



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 allegations by the Professional Conduct Committee

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## **NOTICE OF FINDINGS BY THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL CHIROPRACTIC COUNCIL**

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Name of Respondent:	<b>Peter John Proud</b>
Address of Respondent:	<b>126 Norton Road Stourbridge West Midlands DY8 2TA</b>
Registration Number of Respondent:	<b>01537</b>
Case Reference Numbers:	<b>0605/01537/02 0705/01537/03 0905/01537/04 1205/01537/05 1205/01537/06</b>

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## **ALLEGATIONS**

On 15 – 19 January 2007 the Professional Conduct Committee (“the Committee”) of the General Chiropractic Council met to consider the following allegations against you, referred to it by the Investigating Committee in accordance with Section 20(12)(b)(ii) of the Chiropractors Act 1994 (“the Act”):

**Complaint Reference Number: 0705/01537/03**

*That, whilst a registered chiropractor:*

1. *On a date prior to 30<sup>th</sup> June 2005 you caused or allowed to be provided to the Stourbridge News the text of an article or advertisement written in your name ("the advertisement");*
2. *The advertisement was published in your name in the Stourbridge News in the edition of 30<sup>th</sup> June 2005 under the heading "A Doctor's Confession to the Town of Stourbridge...";*
3. *The advertisement included the following words or phrases:*
  - (a) *"Dr Peter Proud, spinal specialist";*
  - (b) *"you're Dr Peter" ;*
  - (c) *"I'm a graduate of the prestigious Sydney University in Australia where I obtained my Degree in Medical Science"*
  - (d) *"further care is very important to consider when making your choice of doctor";*
  - (e) *"Can you imagine not having to wait at a doctor's office? Well your time is as valuable as mine".*
4. *The advertisement did not make clear:*
  - (a) *that you were a registered chiropractor;*
  - (b) *that you were not a registered medical practitioner;*
5. *Your conduct as set out at 1 to 4 above was:*
  - (i) *inappropriate;*
  - (ii) *unprofessional;*
  - (iii) *liable to mislead the public as to the meaning or significance of the title "doctor";*
  - (iv) *liable to bring the profession into disrepute.*

*And, in relation to the facts and matters alleged, you are guilty of unacceptable professional conduct.*

**Complaint Reference Number: 1205/01537/06**

*That, whilst a registered chiropractor,*

1. *Between about November 2003 and about December 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8*

2TA;

2. *In or about February 2004 you accepted Patient A, a child, as a patient;*
3. *At Patient A's first visit an x-ray was taken;*
4. *The x-ray of Patient A referred to at 3 above was:*
  - (a) inappropriate;*
  - (b) not clinically indicated by the case history and examination findings contained in Patient A's records;*
  - (c) contrary to the best interests of Patient A;*
5. *Your records of the care and treatment provided to Patient A indicate that:*
  - (a) you identified a number of subluxations;*
  - (b) your clinical impression was of "marked abnormal spinal biomechanics";*
6. *The clinical impression of "marked abnormal spinal biomechanics" referred to at 5(b) above was not justified by the case history and examination findings contained in Patient A's records;*
7. *On or about Patient A's second visit, when speaking to Patient A's parents you:*
  - (a) spoke in an alarmist manner to the Patient's parents;*
  - (b) misrepresented the gravity of Patient A's condition;*
  - (c) failed to treat Patient A's parents with consideration;*

*when saying words to the effect that:*

  - (a) what you had to say about Patient A was very serious;*
  - (b) you did not want Patient A to hear and be alarmed;*
  - (c) you were extremely worried about Patient A's spine;*
  - (d) Patient A's problems were very severe;*
8. *At the next visit you recommended that Patient A undergo corrective treatment from you over a twelve month period, which would include about 68 adjustments and cost £840;*
9. *Your recommendation of the course of treatment referred to at 8 above was:*
  - (a) excessive;*
  - (b) not in the best interests of Patient A;*
10. *Between approximately February 2004 and August 2004, as part of your corrective treatment of her, you provided Patient A with approximately 71 treatments;*

11. *The provision of the number of treatments specified in 10 above was:*
  - (a) *inappropriate;*
  - (b) *excessive;*
  - (c) *contrary to the best interests of Patient A;*
  
12. *In or about August 2004, a further x-ray of Patient A was taken as you “wanted to know how things were going”;*
  
13. *The x-ray referred to at 12 above was not clinically justified;*
  
14. *Having viewed the x-ray referred to at 12 above, you said to Patient A’s mother words to the effect that:*
  - (a) *Patient A required maintenance treatment, which would cost £840 for the next 12 months;*
  - (b) *without maintenance treatment, Patient A could revert to her pre-care state;*
  
15. *Your comment at 14(b) above was alarmist;*
  
16. *Your conduct, as set out at 3 to 15 above, was:*
  - (a) *inappropriate;*
  - (b) *unprofessional;*
  - (c) *contrary to the best interests of Patient A;*

*And that, in relation to the facts and matters alleged, you are guilty of unacceptable professional conduct.*

**Complaint Reference Number: 1205/01537/05**

*That, whilst a registered chiropractor,*

1. *Between about November 2003 and about December 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;*
  
2. *In or about February 2004 you accepted Patient A, a child, as a patient;*
  
3. *In or about April 2004 you suggested to Patient A’s mother, Patient B, that she would benefit from an x-ray of her spine;*
  
4. *On or about 13 April 2004 you recorded that Patient B should be x-rayed due to trauma;*
  
5. *You failed to:*

- (a) *assess Patient B adequately or at all prior to the x-ray;*
  - (b) *keep any or an adequate record of your assessment;*
6. *Taking an x-ray of Patient B for the reason at 4 above was:*
- (a) *inappropriate;*
  - (b) *not clinically necessary;*
  - (c) *contrary to the best interests of the patient;*
7. *Following the taking of the x-ray at 4 above, you spoke to Patient B in an alarmist manner by using words to the effect that:*
- (a) *you were very concerned by the results;*
  - (b) *she would benefit greatly from your help;*
  - (c) *with a spine out of alignment it was possible to suffer many problems later in life – and you spoke to Patient B of cancer and heart disease;*
8. *On or about 13 April 2004 it was recorded that the reason for Patient B's consultation with you was shoulder pain;*
9. *You failed to:*
- (a) *examine Patient B's shoulder;*
  - (b) *record an examination of Patient B's shoulder;*
  - (c) *record in the patient's notes, adequately or at all, a working diagnosis or clinical impression relating to Patient B's shoulder pain;*
  - (d) *keep any or adequate records relating to Patient B's shoulder pain;*
10. *You recommended that Patient B undergo treatment from you over a twelve month period, which would involve about 65 treatment sessions and cost about £640;*
11. *Your recommendation of a twelve-month course of treatment in respect of Patient B's presenting complaint was:*
- (a) *excessive;*
  - (b) *not in the best interests of Patient B;*
12. *Patient B agreed to a maintenance care plan and you accepted her as your patient;*
13. *Patient B received treatment from you at various dates in and between April 2004 and February 2005;*
14. *A number of months after treatment had commenced, Patient B told you that the treatment made her feel unwell;*
15. *In relation to the matter told to you by Patient B, referred to at 14 above, you failed to:*
- (a) *keep any or an adequate record in the patient's notes;*

