2013 Report from the Independent Complaints Moderator for BAcC

This report is my second one as moderator of complaints for the British Acupuncture Council (BAcC). It covers the period 1 January – 31 December 2013, as well as one case that was carried over from 2012, under the following headings:

1. