

Independent Review of General  
Chiropractic Council Fitness to Practise  
Cases 2010 – 2013

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## Acknowledgments

Particular thanks go to Richard Kavanagh at the GCC for responding to requests for additional information so swiftly and helpfully.

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## ABOUT THE AUTHOR

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Sally also conducts invited reviews of NHS services on behalf of the Royal College of Surgeons of England and the Royal College of Paediatrics and Child Health, and she is a Lay Assessor with the National Clinical Assessment Service. She sits on the Nursing and Midwifery Council's Conduct and Competence Committee as a fitness to practise panellist and also adjudicates on complaints about private healthcare.

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## EXECUTIVE SUMMARY

The General Chiropractic Council (GCC) is the second smallest of the nine regulators of healthcare professionals. Its size brings both advantages and disadvantages in terms of the discharge of its statutory functions. The number of complaints made about chiropractors has been modest when compared with other professional regulators, and only a small number of registrants have passed all the way through the fitness to practise process each year. This caseload lends itself to a personalised, customer-focused approach.

What is often missing with a smaller caseload is the pressure to systematise, drive performance through the use of metrics, and derive benefits from economies of scale. This was evident in early 2012, following a review by the GCC Executive of the investigation processes carried out by the office. The review identified inconsistencies in the way cases were referred onwards, as well as in the circumstances in which certain powers were applied, and cases meandered in the absence of case plans (GCC, 2012a). The GCC introduced a raft of actions to improve its processes, including new guidelines and staff training, and an external audit was planned for 2013 to ensure the effectiveness of the changes. The GCC also applied to the Department of Health requesting immediate legislative changes to enable it to improve its handling of fitness to practise cases.

It is against this backdrop that the GCC commissioned an independent review of its fitness to practise cases between 2010 and 2013, with the objective of understanding the themes arising from allegations made about chiropractors. A review of case documentation was undertaken and allegations were classified into categories and also by type, and sometimes sub-type.

### Key findings

- > More complaints are made about male chiropractors – for example, 81% of allegations relating to ‘relationships with patients’ concerned male chiropractors.
- > The largest single category of allegations, relating to 81 cases, concerned **complaints about clinical care**, including excessive or aggressive treatment, inadequate assessment and a lack of clinical justification for investigations or x-rays. There was a sharp increase in allegations about treatment causing injury or pain in 2012, which remained high in 2013.
- > Almost as many allegations (occurring in 80 cases) were made about **relationships with patients**, including issues around communication and obtaining consent, maintaining professional boundaries, and privacy and dignity. Often a single case contained allegations about both clinical care and relationships with patients. The most frequently occurring allegations under this category related to communication and, most commonly, that the chiropractor failed to explain the diagnosis, treatment plan or results.
- > **Allegations about probity** were the third biggest category, occurring in 57 cases – and in fact probity allegations increased more than threefold across the four year period. The most common probity allegations were about use and handling of patient data, advertising, and how chiropractors represented their skills, experience and registration.

- > Another notable category was **allegations about business disputes** and employment issues, which arose in 16 cases. Most commonly, a chiropractor had complained that another chiropractor had left their clinic to set up a practice nearby. Others concerned the conduct of the chiropractor as an employer. Such complaints will often be outside the scope of the GCC and no case to answer was found in all 16 instances.
- > There was more than a doubling in the **number of sexual allegations** between 2011 and 2012, and this higher level was sustained in 2013. The 'Yewtree effect' and Jimmy Savile inquiry may explain some of this increase. Since 2011 there have been 40 allegations of a sexual nature, spread across 25 cases.
- > The **five most commonly occurring allegations** over the time period were:
  - treatment causing injury/pain;
  - inadequate record keeping;
  - failure to explain diagnosis/treatment plan;
  - misleading advertising;
  - failure to obtain informed consent.
- > The most commonly occurring allegations suggest that greater attention should be given to **professionalism, ethics and relationships with patients**. The increases in allegations of a sexual nature, about probity, and also relating to business disputes, indicate a need to raise the profile of professionalism for chiropractors – what it means to be a registered chiropractor and the values and behaviours expected of them as healthcare professionals.
- > The GCC must ensure that it is clearly articulating expectations in these areas, and that it is up-to-date, or even ahead of stakeholders' expectations of the profession regarding ethics and professionalism.
- > The review of the case documentation gave rise to a number of further findings (see section 6), including the language used to convey decisions, the expectations made of complainants, linking multiple complaints made about a chiropractor, the test used to decide an allegation, and expanding the powers of investigation and adjudication. The GCC has been pursuing legislative change to streamline its investigation and disposal of cases, which may address some of these issues.

## The GCC should...

- 1 Develop explanatory guidance in the following areas, to support chiropractors in embedding standards of professionalism and ethics in their everyday practice:
  - > communication with patients
  - > consent
  - > maintaining clear sexual boundaries
- 2 Engage the profession in discussions about what professionalism means for chiropractors in the context of changing public expectations and increasing allegations about probity.
- 3 Clarify its scope with regard to business disputes and the type of issues that would be better directed elsewhere, such as an employment tribunal or for legal advice.
- 4 Conduct research into the experiences of people who make a complaint about a chiropractor, to understand their needs for support and whether this has any bearing on the number of complaints that are withdrawn.
- 5 Reflect on whether its expectations of complainants in terms of the provision of evidence are reasonable and whether it provides sufficient guidance on gathering together evidence, including how to go about securing an expert report, where necessary.
- 6 Tighten up the language used in Investigating Committee decision letters, including avoiding the use of acronyms and explaining concepts that may be unfamiliar to the general public. Particular attention is needed to the language used to convey decisions about consent.
- 7 Consider its approach to categorising and capturing linked cases, to ensure allegations about a registrant are understood in the round. A number of minor allegations may point to a more serious problem, however existing processes for linking cases of a similar nature are not capturing this consistently and it is unclear whether there is a mechanism for capturing cases that are different in nature but which could indicate fitness to practise concerns.
- 8 Consider an extension of its powers to include warnings, letters of advice, undertakings and voluntary removal. This would align with moves towards greater consistency of decision making across the nine regulators of healthcare professionals.
- 9 Ensure that registrant members of fitness to practise committees are clear about their role and when expert advice for an independent chiropractor may be required.
- 10 Clarify the circumstances in which a registrant may face allegations of both unacceptable professional conduct and professional incompetence, and that panellists are up-to-date with relevant case law in this area.
- 11 Seek legal advice on whether Professional Conduct Committee decisions should consider the concept of impairment, in line with other regulators of healthcare professionals, and improve the way decisions are conveyed – including what it means to find an allegation ‘well founded’.
- 12 Develop and publish key performance indicators to drive the timely resolution of fitness to practise cases – two cases referred to the GCC in 2011, and 10 from 2012, were pending consideration by the Professional Conduct Committee, as at March 2014.

## 1. INTRODUCTION

The General Chiropractic Council (GCC) is the statutory body established by Parliament to regulate all chiropractors in the UK. Its overriding objective is to ensure the safety of patients undergoing chiropractic care.

One of the GCC's key statutory functions is to investigate concerns about the fitness to practise of chiropractors registered to work in the UK. The number of concerns it receives, usually in the form of complaints, has been increasing. The nature of allegations made against chiropractors also seems to have altered in recent years.

To understand what might lie behind these perceived shifts, the GCC commissioned an independent review of its fitness to practise cases between 2010 and 2013. The main objective was to provide a detailed understanding of the themes arising from allegations made about chiropractors.

### Approach

A review was undertaken of documentation<sup>1</sup> for every case for which it was available between 2010 and 2013<sup>2</sup>. Each allegation pinpointed in the documentation was classified into one of the categories identified below. Allegations were also classified according to type and in some cases also by sub-type. Due to the nature of the profession some types of complaints occur much less frequently; for such categories allegations were not broken down.

Category	Type	Sub-type
Clinical care	e.g. Substandard care	e.g. Inadequate assessment e.g. Failure to refer, when appropriate
Probity	e.g. Patient data	e.g. Improper alteration of patient records e.g. Removal of patient records from clinic
Relationships with patients	e.g. Communication	e.g. Failure to explain diagnosis e.g. Rudeness to patient
Working with colleagues	e.g. Undermining advice of healthcare colleagues	
Health	e.g. Substance/alcohol problems	
Conviction/caution/criminal offence	e.g. Assault	
Teaching/supervision		
Compliance with GCC investigations		
Business/employment issues		
Other		

<sup>1</sup> Investigating Committee decision letters and Professional Conduct Committee Notice of Allegation and Notice of Findings.

<sup>2</sup> No documentation was available for 21 cases either awaiting consideration by the Investigating Committee or which did not satisfy the criteria under Section 20 of the Chiropractors Act 1994 to constitute a complaint requiring investigation. Some other cases had only been decided upon by the Investigating Committee recently and documentation had not been issued; in these cases, the GCC provided a summary of the case and the decision.

More than one allegation could be recorded in a single case, for example a complaint may contain allegations relating to both clinical care and relationships with patients. The case will only have one outcome however, and the outcome may reflect some allegations but not others.

The classification captures concerns and alleged failures by chiropractors. It does not reflect proven facts, and it is notable that the majority of cases do not pass beyond the first stage of the fitness to practise process and are closed as 'no case to answer'. What the classification provides however, is insight into the type of concerns that arise about chiropractors, which may highlight areas for response by the regulator, such as developing targeted guidance.

This classification system also provides a framework the GCC can use to categorise cases on an ongoing basis, to aid its own analysis of its fitness to practise caseload and to identify trends in complaints. In addition to allegations, it captures the source of referral of a complaint and the outcome for each case. This framework could be developed to enable the GCC to examine the length of time it takes to progress cases against the category of allegation and source of referral.

### This report

This report presents the findings of the review of fitness to practise cases between 2010 and 2013.

- > Section 2 gives a brief overview of the GCC's approach to fitness to practise and its powers with regard to the disposal of cases.
- > Section 3 outlines fitness to practise activity and outcomes over the four year period.
- > Section 4 examines the allegations made about chiropractors, including the most commonly occurring allegations, and how they break down into type and sub-type.
- > Section 5 explores the demographic profile of chiropractors about whom a complaint has been raised, including their gender and age.
- > Section 6 highlights a number of issues that the GCC may wish to consider further, in the light of the findings of this review.

## 2. ABOUT FITNESS TO PRACTISE

The GCC's *Code of Practice and Standards of Proficiency* represents the benchmark of conduct and practice against which chiropractors are measured.

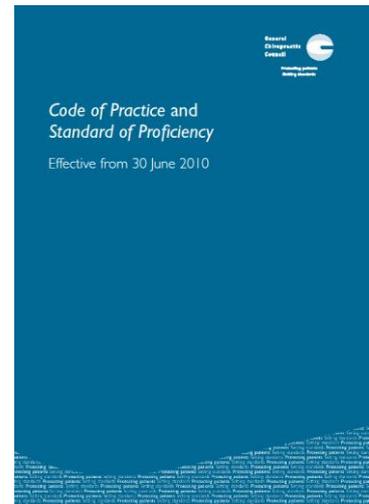
Three statutory committees are concerned with chiropractors' conduct, proficiency and physical and mental health – see page 12, for an outline of each committee.

The GCC must investigate any complaint made about a registrant.

The types of complaint it can investigate are:

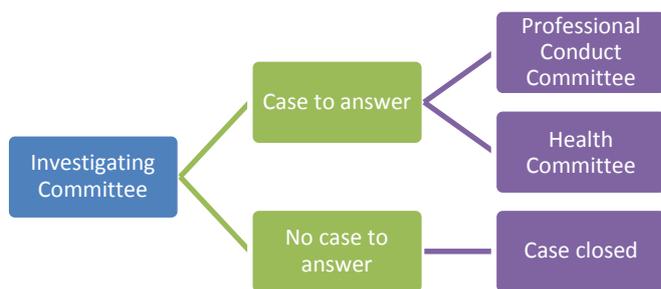
- Unacceptable professional conduct
- Professional incompetence
- Criminal convictions
- Concerns about a physical or mental condition that has the potential to impact on a registrant's ability to treat patients.

It cannot take forward complaints about companies or clinics, or about compensation or the refund of fees.



## The Investigating Committee

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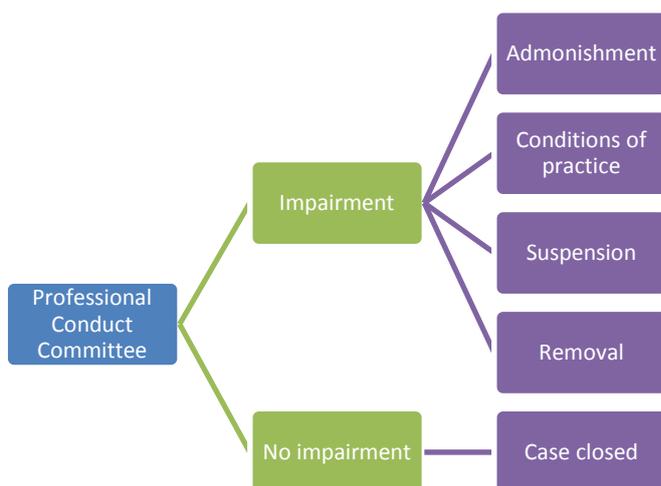


Complaints that are taken forward are subject to further investigation before being referred to the Investigating Committee. The Investigating Committee meets in private and decides whether the chiropractor's fitness to practise may be in question. If it decides that there is a case to answer, the complaint is referred for a

formal hearing to the Professional Conduct Committee (PCC) or, for complaints about the health of a chiropractor, to the Health Committee (HC). The Committee may decide to order that a chiropractor's registration be suspended for up to two months while the case is investigated, where it considers this necessary to protect the public.

## The Professional Conduct Committee

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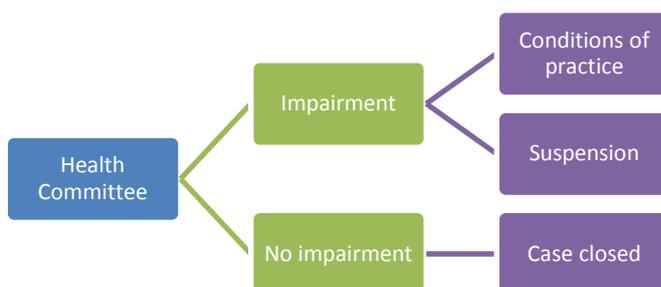
The PCC decides whether the fitness to practise of the chiropractor is impaired by means of their:

- Unacceptable professional conduct
- Professional incompetence

A meeting is held to decide whether the allegation should be considered at a public hearing or at a private meeting and whether an interim suspension order should be imposed.

## The Health Committee

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The HC can also decide whether to determine a complaint by public hearing or by private written submissions of evidence. If it decides that the fitness to practise of the chiropractor is impaired by means of their physical or mental health, it can decide to impose conditions of practice or a suspension.

