General Chiropractic Council

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

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

Name of Respondent:	**Benjamin Gartside Mathew**
Address of Respondent:	**Cardiff Bay Chiropractic** **36 West Bute Street** **Cardiff** **CF10 5LH**
Registration Number of Respondent:	**02665**

On 9-13 and 16-20 July, and 10-14 and 17-21 September 2018, the Professional Conduct Committee ("the Committee") of the General Chiropractic Council met to consider an 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 original allegation was in the following terms:

THE ALLEGATION:

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

PARTICULARS OF ALLEGATION 1:

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 Cardiff Bay Chiropractic, Unit 1, St Clair's Court, West Bute Street, Cardiff Bay, Cardiff CF10 5EN

2. On or about 21 February 2017 you gave a talk at the clinic to patients and other members of the public which was advertised as 'An educational talk about the benefits and research of chiropractic care'. During that talk you said the following (or words to similar effect):

    (a) In relation to vaccinations and measles:

        i. That you were treating patients with scarring from vaccination

        ii. That you treated patients who had been damaged or had disease caused by birth trauma in addition to vaccination

        iii. That vaccines contained harmful substances

        iv. That vaccination was causing autism

        v. That measles was not a very harmful disease

        vi. That measles has never killed anyone

        vii. That there was no evidence that the MMR vaccine was effective against measles

        viii. That you supported the decision of a woman who said she had not taken her children to have the MMR vaccine.

    (b) In relation to mammographic screening:

        i. That mammographic screening, and in particular squashing a breast and passing radiation through it, can cause breast cancer

        ii. That mammographic screening can cause radiation damage and/or should be avoided due to x-ray exposure.

(c) That Hilary Clinton agrees with full term abortion.

3. Prior to or during your consultation with Patient A at the clinic on or about 21 February 2017:

(a) You asked Patient A, who is a dentist, about the treatment of dental abscesses in circumstances which made it obvious you were discussing the condition of a young female patient (Patient C) who was also attending the clinic for a consultation with you

(b) You referred to a female who attended the talk referred to in 2 above and who appeared to disagree with your comments about mammographic screening as a 'miserable cow'.

4. On or about 21 February 2017 Patient A told you, whilst you were taking a medical history from her, that she was 6.5 weeks pregnant. On or about 22 March 2017 whilst you were treating Patient B, who is Patient A's mother, you told her that Patient A was or was trying to become pregnant.

5. The statement(s) referred to:

(a) In 2(a) and/or 2(b) were:

i. Misleading and/or not factually verifiable

ii. Not adequately balanced or evidence based

iv. On matters which it was beyond your skills and competencies to make statements on

v. Capable of deterring or discouraging people from seeking or accepting appropriate healthcare.

(b) In 2(c) and/or 3(b) were:

i. Distasteful and/or inappropriate

ii. Likely to bring yourself and your profession into disrepute.

(c) In 3(a) were:

i. In breach of your duty of confidentiality to Patient C

ii. In breach of Patient C's right to privacy.

(d) In 4 were:

i. In breach of your duty of confidentiality to Patient A

ii. In breach of Patient A's right to privacy.

PARTICULARS OF ALLEGATION 2:

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

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at Cardiff Bay Chiropractic Clinic, 36 West Bute Street, Cardiff CF10 5LH ("the Clinic").
2. You were the lead chiropractor at the Clinic.
3. On or before January 2017, you issued and/or endorsed the issue of "health check pass" cards which contained promotional material about the Clinic and entitled the bearer to an initial "health check" consultation for £30, consisting of "initial consultation, examination, computerised neurological scan and orthopaedic tests, a report of findings and x-rays if necessary".
4. On those "health check pass" cards, below a picture of you, were the words "chiropractic may help with" and then a list of medical conditions and complaints, including:
    a. Reflux;
    b. Colic;
    c. Scoliosis;
    d. Whiplash;
    e. Tiredness and fatigue.
5. The efficacy of chiropractic treatment in relation to the conditions and complaints referred to in paragraph 4 above is not verifiable because it has not been substantiated by trials with a methodology capable of determining cause and effect.

6. By issuing and/or endorsing the issue of the “health check pass” cards you were therefore responsible for making misleading claims in relation to the efficacy of chiropractic treatment provided at the clinic.

7. Between approximately 16 January 2017 and 22 March 2017 you provided chiropractic treatment to Patient A.

8. On or about 16 January 2017 you referred Patient A, or instructed or caused her referral, for radiographs to be taken. The radiographs which were taken included:

    a. X-rays of the thoracic and lumbopelvic areas;

    b. Non-standard views of the cervical spine including anteroposterior and lateral cervicothoracic, and anteroposterior and lateral thoracolumbar views.

9. The x-ray films referred to in paragraph 8(a) and (b) above:

    a. Were not clinically justified;

    b. Caused Patient A to be exposed to unnecessary and harmful radiation.

10. You failed, throughout the period when you were providing treatment to Patient A, to report on any of the radiographs taken or to ensure that reporting was done.

11. On or about 18 January 2017, at an appointment to provide Patient A with a report of findings, you:

    a. Failed to establish and/or record an accurate and/or appropriate and/or adequate diagnosis;

    b. Failed to provide any or any adequate explanation to Patient A as to your diagnosis, the nature of her problem or your plan of treatment;

    c. Failed to ensure that Patient A’s consent to treatment was properly informed;

    d. Failed to draw up an adequate or appropriate plan of treatment;

    e. Recommended and/or encouraged and/or permitted Patient A to sign up to a treatment plan

        i. over a period of 6 months; and/or

        ii. for 48 treatments;

    f. This treatment plan was:

        i. Excessive in intensity and/or duration of treatment;

ii. Not clinically justified;

iii. Not in the best interests of Patient A.

12. At the same appointment on or about 18 January 2017, you gave Patient A a prognosis, in that you:

    a. Gave the impression that you could make her better; and/or

    b. Gave the impression that you could rid her of her neck pain; and/or

    c. Said “Shall we make you better?” or words to that effect.

13. This prognosis was misleading.

14. Your actions in charges 12 and 13 above were dishonest, in that you intentionally misled Patient A as to her prognosis.

15. Between 18 January and 22 March 2017 you failed to carry out any or any adequate formal reviews of Patient A’s progress.

16. On an unknown date between 18 January and 22 March 2017 you told Patient A that the surgeons who previously treated her neck had “fucked up your neck”, or words to that effect. This comment:

    a. Was inappropriate and unprofessional in the language used;

    b. Amounted to inappropriate and unprofessional derogatory criticism of other healthcare professionals.

17. At an appointment on or about 27 February 2017 you displayed an inappropriate and unprofessional manner and tone towards Patient A, after she reported deterioration in her symptoms and/or that she had experienced painful symptoms since the previous appointment. In particular:

    a. You spoke to her loudly and/or firmly and/or in an intimidating and humiliating manner on several occasions during the remainder of the appointment, in the presence of other patients;

    b. Your demeanour towards her changed and you said to her, “I don’t know what has happened to you in the last fortnight” or words to that effect.

    c. You told her in a loud voice, “I never told you I could get rid of the pain” or words to that effect;

d. You said to her, in a threatening manner, “if you want I can finish your adjustments and put you back to where you were”.

18. At an appointment on or about 20 March 2017 you allowed another member of staff at the clinic to be present throughout your treatment of Patient A without informing her of his presence or obtaining her consent.

19. Between approximately 6 February 2017 and 22 February 2017 you provided chiropractic treatment and/or advice to Patient B, who was the daughter of Patient A.

20. At an appointment on or about 21 February 2017 Patient B informed you that she was 6.5 weeks pregnant.

21. At an appointment with Patient A on 22 March 2017, you breached Patient B’s confidentiality, in that during Patient A’s appointment you referred to Patient B’s pregnancy, without Patient B’s knowledge of or consent to the disclosure of that information.

PARTICULARS OF ALLEGATION 3:

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

1. At all material times you were a registered chiropractor providing chiropractic treatment to patients at Cardiff Bay Chiropractic Clinic, 36, West Bute Street, Cardiff CF10 5LH.

2. On days between 1 March 2016 and 31 January 2017, you provided chiropractic treatment to Patient A.

3. Before commencing treatment with Patient A, you received a chiropractic radiology report dated 24 March 2016 which stated: ‘Bilateral hip arthrosis, advanced on the right. Orthopaedic referral for care options and MRI is recommended.’

4. During the appointment with Patient A on 29 March 2016, and at subsequent appointments thereafter, you failed to inform Patient A of:

   (a) The recommendation for orthopaedic referral for care options;

(b) The recommendation that she undergo an MRI scan;

(c) That she had advanced hip arthrosis on the right.

5. You failed to obtain informed consent from Patient A for Patient A's treatment by reason of 4(a) and/or 4(c).

6. You failed to refer Patient A on 29 March 2016 or thereafter for orthopaedic assessment and/or care.

7. You recommended a treatment plan for Patient A that was inappropriate to her hip condition.

8. Your actions in 4 and/or 6 and/or 7 arose because:

(a) You failed to recognise the severity of the pathology in the right hip; and/or

(b) You failed to consider the right hip as the cause of the right knee pain; and/or

(c) You failed to recognise the limits of your competence; and/or

(d) You sought to gain financially from Patient A by dishonestly withholding information from Patient A, which if disclosed to Patient A, may have led to Patient A seeking care elsewhere.

9. You unnecessarily exposed Patient A to risks of ionising radiation by having further x-rays taken of her pelvis on 7 December 2016.

AGREED AMENDED CONSOLIDATED PARTICULARS OF THE ALLEGATION:

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

1. Between around March 2016 and 22 March 2017 you were the Director/ Principal Chiropractor providing chiropractic treatment to patients at Cardiff Bay Chiropractic Clinic, West Bute Street, Cardiff ("the Clinic").

Complaint 1

2. On or about 21 February 2017 you gave a talk at the Clinic to patients and other members of the public, including Mr B and Patient B, which was advertised as 'An educational talk about the benefits and research of chiropractic care'(The "Talk").

3. During the Talk you said the following (or words to similar effect):

   (a) In relation to vaccinations and measles:

      i. That you were treating patients with scarring from vaccination;

      ii. That you treated patients who had been damaged or had disease caused by birth trauma in addition to vaccination;

      iii. That vaccines contained harmful substances;

      iv. That vaccination was causing autism;

      v. That measles was not a very harmful disease;

      vi. That measles has never killed anyone;

      vii. That there was no evidence that the MMR vaccine was effective against measles;

   (b) In relation to mammographic screening:

      i. That mammographic screening, and in particular squashing a breast and passing radiation through it, can cause breast cancer;

      ii. That mammographic screening can cause radiation damage and/or should be avoided due to x-ray exposure.

4. Prior to or during your consultation with Patient B at the Clinic on or about 21 February 2017, you referred inappropriately to a female who attended the talk referred to in 2 above and who appeared to disagree with your comments about mammographic screening as a '*miserable cow*'.

5. The statement(s) referred to:

   (a) In 3(a) and/or 3(b) were:

i. Misleading and/or not factually verifiable;

ii. Not adequately balanced or evidence based~~;~~

iii. On matters which it was beyond your skills and competencies to make statements on.

Complaint 2:

6. On or before January 2017, you issued and/or endorsed the issue of "health check pass" cards which contained promotional material about the Clinic and entitled the bearer to an initial "health check" consultation for £30 consisting of "initial consultation, examination, computerised neurological scan and orthopaedic tests, a report of findings and x-rays if necessary".

7. On those "health check pass" cards, below a picture of you, were the words "chiropractic may help with" and then a list of medical conditions and complaints, including:

   a. Reflux;

   b. Colic;

   c. Scoliosis;

   d. Whiplash;

   e. Tiredness and fatigue.

8. The efficacy of chiropractic treatment in relation to the conditions and complaints referred to in paragraph 7 above is not verifiable because it has not been substantiated by trials with a methodology capable of determining cause and effect.

9. By issuing and/or endorsing the issue of the "health check pass" cards you were therefore responsible for making misleading claims in relation to the efficacy of chiropractic treatment provided at the clinic.

10. Between approximately 16 January 2017 and 22 March 2017 you provided chiropractic treatment to Patient A.

11. On or about 16 January 2017 you discussed and/or endorsed a decision by a colleague to refer Patient A for radiographs to be taken. The radiographs which were taken included:

(a) X-rays of the thoracic and lumbopelvic areas;

(b) Non-standard views of the cervical spine including anteroposterior and lateral cervicothoracic, and anteroposterior and lateral thoracolumbar views.

12. The x-ray films referred to in paragraph 11(a) and 11(b) above:

(a) Were not clinically justified;

(b) Caused Patient A to be exposed to unnecessary and harmful radiation.

13. You failed, throughout the period when you were providing treatment to Patient A, to report on any of the radiographs taken or to ensure that reporting was done.

14. On or about 18 January 2017, at an appointment to provide Patient A with a report of findings, you:

(a) Failed to establish and/or record an accurate and/or adequate diagnosis;

(b) Failed to provide any or any adequate explanation to Patient A as to your diagnosis;

(c) Failed to provide any or any adequate explanation to Patient A your plan of treatment;

(d) Failed to ensure that Patient A's consent to treatment was properly informed;

(e) Recommended and/or permitted Patient A to sign up to a treatment plan

i. over a period of 6 months; and/or

ii. for 48 treatments;

(f) This treatment plan was:

i. Excessive in intensity and/or duration of treatment;

ii. Not clinically justified;

iii. Not in the best interests of Patient A.

15. Between 18 January and 22 March 2017 you failed to carry out any or any adequate formal reviews of Patient A's progress.

16. On an unknown date between 18 January and 22 March 2017 you told Patient A that the surgeons who previously treated her neck had "fucked up your neck", or words to that effect, which was inappropriate and unprofessional in the language used.

17. At an appointment on or about 27 February 2017 you told Patient A:

(a) "I never told you I could get rid of the pain" or words to that effect, which was contradictory to the advice given by you at the outset of her treatment;

(b) in a threatening manner and/or in a tone likely to be overhead by other patients "if you want I can finish your adjustments and put you back to where you were".

18. At an appointment on or about 20 March 2017 you allowed another member of staff at the clinic to be present during your treatment of Patient A without informing her of his presence or obtaining her consent.

19. Between approximately 6 February 2017 and 22 February 2017 you provided chiropractic treatment and/or advice to Patient B, who was the daughter of Patient A.

20. At an appointment on or about 21 February 2017 Patient B informed you that she was 6.5 weeks pregnant.

21. At an appointment with Patient A on 22 March 2017, you breached Patient B's confidentiality, in that during Patient A's appointment you referred to Patient B's pregnancy, without Patient B's knowledge of or consent to the disclosure of that information.

Complaint 3:

22. On days between 1 March 2016 and 31 January 2017, you provided chiropractic treatment to Patient C at the Clinic.

23. Before commencing treatment with Patient C, you received a chiropractic radiology report dated 24 March 2016 which stated: 'Bilateral hip arthrosis, advanced on the right. Orthopaedic referral for care options and MRI is recommended.'

24. During the appointment with Patient C on 29 March 2016, and at subsequent appointments thereafter, you failed to inform Patient C of:

(a) The recommendation for orthopaedic referral for care options, including an MRI scan;

(b) That she had advanced hip arthrosis on the right.

25. You failed to obtain informed consent from Patient C for Patient C's treatment by reason of 24(a) and/or 24(b).

26. You failed to refer Patient C on 29 March 2016 or thereafter for orthopaedic assessment and/or care.

27. You recommended a treatment plan for Patient C that was inappropriate to her hip condition in that:

    (a) It was not informed by an appropriate diagnosis;

    (b) It was not informed by a reasonable prognosis;

    (c) The treatment planned was unlikely to benefit the condition;

    (d) The frequency and duration of treatment planned was not in the patient's best interests;

    (e) The reviews planned were inadequate.

28. With respect to your actions at 24 and/or 26 and/or 27, you deliberately withheld relevant information from Patient C, in order to encourage her to commit to treatment with you.

29. Your conduct as described at 28 was:

    (a) Dishonest;

    (b) Financially motivated.

30. You unnecessarily exposed Patient C to risks of ionising radiation by having further x-rays taken of her pelvis on 7 December 2016.

DECISION

1. The Professional Conduct Committee ('the Committee') convened to consider an Allegation against Mr Mathew. Mr Christopher Hamlet appeared on behalf of the General Chiropractic Council ('the GCC'). Mr Mathew attended and was represented by Mr Jonathan Goldring.

Application to amend the Particulars of the Allegation

2. At the outset of the hearing Mr Hamlet made an application to amend the Particulars of the Allegation, which included offering no evidence in relation to some of the original Particulars. The reasons for the application were largely to streamline and consolidate the three hitherto separate Allegations, which had been formally joined at a previous hearing. Mr Hamlet said that in relation to those matters upon which the Council wished to offer no evidence, this followed conferences with Mr Young, the expert Chiropractor instructed on behalf of the GCC, and his opinion that some of those matters would not amount to Unacceptable Professional Conduct ('UPC') either individually or collectively, or were matters covered by other allegations and were therefore potentially duplicitous. In addition, some of the original Particulars alleged matters that should rightly be dealt with at Stage 2 when considering whether facts found proved amounted to UPC and were matters of judgement of the Committee rather than matters that required proof by way of facts.

3. Mr Goldring, on behalf of Mr Mathew, did not object to the proposed amendments or suggest that there was any unfairness or injustice to Mr Mathew in allowing them. However, Mr Goldring raised a potential issue about the extent to which the Committee could make judgement decisions at Stage 2 without a possible factual basis having been established at Stage 1, but he emphasised that he did not oppose the amendments and withdrawals requested.

4. The Committee accepted the advice of the Legal Assessor that it had the power to allow amendments provided they could be made without injustice. The Committee was satisfied that the proposed amendments and withdrawals could all be made without injustice in that: they streamlined the original three Allegations; they more accurately and appropriately reflected the matters alleged; they removed matters that could not amount to

UPC, whether considered separately or collectively; they removed matters which were duplicitous; and they removed matters relevant at Stage 2 when considering UPC which were matters of judgement of the Committee and not matters that required proof by the GCC. The Committee noted that Mr Mathew had not raised any objections to the proposed amendments. The Committee was also satisfied that the removal of several of the Particulars did not mean that the matter was in any way being 'under-prosecuted'. Accordingly, the Committee allowed the amendments requested and proceeded on the basis of the Consolidated Allegation as detailed above.

5. The Committee noted Mr Goldring's slight reservations, but was satisfied that it could revisit the issue, if needed, and in any event would invite submissions at Stage 2, if appropriate.

Admissions

6. Following the allowed amendments, the Particulars of the Allegation were incorporated into the record and Mr Goldring, on behalf of Mr Mathew, indicated that Particulars 1, 2, 3(a)(iii), 3(b)(ii) (in that mammographic screening can cause radiation damage but not that it should be avoided due to x-ray exposure), 6, 7(a) to (e), 8, 9, 10, 11(a) and (b), 14(e)(i) & (ii), 19, 20, 21, 22, and 23 were admitted. The Chair accordingly announced that these Particulars were found proved.

7. At the commencement of the Defence case, on 10 September 2018, Mr Goldring indicated that Mr Mathew now admitted Particular 13. His previous denial had been based on the understanding that failing to report on the radiographs meant failing to say anything to the Patient. He now understood, and Mr Hamlet confirmed, that what was alleged in Particular 13, was not a failure to speak to the Patient about the radiographs, but rather was directed to the failing to record in the clinical notes his report on the radiographs, in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000, as amended ('IRMER'). Accordingly, the Chair announced that Particular 13 was found proved on the basis of Mr Mathew's admission.

Application for part of Patient C's evidence to be in private

8. The Committee heard an application for part of Patient C's evidence to be dealt with in private because Mr Goldring anticipated asking the Patient some questions about her medical records. Mr Hamlet supported the application.

9. The Committee accepted the advice of the Legal Assessor and agreed that those parts of the evidence that dealt with Patient C's GP records, and her chiropractic records where those records overlapped with the GP records, would be dealt with in private. The Committee considered this was important in order to protect her dignity because, although her identity was anonymised, it would be unfair to expect her to speak of such matters in a public forum or for those matters to form part of the public record of the proceedings.

Background and Nature of the Allegations

10. Mr Mathew is, and was at all relevant times, a Chiropractor registered with the GCC. He has been the owner of Cardiff Bay Chiropractic, Cardiff (the 'Clinic') since 2006, the same year in which he qualified as a Chiropractor.

11. This case concerned three complaints relating to Mr Mathew's practice, spanning the period March 2016 to March 2017, when he was the Director and Principal Chiropractor at the Clinic.

12. The complaints raised a range of concerns about Mr Mathew's practice. The first complaint was referred to the GCC by Mr B, who attended the Clinic on 21 February 2017 with his wife, Patient B to hear a talk given by Mr Matthew. It was alleged that during the talk Mr Mathew made a series of statements that were misleading and/or factually unverifiable; and were directed at topics that were beyond his skills and competencies as a Chiropractor. These included statements about the effects of vaccinations, of measles and of mammographic screening. It was also alleged, by Patient B, that Mr Mathew made disparaging comments about another patient during a consultation after the talk. In addition to the evidence of Mr B and Patient B, the GCC relied on the expert evidence of Dr Couriel, Consultant in Paediatric Respiratory Medicine, Professor Fentiman, Professor of Surgical Oncology and Martin Young, called as an expert witness in Chiropractic.

13. The second complaint was referred by Patient A who, as well as being a patient of Mr Mathew, was also the mother of Patient B. It was alleged that Mr Mathew made unverified and misleading claims about chiropractic in a "health check pass/card" produced by the Clinic in order to encourage prospective patients to seek treatment at the Clinic on a false understanding of its benefits. In addition, as regards Patient A, it was alleged that Mr Mathew devised an excessive treatment plan, took clinically unjustifiable x-

rays of her, and provided an inadequate diagnosis of her condition. Furthermore, it was alleged that he was unprofessional and inappropriate in the way he spoke to Patient A and also that he breached Patient B's confidentiality by disclosing to Patient A the fact of the former's pregnancy. In addition to the evidence of Patient A and her husband Mr A, the GCC relied on the expert chiropractic evidence of Mr Young.

14. The third complaint was referred by Patient C who attended an appointment on 21 March 2016 to address an issue with her right knee and carpal tunnel syndrome in her right hand. She was seen on that day by a colleague of Mr Mathew, who conducted assessments and took x-rays of her neck, spine and hips. Mr Mathew then arranged for those x-rays to be reported on by an expert in chiropractic radiology interpretation. That expert provided a report to the Clinic on 24 March 2016 and identified bilateral hip arthrosis, which was advanced on the right, and recommended, "Orthopaedic referral for care." The GCC alleged that thereafter Mr Mathew deliberately, dishonestly and for financial gain, withheld the content of that report in order to encourage Patient C to commit to an extensive programme of treatment. It is also alleged that, some nine months into the course of that treatment, Mr Mathew took further x-rays that were unnecessary because they did no more than confirm what he already knew from the March 2016 x-rays.

Submission of no case to answer in respect of Particular 18

15. At the conclusion of the GCC's case, Mr Goldring made a submissions that there was no case to answer on Particular 18, based primarily on the fact that the treatment of Patient A on 20 March 2017 took place in an open plan part of the Clinic and therefore the presence of another member of staff could hardly have been objectionable. Mr Hamlet had already conceded the point and said that the GCC did not oppose the application.

16. The Committee accepted the advice of the Legal Assessor, who referred to Rule 6(7) of the General Chiropractic (Professional Conduct Committee) Rules 2000. Rule 6(7) states that the Committee may determine that insufficient evidence has been adduced to satisfy it that the allegation, or particulars of the allegation, are well founded and dismiss the allegation, or particulars of the allegation, without hearing evidence for the respondent on those particulars.

17. At her appointment with Mr Mathew on 20 March 2017, Patient A said that her husband accompanied her. At the conclusion of her adjustment she noticed another member of the Clinic, possibly another chiropractor was in the room. Her husband later told her that this person had been in the room during the adjustment. Patient A said that Mr Mathew had not told her that there would be another man in the room during her adjustment.

18. In oral evidence from both Patient A and Mr A, it was apparent that there were two stages to the appointment on 20 March 2017. The first involved Mr Mathew discussing his Report of Findings with Patient A and this was clearly confidential and private. Neither Patient A nor Mr A said that they were aware of the man being present during this phase. The second part was an adjustment carried out by Mr Mathew on Patient A and this was done in the same room, namely Room 1. However, it was agreed by all that Room 1 was an open plan room with often more than one patient being treated at the same time. It would not be unusual during adjustments for other people to be present. At its highest, the evidence was that the colleague was in Room 2, near the open archway into Room 1, during part or all of the adjustment.

19. Mr Young said that following the evidence of Mr A and Patient A about the timing of that person's presence in the room, and the phase of treatment taking place, he did not maintain that Patient A's confidentiality had been breached because there was no evidence that the person had been present during the Report of Findings when he could have overheard confidential discussions. Mr Young said he was not critical of a colleague's presence during the treatment phase in the context of an open plan treating environment that Patient A had been treated in many times before and had clearly provided consent.

20. The mischief in Particular 18 was the alleged failure of Mr Mathew to inform Patient A of the presence of another member of staff, and thereby obtain her consent to that member being present, during her treatment. However, once it was established that the treatment took place within an open plan part of the clinic where other patients and members of staff were often present, the Committee was satisfied that it would not have been necessary to inform Patient A, or obtain her consent, in such circumstances. She had been treated in that same area on other occasions and would have been aware of the fact that it was an open plan area and that it was highly likely there would be other patients and/or members of staff present.

21. The Committee therefore accepted Mr Goldring's submission and decided there was insufficient evidence to satisfy it that Particular 18 was well founded. Accordingly, the Committee dismissed Particular 18.

Findings of fact

22. The Committee considered with care all the evidence presented, both oral and documentary. It took into account the submissions made by Mr Hamlet on behalf of the GCC and those made by Mr Goldring on behalf of Mr Mathew. The Committee accepted the advice of the Legal Assessor and bore in mind that it was the GCC which brought the case and had the burden of proving the disputed facts on the balance of probabilities.

23. The Committee heard from the following witnesses on behalf of the GCC:

- Patient A - patient of Mr Mathew
- Mr A - husband of Patient A
- Patient B - patient of Mr Matthew and daughter of Patient A and Mr A
- Mr B - husband of Patient B
- Patient C - patient of Mr Mathew
- Mr C - husband of Patient C
- Dr Couriel - Consultant in Paediatric Respiratory Medicine
- Professor Fentiman - Professor of Surgical Oncology (evidence agreed and read)
- Martin Young - Chiropractor and expert witness

24. The Committee heard from the following witnesses on behalf of Mr Mathew:

- Mr Mathew - Registrant
- Paul McCrossin - Chiropractor and expert witness
- Justin Lewis - present at the talk given by the Registrant (evidence agreed and read)
- JT - patient at the Clinic (evidence agreed and read)
- Laura Attridge - Clinic Chiropractic Assistant (evidence agreed and read)
- Jan Beytell - Clinic Practice Manager (evidence agreed and read)
- Kirsten Morris - Clinic Chiropractic Assistant (evidence agreed and read)
- Suzanne Moreno - Clinic Technical Chiropractic Assistant (evidence agreed and read)

25. The Committee also received a large number of testimonials regarding Mr Mathew's clinical ability and his good character.

1 - admitted and found proved

26. This was a purely background factual statement, which was admitted by Mr Mathew.

COMPLAINT 1

2 - admitted and found proved

27. Mr B and his wife Patient B said that, on 21 February 2017, they attended a talk given by Mr Mathew at the Clinic. They said that the title of the talk, as shown on the clinic's website, was *'An educational talk about the benefits and research of chiropractic care.'*

28. Mr Mathew admitted he gave this talk. He said that he has been giving this talk every week for a number of years, it usually lasts an hour and is for new patients at the practice, their spouses, friends and shadowing chiropractors. He said the class was by appointment only and not freely open to members of the public. He uses the class to introduce himself, give a brief history of chiropractic and to make it clear that *"Dr"* means *"teacher"* as well as someone who diagnoses and treats disease. He said he sometimes gives his own and his family's experiences as a patient of chiropractic. He reviews how the nervous system works and how interference to the nervous system affects health. He talks about physical, chemical and emotional stressors and gives examples of what they may be. Physical stressors might be posture, sport, or for mothers the birthing process. Chemical stressors might be the food we eat, fluids we drink and medications that we take, including vaccinations. He said that during the course of his talk he would use a variety of slides.

29. Mr Lewis, another patient at the Clinic, attended the same talk. He said that the particular things that stood out to him during the talk were the effects that sugar and sweetener can have on the body. He said that Mr Mathew went on to discuss vaccines and commented that it would be better not to become unwell in the first place, before going on to speak about his personal experiences and beliefs about the use of

vaccinations. Mr Lewis said that *"it was not given as advice not to be vaccinated. I would say that it wasn't to discourage, but possibly look to ask further questions about what it would offer."*

30. The Committee did not have a record or transcript of this talk, nor did it have access to the slides used by Mr Mathew or any of the other material used during the talk. What it did have was a number of witnesses who were present: Patient B, Mr B, Mr Lewis and Mr Mathew. Patient A also attended a similar talk a month earlier and although that was of limited assistance because it was a different date, in so far as she was able to remember matters her account could be said to have supported Mr Mathew, who said he effectively gave the same talk every time. All the witnesses reported hearing different things, with very little consistency. Patient B and Mr B accepted in cross-examination that they could each only recall approximately 50% of the talk. These factors made it difficult for the Committee to be clear about what was and was not said. The Committee was satisfied that during the course of his talk on chiropractic, Mr Mathew did briefly make mention of vaccinations and measles, but it could not be clear about the exact context or the words used given the conflicting accounts of the witnesses. This was not a talk about the use of chiropractic to treat conditions such as autism or common illnesses, but it appeared rather that Mr Mathew was using these as examples to illustrate the way in which he took a vitalistic approach towards health and well-being.

31. It was suggested that Patient B and Mr B had discussed their evidence between themselves and that this had affected their independent recollection of events. Both witnesses accepted that they had discussed matters on their journey home in the car, but said they had not colluded in providing their accounts on what they said they had heard. The Committee noted a number of inconsistencies between their accounts and was left with the impression that their accounts genuinely reflected their independent recollections and that there was no compelling evidence of collusion.

32. It is against that background that the Committee considered the sub-headings in Particular 3. The Committee looked very carefully at the extent to which there was corroboration and/or consistency from the evidence. The witnesses often said they did not recall specific phrases or words used and focused on matters which particularly concerned them and clearly did not remember quite a lot of what was said. Mr Mathew accepted that his talk was not scripted, it was possible he made off-the-cuff remarks and his communication on that day could have been clearer.

3(a)(i) - not proved

33. Mr B stated that during the talk that he attended, Mr Mathew said he was treating patients in the clinic with *'scarring'* from vaccination. He said that Mr Mathew did not specify how chiropractic could treat *'scarring'* from vaccination but said that he was treating patients, including children, who had sustained *'scarring'*. He said he had the impression that Mr Mathew was referring to physical scarring. Mr B, a General Surgical Registrar, said he himself was not aware of any physical scarring caused by vaccinations.

34. Patient B said that she did not remember any mention of scarring during the talk, but added that she probably would not have remembered such a word because it would have meant nothing to her and would have gone *"over my head".* She said she was more interested in people's reactions in the room and that scarring was not something that would have stuck in her mind. She said that although she and her husband talked in the car on the way home about things that had been said, that did not include any mention of scarring.