- (b) *modify the treatment in response;*
16. *On or about 14 April 2005 Patient B was x-rayed again;*
17. *The further x-ray referred to at 16 above was:*
- (a) *inappropriate;*  
(b) *not clinically necessary;*  
(c) *contrary to the best interests of the patient;*
18. *After taking the further x-ray, you told Patient B words to the effect that:*
- (a) *“things aren’t looking good”;*  
(b) *her upper back “was looking really worrying”;*
19. *Your description of Patient B’s condition as set out at 18 above:*
- (a) *was unduly alarmist;*  
(b) *misrepresented the gravity of Patient B’s condition;*
20. *Your conduct, as set out at 3 to 19 above, was:*
- (a) *inappropriate;*  
(b) *unprofessional;*  
(c) *contrary to the best interests of Patient B;*

*And that, in relation to the facts and matters alleged, you are guilty of unacceptable professional conduct.*

**Complaint Reference Number: 0905/01537/04**

*That, whilst a registered chiropractor,*

1. *In or about December 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;*
2. *In or about June 2005 you accepted Patient C as a patient;*
3. *On or about 16 June 2005 Patient C underwent a clinical examination and clinical assessment, including x-rays;*
4. *At Patient C’s next visit, on or about 27 June 2005, you showed Patient C the x-rays and spoke to her in an alarmist manner in relation to her condition, when saying to her words to the effect that:*
  - (a) *“I’m afraid I have bad news for you” “I have discovered several areas of subluxation in your spine”;*
  - (b) *“it would take twelve months treatment to bring about improvement”;*

5. *When asked by Patient C about your profession and who you were regulated by you failed to disclose to her that you were a registered chiropractor regulated by the General Chiropractic Council;*
6. *Your conduct as set out at above, was:*
  - (a) *inappropriate;*
  - (b) *unprofessional;*
  - (c) *contrary to the best interests of Patient C;*

*And that, in relation to the facts and matters alleged, you are guilty of unacceptable professional conduct.*

**Complaint Reference Number: 0605/01537/02**

*That, whilst a registered chiropractor,*

1. *Between about March 2005 and about May 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;*
2. *On or about 24 March 2005 you:*
  - (a) *accepted Patient D as a patient;*
  - (b) *undertook a clinical examination and clinical assessment of Patient D, which included the taking of x-rays;*
  - (c) *told Patient D that, if she had subluxation, you would recommend a course of treatment over a twelve month period at a cost of about £3,000;*
3. *On or about 5 April 2005 you said to Patient D words to the effect that you had very bad news for her, very bad news, and that she did have subluxation;*
4. *In speaking to Patient D as set out at 3 paragraph above you:*
  - (a) *spoke in an unduly alarmist manner to the patient;*
  - (b) *failed to treat Patient D with consideration;*
  - (c) *misrepresented the gravity of Patient D's condition;*
5. *At the appointment on or about 5 April 2005, you recommended to Patient D that she undergo a one-year course of treatment;*
6. *At appointments on or about 23 March 2005 and 5 April 2005 you asked Patient D to sign documents which included the words:*

*“The Doctors at Living Health are spinal specialists and are specifically trained in the detection and correction of spinal subluxation. They are not medical doctors, osteopaths, chiropractors, or physiotherapists”;*

7. *The wording referred to at 6 above was misleading, in that, at the material time, you were a qualified chiropractor registered with the General Chiropractic Council;*
8. *You required Patient D to remove paper from the treatment bench after receiving treatment;*
9. *Requiring the patient to so act was:*
  - (a) inappropriate;*
  - (b) unprofessional;*
10. *You did not keep an adequate written record, in relation to Patient D of:*
  - (a) her case history;*
  - (b) the initial physical examination;*
  - (c) the x-ray findings;*
  - (d) your working diagnosis or clinical impression;*
  - (e) your initial management or clinical treatment plan;*
  - (f) the patient's prognosis;*
  - (g) the patient telling you about her response to treatment;*
  - (h) pain she advised you she was experiencing;*
  - (i) your response to the patient's concerns;*
11. *Your conduct, as set out above was:*
  - (a) inappropriate;*
  - (b) unprofessional;*
  - (c) contrary to the best interests of Patient D;*

*And that, in relation to the facts and matters alleged, you are guilty of unacceptable professional conduct.*

In accordance with the provisions of Rule 18(1)(a) of the General Chiropractic Council (Professional Conduct Committee) Rules 2000 ("the Rules"), notice is hereby given of the decision of the Committee.

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## **DECISION**

The Committee has considered carefully all the oral and documentary evidence, before reaching a decision on the allegations, none of which were admitted. In the absence of Mr Proud or any witnesses on his behalf, the Committee heard only from witnesses brought by the General Chiropractic Council ("the GCC"). It also took account of the 4 letters received from Mr Proud.

The Committee has taken into account the advice of the Legal Assessor, and has reminded itself that the burden of proof is on the GCC to prove its case and that the standard of proof is the civil standard, so that the Committee is to be satisfied that the facts are proved on the balance of probabilities. The Committee also reminded itself that Mr Proud's absence was not an admission of guilt and added nothing to the Council's case.

In reaching its decisions, the Committee has considered the evidence in respect of each Allegation separately.

## **PRELIMINARY ISSUES**

### ***Jurisdiction***

It appears from his correspondence that Mr Proud contends that he is not subject to the jurisdiction of the GCC as he no longer considers himself to be a chiropractor. He also maintains that he is now practising as a spinal specialist, not as a chiropractor.

The Committee has dealt with this as a preliminary matter.

It heard evidence from Mrs Coats, who is the Registrar and Chief Executive of the GCC. She confirmed that Mr Proud has, at all times since October 2001, been registered with the GCC. The Committee finds as a fact that at all material times, and to date, Mr Proud is a registered chiropractor.

Section 20 of the Chiropractors Act 1994 applies where allegations are made against "registered chiropractors" and under section 22 of the Act it is the statutory duty of this Committee to consider such allegations concerning registered chiropractors that are referred to it.

Throughout this period, Mr Proud continued on the Register and is therefore subject to the jurisdiction of the GCC. The Committee has no hesitation in exercising its statutory duty to consider allegations against him.

### ***Practising as a chiropractor***

Aside from the registration issue, Mr Proud contends that from some time in 2004-5 he ceased to practise as a chiropractor. This is relevant to the allegations concerning Patients C and D. The Committee determined to resolve this at the outset.

The Committee accepts that Mr Proud indicated to Patients C and D that he was not a chiropractor. It is necessary for this Committee to determine whether or not he was practising as a chiropractor at the material times.

It is clear from the evidence the Committee has heard, and from Mr Proud's letters, that at some stage in 2004/2005 Mr Proud changed his practice's name from "Living Health Chiropractic" to "Living Health Family Spine Centre" and Patient D's signed a consent form which contained the following: "The Doctors at Living Health are Spinal Specialists.....They

are not Medical Doctors, Osteopaths, Chiropractors or Physiotherapists.” Furthermore, Mr Proud referred to himself as a spinal specialist and not a chiropractor.

The Committee noted that the consent form used for Patient D (page 220) in 2005 described the diagnosis and treatment approach Mr Proud employed in almost identical terms to that in the earlier standard consent form used in 2004 by “Living Health Chiropractic” for Patients A (pages 31-32) and B (page 129). The major difference between the two was the substitution in 2005 of the words “spinal health care” for “chiropractic health care” (used in 2004) and other similar consequential substitutions.