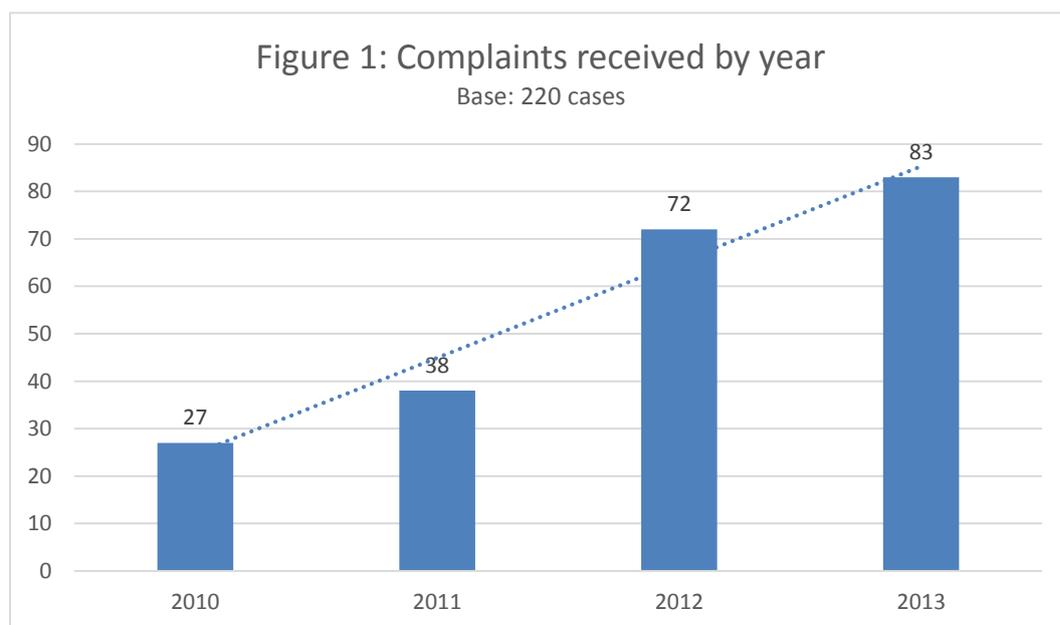
### 3. FITNESS TO PRACTISE ACTIVITY AND OUTCOMES 2010-2013

The GCC received 224 complaints during the time period. Of these, four complaints were linked to other complaints and merged to become one case, so this took the sample down to 220. A further 21 cases were in the pipeline at the time of this analysis, either because they were awaiting consideration by the Investigating Committee or because they had not yet satisfied the criteria of a complaint that the GCC could consider. The analysis therefore focused on the 199 cases properly in the system and about which the allegations are known.

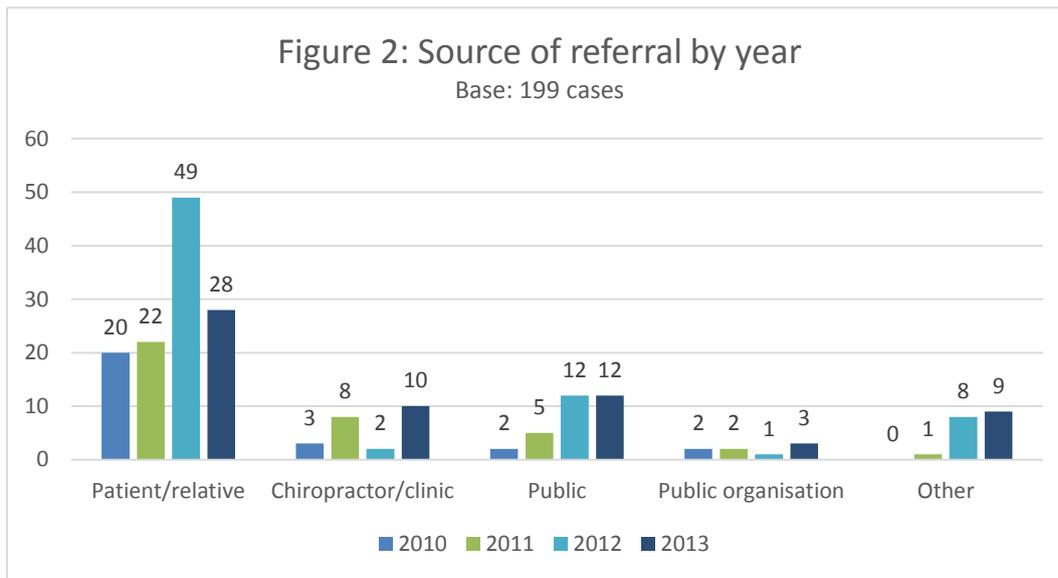
<b>TOTAL COMPLAINTS RECEIVED BY GCC 2010-2013</b>	<b>224</b>
Complaints merged with linked cases	4
Complaints in the pipeline (e.g. waiting to go before IC)	21
Complaints sample analysed	199

#### Complaints caseload

As figure 1 shows, the number of complaints made about chiropractors has increased over the time period. This echoes trends in other professional regulators, which have similarly experienced rising numbers of complaints year on year.<sup>3</sup> If the trajectory continues, the GCC is likely to see this area of activity grow markedly.



<sup>3</sup> See for example, GMC (2012), *2012 Annual Statistics for our investigations into doctors' fitness to practise*.



The GCC receives more complaints from patients than any other source – 60% of the 199 cases analysed came from patients or a relative. In the vast majority of cases, the allegations were made by a patient of the chiropractor, however in three cases the source of the complaint was the patient of a colleague of the chiropractor complained about. There was a spike in complaints from patients in 2012, although many of the 21 cases in the pipeline for 2013, and not shown in figure 2 above, are likely to be referrals from patients, which may make the increase in 2012 less marked.

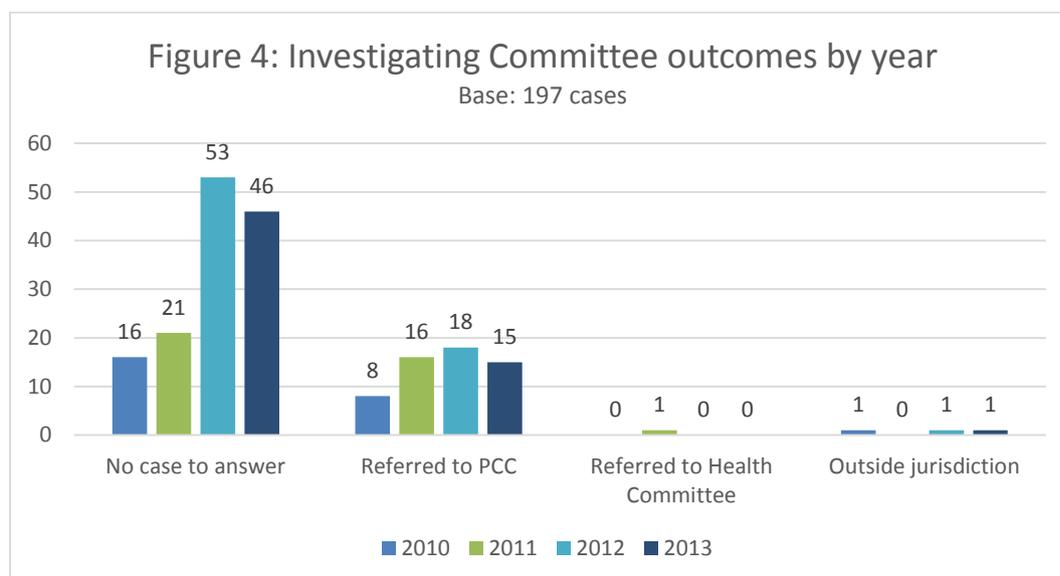
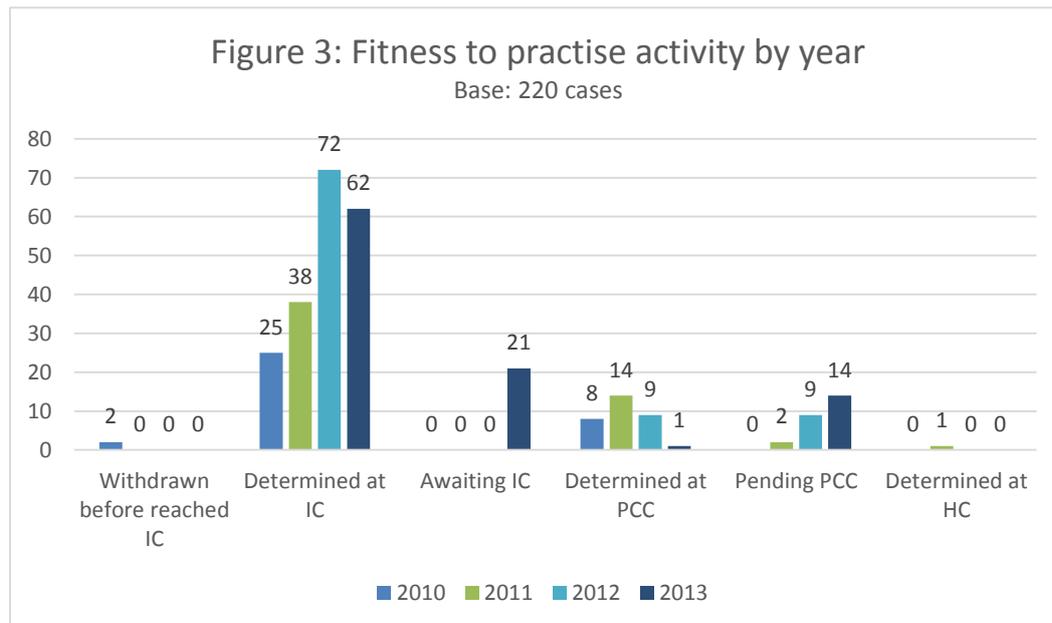
The next largest category (31 of the 199 cases) were referrals from the public – classified as a member of the public or an organisation, such as a healthcare cash plan provider. A total of 23 referrals came from another chiropractor or a clinic where the chiropractor complained about had worked.

Referrals from public organisations, like the police or local authorities, accounted for just eight cases. The ‘other’ category shown in figure 2 included complaints referred to the GCC by the Registrar (1), self-referrals (4) and anonymous complaints (13). While just one case over the four year period was initiated by the Registrar, in some other cases the Registrar assumed cases that had been referred to the GCC from another source.

## Fitness to practise outcomes

At the time of analysis, 197 cases had passed through the IC between 2010 and 2013, and a further 21 cases were awaiting consideration by this committee. Two additional cases were withdrawn before they reached the IC – see figure 5.

As figure 3 shows, the PCC had concluded 32 cases and 25 were pending at the point of analysis, including two cases from 2011 and 10 from 2012. One case had been concluded by the Health Committee.



The IC found no case to answer for 68% of the cases it considered during the time period. A higher percentage of cases was referred by the IC to the PCC in 2011 and fewer in 2012 and 2013. Overall, the IC referred 57 cases to the PCC and one to the HC during the time period; 26 cases referred to the PCC were still pending as at March 2014. The IC imposed an interim order of suspension with

respect to three linked cases in 2013. The issues arising in one case were referred to the Registrar to pursue, however no case to answer had been found.

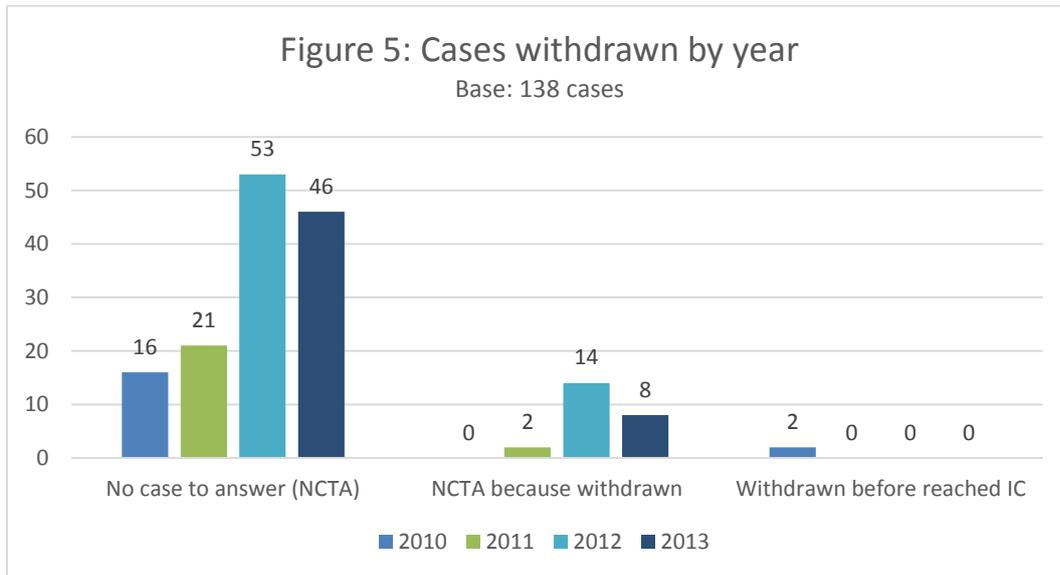


Figure 5 shows the number of complaints withdrawn over the period. Overall 26 complaints were withdrawn. In the majority of cases this resulted in a ‘no case to answer’ decision by the IC, but two cases were withdrawn in 2010 before reaching the IC. It means that over the time period 18% of complaints before the IC were withdrawn – in 2012 alone 26% cases where the outcome was no case to answer were withdrawn. The potential significance of this is considered further in section 6.

