VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

ADMINISTRATIVE DIVISION

OCCUPATIONAL & BUSINESS REGULATION LIST

VCAT REFERENCE NO. B78/2005

CATCHWORDS

Occupational & Business Regulation List – chiropractors – treatment and payment plans – whether treatment and payment plan appropriate for patient's circumstance – patient being able to make informed decision – whether informed decision made – conduct of chiropractor in delivering care and payment plan – *Chiropractors Registration Act* 1996 s 1, 3 and 46

APPLICANT	Dr Mark Pearson-Gills
RESPONDENT	Chiropractors Registration Board
WHERE HELD	Melbourne
BEFORE	Robert Davis, Senior Member
HEARING TYPE	Hearing
DATES OF HEARING	13-17, 21, 23-24, 27-28 February 2006, 2, 3, 9 and 10 March 2006
DATE OF ORDER	22 March 2006
CITATION	[2006] VCAT 436

ORDER

1 The decision of the respondent is set aside.

2 The registration of Dr Pearson-Gills is suspended for a period of 10 months commencing 28 days from the date of this order.

3 The applicant undergo further education at his expense with a body approved by the respondent. Such education to include patient management, case history taking, patient examinations, diagnosis and management plan and professional ethics with particular reference to children under 12 years of age. This education programme is to commence within 3 months of the applicant regaining registration as a chiropractor and

is to be completed within 12 months of commencement. A report concerning the education process learnt and the intended implementation of the process is to be provided by the applicant to the respondent at the completion of the educational course.

The final nature and content of this report is to be at the discretion of the respondent.

4 The applicant is, within 30 days after his re-registration, to undergo a mentoring component to his educational process. The mentor is to be chosen by the applicant from a list of recommended chiropractors by the respondent. The mentoring process shall continue for a period of 6 months after it is commenced.

Regular reporting mechanisms, the exact nature and contents to be forwarded by the respondent will be implemented at the discretion of the respondent. As well, the applicant is to take reasonable steps to implement any recommendations made by the mentor in alignment with the respondent's requirements. These will include, but not be limited to, practising procedures in relation to communication protocol of self and staff, documentation with patients referring to diagnosis, treatment plans, payment plans, his relationship with patients, his practice and professional ethics.

5 The mentor or some other person as directed by the respondent will regularly for a period of 6 months from the commencement of the mentoring program referred to in order 4 hereof, conduct an audit of the applicant's practice to ensure that he has complied and continues to comply with the conditions set out by the Board.

6 The expense of the mentoring process referred to in orders 4 and 5 hereof and each of the elements within the process is to be borne by the applicant.

7 Costs reserved.

Robert Davis
Senior Member

APPEARANCES:

For Applicant	Mr T V Hurley of counsel instructed by Riordan Hume, solicitors
For Respondent	Ms F McLeod SC with Mr McWilliams of counsel

REASONS FOR DECISION

1 The applicant is a registered chiropractor practising under the name of "Knox Family Chiropractic" at Wantirna South, Victoria. He has applied to review a decision of the respondent made on 5 July 2005 ("the decision"). The respondent found that the applicant had engaged in "unprofessional conduct of a serous nature" pursuant to s 46(1)(a) of the *Chiropractors Registration Act* 1996 ("the Act") and as a consequence decided :

> In the matter of a complaint made pursuant to the provisions of the *Chiropractors Registration Act* against Dr Pearson-Gills, this Panel seeks to achieve two objectives; the first protection of the public and second, this Panel seeks to maintain professional standards of the profession within the eyes of the public. With those two objectives in mind this Panel makes the following determinations.
>
> That Dr Pearson-Gills undergoes further education at his expense with a body to be approved by the Chiropractors Registration Board. Such education is to include patient management, case history taking, patient examinations, diagnosis and management plan and professional ethics with particular reference to children under the age of 12 years.
>
> The education program is to commence within three months and is to be completed within twelve months of commencement. A report concerning the educational process learnt and the intended implementation of that process is to be provided by Dr Pearson-Gills at the completion of the educational course.
>
> The final nature and content of this report is to be at the discretion of the Chiropractors Registration Board.
>
> It is the intention of this Panel that at the conclusion of the educational process the chiropractor is able to demonstrate to the satisfaction of the Board that he implements and continues to implement the practices enunciated within the educational process.
>
> Dr Pearson-Gills is to undergo a mentoring component to this educational process. The mentor is to be chosen by Dr Pearson-Gills from a list of recommended chiropractors by the Chiropractors Registration Board. The mentoring process should commence within three months of this determination and will continue for as long as deemed necessary by the Board.
>
> Regular reporting mechanisms, the exact nature and contents to be forwarded by the Board will be implemented at the discretion and direction of the Board. As well, Dr Pearson-Gills is to take reasonable steps to implement any recommendations made by the mentor in alignment with the Board's requirements. These will include, but not be limited to practising procedures in relation to communication,

> protocol of self and staff, documentation with patients referring to diagnosis, treatment plans, payment plans, his relationship with patients, his practice and professional ethics.
>
> As well as directed by the Board the mentor or some other person as directed by the Board will regularly conduct an audit of Dr Pearson-Gills' practice to ensure he has complied and continues to comply with the conditions as set out by the Board. The expense of this process and each of the elements within the process is to be borne by Dr Pearson-Gills.
>
> The compliance of Dr Pearson-Gills with the determinations of this Panel in respect to the questions of education and mentoring be a condition of the ongoing registration of Dr Pearson-Gills. That the Chiropractors Registration Board make further determinations with regard to the ongoing registration of Dr Pearson-Gills upon conclusion of the education process and the mentoring period.
>
> That the registration of Dr Pearson-Gills be suspended for a period of four months. That the commencement of the period of suspension be delayed for a period of eight weeks from today to allow Dr Pearson-Gills to make any necessary arrangements with regard to his current patients and to his practice.
>
> That is the determination of this Panel.

2 It should be noted that I stayed the decision until further order or until the final determination of this proceeding.

BACKGROUND

3 DC, the mother of an infant CC, took her child to see the applicant at his practice in Wantirna South on 9 February 2004 after reading an advertisement promoting the applicant's practice and offering a first session at a reduced rate of $20. At the time of the first consultation, the baby CC was approximately 4½ weeks old, having been born on 8 January 2004. It should be noted that CC, was DC's first child. Upon arrival at the applicant's practice on 9 February 2004, DC was given a form by one of the applicant's staff, which she was requested to complete. The form was headed "Welcome to Knox Family Chiropractic". DC wrote on the form in response to a question in relation to the purpose for her visit : "to have posture etc. .. checked over – forceps delivery – peace of mind". She also noted that the baby was feeding correctly and that she (DC) had systemic Lupus. Further she ticked a "yes" box to the question : "Did you have a traumatic birth?". Under the heading "Our Purpose", the following was written on the welcome form :

> Our Mission is to bring as many families as possible closer to God by creating a new awareness of life … restoring and renewing a state of optimal health allowing the timeless wisdom of God's power to recreate its perfection from the inside out. An optimal functioning spine and nerve system is necessary for optimal health. Misalignments of the spine and nerve system are called subluxations

and prevent the body from having optimal health. Throughout life there are many things that cause interference with our nerve system, such as physical injuries, emotional stress and even poor diet. These everyday stresses place tension on our spine and cause subluxation. Today we will be looking for any possible causes of subluxation in your spine to determine if Chiropractic care is something that will benefit your health.

4 Further, at the bottom of the form, there was a box headed "Understanding Chiropractic" in which the following was written :

Understanding Chiropractic

IMPORTANT INFORMATION FOR PATIENTS

This information must Be Read by All Patients

Congratulations! You are about to join some 30 million others worldwide who receive care from a doctor of chiropractic each year. In order to get the full benefit of chiropractic care, you need to understand exactly what your chiropractor does – and doesn't do.

First of all, there are different types of chiropractors, just as medical doctors or dentists have different approaches and healing philosophies. Your doctor is a 'subluxation-based' chiropractor.

That means that :

The SOLE purpose of your chiropractic examination and care is to locate and correct subluxations.

As your doctor will explain more fully a spinal bone which has lost its normal placement or alignment, is said to be 'subluxated'. These subluxations can interfere with the nerve impulses travelling from the brain to every part of the body, and back again, resulting in health problems. Some of the techniques used to detect subluxations are palpation (using the hands to feel the spinal bones for misalignments), X-rays and postural assessment.

No matter what kind of examination is used your doctor of chiropractic is only looking for subluxations – not for evidence of other, non-chiropractic problems

A medical doctor who views a spinal x-ray would probably not be able to recognise a subluxation, and wouldn't be looking for it. That's not in the scope of practice of a medical doctor. In the same way, recognizing and evaluating signs of non-chiropractic medical conditions is not in the scope of practice of your doctor of chiropractic. Chiropractors do not diagnose diseases such as cancer, diabetes, ulcers, etc. They are looking only for the direct cause of many health problems – vertebral subluxations.

If you think you may have a non-chiropractic medical problem or condition that you want diagnosed, you need to be examined by a health care practitioner who provides medical diagnoses.

I, …….. (print name) have read this Important Information for Patients. I fully Understand that the purpose of my chiropractic examination today is to detect the presence of vertebral subluxations.

5 The applicant then examined the infant CC, and reported to DC, that CC had a subluxation but that he did not wish to treat the infant that day as his thermal imaging machine was not working. He therefore requested the applicant to return on 11 February 2004.

6 The applicant's examination notes made on 9 February 2004 record as follows :

> Posterior birth presentation
>
> Delivery with forceps after attempted vacuum extraction
>
> Birth presentation – attempted rotation of baby in womb with forceps
>
> Five hour delivery second stage labour
>
> Baby not lying on right side of head, decreased motion noted to right side
>
> Breast feeding poor at start, now feeding OK
>
> Feeds much better on left, baby is better when lying on right side
>
> Feeding poor on right breast
>
> Baby gets distressed when on right breast lying on left side
>
> Jittery and lots of head movement lying on left
>
> Vaccinated Hep B Vit K at birth
>
> Head of baby eccentric in nature with cone elongation presentation
>
> Indentation on left and right temple due to forceps
>
> Brought up bile? 2 days after birth – no normal feeding for bile examination explained to patient.

7 On the 2nd visit by DC and CC to the applicant's practice on 11 February 2004, the applicant conducted a further examination and performed two scans using equipment known as thermology. The scans showed "hot spots" around the C1 vertebra of CC, however the two scans even though taken only a minute apart showed different shaped "hot spots".

8 As a result of the applicant's diagnosis, he performed an adjustment to CC's spine using an activator which is a hand-held instrument that delivers a sharp rap to the region of the vertebra with the intention of unblocking or jarring the joint. DC was then asked to bring the baby back to the practice the following day, and charged $40 for her visit that day.

9 On 12 February 2004 (3rd visit), CC was again treated by adjustment with the activator in relation to the right side of her C1 vertebra in relation to the subluxation at that point which the applicant had diagnosed. Following that treatment, DC was invited to "an educational session" with another patient

who was an elderly male. At the conclusion of the educational session, she was provided with advice about the future treatment of CC and presented with a plan and payment schedule. The plan and payment schedule was as follows :

PLAN AND PAYMENT SCHEDULE

RECOMMENDED CHIROPRACTIC CARE

FOR OPTIMAL SPINAL CORRECTION

The objective of Chiropractic Corrective care in this office is to move your spine through a process of correction, stabilization and into wellness care to achieve and maintain the most optimal function possible. The schedule recommended may change at any time depending on the presenting clinical indicators of subluxation.

SCHEDULE FOR 12 MONTHS OF CORRECTIVE CARE

This schedule is a prediction of possible care based on the doctor's experience.

Each visit to the office may be comprised of any or all of the following – assessment, adjustment, education and advice

Recommended Care Plan

3 times per week for	4 weeks =	12	
2 times per week for	4 weeks =	8	
1 time per week for	40 weeks =	40	
Estimated Total Visits	=	60	Visits @$40 = $2,400
Re-examination every 12 visits	=	5	Re-Exams @$50=$250
Traction Wedge (if required)	=	$80	
Re-Xray at 3 & 12 months (if required)	=	No charge	
Workshop Attendance	=	No charge	
Optimal Health University	=	No charge	
Retail Fee	=	**$2,730**	

CHIROPRACTIC CARE – CAPPED FEE

To ensure our patients and their families receive the highest quality of care at the most affordable fees possible we have capped our fees and offer this for payment programs only

Retail Fee	=	**$2,730**
Capped Fee Savings	=	$1,330
Capped Fee	=	**$1,400**

PAYMENT PLAN SCHEDULE FOR

12 MONTH CORRECTIVE CARE PLAN

Retail Fee	$2,730
Capped Fee	$1,400

Option 1 One time payment – Most Cost Effective Program
(Total Savings $1,530) **$1,200**

Option 2 Monthly payments – (Total Savings $1,330) **$1,400**

Down payment of $400
And 5 payments of $250 per month
Due on the 15th of each month from March 2004 through to July 2004

DISCONTINUATION POLICY

If care is ceased for *any* reason, or if care is no longer clinically indicated, I (the Patient) will *only* be charged for **services received** calculated at retail fees of $40.00 per visit, I will be charged this total or the full $1,400 (option 2), whichever is **LESS.**

Any outstanding fees owing to this office after 30 days of ceasing care will be passed onto a debt collection agency for recovery and may incur additional costs.
If a refund is due that shall be payable by Knox Family Chiropractic **immediately.**

I understand and I commit to option 2 to its benefits and responsibilities.

Payment Method, VISA ___/M/C___/EFT___/Cheque___/Cash___

Date 12/2/04

Patient Name CC

Patient Signature _____

Team Member _____

10 It should be noted that it was agreed by all parties that the words in the Schedule under Option 2 should not be "5 Payments" but rather "4 payments".

11 The applicant signed the form and DC indicated that she preferred Option 2. However, at some point, after being presented with the form, DC became alarmed at the recommended treatment, as it suggested to her that there was

significant health issues with her daughter CC, as well as the fact that she was required to pay a significant amount for the treatment of CC.

12 In a telephone conversation between the applicant and DC, DC explained to the applicant that she was not going to continue with the plan and that she was involved in a custody hearing in relation to her husband's daughter. DC maintained that the applicant said words to the effect, "the impression she got was that I was not doing the right thing by DC … whichever I feel is the most appropriate way to go, either pay for custody hearings for my step-daughter or to have my child seen by Chiropractic Care". She stated that she was upset by that. The applicant denies that he used those words and he maintained that he said, "it was a matter for DC".

13 DC then sought a second chiropractic opinion in relation to CC's alleged health problems from Dr MB. Dr MB consulted with DC in relation to CC on 24 February 2004. At that consultation, Dr MB noted DC's concern in relation to head position and feeding on the left breast. He adjusted CC, and she returned a week later for review and further treatment. She was then reviewed about a month later. DC continued to attend Dr MB with CC (14 times in a 12 month period), and Dr MB adjusted CC on 7 occasions between 24 February 2004 and 14 January 2005. It is noted that CC developed in accordance with normal physical and neurological milestones, including size, weight, rolling, sitting, crawling and walking.

14 Dr MB on 24 February 2004 wrote to the respondent in relation to the visits by CC and DC to the applicant, inter alia, in the following terms :

> I am not familiar with the type of therapy or adjusting techniques recommended by this chiropractor. I do take exception to the frequency or care recommended and to the message put out to the public by this recommendation. I am unfamiliar with the chiropractor's educational background. I am unaware of his knowledge of paediatrics.

15 By a further letter of 23 March 2004 to the respondent, MB, inter alia, wrote :

> I am sickened to witness these recommendations to a new born child by a person claiming to practice the same profession as myself. I trust the Board investigates this matter.

16 At the request of Dr MB, DC wrote to the respondent setting out her concerns in relation to the applicant's conduct and a brief history of her dealings with the applicant.

17 As a result of the complaints by MB and DC, the respondent caused CC to be examined by a doctor Brandon Keil on 7 March 2005 (at that time CC was 14 months of age). Dr Keil is a chiropractor specialising in paediatrics. He noted that CC had no palpable abnormality of the atlas (C1) vertebra and compiled a report to the respondent dated 14 March 2005.

18 Ms Macleod and Mr McWilliams, who have appeared for the respondent, have summarised that report as follows :

- The history is consistent with diagnosis of right atlas subluxation
- The literature suggests head symmetry and subluxation in an infant will be fully corrected after 3.72 corrections – therefore the recommendation of 60 consultations over a year was unwarranted and excessive and contrary to undergraduate training
- The cause of her condition confirmed by clinical notes and the conclusion of her condition was initially remained uncomplicated
- Management of adults is very different to infants, median number of treatments is 2, it is unusual to require more than 4 in uncomplicated cases
- The programme recommended by Dr Pearson-Gills is excessive and not clinically indicated by any information in the patient's notes.

19 It should also be noted that the letters of complaint by Dr MB and DC were forwarded to the applicant and he replied to the same. Again, Ms MacLeod has summarised the reply by the applicant to the complaint, in the following terms :

a the plan identifies a visit may compromise any of – assessment, adjustment, education and advice and that the schedule may change at any time depending on the presenting clinical indicators of subluxation;

b the plan was provided to make the payment of the care more manageable and affordable;

c he refers to the discontinuation policy;

d the care plan is based on clinical findings and history of the individual and printed with personalised information of the patient;

e the plan was in accordance with the council on Chiropractors' Clinical Guidelines (CCP Guidelines);

f his recommendations for the visit programme were based on the presence of subluxation;

g the CCP guidelines state that complicated deliveries represent a higher risk to the child of spinal cord damage and given the forceps delivery in this case the birth was not indicative of one without difficulties;

h a conference paper presented by Maxine McMullen supported the view that changes from the normal birth process cause subclinical signs with symptoms arising at a later time, these subluxations should be analysed and corrected as soon as possible after birth to prevent this condition;

i in his view he had complied with the highest standard and complied with the best chiropractic clinical practice and procedures.

20 By a notice of formal hearing dated 15 March 2005, the respondent wrote to the applicant and, inter alia, set out the allegations which it intended to make. At paragraph 3 of that notice, it is stated :

> At the formal hearing you will be required to answer the following allegations :
>
> (a) in about February 2004 at Knox Family Chiropractic, Suite 2A, 426 Burwood Highway, Wantirna South, as a chiropractor, you engaged in unprofessional conduct with an infant patient you were treating, CC, and her mother and guardian, DC, in that you recommended a course of care (including treatment or consultations) which, having regard to the child's condition, was not necessary, appropriate, or in the interests of the patient, and was more frequent than was justified, was not required for the wellbeing of the patient and did not have regard to the individual needs of the patient
>
> (b) in about February 2004 at Knox Family Chiropractic, Suite 2A, 426 Burwood Highway, Wantirna South, as a chiropractor, you engaged in unprofessional conduct with an infant patient you were treating, CC, and her mother and guardian, DC, in that you recommended or tried to induce DC to enter into a payment, care, treatment and consultation regime the characteristics of which are not appropriate, fair or in the interests of the patient or her mother.

21 As a result of the hearing which subsequently took place, the respondent made the decision to which I have referred above (see paragraph 1) and to which the applicant now seeks review.

RELEVANT LEGISLATION

22 Section 46 of the Act states :

> **46**. ***Findings and determinations of a formal hearing into conduct***
>
> (1) After considering all the submissions made to a formal hearing into the professional conduct of a registered chiropractor the panel may find that—
>
> (a) the chiropractor has, whether by act or omission, engaged in unprofessional conduct of a serious nature; or
>
> (b) the chiropractor has, whether by act or omission, engaged in unprofessional conduct which is not of a serious nature; or
>
> (c) the chiropractor has not engaged in unprofessional conduct.

(2) If the panel finds that the chiropractor has, whether by act or omission, engaged in unprofessional conduct of a serious nature, the panel may make one or more of the following determinations—

(a) require the chiropractor to undergo counselling;

(b) caution the chiropractor;

(c) reprimand the chiropractor;

(d) require the chiropractor to undertake further education of the kind stated in the determination and to complete it within the period specified in the determination;

(e) impose conditions, limitations or restrictions on the registration of the chiropractor;

(f) impose a fine on the chiropractor of not more than $2000;

(g) suspend the registration of the chiropractor for the period specified in the determination;

(h) cancel the registration of the chiropractor.

(3) If the panel finds under sub-section (1)(b) that the chiropractor has, whether by act or omission, engaged in unprofessional conduct which is not of a serious nature, the panel may make any determination which a panel at an informal hearing is able to make upon making such a finding.

(4) The panel must not impose a fine where the conduct which is the subject of the finding has resulted in a fine being imposed by another tribunal or court of law.

23 "Unprofessional conduct" in s 3 of the Act means –

"unprofessional conduct" means all or any of the following—

(a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered chiropractor;

(b) professional conduct which is of a lesser standard than that which might reasonably be expected of a chiropractor by his or her peers;

(c) professional misconduct;

…..

APPLICANT'S TYPE OF PRACTICE

24 The applicant maintains that his practice is that of a subluxation/wellness chiropractic practice. This, in effect, means that the applicant will assess patients for subluxations and then correct the same and continue seeing the patient to ensure that the correction of the subluxation remains (stabilising

those) and that no further subluxation occurs (wellness phase). This may incur regular and frequent visits by the patient to the applicant. The Code of Professional Conduct and Practice of the Chiropractors Association of Australia, at para 5.1 defines subluxation to mean :

> Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation.
>
> A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.

It should be noted that this definition of "subluxation" is used by Professor Neil Davies in his book *Chiropractic Pediatrics* at p 2.

25 Generally, a chiropractor will identify a subluxation by palpation, range of movement of the patient and x-ray. In this particular instance, the applicant relied largely upon palpation, thermal scanning and his clinical experience to identify a subluxation of CC at her C1 vertebra (the atlas).

26 After the applicant has achieved relief of the subluxation, he will move the patient to reconstructive or rehabilitative care (stabilisation). This is defined by Claudia Anrig in Pediatric Chiropractic at p 326 to mean :

> Reconstruction/rehabilitative care is the delivery of care to alter more permanently the biomechanical structure of the spine. This type of care would be required for example when a … or kyphosis of the cervical spine or scoliosis is present.

27 The third phase of care is called prevention or wellness. This has been defined by Anrig again at p 326 to mean :

> The third phase of care has been called by the following names; prevention or wellness. This program is the rendering of spinal adjustments when subluxations are present to allow the developing spine and its influence on the nervous system to have optimal function during the course of the child's developmental process.

28 At p 4 of Professor Davies' work, he sets out what he believes to be the proper frequency of visits for wellness care :

> This frequency is considered the basic minimum for well children. Additional VSC (vertebra subluxation complex) assessments should be made in the event a child suffers any trauma, receives a vaccination, becomes infected or manifests any change in demeanour, feeding or sleeping habits.