35. Dr Couriel said that he did not understand what could have been meant by '*scarring'* since the only vaccination that causes any sort of physical scarring is the BCG injection for tuberculosis.In relation to *"scarring"*, Dr Couriel said, *"I do not recognise or understand what the registrant was referring to when he talked about "scarring" caused by vaccination. The only form of vaccination which I am aware of causing physical scarring is BCG, a vaccination which reduces the risk of children developing tuberculosis and its most severe complications. BCG vaccination can lead to localised scarring of the skin at the site of the injection. I know of no scientific evidence of other immunisations which lead to scarring. If there is some other form of scarring which the registrant was referring to, I am unaware of what that would be or what the scientific evidence is to support that belief."*

36. Mr Mathew denied that he used the word *'scarring'*. He said that was not a word he would use when discussing vaccine adverse reactions. He said that as far as he was concerned scarring related to the healing of damaged tissue. In oral evidence Mr Mathew said, *"I may well have used 'damaged' but I do not believe that the word 'scarring' is something that I would have used."*

37. Mr B was sure that the word *"scarring"* had been used. It appeared in his online complaint the day after the talk and also in his statement to the GCC a month later. Patient B, however, did not hear that word being used, although she accepted she did not

remember everything that was said. Mr Lewis made no mention of hearing the word *"scarring"* and Dr Couriel could think of no circumstances where the word *"scarring"* would be applicable to vaccinations. Mr Mathew denied using that word and it was not a term which would be recognised in chiropractic or indeed the medical profession in this context. In all the circumstances the Committee was not satisfied, on the balance of probabilities, that Mr Mathew had said words to the effect that he was treating patients with scarring from vaccination.

38. The Committee therefore found 3(a)(i) not proved.

3(a)(ii) - not proved

39. Mr B said that he recalled Mr Mathew saying that he had treated patients who had been *"damaged"* or had *"disease"* caused by birth trauma in addition to vaccination. He said he did not think Mr Mathew had been saying *"dis-ease"*, what he heard was the word disease.

40. Patient B said she could not recall this particular phrase being used. She remembered the word disease being used but could not help with the context. She did not remember Mr Mathew referring to *"dis-ease".*

41. Mr Mathew said there had been occasions when he had patients in the Clinic who had had adverse reactions to vaccines. He had also had children in the practice who had suffered birth trauma. He added, however, that it was not his usual practice to use the word *"treat".* He also said that he talks about a state of *"ease"* and *"dis-ease"* as in a lack of *"ease"*. He said this was a common term used in chiropractic. He also said that when he said dis-ease his usual practice was to say *"diss hyphen ease"* to make it clear what he was saying, and that is what he would have said. He added that it was his usual practice to take care to distinguish *"diss hyphen ease"* from *"disease"* and would also refer to *"disharmony"*.

42. Mr McCrossin said that in the context of describing dysfunction he was aware of Chiropractors using the term dis-ease to represent a lack of ease.

43. Mr Mathew accepted that he would treat patients who had suffered from birth trauma. He denied that he made any link between birth trauma in addition to vaccination.

The Committee noted that there was a potential inconsistency between the two witnesses, Patient B and Mr B, in that both were at the same talk but Patient B has no recollection of these comments being made, although she did have a recollection of the word disease being used. The Committee also noted that Mr B had not referred to this in his online complaint, it first appearing in his statement. That said, the Committee was aware that people can remember additional matters on reflection and thus its absence from the online complaint was not necessarily determinative of the issue. Mr Lewis made no mention of hearing this phrase and Mr Mathew denied saying it. The Committee noted that, according to Mr Mathew, he would say *"diss hyphen ease",* emphasising the hyphen. In those circumstances the Committee could not see how this could be confused with the word *"disease"* because of the inclusion of the word *"hyphen"*. The Committee was, therefore, satisfied that Mr Mathew had used the word disease at some stage. However, it was not clear in what context that word had been used and, given the complete lack of corroboration, the Committee was not satisfied that the use of the word disease had been linked to damage caused by birth trauma and vaccination.

44. The Committee thus found 3(a)(ii) not proved.

3(a)(iii) - admitted and found proved

45. Mr B stated that during the talk, Mr Mathew used slides, one of which had a list of chemicals that he said were found in some vaccines and included Formaldehyde and Mercury. Mr B said that Mr Mathew said that vaccines contained harmful substances.

46. Mr Mathew admitted that he said vaccines contained harmful substances.

3(a)(iv) - not proved

47. Patient B said that Dr Mathew told them that vaccination was *'causing'* autism. She said that he *'got really passionate about it.'* In her oral evidence she said she could not recall him providing any examples of how this was being caused or any evidence in support of his assertion.

48. In his oral evidence Mr B said that he did not recall Mr Mathew saying that vaccination was causing autism. He said that a member of the audience raised the subject

and he felt the Registrant was validating she was saying, that is to say not giving MMR was okay and that it was wrong that she should have felt ostracised as a result. Mr B said he did not hear the direct link being made with autism and admitted that he would have felt upset had he heard those words.

49. Mr Mathew said that he did not say vaccination was causing autism. He said he sympathised with a woman who felt that a vaccination had been associated with autism and that she had been ostracised by her family and doctor for holding that view. Mr Mathew stated that he said to the woman that he understood her position, he thought it was very unfortunate and that nobody should be ostracised for holding such a view. He said that he was trying to convey to the audience that a balanced approach was best, he was certainly not trying to maintain that vaccination caused autism, nor was he validating her decision not to vaccinate.

50. Mr Mathew accepted that his personal view is that there are a number of independent studies that show there is a link between vaccination and autism, but that is not what he talked about at that meeting. He maintained that it was the audience member who brought up the question of autism, not him.

51. Mr Lewis said that he remembered Mr Mathew discussing vaccines and said that it would be better not to become unwell in the first place. He said Mr Mathew then went on to speak about his personal experiences and beliefs about the use of vaccines, but it was not given as advice not to be vaccinated. Mr Lewis was of the view that what Mr Mathew was saying *"wasn't to discourage* [the use of vaccines] *but possibly look to ask further questions about what it would offer."*

52. The Committee noted that Patient B was clear that she heard Mr Mathew saying that vaccination caused autism and this was reflected in her note made shortly after the talk where she recorded *"vaccinations are causing disease/autism."* She repeated that in her statement and in her oral evidence. She said she was sure they had discussed this in the car on the way home. However, this account was not supported by Mr B, who said he would have been upset if Mr Mathew had used those words and in the Committee's view this undermined Patient B's remembered account. Mr Lewis, who had been at the same talk, did not mention hearing this. Mr Mathew denied using this phrase. With one person saying she heard this comment and two effectively not hearing it and Mr Mathew denying it was said, the Committee could not be satisfied that it was said.

53. The Committee therefore found 3(a)(iv) not proved.

3(a)(v) - found proved

54. Mr B said that Mr Mathew told his audience that measles was not a very harmful disease. He accepted he had not mentioned this in his online complaint to the GCC, but said that when providing his statement to the GCC he was more comprehensive as he had had more time to think about all that he remembered being said. He was asked if he remembered Mr Mathew saying that measles was a self-limiting disease that normally resolves within a week, rather than that it was not a very harmful disease, but this did not accord with his recollection. He said that this was one of the first comments that made him angry.

55. Patient B had not mentioned this in either her notes or statement, but when questioned in evidence at the hearing she said that she was sure that Mr Mathew had said that measles was not a very harmful disease. When asked why it was not in her statement she said that she had been answering questions on the telephone to a GCC employee and that there, *"may be certain things that I recall that are not in my statement."* She added that there was so much that she wanted to write down in her original notes and the fact that Mr Mathew said measles never killed anyone was most prominent in her mind, so that is what she had recorded.

56. Mr Mathew denied that he had said measles was not a very harmful disease. He believes he may have said words to the effect that lots of people have measles and it is *"a mild and potentially self-limiting disease of childhood which often resolves within a week"*.

57. Mr Lewis said he did not recall Mr Mathew saying that measles was not a fatal disease. He said, *"He discussed one of his own family experiences with it, mentioned that the majority of people are likely to suffer with it in their lifetime, usually at a younger age."*

58. Both Mr B and Patient B remembered Mr Mathew saying that measles was not a very harmful disease, albeit Patient B had not mentioned it in her statement. The Committee considered that in describing measles as *"a mild and potentially self-limiting disease"*, as admitted by Mr Mathew, he was effectively saying that measles was not a

very harmful disease. Accordingly, the Committee considered it more likely than not that he did say measles was not a very harmful disease, or words to similar effect.

59. The Committee therefore found 3(a)(v) proved.

3(a)(vi) - not proved

60. Patient B said that during the talk, Mr Mathew said that *"measles had never killed anyone"*. She said she was in *"utter shock"* as a result since she knew this not to be true. This was recorded in her original notes and her statement. In her oral evidence she was not in any doubt about his use of these words.

61. Although he had not mentioned it in his online complaint to the GCC or in his statement, in his oral evidence Mr B said that Mr Mathew did say at the talk that measles had never killed anyone. When asked why this was not in his statement, he said that he had a telephone conversation with someone from the GCC, that they spoke over a period of time and he aimed to get all of the important things across, but *"not the absolute detail of everything."* He said he was not pooling his recollection with his wife, and that he did recall him using those words.

62. Mr Mathew denied that he said measles had never killed anyone. He said that he may have said measles was a mild and potentially self-limiting disease of childhood, which often resolves within a week. He said he certainly was not trying to convey that measles should be ignored and he denied making deliberately incendiary comments to discourage people from having vaccinations.

63. Mr Lewis said he did not recall Mr Mathew saying that measles was not a fatal disease. He said, *"He discussed one of his own family experiences with it, mentioned that the majority of people are likely to suffer with it in their lifetime, usually at a younger age."*

64. The Committee considered this to be a difficult decision because there were two people saying it was said and effectively two saying it was not. Mr B had made no mention of this quite striking comment in either his online complaint or his statement. On balance the Committee decided that the GCC had not proved this Particular.

65. Accordingly, the Committee found 3(a)(vi) not proved.

3(a)(vii) - not proved

66. Mr B said that when talking about measles, Mr Mathew said that there was no evidence that the MMR vaccine was effective against measles. He accepted this was not in his online complaint but said that was the general areas of concern and that he provided much more detail when giving his statement. He was adamant that Mr Mathew had said this.

67. There was nothing in Patient B's note or statement about this. In her oral evidence she said, *"I don't recall him saying the MMR vaccine didn't work, but at that point certain things he said I was running over in my head so I don't know if that was said. He may have said more things in the talk but I was relaying things through my head and so may have missed certain sentences."*

68. Mr Lewis did not mention this in his statement.

69. Mr Mathew denied saying that there was no evidence that MMR was effective against measles. He was talking about chemical toxicity and how it affects neurological health. When asked in re-examination whether he agreed that the MMR vaccine was effective against measles, Mr Mathew said, *"the accepted literature suggest that the MMR vaccine has been effective but also sanitation and lifestyle have played a significant role if you actually look at the documented data which has been collated over the years from the early 1900s with regards to measles incidence and mortality."* He went on to say that measles had occurred in populations that have had the measles vaccine.

70. The Committee considered Mr Mathew's response in re-examination to be an honest one which reflected his personal views and lent some support to the evidence of Mr B. However this did not make it more likely than not that he had in fact said it. Patient B did not hear it; Mr Lewis did not mention it; and Mr Mathew denies it.

71. In those circumstance the Committee could not be satisfied that this was in fact said and so found 3(a)(vii) not proved.

3(b)(i) - found proved

72. Mr B (who, in addition to being a General Surgical Registrar, also has a special interest in oncology, specifically regarding hormone resistance in breast cancer) said that during the talk, Mr Mathew also made reference to mammographic screening saying, "*When you squash a breast and pass radiation through it, this itself can cause breast cancer."* Mr B said his impression was that it was a combination of the two that could cause breast cancer. He said he was clear about the words used by Mr Mathew. He accepted that *"squashing"* was not mentioned in his online complaint.

73. Patient B told the Committee that Mr Mathew said that mammographic screening was *"causing"* cancer. She said that Mr Mathew spoke about how *"squashing a breast"* and passing radiation through the breast was not natural and could cause radiation damage. This account was mirrored in her contemporaneous notes.

74. Mr Mathew said "*I did not say squashing a breast and passing radiation through it can cause breast cancer. I said "according to some studies, radiation passing through breast tissue may, in fact, cause tissue damage (by which I meant cancer). I was not suggesting that the squashing of the breast would contribute towards the risks of tissue damage/cancer. That is why we don't over expose our patients to radiation and try to limit the amount of exposure".*

75. When cross-examined Mr Mathew was asked, *"Do I take it from your answer that you do not accept that you went on to make the statement that squashing the breast and passing radiation through it can cause cancer?"* He answered, *"I go back to the point that passing radiation through any tissue is going to cause tissue damage."* He was then asked, *"So is it perfectly possible that you did say words to that effect?"* To which he responded, *"Possibly, yes. There is also scientific evidence which will support that statement as well."*

76. Mr Lewis said that he recalled Mr Mathew talking about breast cancer and *"he referenced that there was potentially a review because of a possible link to the technology used in the scanning due to the exposure to x-ray. But this was not confirmed by Mr Mathew, just supplied as guidance and information that he was aware of."*

77. The Committee noted that Mr Mathew accepted that it was possible he said words to the effect of that which was alleged. This together with the evidence of Mr B and Patient B satisfied the Committee that this fact was proved.

3(b)(ii) – admitted in part and found not proved where denied

78. Patient B said that Mr Mathew stated that *"Squashing a breast and passing radiation through the breast was not natural and could cause radiation damage."* She said that he found the way Mr Mathew talked to be very persuasive and it seemed as though he was trying to influence the audience and discourage women from undergoing screening.

79. On the subject of mammographic screening, Mr B said that Mr Mathew said it should be avoided due to x-ray exposure. He went on to say that Mr Mathew *"… didn't say anything positive about MS* [mammographic screening]."

80. Both Patient B and Mr B accepted in their oral evidence that Mr Mathew did not actually say that mammographic screening should be avoided, but rather this was just the impression they had formed from what he said.

81. Mr Lewis said that he recalled Mr Mathew talking about breast cancer and *"he referenced that there was potentially a review because of a possible link to the technology used in the scanning due to the exposure to x-ray. But this was not confirmed by Mr Mathew, just supplied as guidance and information that he was aware of."*

82. Mr Mathew admitted that he said mammographic screening can cause radiation damage. However, he denied that he also said that mammographic screening should be avoided due to x-ray exposure. He said he was in the flow of things and had just recently read a book on mammography and correlated the similarities of limitations with X-rays for a method of identifying degeneration in a similar way to mammographic screening not picking up breast cancer early. He said he wanted his audience to understand the limitations of the technologies that he had at his office. He accepted he had not provided any statistics or said any more about it, but that was not the purpose of his talk. He was not seeking to dissuade people from having mammographic screening. He was really talking about the limitations of his x-rays as a way of identifying issues early.

83. The Committee noted that both Patient B and Mr B accepted in oral evidence that Mr Mathew had not actually said that mammographic screening should be avoided, but rather this was an impression they had formed from what he had said.

84. Accordingly, the Committee found the part admitted by Mr Mathew proved and the second part, *“and/or should be avoided due to x-ray exposure”* not proved.

4 - not proved

85. Patient B said that during the talk, just after the comments about mammographic screening *“causing”* cancer, a woman sitting next to her husband grabbed her coat and put it on as if to leave. She said that the woman looked uncomfortable and unhappy with what Mr Mathew had just said, however she did not in fact leave. After the talk, when Patient B was having her consultation with Mr Mathew, she said that he mentioned the lady who had moved to put her coat on half way through the talk but stayed. Patient B said that Mr Mathew said, *"you cannot please everyone. That woman is such a miserable cow."* Patient B said she was shocked by this comment. She said that he was trying to come across as friendly, but he was not. She remained firm in her oral evidence saying that she heard him say those words. There was nothing in Patient B’s contemporaneous note about this comment.

