risks/benefits, diagnosis, Report of Findings and plan of care is strictly adhered to in both verbal and written context. I will be obtaining initialled consent to any treatment given to ensure that the patient has understood the risks and benefits of treatment for their particular symptoms/diagnosis. I will broaden my approach even further in respect of providing exercises, referral etc."

125. Mr Goldring concluded by saying that the chances of this behaviour being repeated were so remote as to be non-existent. He said that there was no current risk of harm, that Miss Le Mare had learned lessons from this whole process that would resonate with her for the rest of her career and he submitted that an admonishment would be the appropriate and proportionate sanction in this case.

126. In reaching its decision on sanction the Committee paid due regard to the aggravating and mitigating factors present in this case, however the Committee found there to be no aggravating factors.

127. The Committee found the following mitigating factors: a previously long and unblemished professional career, albeit most of it in a different, regulated profession; at the time in question Miss Le Mare had been an inexperienced, newly qualified Chiropractor and had only been practising for a few months before being faced by a patient with particularly challenging health issues (Mr Brown, in his very long career as a Chiropractor, said he had only encountered such a patient twice, suggesting this was fairly unique and that Miss Le Mare had been most unfortunate to have been presented with such a case so early on in her career); most of the treatment she provided was not absolutely contra-indicated; her failure to obtain consent was on a narrow basis and not a complete failure; she took steps

to learn more about the condition between the first and second appointments; she was proactive in encouraging Patient A to return to the practice after she highlighted issues following the third appointment, including taking advice from a senior colleague; a positive reference from her previous career as a chartered surveyor, attesting to her high level of professionalism; genuine expressions of remorse and regret.

128. Due to factors beyond anyone's control, this case took a very long time to conclude and the Committee recognised the strain that this has inevitably placed upon Miss Le Mare, who had fully engaged with the process. As stated when reaching its decision on UPC, the Committee accepted Miss Le Mare's assertion that she would never have wanted to harm Patient A. The Committee was also satisfied that this was not a case of a chiropractor showing a reckless disregard for patient safety by acting in a malicious or cavalier way and that Miss Le Mare had not exhibited any attitudinal problems.

129. The Committee noted that Miss Le Mare accepted the findings of the Committee, in the sense that she did not seek to go behind them, whilst still maintaining a denial of the conduct underpinning the findings. In that regard the Committee considered the case of Yusseff v GMC [2018] EWHC 13 (Admin), in which it was said that admitting the misconduct is not a condition precedent to establishing the Registrant understands the gravity of the offending and is unlikely to repeat it. The Committee was satisfied that, notwithstanding her denials, Miss Le Mare does understand the gravity of the matters found proved against her, she does have knowledge of the WHO Guidelines and those issued by the McTimoney College, she does have an understanding of connective tissue disorders and how to treat patients with hypermobility and, following on from these lengthy regulatory proceedings, she is unlikely to repeat her actions.

130. The Committee was also satisfied that Miss Le Mare understands the need and importance of ensuring all risks and benefits are explained to patients and that any consent obtained is therefore fully informed. On the question of consent, the Committee noted that this was not a case where Miss Le Mare had done nothing about obtaining consent. She had taken a number of necessary steps but had not gone far enough in ensuring Patient A was aware of all the risks and benefits of the proposed treatment. Accordingly the failure to obtain informed consent was on a fairly narrow basis. The Committee was satisfied that Miss Le Mare had insight into the matters found proved against her and that she is most unlikely to repeat them. In all the circumstances, the Committee was satisfied that Miss Le Mare does not pose an ongoing risk to the public.

131. Having concluded that Miss Le Mare no longer posed a risk of harm to the public and would be most unlikely to repeat the conduct highlighted in this case, the Committee considered whether an admonishment would be a sufficient sanction to maintain public confidence and uphold professional standards. An admonishment is appropriate when the behaviour is at the lower end of the spectrum of UPC and the Committee considered that these failures, although serious, could be considered to be at the lower end of the spectrum, when considered in the specific context of this case. As stated above, Miss Le Mare was only months into her career as a chiropractor when she was presented with a patient with particularly challenging health issues. It has not been alleged, and not been found, that there was any harm caused to Patient A. In many respects her actions were appropriate. She made a specific note in the record that Patient A was hypermobile and that no diversified neck or back adjustments should be carried out. Unfortunately she then failed to fully comply with her own instruction by carrying out the 'Carver' adjustment. However, the rest of her adjustments were all in compliance with the WHO guidelines and in finding Particulars 5 and 6 not proved, the Committee had been satisfied that Miss Le Mare had not acted inappropriately in terms of reassessing Patient A. Her failure to obtain consent to the three adjustments, whilst serious, was, as stated above, on a narrow basis, rather than a complete failure.

132. The Committee noted that many aspects of the factors listed in the Guidance on Sanctions where an admonishment is appropriate, were relevant in this case, namely:

a) evidence that the behaviour did not (and would not have caused direct or indirect) patient harm;

b) evidence of sufficient insight into the matters found proved;

c) the behaviour was an isolated incident, which was not deliberate;

d) a genuine expression of regret or apologies;

e) …

f) previous good history;

g) no repetition of the behaviour since the incident;

h) evidence that effective rehabilitative or corrective steps have been taken.

133. There was no evidence that Miss Le Mare's treatment of Patient A caused her actual harm, albeit the risk of harm, particular with the 'Carver' adjustment was high. As stated above, the Committee was satisfied with the level of insight shown by Miss Le Mare, who recognises that she is an autonomous professional with a sense of responsibility for all she does, underpinning her approach to how she practises. Her failings in this case related to one patient at two appointments and the Committee was prepared to accept that this was essentially an isolated incident, which was not deliberate. There was no doubting the genuineness and profoundness of her expressions of regret and apology. It was clear to the Committee from the reference provided by the Director at her former employment as a chartered surveyor, who described her as the best professional management surveyor he had ever worked with, that she is a person who has very high standards who wants to do her best for people. Miss Le Mare's description of how she would approach future employment and return to practice as a chiropractor was reassuring to the Committee and demonstrated appropriate corrective steps and her commitment to high standards. It was clear to the Committee that she was mortified to have been subject to these proceedings by her Regulator.

134. Taking into account the nature of the UPC found, the lack of aggravating and the extensive mitigating factors, the Committee concluded that an admonishment is the appropriate and proportionate sanction in this case. A finding of UPC is a serious matter in itself and the Committee was satisfied that an admonishment for that UPC would send a clear message to the public and the chiropractic profession of: the importance of complying with the WHO guidelines and the GCC Code, when treating patients suffering from hypermobility; and the need to ensure all risks, benefits and alternative treatments are discussed with a patient, to ensure they are in a position to provide properly informed consent to the treatment proposed. When treatment is contraindicated this must be fully explained to a patient. The Committee was confident that, in the seemingly unlikely event (given the rarity of the condition) that Miss Le Mare was again faced with a patient suffering from generalised hypermobility, she would not make the same mistakes she made with Patient A.

135. The Committee did not consider that a Conditions of Practice Order would be appropriate because Miss Le Mare no longer poses a risk to the public, there is no part of her practice

that requires remediation and such a sanction would be disproportionate in all the circumstances.

136. The order of this Committee, therefore, is that Miss Le Mare be admonished. She should be in no doubt that any finding of unacceptable professional conduct by her regulatory body is a serious matter and she should not take this admonishment lightly.

137. In accordance with Section 31 of the Chiropractors Act 1994, this decision will not have effect until the expiry of 28 days from the date on which notification is served on Miss Le Mare or, where an appeal is made, until the appeal is withdrawn or otherwise disposed of.

138. That concludes this case.

Chair of the Professional Conduct Committee

In accordance with provision of Rule 18(1)(a) of the General Chiropractic Council (Professional Conduct Committee) Rules 2000, we must remind you of your right of appeal under Section 31 of the Chiropractors Act 1994, as amended by Section 34 of the National Health Service Reform and Health Care Provisions Act 2002, to the High Court of Justice in England and Wales against this decision of the Committee. Any such appeal must be made before the end of the period of 28 days, beginning with the date upon which this notice is served upon you.

Please note that the decision of this Committee is a relevant decision for the purposes of Section 29 of the National Health Service Reform and Health Care Professions Act 2002.

The Professional Standards Authority has a period of 40 days, in addition to any appeal period provided to the chiropractor, in which to lodge an appeal.

Signed: Dated: 4 February 2021

Satpal Singh Bansal
On behalf of the Professional Conduct Committee

Explanatory Notes:

Notices of Finding are normally divided into three sections, which reflect different stages of the hearing process:

1. The Allegation: This section contains the full allegations as drafted by the Investigating Committee and as considered by the Professional Conduct Committee.

2. The Decision: This section contains the findings of fact reached by the Professional Conduct Committee on the allegation and the reasons therefore. In particularly complex cases the reasons may be given separately from the findings of fact for purposes of clarity.
3. The Sanction: This section contains details of the sanction applied by the Professional Conduct Committee. In certain cases the section may be sub-divided for the purposes of clarity.