The Professor then sets out the following :

Box 1.1 Key developmental ages at which children should be evaluated for vertebral subluxation complex and developmental progress
• 6 weeks • 3 months • 6 months

- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Every 6 months thereafter until school entry

29 Dr Keil, a pediatric chiropractor, who was called on behalf of the respondent, in his witness statement which was prepared for the hearing before the respondent, at para 17 sets out what he believes to be the correct amount of visits for a child in relation to wellness care :

> … Dr Pearson-Gills recommends a course of 60 consultations over a period of one year. A recent study of 25 infants with a mean age of 3.7 months presenting with head asymmetry with associated spinal and/or extremity subluxations revealed full correction of the subluxation after an average of 1.8 treatments over an average of 3.72 consultations (Davies 2002). In light of this study, any recommendation concerning an infant indicating a need for 60 consultations over a one-year period is unwarranted and excessive; particularly when there are no apparent complications that may indicate a need for more extensive treatment. The recommendation provided to undergraduate chiropractic students at RMIT University during their pediatric studies is that referral for specialist chiropractic paediatric assessment is indicated in cases with persistence of the subluxation after 6 treatments or if specialist chiropractic pediatric assessment is not available then the opinion of a colleague with some paediatric experience should be sought. The recommendation regarding on going care for an infant with no apparent complications and after correction of the subluxation is assessment at three monthly intervals or the following ages : 3 months of age, 4.5 months of age, 6 months of age, 9 months of age and 12 months of age. This is a similar program to that used by maternal and child health nurses. The parents are instructed to return between these ages if there is reason to do so such as reocurrence of symptoms, accidents or injuries, behavioural changes or any concern regarding the infant.

30 The International Chiropractic Association in their Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic at p 231 also state what it believes to be a proper interval for wellness treatment. (It should be noted that these guidelines have incorporated the guidelines of Council of Chiropractic Practice(CCP)) :

> Chiropractic clinical experience, since 1895, has demonstrated that periodic chiropractic assessment in a Level III (wellness care) regimen does have merit. The current body of research in this area supports the observation that initial degenerative changes are measurable within one week of the occurrence of vertebral subluxation and other malpositioned articulations and structures. Vertebral subluxations and other malpositioned articulations and structures, regardless of their origin, will initiate negative physiological changes. Weekly or semi-

> monthly office visits are appropriate. A chiropractor views the detection, location, control, reduction and correction of vertebral subluxations and other malpositioned articulations and structures during all levels of care to be vital toward the optimum expression of health.

DIVERSIONS OF VIEWS WITHIN THE CHIROPRATIC PROFESSION IN AUSTRALIA

31 Three different views were presented at the hearing of this application as to the way chiropractic should be practised. First, is that of the applicant and nearly all of the witnesses called on his behalf, who are of the view that subluxation can be detected by the means used by the applicant that there should be adjustment, stabilisation and a continuation of that treatment with frequent visits either weekly or fortnightly. These chiropractors subscribe to the views held in the ICA (International Chiropractic Association) and the CCP Guidelines.

32 All the applicant's witnesses (who were numerous) supported the care plan prepared by the applicant for CC and most supported the payment plan. Although many, including Dr Croke said he asks his wellness case patients to attend fortnightly. It should be noted that one of the applicant's witnesses, Dr Pyke, practises as both a symptomatic and wellness practitioner. Many of the applicant's witnesses supported their assertion that for wellness case patients should be examined weekly or more frequently by reference to their own family. However, I found the reference to the chiropractors' own family unhelpful as such examinations were not of a burden to the patient in relation to time or money.

33 It should be noted that all the chiropractors called to give evidence on behalf of the applicant, except Dr Sipser, had at one time or another been involved in what was called "Waiting List Practice" (WLP). WLP is an organisation run by a Dr Mertz which is a coaching group for chiropractors that, amongst other things, instructs chiropractors in the best way of conducting their practice. The applicant was a member of WLP from approximately 1999 to November 2003. During this time, he assisted Dr Mertz in conducting tutorials and seminars throughout Australia. The applicant denied having any relationship with WLP after November 2003. However, it is noted that a Di Coleman, an executive of WLP, sent out many requests to chiropractors, to assist the applicant in the preparation and conduct of this proceeding and the proceeding that was before the respondent Board. These requests were sent out on WLP letterhead. While it was difficult to establish what was actually taught by WLP in relation to patient care programmes, I find that it is likely that the care programme and payment schedule used by the applicant in relation to the proposed treatment of CC was probably similar to that suggested by WLP. It is difficult to be definitive about this matter because the applicant and a number of his witnesses were either unable, or refused to produce what was known as "The Mastery Volume" which is the guidebook to WLP practice.

However, on the balance of probabilities, using the *Briginshaw* standard of proof, I have come to the conclusion that the care plan and payment plan used by the applicant for the child CC did resemble what was promoted by WLP.

34 Secondly, there are those that follow similar principles, but do not believe in the frequency of visits for well children as that practised by the applicant. This frequency has largely been outlined by Dr Keil to whom I have referred above (see paragraph 29). It should also be noted, that the author Professor Davies seems to adopt this view, as does Dr MB, as does Dr Turner-Jensen who gave evidence before me and whose practice involves predominantly treating children. It should be noted that Dr Keil expressed the view that atlas subluxations which have been identified, should be resolved after two to five treatments. He agrees with Dr Davies' recommendations that a child seeking "well child care" should visit the chiropractor six times in a twelve month period, and in the case of an ill child, a concentrated series of visits for two to three days. He agrees with Dr Davies' statement that all except the acutely ill child, the dictum "less is better" is a sound rule to follow in the chiropractic management of children. He also referred to a manual of care for infants prepared by Dr Biederman that treatment should be limited to one or, at most, a few treatments and treatments in excess of this may be detrimental to the child. One of the applicant's witnesses, a Dr Deitch (chiropractor), also agreed with the view of treatment stated by Dr Biederman.

35 Dr Turner-Jensen stated that CC's nervous system is underdeveloped at the early stage where she was seen by the applicant and any stimulus administered to the patient at that stage will have an effect and to ensure that a desired effect is achieved, a cautious and conservative approach to treatment is warranted. He accepted the approach of Professor Davies set out in the table 1.1 (see paragraph 28).

36 The third type of chiropractic that is practised is symptomatic chiropractic care. The witnesses called on behalf of the respondent, Dr Crawford and Dr Charlton, were by and large exponents of this type of chiropractic treatment. They held the view that subluxations, if they exist at all, could only be detected by imaging, that is, x-ray or MRI. They denied that subluxations could be detected by palpation. They also denied the use of thermal imaging in the assistance of detection of subluxations. Their view was basically that there is no proof that subluxations exist. They said that the proper practice of chiropractic was for musculo skeletal disorders and vertebral subluxation as a "theoretical construct" for which there is no evidence "beyond anecdote and intuition". Further, they state that the view held by the applicant and his witnesses was largely driven by their desire to build their practices and increase patient visits by propagating conditions for which there is no apparent scientific evidence of its existence.

37 It should be noted that the three types of chiropractic care I have described above is not necessarily an all inclusive list of the type of chiropractic care

that is available. It was suggested in evidence that the type of care available is vast.

38 By referring to the three types of care above, I am not necessarily at this point suggesting that such care is appropriate, legitimate or reasonable. Whether the type of care is appropriate needs to be considered are in light of the patient that is being treated. However, extra caution should be used with particularly very young infants, such as CC, at the time she was examined by the applicant, because they are incapable of communicating their problems (if any) to the examiner and there appears to be little if any chiropractic research concerning young infants.

PARLIAMENTARY COMMITTEE

39 Mr Hurley, counsel for the applicant, submitted that chiropractic is an art, science and philosophy. He stated that the 1975 Report of the Committee of the Victorian Parliament into Osteopathy, Chiropractic and Naturopathy, was unable to find that chiropractic was scientifically based in the sense that orthodox medicine claims to be. It is stated in the report :

> 4.3.5 The Committee is unable to find that chiropractic is scientifically based in the sense that orthodox medicine claims to be. It is unable to see clinical confirmation of the claims made by chiropractors. It is conceded that chiropractic treatment often relieves symptoms, often very acute, such as muscle spasm, neuro-muscular-skeletal problems, often with great rapidity. It might be more accurate to say that it appears to relieve them and the patients certainly claim relief.
>
> ….
>
> 4.3.8 In diagnosis, chiropractors rely heavily on palpation and X-ray. Palpation certainly appears to be effective both as diagnosis and remedy but it is not clear why this should be so. For example, in palpating the spine chiropractors do not feel the vertebrae themselves but the spiny ridges or spurs (spinous process) at the back. They made judgments on the misalignment (subluxation) of the vertebra working from the relative position of the spur although there is no doubt that a perfectly functional spine may have many misplaced spurs.
>
> …..
>
> 4.3.13 Accordingly the Committee is unable to find that chiropractic is scientifically based.
>
> ….
>
> 4.15.1 ….
>
> (ii) Chiropractic should be defined in the Act as "a system of diagnosis and treatment, based on theories originated by Daniel David Palmer, in which physical illness or malfunction is treated primarily by adjusting the

articulations of the spine by hand alone in order to relieve interference with nerve transmission.

…..

(xiii) No chiropractor or osteopath should treat a child under the age of twelve years without a written referral from a medical practitioner.

40 In spite of the misgivings of the committee, the 1978 Act was passed; chiropractors were not restricted in their treatment of children and "chiropractic" was defined in s 8(5) of that Act as follows :

> (5) In this section and in sections 3, 6, 9, 17, 20 and 25 'chiropractic and osteopathy' means -
>
> (a) the use by application to the human body of manipulation or a proclaimed method for the purpose of curing, alleviating or preventing a physical disability or abnormality; and
>
> (b) the use of and instruction in therapeutic exercise and adjustment of the articulations of the human body for the purpose of curing, alleviating or preventing a physical disability or abnormality.

41 However, "chiropractic" is not defined in the current Act. Therefore, Mr Hurley argued that chiropractors should be able to now define their own profession.

42 Ms McLeod for the respondent submitted that :

> The applicant's arguments are illogical. The fact that Parliament saw fit to regulate the practice of chiropractic (and all manner of alternative therapies unregulated before this time) is not evidence of the acceptance of the principles espoused by the profession at the committee hearing. Rather, the decision to regulate is consistent with the objectives now expressed in the Act including the desire to protect the public and the creation of a Registration Board and accreditation and licensing procedures towards that end.

43 I agree with the submissions of Ms McLeod. The purposes that Ms McLeod has referred to are set out in s 1 of the current Act. The fact that the committee saw the difficulties which existed, and Parliament in fact passed the legislation in any event, does not mean that Parliament accepted those difficulties.

44 However, it does seem to me that there is good authority for the proposition that a great many in the chiropractic profession believe that it is an art, a science and a philosophy. These groups would include both those led by the applicant and those to which doctors MB, Keil and Professor Davies subscribe. In the preface to Professor Davies' book (which I have already referred to), he states :

> I am firmly of the opinion that chiropractic is a clinical art as much as it is a science and therefore the 'best evidence' will always be a balance between the available research literature and clinical experience, both being tempered by sound knowledge of the natural history of the particular condition with which the patient presents.

PARTICULARS OF COMPLAINT

45 Mr Hurley made objection to the particulars of complaint as being a "scatter gun". Mr Hurley makes complaint that the respondent was initially relying on paragraph (e) of the definition of "unprofessional conduct" in s 3 of the *Chiropractors Act*. However, at the outset of the hearing, Ms McLeod made it clear that the respondent was no longer relying on this definition as only a minimal amount of services were delivered by the applicant to CC. While this definition may have been considered by the respondent Board, in my view, it does not detract from the respondent's case because it is no longer relying upon the same. Mr Hurley then submitted that the allegations made by the respondent in relation to both the care plan and payment plan are too wide and too varied.