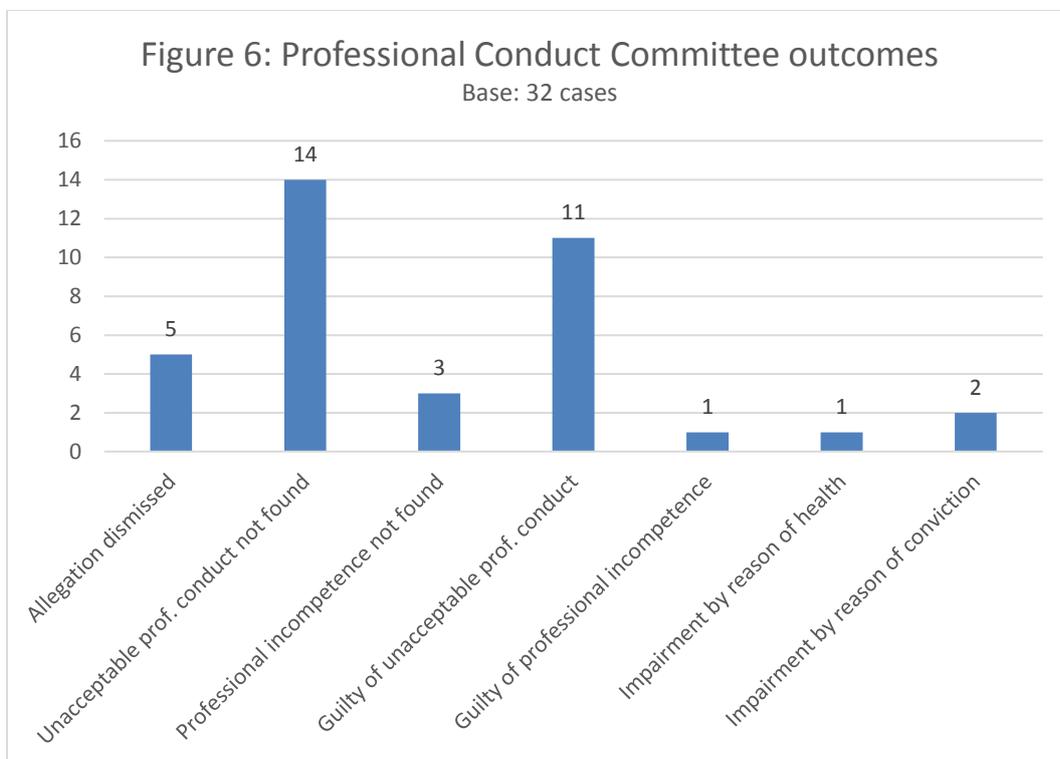


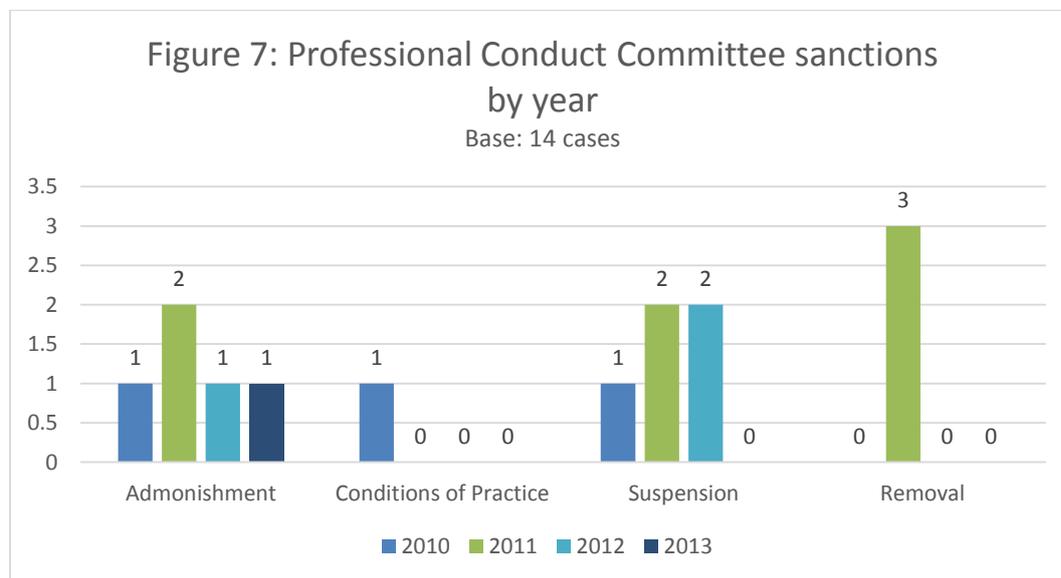
Figure 6 shows that 22 allegations heard by the PCC were not well founded, because the allegation was dismissed or because either unacceptable professional conduct or professional incompetence

were not found. Allegations were well founded in 15 cases, mainly for the reason of unacceptable professional conduct.

For the majority of cases the PCC considered just one allegation: either unacceptable professional conduct, professional incompetence or criminal convictions. However, in four cases, both unacceptable professional conduct and professional incompetence were alleged – in one of these neither the grounds of conduct nor incompetence were well founded; for a second, both allegations were well founded; and for the remaining two cases, the grounds of conduct were well founded and the allegation of professional incompetence was dismissed.

One case was decided with regard to Section 22(3) of the Chiropractors Act 1994, which deals with whether action should be taken in respect of criminal convictions. A further case was decided on the basis of a criminal offence.

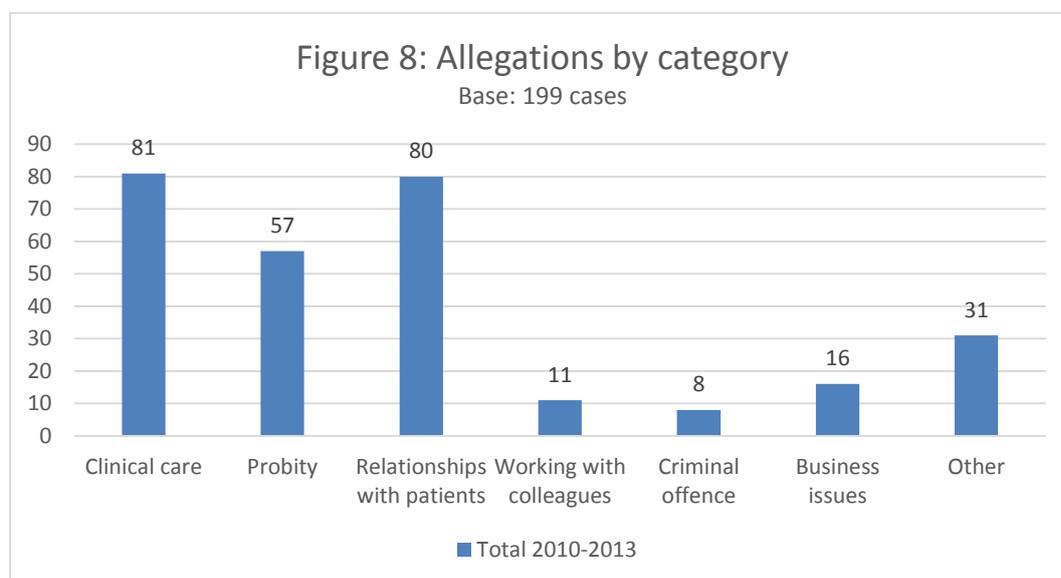
As only a single case during the period was considered by the Health Committee, this has been included in the outcomes shown in figure 6.



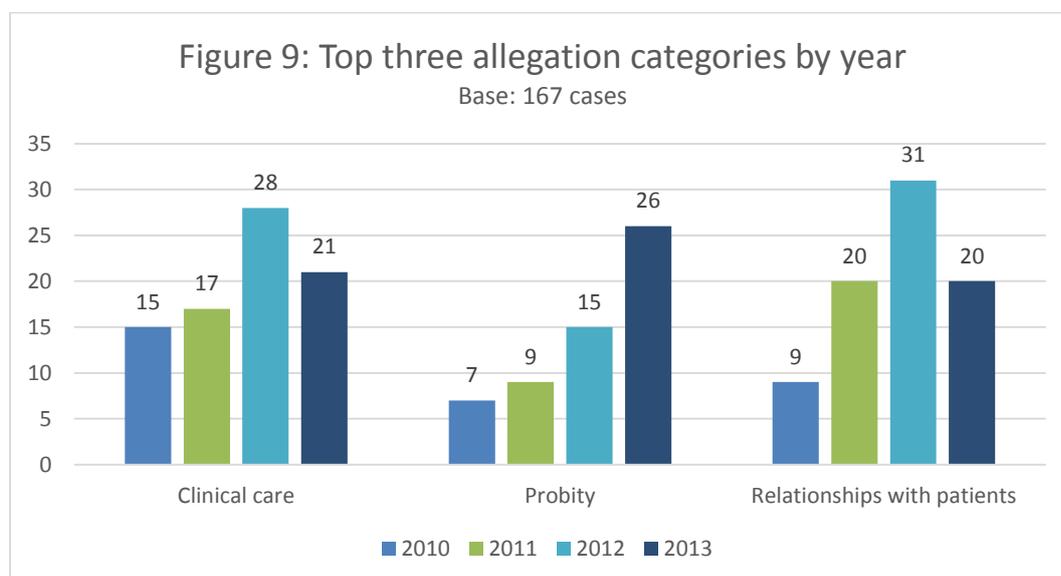
A sanction was imposed for all the cases where the allegation was well founded. For one case, the registrant was found guilty of unacceptable professional conduct as well as professional impairment and a sanction (removal from the register) was imposed for each allegation, however this was reflected as just one sanction. Admonishment and suspension were the sanctions most frequently imposed.

## 4. ALLEGATIONS

The classification of allegations as given in case documentation is inherently subjective. Having a single person undertake the classification within a short period of time however, means that subjective elements should be consistent and it becomes easier to identify clusters. A few clusters of complaints about the same type of allegation were identified. For example, in 2013 there was a small cluster of complaints relating to claims made by chiropractors on their websites. In 2012, a cluster of allegations of a sexual nature surfaced, and another cluster related to patients alleging injury or pain arising from chiropractic care. The reasons for these clusters are often hard to fathom, particularly as the overall numbers of complaints received by the GCC are relatively small, although theories for the rise in sexual allegations are suggested below.



The categories that attracted most allegations during the period were clinical care and relationships with patients – often a single case would contain allegations in both of these categories. A handful of cases contained allegations relating to clinical care, probity and relationships with patients.



Allegations about probity have increased more than threefold during the time period. Figure 9 shows it is too early to identify any trends with respect to the other two main categories, although the number of allegations that fall into each category have increased overall.

## Clinical care

Figures 10 and 11 show the breakdown of allegations about clinical care by type, and how this has changed over the years. By far the most commonly occurring allegation type is substandard care, which can be broken down further into sub-type, as shown in figure 11.

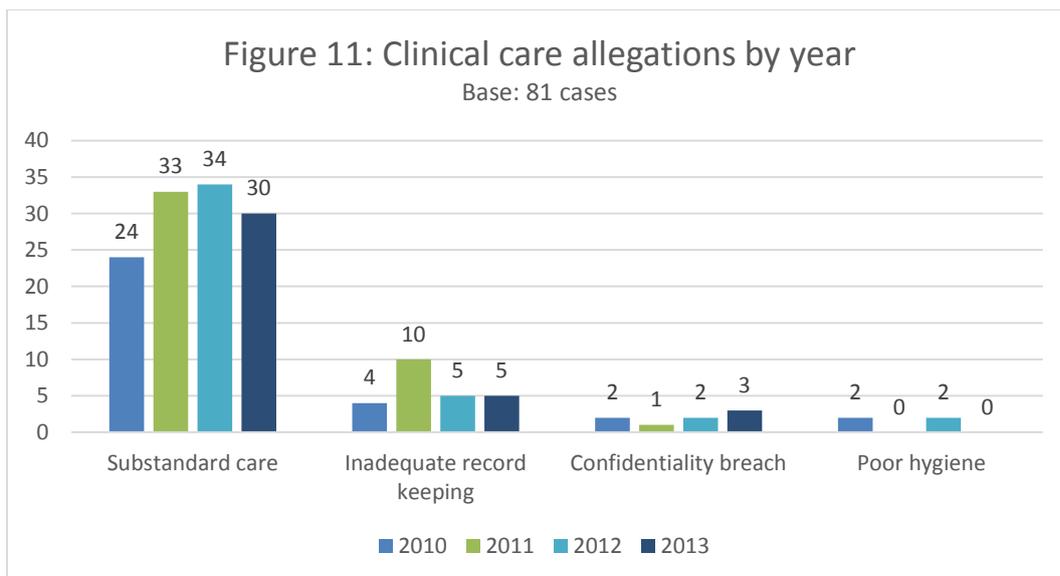
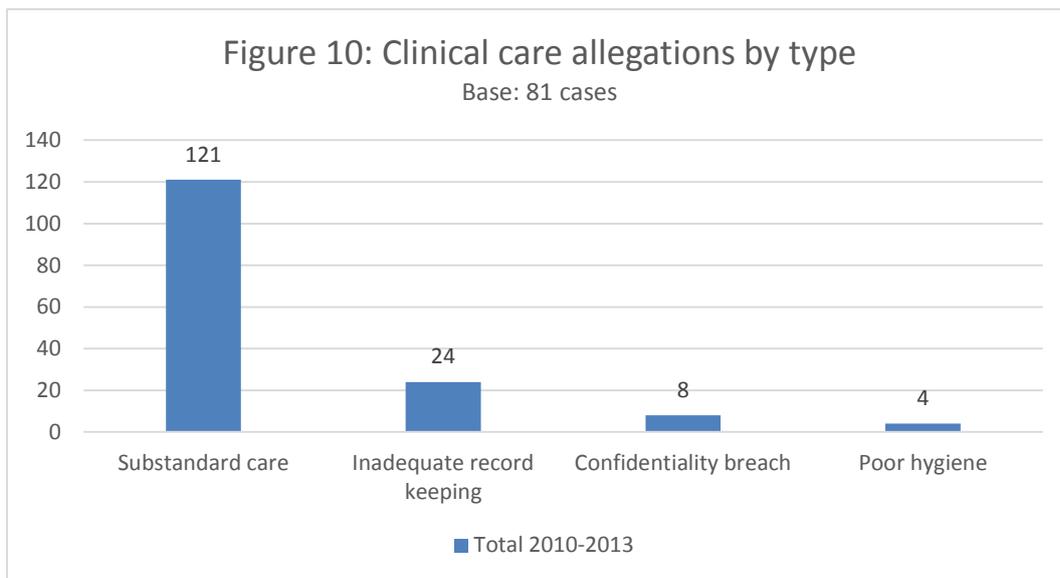


Figure 12 shows a breakdown of substandard care by sub-type. Treatment causing injury or pain (which also includes allegations of rough treatment) was the largest sub-type. The next largest sub-types attracted similar numbers of allegations. The 'other' category encompassed the following sub-types: concern about treatment techniques/approach (8); lack of follow up/review (7); failure to refer, when appropriate (7); misdiagnosis (6); and failure to work within limits of knowledge, skills and competence (3) – the numbers in brackets denote the occurrence of allegations of this nature.