Additionally, Patient A and Patient B’s treatment spanned the period during which Mr Proud changed the name of his clinic. Patient B confirmed that she both observed and experienced no difference in the treatment or practice in the clinic in this period. Patient B signed a form “Understanding Chiropractic Care” (pages 154-155) which was identical save for the change of titles to “Understanding Spinal Care” signed by Patient D (pages 222-223).

The Committee has no doubt, on the evidence that Mr Proud was at all times working as a chiropractor. Nothing material had changed. Any changes were cosmetic only. The substance of his practice remained the same and the Committee finds as a fact that he was working as a chiropractor.

## **DETERMINATION IN RELATION TO COMPLAINT: 0705/01537/03**

### ***Allegation 1.***

***On a date prior to 30<sup>th</sup> June 2005 you caused or allowed to be provided to the Stourbridge News the text of an article or advertisement written in your name ('the advertisement');***

The Committee found the evidence of Caroline Smith, Advertisement Manager of the Stourbridge News, to be credible. She stated that Mr Proud provided all the content of the advertisement without any intervention from the Paper.

### ***Allegation 2.***

***The advertisement was published in your name in the Stourbridge News in the edition of 30<sup>th</sup> June 2005 under the heading “A Doctor’s Confession to the Town of Stourbridge...”;***

The Committee accepted as a fact Ms Smith’s confirmation that the advertisement was published in the 30<sup>th</sup> June 2005 edition of the Stourbridge News.

### ***Allegation 3.***

***The advertisement included the following words or phrases:***

- (a) “Dr Peter Proud, spinal specialist”;***
- (b) “you’re Dr Peter” ;***
- (c) “I’m a graduate of the prestigious Sydney University in Australia where I obtained my Degree in Medical Science”;***

*(d) “further care is very important to consider when making your choice of doctor”;*

*(e) “Can you imagine not having to wait at a doctor’s office? Well your time is as valuable as mine”.*

The advertisement was produced to the Committee and contained all the phrases set out in this head of charge.

This Allegation is therefore proved.

#### ***Allegation 4***

***The advertisement did not make clear:***

***(a) that you were a registered chiropractor;***

***(b) that you were not a registered medical practitioner;***

The Committee is satisfied that the advertisement did not make clear that Mr Proud was a registered chiropractor as it described him as a spinal specialist and there is no mention of the word “chiropractor” anywhere in the article. Further, Mr Proud used the title “spinal specialist” in the article, and described his training as having given him a degree in Medical Science. The article gave no indication, to a reader, that he was a registered chiropractor.

The article contained the reference to the degree in Medical Science in conjunction with the repeated use of the title “Doctor” in relation to Mr Proud and without any clarification. The Committee is satisfied that the article did not make clear that Mr Proud was not a registered medical practitioner and this Allegation is therefore proved.

#### ***Allegation 5***

***Your conduct as set out at 1 to 4 above was:***

***i inappropriate;***

***ii unprofessional;***

***iii liable to mislead the public as to the meaning or significance of the title “doctor”;***

***iv liable to bring the profession into disrepute.***

The Committee is satisfied that the conduct it found was liable to mislead the public as to the meaning or significance of the title “Doctor” because a reasonable person reading this advertisement could easily conclude that Mr Proud was a registered medical practitioner and would not be able to identify that he was, in fact, a registered chiropractor.

Mr Proud’s conduct in producing such a misleading article was clearly both inappropriate and unprofessional as well as being liable to bring the profession into disrepute because of the risk of the public being misled. The fact that the title “Doctor” is not a title protected by law, as Mr Proud pointed out in his letter of the 25<sup>th</sup> July 2005, makes no difference to this Committee’s view as to the misleading nature of this advertisement. The Committee finds as a fact that this was a deliberate attempt to mislead the public.

## **DETERMINATION IN RELATION TO COMPLAINT: 1205/01537/06**

The oral evidence as to the allegations concerning Patient A, came from Mrs B who is Patient A's mother. Patient A is a minor and is now aged some 11 years and did not appear before the Committee. The Committee found Mrs B to be an impressive and credible witness, who had a clear and accurate recall of events. The Committee finds that she did her best to assist it with its task and accepts her evidence.

### ***Allegation 1:***

***Between about November 2003 and about December 2005 you practiced as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;***

The Committee finds this factual paragraph established on the evidence of Mrs B and the documents, although it notes that the name of the practice changed at some date in 2004/2005.

### ***Allegation 2:***

***In or about February 2004 you accepted Patient A, a child, as a patient;***

The Committee is satisfied on the basis of the records before it and Mrs B's evidence that Mr Proud accepted patient A at this date.

### ***Allegation 3:***

***At Patient A's first visit an x-ray was taken;***

This is established by the records and Mrs B's evidence.

### ***Allegation 4:***

***The x-ray of Patient A referred to at 3 above was:***

- (a) inappropriate;***
- (b) not clinically indicated by the case history and examination findings contained in Patient A's records;***
- (c) contrary to the best interests of Patient A;***

Dr Brown, the expert called for the GCC did not support the allegations here. He contended that the X-ray was justified in clinical terms on the basis of the previous trauma, even though it was 12 months before. The Committee rejects this view and finds each of the Allegations a, b, and c proved for the following reasons:

Mr Proud, on the basis of the case history and examination, made the decision to take radiographs of Patient A's cervical spine. In the patient records, Mr Proud cites "trauma" and "investigation of extreme postural anomaly" as the criteria used to justify the x-ray exposure to the patient. The Committee does not accept that, in this case, the radiographic

investigations were clinically justified by the criteria cited or clinically indicated by the recorded findings from the history and examination.

The historical finding of “lots of falls off push-bike” is not a remarkable one for an 8 year old child and would not reasonably lead to radiographic investigation unless it related to recent, significant trauma, suggestive of serious structural damage. The trauma here was not recent. Likewise, the recorded postural findings of “some forward head carriage” and “elevated right shoulder” do not, in the Committee’s view, constitute an “extreme postural anomaly”.

Exposure to ionising radiation is associated with well established risks to long term health and it is incumbent upon those employing such methods of investigation to minimise and restrict exposure to levels as low as reasonably achievable. In addition the age of the patient and the type of tissue likely to be exposed during any procedure also have a bearing on the assessment of risk. In this case, Patient A was a child of 8 years and at greater risk than that of an adult, whose tissues, skeletal or otherwise, would have reached maturity. The X-ray views taken also involved irradiating the thyroid gland, an organ known to be particularly sensitive to radiation damage. Further, for reason or reasons unknown and unrecorded, Mr Proud also chose to take a radiograph of the cervico-thoracic spine, thus exposing further organs to potential risk. Had Mr. Proud made adequate inquiries regarding Patient A’s past medical history, he would have discovered that a referral for MRI scanning was in progress, which would have obviated the need for x-ray examination.

***Allegation 5:***

***Your records of the care and treatment provided to Patient A indicate that:***

- (a) you identified a number of subluxations;***
- (b) your clinical impression was of “marked abnormal spinal biomechanics”;***

This is clear on the face of Patient A’s records at pages 23-25 of the bundle.

***Allegation 6:***

***The clinical impression of “marked abnormal spinal biomechanics” referred to at 5(b) above was not justified by the case history and examination findings contained in Patient A’s records;***

Dr Brown, the expert witness, stated in his report that the clinical impression could be justified. However on Committee questioning he conceded that he could not identify or justify the description “marked”. Nevertheless he still held with the view that the clinical impression was justified.