46 With respect to this matter, Ms McLeod stated :

> With respect this is nonsense and is a selective reading of each allegation. Each allegation addresses recommendations made to the mother DC in February 2004. The reasonableness or otherwise of those recommendations must be judged by the condition of the child at that time, the motivation for the recommendations and whether there was any proper basis for making them.

47 During the hearing, evidence was led by both the applicant and the respondent as to whether the care plan was clear to the patient's mother and whether the plan was clear on its face. Evidence was also led as to whether if the plan was clear and clear to the patient, there was a proper basis to make recommendations about it and whether it meets all or any other combinations of components alleged in paragraphs (a) (course of care) and (b) (payment plan).

48 Therefore, in my view, not only did the applicant not suffer any disadvantage by the way that the allegations were framed, it is clear to me that both the applicant and his counsel understood the nature of the allegations and did their very best to answer the same. I thus agree with the submissions of Ms McLeod.

DR EFRON

49 The respondent called Dr Efron to give evidence in this proceeding. Dr Efron is a medically qualified paediatrician. Mr Hurley submitted that his evidence was irrelevant and should be disregarded. The objection to Dr Efron's evidence was made at the commencement of such evidence. I informed Mr Hurley that I was not in a position at that time to rule on the relevance of such evidence. After hearing all the evidence in this case, I am

of the view that Dr Efron's evidence is relevant. While the chiropractic profession is not solely a body of science, it is nonetheless important to receive evidence as to what the medical profession may think of both the health of the child CC when she was treated by the applicant and the nature of the treatment proposed by the applicant. It was also particularly relevant to hear Dr Efron's evidence of the rarity of injury arising from assisted deliveries (forceps and vacuum). This was opposed to the evidence given by the applicant and a number of his witnesses which said that assisted deliveries were traumatic, can often cause subluxations, and in the case of Dr Sawyer (chiropractor) he said that one third of all babies delivered by forceps had a fractured skull. Certainly Dr Efron's evidence was useful in relation to this unusual proposition, and enables me to reject that evidence even though Dr Sawyer said that he made that allegation by means of readings which he had previously done.

CREDIT OF APPLICANT

50 The applicant's credit is important both as to motivation in the preparation of the care and payment plans and his report of the information sessions that he gave to DC which sessions would have in total lasted between two and three hours. The applicant gave evidence that the CCP guidelines now incorporated in the ICA guidelines were accepted by the government of the United States. This statement is not correct. In fact all that can be said is that the guidelines have been accepted as fulfilling the criteria of the guidelines Clearing House of the United States. The website of that Clearing House makes it very clear that that body does not endorse the publication in any way.

51 From the body of the evidence given, the applicant makes it very clear that he informed DC of the benefits of his treatment for CC. However, it is not apparent from the evidence he gave that he informed DC of any of the difficulties that may result from the treatment or of the contrary views held by many of his chiropractic colleagues as to the treatment that was given. For example, the applicant admitted on questioning from me that he had not informed DC of the views held by Drs Charlton and Crawford. This is particularly concerning because he admitted that DC was particularly stressed at the time that the plan was submitted to her, and yet he did not tell her that some members of his profession would not think there was any need for treatment of CC at all. Further, other members who had a similar idea of subluxation and wellness to the applicant might say that the treatment plan was excessive and he could have referred to the type of view that Professor Davies held, which he (the applicant) did not.

52 In December 2002, the respondent Board published findings in relation to allegations against the applicant relating to an infant RB who was a few weeks older than at the relevant time the infant was examined in this case. In that case, the applicant admitted the following allegations :

(a) ….

(b) between 21 November 2001 and 27 November 2001 (inclusive) you engaged in unprofessional conduct as a chiropractor at Knox Family Chiropractic Clinic in that you inappropriately or inadequately explained your diagnosis and proposed treatment of your patient, RB to his parent or parents by

  (i) exaggerating the seriousness of your patient's condition; and

  (ii) providing written information which was not sufficiently relevant to your patient's condition and circumstances; and

  (iii) indicating the need for your patient to receive more and extensive frequent treatment than was justified in all the circumstances; and

  (iv) by recommending a treatment regime that was excessive, unjustified and not reasonably required for the well being of the patient;

(c) between 21 November 2001 and 27 November 2001 (inclusive) at Knox Family Chiropractic Clinic as a chiropractor you engaged in unprofessional conduct in that you recommended a course of treatment for your patient, RB, which was -

  (i) excessive and involved attendances by the patient which were more frequent than was justified in all the circumstances; and

  (ii) was planned in response to practice, policies and objectives rather than the individual and changing needs of your patient, RB; and

  (iii) was not fully justified or required for the well being of your patient, RB; and

  (iv) was ineffective or did not demonstrate significant benefit for the patient's well being; and

  (v) involved payment of fees in accordance with a fee structure which was excessive, unjustified and fixed in response to practice policies and objectives rather than the individual needs of your patient or the financial constraints; and

  (vi) involved 'over servicing' your patient, RB.

(d) between 21 November 2001 and 27 November 2001 (inclusive) at the Knox Family Chiropractic Centre as a chiropractor, you engaged in unprofessional conduct in your treatment of your patient, RB, in that you failed to prepare and make treatment/patient records which were adequate, accurate and comprehensive.

53 In spite of admitting these allegations, the applicant consistently stated that it was his paperwork that was the problem. He prepared a treatment schedule very similar to the one he prepared for CC. However, that treatment schedule alongside the number of visits had the word "adjustments". He said it was the fact that he wrote adjustments against each one of the visits that was to take place that caused him to admit the allegations of the respondent.

54 He maintained that because the word "adjustments" did not appear in the treatment plan for CC, it was not of the same character as the RB case. He further said that by deletion of the word "adjustments", he had cured the problem considered by the Board in the RB case. When one reads the document entitled "Findings" and the allegations made against the applicant in the RB case, it is perfectly clear that the allegations which were made against the applicant in that case were far wider than just the word "adjustment" appearing and they went to the whole nature of the treatment and payment scheme that was proposed.

55 Thus, by the applicant stating the limited nature of the RB case to relate to the word "adjustment" he was at best deluding himself, and at worst attempting to deceive me in the evidence he was giving.

56 Mr Hurley submitted that I should not place a lot of emphasis on the applicant's admission in the *RB* case because of his belief that the problem with that case plan was that it referred to "adjustments" and not "consultations". Throughout the hearing of this proceeding, both in giving evidence and sitting behind his counsel, the applicant appeared both astute and careful. When giving evidence, he was reluctant to give answers before thoroughly thinking about the question and then if he thought answering the question was not to his advantage would attempt to avoid giving an answer. While sitting behind his counsel, the applicant appeared to make continuous notes and frequently passed notes to his counsel or his instructor. Thus, the applicant does not strike me as a man who could have misunderstood the allegations to which he was admitting in the *RB* case.

57 Subsequent to the *RB* case, the applicant maintained that he sent a schedule similar to the one used for CC's treatment to the respondent Board and that the respondent Board had no objection to the same. It is not clear whether the respondent Board received that schedule. In any event, it does not seem to me to be very important. The applicant states that the schedule he sent to the respondent Board did not have any figures on it. That is, it did not state the number of treatments, the number of weeks for treatment or the amount of money the treatment would cost. If this is the case, I fail to see how any approval or non-approval by the respondent of that document could relate to this case. Clearly, what the respondent is concerned with in this situation is, inter alia, the amount of treatments and the cost of such treatment. Therefore, without the figures inserted, it would have been impossible for the Board to make any conclusions about the same.

58 The applicant was challenged as to whether DC was permitted to pay per visit for CC's treatment. He stated on several occasions "that was always an option". He did this so that I would believe that it was an option known and given to DC. However, the option did not appear on the payment plan, and I have no confidence that the option was ever told to DC. Further, the applicant stated that approximately 80% of his patients are on care plans with planned prepayment. Under these circumstances, I have formed the view that paying by visit was never an option given to DC.

59 In the applicant's second witness statement, he stated that :

> After further discussions regarding our objectives DC agreed that she did not want symptomatic care for CC.

60 However, it is noted that prior to that time (7 February 2006), the applicant had written a lengthy letter to the respondent and had made a previous witness statement before the respondent Board. On neither of those occasions did he make a statement such as quoted above. Ms McLeod suggested that this was suggestive of recent invention. I agree with the suggestion of Ms McLeod and also agree that the possible explanation for the recent invention is that the applicant's experts gave evidence that what was said to DC was very important and that she had to be empowered to make a proper decision whether or not to accept treatment.

61 The applicant gave evidence that the care plan submitted to DC for CC was personalised for CC. However, as the evidence unfolded, it became clear that the only real personalisation in the plan was related to CC's name being inserted. It is true that the amount of visits may not appear on all the applicant's care plans, but it is also clear that they would appear on many of them. It is noted a similar amount of visits appeared on the *RB* care and payment plan.

62 The applicant appeared prone to exaggerate the effects that might occur if DC did not accept the applicant's recommendation for treatment of CC. In the applicant's advertising, it is clear that he suggested that if patients were not treated for subluxation, the effects could be "spinal fusion" and "heart attacks". When being cross-examined, the applicant claimed that he observed a patient with no previous surgical or chiropractic care with spinal fusion. However, he then appeared to qualify this statement by referring to "degeneration" rather than "fusion".

63 I have already referred to the applicant's relationship with WLP, and the fact that he stated subsequent to November 2003 he had no relationship with that organisation. However, he relied on Di Coleman from that organisation to assist him with this proceeding (see paragraph 33).

64 The applicant stated that CC was likely to have subluxations in utero because DC was treated with medication for Lupus. However when I questioned him about what medication was used to treat DC for her Lupus

or what medication is used to treat Lupus generally, the applicant had no idea whatsoever. It seems to me that it is impossible for the applicant to have deduced that CC could have a subluxation in utero because of DC using medication, when he had no idea either what that medication was or what it may have been.

65 The applicant stated on the care plan that he provided a copy of "Optimal Health University" at no charge. When questioned about this, the applicant revealed that "Optimal Health University" was in fact a newsletter. It was not published by any "university" at all and it was published by some private organisation of which he was unable to remember the name. It seems to me that by using the words "Optimal Health University" it is very suggestive on the care plan that anyone being involved would receive something from a tertiary institution which is the common meaning of university. While it was not the applicant that was printing this document (Optimal Health University), it was certainly the applicant who was distributing it and happy to go along with any belief that it may incur in his patients that it related to a tertiary institution.

66 On a number of occasions while giving evidence, the applicant voluntarily stated that if a patient was committed to chiropractic care, he would provide treatment at a reduced cost or at no cost if the patient could not afford to pay for such treatment. In the telephone conversation between the applicant and DC, it was apparent that DC was concerned about the cost of treatment to CC because she was otherwise committed in relation to her husband's child's custody case. However, even though DC stated she was concerned about the cost, the applicant made no offer to treat at a reduced cost. Thus, I am sceptical that the applicant does treat patients in need of chiropractic care at no cost or at a reduced cost. By claiming that he did treat the poor at no cost or reduced cost, the applicant was attempting to show that he was generous, committed to the treatment he gave and that his motives were pure. I have considerable doubt about those matters.

67 Further, the applicant appears to have used ploys on his care plan to make it appear that the patient was going to save more than was actually saved. For example, he refers to "traction wedges" which may not even be provided. He refers to "re-x-rays" when initial x-rays were not taken.

68 In spite of the Board issuing newsletters warning against advertising pamphlets containing a heading "A Doctor's confession to the State of Victoria" and providing self testimonials, the applicant continued to do precisely that and continued on doing that until a few weeks prior to this hearing. It is noted the applicant's advertising pamphlet was headed "A Doctor's confession to the City of Knox".

69 On numerous occasions during the hearing, the applicant was warned by me to answer the questions. He seemed to be taking pains not to answer questions in a responsive manner, where to do so would not have been in

his best interest. As a result, on several occasions, I was required to warn the applicant.

70 The applicant gave evidence that he was able to remember the visits of CC because of the remarkable similarity with the RB case. However, he agreed in cross-examination, that he had no reason to consider specific details of the consultation with CC at any time between February 2004 and at the earliest April 2004 when he received notification of the complaint. Further, it should be noted that the applicant sees more than 400 patients a day, including many infants, and he agreed that he had no particular reason to recall CC or DC. It is further noted that then senior counsel for the applicant, submitted before the respondent Board, during the original hearing of this matter before the Board :

> It is difficult, I think, from the Panel's point of view, that the evidence being a little bit one-sided, in the sense that the patient could remember the actual instance, whereas Dr Person-Gills could not remember with any accuracy the actual patient. (Panel transcript 354).

71 I do not accept that the applicant has a good memory of this matter because of the *RB* case. Such a proposition defies belief to the extent that, his memory is only likely to be a vague recollection. Mr Hurley suggested that I should take little account of the submission made to the Board by the applicant's senior counsel because it was made at a time after the Board had found the allegations proven and was deciding a penalty. I do not accept that senior counsel would make such a submission without instruction and it makes little difference to the truth or otherwise of the statement that was made after the Board found the allegations proven.

CREDIT OF DC

72 Mr Hurley submitted that DC was inconsistent in the evidence she gave. He contrasted two pieces of evidence given by DC at p 571 and 572 of the transcript:

> Line 29 (p 571) DC was asked, "Did he (the applicant) talk about what could happen if subluxation was not corrected? … Yes
>
> What did he tell you would happen or might happen? … That CC's growth and development <u>may not</u> have been – I don't know what the right (sic) would be to use – would be health for her growing – development. She wouldn't have a healthy development? … Development if she wasn't receiving the (sic) – having the subluxation assessment.
>
> Knowing that information, what did you think the 60 visits were necessary for? … I thought for my child that there <u>was</u> something seriously wrong" (underlining supplied).

Mr Hurley pointed to the fact that in the first part of this evidence DC used the words "may not" while later she used the word "was". He suggested

that this meant that on this important point, in particular and generally, DC's evidence was unreliable.

73 I do not agree with Mr Hurley. Because a witness such as DC using the words "may not" on one occasion and "was" on another does not mean that she is either unreliable or contradictory. Further, at p 588 of the transcript, DC made it clear she believed that if she did not do what the applicant was telling her to, CC's health and spine would be damaged for the rest of her life.

74 DC was generally consistent in her evidence. She made proper concessions when she did not have a recollection or even when the evidence favoured the applicant. For example, DC stated that the applicant "could be a fine chiropractor, I am not here to say he wasn't". She also conceded that the lecture given to her by the applicant was helpful. DC also suggested that the applicant acted professionally at all times.

ISSUES BETWEEN APPLICANT AND DC

75 Thus, where there is a conflict between the evidence of the applicant and the evidence of DC, I prefer the evidence of DC. It is apparent from the evidence of DC, that the applicant made her believe that there was something seriously wrong with her daughter. At p 572 of the transcript, it is clear that DC thought that the 60 visits were because there was something seriously wrong with her child. On questioning from me, DC stated that she gained the impression that if CC did not have the treatment suggested by the applicant, CC's health and spine might be damaged for the rest of her life. For a professional person, such as the applicant, to give the impression that he gave to DC about her daughter's health, in my view, is inexcusable. Mr Hurley stated that it is not the applicant's fault if DC gained the wrong impression and did not tell him about it. However, the applicant is a professional person and a first instance health provider. It is important that the correct impression is given to his patients. It should be noted that DC had only 4½ weeks earlier given birth to a child and, in all probability, was emotional and had had many sleepless nights. Under those circumstances, the applicant should have been particularly aware of her condition and what he was saying to DC. It is quite apparent that he was not. In my view, the words that the applicant used to put this type of fear into DC were not used inadvertently but were used for the intention of having her sign up to the care and payment plans that he was offering. This was done without any regard to the type of fear that it may instil in DC.

GUIDELINES

76 One of the applicant's witnesses, Dr Pyke, agreed as did Dr Efron, that :

(a) the treatment should do the patient good;

(b) the care is justified in terms of time and cost;

(c) the treatment does not create false hopes or anxieties for the patient.

I agree that this is a proper basis on which treatment should be given and agree with the submission of Ms McLeod.

77 Mr Hurley referred to the ICA Guidelines and in particular to the quotation referred to above which is to be found on p 231 of those Guidelines (see paragraph 30 hereof). However, it must be remembered that those guidelines do not refer to infants; and they also refer to weekly or semi-monthly office visits.

78 Having regard to the principle that the care must be justified in terms of time and cost, it is difficult to understand why the applicant prescribed weekly visits for wellness care rather than fortnightly. Particularly in light of some of the witnesses that were called by the applicants indicating that even though they did not have a problem with the care plan, they would have prescribed a less amount of visits. It should be mentioned that Dr Gold stated that CC was his patient, "I would monitor the spine daily for the first month". Even though Dr Gold was not cross-examined because he was in the USA, he was prone to exaggeration. For example, he stated "in such a case (CC) … subluxations are extremely difficult to detect and can have serious life-threatening implications for a child".

79 It should also be noted that the ICA Guidelines should be treated with some suspicion. These guidelines incorporate the CCP Guidelines and appear to be espoused by the World Chiropractic Association which seems to have a similar membership to those that studied under Dr Mertz to whom I have previously referred. Thus, in my view, it is likely that these guidelines were written in order to justify the author's own practices, ie practices espoused by Dr Mertz, CCP and those subluxation/wellness practitioners, including the applicant and most of his witnesses. That is, the advocating of frequent wellness case consultations.

80 Further, it is stated that these guidelines have peer reviews. However, one of the peer reviews to the CCP Guidelines was the applicant himself. He reviewed these guidelines in 1997 or 1998, which was a little after a year since he commenced practice. It would seem to me unbelievable that a chiropractor who has been in practice for approximately one year would be able to properly review such important documents. Under those circumstances, in my view, those guidelines should be treated with some considerable caution. Ms McLeod acknowledged that in the Standard Practice Guidelines (Victorian Guidelines), there was a reference to an adaption of the ICA Guidelines. However, she stated that this "is not an indicator that the practitioner need go beyond the document for the source (it is) only acknowledgement or attribution". In my view, this is a correct statement.

81 The Victorian Code of Professional Conduct (Victorian Code) provides that a chiropractor must, amongst other things, explain the nature and purpose of

the care proposed to a patient. In this particular instance, I believe rather than attempting to explain the care to DC, the applicant was more concerned with a "sales pitch" (see paragraph 119 below). It may well have been that in giving this "sales pitch", some of the care was in fact explained. However, such explanation of care should be given in an impartial manner and I do not find that that was given in this case.

82 The respondent conceded that both the Victorian Code and Victorian Guidelines did not prescribe a specific period of accepted care for any patient. On this basis, it was argued on behalf of the applicant that where the Code and the Guidelines are silent, it was up to the practitioner to adopt whatever care plan they felt appropriate. However, such a care plan must be done in a professional manner and not one calculated to benefit the practitioner rather than the patient. Further, the plan must be justified.

83 Ms McLeod has also noted that the Chiropractic Association (Victoria) (CA Vic) is a professional association representing the interests of approximately 700 of more than 1000 registered chiropractors in Victoria. This organisation has its own code of ethics which provides at section C paragraph 6 that a member, "shall not exaggerate for his/her own advantage the condition of any patient to that patient, but shall given an honest evaluation of the patient's condition and prognosis". The applicant is a member of the CA Victoria. In my view, in promoting the fear that the applicant did to DC about her daughter's health, he was exaggerating for his own advantage.

84 Further, it is noted that CA Vic is a member of the National Chiropractors Association of Australia (CAA). The CAA has published a code of professional conduct for chiropractors which postdates the care provided by the applicant to CC. That code recommends that the use of outcome measures as essential in every case and at least 12 visits or every six months which is ever the sooner.

85 Mr Hurley referred to the South Australian Guidelines. I disagree with Mr Hurley that the model used in the South Australian Guidelines corresponds with the model used by the applicant for CC. This is because the example referred to in those guidelines by Mr Hurley is silent as to the frequency of visits beyond the initial period of acute care. Also, as Ms McLeod notes, when referring to the South Australian Guidelines, "the fact that it recommended musculo/skeletal work during the acute phase (not possible in a 30 second to 3 minute session most likely)" with the applicant.

86 I agree with Ms McLeod's submissions that there were no guidelines which were produced by the applicant which "provide the applicant with support for visits of any frequency higher than weekly. Weekly visits are only mentioned in the ICA Guidelines but not with respect to infants". She also stated that the witnesses appeared to all agree that there were no guidelines related to the frequency of care for children and none for infants under 12 months.

87 Weighing all the matters up in relation to guidelines, I have come to the conclusion that the applicant can gain little comfort by referring to the ICA Guidelines, as they do not refer to the care of infants, and are in any event somewhat of a dubious quantity.

88 Mr Hurley mentioned that the respondent has power to produce guidelines and has not done so. Therefore, he concluded that this has made it very difficult for the profession. I can only guess at the reason why no guidelines as to the frequency of care have not been produced by the respondent and it would be unwise for me to enter into such a debate. However, I do not believe that the lack of guidelines produced by the respondent entitles the applicant to recommend a frequency of treatment that he has in the plan that he prepared for CC. CC's condition at the time of the applicant's examination, while having a subluxation, did not suggest any serious problems with her body. Under those circumstances, in my view, it may well have been proper for the applicant to correct subluxation, have a further appointment to make sure that the subluxation remains stable and then a programme of wellness care as prescribed by Dr Davies in the work to which I have referred. It is noted, that when CC was referred to Dr MB, he corrected seven subluxations in a period of 12 months with 14 visits. This is far less than that proposed by the applicant. I note that the applicant said that his care programme was subject to alteration. However, such alteration would have needed to be so drastic as to have made the care plan useless. It is difficult to see at the time the care plan was produced that, in all the circumstances of this case, it is justified by the guidelines. I realize that in comparing the treatment given by Dr MB to that proposed by the applicant, I have the benefit of hindsight, but that does not alter my view. Had the applicant looked at CC's condition one visit at a time, it would have been obvious 60 visits in 12 months were unnecessary.

RESEARCH LITERATURE

89 Mr Hurley in his submissions relied on the findings of Dr Lantz and the writings of Dr Videmann to support the proposition that subluxation leads to change in osseous (bony) development of joints within two weeks.

90 The Videmann's studies were performed on rabbits by immobilizing them with the intention of producing osteoarthritic changes in their joints. In particular, the hip and knee joint. Drs Crawford and Charlton were of the view that such studies were of little assistance in calculating a care plan for a young infant. An infant human is obviously not the same as a rabbit, the study concerned cartilaginous joints whereas an infant's spine is bony with some portion of cartilage and the study of the knee and hip joints which are weight bearing which is distinctly different from the vertebra of a 4 week old child. It should also be noted that while osseous changes in the joint were apparent microscopically after two weeks, no macroscopic changes would be detectable by a practitioner on palpation after two weeks.

91 Thus I conclude that the experimentation by Videmann on rabbits in relation to the hip and knee joint, bear no relationship and gives no guide to the care plan that would have been suitable for CC. I come to this conclusion in spite of the writings of Dr Lantz who is highly regarded in the chiropractic profession, because his writings are largely based on the experimentation of Videmann. There was evidence from Drs MB, Turner-Jensen, Dr Keil, Dr Sawyer and Dr Snodgrass for the proposition that subluxation based chiropractors accept that frequent examination, up to daily, is desirable. In the case of Dr MB, he was commenting on a proposition that was put to him about "an ideal world". Clearly, this world is not an ideal world, and chiropractors must have regard to whether the care is justified in terms of time and cost. When examined in this light, I believe it would be stretching the truth too far to say that Dr MB was of the view that there should be daily examinations, except in the most exceptional type cases.

92 Again, Dr Turner-Jensen while agreeing there may be some cases where asymptomatic subluxations are examined daily, he said : "it is not practical. I don't even examine my own children every day" (see transcript p 356).

93 Again, Dr Keil was referring to an ideal world when he made this statement about daily examinations. It is further noted that Dr Keil accepts that the frequency of treatment as set out by Professor Davies in his text, namely, six times in the first twelve months is appropriate for infants.

94 As far as Dr Sawyer is concerned, in my view, his evidence became badly tainted when he asserted that one third of children delivered by forceps extraction suffered skull fractures and he would treat those with manipulation. Even a number of the other witnesses called on behalf of the applicant were aghast at such a thought. Further, it should be noted that at p 1203 of the transcript, Dr Sawyer said that he adjusted his own children weekly, "because I can. I would be happy if they were adjusted fortnightly, I would consider that to be an adequate minimum for them for wellness". Clearly, when Dr Sawyer was referring to the weekly adjustment, he was referring to his own children which is not something that would have to be justified in terms of time and cost.

95 As far as Dr Snodgrass is concerned, he has no post graduate chiropractic paediatric qualifications and he stated that he was before the Tribunal representing WCA Australia of which he is the President and he is still a member of WLP. Again, Dr Snodgrass was referring to examining his own children each week. He also stated that although he sees patients weekly, it is also common practice for fortnightly and some go out as monthly.

96 Taking the evidence as a whole, including witnesses that I have not specifically referred to, unless an infant child has a serious problem, in my view, there is no justification for examining the child CC weekly and I would doubt very much if there is even justification for examining fortnightly. I say this with knowledge that the ICA Guidelines recommend

weekly or bi-monthly, however, they are not dealing with infants and they were written and/or reviewed by those who had an interest in maintaining their practice of seeing patients frequently for wellness care.

97 Mr Hurley referred to the fact that the applicant and 12 of his witnesses all agreed that the applicant's care plan was appropriate. This was entirely different to the view expressed by the respondent's witnesses. It should be noted that Dr Keil is an experienced chiropractor specialising in paediatrics and obtained a Masters of Chiropractic Science (Paediatrics) by degree in 1999. Further, he is the senior lecturer in chiropractic paediatrics at RMIT University and he supervised Dr Sipser with Professor Davies. He is highly qualified to give an opinion and expressed the opinion that a patient with an atlas subluxation should resolve after two to five treatments. He also agreed with the well child programme espoused by Professor Davies in his book. It is noted that Mr Hurley suggested that Dr Keil's evidence should be treated with some caution because he requested to amend his witness statement by deleting the word "adjustment" on two occasions and inserting the word "consultation" instead. As this request was made prior to the statement being adapted on oath, I find it difficult to understand how this alteration can be cause for criticism of Dr Keil.

98 Also, Dr Turner-Jensen has a degree in paediatrics from RMIT and his practice involves predominantly that of treating children. He also subscribed to the frequency of treatment set out by Professor Davies.

99 Dr MB was also of the view that Professor Davies' plan of treatment should be followed. It is noted that Dr MB is part way through his course in Master of paediatrics at RMIT and currently treats a lot of children.

100 Against this view, were the views of all the applicant's twelve witnesses plus the applicant that the care plan was reasonable. It is noted that none of the applicant's witnesses specialise in paediatrics (although one was currently undertaking paediatric study), and with the exception of Dr Sipser, they all belong to WCA (World Chiropractic Association) and have at one time or another been coached by Dr Mertz from WLP. Further, none of those witnesses are qualified with a specialised paediatrics qualification.

101 Also, Ms McLeod noted the following :

(a) Many of the applicant's experts expressed opinions in a vacuum without having been provided with material relied upon by the respondent, including the letters of complaint, report of Dr Keil and notice of formal hearing.

(b) The evidence of practice standards were not applicable to Victoria or even Australia

(c) There was no proper scientific basis to support the experts' assertion as to results of benefits of treatment and the risks of failing to treat or appropriate course of treatment. While a number of the experts said that the applicant's care plan was appropriate, no one could point to any basis whatsoever to

> support visits more frequent that once per week (except for Dr Pyke referring to Dr Chestnut's writings).

102 However, in my view, Dr Chestnut's writing should be treated with considerable caution. It is quite clear that Dr Chestnut's writings are promotional literature which supported his research into 14 Foundational Principles which, in my view, at times seems to be quite illogical. His 14th principle is stated to be based on the 13 principles that preceded it. That is the principle that relates to "time to take our position to the top of the healthcare ladder, patients are willing to pay for case and its time that we tapped into it".

103 I agree with Ms McLeod when she states :

> What this literature is, is literature created to support a program of care promoted by and trademarked by Dr Chestnut for whatever purpose and is not research that the Tribunal should give any credence or weight to without critical examination.

It is noted that Chestnut's case plan is not supported by the evidence and is not a study.

104 I agree with the submissions made by Ms McLeod and agree with her conclusions that none of the applicant's witnesses are truly independent, apart from Dr Sipser, and they were attempting to justify their own practice. These witnesses were associated with the applicant through WCA or training in WLP. Some had assisted the applicant in his initial hearing before the Board by responding to surveys from either Di Coleman of WLP or other individuals such as Dr Pyke. A great deal of these witnesses responded to a fax sent by Di Coleman of WLP on that organisation's letterhead. That fax stated :

> The chiropractor is facing vicious issues in front of the Victorian Board, one of these could have serious ramifications for the futurability or rights of a chiropractor to administer chiropractic chare to children. If you choose to fill out the attachment, please fax it to me ASAP on ….

DR LAWSON HEATH

105 The applicant also sent a fax to Lawson Heath who is a chiropractor who wrote a witness statement but was not called to give evidence and there was no explanation as to why he was not so called. In the fax dated 18 March 2005, the applicant stated :

> This case, which we plan to win with the help of our peers will be a significant win for Subluxation Based Wellness chiropractors and their rights to serve the public. It will forge our inroads to protect our rights to deal with asymptomatic children the way we know works best. If you can please print off copies of the document and circulate them to the participants that would be fantastic. Everything in relation to this case needs to be kept confidential and people are not to retain the document for obvious legal reasons ….

106 Thus, it is apparent that the people that responded to this survey, which were many in number of the applicant's witnesses, all had some personal interest in the case.

DR MCCOY

107 Special mention should be made of Dr McCoy who travelled from the USA to give evidence for the applicant. He has not practised since 2003, and between July 1999 and May 2003, he was working as a clinical instructor, then director of research with Life University Georgia USA and assisting student patients. He has strong allegiances to WCA.

108 In his evidence, Dr McCoy agreed that the CCP Guidelines were created by a private organisation WCA and stated there is no scientific or clinical literature to support a specific time period for the treatment of subluxation. He agreed the priority should be given to the Victorian Guidelines. Further, Dr McCoy agreed that there was no research into the effects of untreated subluxation on infants and none to substantiate treatment of more than once a week.

109 Ms McLeod summed up the position of Dr McCoy in relation to giving evidence and I agree entirely with her summary. She stated :

> Dr McCoy gave evidence at the request of Dr Pearson-Gills and his solicitor and his attendance in Australia was funded by Dr Pearson-Gills. Despite his protestations that he appeared against chiropractors, the inescapable conclusion is that Dr McCoy is a partisan witness committed to defending the practices of subluxation based chiropractors against malpractice claims and registration board investigations. He demonstrated a high level of 'expert witness training' in his refusal to answer questions in cross-examination without the constant need to define the terms of the question. He and the applicant asserted the CCP Guidelines had been adopted by the US Government when in fact they had been published on a website when the relevant clearing house was satisfied they met public criteria but subject to the disclaimer the contents were not endorsed in any way by publication.

110 As a result, I will discount any evidence that Dr McCoy gave, which supported the applicant's case. I gained the impression watching him that he had flown to Australia to give evidence to VCAT as part of his job in supporting WCA practitioners. In my view, he was far from impartial, and appeared to understand little of the Tribunal's Practice Note requiring experts to be impartial.

DR SIPSER

111 Dr Sipser was possibly the only witness produced by the applicant that I believed was genuine in what he said. He stated that the care plan was reasonable, provided it had been properly explained by the applicant to his patient. However, I have previously stated that I do not accept that the care

plan was properly explained to DC. Dr Sipser also stated that he would not recommend 60 visits for any patient from the very outset of care and he believed three treatments should have been enough to correct the subluxation in the patient and the majority of recommended treatments would have been for wellness care. Further, Dr Sipser said that one must be conservative when recommending treatment for infants and there is a dearth of research on frequency of treatment for infants.

WHICH WITNESS SHOULD BE ACCEPTED?

112 While I have not made mention on each one of the witnesses who gave evidence on behalf of the applicant, I have read their statements and heard their evidence. In my view, there is sufficient evidence to come to the conclusion, that where there is a conflict between the evidence of the applicant's witnesses and the experts called on behalf of the respondent, I much prefer the evidence of those called on behalf of the respondent. Both Drs Keil and Turner-Jensen were qualified chiropractic paediatricians and Dr MB is well into his paediatric course. Under those circumstances, I find that the treatment prescribed by the applicant for CC was excessive and that a treatment plan as set out by Professor Davies in his book would have been far more appropriate; and prior to entering into such a treatment plan, I find it would have been far more appropriate for the applicant to have satisfied himself that the infant CC's subluxations had been adjusted and that such adjustment had been successful.

113 Ms McLeod in her submissions summarised in my view, correctly many of the applicant's experts which show concern for the lack of clarity or failure in the care plan in terms of :

a) The statement of objectives

b) The intended transition from acute treatment to wellness care and the estimated time frame or number of visits required for each

c) The actual intended composition of visits

d) Claims for items not to be provided eg. Traction wedges and x-rays

e) Problems with the discontinuation policy

f) The assumption that the options for pre-payment included an option to pay per visit

g) The assumption the patient could initiate visits as necessary

h) The assumption that the patient actually made a saving as suggested in the plan itself whereas the practice was always ahead until 35 visits or at least 6 months of care

i) The frequency of visits was always discretionary and in the absolute control of the practitioner

j) The applicant asserts at 8.7 of his submissions the plan allows for cooling off. We presume he means the patient could take it home, but the plan is silent concerning cooling off after committing to care and paying under option 1 or 2

k) The plan does not indicate the sessions with the practitioner will not be anything like the 45 minutes he has spent with her on each occasion so far. In fact he will spend anything from half a minute up each occasion.

114 The applicant in his evidence maintained that his clinical experience after examining the patient was the best indicator of what was appropriate for a care plan. Ms McLeod stated :

> It was not asserted by any witnesses on behalf of the applicant that his clinical experience or judgement could be exercised unreasonably or capriciously, rather it must be based on objective findings and proper diagnosis.
>
> Dr Pearson-Gills agreed that the only thing that allowed him to see a child 3 times a week is beneficial is his experience of 10 years and the anecdotal evidence of his peers. He said he sees changes in his patients and patients' report. However, he has no reliable source of data to form these decisions – he does not maintain review records, he does not accumulate data concerning outcomes and does not record negative outcomes in any manner whatsoever.

115 I agree with the submissions of Ms McLeod in this respect and on the body of evidence which I accept in this matter, they are undoubtedly correct.

CARE PLAN

116 Mr Hurley submitted that the care plan was supported by the teachings of the chiropractic profession therefore, the care that it provided would be that which was expected by the public of a registered chiropractor within the definition of paragraph (a) of the definition of "unprofessional conduct" in s 3 of the Act. He stated that the care plan was supported by the applicant's peers and in particular, he referred to 12 witnesses who were either called by the applicant to give evidence or whose statements were tendered into evidence. Mr Hurley also supported this submission by the ICA guidelines, the findings of Dr Lantz and writings of Dr Videmann. He also stated that the respondent's witnesses MB, Turner-Jensen and Keil, accepted that there could be frequent chiropractic examinations in relation to subluxation. Further, he stated that the model used by the applicant in respect of CC corresponded with the example of a care plan adopted by South Australia in October 2005.

117 In relation to the support of the care plan by practitioners, the support seemed to be coming basically, with the exception of Dr Sipser, from those practitioners that had been involved with WLP. All those practitioners practised in wellness care (at least in part) and described themselves as subluxation based practitioners. Most also stated that they did not treat

asymptomatic conditions. However, it will be remembered that this principle was challenged by Drs Crawford and Charlton on the basis that there was no objective scientific evidence for wellness care or for the existence of subluxations.

118 While it is very difficult to say there is any consensus in the chiropractic profession as to whether wellness/subluxation care is the proper way to treat, but it is clear that there is a substantial number of people in the profession in Victoria that adopt that method of treatment. However, the majority of the applicant's witnesses caveated their approval of the care plan on the basis that the same was properly explained to the patient and the patient was empowered to make a proper decision. Most witnesses said it was important that DC make an informed decision. I note that the applicant said on several occasions that he gave DC all the necessary information. However, he did not provide details of the necessary information that he alleges he provided. Mr Hurley also referred to the words in the welcome document and the words in the care plan itself (see paragraphs 4 and 12 hereof) on consideration of the whole of the evidence, in my view, unlikely that DC both read and understood the information contained in those written documents. And I am certainly not of the opinion that it was properly explained to her by the applicant.

119 The fact that the applicant came away from the session where "the care and payment plan was explained to her" with fear for the safety of her child and a concern that her child's health and spine would be damaged for the rest of the child's life, indicates to me that the applicant certainly did not empower DC to make any proper decision as to whether or not to accept the care plan. In fact after hearing both the applicant and DC, I have gained the firm impression that what the applicant did in the three sessions to which DC and CC attended, was to provide a sales talk of his service, rather than information sessions. Thus, I find that DC was not only not empowered to make a proper decision; she was frightened as a result of the applicant's conduct and was unable to make an informed decision.

120 Ms McLeod submitted that whatever the belief of individual practitioners in the profession or a proportion of them was the treatment and recommendations for treatment must be appropriate and justifiable. She stated that if the treatment and recommendations are not justifiable, they are "prima facie unethical". I agree with that submission.

PAYMENT PLAN

121 As far as the payment plan is concerned, for the allegation of unprofessional conduct to be made out, I must be satisfied that the applicant attempted to induce CC's mother DC to enter into the payment, care, treatment and consultation regime, the characteristics of which are not

a appropriate

b fair; or

c in the interest of the patient or her mother.

122 I have already found that the applicant rather than explaining the care plan in a proper manner setting out the pros and cons of the same, did in fact give DC a "sales pitch" relating to the same, and frightened DC by referring to things like fusion of CC's spine. In my view, this is what the Board referred to in the newsletter of 11 August 2005 as a scaremongering tactic. I also refer to the newsletter of the respondent dated 5 July 2003 where it is stated :

> Whilst contracts of care are not illegal, they are a commercial arrangement between the practitioner and the patient. All can, and should, be well if some basic rules are followed :
>
> a set out the exact terms of the contract, the costs the time and withdrawal conditions
>
> b use no coercive practices to persuade the patient to sign eg 'if you don't follow this program, you could become seriously ill, die, require a wheelchair (choose your colour) – you get the drift
>
> c allow a cooling off period where the patient has the time to consider this, and may decide not to proceed.
>
> If some considerable dissatisfaction exists when patient ceases a program of care and then have their visit fees recalculated at the higher rate, or non discount rate, and receive no refund or in fact receive a bill! Layout the terms and conditions of contracts very clearly.
>
> On the subject of contracts, it would appear that some practitioners are using some contract terms and conditions regardless of age of the patient or presenting complaint. That clearly would be difficult to justify and a number of observant lay-people have commented about this as part of the inquiries to the Board.

123 In relation to the discontinuation policy in the schedule of payments, it is clear that in the event of a discontinuation, the patient would have to pay at the higher rate of $40 per visit rather than at the contracted discounted rate. I agree with the respondent newsletter when it says that this is extremely undesirable. Not only I think it is undesirable but, in my view, it is unfair to the patient.

124 Further, Ms McLeod made it very clear when cross-examining the applicant, that it would be approximately six months pursuant to the care plan or 35 weeks before the patient would "get ahead". In that time, the applicant's practice would have use of the patient's money by way of interest of which none would be refundable at the discontinuation.

125 Further, even though it is not suggested that it would happen, the applicant could decide after 35 weeks that no further visitation or treatment was necessary in which case the patient probably would not be welcome at the clinic. Thus, the patient would have received no benefit from the payment plan at all.

126 Further, there were matters concerning the payment plan which, in my view, would likely lead a patient to consider that they were saving more than they actually were by agreeing to such plan. For example, the applicant included the cost of traction wedges and re-x-raying when such may not actually happen and as far as the x-ray there was no x-ray in this particular instance.

127 Further, the applicant referred to re-examination every 12 visits, that is five re-examinations at $50 per examination. When I asked the applicant about this matter he said that the re-examination consisted of more than the normal assessment that takes place in each visit. In my view, a thorough assessment should take place each visit before any adjustment is done. If this were to take place, there would be no need for any re-examination to include such matters as thermo scans or x-rays.

128 Thus, in my view, the payment plan is unfair, not appropriate or in the interests of the patient and, in this particular instance, in all probability, using the *Briginshaw* test, I believe was not properly explained to DC.

129 In coming to this conclusion, I have taken into account the views expressed by the applicant's expert witnesses. I note that one of the applicant's expert witnesses stated that he does not have a payment plan but rather provides blocks of assessments or treatments to a patient at a certain discounted rate. The blocks he offers are up to 50 visits at a time. In the event that the patient stops using his services, he allows them to either transfer these blocks of time or gives a full refund on a pro rata basis relating to the cost per visit paid for the block of treatment. This system sounds a much fairer system if the practitioner is desiring to give a patient who may have to attend on a number of times some type of discount.

130 It should also be noted that I find it curious that the applicant said in relation to both the care plan and payment plan that he did not intend to see CC each week no matter what and what he gave was an outline only. However, the outline was based on 60 visits. While the applicant said he would credit the 60 visits into the following years if they were not all used up in year 1, that is not made clear on the payment plan. Under those circumstances, I believe that makes the payment plan in itself quite unfair.

UNPROFESSIONAL CONDUCT

131 Having concluded that both the care plan and payment plan were unfair, not appropriate nor in the interests of the patient and not desirable given all the circumstances of CC's case, the question remains as to whether that amounts to unprofessional conduct within the meaning of the Act. Mr Hurley has submitted :

> VCAT should find the Respondent has not established that there was no basis within the learning of the discipline for the conduct of the Applicant. VCAT should find his conduct :

- is of a 'standard' which the public might reasonably expect of a registered chiropractor. The care plan is within the logic of the teachings of chiropractic. The payment plan is within the guidelines of the Board. Any failure in communication occurred notwithstanding transmission of written information and verbal information over a period that exceeded two hours is a failure that occurred despite the best endeavours of the Applicant as a professional. The public expects a standard of endeavour and effort. It does not require a standard of perfection;
- both the care plan and payment plan have been endorsed in terms by peers of the Applicant.

Three forms of 'unprofessional conduct' are alleged. In relation to the definition in para (a) the Applicant must be judged as to whether he has applied the teachings of his discipline. VCAT should find that he has. In relation to (b) the conduct of the Applicant in relation to both the care plan and payment plan is supported by evidence of several practitioners from Victoria and elsewhere. There may be disagreement but these are practitioners of standing and experience. There are no guidelines to assist a practitioner in this area. In relation to (c) the definition addresses conduct which falls short to a substantial degree of the standard observed or applied by members of the profession (*Campbell v Dental Board* [1990] VSC 113 at pp 20-24). The Applicant cannot be condemned because DC did not reveal her concerns to him.

132 Looking at the case of *Campbell v Dental Board* referred to by Mr Hurley, at paragraph 43, his Honour Mandie J stated :

> In my view, furthermore, the appellant's said conduct consistently fell short, to a substantial degree, of the standard of professional conduct (or competence) observed or approved by members of the dental profession of good repute and competency.

133 Mr Hurley submitted that the word "peers" as referred to in s 3 paragraph (b) of the definition of "unprofessional conduct" in the Act should be in this case confined to subluxation/wellness care practitioners practising in a similar manner to the applicant. However, the Act does not differentiate between types of chiropractors' practices. There is no provision in the Act for chiropractors practising differently or pursuant to different principles. Thus, in my view, the word "peers" means those practising chiropractic in Victoria. The difficulty it is not a homogenous profession and, as a consequence, there is little consensus between various groups of members.

134 In this particular instance, the care plan did fall short of what members of the profession would have expected in that Drs MB, Keil and Turner-Jensen all disapproved of both the care plan and payment plan. However, Mr Hurley submitted that the applicant's witnesses who represented a substantial body of people in the profession said that the care plan and payment plan were both reasonable. However, most of the applicant's

witnesses made that statement on the assumption that the applicant had explained the matters contained in the plans properly to DC so that she could make an informed decision. I have found that no such explanation was forthcoming. In fact I have found that the applicant made a "sales pitch". Under these circumstances, applying the principle laid down by Mandie J in my view, the applicant's conduct fell short to a substantial degree of the standard of professional conduct expected by the profession or by the applicant's peers.

135 I also note that the evidence of both Dr Efron (the paediatrician) and Dr Pyke (the chiropractor) stated that the public might reasonably expect a practitioner to comply with or observe the body of professional learning and ethics, science and objective evidence. In this particular instance, in my view, for the reasons stated in relation to both the care plan and the payment plan, the applicant's conduct has fallen well short of what may be expected by both the public and the profession.

136 However, there does appear to be a strong view even though it may not be unanimous that any treatment must be justified and that patients should not be asked to make a decision about treatment unless it is an "informed" decision. In this particular instance, in spite of the evidence from the applicant's witnesses, it is difficult to see how the proposed treatment could be justified bearing in mind all the circumstances of the case, including the age of the child. It may be in relation to an adult or adolescent that such a plan could be justifiable but not at the age the applicant was treating CC.

137 I make these findings conscious of what Morris J has said at VCAT in the case of *Vissenga v Medical Practitioners Board* (2004) VCAT 1044 (2 June 2004 para 33). There his Honour stated :

> I wish to revisit the words of paragraphs (a) and (b) of the definition of unprofessional conduct. In both of these paragraphs attention is directed at professional conduct which is of a lesser standard than that which might 'reasonably' be expected of a registered medical practitioner by the public or by the peers of the practitioner. In my opinion, neither the public nor the peers of a medical practitioner expect perfection at all times. Human frailty visits every person, including those who are medical practitioners. Reasonable members of the public, and the reasonable peers of medical practitioners, understand this. Reasonable people are tolerant of occasional lapses, particularly if these lapses do not form a consistent course of conduct or, if taken separately, are insufficiently serious to warrant intervention by those charged with acting on behalf of the State.

138 It is difficult to see the applicant's conduct as "an occasional lapse". The applicant gave evidence that 80% of his patients were on care plans. It seems clear that those plans are of a similar nature to the one that I am concerned with at present. Further, I note that the care plan used in the RB case was of a similar nature to this instance except the word "adjustment" was used in the RB case. I do not see that as a substantial difference.

Further, I have no doubt that the lecture that DC received from the applicant, was not of a dissimilar nature to that received by most of his patients. I have found that DC was given a "sales pitch" by the applicant and the learning and literature when critically examined does not support his view. Thus, having found that, it seems to me likely that such a "pitch" were given to many of his patients. Further, when giving evidence at this hearing, the applicant did not see anything wrong with his conduct. Thus, I do not believe this conduct can be occasional conduct as referred by Morris J. In my view, the conduct displayed by the applicant was more than just negligent conduct, it was conduct that was deliberate in order to induce DC to enter into both the care plan and payment plan on behalf of CC.

139 It should be noted that the definition of "unprofessional conduct" in both the *Medical Act* and the *Nurses Act* is identical with the *Chiropractors Act*.

140 Having made these findings, it necessarily follows that the applicant has committed unprofessional conduct within the meaning of the definition of "unprofessional conduct" in (a), (b) and (c) of s 3 of the Act.

WHETHER SERIOUS MISCONDUCT

141 It remains now for me to decide whether the applicant's unprofessional conduct was of a serious nature within the meaning of s 46 of the Act. In *Re Parr v Nurses Board of Victoria* (1998) 16 VAR 118 at 123, Kellam J stated :

> In my view the question of whether or not a nurse has engaged in unprofessional conduct of a serious nature must depend upon the facts of each case. Clearly such conduct would not be serious if it was trivial, or of momentary effect only at the time of the commission or omission by which the conduct was so defined. It must be a departure, in a substantial manner, from the standards which might be reasonably expected of a registered nurse. The departure from such standards must be blameworthy and deserving of more than passing censure.

142 In this particular instance, it cannot be said that the applicant's conduct was "trivial or of momentary effect only". Here, the applicant has embarked upon a course of conduct to try and persuade DC to sign up to both the care plan and the payment plan. To do so, he has taken a lady who had given birth for the first time approximately 4½ weeks earlier and whom I imply would have been in a tired and emotional state and attempted to persuade her to sign up to these plans by the use of fear and by the use of coercive practices in suggesting that DC's baby CC could have serious problems if the care plan was not undertaken. It would have been open to the applicant to treat CC for her subluxation, have further investigations and then at a later and more appropriate time, consider what the appropriate wellness care would be. In my view, the applicant undertook the course he did, not with the patient's best interests in mind but rather his own financial interests being at the forefront of his thoughts. The applicant was asked the

question about whether he had his own financial interests at the forefront of his thoughts and denied such allegation. However, taking all the matters as a whole, including the fact that the applicant stated that he helped his patients who were in financial difficulty with treatment but no such help was given to DC, I have formed the opinion that the applicant's own financial interests took precedence to those of his patient.

143 In any event, even if the applicant was not influenced by his own financial interests, having found the care plan and payment plan were not justified and not in the interests of the patient, in my view, that alone is sufficient to justify a finding of serious unprofessional conduct.

144 Given the circumstances as described above, in my view, the applicant's conduct is "serious" within the meaning of s 46 of the Act.

WHAT IS THE APPROPRIATE DETERMINATION

145 Having found that the applicant has engaged in unprofessional conduct of a serious nature, it remains for me to consider what is the appropriate determination. Section 1(a) of the Act makes it clear that it is an Act to protect the public. That section states as follows :

> **1. Purposes**
>
> The main purposes of this Act are –
>
> (a) to protect the public by providing for the registration of chiropractors and investigations into the professional conduct and fitness to practise of registered chiropractors; …

146 Section 6(2) of the Act refers to the character of applicants for registration and their fitness to practise. It states :

> (2) The Board may refuse to grant registration to an applicant on any one or more of the following grounds—
>
> (a) that the character of the applicant is such that it would not be in the public interest to allow the applicant to practise as a registered chiropractor; …

147 Thus it is apparent that the Act was designed to protect the public and looks at the interest of the community. In *Robbins v Business Licensing Authority* (2000) VCAT 457 (29 January 2000), Kellam J considered the public interest in the context of the *Motor Car Traders Act*. For this purpose, I do not consider there is any real difference between public interest in relation to the *Motor Car Traders Act* or in relation to the *Chiropractors Act*. At p 4 of that decision, his Honour considered the public interest and what it meant. He stated :

> It is apparent that the term 'public interest' embraces matters, among others, of standards of human conduct acknowledged to be necessary for the good order and well-being of the public, and in the circumstances of this case, those members of the public who buy and sell motor cars. Accordingly, the function of the Business Licensing

> Authority (and this Tribunal on an application to review a decision of the Authority) is entirely protective, not punitive. The Authority (and this Tribunal) may only grant permission for a person who has a conviction for a serious offence within the last ten years to be employed in a customer service capacity, if satisfied that to do so will not be contrary to the public interest.
>
> As Murphy J said in *Inglese v Estate Agents Board & Anor* (unreported Supreme Court of Victoria, 15 August 1988):
>
> > 'If an estate agent is to be disqualified, the purpose which the Tribunal should have in mind is not the punishment of the individual (though it may appear to be a punishment to him) but the importance of protecting the public and the necessity to maintain standards in the conduct of an estate agent's business'.
>
> Those words apply equally to motor car traders, and their employees, under the system established by the Act. Accordingly, notwithstanding the fact that the applicant has been punished by the criminal justice system, the issue of the protection of the public remains to be considered.

148 I would add to what his Honour said that the "words apply equally" to the chiropractic profession.

149 Ms McLeod also submitted that :

> The Tribunal should consider what is necessary for general deterrence purposes. This may include such considerations as the need to send a message to practitioners generally that conduct of this nature is unacceptable and will be met with appropriate consequences. It is also relevant to consider the interests of the public in observing that the profession upholds its rules of ethics and that they can trust that registered chiropractors maintain strong ethical standards.

150 I agree with the submission made by Ms McLeod. This is in line with what I decided in *Whiting v AMC Investments Pty Ltd* (2005) VCAT 1830 (22 August 2005). In considering the determination in this matter, I take into account the fact that in the RB case, to which I have already referred, the applicant was suspended for a period of two weeks and ordered to undergo some retraining. That suspension was only a short time before the occurrence of the acts in this matter.

151 Ms McLeod has mentioned that previously the applicant has been in trouble for breach of the advertising standards. However, no real evidence was led about this matter and bearing in mind that I am not sufficiently aware of the circumstances surrounding it, I will not place any reliance on it whatsoever.

152 I must now consider which of the determinations referred to in s 46(2) I should make having regard to the fact that I have found the applicant to have engaged in unprofessional conduct of a serious nature.

153 In this regard, Mr Hurley has submitted, that I should not impose a period of suspension on the applicant. He referred to the fact that s 46(2)(f)

empowers me to impose a fine of not more than $2000. He then submitted that the applicant in any penalty I impose should not suffer a loss of any more than $2000. Therefore, he said that any suspension which I may give should not be any longer than would cost the applicant $2000 in loss of work as a chiropractor or in the loss of his practice. He then stated :

> The Applicant in resisting the proceedings brought by the Board has been obliged to sell his domestic premises and has incurred significant costs. Any suspension or cancellation of the registration of the Applicant will see his patients denied a form of care that they desire. The Applicant can obtain the service of a locum at a significant cost to him as he will have to continue to pay the running costs of the practice. The practice costs include wages of $13360 pm and rent of $1400 pm. The Applicant estimates the cost of a locum at between $4000 and $5000 pw to treat the patients now seen by the Applicant.

154 There has been evidence given that the applicant sees some 400 to 500 patients per day. The applicant also gave evidence that the retail cost of each patient is $40 but that 80% of his patients are on payment plans. Ms McLeod stated that on this basis, if the submission of Mr Hurley was to be accepted, the applicant could not be suspended for more than half a day.

155 In my view, if I were to accept Mr Hurley's submission, it would create a nonsense situation. The Act does not relate one type of penalty to another. In my view, the fact that the applicant can be fined $2000, does not in any way limit the period of suspension that I may impose pursuant to s 46(2)(g). It certainly would not be in the public interest or serve any purpose. It is important that professional standards of the chiropractic profession be maintained in the eyes of the public so the public can have confidence in the profession. If the applicant was suspended for ½ a day, such a period would be no more than "a joke".

156 Ms McLeod has submitted that I am at large in determining what is the correct determination in this matter and that I am at liberty to increase or decrease the period of suspension made by the respondent Board, she stated I am even at liberty to cancel the applicant's registration pursuant to s 46(2)(h). I agree with this submission and in fact, at the outset of the proceedings, I warned the applicant through his counsel, that if it found the allegations proved, I was at large should it be appropriate to increase the suspension of four months that was given by the respondent Board. Mr Hurley informed me that his client was well aware of that matter. In considering all the matters referred to above, I have formed the view that the period of suspension of four months given to the applicant by the Board is inadequate. Such a period is too little in light of what I have found to be in the public interest and for the protection of the public. This type of serious unprofessional conduct cannot be tolerated.

157 I was referred to a number of other determinations of the respondent Board where chiropractors had been suspended for periods of up to four months. However, I am aware that this is the first instance of a disciplinary matter

concerning a chiropractor that has been before VCAT. While I could have regard to the previous determinations of the Board, I think it is important that all cases be determined on their own merits and with reference to the unprofessional conduct of the applicant, other matters to which the applicant has engaged and my findings in this instance.

158 One of these other matters is that in spite of the respondent Board sending a newsletter stating that it did not approve of a particular type of advertising that is advertising beginning with "A Doctor's Confession to the State of Victoria", the Board also disapproved in that newsletter of self-testimonials by chiropractors. In spite of that newsletter and in spite of these proceedings pending, a few weeks before this proceeding was called on for hearing, the applicant distributed a pamphlet throughout the city of Knox which began with the heading "A Doctor's Confession to City of Knox" and contained self testimonials. It should be noted as a matter of interest that this was similar advertising, but not identical, which attracted DC to the applicant's surgery in 2004. This conduct indicates to me that the applicant has little or no regard for the views of the Board, which Board was set up to regulate the profession of which he is a member.

159 Given all these circumstances, in my view, the applicant's registration to practise as a chiropractor should be suspended for a period of 10 months commencing 28 days from the date of this decision. I make the decision to increase the period of suspension taking into account matters referred to above, and to borrow a phrase from Batt JA in *DPP v Goldberg* [2000] VSCA 107 (27 July 2000) that my intervention is justified to correct the determination which is so disproportionate to the seriousness of the circumstances "as to shock the public conscience". I realise his Honour made this statement in the context of a criminal appeal, however, having regard to the appropriate factors in this proceeding, his Honour's phrase is appropriate.

160 I further intend to make similar orders to that ordered by the respondent for education, training and mentoring. However, because I do not believe there is any power to make those orders while the applicant's registration is under suspension, those orders will not come into force until the applicant's period of suspension has concluded.

161 It should be noted that because of the period of suspension, I have decided that a fine would not be appropriate in these circumstances.

Robert Davis
Senior Member