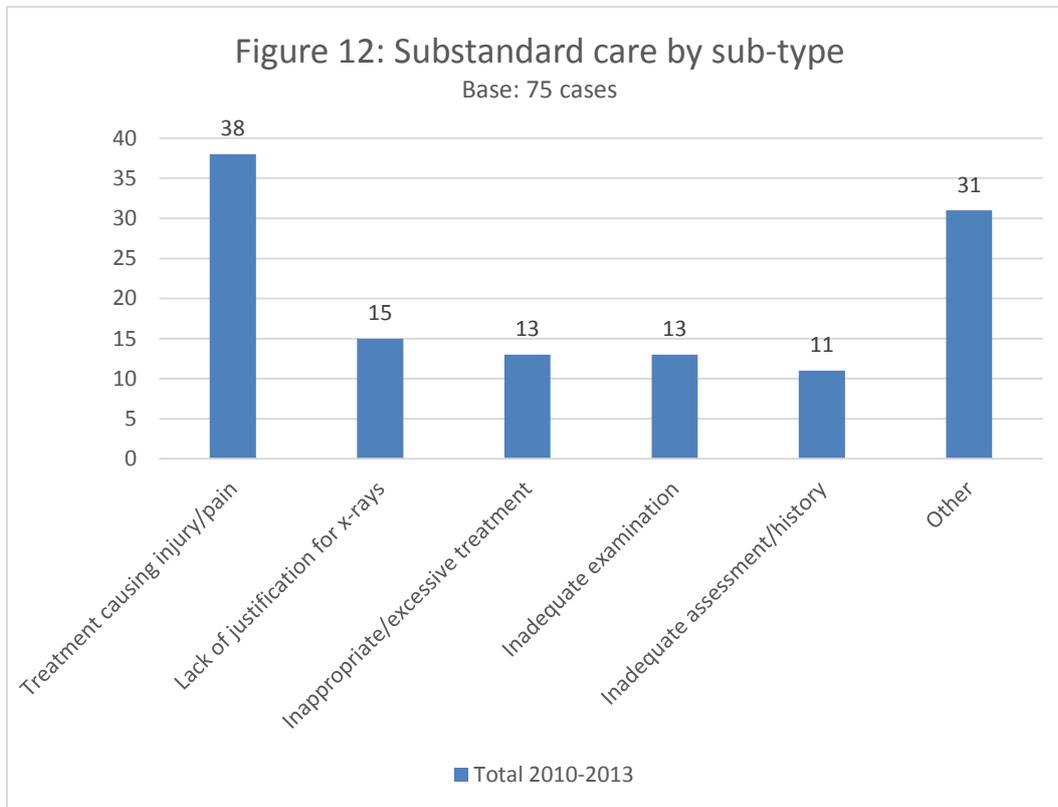
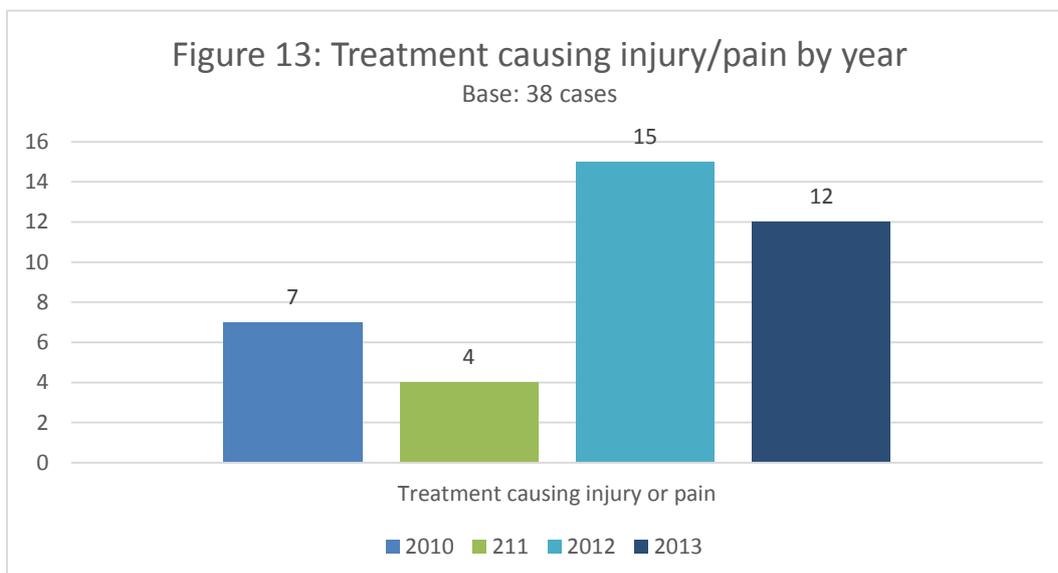
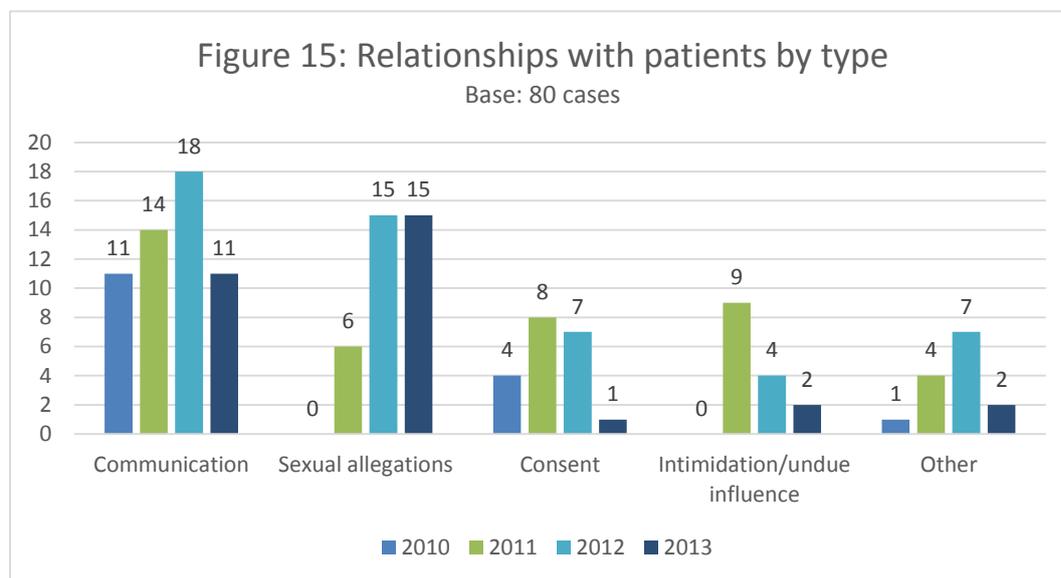
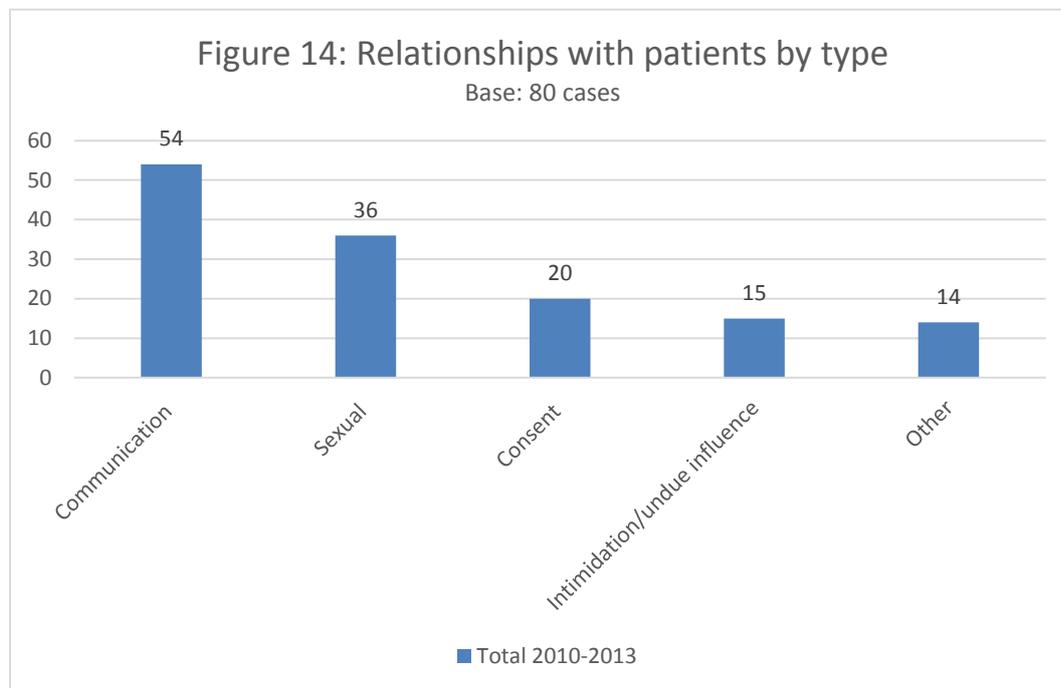


Figure 13 illustrates the spread of allegations regarding the largest sub-type: care causing injury/pain, across the four year period. No clear trend can be identified, however there was a sharp increase in allegations of this nature in 2012, which was almost replicated in 2013.



## Relationships with patients

There were almost as many allegations about relationships with patients as about clinical care. The most commonly occurring allegations under this category related to communication between the chiropractor and the patient – as shown in figures 14 and 15.



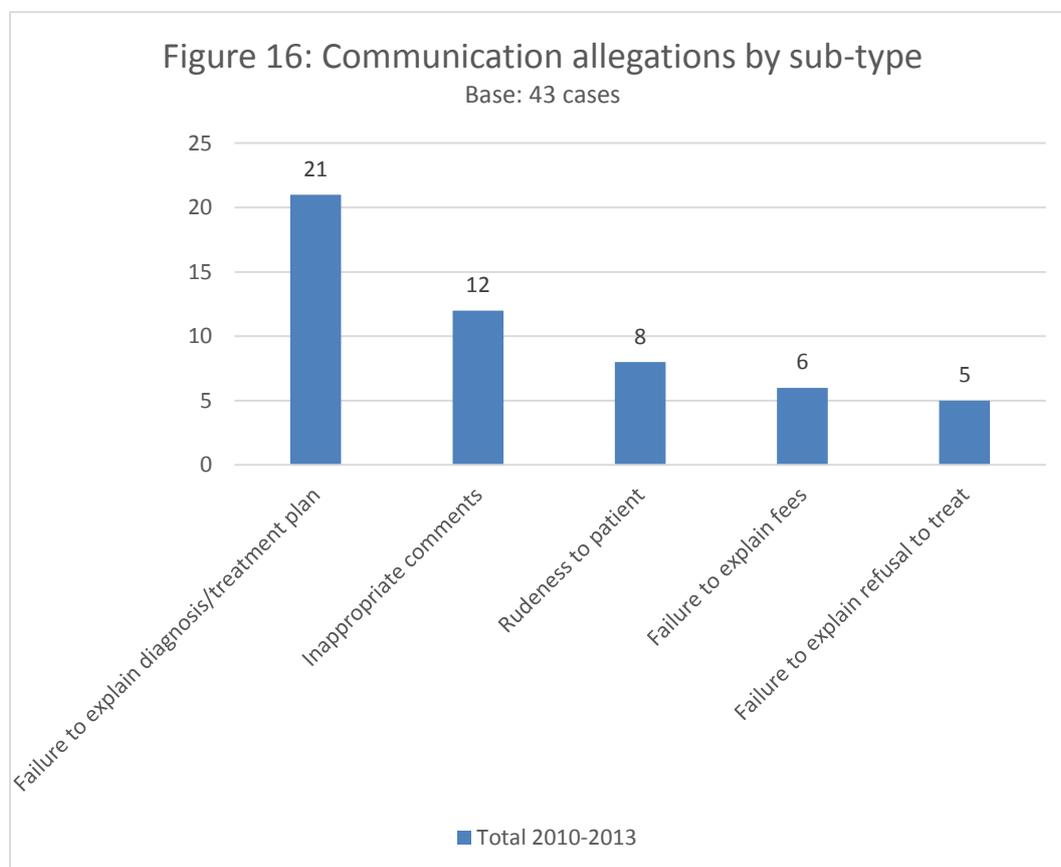
There was a cluster of complaints in 2011 by patients alleging that chiropractors had intimidated them or used undue influence to encourage them to sign up to a course of treatment. Typically, the allegation centred on the chiropractor emphasising the benefits of chiropractic care in alleviating the patient's symptoms, in such a way that the patient felt under pressure to agree to what were sometimes a large number of treatments. The GCC has condemned such practice, stating: *'using strategies designed to lock patients into treatment plans that are excessive in both frequency, duration and not in the patient's best interests is not acceptable'* (GCC, 2013).

The 'other' type of allegations indicated in figures 14 and 15 encompassed the following: failure to preserve the patient's privacy and dignity; failure or delays in providing access for the patient to their records; and financial impropriety with patients (such as asking a patient for a loan).

### Communication issues

Allegations about communication were the most frequently occurring type of allegation in respect of relationships with patients. Figure 16 shows how this was broken down into five sub-types, of which the most frequently occurring allegation was that the chiropractor failed to explain the diagnosis, treatment plan or results.

Twelve allegations during the period concerned inappropriate comments made by chiropractors. In such cases, it was alleged by the patient that the chiropractor had made comments that made them feel uncomfortable. One example concerned a chiropractor who allegedly passed comment on the patient's underwear and asked where he could purchase similar for his wife.



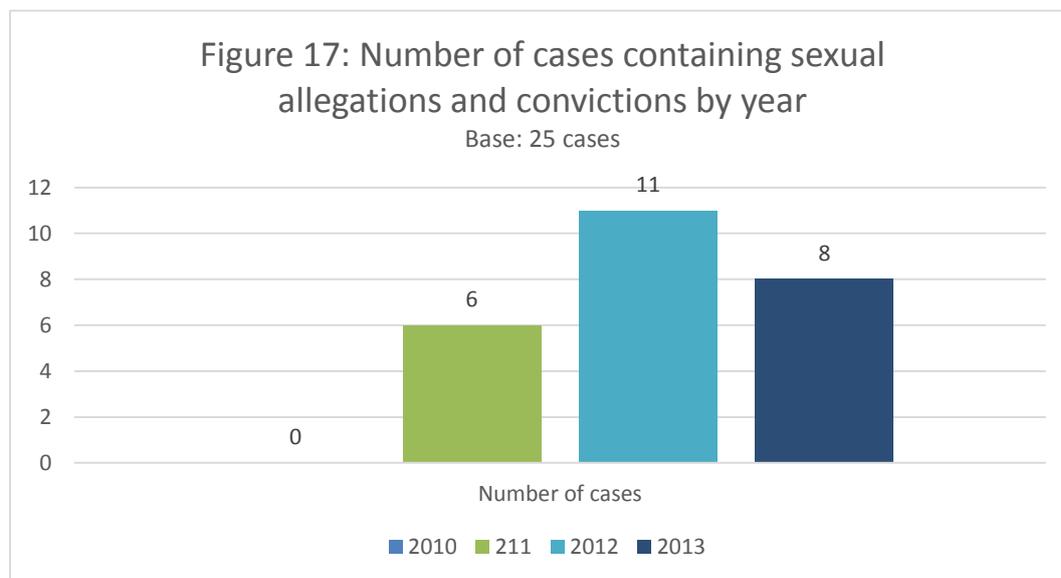
### Sexual allegations

It is evident that sexual allegations have increased during the period, with more than a doubling in the number of allegations of this nature between 2011 and 2012. It is too early to identify a trend, however it is notable that the number of sexual allegations in 2013 remained at the same level as 2012.

In addition to the 36 sexual allegations shown in figures 14 and 15, there were four convictions for sexual offences (including sexual assault, voyeurism and child pornography). A breakdown of sexual

allegations by sub-type is shown in figure 18. These 40 allegations (36 sexual allegations and four convictions) were spread over 25 cases in total – figure 17 shows the spread of cases across the last three years of the period.

In 2011, five complaints concerned sexual allegations and a sixth case was about a conviction for child pornography. In 2012, there were ten complaints of sexual allegations and an eleventh criminal case for voyeurism. In 2013, there were eight complaints of sexual allegations, which included a criminal case of sexual assault and voyeurism. Presented in this way, the increase in complaints containing sexual allegations may not seem quite as marked as the increase in the numbers of allegations. However, given that complaint numbers overall are small it remains noticeable – with almost a doubling in the number of cases containing sexual allegations between 2011 and 2012.