86. Mr B did not say anything about a woman standing up, although according to Patient B the woman was sitting next to Mr B; and he was not present at the later consultation with Patient B.

87. Mr Mathew denied saying this. He said if he used words like this he would lose patients. He was adamant that this was simply not the sort of language he would use. He did remember a lady in the audience standing up and he thought she was just stretching her back.

88. The Committee considered Patient B to be an honest witness who had done her best to recall things that were said and happened at the talk and thereafter and could see no reason why she would make up the comment about the lady being a miserable cow, although it noted this comment did not appear in her contemporaneous notes. That inconsistency together with Mr Mathew’s denial and the fact that this was alleged to have been said in an open plan office with others present led the Committee to question whether the GCC had adduced sufficient evidence to establish that this charge was proved. The Committee also considered that, in light of the favourable comments made by

his staff and patients about his professional conduct, together with his good character, it was inherently improbable that Mr Mathew would have made such a comment.

89. In those circumstances the Committee was not satisfied that the GCC had discharged the burden of proof and found this allegation not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(i) - not proved

90. The Committee did not find Particular 3(a)(i) proved and therefore it follows that 5(a)(i), (ii) and (iii) in relation to 3(a)(i) are also found not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(ii) - not proved

91. The Committee did not find Particular 3(a)(ii) proved and therefore it follows that 5(a)(i), (ii) and (iii) in relation to 3(a)(ii) are also found not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(iii) - not proved

92. Mr Young said that there was a difference between a talk which was entirely educational and one that had a promotional element to it, in that for the former the use of non-verifiable, but evidence-based, material was appropriate. Such material could be based on the clinician's own practical experience and did not necessarily have to be supported by any independent research. If the latter, then there is a higher threshold to be satisfied and all claims in regard to health care needed to be supported by Level One evidence. Level One evidence is evidence based on accepted scientific facts or of systematic reviews, meta-analyses and the randomised controlled trials on which they are based.

93. Mr Young also said that chiropractors were under a duty to ensure that material presented at a talk was not misleading and in order to achieve that it must be presented in a way that is both honest and balanced. He said that where there is conflicting evidence it would not be honest or ethical to ignore some evidence in order to promote an argument or particular point of view.

94. Dr Couriel said that if the description of Mr Mathew's comments about vaccinations was accurate then he believed Mr Mathew was putting forward a biased and unduly negative point of view about the risks and benefits of vaccination. He said that such views would be shared by very few, if any, conventional health care professionals.

95. Mr McCrossin was broadly in agreement with Mr Young about the need to be balanced at such a talk. He said, *"Any such talk should be balanced in placing information in the appropriate context and presenting both sides of an argument or point."* However, he did not agree that a talk which may have a promotional component could only include claims supported by Level One evidence (accepted scientific facts, systemic reviews, meta analyses and randomised clinical trials). He said that a practitioner's experience, observation and opinion can be relevant and beneficial when properly contextualised. He said that Chiropractors often use these talks to explain underlying principles that they work by and about which the audience may be unaware, to better inform them in making choices about whether care is appropriate for them. He added that, *"In reality it may be difficult to determine if a talk is for information only to benefit understanding of care or treatment or promotional, as this can come down to the perception of the audience as much as the intent of the presenter."*

96. Mr Mathew said, *"The talk was to patients, their families or people who were interested in chiropractic. It is not intended to be for members of the public "off the street". It would have to be by appointment. The main purpose of the talk is to inform people who have already expressed an interest in receiving care. In the 9 years that I have been giving the talk I can only remember one person who attended who was not linked to a patient or someone who had booked an initial appointment. Practically all of the participants in the class would have attended for an initial appointment themselves or be the spouse of such a person before they attend the class."* When cross-examined he said that he did the talk purely to educate people about chiropractic. He accepted there could be a commercial aspect to the talk, but that was not its purpose. He said his whole focus was on promoting chiropractic. He uses the class to introduce himself, give a brief history of chiropractic and to make it clear that *"Dr"* means *"teacher"* as well as someone who diagnoses and treats disease. He said he sometimes gives his own and his family's experiences as a patient of chiropractic. He reviews how the nervous system works and how interference in the nervous system affects health. He talks about physical, chemical and emotional stressors and gives examples of what they may be. Physical stressors might be posture, sport, or for mothers the birthing process. Chemical stressors might be the food we eat, fluids we drink and medications that we take, including vaccinations.

97. The Committee considered that the talk was primarily educational and that was its purpose. Mr Mathew accepted that there may be a commercial element but that was not the function of the talk. The Committee preferred Mr McCrossin's opinion that at an educational talk which may have a promotional element, it was not necessary for everything said to be supported by Level One evidence and that it was appropriate for Mr Mathew to refer to his own experience as a practitioner. However, the Committee was of the view that where such references were made it was most important that, as both experts opined, Mr Mathew should have provided context and a balanced view.

98. In relation to 3(a)(iii), Mr Mathew admitted that he said vaccines contain harmful substances because, he asserted, they contain substances such as mercury, aluminium and formaldehyde. Dr Couriel said, *"With respect to the alleged claim that vaccines contain harmful substances, I am unaware of any reliable scientific evidence that modern vaccines contain substances which are harmful to the health of recipients. In the past, the safety of mercury in vaccines was challenged, but the recent evidence is that there is no link between mercury and any alleged adverse effects of vaccination."*

99. However, in cross-examination Dr Couriel accepted that a common adjuvant found in current vaccines is aluminium; that it is a known neurotoxin; and, in sufficient doses, it can be harmful.

100. The Committee accepted the expert evidence of Dr Couriel that some vaccines contain aluminium, which can be harmful. Therefore the comments made by Mr Mathew were not open to criticism in the manner detailed in the Particulars. On that basis the Committee found these charges not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(iv) - not proved

101. The Committee did not find Particular 3(a)(iv) proved and therefore it follows that 5(a)(i), (ii) and (iii) in relation to 3(a)(iv) are also found not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(v) - proved

102. The Committee found as a matter of fact that Mr Mathew said that measles was not a very harmful disease (or words to similar effect).

103. Dr Couriel said, *"This alleged assertion is incorrect. On its Fact Sheet, updated in March 2017, the World Health Organisation states that "measles is one of the leading causes of death among young people… In 2015 there were 134,200 measles deaths globally (15 deaths per hour). On its current webpage on "Measles Vaccination", the highly respected CDC explains that in the US before measles vaccination was introduced, 400-500 people died each year from measles: 48,000 people were hospitalised and 1000 developed encephalitis (infection and swelling of the brain). The CDC estimates that 30% of children who develop measles have complications, including pneumonia (6%), diarrhoea (8%), otitis media (7%), encephalitis (0.1%) and death (0.2%). There is therefore overwhelming evidence that measles is a major cause of illness and death, especially in young children and those who have not been vaccinated against the illness."*

104. Dr Couriel added, "*It appears that the aim, and/or the predictable consequences, of the incorrect claims about measles and MMR, would be to deter parents from having their children immunised against measles, mumps and rubella. The scientific evidence is that if parents were to decline immunisation on the basis of this advice, then their children would be at an increased risk of developing measles and/or other important infections which are prevented by vaccination."* He said that in his view the alleged comments relating to vaccinations and measles were highly misleading, were not factually verifiable and were not supported by scientific evidence.

105. The Committee accepted the unchallenged expert evidence of Dr Couriel and on that basis found these charges proved. The Committee was satisfied that a chiropractor who makes statements that are misleading, not factually verifiable and not adequately balanced or evidence based, is unlikely to be speaking on matters that were within his skills and competencies. In addition the Committee was presented with no evidence to indicate that Mr Mathew had any qualification or level of expertise in immunology.

5(a)(i), (ii) & (iii) in relation to 3(a)(vi) - not proved

106. The Committee did not find Particular 3(a)(vi) proved and therefore it follows that 5(a)(i), (ii) and (iii) in relation to 3(a)(vi) are also found not proved.

5(a)(i), (ii) & (iii) in relation to 3(a)(vii) - not proved

107. The Committee did not find Particular 3(a)(vii) proved and therefore it follows that 5(a)(i), (ii) and (iii) in relation to 3(a)(vii) are also found not proved.

5(a)(i), (ii) & (iii) in relation to 3(b)(i) - proved

108. The Committee found as a matter of fact that Mr Mathew said that mammographic screening, and in particular squashing a breast and passing radiation through it, can cause breast cancer (or words to similar effect).

109. Professor Fentiman, Professor of Surgical Oncology, provided an unchallenged opinion upon Mr Mathew's alleged comments on mammographic screening during the talk. He stated *"Although there is debate concerning the absolute benefits of screening there are no responsible doctors or healthcare workers who would actively discourage their patients from attendance at screening clinics."* He goes on, *"Screening offers the opportunity to detect implacable breast cancers, often before they have metastasised to axillary nodes and this usually means less extensive surgery and a better outcome"*

110. Professor Fentiman's report stated that the risk of radiation during screening is extremely low and *"there is no evidence that compression of the breast as part of mammography leads to tissue damage or dissemination of cells from a cancer."* If it did, he says, *"…it would manifest as an increased mortality rate among screened women and there is abundant evidence that screening mammography is safe."*

111. Based on the unchallenged evidence of Professor Fentiman, the Committee was satisfied that Mr Mathew's comments were misleading, not factually verifiable and not adequately balanced or evidence based. In addition, the Committee was satisfied that Mr Mathew, by in particular including a reference to breast squashing, was speaking on matters beyond his skills and competencies as a Chiropractor.

112. The Committee therefore found these charges proved.

5(a)(i) in relation to 3(b)(ii) - not proved: 5(a)(ii) & (iii) in relation to 3(b)(ii) proved

113. Mr Mathew admitted that he said that mammographic screening can cause radiation damage, but denied adding that it should be avoided due to x-ray exposure. Mr Mathew stated that what he had said at that talk was *"according to some studies, radiation passing through the breast tissue may, in fact, cause tissue damage (by which I meant cancer). I was not suggesting that the squashing of the breast would contribute towards the risks of tissue damage/cancer. That is why we don't over expose our patients to radiation and try to limit the amount of exposure". I have produced two reports which were available prior to my talk and which I had read prior to my talk as exhibit BM/9 which deal with mammographic screening."*

114. Professor Fentiman's report stated that the risk of radiation during screening is extremely low and *"there is no evidence that compression of the breast as part of mammography leads to tissue damage or dissemination of cells from a cancer." If it did, he says, "…it would manifest as an increased mortality rate among screened women and there is abundant evidence that screening mammography is safe."*

115. The Committee did not find that Mr Mathew went beyond saying that mammographic screening can cause radiation damage. Since there is such a risk, according to Professor Fentiman, however low, the Committee did not find this comment to be misleading because it was factually verifiable. The Committee did not therefore find Particular 5(a)(i) in relation to 3(b)(ii) proved.

116. However it did find Particular 5(a)(ii) and (iii) proved in relation to 3(b)(ii), because it did not believe Mr Mathew provided an adequately balanced view given Professor Fentiman's evidence that the risk is extremely low. One such dose would be equivalent to the level of risk of taking a 10-mile car journey, smoking one-eighth of a cigarette, or living for 3 minutes at the age of 60. It was therefore incumbent on Mr Mathew to have provided a balanced view and this he failed to do. The Committee was also satisfied that Mr Mathew was speaking on matters beyond his skills and competencies. This was a very specialist area as demonstrated by the expert evidence of Professor Fentiman, and not one about which Mr Mathew should have been expressing opinions in a forum of this nature.

COMPLAINT 2

6 - admitted and found proved

116. Patient A suffered a fall in 2009/2010. She did not seek any treatment at the time but in due course her neck, right arm and shoulder became very painful. She visited her GP and had some physiotherapy without success and then opted for surgery, undergoing a C4-C5 Foramenotomy at Parkside Hospital. Initially she felt a little better, however the pain returned in 2013 and she went back to the consultant at Parkside and was advised that another disc had slipped in her neck and a further operation was an option. Patient A decided not to have a further operation, but instead to try and manage the pain herself. She tried various painkillers, prescription medication and massage but the pain continued and forced her into an early retirement from her teaching career. She found that removing the stress of work helped.

117. In January 2017, Patient A was told by a friend about the Clinic and the possibility of a health check for £30 instead of the usual £130. She contacted the Clinic and had an initial health check on 16 January 2017, although that was not with Mr Mathew. She was given a 'Health Check Pass' card entitling the bearer to an initial 'health check' consultation for £30, consisting of *"initial consultation, examination, computerised neurological scan and orthopaedic tests, a report of findings and x-rays if necessary."* The Committee was provided with a copy of the 'Health Check Pass' card.

118. Mr Mathew admitted Particular 6, saying that he accepted he was ultimately responsible for the content of the cards. He maintained, however, that he had had no input into the cards' content. He said they had been designed by a consultancy and then adapted by his wife and Practice Manager. He said that on review, and on advice from his legal team, the cards were removed. At this stage the Committee made no factual finding about Mr Mathew's actual state of knowledge, during the seven years that the cards were in circulation, in relation to the health check cards.

7(a) to (e) - admitted and found proved

119. The ‘Health Check Pass’ card seen by the Committee had a photograph of Mr Mathew on it, the words ‘chiropractic may help with’ and a list of medical conditions and complaints, including: reflux; colic; scoliosis; whiplash, tiredness and fatigue.

120. Mr Mathew admitted Particular 7(a) to (e).

8 - admitted and found proved

121. Both Mr Young and Mr McCrossin agreed that the efficacy of chiropractic treatment in relation to the conditions and complaints referred to in Particular 7 was not verifiable.

122. Mr Mathew admitted this Particular.

9 - admitted and found proved

123. Both Mr Young and Mr McCrossin agreed that by issuing or endorsing the issue of the ‘Health Check Pass’ cards, Mr Mathew was responsible for making misleading claims in relation to the efficacy of chiropractic treatment provided at the Clinic.

124. Mr Mathew admitted this matter.

10 - admitted and found proved

125. Patient A gave evidence about the chiropractic treatment she received from Mr Mathew between January and March of 2017.

126. Mr Mathew admitted that he treated Patient A during this period.

11(a) & (b) - admitted and found proved

127. Patient A said that at her first appointment at the Clinic she was seen by someone other than Mr Mathew and that person said he would ‘scan’ her. She then had some x-rays taken but could not comment on what x-rays were taken and why.

128. Mr Mathew admitted Particular 11(a) and 11(b).

12(a) & (b) in relation to 11(a) - not proved

129. Patient A said that she thought the x-rays were important and necessary for her Treatment Plan. However, the Committee noted that she was not an expert and would not, therefore, be expected to know whether particular x-rays were clinically justified or not. Accordingly the Committee gave little weight to her evidence on this point.

130. The x-rays were in fact taken by a Chiropractic colleague and employee of Mr Mathew, Mr Deady. However, Mr Mathew had added his signature to the document justifying the x-rays and had thereby assumed responsibility for them as both the Employer and also as Practitioner.

131. Mr Young said that in his opinion, whilst there were a number of indications for taking cervical x-rays, there were no indications for either thoracic films or lumbopelvic films and that those x-rays could not have been justified on the clinical information available. He said even if justification was recorded it was not applicable and in his view these x-rays should not have been taken.

132. Mr Mathew accepted that he checked his colleague's justification for the x-rays and he signed the form to endorse that justification. He also endorsed the decision to take non-standard views of the thoracic spine and lumbopelvic areas. He said that it was clear from Mr Deady's examination that at L4 there was a reference to *"Patellar Left 2+, right 2+. This is normal. L5 is Posterior Tibialis (inside of the foot) is 0 so there is no reflex on this bilaterally. If she had a fall flat on her back you must rule out any other trauma to her spine. I think that there was every justification for an x-ray of the cervical, thoracic and lumbar spine. There were only 4 x-rays taken but the collimation was longer than a normal standard series. It is not standard process in the clinic to do so but in view of the patient's accident in 2012 where she knocked herself unconscious I say we should rule out any other injury to her spine."*

133. The clinical notes recorded, *"The rationale was due to need of structural integrity assessment and clinical need to visualize vertebral alignment."* The Patient Consent Form and justification for x-ray, counter-signed by Mr Mathew, had four areas circled by Mr Deady as justification for the x-rays, namely: patient over 50; significant injury/trauma; history of surgery in region; and evaluation of complex postural or bio-mechanical disorders.

134. Mr McCrossin stated he was *"aware of a reasonable body of Chiropractors beyond just Mr Mathew and Mr Deady that would take thoracic and lumbar films in a lady with a traumatic history involving a road traffic accident and a fall onto her back that she cannot recollect as she lost consciousness. This coupled with postural findings of hyper-kyphosis, a high right shoulder, trunk rotation and a high left hip along with the anterior head carriage are suitable justification for such films."* He emphasised that the Chiropractor has to build up a complete picture and all these are factors which can be taken into account.

135. The Committee considered the starting point to be the Regulations governing the taking of radiographs, IRMER, which state that, *"The practitioner is responsible for the justification of each individual medical exposure. This should be based on his knowledge of the hazard associated with the exposure and the clinical information supplied by the referrer.*

136. Chiropractors are also assisted by guidelines which are endorsed by the Royal College of Chiropractors, the British Chiropractic Association and the UK's undergraduate institutions. These guidelines are adapted from those published by the Royal College of Radiologists to reflect the fact that Chiropractors undertake forceful manipulation of skeletal structures. The guidelines are evidence-based and ensure that the criteria used to justify the x-rays have diagnostic yield that ensures the risk of harm from ionising radiation is outweighed by the potential diagnostic benefit to the patient.

137. The Committee recognised that the decision to be made about whether or not to take x-rays and the specific type to be taken depends very much on the clinical decision taken by the Practitioner at the time, based on the evidence before them. The Committee had concerns about the justification for these x-rays, but in light of the conflicting views of the experts in this case, the Committee could not be satisfied, on the balance of probabilities, that the x-rays taken of Patient A were not clinically justified. The Committee therefore found this Particular not proved.

138. Having found this Particular not proved, it follows that Particular 12(b) in relation to 11(a) is also not proved.

12(a) & (b) in relation to 11(b) - found proved

139. Mr Young said that regarding Mr Mathew's radiological practice, certain x-rays taken of Patient A on or about 16 January 2017, were 'non-standard' images of A's cervical spine. Standard x-ray protocols define the views to be taken in order to ensure that x-rays are of diagnostic quality and that patient exposure to ionising radiation is minimised.

140. His criticism of the non-standard x-rays taken of Patient A were that first the area of injury and surgery could not be clearly visualised; and secondly some of the images included adjacent areas of the spine which meant there was additional exposure to ionising radiation of clinically irrelevant areas. Consequently, Mr Mathew caused Patient A to be exposed to unnecessary ionising radiation.

141. Mr Mathew said he agreed that he took non-standard exposures. He said he adopted a different approach to standard, which was based on his clinical experience of caring for thousands of patients over many years.

142. Mr McCrossin said that whilst he agreed with Mr Young that the views that had been taken of the cervical spine were unorthodox and not ideal, he said he has seen such films taken in Chiropractic practice, particularly to assess posture. He said that these four films had been stitched together to give a full spinal view and it was difficult to stay that the cumulative dose as a result would have been higher by comparison to taking three separate cervical views along with anterior-posterior and lateral thoracic and lumbopelvic views, which would have required seven films.

143. Mr McCrossin said that IRMER does not stipulate what criteria to use for justification of x-rays, rather that the process is that the benefits must outweigh the risks. Mr McCrossin said it followed that if the x-rays were, as he opines, justified, then the ionising dose will have been necessary and the benefits will have exceeded the risk.

144. The Committee considered that there was insufficient diagnostic potential for these x-rays to be justified because the area of surgery could not be clearly seen. Furthermore, a wider area than was necessary was exposed so that even if the non-standard views had been appropriate, the x-rays were not clinically justified.

145. Having concluded that the x-rays were not clinically justified it followed that Patient A was exposed to unnecessary and harmful radiation. The Committee was

satisfied that Mr Mathew had caused those x-rays to be taken as both the Practitioner who endorsed Mr Deady in the taking of the x-rays and as Mr Deady's Employer.

146. The Committee therefore found 12(a) and (b) in relation to 11(b) proved.

13 - admitted and found proved

147. Patient A said that Mr Mathew did not report to her on the x-rays. Mr A said that he did not remember anything being said about the x-rays either.

148. Mr Young said that there was no evidence that the x-rays taken on 16 January 2017 were reported on by Mr Mathew until Dr Grace's report of 2 May 2017, over six weeks after Patient A had terminated her treatment and after she had made a complaint to the GCC. He said there should have been such a report, which should normally be done within a day of the images being taken. Mr Young said that if the x-rays are not reported on then there is not much point in taking the x-rays in the first place. He said this was not mitigated by reporting seven months later because it meant a lot of Patient A's treatment was not informed by the x-rays taken. He added, however, that if Mr Mathew had been able to look at the films each time he treated Patient A and had time to extract diagnostic information from the films then whilst this was not good practice, it did not fall far below the standards expected.

149. Mr Mathew maintained that he did speak to Patient A about the x-rays, but admitted that he had failed to report in the clinical notes on the radiographs taken, as required by IRMER. When he was clear that it was this failure that was alleged he sought to retract his denial, and admitted this Particular. He said that he had relied on newly recruited graduate chiropractors that he employed to do the recording, but they had not done so on this occasion. Mr Mathew also accepted that it was a further failure on his part to not follow up on their failures to record. He apologised for the oversight.

14(a) - proved (on the basis of failing to record an adequate diagnosis)

150. Patient A said that on 18 January 2017, she attended a Report of Findings appointment at the Clinic. She was accompanied by her husband Mr A. She said that Mr Mathew said he was going to explain the context of the test results (carried out on 16

January 2017). Patient A said that Mr Mathew told her the treatment would take six months. She said he was very persuasive and gave the impression that he could *"make her better."*

151. Mr Young was taken to the diagnosis set out in the Report of Findings, namely: *"Chronic severe postural subluxation complicated by cervical surgery, with associated radicular symptoms of the right arm."* He said it failed to capture the key aspect of Patient A's diagnosis. He said her presentation was indicative of chronic, post-traumatic C6 and C7 right-sided radiculopathy, complicated by previous surgery to the C5 level.

152. Mr Mathew said he did record an adequate diagnosis. He added that one can look at the history to see where the symptoms emanate from. He defended his use of the word *'subluxation'* in his diagnosis.

153. Mr McCrossin said that it is commonplace for Chiropractors to use the term subluxation in the diagnoses they formulate and there is a reasonable body of Chiropractors that do so. He said that it is not uncommon for practitioners to vary in their diagnoses and it does not always follow that one must be right and the other wrong. He concluded that the diagnosis recorded in Patient A's file was adequate and not significantly different from that proposed by Mr Young. He said what was recorded was not ideal but not inadequate.

154. The Committee was satisfied that Mr Mathew had established an adequate diagnosis. It accepted the criticisms levelled by Mr Young and was of the view that the diagnosis could have been better. It also recognised the differing approaches within the profession to the use of the word *"subluxation",* and that the use of the word in chiropractic practice differs from its use in medical practice (where it relates to a partial dislocation). Whilst the diagnosis could have been more detailed, the Committee was not satisfied that the diagnosis was inadequate, in that it provided Mr Mathew with a basis to formulate a plan of treatment.

155. However, the Committee was concerned about the record of the diagnosis. The Committee concluded on the basis of the expert evidence that Patient A had a cervical nerve root compression. However, there was no mention of the level of the spinal surgery or the suspected level of nerve root impingement in the diagnosis. That was a minimal requirement and both Mr Mathew and Mr McCrossin accepted that it was not ideal to have made this omission. The record refers to chronic severe postural

subluxation. Mr McCrossin and Mr Mathew both agreed there is no single definition of what a subluxation is, so including it within a diagnosis that another chiropractor should be able to read in order to understand readily the nature of the presenting condition, is not clear enough. That lack of clarity as to the meaning of subluxation, together with the omission of the level of the spine at which the surgery had been carried out and the suspected level of nerve root impingement, meant that the Committee considered the record of the diagnosis to be inadequate. Mr Mathew himself admitted in evidence that there was scope for confusion with the use of the term 'subluxation'. It may have been an adequate diagnosis in that Mr Mathew may well have known what he was referring to, but it was not an adequate record because of its lack of clarity, detail and precision.

156. The Committee therefore found this fact proved on the basis of an inadequate record only.

14(b) - not proved

157. Patient A said that at the 18 January 2017 appointment, Mr Mathew did not offer a diagnosis. When pressed on this she said that she could not recall any diagnosis being offered.

158. Mr A, who accompanied Patient A to this appointment, said that Mr Mathew did not say anything specific about treatment for his wife, but spoke rather in very general terms and was extremely positive. He talked about his state of the art equipment and the virtues of chiropractic care. Mr A said that Mr Mathew was very confident in his ability to treat Patient A, however he did not mention anything specific in respect of a diagnosis or a treatment plan, other than indicating a timeline of six months. He did, however, recall mention of the word *"subluxation"* and references to the spine.

159. Mr Mathew denied this allegation. He referred the Committee to the page of the records where Patient A had signed the following declaration, *"I have been given a verbal Report of Findings at which my diagnosis and care plan were fully explained."*

160. Mr McCrossin said that there was an obligation on Mr Mathew to explain his diagnosis in terms that the patient would understand.

161. Suzanne Moreno, a Technical Chiropractic Assistant at the Clinic, remembered Patient A and was present at the appointment when the report of findings was discussed. She said, *"Generally, at a report of finding, Ben Mathew firstly explains what chiropractic is, what a subluxation is and how he can remove it. He will then continue to thoroughly go through the patient's x-rays in detail, then results of the scans, taking the time to answer any questions or queries a patient would have. This takes place standing in front of the touch screen computer where I take notes. I believe that he went through the findings the same way, in the same detail, on this occasion with Patient A, the same way as with every other patient who attends his clinic."*

162. In light of the evidence of Mr Mathew, the signed declaration and the unchallenged evidence provided by Ms Moreno, the Committee was not persuaded, on the balance of probabilities, that Mr Mathew had failed to provide an adequate explanation to Patient A as to his diagnosis of her condition. The Committee recognised that patients and their partners may not remember all that was said at a consultation and that it was therefore possible that the diagnosis was adequately explained. Furthermore, Mr A remembered the term subluxation being used, which suggested to the Committee that Mr Mathew had provided an explanation of his diagnosis.

163. Accordingly, the Committee found this Particular not proved.

14(c) - not proved

164. Patient A said that at the 18 January 2017 appointment, Mr Mathew began treatment and that the adjustment lasted approximately five minutes. She could not recall which part of her body he adjusted and she could not recall him telling her what he was going to do. She could not recall if Mr Mathew said what he was doing as he did it. She did not recall being shown a poster and being taken through the three stages of care.

165. Mr A, who accompanied Patient A to this appointment, said that Mr Mathew did not say anything specific about treatment for his wife, but rather spoke in very general terms and was extremely positive. He talked about his state of the art equipment and the virtues of chiropractic care. Mr A said that Mr Mathew was very confident in his ability to treat Patient A, however he did not mention anything specific in respect of a diagnosis or a treatment plan, other than indicating a timeline of six months. He recalled subluxation

being mentioned and reference to the spine. He did not recall *"three stages of chiropractic"* and a poster or any discussion about it.

166. Mr Mathew denied that he had failed to provide an adequate explanation to Patient A about her plan of treatment. He said he took her through the three stages of care as shown in the diagram on a poster in the clinic. He added that she had signed the declaration in the notes to say that her plan of treatment and been explained to her and that she could ask any questions should she have wished to do so.

167. Suzanne Moreno, who was present at the appointment when the report of findings was discussed with Patient A, said, *"Generally, at a report of finding, Ben Mathew firstly explains what chiropractic is, what a subluxation is and how he can remove it. He will then continue to thoroughly go through the patient's x-rays in detail, then results of the scans, taking the time to answer any questions or queries a patient would have. This takes place standing in front of the touch screen computer where I take notes. I believe that he went through the findings the same way, in the same detail, on this occasion with Patient A, the same way as with every other patient who attends his clinic."* She added that, *"Ben Mathew had informed Patient A that in her history, she would need to have care for about 6 months."* Ms Moreno said that she took Patient A and her husband through the payment options based on the number of adjustments Mr Mathew had told her were necessary for the three phases of care.

168. The records showed that Patient A had signed the following declaration, *"I have been given a verbal Report of Findings at which my diagnosis and care plan were fully explained."* A photograph of the treatment room at the Clinic showed a poster depicting the three stages of care, which Mr Mathew said he took Patient A through. In light of this evidence and the unchallenged account given by Ms Moreno, the Committee could not be satisfied, on the balance of probabilities, that Mr Mathew had failed to provide an adequate explanation to Patient A of his plan of treatment.

169. The Committee therefore found this Particular not proved.

14(d) - not proved

170. Mr Young said that the consent form signed by Patient A suggested she accepted that all had been explained and she had given her consent. He added, however,

that if Mr Mathew had not explained adequately or at all, then the fact that she signed the consent form did not mean consent would remain valid. He said that the guidance given to Registrants is very much based on a patient's understanding and that merely signing a piece of paper is not sufficient. The patient must have the information they need to make informed decisions about their healthcare options.

171. Mr Young said that it was important that the patient knows all the elements required in order to give informed consent. They need to understand the nature of what is wrong with them, the nature of the proposed intervention, the prognosis - ie the chances of success - the nature and purposes of treatment, the risks and benefits of treatment and alternatives to that treatment, which would include doing nothing. My Young said that that information was not captured adequately on the 'consent' document. He said some of it was, but not enough for the patient to make an informed choice about their healthcare.

172. Mr Mathew denied this allegation. He referred the Committee to the page of the records where Patient A had signed the following declaration, *"I have been given a verbal Report of Findings at which my diagnosis and care plan were fully explained. I agree to treatment in the following areas: NECK - UPPER BACK - LOWER BACK - EXTREMITIES. The benefits and risks have been explained to me. I have had the opportunity to ask questions. I am happy for a report to the sent to my General Practitioner if the need arises. I consent to Chiropractic adjustments."* Mr Mathew added that he appreciated that such a signature is *"ineffective in isolation to verify consent"* and that is why he *"always explain in detail the theory and purpose of chiropractic care in the talks to patients and their families and also the individual aims, objectives and risks of care to individual patients in a lengthy report of findings.*

173. This allegation was predicated on positive findings in relation to 14(a) to (c). The Committee found allegations 14(b) and (c) not proved, and found that, in relation to 14(a) Mr Mathew had more likely established an adequate diagnosis (albeit not adequately recorded). These findings, together with the signed declaration that the risks and benefits had been discussed, were sufficient, the Committee determined, to show that Patent A's consent to treatment was properly informed.

174. The Committee therefore found this Particular not proved.

14(e)(i) & (ii) - admitted and found proved

175. At the conclusion of the appointment on 18 January 2017, Mr Mathew left the room and Patient A was left with an assistant to discuss the treatment plan. Patient A said the six-month indication was the only detail Mr Mathew had mentioned. The assistant discussed care plans with Patient A her husband. Patient A said she was given no guidance or explanation as to what the plans were, why they were certain lengths, and which one would be better suited to her. However, notwithstanding this lack of guidance, she and her husband decided to opt for the plan that began with three sessions per week for eight weeks, then two sessions per week for six weeks and finally one session per week for 12 weeks. In total the plan was for 48 adjustments. Patient A said that this seemed like the most comprehensive package as they thought that Mr Mathew would be able to get rid of her pain. She said that no explanation was given as to why this many adjustments were required.

176. Mr Mathew admitted Particulars 14(e)(i) and (ii).

14(f)(i), (ii) & (iii) - not proved

177. Mr Young discussed the three phases of care, which he referred to as intensive care, rehabilitation and maintenance. He said that from a clinical prospective it was wrong to start on the basis of a worst case scenario, because when taking money from patients in advance it changes the doctor/patient relationship. Thus, when recommending a treatment plan to a patient many Chiropractors will adopt the approach of being conservative but realistic, rather than a worse case scenario. Mr Young posed the question that if a patient were not better in 12 or 15 treatments then why are they likely to get better with more.

178. Mr Young added that Patient A had a chronic condition involving damage to a nerve which would take longer to heal than average presentations and it followed that Patient A would be likely to need more treatment than average. He considered that, with her history, 12 treatments over 6 weeks would have been more appropriate. He said she had already failed to respond to conservative care, so there was every chance that she may not respond to chiropractic. In such circumstances, to suggest an extended course of treatment one would have to be very confident that the patient was going to respond. His conclusion was that there was no justification for the intensity of treatment recommend by

Mr Mathew, which was likely to foster dependency and so was not in the best interests of Patient A.

179. Mr Mathew said "*I deny this from my clinical experience. She had a complicated and chronic history. She had sought help from a wide variety of other health professionals all without improving her condition. She had cervical surgery which was unsuccessful. She had chronic pain with associated radicular symptoms on the right arm. It was my understanding that she wished not just pain relief but rehabilitation and maintenance too. In my report on findings to her I estimated that the pain relief section of the treatment could be dealt with in 12 sessions but as a worst-case scenario 24 with reviews at every appointment and formal reviews (re-report) every 12 appointments."* Mr Mathew added that he had planned for a *" worse case scenario."*

180. Mr McCrossin said that in his opinion the Treatment Plan was not inappropriate and there are many Chiropractors who would have proposed a similar Treatment Plan. He said if there was no resolution by the 12th session the Chiropractor should not necessarily stop. He said you would want to see that the patient was responding to care and if so there was no reason why the Chiropractor cannot continue. He said that from the records it was apparent that Patient A was responding to care and therefore there was no indication that Mr Mathew should have stopped. Mr McCrossin said there was nothing wrong with planning for the worst case scenario, provided reviews were built in.

181. The Committee noted that there was significant scope for individual clinical judgement when deciding the intensity and/or duration of a treatment plan. The Committee was surprised at the number of treatments proposed, but noted that there were built in reviews which meant that the plan could change if required.

182. In all the circumstances, the Committee could not be satisfied that the treatment plan was excessive in either intensity or duration of treatment. It followed that the Committee could not conclude that the treatment plan was not clinically justified and not in the best interests of Patient A.

183. The Committee therefore found these Particulars not proved.

15 - not proved

184. Mr Young said that in his opinion there was no meaningful review of Patient A during her 24 treatments with Mr Mathew, despite her worsening symptoms.

185. Mr Mathew said he informally reviewed Patient A on every visit and she was formally reviewed on two occasions as shown by the visual charts which indicated the tests that were carried out by the reviewing practitioner. That practitioner would then feed back the results to Mr Mathew, and he said that he explained these to Patient A. He accepted that the findings were not additionally recorded in the Chart Notes, but considered the visual charts, which he said were part of the clinical notes, were sufficient. He added that any lack of notes did not mean that he had not carried out the reviews and he should have been monitoring the note taker he had employed, more closely.

186. Mr McCrossin said that Patient A had 25 treatment sessions between the consultation on 16 January 2017 and her last visit on 23 March 2017. Within this period she had two re-examinations, one on 8 February 2017 and the other on 16 March 2017. In his opinion this was a reasonable frequency of reassessment for the time period of care if Patient A was responding as expected.

187. The Committee noted that the allegation was that Mr Mathew had failed to carry out any or any adequate formal reviews of Patient A's progress. It was not a failure to adequately record. The records that were available clearly showed that formal reviews had taken place on the 8 February 2017 and 16 March 2017 and thus the question to be determined was whether they were adequate. It was common ground that this was a reasonable frequency of reassessment for the time period of care and the way in which Patient A was responding. The Committee noted that there was an absence in the notes of objective tests having been carried out. There were some objective scans. Mr Mathew maintained that he had carried out objective tests, they had just not been recorded separately in the Chart Notes.

188. There was no doubt that the notes were lacking in quality in relation to the reviews, but the Committee was not satisfied on the balance of probabilities that the formal reviews actually carried out were inadequate.

189. Accordingly, the Committee found this allegation not proved.

16 - not proved

190. Patient A said that although she could not recall at which appointment it occurred, on one occasion Mr Mathew said to her *"They fucked up your neck."* She recalled that he was standing beside her left shoulder in room 1 when he made the comment and his voice was very quiet, so she did not think anyone else would have heard what he said. Patient A said that although she could not remember the appointment at which this was said, it was about half-way through her treatment. In terms of context she said that she was having pain and was talking to Mr Mathew about the operation she had at the Parkside Hospital. She said she replied something to the effect of *"the operation was not successful."* In her oral evidence she said that she thought it was a very unprofessional statement to have made and she therefore made a note about it. She thought this comment was made before the 27 February 2017 appointment, although she could not be sure. She accepted it was not in her original complaint, however she said she had made notes but had subsequently shredded them.

191. Mr Mathew's evidence was that this was simply not said and he would never use such words to a patient.

192. Laura Attridge, a Chiropractic Assistant at the Clinic, was present at a number of the occasions when Patient A received care. She said she was not aware of anything untoward occurring during those appointments and she had never heard Mr Mathew swearing when the clinic was running.

193. Jan Beytell, the Clinic Practice Manager, said that he was aware of Patient A and her husband and although he was not present during any of the care given to Patient A, he had never heard Mr Mathew swearing in the clinic or using the term *"fucked up".*

194. *S*uzanne Moreno, a Technical Chiropractic Assistant at the Clinic, said that she had never been present when such words as this had been spoken by Mr Mathew.

195. This was essentially a case of one person's word against another, since it was not known when these comments were alleged to have been said and thus whether or not Ms Attridge or others would have been present. Since the Committee found both Patient A and Mr Mathew to be credible witnesses, it was not possible to say, on the balance of probabilities, that this comment had been made. The Committee took into account the

evidence of other staff members at the Clinic who had never heard Mr Mathew using this type of language and also Mr Mathew's good character which supported his credibility.

196. The Committee therefore found this Particular not proved.

17(a) - not proved

197. At her appointment on 18 January 2017, Patient A said she told Mr Mathew that she was in a lot of pain and he said *"Shall we make you better?"* Patient A said that she and her husband made it clear that she was only there to treat her pain and that at no time did Mr Mathew say he could not do so. She said she *"assumed he would tell me if he could not get rid of the pain."*

198. Patient A said that at the appointment on 27 February 2017, she told Mr Mathew that she had been suffering badly, with pain in her right arm and shoulder. She said that Mr Mathew, shortly afterwards, said to her in a loud voice, "*I never told you I could get rid of the pain … because of the operation."* He then said he could treat subluxation. Patient A said she was in shock and did not reply. She said she felt sick. She was only there to get rid of the pain. She said that if Mr Mathew had told her that he would not be able to get rid of the pain when she first went to him, she would not have booked any treatment sessions. When cross-examined, she accepted that at no time had Mr Mathew specifically said that he could get rid of her pain.

199. Mr A, who was present at the appointment on 18 January 2017, said that Mr Mathew did not specifically say that he could get rid of the pain, but he, Mr A, made it categorically clear that that was why they were there. Mr A said there were no caveats or negativity and there was nothing mentioned that would suggest that the treatment would not remedy the pain that his wife was experiencing. Mr A said that Mr Mathew was very positive and charming and he told Mr Mathew that he had given them hope and they believed he could get rid of the pain. Mr A heard Mr Mathew say to his wife, *"Shall we make you better?"*

200. Mr Mathew said he probably did say words to the effect that he never told her he could get rid of the pain at the appointment on 27 February 2017, but denied previously ever having said or suggesting that he could. He therefore denied that, if he did say those words, they were in any way contradictory to advice given by him at the outset.

201. The Committee thought it more likely than not that on 27 February 2017 Mr Mathew had said to Patient A words to the effect of *"I never told you I could get rid of the pain."* The allegation, however, was that this was contrary to the advice that he had given to her at the outset of her treatment. The Committee did not doubt that Patient A and Mr A had formed the view at the outset that Mr Mathew could indeed get rid of the pain. However, they both accepted that he had not in fact said in terms that this is what he would do. The Committee did not feel able to infer from the comment, if indeed it was made, *"shall we make you better"* that Mr Mathew had advised Patient A that he could get rid of her pain. In all the circumstances the Committee could not be satisfied, on the balance of probabilities, that Mr Mathew had advised at the outset of treatment that he could get rid of Patient A's pain.

202. The Committee therefore found this Particular not proved.

17(b) - not proved

203. Patient A said that Mr Mathew was treating her differently and his tone of voice was very firm and he also said, *"If you want I can finish your adjustments and put you back where you were."* Patient A said that sounded to her like a threat and she felt numb as a result. She said she felt shocked and humiliated as there were other patients waiting behind the divide in the treatment room who would have been able to hear what had been said.

204. Patient A said that as she left the treatment room there were five people waiting to be treated and she felt terribly embarrassed because Mr Mathew had been *"having a go at me."* One of her friends was waiting and he would usually say hello and wave, but on this occasion he was looking at the floor. She left the Clinic and told her husband who was waiting in the car. She said he was furious, but she wanted to get better and Mr Mathew had initially given her hope so she thought she must continue with the treatment notwithstanding his behaviour. Patient A said that after what had happened her husband advised her to make notes so that is what she did as soon as she got home. She later used those notes to write her report, but then shredded the notes because she did not think she needed to keep them. Patient A said that despite what had happened she decided to continue because she wanted to get better. However, by that point she had lost faith in Mr Mathew. She said she did not raise her concern directly with Mr Mathew

because she was afraid of how he would react. Patient A said that at the next appointment, on 20 March 2017, Mr Mathew made no mention of the previous appointment, but he was charming and being overly helpful which made her think he was feeling guilty about the way he had behaved. She therefore continued with her treatment.

205. Mr A attended the appointment on 20 March 2017 with his wife because she felt uncomfortable about being alone with Mr Mathew following his behaviour on the previous occasion. He said that when Mr Mathew walked in he seemed ill at ease, his whole demeanour was different from the last occasion he had seen him, on 18 January 2017, and he was less self-assured. Mr A said that at one stage Mr Mathew faced his wife, put his hands on her upper forearms, looked her in the eyes and said, *"You know that sometimes I have to be stern with you"* or words to that effect, which Mr A found bizarre behaviour. Patient A also made reference to this same comment.

206. Mr Mathew denied saying he could put Patient A back to where she was, he said he would never say anything like that in his practice. He said that he could have said *"if you want to finish your care my fear is that you would go all the way back to where you were before and lose out on the gains we have made."* He denied that this was effectively saying the same thing as that which was alleged or that it was in any way meant as a threat to continue her treatment. He said he would never put somebody back to where they were. He denied it was anything to do with the tone he used.

207. The Committee noted that this was not a Particular where it was alleged that it was these words or *"words to that effect"* that were said. There were two opposing accounts and whilst similar words may have been used in each they could not otherwise be reconciled. Putting someone back to where they had been and relapsing back are quite different. Patient A was clear that she thought what was said sounded like a threat. Mr Mathew was equally clear that he would not have threatened a patient, but that he may well have expressed his concern that if she were to stop treatment she might lose the gains she had made. In the circumstances the Committee could not be satisfied that Patient A's account of what was said was accurate and furthermore, Mr Mathew had provided a plausible alternative.

208. The Committee therefore found this charge not proved.

18 - dismissed following half-time submission of no case to answer

19 - admitted and found proved

209. Patient B said that she had been suffering with back and neck pain and that Mr Mathew was recommended to her by her mother, Patient A, who was receiving chiropractic treatment from him. She attended the Clinic for the first time on 6 February 2017, to undergo initial scans. The next, and only other, time she attended was the day of the talk and her second appointment on 21 February 2017. At that appointment Mr Mathew discussed the scan and told Patient B that there was a link between the tension she was experiencing at the top of her neck, and in the right side of her back, and her liver and gall bladder. He advised her to start with three sessions a week for four weeks and then left her with an assistant to discuss payment plans.

210. Mr Mathew admitted he provided chiropractic treatment and/or advice to Patient B between 6 February 2017 and 22 February 2017.

20 - admitted and found proved

211. Patient B told the Committee how, at a consultation with Mr Mathew on 21 February 2017, she told him that she was six and a half weeks pregnant. She said that Mr Mathew then said to his assistant, who was taking notes, *"6.5 weeks pregnant; confidential information."*

212. Mr Mathew admitted this Particular.

21 - admitted and found proved

213. Patient A said that during an appointment with Mr Mathew on 22 March 2017, he asked her in a loud voice, *"How is your daughter?"* This made Patient A feel uncomfortable because she knew he was referring to Patient B who had, by that point cancelled all her appointments with him and intended making a complaint against him. Patient A said that she responded by saying that she had two daughters. She said that Mr Mathew then spoke very quietly to her and she heard the words *"she"* and *"pregnant"*. She said she responded by saying she didn't know and that Mr Mathew then *"quietly uttered*

the word "trying" and I responded again saying I did not know." Patient A said that Mr Mathew said nothing more, but she understood that he was trying to tell her that Patient B was pregnant or trying to become pregnant. She said nothing to Mr Mathew but did tell her husband who was waiting in the car for her outside.

214. Patient B said that the information about her being pregnant was confidential and she had not given her consent for it to be revealed to anyone. Patient B said that she and her husband had planned to tell her mother, Patient A, about the pregnancy on Mothers' Day. However, when they gave her mother a Mothers' Day card announcing the pregnancy it was apparent that she already knew and she told them how that was the case. Patient B said she was shocked, disgusted and angry when she discovered that Mr Mathew had passed this news on to her mother without her consent. Patient B said that, *"telling your mother you are pregnant should be a very special moment and he took that away from us. Mothers' Day was ruined."* Patient A said that she was very cross because she felt that Patient B had obviously confided in Mr Mathew, who had then told her. She said her trust for him completely went and she consequently cancelled all further appointments with him.

215. Mr Mathew admitted this breach of patient confidentiality.

COMPLAINT 3

22 - admitted and found proved

216. Patient C said that she received treatment from Mr Mathew between March 2016 and January 2017 at the Clinic.

217. Mr Mathew accepted that he treated Patient C during this period.

23 - admitted and found proved

218. On 24 May 2017, Patient C obtained copies of all her x-rays from the Clinic. In the envelope she was sent there was a chiropractic radiologist's report from Grace Radiology Consulting in New Zealand dated 24 March 2016, which analysed her x-rays. The report ("the Grace Report") records the referrer as Dr Ben Mathew and stated under

"Impressions", "Bilateral hip arthritis, advanced on the right. Orthopaedic referral for care options and MRI is recommended." A copy was provided to the Committee.

219. Mr Mathew admitted this Particular on the basis that he accepted the Grace Report had been received by the Clinic about two hours before Patient C attended for the Report of Findings, although he would not necessarily have seen or been able to access the Report.

220. Overall, the Committee found it necessary to treat Patient C's evidence with caution. She maintained that Mr Mathew never mentioned her hips on any of the occasions that she visited him and yet there are a significant number of entries (16 or more) in the records where the hips are mentioned. Patient C said that those entries were all made up and not true. The Committee also noted that Patient C denied she was diagnosed or told by her GP that she had osteoarthritis in her right knee, notwithstanding there being two entries in her GP notes to this effect, from a time prior to her first visit to Mr Mathew.

24(a) - proved

221. Patient C said she met Mr Mathew for the first time on 29 March 2016. He *"went through"* her x-rays and explained that they *"…confirmed his diagnosis of a head forward condition".* Patient C said that Mr Mathew made no mention of any problems with her hips and he did not refer to the Grace Report and its *"Impressions".* She said he produced a Report of Findings which recommended a plan of 48 treatments over 6 months and she duly signed up. Patient C said that she only became aware of the Grace Report on 24 May 2017 when she collected copies of all her x-rays from the Clinic.

222. Mr Young said that Mr Mathew's notes for the Report of Findings on 29 March 2016 say that Patient C's knee pain *"may well be linked to the Vertebral Subluxation Complexes identified in the physical exam."* He has also recorded that, *"Incidentally, advanced degeneration "wear and tear" has been identified in both hips, greater on the right though currently asymptomatic may be altering gate* [sic] *and should be monitored as part of explained care plan."* Mr Young thought this suggested that the information about her hip arthrosis from the Grace Report had been imparted to Patient C, because *"wear and tear"* was synonymous with arthrosis.

223. Mr Mathew said "*I would point out that our system then was that examining chiropractors would conduct the initial assessment and their findings, together with x-rays if necessary, were often referred to Dr Grace in New Zealand for her views. Dr Grace has recommended a referral for care options, including an MRI scan. Orthopaedic care options could take a variety of care routes including conservative care if necessary. Dr Grace did not have the benefit of carrying out her own examination of the patient and, even though she provided a report at our expense the ultimate recommendation for care rests with the chiropractor whose patient she is, not Dr Grace. The patient was not charged for Dr Grace's report. Having said this my usual practice was then and is now always to report to patients on x-rays and any report received from Dr Grace in their case, in particular if there is a recommendation for a MRI report. As I make clear in this statement I maintain I did refer Patient C to the fact she had "wear and tear" in her hips, particularly the right hip though currently asymptomatic. Although I cannot specifically remember I believe because it is my normal practice that I would have referred her to Dr Grace's report and recommendations, if not at the appointment on 29th March 2016 then on a subsequent appointment when it would have come to my attention. As her symptoms were improving the hips were not the focus of my care, however, we were monitoring them and they were subsequently the subject of review and re-x-ray later in the year in the course of her treatment. After this length of time it is very difficult to remember clearly and I am relying on my normal practice and the reference to her hips in the chart notes. I have been asked why if I did say that Dr Grace had recommended referral for orthopaedic care options and a MRI that I did not also recommend this. I would say it was because she was responding to conservative care, her hip remained asymptomatic, I would have taken into account my experience of patients I had referred for NHS orthopaedic care options and MRI and as is apparent from her statement she wanted to try a holistic approach to her health. So as her hip was asymptomatic and as she wished care in relation to her knees and carpel tunnel syndrome we could nevertheless continue with conservative care and keep her hips under review. From my experience there may be a considerable delay in the NHS following up on orthopaedic care options and in particular a MRI in relation to asymptomatic hips. I cannot specifically recall if I mentioned private orthopaedic care options and MRI for her. I strenuously deny that I would deliberately withhold this information from a patient for dishonest personal gain. I have been in practice for 12 years and have no previous disciplinary findings or criminal convictions or cautions against me. There is no way I would put the career I love at risk by dishonest conduct of the sort alleged against me by the GCC."*

224. The Committee noted that the seven *"Impressions"* from the Grace Report appeared in Mr Mathew's chiropractic notes dated 29 March 2016, which was when Mr Mathew first saw Patient C, although it had not been established when the notes were entered. It was apparent that they were a *"cut and paste"* from the original Grace Report and Mr Mathew said that this would have been done by one of his assistants. However, he could not say when the entry had been made and that, whilst the report had been received by the time he saw Patient C on the evening of 29 March 2016, he could not say whether he had actually seen the Report itself or the entry in the notes prior to, or at the time, when he had his appointment with her. He said that it would have been uploaded to a different screen and because his IT skills were limited he may not have accessed it at the time. However, he said it was inconceivable that he would not have passed on the information to Patient C either at the Report of Findings, or at a subsequent appointment. In any event, he had identified the advanced wear on the hips and had passed this on to Patient C in layman's terms, referring to *"wear and tear in both hips, particularly the right"*. The Committee concluded that, if Mr Mathew had not told Patient C of the Grace Report recommendation for orthopaedic referral at the Report of Findings on 29 March 2016, there was no obvious trigger in subsequent events which might have prompted him to mention this to Patient C. It seems highly likely that the following appointments would have involved only a short interaction between Mr Mathew and Patient C, because of the manner in which he organised his practice, and there is nothing in the notes to suggest that any belated reference was made to this recommendation.

225. Mr Mathew insisted that he often makes referrals to medical practitioners and would always do so where he felt it was necessary and where the patient agreed. In support of this assertion the Committee had the benefit of a statement from another of Mr Mathew's patients, JT, who said that she saw Mr Mathew in May 2017. There was a full examination and x-rays were taken, but not adjustments as Mr Mathew, *"… made it clear to me that he did not wish to work on me until he knew the results of the x-rays."* JT said that she returned to see Mr Mathew when the results of the x-rays have been received and they revealed that she had advanced osteoporosis. She said Mr Mathew advised her to consider having a DEXA scan (Duel energy x-ray absorptiometry) and that he would not begin care until that was obtained. JT said that Mr Mathew asked her if she wanted him to write a referral letter to pass on to her GP. She said she did and this was done. She said that once the results of the DEXA scan were known, Mr Mathew began caring for her and helped her with her pain. This example demonstrated to the Committee the approach ordinarily taken by Mr Mathew and, having seen and heard from him, the Committee was

satisfied that he would not have deliberately withheld the results of the Grace Report on Patient C's x-rays.

226. In all the circumstances the Committee concluded that it was unlikely that Mr Mathew had informed Patient C about the recommendation in the Grace Report. There is no evidence in any of the records that he had done so and Patient C denied she had ever been told and hence her shock when she saw the report in May 2017. Whilst the Committee placed limited weight on her evidence, for the reasons referred to in its findings on Particular 24(b) below, in this instance the lack of records supported her account. The Committee looked with care at all the mentions of hips that appear in the Chart Notes, but none of them even hint at him having mentioned the Grace Report. The first mention of 'referral' is not until 10 November 2016 and follows a lack of improvement at that stage causing Mr Mathew to question whether the knee pain might be linked to the hip. He then considered x-raying the pelvis again and possibly making a referral. This entry rather suggested that this was the first time that he had considered the possible link between the knee and the hip and thus the possible need for a referral. That conclusion did not support his assertion that he would have seen the Grace Report and passed its recommendations on to Patient C. The Committee did not consider this omission was in any way deliberate, but more probably resulted from his poor record keeping and the fact that once the *"Impressions"* from the Grace Report had been pasted into the Chart Notes on or around 29 March 2016, thereafter there would have been nothing to prompt Mr Mathew to pass on that information.

227. The Committee therefore found this Particular proved.

24(b) - not proved

228. Patient C said that during her appointment with Mr Mathew on 29 March 2016, he made no reference to any problems with her hips. Following many months of treatment, Patient C said she had a meeting with Mr Mathew on 28 November 2016, to review her progress. Patient C said that it was at that meeting that Mr Mathew said she should have her x-rays re-done to see if there was a reason for the lack of progress with her mobility. Those x-rays were taken on 7 December 2016. Patient C said that on 15 December 2016 Mr Mathew explained to her that the x-rays had shown nothing of any significance but gave him better information about how to treat her. She said that he made no mention about the state of her hips. Patient C told the Committee how, on 11 May 2017, she saw a Consultant Orthopaedic Surgeon, Mr White, who, having obtained x-rays,

informed her that she had a grossly arthritic right hip that required replacement as a matter of urgency. That was carried out on 20 June 2017.

229. Mr Mathew said, "*I did not say to the patient that she had advanced hip arthrosis on the right. I try to use everyday language that patients will understand and would not have used the word "arthrosis" but I would have used the word "wear and tear". On page 49 of the bundle the following is produced in the Chart Notes for this date "Incidentally advanced degeneration "wear and tear" has been identified in both hips greater on the right, though currently asymptomatic, may be altering gate* [sic] *and should be monitored as part of explained care plan". I believe this wording in the notes is mine. My handwriting appears on the report on findings sheet on page 621 of the bundle starting with the words "1st phase". Furthermore the appointment is shown as being at 7 pm. By this time I believe that the chiropractic assistant would have finished for the day. I believe I saw her and her husband on my own. I am not as computer literate as I would like and this was a new system at the time. 29/3/16 was a Tuesday. My practice at that time if I was on my own (without an assistant) was to write down relevant details from the report on findings appointment with the patient and then enter them in the chart notes on my Administration day (which was a Friday) or to ask an assistant to record the details on the chart notes for the patient. I believe these words were the conversation I would have had with Patient C, in particular the words in inverted commas i.e. "wear and tear" .I would have realised about the wear and tear from the x-rays which were taken. I do not believe that I was aware of the recommendation from Dr Grace when I saw Patient C on 29th March 2016 and I believe I would have followed my usual practice and reported it to her on a subsequent occasion when it came to my attention. I cannot now remember when that was. I therefore deny this allegation."*

230. Mr McCrossin said that in describing findings it is commonplace and good practice to use lay person's language so that a patient may better understand their findings. He said if Mr Mathew had explained to Patient C that she had *"wear and tear"* in describing her hip arthrosis then this would have been reasonable.

231. Mr Young agreed that *"wear and tear"* was synonymous with arthrosis.

232. The Committee preferred the evidence of Mr Mathew that he told Patient C that wear and tear had been identified in both hips, greater on the right. As explained above, the Committee treated Patient C's evidence with caution on this issue. Her evidence was in clear contrast with the evidence given by Mr Mathew and contained

within the clinical notes. The Committee saw no basis for Patient C's assertion that the records in relation to various references to her hips had been altered or fabricated. This would have required a significant level of IT skills on the part of Mr Mathew, together with the collusion of other members of staff. This is inherently unlikely and is unsupported by any independent evidence.

233. The Committee was satisfied that it was more likely that Mr Mathew had informed Patient A that she had *"wear and tear"* in her hips, greater on the right, as recorded in the Chart Notes. Whilst this is not the same as saying *"advance hip arthrosis on the right",* the Committee accepted the evidence of Mr McCrossin that it was a reasonable lay person's explanation. This was further supported by Mr Young's acceptance that *"wear and tear"* was synonymous with arthrosis.

234. The Committee therefore found this Particular not proved.

25 - proved

235. Patient C said that Mr Mathew informed her that her x-rays showed a head forward position and that her head and body were not in alignment. He provided her with a Report of Findings and said she needed a series of adjustments. He proposed three a week for eight weeks followed by twice a week for six weeks and then finally weekly sessions for 12 weeks, a total of six months. Patient C said she signed up for 48 sessions and then later, in September 2016 a further 48 sessions. The Committee noted that Patient C had not signed the consent form at the beginning of the treatment. Mr Mathew said that it was an administrative oversight. The Committee recognises that the mere signing of a consent form is not, in itself, indicative of fully informed consent being given by the patient, but the Committee cannot condone the poor practice which led to an incomplete record being made.

236. This allegation was predicated on the alleged failures in Particular 24. In the Committee's view, it was likely the Mr Mathew had told Patient C about the wear and tear to her hips and that his plan of treatment was not aimed at treating this condition (or indeed any other specific symptoms). However, by failing to inform Patient C of the Grace Report's recommendation for orthopaedic referral, he had not fully explained her treatment options to her. Consequently, it cannot be said that her consent was fully informed.

237. To this extent, the Committee found this allegation proved.

26 - not proved

238. Patient C said that in March 2016, Mr Mathew had an expert radiologist's report on the need for her to have an orthopaedic referral because of hip problems. She said that was before she started chiropractic treatment and she was thus concerned about how and why Mr Mathew did not act on the information provided by Grace Radiology Consulting and share the information with her.

239. Mr Young said that what was contained within the Grace Report was not a mandate to refer, it was a recommendation. He added, however, that if one employs an expert and they give a clinical recommendation then there would have to be a strong reason for ignoring the recommendation and be sure you are acting in the patient's best interests. He said he would expect that to be noted in the records. He accepted the there could be reasons not to refer but he would expect there to be a note of the discussion within the notes.

240. Mr McCrossin said that there was clearly an obligation on Mr Mathew to discuss the referral recommendation in the Grace Report, but the decision would be the patient's to make and for any referral there would have to be the express agreement of the patient to make the referral.

241. Mr Mathew said, "*Dr Grace recommended referral for orthopaedic care options and MRI, not necessarily orthopaedic assessment and/or care. Whilst I cannot specifically remember, I believe because it was my normal practice to tell patients about Dr Grace's recommendations that I would have told her this during the course of her care, when Dr Grace's report became known to me. I did not refer her for orthopaedic care options and MRI because I believed I could care for her for the conditions she was seeking help with and her hips were asymptomatic. It was my belief that Patient C wanted a holistic approach to her care."*

242. The Committee was not satisfied that Mr Mathew was under a duty to refer Patient C for orthopaedic assessment and/or care. It was satisfied that he had a duty to discuss the Grace Report recommendation with Patient C, but the decision to refer could only have been made once the patient had consented to such a referral.

243. If there was no duty there could not be a failure and therefore the Committee found this not proved.

27(a) to (e) - not proved

244. Mr Mathew said, "*The treatment plan given to Patient C was never intended specifically for her hip condition. She asked for care in relation to her knee and hand. I maintain the treatment plan was appropriate … The reference in the chart notes to wear and tear of her hips, especially on the right would suggest that I did diagnose wear and tear on her hips. However the hips were asymptomatic and were not the stated purpose of her visit for care."*

245. Mr Young said that Patient C presented with two complaints: knee pain and carpal tunnel syndrome. He said that on the balance of probabilities her median nerve systems arose from a 'double crush injury' in the wrist and cervical spine and these symptoms appear to have resolved early in her course of care following cervical spinal manipulative therapy. He added that, on the balance of probabilities, her knee symptoms arose from her degenerate hip, although her hip was never tested orthopedically to determine whether it created the knee pain. He said, *"As such, it should at least have been considered as a differential diagnosis and re-visited either during re-assessment or when it became clear that Patient C was continuing to experience knee pain. Dr Mathew appears to have attributed all of Patient C's symptoms to 'vertebral subluxation.' My opinion is, therefore, that the treatment plan was not informed by an adequate diagnosis."*

246. Mr McCrossin said that the use of the colloquial term *"wear and tear"* in describing the arthrosis was essentially correct. He added that the notes record, *"the care plan to be explained will not be focussed specifically on treating her health concerns, instead on the removal of VSC (vertebral subluxation complex) to enhance her neurological function and improve her innate ability to heal and self regulate."* He said it was also noted that *"Patient C was informed that care provided will be focused on the removal of subluxations and not the treatment of symptoms. Patient C presented with right-sided carpal tunnel and bilateral knee pain. Ben Mathew has made a note that these may be related to her vertebral subluxation complexes along with neck pain."* He added, *"It appears that the proposed treatment plan is focussed on the removal of subluxations rather than to treat Patient C's hips and the right hip in particular, which was*

asymptomatic." Mr McCrossin concluded that, whilst there is some debate in the profession about the use of the term subluxation, it is nonetheless a widely used and accepted term and diagnosis within the profession.

247. The Committee was satisfied that Mr Mathew's treatment plan for Patient C was not aimed at the issue in her right hip, but rather was intended to deal with her subluxation and accordingly the whole premise of Particular 27 was absent. It was agreed that hip arthrosis is not a contraindication to chiropractic treatment. The Committee did not find that Mr Mathew deliberately withheld the Grace Report recommendation and it had found that he had identified the advanced hip arthrosis. The Committee accepted that the treatment plan was designed to address the patient's overall health whilst monitoring and providing palliative care for knee pain and was not aimed at the hip condition. The Committee concluded that the stem of Particular 27 was not therefore made out and it followed that the sub-headings, which were all predicated on the stem, must also fall.