It is the Committee’s view that neither the records of the examination nor the X rays show any abnormalities that were any more than moderate or mild with respect to position or movement. The Committee therefore concludes that the case history and examination findings contained in Patient A’s records do not justify a clinical impression of “marked abnormal spinal biomechanics”.

This Allegation is therefore found proved.

***Allegation 7:***

***On or about Patient A's second visit, when speaking to Patient A's parents you:***

- (a) spoke in an alarmist manner to the Patient's parents;***
- (b) misrepresented the gravity of Patient A's condition;***
- (c) failed to treat Patient A's parents with consideration;***

***when saying words to the effect that:***

- (a) what you had to say about Patient A was very serious;***
- (b) you did not want Patient A to hear and be alarmed;***
- (c) you were extremely worried about Patient A's spine;***
- (d) Patient A's problems were very severe;***

The Committee accepts the evidence of Mrs B that Mr Proud required Patient A to leave the room before briefing her parents on her condition and that he told her that Patient A's condition was "very serious" and "really bad news". The Committee finds as a fact that Mr Proud said that Patient A's condition was "very serious indeed"; "far worse than he thought" and that he had "never seen a child with such a condition as Patient A had" and that such language was alarmist. The Committee has no doubts that this misrepresented the gravity of Patient A's condition. The information that Mr Proud had did not support any diagnosis that would justify the conclusion that this was a serious condition. Speaking in this way to parents, including the fact of sending the daughter out of the room and using such extreme and exaggerated language is clearly, in the Committee's view, not treating Patient A's parents with consideration.

The Committee find this Allegation proved.

***Allegation 8:***

***At the next visit you recommended that Patient A undergo corrective treatment from you over a twelve month period, which would include about 68 adjustments and cost £840;***

The Committee accepts Mrs B's account that Mr Proud recommended that Patient A undergo a 12 month "Corrective Treatment Programme" and Mrs B's evidence that Mr Proud persuaded her to sign up for this. While some of the documentary records indicate that the course was for 6 months, Mrs B was adamant, under questioning by the Committee, that it was a 12 month programme. While it notes the form at page 51 of the bundle, referring to a "6/12" programme, this form is not signed by Mrs B, who denied having seen it before. The Committee therefore places little weight on this document and prefers Mrs B's evidence that it was a 12 month programme.

This allegation is therefore proved.

***Allegation 9:***

***Your recommendation of the course of treatment referred to at 8 above was:***

- (a) excessive;*
- (b) not in the best interests of Patient A;*

The Committee finds that the recommendation of such a course of treatment to be excessive. This is because, even taking the relevant records and X-rays at their highest, they revealed no more than “mild to moderate” condition. This was agreed by the Council’s expert Dr Brown.

The Committee concludes that it was not in Patient A’s best interests for such a recommendation to have been made as it could create a risk of patient dependency and further, it sent a message to Patient A that she was sufficiently unwell to need an intensive course of treatment lasting at least 12 months. In the Committee’s view this could significantly affect the sense of well-being of an 8 year old child as well as restrict her day-to-day activities.

This Allegation is therefore proved.

***Allegation 10:***

***Between approximately February 2004 and August 2004, as part of your corrective treatment of her, you provided Patient A with approximately 71 treatments;***

On the basis of the financial records detailing the dates of the treatments given at pages 39-42 of the bundle, the Committee finds this head proved.

***Allegation 11:***

***The provision of the number of treatments specified in 10 above was:***

- (a) inappropriate;*
- (b) excessive;*
- (c) contrary to the best interests of Patient A;*

Dr Brown, in his report at paragraph 48, stated that: “...such a frequency of treatment is likely to run the risk of encouraging treatment dependence. As such, I believe it was inappropriate to have delivered such an intensive programme of care. Such a programme was, in my view, excessive and not linked to the clinical indications arising from the assessment. As such, I do not think that this programme of care was in the interests of Patient A.”

The Committee accepts this opinion of Dr Brown. The Committee also notes that Mrs B told us that frequently after treatments she had to apply ice-packs to her daughter’s neck because of the pain she was in.

The Committee finds this Allegation proved in all parts.

***Allegation 12:***

***In or about August 2004, a further x-ray of Patient A was taken as you “wanted to know how things were going”;***

Mrs B confirmed that a further x-ray was taken of Patient A in August 2004 as Mr Proud wanted to see how things were going. The Committee accepts her evidence.

***Allegation 13:***

***The x-ray referred to at 12 above was not clinically justified;***

The Committee is satisfied that this repeat X-ray was not clinically justified. The Committee accepts the expert opinion of Dr Brown (paragraphs 52-53 of his report) to the effect that, in order to justify repeating an x-ray here there would need to be evidence of significant change in Patient A's clinical presentation or of some significant subsequent trauma. There was no such evidence here. Further, the Committee accepts Dr Brown's view that "wanting to know how things were going" does not constitute adequate justification for exposing a child to ionising radiation.

Therefore this Allegation is proved.

***Allegation 14:***

***Having viewed the x-ray referred to at 12 above, you said to Patient A's mother words to the effect that:***

- (a) Patient A required maintenance treatment, which would cost £840 for the next 12 months;***
- (b) without maintenance treatment, Patient A could revert to her pre-care state;***

The Committee finds as a fact on Mrs B's testimony, that Mr Proud said to her that Patient A required maintenance treatment. He even took the step of telephoning her at home to say how foolish she was being if she didn't continue A's treatment, as without it A "...would slip backwards very quickly" into her pre-care state. Accordingly, the Committee find both a) and b) of head 14 proved.

***Allegation 15:***

***Your comment at 14(b) above was alarmist;***

The Committee heard from Mrs B that Mr Proud had previously led her and her husband to believe that Patient A's case was the most serious he had ever seen in a child. This was thus their understanding of Patient A's pre-care state. Therefore, any suggestion that she might revert to it without further care was clearly, in the Committee's view, alarmist.

This Allegation is therefore proved.

***Allegation 16:***

***Your conduct as set out at 3 to 15 above, was:***

- (a) inappropriate***
- (b) unprofessional***

*(c) contrary to the best interests of Patient A;*

The Committee has no hesitation in concluding that Mr Proud's conduct in relation to Patient A and her parents, which included:

- arriving at a clinical impression without any adequate examination or assessment;
- x-raying a young child without justification;
- persuading Patient A to have treatment that was not justified;
- speaking to Patient A's parents in an alarmist manner;
- misrepresenting the gravity of Patient A's condition; and
- recommending, carrying-out and charging for packages of care that were not justified,

amounted to conduct which was inappropriate, unprofessional and not in the best interests of Patient A.

### **DETERMINATION IN RELATION TO COMPLAINT: 1205/01537/05**

It should be noted that Patient A's mother, Mrs B, went on to become a patient of Mr Proud and henceforth will be referred to as Patient B.

*That, whilst a registered chiropractor,*

*Allegation 1:*

*Between about November 2003 and about December 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;*

The Committee finds this factual paragraph established on the evidence of Patient B and the documents, although it notes that the name of the practice changed at some date in 2004/2005.

*Allegation 2:*

*In or about February 2004 you accepted Patient A, a child, as a patient;*

The Committee is satisfied on the basis of the records before it and Patient B's evidence that Mr Proud accepted Patient A at this date.

*Allegation 3:*

*In or about April 2004 you suggested to Patient A's mother, Patient B, that she would benefit from an x-ray of her spine;*

The Committee found Patient B to be a credible and impressive witness who described how some weeks after Patient A's treatment had commenced Mr Proud "badgered" Patient B on several occasions so that she felt worn down and accepted the offer of free x-rays. The Committee therefore find this allegation proved.