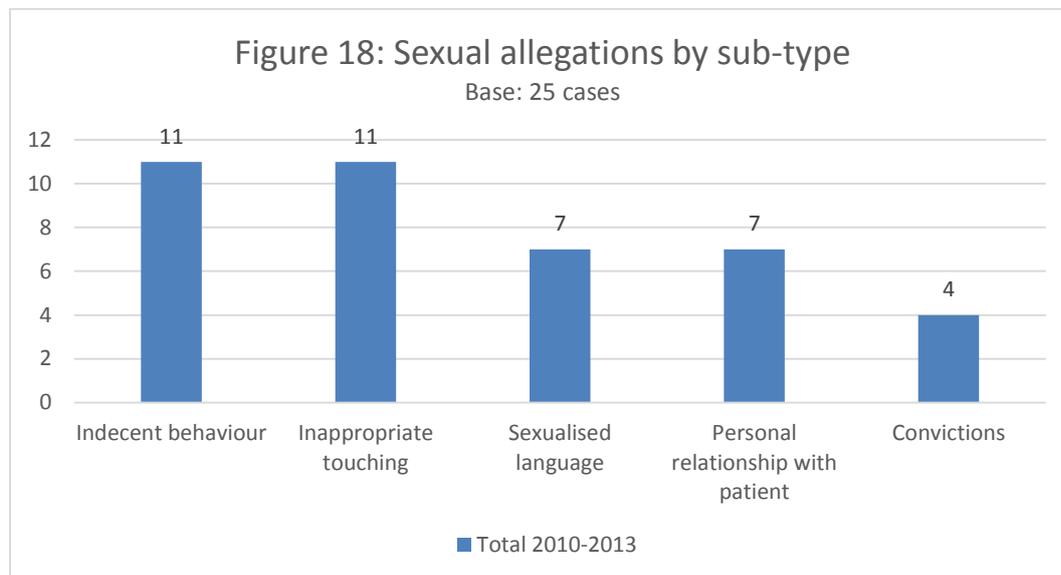


Sexual assault attracted a great deal of attention nationally during 2012. Operation Yewtree, the police investigation into sexual abuse allegations against Jimmy Savile and others, started in October 2012. Other high profile cases of sexual assault dominated the headlines, including allegations against WikiLeaks founder Julian Assange and veteran BBC Broadcaster Stuart Hall, and sexual abuse of young girls in Rochdale. Society’s treatment of victims of sexual assault also came under scrutiny (The Independent, 2012).

The Crown Prosecution Service reported that its sexual offences caseload had risen in 2012-2013, compared with the previous year (Crown Prosecution Service, 2013). Police figures show an increase of 9% (more than 4,500 extra) in all sexual offences for the year ending June 2013 compared with the previous year (Office for National Statistics, 2013). Increased publicity of crimes reported as part of Operation Yewtree and the Jimmy Savile inquiry are thought to have led to an increase in reporting of both historical and recent sexual offences in England and Wales (Office for National Statistics, 2013).

What has become known as the ‘Yewtree effect’ may offer some explanation for the increase in sexual allegations reported to the GCC – patients may have felt encouraged to come forward and

report behaviour that previously would have gone unreported. Five of the 11 cases containing sexual allegations in 2012 were received by the GCC in the last three months of that year.<sup>4</sup>



There is sometimes a fine line between allegations about consent and sexual allegations. Allegations about consent were broken down into two sub-types: failure to obtain informed consent and removing patient clothing without consent. An example of the latter was unclipping or removing the bra of a female patient without consent. Unless the alleged behaviour was deemed to be sexually motivated, it would be classified as an allegation about consent.

This was the case for one complaint made in 2012<sup>5</sup>, where it was alleged that the chiropractor had failed to preserve the patient’s privacy and dignity or to seek consent for the removal of underwear. Two further complaints were made about the same chiropractor – the second was made jointly with the first, but in addition alleged sexually motivated behaviour<sup>6</sup>; no documentation was provided for the third complaint, which the GCC reported concerned sexual allegations<sup>7</sup>. The particulars of the allegation of unacceptable professional conduct, not yet heard by the PCC, refer only to the first two complaints and do not allege sexually motivated behaviour.

Other cases similarly highlight challenges for the PCC in deciding whether language or behaviour is sexually motivated.<sup>8</sup> In one case the PCC referred to the Professional Standards Authority’s guidance on clear sexual boundaries (Council for Healthcare Regulatory Excellence (CHRE), 2008) to assist in determining whether acts or comments were sexually motivated.<sup>9</sup>

<sup>4</sup> 2012/1094, 1084, 1092, 1096, 1097

<sup>5</sup> 2012/1093

<sup>6</sup> 2012/1092

<sup>7</sup> 2012/1096

<sup>8</sup> E.g. 2011/982

<sup>9</sup> 2013/1142

## Probity

The third most frequently occurring category of allegations was ‘allegations about probity’. Such allegations arose in 57 cases referred to the GCC, and have increased more than threefold during the time period.

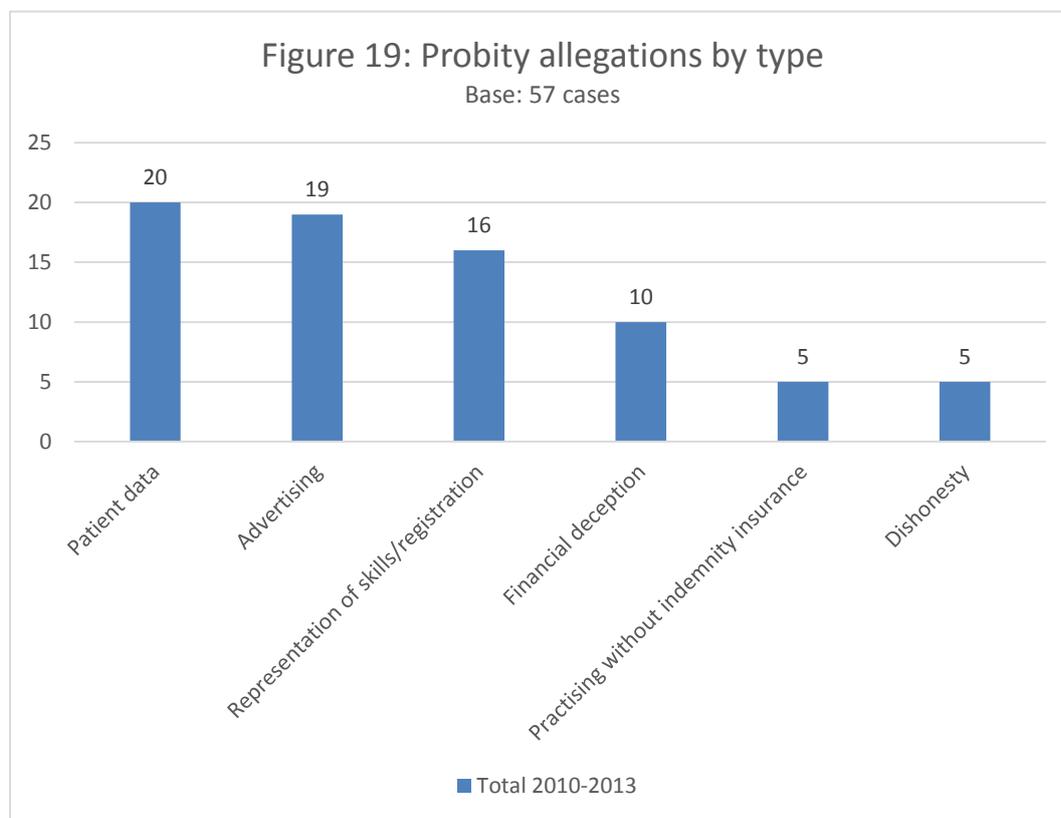


Figure 19 shows these allegations by type, and figure 20 shows how the most commonly occurring type – probity relating to patient data – was further broken down into sub-type. The other types of allegation shown here did not break down further into sub-types.

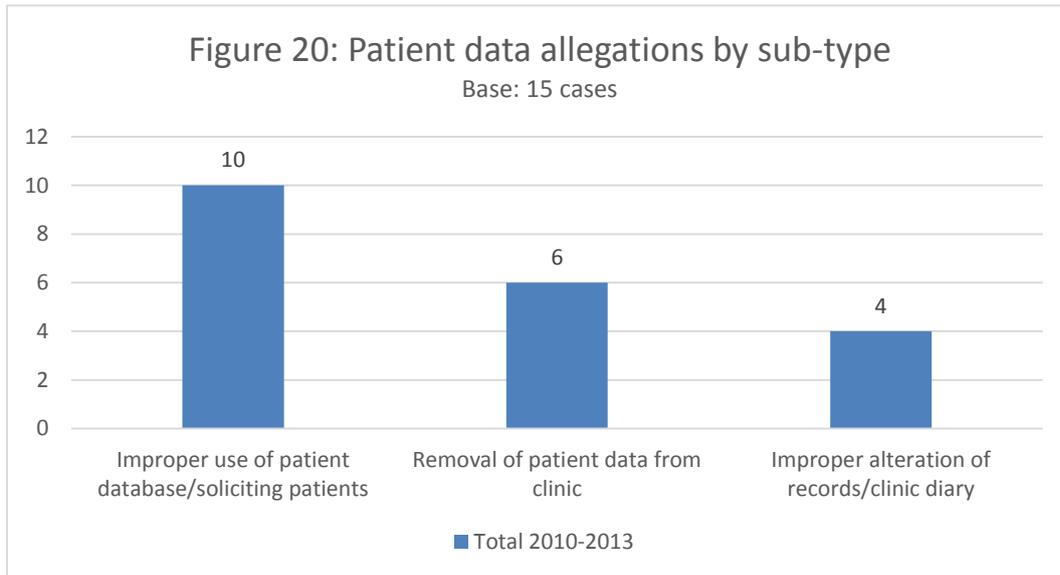
### Use of ‘Doctor’

A number of complaints during the period reflected concern about use of the title ‘Dr’ by chiropractors. IC decision letters indicate that it is acceptable for a chiropractor to use the courtesy title ‘doctor’ provided that the patient is not misled – it should be made clear that the chiropractor is not a registered medical practitioner (GCC, 2012c). Where allegations were made about a chiropractor’s use of the title ‘doctor’, none of the chiropractors were found by the GCC to be deliberately misleading and the allegations were dismissed as no case to answer. Yet the fact that this type of allegation arises a number of times points to uncertainty amongst the public over this issue.

### Patient data

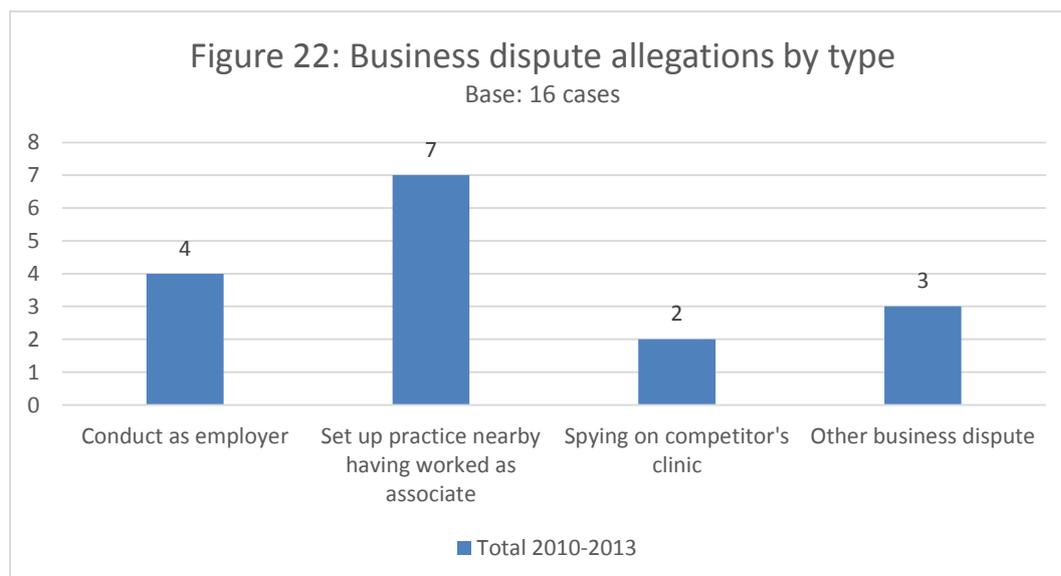
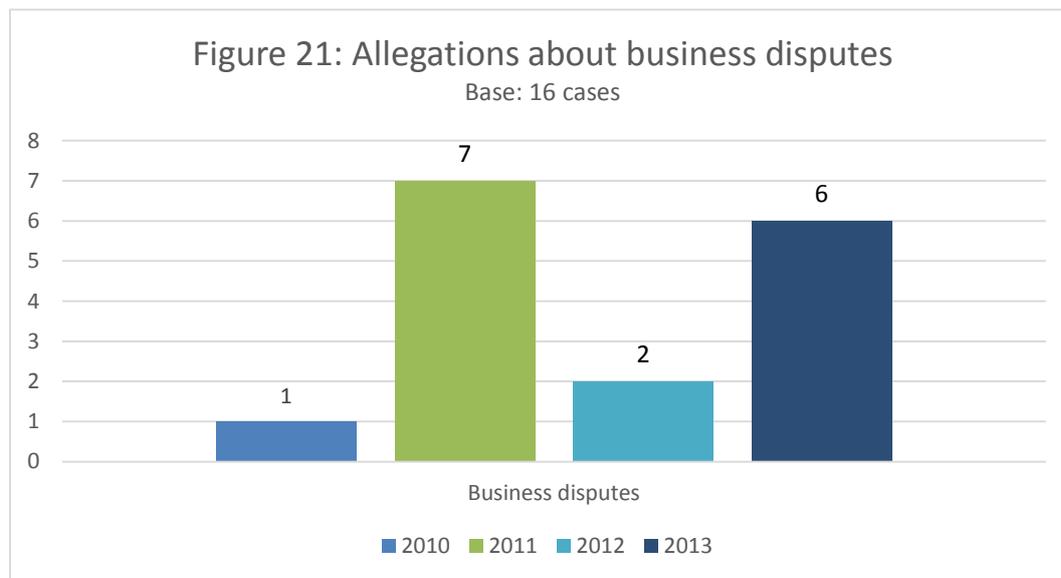
There were three sub-types of allegation of impropriety with respect to patient data, as shown in figure 20 on the following page. Many of the complaints alleging probity concerns about patient data were made by chiropractors and were associated with allegations about business disputes. A

common complaint was that the chiropractor had removed patient records from the clinic and used patient databases improperly to solicit patients for a newly established clinic.