248. It followed that Particulars 27 (a) to (e) were found not proved.

28 - not proved

249. The Committee did not find Particulars 26 and 27 proved. In relation to Particular 24 the Committee had already indicated that it did not believe Mr Mathew deliberately withheld information in the Grace Report from Patient C, but rather this had been an oversight, likely to have been brought about by his poor record keeping and monitoring and exacerbated by his business model and the pace and volume of his business. There is evidence in the Chart Notes of the hip being mentioned on many occasions and at any time Patient C could have asked to see her notes and would have seen the Grace Report *"Impressions"* pasted in on 29 March 2016. Mr Mathew had also provided a copy of the Grace Report when requested to provide Patient C's records. None of this suggested that he had deliberately withheld the content of the Grace Report from Patient C. Furthermore, the Committee was satisfied that, in light of his good character, such action would be highly improbable.

250. The Committee therefore found this charge not proved.

29(a) & (b) in relation to 28 not proved

251. Patient C said that Mr Mathew was in possession of significant information regarding her x-rays that he should have shared with her. Instead, from April 2016 to January 2017, Mr Mathew provided her with chiropractic treatment without acknowledging her existing adverse medical condition. Patient C said that she had an arthritic hip which required replacing and therefore Mr Mathew should have told her in March 2016 that he could not treat her. Instead, he allowed her to purchase two care packages and proceeded to treat her over a period of ten months for a condition that was untreatable by chiropractic. Patient C said she had paid over £2,000 for chiropractic treatment over ten months, which could never have resolved the problem of her arthritic hip.

252. The GCC alleged that this was done for financial gain and was therefore dishonest.

253. Mr Mathew emphatically denied this and said that integrity and honesty underpinned all that he did.

254. As already stated, the Committee was satisfied that Mr Mathew did acknowledge Patient C's adverse medical condition at the very outset of his treatment during the Report of Findings on 29 March 2016, and it was not persuaded that Mr Mathew had deliberately withheld the Grace Report from Patient C and that he had done so for financial gain. The Committee concluded that this had been an oversight, exacerbated by his business model and the pace and volume of his business. The Committee was satisfied that ordinary decent members of the public would think he was over-stretching himself somewhat, but not that he was dishonest or that his actions were financially motivated.

255. The Committee therefore found Particulars 29(a) and (b) not proved.

30 - proved

256. Mr Young said that Dr Grace in her report of 24 March 2016 clearly identified the severe degenerative joint disease in the right hip from the x-rays taken on 21 March 2016. He said that a further plain film hip series of x-rays would not advance the diagnosis and was therefore unjustifiable in terms of weighing patient benefit against the potential harm from ionising radiation. He added that although a failure to respond to treatment may

be a justification for x-rays, this generally applied to patients who have not previously had x-rays.

257. Mr Young added that Mr Mathew had not taken a specialist view of the hip in December 2016, he had merely repeated the view of the pelvis, albeit with better collimation. He said this would not have told him anything he did not already know. He said that would have been the time, albeit belatedly, to consider referral for an MRI scan which can give far more information about the hip. Such a scan shows the cartilage, is more sensitive in identifying changes to the bone marrow in terms of cyst formation, one can view the ligaments and it also allows one to view the capsule and surrounding bursi. Mr Young concluded that he could not see any logical or rational reason to retake exactly the same view.

258. Mr Mathew denied this allegation. He said, *"I maintain that once she* [Patient C] *started experiencing stiffness in her hip with less range of motion (which she had not done previously) even though they were not causing pain an x-ray would assist with regard to attempts to deal with this symptom which had recently arisen. The original x-rays were a lumbar pelvic x-ray which also viewed the medical acetabulum and partial hip bilaterally not giving a full understanding of the complete integrity of the joints."*

259. The clinical note dated 17 November 2016 stated, *"has been away working but she did get some rest. couldn't walk very far, legs have not been good, really frustrated as had been doing very well. We have decided to take some further X arys* [sic] *of knees and pelvis to re assess the situation."* The note from the preceding appointment dated 10 November 2016 stated, *"weight distribution still poor on the right, maybe that rip hip is starting to cause issue re mechnicas* [sic] *and loading though still asymptomatic, could be causing referral to knee, though knee clears when adjusted?? Must consider re x raying pelvis and poss referral."*

260. Mr McCrossin said the process of justification is something the practitioner has to go through, and decide do the benefits outweigh the risks. Patient C was not responding as Mr Mathew felt she should have been and he therefore needed a more thorough investigation of the hip and thus taking the additional x-ray was justified. He did not agree that it was clinically unnecessary because of the earlier x-ray which showed hip arthrosis, because that earlier view had not visualised the entire hip. He said the x-ray was justified to see if the arthrosis had progressed. There had been improvement over a number of months which then appeared to stop. It was not known if that meant the

improvement had plateaued or whether it had relapsed and may therefore benefit from further care.

261. As with the earlier allegation relating to the taking of x-rays, the Committee considered the starting point to be IRMER, and its requirement that in justifying x-rays the benefits must outweigh the risks. It noted that the decision whether to take x-rays is very much a clinical decision by the practitioner based on all the presenting facts.

262. In this instance Mr Mathew already had x-rays showing the advanced hip arthrosis and they were of diagnostic quality. It was true that they could have been more complete because they did not show the lateral aspect of the hips, but enough of both hips was visible for an experienced chiropractic radiologist (Dr Grace) to make a report identifying the severity of degeneration and to make a recommendation. This illustrated that the x-rays were good enough to make a decision on an appropriate plan of treatment without having to take further images of the area. The Committee thus concluded that the further x-rays taken on 7 December 2016 were unjustified and that accordingly Patient C was unnecessarily exposed to the risks of ionising radiation.

263. The Committee therefore found this charge proved.

UNACCEPTABLE PROFESSIONAL CONDUCT

264. Having found a number of the facts proved, the Committee then considered whether they amounted to Unacceptable Professional Conduct ('UPC'), which is defined in the Chiropractors Act 1994 as conduct which falls short of the standard required of a registered Chiropractor. In deciding whether the facts found proved amounted to UPC, the Committee took into account all the evidence provided, both oral and written, together with the submissions made by Mr Hamlet and those made by Mr Goldring. The Committee accepted the advice of the Legal Assessor.

265. The Committee was invited to consider the factual basis of Particulars 6 to 9 that concerned the production and dissemination of the Health Check Pass cards containing misleading claims in relation to the efficacy of chiropractic treatment provided at the Clinic. Mr Mathew said it was not an element of the business that he dealt with. He delegated the production to a consultancy and relied on his wife and Practice Manager to deal with the content. Mr Hamlet on behalf of the GCC submitted that it was inconceivable

that he would not have been involved in the production and would not have been aware of the contents of the card, which were in circulation for many years promoting him and his clinic.

266. The Committee considered that either Mr Mathew knew about the content of the cards and allowed them to be used, which is serious, or he completely closed his mind to them and disregarded his responsibility of ensuring any such material was accurate and complied with the relevant standards, which is equally serious and so would make no difference to his ultimate culpability. As the owner of the business he was responsible for the content of the cards and since either view would, in the Committee's view, be equally serious, the Committee did not find it necessary to decide this matter one way or the other.

267. When deciding whether or not the facts found proved amounted to UPC the Committee found there to be breaches of the following parts of the 2010 Code of Practice in relation to Particulars 24(a) and 25:

Standards

B3: Accurate, relevant and clear information: essential components of consent - you must share with patients the information they want or need to make decisions about their health and wellbeing, their health needs and related care options.

Guidance

2. The information that is usually shared with patients includes:
(b) options for care;
(g) any reasons for referring the patient to another healthcare professional or for your working with another healthcare professional to treat them.

268. When deciding whether or not all the other facts found proved amounted to UPC the Committee found there to be breaches of the following parts of the 2016 Code (Standards of conduct, performance and ethics for chiropractors):

B3 - you must use only honest, legal and verifiable information when publicising yourself as a chiropractor, advertising your work and/or your practice … The information must comply with all relevant regulatory standards.

C3 - you must use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must document. You must keep the patient fully informed.

C8 - you must ensure that investigations, if undertaken, are in a patient's best interests and minimise risk to the patient. All investigations must be consented to by the patient. You must record the rationale for, and outcomes of, all investigations. You must adhere to all regulatory standards applicable to an investigation which you perform.

H1 - you must keep information about patients confidential and avoid improper disclosure of their personal information.

269. Whilst accepting that not every breach of the Code will amount to UPC, the Committee noted that it had found a significant number of Particulars proved in this case on matters including: the making of misleading comments at a talk, with the potential to deter parents from having their children vaccinated against measles and women from participating in mammographic screening to detect breast cancer; through the use of the Health Check Pass cards, the making of inappropriate claims about the efficacy of chiropractic or its potential for the treating of certain conditions, where he either knew, or ought to have known, it was inappropriate to do so; a gross breach of patient confidentiality; an oversight which led to a patient not being properly informed about her care options which impacted upon the validity of her consent; failures to comply with the statutory requirements of IRMER in the taking of unjustified x-rays, thereby exposing patients to the risk of unnecessary and harmful radiation; poor record keeping in a variety of areas including the recording of diagnosis and the reporting on radiographs.

270. The Committee considered that Mr Mathew's conduct demonstrated a lack of the responsibility required when practising as a healthcare professional. These were wide ranging failures in fundamental aspects of chiropractic and the Committee was satisfied that, when considered collectively, his conduct fell far below the standard required of a reasonable chiropractor and amounted to Unacceptable Professional Conduct.

SANCTION

271. 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 Mr Hamlet. It also considered the Guidance on Sanctions issued by the GCC. The Committee was cognisant of the fact that the purpose of sanctions is not to punish Mr Mathew but to protect the public, maintain public confidence in the profession and maintain proper standards of conduct. The Committee considered each sanction from the least serious before deciding the appropriate sanction and accepted the advice of the Legal Assessor.

272. The Committee considered the following to be aggravating factors: although not its primary function, the talk touched on difficult, highly emotive subjects for potentially vulnerable groups of the general public, namely parents of young children who may have had concerns about vaccinations and women who may have had concerns about breast cancer; gross breach of trust with regard to patient confidentiality; risk of harm to patients.

273. The Committee found the following mitigating factors: a previous unblemished career; insight as demonstrated by admissions to a number of the allegations; action taken to remove the offending Health Check Pass cards; action taken to ensure his talk does not stray into areas upon which he is not qualified to speak; apology; significant number of relevant testimonials; evidence of changes made to forms and practices used by the Clinic and aimed at addressing some of the issues in this case; attendance on an IRMER update course.

274. The Committee noted and was pleased to see the changes Mr Mathew indicated have been made at the Clinic and his attempts to address some of the issues raised in this case. The Committee was satisfied that Mr Mathew was now aware of the issues that he should avoid during any talk given at his Clinic and the importance of guarding against the inadvertent making of misleading comments. The Committee noted that Mr Mathew intends to stop the talks and replace them with a pre-recorded introduction to the Clinic and chiropractic, in order to avoid the possibility of any impromptu inappropriate comments. The Committee was reassured by this approach. The Committee was also satisfied that Mr Mathew was aware of the need to ensure that any advertising or promotional material complied with the relevant standards. The Committee noted that the conditions that had appeared on the cards were conditions that chiropractors do treat but which are not supported by Level One evidence (as required for promotional material), rather than being conditions that are simply not treatable. In any event Mr Mathew had withdrawn those cards some time ago. The Committee was also satisfied that Mr Mathew was most unlikely to repeat a breach of confidentiality and had

shown insight by his ready acceptance of the allegations relating to the breach and his offer of an unreserved apology.

275. There remained, however, a number of significant clinical failings that had been found proved and were of concern to the Committee, particularly in relation to record keeping and the taking of, reporting on, radiographs. The Committee was encouraged to see that Mr Mathew and his staff had attended radiographic courses well before the factual decisions made in this case. Generally, the Committee noted the changes and administrative safeguards Mr Mathew is said to have now put in place. However, it was not possible to know, without some objective independent scrutiny, whether those safeguards, and the changes to his practice identified by Mr Goldring, were effective and being consistently followed.

276. The Committee first considered an admonishment, but determined that the facts found proved against Mr Mathew were of sufficient seriousness that an admonishment would be both disproportionate and insufficient. The Committee had found that Mr Mathew had made wide-ranging and fundamental errors in his clinical practice in relation to three patients over a considerable period of time. The Committee considered that whilst Mr Mathew has demonstrated some insight into his failings, by way of his admissions and the steps he has taken to remedy failures identified in this case, that insight has yet to be fully developed. The Committee was of the view that Mr Mathew's conduct was not at the lower end of the spectrum. Importantly, an admonishment would not protect patients, nor would it demonstrate how seriously these matters were taken by the Regulator. Such an outcome could potentially damage public confidence. The Committee considered that some restriction on Mr Mathew's registration is necessary in order to ensure that patients were adequately protected from the risk of harm.

277. The Committee next considered a Conditions of Practice Order. The Committee noted that the main aim of conditions is to protect patients from harm, whilst allowing the chiropractor to put right any shortcomings in their practice which led to the finding of UPC. This sanction is appropriate when there are clinical failings that can be remedied and where the Committee is satisfied that the Registrant would comply with the conditions. The Guidance on Sanctions states that a Conditions of Practice Order may be appropriate when the following matters are apparent:

(a) there is no evidence of harmful deep-seated personality or attitudinal problems;

(b) there are identifiable areas of a chiropractor's practice in need of review, retraining or assessment;
(c) there is no evidence of general incompetence;
(d) there is evidence of a willingness to undertake, and the potential to respond positively to, further training and assessment;
(e) …
(f) patients will not be put at risk either directly or indirectly as a result of continued registration with conditions;
(g) the conditions will protect patients during the period they are in force;
(h) it is possible to formulate appropriate, practicable and assessable conditions to impose on registration.

278. The Committee considered all these factors to be present in this case and thus decided that the most appropriate and proportionate sanction in this case was a Conditions of Practice Order. The Order will be for a period of 12 months to enable Mr Mathew's practice to be audited on four separate occasions which will provide the reviewing Committee with the evidence to show whether or not Mr Mathew has embedded the necessary improvements into his practice. It will also allow Mr Mathew sufficient time to comply with the conditions and to satisfy the reviewing Committee in due course that he has remedied his shortcomings and that any unacceptable risk to patients has been eliminated.

279. The conditions are as follows:

(i) You will be subject to an audit process to be undertaken by an Auditor, who will be a registered chiropractor appointed by the GCC, to audit the following aspects of your practice:

Record keeping, including but not restricted to the following: recording of diagnoses; informal reviews; formal reviews, with detail of any testing carried out at appointments with patients; reporting on radiographs; recording of consent.

Radiographic practice and in particular the justification for radiographs and the diagnostic quality of radiographs taken.

(ii) You will cooperate with the Auditor and make available all such information, documentary and oral, that he/she requires in assessing the standard of your practice.

(iii) At each audit the Auditor will select a random sample of at least 30 records to be audited.

(iv) The audits will take place at intervals of 2 to 3 months from the commencement of this Order and the 4th audit must be carried out in sufficient time for the report to be provided to the reviewing Committee.

(v) You are to ensure that a report from the auditor is provided to the GCC within 14 days of the completion of each audit.

(vi) You must advise all current patients that your records and/or appointments are subject to review and audit by a registered chiropractor.

(vii) You shall be responsible for paying for the costs of your audit reports and shall pay any relevant invoice within 28 days.

280. This Order will be reviewed before its expiry. At the review hearing the Committee is to be provided with the four audit reports. The Auditor should be available on the telephone in the event that the Committee needs to explore matters further with the Auditor.

281. The Committee did consider whether to suspend Mr Mathew from practice but concluded that such an outcome would be disproportionate. Mr Mathew had demonstrated developing insight into his failings and the Committee considered Mr Mathew could remedy his failings, provided he complied with the conditions identified by the Committee.

282. 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 Mr Mathew or, where an appeal is made, until the appeal is withdrawn or otherwise disposed of.

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: 21 September 2018

Richard Kavanagh
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.