***Allegation 4:***

***On or about 13 April 2004 you recorded that Patient B should be x-rayed due to trauma;***

The Committee find this proved on the basis of the evidence in the records (page 138 of the bundle).

***Allegation 5:***

***You failed to:***

***(a) assess Patient B adequately or at all prior to the x-ray;***

The Committee accepts the evidence of the expert witness Dr Brown in relation to the areas that were X-rayed, that there is no evidence that Mr Proud undertook a proper examination of the right shoulder, the neck or the lower back of Patient B in determining whether he should proceed to X-ray.

Further, the Committee accepted the oral evidence of Patient B who said Mr Proud did not examine her shoulder. She also told the Committee that during any examination that did take place she was, at all times, fully clothed.

***(b) keep any or an adequate record of your assessment;***

The Committee accepts the evidence of Dr Brown that, not having undertaken an adequate assessment, Mr Proud did not keep an adequate record of his assessment prior to taking the X-ray.

Both parts of this Allegation are therefore found proved.

***Allegation 6:***

***Taking an x-ray of Patient B for the reason at 4 above was:***

***(a) inappropriate;***

***(b) not clinically necessary;***

***(c) contrary to the best interests of the patient;***

In respect of the X-rays of the cervical spine, the Committee accepts the evidence of Dr Brown who did not consider that there was adequate clinical justification to warrant x-ray examination of the cervical spine from either the case history or the physical examination and that such an x-ray was inappropriate, not clinically necessary and contrary to the best interests of the patient.

In relation to x-raying the lumbar spine, Dr Brown's initial view as set out in his report, was that it was not inappropriate and could be considered to be clinically necessary and in the best interests of Patient B. However, under questioning from the Committee, he revised that view. This was in light of Patient B's evidence that:

- she did not have any pain in this area,

- any discomfort she did have did not interfere with her daily routine,

Additionally, Patient B is a young woman of child-bearing age in whom the dose of radiation from two abdominal x-rays to the ovaries was unjustified in the circumstances.

Accordingly, the Committee find all parts of this allegation proved.

***Allegation 7:***

***Following the taking of the x-ray at 4 above, you spoke to Patient B in an alarmist manner by using words to the effect that:***

- (a) you were very concerned by the results;***
- (b) she would benefit greatly from your help;***
- (c) with a spine out of alignment it was possible to suffer many problems later in life – and you spoke to Patient B of cancer and heart disease;***

The Committee relied on the oral evidence of Patient B, a credible witness. Even at this distance in time she was able to recall for the Committee the words that Mr Proud used, including the phrases, “really bad news”, and “very serious”.

The Committee finds that Mr Proud spoke to her in an alarmist manner. He told her that her case was very serious, and even spoke of a possible association with cancer and heart disease. Further, the Committee accepts that he said to Patient B he was really pleased to tell her that he could accept her case, the implication being that she would benefit greatly from his help.

The Committee is satisfied that this Allegation is proved.

***Allegation 8:***

***On or about 13 April 2004 it was recorded that the reason for Patient B’s consultation with you was shoulder pain;***

The Committee find this proved. The records show that the reason for the consultation was shoulder pain (page 132).

***Allegation 9:***

***You failed to:***

- (a) examine Patient B’s shoulder;***
- (b) record an examination of Patient B’s shoulder;***
- (c) record in the patient’s notes, adequately or at all, a working diagnosis or clinical impression relating to Patient B’s shoulder pain;***
- (d) keep any or adequate records relating to Patient B’s shoulder pain;***

The Committee accepts Patient B’s evidence that Mr Proud did not examine her shoulder. There is no record of such examination. There is no diagnosis or clinical impression recorded in relation to her shoulder. Thus there was a failure to keep adequate records in relation to the

shoulder and there was no adequate record relating to shoulder pain because such entries as there were simply recorded the fact that it existed.

This allegation is therefore found proved in all parts.

***Allegation 10:***

***You recommended that Patient B undergo treatment from you over a twelve month period, which would involve about 65 treatment sessions and cost about £640;***

The Committee find this allegation proved. It accepts Patient B's evidence that Mr Proud recommended a maintenance programme of treatment for a period of 12 months costing £640.

***Allegation 11:***

***Your recommendation of a twelve-month course of treatment in respect of Patient B's presenting complaint was:***

***(a) excessive;***

The Committee accepts the evidence of Dr Brown, the expert witness, that "on any analysis of the facts, Patient B's condition was not serious". Further, that the results of the assessment do not support the view that this was a serious condition that warranted a protracted course of care. The Committee finds a recommendation for such a course of treatment to be excessive.

***(b) not in the best interests of Patient B;***

It was the expert's view that it was wholly inappropriate on the basis of the history and assessment to advise Patient B that she required 65 treatment sessions. It is more likely than not that such a protracted and intensive programme of care may have rendered Patient B vulnerable to treatment dependence, particularly in relation to what she had been told about the severity of her condition. Moreover, the records show that by August 2004 the complaints of neck stiffness, forearm, ulnar and shoulder pain exhibited 100% improvement. Despite this level of improvement within a four month period, treatment continued for a further 9 months until May 2005. The Committee finds that this was not in the best interests of Patient B. Both parts of this Allegation are therefore found proved.

***Allegation 12:***

***Patient B agreed to a maintenance care plan and you accepted her as your patient;***

This allegation is found proved on the basis of Patient B's oral evidence and her records.

***Allegation 13:***

***Patient B received treatment from you at various dates in and between April 2004 and February 2005;***

This allegation is found proved on the basis of Patient B's oral evidence and her records.

***Allegation 14:***

***A number of months after treatment had commenced, Patient B told you that the treatment made her feel unwell;***

The Committee accepted the oral evidence of Patient B who described and demonstrated the nature and location of her problems as she had told Mr Proud.

This allegation is found proved.

***Allegation 15:***

***In relation to the matter told to you by Patient B, referred to at 14 above, you failed to:***

***(a) keep any or an adequate record in the patient's notes;***

Whilst in Patient B's notes it is recorded she frequently reported soreness, the Committee is satisfied from her evidence, that this was neither an adequate record of what she told Mr Proud nor an adequate record of the extent to which the treatment made her feel unwell.

***(b) modify the treatment in response;***

Patient B described her treatment as being the same every time and this is confirmed in that virtually all the entries in her records are identical and reveal no modifications to the treatment. This supports Patient B's evidence that her treatment was always the same.

Both parts of his Allegation are therefore found proved.

***Allegation 16:***

***On or about 14 April 2005 Patient B was x-rayed again;***

This allegation is found proved on the basis of Patient B's oral evidence and her patient records.

***Allegation 17:***

***The further x-ray referred to at 16 above was:***

***(a) inappropriate;***

***(b) not clinically necessary;***

***(c) contrary to the best interests of the patient;***

On the basis of the x-ray consent form (14/4/05), Mr Proud's justification for re-x-raying Patient B was investigation of 'extreme postural anomaly'. The expert witness's evidence was that neither at the commencement of treatment nor at the time of the second x-ray was there evidence that Patient B was exhibiting an extreme postural anomaly. He said further, that such a justification is not backed up by any supportive clinical evidence either on the notes or on the original x-rays and to have re-x-rayed Patient B regardless of the given justification

would have been inappropriate and not clinically indicated. The Committee accepts this view and concludes that this further x-raying of Patient B was not in her best interests.

This Allegation is therefore found proved in all parts.

***Allegation 18:***

***After taking the further x-ray, you told Patient B words to the effect that:***

- (a) “things aren’t looking good”;***
- (b) her upper back “was looking really worrying”;***

The Committee accepted the oral evidence of Patient B who said that Mr Proud told her “You’re not going to like this. Its really bad news. Your spine has really deteriorated.”

The Committee is therefore satisfied that this Allegation is found proved.

***Allegation 19:***

***Your description of Patient B’s condition as set out at 18 above:***

- (a) was unduly alarmist;***
- (b) misrepresented the gravity of Patient B’s condition;***

Having examined all of the x-rays taken by Mr Proud, the expert witness could find no evidence for any cause for concern in relation to the patient’s upper back and therefore no evidence from the x-rays taken at the time to support Mr Proud’s statement. Such words were unduly alarmist and misrepresented the gravity of the patient’s condition.

This Allegation is therefore found proved.

***Allegation 20:***

***Your conduct, as set out at 3 to 19 above, was:***

- (a) inappropriate;***
- (b) unprofessional;***
- (c) contrary to the best interests of Patient B;***

There were many features of Mr Proud’s treatment and care of Patient B which caused the Committee grave concern. These included:

- “Badgering” a patient to have unnecessary x-rays
- Unnecessary exposure to ionising radiation
- Excessive unnecessary treatment with no justification because there was no assessment or examination of the presenting complaint
- Misrepresentation of the gravity of the patient’s condition
- The use of alarmist words before recommending an excessive treatment programme
- Lack of adequate records of what examination and assessment may have taken place

- Inadequate response to patient's concerns when pain occurred in the course of treatment either by re-examination or changing treatment

In light of the above, the Committee is satisfied that Mr Proud's conduct was inappropriate, unprofessional and contrary to the best interests of the patient and this allegation is therefore found proved.

## **DETERMINATION IN RELATION TO COMPLAINT: 0905/01537/04**

*That, whilst a registered chiropractor,*

### ***Allegation 1:***

***In or about December (amended to June) 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;***

At the outset of the hearing the Committee accepted a submission on behalf of the GCC to amend the date in this Allegation to June 2005.

For the reasons set out in the Preliminary Issues, the Committee found this Allegation as amended proved.

### ***Allegation 2:***

***In or about June 2005 you accepted Patient C as a patient;***

For the reasons below the Committee found this proved.

Patient C presented as a cogent and credible witness. She told the Committee that on her arrival on the 16<sup>th</sup> June 2005 at 126 Norton Road for her assessment, there was a sign welcoming her personally. She was then asked to complete various consent forms and was handed testimonials from other patients.

### ***Allegation 3:***

***On or about 16 June 2005 Patient C underwent a clinical examination and clinical assessment, including x-rays;***

Patient C gave a credible, clear account of the examination and assessment that took place. A "Dr Warren" took a brief history, examined her whilst she was fully clothed and took some digital photos, following which, he suggested that some X-rays be taken; and Patient C was invited to make 2 further appointments.

The Committee found this Allegation proved.

### ***Allegation 4:***

***At Patient C's next visit, on or about 27 June 2005, you showed Patient C the x-rays and spoke to her in an alarmist manner in relation to her condition, when saying to her words to the effect that:***

- (a) "I'm afraid I have bad news for you" "I have discovered several areas of subluxation in your spine";***
- (b) "it would take twelve months treatment to bring about improvement";***

Patient C gave a detailed and credible account of this visit, in which she was first given an illustrated talk on the "3 phases of subluxation". During this talk, Mr Proud specifically drew attention to the effect subluxation could have on other organs, particularly the heart, lungs and digestive system. Patient C explained that this lecture added to her anxiety that had been building up since the X-rays were taken. Indeed, during her testimony when Patient C recalled the event, she became very upset at her memories of this.

Patient C told the Committee that despite telling Mr Proud she did not want to hear "bad news", he persisted in conveying it in the terms set out in these allegations. Patient C felt very distressed and shocked, particularly when Mr Proud said her subluxations were definitely in "phase 2". Mr Proud informed her that the treatment would take 12 months and gave her the impression that her condition was so serious that he and Dr Warren had had to discuss whether or not they would be prepared to treat her before agreeing to do so. Mr Proud caused further alarm by enquiring whether Patient C had a partner to help see her through the prospective treatment.

However, Dr Brown gave both written and oral evidence that subluxations were almost universal in adults, and by itself, the discovery of subluxations did not justify the label "bad news". Furthermore, Patient C was subsequently assessed and treated elsewhere for her problems, which proved minor and needed only modest interventions. The Committee accepts Dr Brown's view and concludes that Mr Proud's account of Patient C's condition was alarmist and exaggerated its gravity.

The Committee found this allegation proved in all parts.

#### ***Allegation 5:***

***When asked by Patient C about your profession and who you were regulated by you failed to disclose to her that you were a registered chiropractor regulated by the General Chiropractic Council;***

Patient C clearly understood the concept of professional regulation, as she herself is a member of a regulated profession. She gave a credible account of the circumstances in which she asked Mr Proud by which professional body he was regulated. Mr Proud claimed to be an "osteomyologist", although he also revealed that he had trained in Australia as a chiropractor, but he did not disclose that he was registered with and regulated by the GCC.

For the reasons below the Committee found this proved.

#### ***Allegation 6:***

***Your conduct as set out at above, was:***

- (a) inappropriate;*
- (b) unprofessional;*
- (c) contrary to the best interests of Patient C;*

Given the evidence that patient C's general condition was not serious, it was clearly inappropriate, unprofessional and contrary to her best interest to have created such alarm and despondency in the patient (the effects of which still manifested themselves when she gave testimony some 19 months later). Furthermore it was similarly inappropriate, unprofessional and contrary to her best interests to have suggested that she needed 12 months treatment.

It was wholly unprofessional to decline to identify the professional body with which you are registered and by whom you are regulated.

For these reasons the Committee found this proved.

### **DETERMINATION IN RELATION TO COMPLAINT: 0605/01537/02**

*That, whilst a registered chiropractor,*

#### *Allegation 1:*

*Between about March 2005 and about May 2005 you practised as a chiropractor at Living Health Chiropractic, 126 Norton Road, Stourbridge, DY8 2TA;*

For the reasons set out in the Preliminary Issues, the Committee found this Allegation proved.

#### *Allegation 2:*

*On or about 24 March 2005 you:*

- (a) accepted Patient D as a patient;*

The Committee found Patient D to be a credible and honest witness. From her oral evidence and the clinic records the Committee found that Mr Proud did accept Patient D as a patient.

- (b) undertook a clinical examination and clinical assessment of Patient D, which included the taking of x-rays;*

The Committee found that the records show that a clinical examination and assessment involving X-rays was performed. This was supported by Patient D's oral evidence.

- (c) told Patient D that, if she had subluxation, you would recommend a course of treatment over a twelve month period at a cost of about £3,000;*

Patient D recalled her first visit to Mr Proud during which she underwent a brief assessment and X-rays were taken. In the office, prior to results of the X-rays being available, she was told that if she had a problem a 12-month course of treatment would be necessary and

would cost £4,000. She made it clear that she “thought it was a lot of money”. Mr Proud then said that the price could be reduced to £3,000.

The Committee accepts this evidence and this Allegation in all parts and is therefore proved.

***Allegation 3:***

***On or about 5 April 2005 you said to Patient D words to the effect that you had very bad news for her, very bad news, and that she did have subluxation;***

In her oral evidence Patient D clearly stated that Mr Proud had told her that he had “very bad news for her, very bad news” and that she had subluxations. The Committee accepts this evidence and find this allegation proved.

***Allegation 4:***

***In speaking to Patient D as set out at 3 paragraph above you:***

- (a) spoke in an unduly alarmist manner to the patient;***
- (b) failed to treat Patient D with consideration;***
- (c) misrepresented the gravity of Patient D's condition;***

The Committee finds these allegations proved for the following reasons:

Patient D clearly remembered her reaction to Mr Proud. She described feeling “shocked” at this news, and thinking “Oh my God, what is wrong?” It is unduly alarmist for a chiropractor to speak to a patient in the way set out in Allegation 3, causing them to be shocked and it demonstrates a failure to treat Patient D with consideration. Furthermore, such language clearly misrepresented the gravity of the Patient D’s condition as recorded in her clinic records.

Dr Brown sets out in his expert report that:

“By saying to a patient.. “I have bad news for you. Very bad news”, I consider that a reasonable patient might think that they are to be diagnosed with a life-threatening disease or illness. In a patient with a number of serious health concerns, it was foreseeable that the use of such terminology was potentially distressing and was likely to cause alarm or distress.”

He further states:

“In my opinion, the discovery of subluxation (areas of vertebral restriction in the spinal joints) is commonplace to the point of universality in patients. It is the duty of a chiropractor to link such subluxations to the clinical finding and case history. To tell a patient that the discovery of subluxation represents very bad news in my view grossly overstates the gravity of a patient’s condition.”

The Committee agrees with Dr Brown and finds all parts of this Allegation proved.

***Allegation 5:***

***At the appointment on or about 5 April 2005, you recommended to Patient D that she undergo a one-year course of treatment;***

In Patient D's oral evidence she told the Committee that after being told it was "very bad news", Mr Proud had said she would need 12 months' treatment. The receipt at page 204 of the bundle is for £600 for the first months' payment (of £600) towards a "12-month Corrective Spinal Programme".

The Committee finds this proved.

***Allegation 6:***

***At appointments on or about 23 March 2005 and 5 April 2005 you asked Patient D to sign documents which included the words:***

***"The Doctors at Living Health are spinal specialists and are specifically trained in the detection and correction of spinal subluxation. They are not medical doctors, osteopaths, chiropractors, or physiotherapists";***

The Committee finds as a fact on Patient D's evidence, the documents in the bundle and on Mr Proud's letter of 18 August 2005 (pages 242-3) that Mr Proud asked her to sign such documents.

The Committee finds this proved.

***Allegation 7:***

***The wording referred to at 6 above was misleading, in that, at the material time, you were a qualified chiropractor registered with the General Chiropractic Council;***

Having accepted that Mr Proud was a registered chiropractor at the material time, for the reasons previously stated, the Committee finds as a fact the assertion that he was not a chiropractor to be misleading.

The Committee finds this proved.

***Allegation 8:***

***You required Patient D to remove paper from the treatment bench after receiving treatment;***

From Patient D's oral evidence, the Committee accepts as a fact that Patient D was required to remove paper from the treatment bench.

***Allegation 9:***

***Requiring the patient to so act was:***

- (a) inappropriate;***
- (b) unprofessional;***

The Committee do not accept the opinion of the expert witness Dr Brown. The Committee draws a distinction between a patient depositing a worn gown in a laundry bin and a patient removing paper from a treatment bench in full sight of other waiting patients. The gown has been worn by the patient and is personal to him or her and cannot be discarded until he or she dresses. The paper is used on the treatment bench which is the working area of the chiropractor, and as such, is the chiropractor's responsibility to maintain.

Consequently the Committee take the view that it was inappropriate and unprofessional for Mr Proud to require a patient (Patient D) to do his housekeeping.

This Allegation is therefore found proved.

***Allegation 10:***

***You did not keep an adequate written record, in relation to Patient D of:***

- (a) her case history;***
- (b) the initial physical examination;***
- (c) the x-ray findings;***
- (d) your working diagnosis or clinical impression;***
- (e) your initial management or clinical treatment plan;***
- (f) the patient's prognosis;***
- (g) the patient telling you about her response to treatment;***
- (h) pain she advised you she was experiencing;***
- (i) your response to the patient's concerns;***

- (a) The Committee does not accept the opinion of the expert witness Dr Brown that Mr Proud recorded an adequate case history. It is ambiguous whether he recorded the case history at all as this consists mainly of tick boxes with no capacity to accommodate the individual patient's narrative. The complaint of "neck back food intolerance" is inadequate as a description and the duration of the main complaint is not recorded at all. The onset is dealt with by ticking one of 4 boxes with no information about how the onset occurred and aggravating and relieving factors are not recorded. The previous health history is completed by indicating from choices on an inadequate and closed list of health problems which omits serious health issues. Since the case history was inadequate, it is inevitable that the record could not be adequate either.
- (b) The Committee does not accept the opinion of the expert witness Dr Brown that Mr Proud adequately recorded a physical examination. The Committee does not accept that Mr Proud kept an adequate written record of the initial physical examination. This examination was carried out through clothing and therefore the ranges of movement recorded for the lower back could not have been valid. The same applies to the postural findings in relation to the shoulder and lower back regions. Because the examination was inadequate, it is inevitable that the record could not be adequate either.

- (c) The Committee agrees with Dr Brown that Mr Proud failed to keep an adequate record of Patient C's X-ray findings in that no such record was found in the documents that he sent as her records.
- (d) The Committee does not concur with Dr Brown that Mr Proud adequately recorded a working diagnosis or clinical impression. The only such information recorded was "Abnormal Spinal Biomechanics". It is the view of the Committee that this term does not support any understanding of the individual patient's problems, or a rationale for treatment.
- (e) The Committee agrees with Dr Brown that Mr Proud did not adequately record an initial management or treatment plan. The only documentation that resembles this is an appointment diary which does not fulfil this role.
- (f) The Committee agrees with Dr Brown that Mr Proud did not adequately record the prognosis. No reference to this was found in the records.
- (g) The Committee agrees with Dr Brown that no discussion of the patient's subjective progress was recorded.
- (h) The Committee agrees with Dr Brown that Mr Proud "failed to make a proper record in relation to the patient's subjective evaluation of the pain". No such information was recorded.
- (i) The Committee agrees with Dr Brown that no adequate record of Mr Proud's response to Patient D's concerns was made. The entry for the date on which Patient D expressed these concerns does not say what these concerns were.

For the reasons set out above, the committee finds all parts of this Allegation proved.

***Allegation 11:***

***Your conduct, as set out above was:***

- (a) inappropriate;***
- (b) unprofessional;***
- (c) contrary to the best interests of Patient D;***

The Committee considers that it is inappropriate and unprofessional for Mr Proud to have spoken to Patient D in an alarming manner, misrepresenting the gravity of her condition. Further, it is inappropriate and unprofessional for a chiropractor to misrepresent themselves so as to mislead the public. Failing to keep adequate records and requiring the patient to "housekeep" for the chiropractor are also inappropriate and unprofessional activities. The Committee considers that such activities and behaviour were not in the best interests of Patient D.

# UNACCEPTABLE PROFESSIONAL CONDUCT

Having considered the evidence on each Allegation separately when determining the facts, the Committee now addresses the issue of whether or not those facts that it has found proved amount to Unacceptable Professional Conduct. Conduct which falls short of the standard required of a registered chiropractor is referred to as Unacceptable Professional Conduct (Section 20(2) of the Chiropractors Act 1994).

The Committee has found, in each of the five separate sets of allegations that the proved facts amount to Unacceptable Professional Conduct. In addition, the Committee has considered the issue of Unacceptable Professional Conduct cumulatively. Its reasons for finding Unacceptable Professional Conduct are as follows:

In the four separate sets of findings involving patients, the Committee has found that Mr Proud's conduct overall was inappropriate, unprofessional and not in the interests of each of those patients. Furthermore, in the remaining set of findings, concerning the advertisement the Committee finds that Mr Proud's publicity was likely to have misled the public.

The Committee concludes that the conduct in the cases of the four patients amounts to a pattern of behaviour that caused the Committee grave concern. Mr Proud's conduct fell short of the standard required of a chiropractor in several areas and in respect of several sections of the Standard of Proficiency and Code of Practice in force at the time. In particular:

1. Examinations, clinical assessments and further investigations were inadequate and superficial, without appropriate preparation of the patient (as they remained fully clothed) and were also inadequately recorded. These are breaches of the original Standard of Proficiency 4.1 and 4.2 and of the revised Standard of Proficiency A1.1, A1.2, A1.3 and D1.1.
2. There was unjustified use of ionizing radiation with the potential to jeopardize patient health. This is a breach of the original Code of Practice 2.12.2 and of the revised Standard of Proficiency A1.3 and A1.6.
3. The Committee concludes that in exaggerating the seriousness of the patients' conditions, thereby misleading them, Mr Proud was dishonest. This is a breach of the original Code of Practice 2.3 and the revised Code of Practice C1.1 and C2.1.
4. The diagnoses were disclosed to the patients in an alarmist manner, without proper respect or consideration for the patients. This is a breach of the original Code of Practice 2.2 and the revised Code of Practice B1.1.
5. After the initial diagnosis, the patients were invariably offered a 12-month course of treatment which was in each case, excessive and with no clinical justification and ran unnecessary risks of treatment dependency. This is a breach of the original Code of Practice 2.1 and 2.3 and the revised Code of Practice C1.3 and C2.3.
6. Mr Proud subjected patients to various forms of pressure and asserted undue influence to persuade them to accept the recommended investigations and/or treatment. This is a breach of the original Code of Practice 2.7 and of the revised Code of Practice A3.2 and C2.3.
7. When treatment commenced, Mr Proud failed to respond appropriately to patients' problems and concerns and did not modify treatment when necessary. This is a

breach of the original Standard of Proficiency 6.1, the revised Code of Practice C1.1 and the revised Standard of Proficiency A2.1 and C2.1.

These common themes led to repeated and flagrant breaches of the standards of conduct and practice. Mr Proud's practices fell far short of the standard required to protect patients from harm, safeguard the public interest and maintain the reputation of the profession.

**Therefore, in relation to the facts and matters alleged, for all these reasons Mr Proud is guilty of unacceptable professional conduct.**

## **SANCTION**

The Committee has carefully considered all the evidence that has been given. The Committee is mindful that its role is to protect patients and the wider public, to maintain public confidence in the profession and to declare and uphold proper standards of conduct. In determining an appropriate sanction, the Committee has taken into account the GCC Indicative Sanctions Guidance, and been mindful that any sanction should be proportionate and is not intended to be punitive, although it may have that effect.

The Committee heard from Mr Cosgrove on behalf of the GCC that Mr Proud is already the subject of an 18 month Suspension Order imposed in February 2006.

The Allegations that have been found proved in this hearing concern Mr Proud's behaviour over a period of time, involving several different patients. The Committee has heard no evidence of remorse and nothing in mitigation.

The Committee first considered whether it would be sufficient to conclude this matter with an admonishment. Given the seriousness of the Unacceptable Professional Conduct the Committee has found, it has no hesitation in determining that this sanction is not an option. An Admonishment is insufficient to protect patients and the public and maintain standards and confidence in the profession.

The Committee next considered whether to impose a Conditions of Practice Order. The pattern of behaviour revealed in this hearing raises serious concerns about Mr Proud's competence to adequately assess and care for his patients.

There is no evidence that Mr Proud is willing to respond positively to any directions from the GCC. Indeed, Mr Proud has endeavoured to evade the GCC's jurisdiction by denying that he is a chiropractor.

Consequently, a Conditions of Practice Order is inappropriate.

The Committee then considered whether or not Suspension of Registration would be sufficient.

The Code of Practice and Standard of Proficiency outline the minimum standards expected of registered chiropractors. Chiropractors who take an ethical, patient centred approach to practice and treat those under their care with competence, compassion and respect are unlikely to transgress either the Code or Standard.

When the behaviour and actions of a chiropractor fall below in multiple areas of these standards, it suggests an elemental disregard of the principles and duties of care expected of registered health care practitioners.

During this hearing, the testimony of patients led the Committee to conclude that Mr Proud does not possess the requisite qualities of a primary health care professional. Indeed his conduct, in respect of those patients brought to the attention of the Committee, was manifestly reprehensible and indefensible.

Mr Proud has shown an unacceptable lack of concern, empathy and respect towards his patients. He has placed personal gain above the welfare of his patients.

Integrity and trust are central to the relationship between chiropractors and their patients and those who place personal gain above the welfare of their patients risk bringing the entire profession into disrepute. In abusing the trust of his patients, and coercing them, through alarmist scare tactics, into excessively protracted and unjustified treatment plans, Mr Proud has undermined the professional standing enjoyed by registered chiropractors.

Mr Proud falls short of the standards required of him, and has sought to evade regulation and criticism by denying his professional title.

Mr Proud's practice demonstrates a serious departure from the accepted principles as set out in the Code of Practice and the Standard of Proficiency. His behaviour certainly had an ongoing effect on the patients who gave evidence. All three patients who gave evidence were clearly distressed and angry when they recalled the events, in particular, the alarmist way in which Mr Proud spoke to them.

His coercion of patients to accept unnecessary excessive treatment, including exposure to ionising radiation, was dishonest and an abuse of his position.

By attempting to deny the jurisdiction of the GCC, and declining to attend the hearing, Mr Proud has demonstrated his persistent lack of insight into the seriousness of his actions.

The Committee was mindful of the Privy Council advice in *Bijl v GMC* that the Committee should not feel it necessary to remove:

“...an otherwise competent and useful [chiropractor] who presents no danger to the public in order to satisfy [public] demand for blame and punishment.”

The Committee also gave consideration to the decision in *Gupta v GMC*:

“The reputation of the profession is more important than the fortunes of an individual member. Membership of a profession brings many benefits, but that is part of the price.”

The Committee determined that a Suspension Order was insufficient to protect the public.

The Committee believes that Mr Proud's behaviour is fundamentally incompatible with continued registration as a chiropractor.

The Committee has determined that the only appropriate sanction that is sufficient to protect the public, uphold high standards and maintain confidence in the profession is to remove Mr Proud's name from the Register of Chiropractors.

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 Proud or, where an appeal is made, until the appeal is withdrawn or otherwise disposed of.

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*Chairman 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.

Signed:

Dated: 22 January 2007

**Emma Willis**  
Specialist Officer (Regulation)  
On behalf of the Professional Conduct Committee

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*Explanatory Notes:*

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

1. The Allegations: 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 allegations 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.