## Business disputes

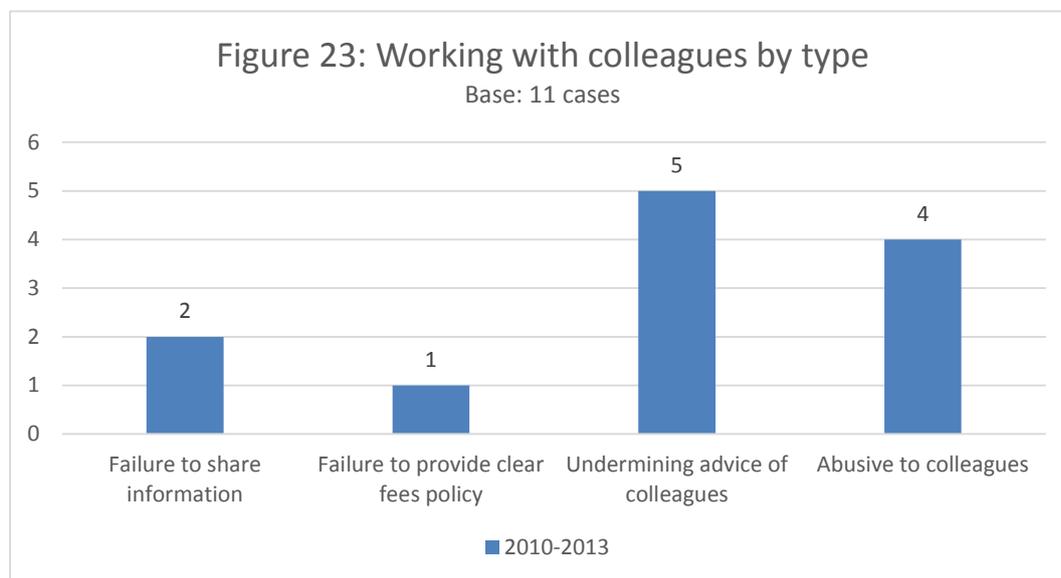
Business disputes and complaints about a chiropractor's conduct as an employer, represented the fourth largest category of allegations. Over the four years, 16 allegations fell into this category. In a number of instances, a chiropractor complained that another chiropractor had left the clinic having worked as an associate and opened another clinic nearby. No case to answer was found for all 16 complaints. The GCC recommends that chiropractors agree a contract when working with other chiropractors, to *'help minimise the possibility of arguments and misunderstandings at a later date'* (GCC, 2013). There may be a need to build on this and clarify the GCC's scope regarding business disputes.



## Working with colleagues

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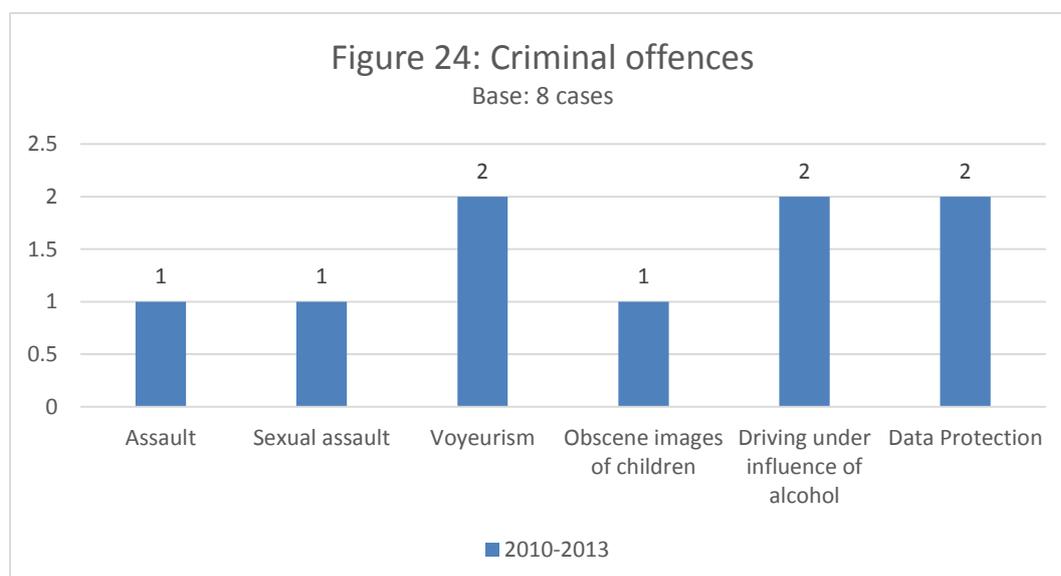
The fifth largest category of allegations was 'working with colleagues'. Allegations in this category arose for eleven cases and figure 23 shows how these divided into type.



## Criminal offences

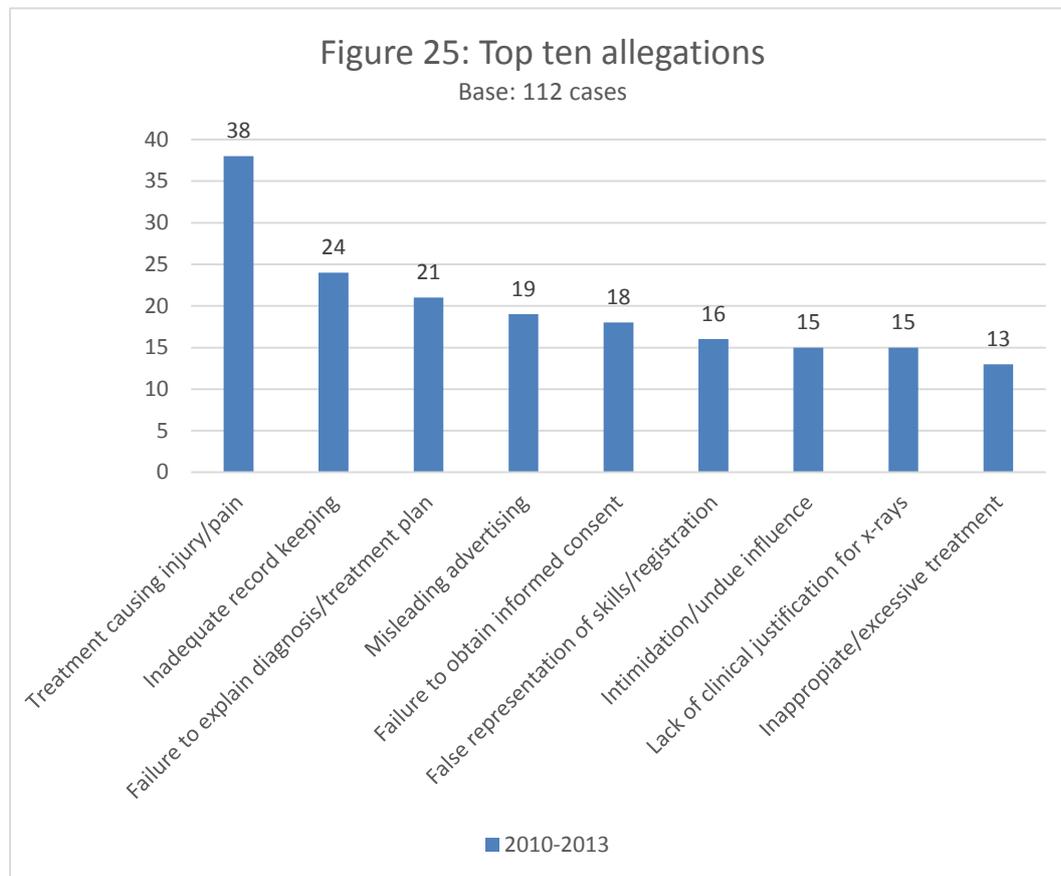
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Eight chiropractors were subject to the fitness to practise procedures during the period partly or wholly due to convictions or cautions for criminal offences. There were ten criminal offences spread across these eight chiropractors, as shown in figure 24.



## Most frequently occurring allegations

The classification of allegations into category, type and sub-type enables identification of commonly occurring allegations at the most granular level, sub-type. These are shown in figure 25.

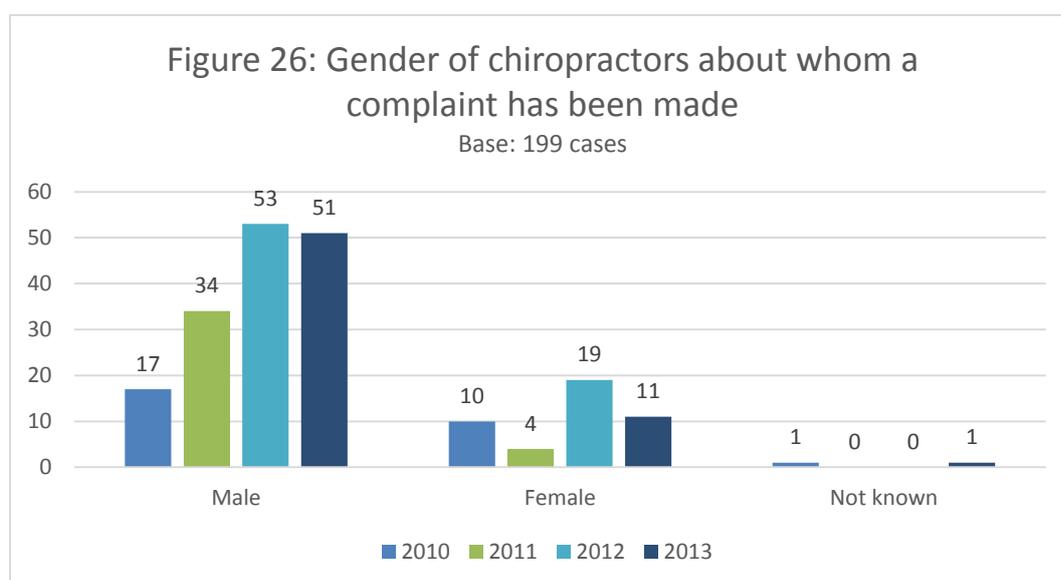


These most commonly occurring allegations were spread over 112 cases. Many cases have more than one allegation, and of the cases that are referred to the PCC, only some will be found proved. Therefore the outcome of the fitness to practise process may reflect some allegations and not others, as may sanction. Analysis of allegation by outcome or sanction would therefore require a different approach that is focused on the allegations found proved at PCC hearings, for example.

## 5. PROFILE OF CHIROPRACTORS FACING ALLEGATIONS

The analysis below has been carried out using demographic data gathered by the GCC. Some data has not been collected uniformly across the time period<sup>10</sup> and the numbers are not always large enough to clearly indicate the profile of chiropractors who are most likely to be subject to fitness to practise proceedings. Nevertheless, the analysis provides a baseline for the GCC to build upon over time and some conclusions can be drawn from the existing data.

### Gender



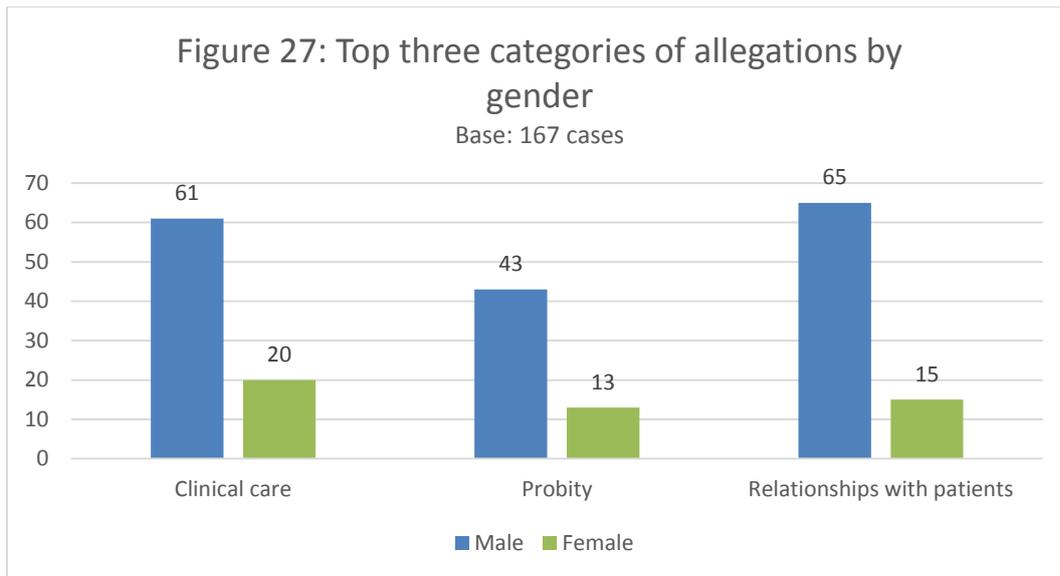
More complaints are made about male chiropractors; this has been a consistent trend across the four years, despite an even split of male to female chiropractors on the GCC register.<sup>11</sup> The gender split of chiropractors registered as non-practising is not known, which might have some bearing here.

The GCC's own analysis of complaints made between 2010 and 2012 found that, overall, 76% of complaints were about male chiropractors. This finding was supported by this independent analysis, which explored how the top three categories of allegations break down by gender – see figure 26. It revealed that 75% of allegations concerning clinical care and also allegations about probity were about male chiropractors. When it came to relationships with patients, 81% of allegations concerned male chiropractors.

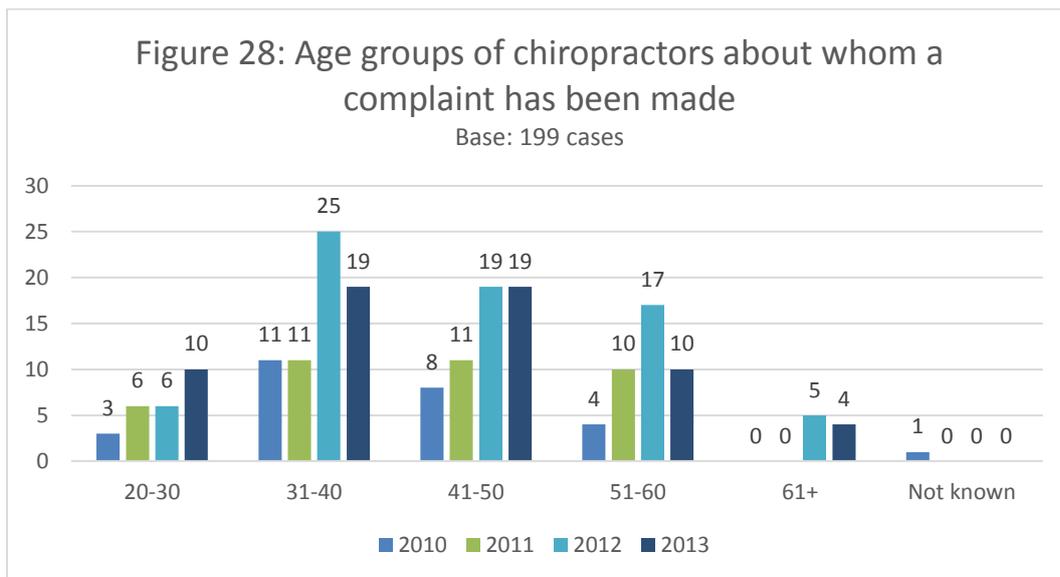
This gender profile is not dissimilar to the one seen for doctors about whom an 'enquiry' is made to the GMC – 73% of enquires received by the GMC in 2012 were about male doctors (GMC, 2013c).

<sup>10</sup> For example, the approach to capturing age has altered over time

<sup>11</sup> GCC's analysis of complaints 2010-2012



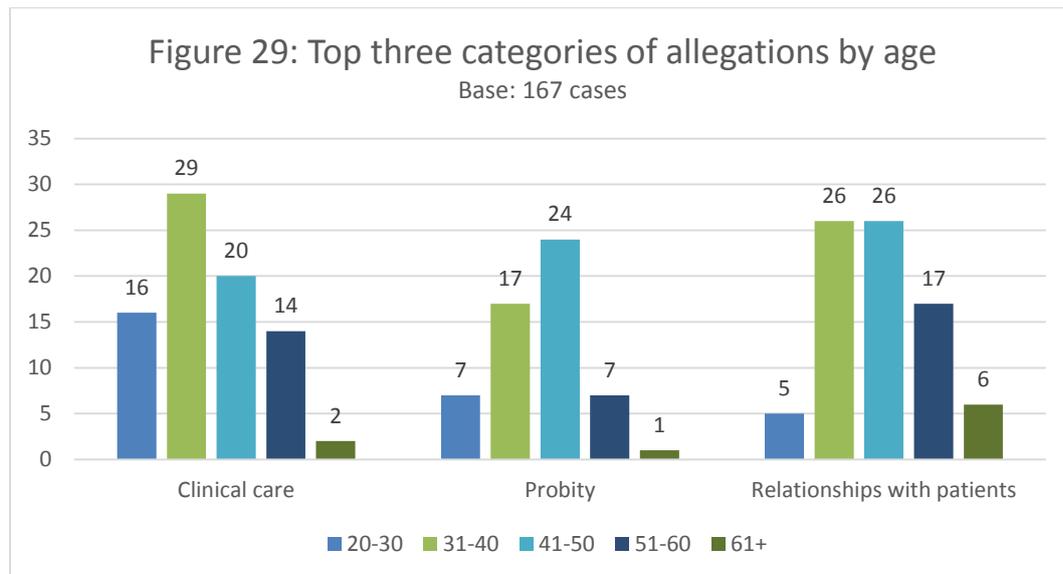
## Age



Most complaints during the period were made about chiropractors aged between 31 and 50. The data shown in figure 28 shows that the trajectory identified by the GCC's own analysis of complaints between 2010 and 2012 in relation to age has not been sustained in 2013. For example, the GCC's analysis found that complaints about registrants in the 51-60 and 61+ groups had increased markedly over the three years. This analysis shows that complaints about chiropractors in both of these age groups fell as a proportion of the complaints received in 2013. Likewise, the GCC found that complaints about chiropractors in the youngest group were decreasing as a percentage, however the figures for 2013 show an increase.

Figure 29 shows that allegations about clinical care are most likely to be about chiropractors aged 31 to 40, whilst allegations about probity are more likely in the 41 to 50 age group. Allegations relating to relationships with patients fall most heavily across these two age bands.

The GMC has found that doctors who qualified over 20 years ago are the subject of a higher percentage of complaints than the proportion of the register they represent (GMC, 2013d). The GCC may wish to extend its data capture to enable it to undertake analysis of the time since a chiropractor’s primary qualification was attained, which might prove a more relevant indicator for cross-analysis.



## Nationality

The vast majority of complaints each year are about British chiropractors, although some have concerned chiropractors of different nationalities registered with the GCC, including Canadian, Australian, South African and American.

It was not possible to conduct an analysis by ethnicity; while the GCC collects some data about ethnicity, it is not captured using the standard list of categories used in the 2001 National Population Census and contains many gaps, which limit its analytical value.

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## 6. FURTHER OBSERVATIONS

The Professional Standards Authority's predecessor concluded that the fitness to practise adjudication processes employed by the nine regulators of healthcare professionals can deliver poor outcomes and identified a *'strong sense of inconsistency in the outcomes between, and inconsistencies within, regulators'* (CHRE, 2011). There have been moves for greater harmonisation across health professional regulation in the investigation and adjudication of fitness to practise decisions, and this review identifies a number of opportunities for the GCC to benefit from approaches taken by other regulators.

In addition, this section includes feedback arising from the review of all the documentation, particularly around the language used to convey fitness to practise decisions.

### Making a complaint to the GCC

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The GCC has previously conducted research exploring the public's expectations of chiropractor treatment (GCC, 2012b). It is not apparent that any research has been conducted to understand the experiences of people making a complaint about a chiropractor to the regulatory body. Where other professional regulators have explored this area, it has illuminated perceptions of the regulator, understanding of regulatory processes and the support needs of complainants (Williams, 2013).

Exploring mechanisms to enable better support and advice for people to raise a concern is one of the areas professional regulators have been asked to give attention to (CHRE, 2011). This reflects research showing that raising a fitness to practise concern with a regulator is often experienced negatively, particularly because of the length of time the process takes and the stress involved (CHRE, 2011). The withdrawal of 26 complaints to the GCC over four years should be considered in the light of this.

For a number of cases during the period, the allegations made by the complainant were unclear and the complainant appeared reluctant to cooperate to move matters forward, for example by providing consent for chiropractic records to be released to the GCC.<sup>12</sup> For example, one case alleged *'unprofessional or sexualised touching and comments'*, however there was no communication from the complainant (a patient) despite a number of attempts by the GCC.<sup>13</sup> As a consequence the IC had no option but to determine that there was no case to answer. Such cases raise questions about the guidance and support offered to complainants, particular where the allegations are sensitive or distressing.

#### *Expectations of complainants*

The GCC asks complainants to provide as much detail as possible about their complaint. On occasion the language used by the IC suggests an expectation that the complainant should provide all the necessary evidence to enable the GCC to pursue a case. For example, for one case, an anonymous

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<sup>12</sup> E.g. 2012/1061, 2012/1062, 2012/1083, 2012/1077, 2012/1019, 2012/1072

<sup>13</sup> 2012/1072

complainant alleged that material on the registrant's clinic Facebook page contained threatening statements and unpleasant images. The GCC was unable to access Facebook from the office computers and therefore could not investigate the matter fully. Consequently the IC could not see all the images that the complainant alleged could be seen. The complaint was withdrawn. The note of the IC's deliberations was as follows:

*'...the Committee had regard to the evidence before it and was of the opinion that it could not pursue the complaint given the lack of evidence. The Committee agreed that if there was further evidence made available to it in support of the allegations, then the subject matter of the allegations was such that it was capable of amounting to UPC.'*<sup>14</sup>

The onus in this case appears to have been on the complainant to provide all the evidence. It is not apparent that efforts were made to secure access to Facebook by other means to enable a proper investigation of the issues.

In another case<sup>15</sup>, the initial consideration of the complaint by the IC was adjourned so that the complainant (a patient) could be asked to supply a copy of any expert report that supported his complaint. This seemed to put the onus on the complainant to provide all the evidence in support of their complaint. In the event, the patient had not obtained an expert report and the IC requested that the GCC obtain one. The GCC may wish to reflect upon whether its expectations of complainants are reasonable and whether it provides sufficient support to complainants in gathering together evidence, including how to go about securing an expert report.

### Capturing concerns in the round

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A GCC case is linked if it is the same complaint made by more than one person. Not all cases about the same chiropractor are linked; for example, complaints about the same chiropractor, but different, unrelated allegations, are treated as separate cases.

The review highlighted inconsistencies in the way that cases are linked, or recorded as having been linked. Until now the GCC has lacked a mechanism for clearly recording whether cases are linked, and so it has not been done systematically. The significance of this is that it could mean that the GCC is not able to see allegations about a registrant in the round – a number of minor allegations that are similar in nature may point to a more serious problem.

Even for cases that are not linked, allegations that are different in nature could indicate a serious problem requiring the attentions of the regulator. The mechanism that enables the GCC to do this was not in evidence from the documentation reviewed. For example, three complaints were received about one registrant in 2011. Two of the complaints progressed to the PCC<sup>16</sup> and a third case was dismissed by the IC as no case to answer.<sup>17</sup> None of these cases were linked as they were different in nature, even though two were serious enough to warrant referral to the PCC.

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<sup>14</sup> 2012/1068

<sup>15</sup> 2012/1065

<sup>16</sup> 2011/989 2011/985

<sup>17</sup> 2011/980

Another registrant faced two complaints in 2011, which were linked.<sup>18</sup> The registrant himself made two complaints about other chiropractors during 2011.<sup>19</sup> In 2012, the GCC received a further three complaints about this registrant, which were all linked.<sup>20</sup> In 2013, another two complaints were made about the same chiropractor, and these were not linked.<sup>21</sup> This registrant therefore attracted seven complaints in three years, and submitted two complaints of his own.

## Understanding IC decisions

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The documentation reviewed at investigating stage consisted predominantly of decision letters. Mostly these were addressed to the registrant, but a number were to the complainant. The review highlighted inconsistency in the detail contained in these letters, as well as in details such as including a case reference number. The language of some letters was legalistic, which might undermine their accessibility to complainants, particularly members of the public. Likewise, the use of the acronym 'UPC', instead of the full term unacceptable professional conduct, could undermine understanding of the decision.<sup>22</sup>

Other issues include explaining titles that members of the public may be unfamiliar with. For example, the response to a patient who alleged that a chiropractor had been practising whilst not registered, was that the practitioner was not practising as a chiropractor but as a 'spinologist'.<sup>23</sup> This same type of complaint occurred on several occasions during the time period, which may indicate some uncertainty for the public over the distinction between chiropractors and spinologists.

On occasion the decision letters use phraseology that could weaken the authority of the decision. As the following extract demonstrates:

*'In looking at the third allegation (You made sexual comments to patient) the Committee was of the view that it was not best practice to make jokes with patients about knickers but of itself this was not capable of amounting to UPC.'*<sup>24</sup>

The somewhat informal language used in this example is compounded by a lack of reproach for what might be perceived as unprofessional behaviour. It could be regarded as dismissive of the complainant's concerns and send a message to the profession that such conduct is not taken seriously.

The IC also needs to be on guard to avoid appearing dismissive of complainants' concerns where it decides that they do not meet the test of a case to answer. The following extract is an example of the type of language that can appear dismissive:

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<sup>18</sup> 2011/960, 2011/965

<sup>19</sup> 2011/984, 2011/985

<sup>20</sup> 2012/1100, 2012/1101, 2012/1102

<sup>21</sup> 2013/1125, 2013/1177

<sup>22</sup> E.g. 2012/1050, 2012/1082, 2012/1067

<sup>23</sup> 2012/1044

<sup>24</sup> 2012/1050

*'The Committee noted your concern about [name of chiropractor] statement that [name of patient] progress had slowed down due to missing some treatments. The Committee considered that this was not an issue of concern.'*<sup>25</sup>

The point that the IC presumably sought to make was that the complainant's concerns were not capable of amounting to unacceptable professional conduct.

## Taking care around consent

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A specific issue was identified with respect to the way some decisions are made about consent. On several occasions the IC concluded that a patient's consent had been implied by, for example, their continued attendance for treatment. The following extracts from IC decision letters illustrate this:

*'With regard to the allegation of lack of consent for treatment to the neck, the Committee noted from the chiropractic records, that you had treated Patient A's neck at all treatment visits, **indicating implied consent** for treatment to the neck, and the Committee noted Patient A's signed consent form for treatment.'*<sup>26</sup> (Emphasis added)

*'The Committee also noted no record of consent for treatment although it observed that the fact that Patient A attended for several treatments indicated **her implied consent** to them.'*<sup>27</sup> (Emphasis added)

*'Although you did not obtain written consent each time you treated, you would not be required to do so. [The patient] returned for assessment, including the test in question and treatment several times, **which implies consent was given**. Further, the consent form states that a patient agrees to treatment by the chiropractor and to any on-going treatment.'*<sup>28</sup>

Great care is needed about the indications that could *imply* an individual's consent, particularly where, as in the first example above, the issue was not that consent for treatment had not been provided, but that the patient had not consented specifically for treatment to the neck. The GCC may consider there is a need for the IC to tighten up the language used to convey decisions about consent and the message it gives about the expectations of chiropractors regarding consent. In the third example above, the IC did not state whether it was reasonable for a consent form to ask a patient to agree to '*any on-going treatment*'.

In another case, the IC appeared to overlook an opportunity to reinforce the importance of consent when undertaking treatments that could result in contact with intimate parts of the body:

*'As to the allegation of contact with your breast during treatment, the Committee observed that given the nature of the treatment recorded ('anterior thoracic' technique), contact with your breast could have occurred without [name of chiropractor]'s knowledge. The Committee*

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<sup>25</sup> 2012/1035

<sup>26</sup> 2010/939

<sup>27</sup> 2010/942

<sup>28</sup> 2012/1073

*also observed that some chiropractic examination and adjusting techniques require a chiropractor to make contact with the patient's body, which can be unavoidable.*<sup>29</sup>

This statement could be interpreted as saying that contact with the breast was acceptable as it might not have been avoided. The point is that the patient was not expecting such contact, inadvertent or not. It is also not apparent that the IC considered whether there could have been a case to answer in terms of maintaining sexual boundaries.

## Expansion of IC powers

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There are a number of cases that have been before the IC in recent years where the IC appeared confined by the existing statutory framework within which it must operate. The IC can conclude a case in one of two ways: decide that there is a case to answer and refer the case onwards or conclude that there is no case to answer and close the case with no further action. There are a few cases where insufficient information was before the IC to consider the allegation capable of amounting to a case to answer, and yet the IC expressed concern about the chiropractor's practice.

An example was a case considered in 2010.<sup>30</sup> The IC considered allegations that x-rays taken at the registrant's clinic were not of diagnostic quality and that there was a policy of taking routine x-rays at the clinic. The IC observed that a broad policy of x-raying patients could breach the relevant section of the GCC's *Code of Practice and Standard of Proficiency*. However, it concluded that there was insufficient evidence to be capable of amounting to a case to answer on this issue. Nevertheless, the IC was sufficiently concerned to determine to ask the GCC's Registrar to consider referring the issue to the Care Quality Commission. The process for drawing concerns to the attention of the Registrar or for ensuring that actions were taken was not transparent. Importantly, given that the IC's decision letter to the registrant concludes *'there is no case to answer and no further action will be taken in respect of this complaint'*, there was no provision to formally mark the IC's concerns to the registrant, the complainant, or any other enquirer to the GCC.

For another case<sup>31</sup>, the allegations were that the treatment provided by a chiropractor was excessive and that the patient had been misled into starting a long course of treatment by a promise that it would restore her to full health. The decision letter records that the IC *'found cause for concern'*. It identified:

*'...a very large number of treatments over a prolonged period. Relatively little benefit is recorded. The chiropractic records are sparse and the level of details recorded was only barely adequate.'*

Nevertheless, the IC concluded that its concerns about the duration and frequency of the treatments would not be sufficient to justify a finding of 'UPC'.

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<sup>29</sup> 2011/951

<sup>30</sup> 2010/946

<sup>31</sup> 2012/1075

## Warnings

In such situations, the IC may be assisted by being able to issue a warning to the chiropractor. The General Dental Council (GDC), General Medical Council (GMC) and General Optical Council (GOC) can issue a warning at both the investigation and adjudication stages. At the investigation stage, the GMC's case examiners or the Investigation Committee must first satisfy themselves that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree requiring action on his or her registration. The question of whether a warning might be appropriate must be considered in all cases where it is decided that the investigation stage test has not been met.

Warnings, which appear on the register for five years and can be disclosed to enquirers, allow the GMC 'to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated'. The GMC's guidance on warnings (GMC, 2012a) may be of interest to the GCC.

The GOC highlights two purposes to a warning: first, it alerts the registrant to steps they can take to reduce the risk of being subject to a complaint or fitness to practise action in the future; second, it allows the regulator to monitor any patterns that may emerge in respect of a registrant (GOC, 2013). Half of the warnings issued by the GOC in 2012-13 were for conduct outside of a registrant's professional practice.

## Letters of advice

Another mechanism is the ability to issue letters of advice. The review highlighted several cases where the IC identified shortcomings in the chiropractor's practice, but they were not sufficiently serious to amount to a case to answer. A number of examples like this related to record keeping.<sup>32</sup> For instance, the following extract is taken from the IC decision letter to the complainant; it highlighted a number of deficiencies, which could appear incongruous with the decision of no case to answer and no further action:

*'The Committee further noted that although a diagnosis, plan of management and some tests were recorded, there [sic] records showed a limited examination had been carried out and they were not clearly written, indicating poor record keeping. The Committee also noted no record of signed consent for treatment, although there was a record of signed consent for an 'examination'. In looking at the issue of record keeping, however, the Committee found this issue, taken at its highest, was not capable of amounting to a case to answer.'*<sup>33</sup>

In these situations, public confidence in the regulator and the profession might be assisted by issuing advice to the chiropractor. This would support the GCC's role of declaring and upholding proper standards of conduct and behaviour. It would also help to formalise advice that the IC sometimes gives currently, as the extract of the following case illustrates:

*'The Committee did have some concerns about the quality of the chiropractic records....The Committee wishes to draw [name of chiropractor] attention to paragraphs B7 and S2.2 of the*

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<sup>32</sup> 2010/943, 2011/951, 2012/1099, 2013/1127

<sup>33</sup> 2011/951

*Code of Practice and Standard of Proficiency which makes clear the duty on a Chiropractor to keep detailed and legible records.*<sup>34</sup>

Another example is as follows:

*'The Committee noted the clinic's complaints procedure document. The Committee felt that this document contains a description of the GCC's procedures which may mislead and may possibly discourage patients from complaining to the GCC. Although the Committee had concerns about this document it did not consider that at this time there was [sic] case to answer that [name of chiropractor] was guilty of UPC for issuing it. The Committee strongly recommends that you revise the wording of this document.'*<sup>35</sup>

In such circumstances, issuing a letter of advice may add more weight to a recommendation by the IC. One decision letter contained text in bold – seemingly, the intention was to emphasise the importance of this text, which makes a specific recommendation to the registrant:

*'Although it was not the subject of the complaint, the committee noted that the consent form in the bundle is very brief and could be seen as placing responsibility for care given on the patient. The committee recommends that it be re-drafted to cover all the relevant issues in more appropriate wording.'*<sup>36</sup>

The downside of letters of advice is that there tends to be no mechanism for monitoring whether the registrant has heeded the regulator's advice and they lack transparency. However, they may be appropriate for less serious concerns, in reminding chiropractors of the standards expected of them and assuring complainants that slips in standards are not dismissed even though they fail to reach the bar necessary to amount to a case to answer.

The GDC can issue letters of advice at Investigating Committee stage, should the GCC wish to explore the practicalities of this mechanism.

### *Undertakings*

The GCC may consider that it would benefit from an extension of its powers to dispose of cases by agreeing undertakings, for example that the chiropractor should re-train or work under supervision. There were no obvious examples of cases where this might be appropriate and it is not known whether any chiropractors have previously approached the GCC offering undertakings.

Under the GMC's processes, undertakings can be agreed with doctors at the investigation stage, rather than referring the case for a public hearing. Its guidance on undertakings provides detail about the circumstances in which undertakings are likely to be appropriate (GMC, 2012b).

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<sup>34</sup> 2013/1127

<sup>35</sup> 2012/1082

<sup>36</sup> 2012/1084

## Expert advice at the investigation stage

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Information for registrants about the fitness to practise process states that when investigating a complaint, the GCC may need to obtain *'independent professional opinions on chiropractic matters'* (GCC, 2011). However, the documentation review highlighted a couple of instances where the chiropractic member of the IC gave what might appear to be expert advice. The extracts taken from an IC decision letter demonstrates the point:

*'The chiropractic member informed the Committee that they could not think of a way in which chiropractic treatment, as described by [the patient], would cause a meniscus tear in a healthy knee.'*<sup>37</sup>

In another case<sup>38</sup>, the complainant alleged that the chiropractor had caused damage to his shoulder in the course of providing treatment. The decision letter records that the chiropractor member *'informed the Committee that rotator cuff degeneration can be asymptomatic'* and the IC concluded that the treatment given *'would be unlikely to have caused a rotator cuff tear in a healthy shoulder'*. The underpinning basis for this conclusion about cause and effect would appear to be the comments made by the chiropractic member of the IC. In such circumstances the IC may need to consider whether specialist advice is required.

## Understanding PCC allegations

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The allegation most commonly considered by the PCC was for unacceptable professional conduct. One case before the PCC highlighted the case law regarding this allegation:

*'The legal assessor reminded the Committee that following the case of Spencer v GOSc [2012] EWHC 3147 (Admin) it is clear that the concept of UPC is essentially the same as serious professional misconduct or impaired fitness to practise due to misconduct, as used in the General Medical Council and General Dental Council.'*<sup>39</sup>

There are four cases during the time period in which both unacceptable professional conduct and professional incompetence were alleged. For each of these, the particulars of the two allegations related to the same events and were very similar in nature.<sup>40</sup> For two of the cases, the allegation of professional incompetence was withdrawn at the beginning.<sup>41</sup> The Notice of Finding gave the reasons for this in one of these two cases as follows:

*'In view of the case law that indicates that the same facts should not normally give rise to findings both of misconduct and deficient performance, the GCC no longer argues that the Committee should make a finding of professional incompetence in this case.'*<sup>42</sup>

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<sup>37</sup> 2012/1079

<sup>38</sup> 2012/1059

<sup>39</sup> 2011/983

<sup>40</sup> 2010/940 2010/949 2011/963 2011/974

<sup>41</sup> 2010/949 2011/963

<sup>42</sup> 2011/963

This decision was reached in May 2012, yet despite the case law it referenced, a case that concluded in February 2014<sup>43</sup> alleged both unacceptable professional conduct and professional incompetence and the particulars for each allegation concerned the same events. It is very difficult to understand how these two allegations sit alongside one another, as the detail of this case illustrates. In deciding whether the chiropractor was guilty of the allegations, the PCC considered first unacceptable professional conduct and then moved on to consider professional incompetence. The PCC found that both allegations were well founded and was advised by the legal assessor that the Act seemed to require that a sanction be imposed for each allegation. The PCC considered professional incompetence first and concluded that the chiropractor should be removed from the register. The PCC then proceeded to consider sanction for unacceptable professional conduct, even though the only sanction that could practically be imposed was removal.

In this case, the PCC did not provide a rationale for why it considered professional incompetence first, in relation to sanction. Arguably, it would have made more sense to have considered sanction in relation to conduct first as incompetence, by its nature, may lend itself to particular sanctions. For both the Health and Care Professions Council (HCPC) and the Nursing and Midwifery Council (NMC), a registrant can only be removed from the register for a serious lack of competence unless they have already been continuously suspended or subject to a conditions of practice order for two years (NMC, 2012; HCPC, 2013a).

### Impairment versus 'well founded'

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The approach taken to decision making on GCC cases is outwith that followed by most of the other regulators of healthcare professionals.

The case law mentioned above aligns the concept of unacceptable professional conduct with serious professional misconduct or impaired fitness to practise due to misconduct, used by the GMC and GDC. However, the way these and other regulators of healthcare professionals decide on a case thereafter differs from the GCC process. The GMC, NMC, GDC, HCPC and others follow a three stage process, which involves deciding:

1. Whether the facts alleged are proved
2. Whether, on the basis of the facts proved, fitness to practise is impaired
3. What sanctions, if any, are required

The GCC's processes involve establishing whether the facts are proved and then deciding whether the allegation is 'well founded'. None of the PCC decisions reviewed made reference to consideration of impairment, with the exception of the single Health Committee case. This reflects the Chiropractors Act 1994, which stipulates that the PCC should consider whether the allegation is 'well founded'. However, deciding whether the allegation is 'well founded' is quite different from reaching a decision on current impairment. The impairment stage usually has two elements to it: determining whether the facts found proved amount to the statutory ground (such as misconduct)

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<sup>43</sup> 2011/974

and, if so, determining whether the registrant is currently impaired. Guidance from the HCPC (2013b) on finding impairment may be of interest.

It means that other professional regulators are deciding on cases using a very different approach to the GCC's PCC. The GCC may consider that greater alignment with the approach taken by other regulators would better support public confidence in the regulator, as well as satisfy a drive for greater consistency in fitness to practise decisions.

## Understanding PCC decisions

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Decisions made by the PCC are not always conveyed clearly or consistently. Usually reference is made to whether an allegation is found to be 'well founded', however in a number of cases it is not explicitly stated whether or not this means that unacceptable professional conduct has been found.<sup>44</sup> In the absence of a clear statement on this, the decision can appear somewhat opaque, particularly to a lay audience unfamiliar with what it means for something to be well founded.

There are also inconsistencies in the language used to convey the PCC's decision on the allegation, as demonstrated by the following extracts from a sample of Notice of Findings:

*'...it [the Committee] concluded that his conduct did not equate to misconduct amounting to "incompetence or negligence of a high degree". Accordingly, the Committee has found that the Allegation is not well founded.'*<sup>45</sup>

*'the Committee has concluded that [name] conduct does not fall sufficiently short of the standards to constitute unacceptable professional conduct.'*<sup>46</sup>

*'...the Committee finds that the allegation is not well founded.'*<sup>47</sup>

*'the Allegation of Unacceptable Professional Conduct is not well founded.'*<sup>48</sup>

Sometimes reference is made to the allegation being dismissed<sup>49</sup>. The GCC explained that these are cases where unacceptable professional conduct is not found and the allegations have been dismissed at the outset of the hearing. However the distinction between the concepts of 'well founded' and 'allegation dismissed' is not always clear, as the following extract illustrates:

*'...the Committee has determined that the Allegation is not well founded and is therefore dismissed.'*<sup>50</sup>

A question arises over whether the distinction between these concepts, and the meaning of the other phraseology highlighted above, is sufficiently clear to the public. Some of this is difficult

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<sup>44</sup> E.g. 2012/1030, 2012/1058, 2011/983

<sup>45</sup> 2011/971

<sup>46</sup> 2010/940

<sup>47</sup> 2011/954

<sup>48</sup> 2010/948

<sup>49</sup> 2010/920 2011/973 2011/989 2011/985 2010/932

<sup>50</sup> 2011/973

language for the public at large, and possibly chiropractors subject to fitness to practise processes, to penetrate in order to fully comprehend the decision.

The Professional Standards Authority (PSA) has emphasised giving reasons for PCC decisions. For many of the PCC cases, the reasons were sufficiently detailed to provide an understanding for why a decision was reached. Three examples where the reasons were not so accessible are detailed below:

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**Example one**<sup>51</sup>: unacceptable professional conduct was alleged and there were a large number of particulars, and yet the decision was summed up in just one paragraph. Having considered new material by the defence, the GCC determined not to present any evidence in support of the allegation and said it could not justify a finding of unacceptable professional conduct. The PCC therefore determined that insufficient evidence had been adduced to satisfy it that the allegation was well founded and dismissed the allegation without hearing evidence from the respondent. The reasons for why the numerous particulars had fallen so rapidly were not made out clearly.

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**Example two**<sup>52</sup>: the commentary detailing the PCC's decisions did not align with the particulars of the allegation and there was nothing to suggest that the particulars as detailed had been amended. For example, reference was made to particular 6a-e and yet no particular 6 was detailed.

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**Example three**<sup>53</sup>: the particulars of the allegation were that the chiropractor provided chiropractic treatment to patients when registered as a non-practising chiropractor, and that he did so without having appropriate professional indemnity insurance. Both particulars were found proved and the PCC decided that his actions amounted to unacceptable professional conduct. The chiropractor was found to have unlawfully provided treatment to between 150 and 180 patients whilst on the GCC's register as a non-practising chiropractor. The PCC rejected the chiropractor's explanation that it was an oversight. It decided that a suspension order for a period of six months, which it described as '*a relatively short period of suspension*', would reflect the seriousness of the offending behaviour. The reasons for the decision on sanction made no reference to the finding that the chiropractor had practised without indemnity insurance, despite the fact that this is the one breach of the GCC's statutory requirements that, in itself, amounts to unacceptable professional conduct (GCC, 2010, p4).

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<sup>51</sup> 2012/1028

<sup>52</sup> 2011/954

<sup>53</sup> 2012/1041

## Extension of adjudication powers

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Some of the other professional regulators allow voluntary removal, whereby a registrant who admits that their fitness to practise is impaired, and who does not intend to continue practising, can apply to be permanently removed from the register without a hearing.

There is one case over the four year period where voluntary removal might have been a useful mechanism for the GCC to have had at its disposal. This was a Health Committee case<sup>54</sup>, where the PCC noted that the chiropractor had consistently made clear for nearly two years that he did not want to remain registered as a chiropractor. The PCC determined that a suspension order should be imposed for a period of five days.

There may be other cases for which this mechanism would enable the GCC to take swift action to protect the public, and to free up resources for cases where the particulars of the allegation are in dispute. Guidance on voluntary removal produced by the GMC (2013e) and the NMC (2013b) may be of interest.

## Explanatory guidance

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The classification of allegations indicates several areas where explanatory guidance might assist chiropractors to apply the *Code of Practice and Standards of Proficiency* to their everyday practice:

- > **Communication** – as the largest type of allegations about relationships with patients, communication is an area that would benefit from further attention. This should include informing patients about their diagnosis, treatment plan and results, as well as issues about the appropriateness of certain topics and putting patients at ease.
- > **Clear sexual boundaries** – the increase in sexual allegations points to a need for explanatory guidance for chiropractors in this area, particularly in the light of the environment in which treatment is given and also the intimate nature of some chiropractic treatments. The GCC outlined CHRE guidance on maintaining sexual boundaries in its *Fitness to Practise Report 2012* (GCC, 2013), however this relies on chiropractors reading this report. The GMC has produced three sets of explanatory guidance targeted at registrants related to maintaining boundaries and sexual behaviour (GMC, 2013f, 2013g, 2013h) and the NMC also issues advice for registrants on sexual boundaries<sup>55</sup>.
- > **Consent** – as mentioned previously, there is a need for the IC to tighten up its use of language regarding consent issues, and also for the GCC to restate its expectations of chiropractors around such areas as whether patients should be asked to give ongoing

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<sup>54</sup> 2011/990

<sup>55</sup> <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Maintaining-Boundaries/>

consent for any treatments, and also about consent in relation to removing a patient's underwear.

- > **Professionalism** – a number of the cases reviewed brought into question the professionalism of individual chiropractors. In the round, such complaints suggest there may be value in restating or reinforcing what professionalism means for chiropractors in the context of changing expectations of patients as well as wider societal changes (including the use of new media). This might be an opportunity for the GCC to engage chiropractors in a positive way, to reflect and understand their views on the attitudes and values that define the profession. The GCC may find the HCPC's research report *Professionalism in Healthcare Professionals* (2011) of interest in helping to define any work in this area.

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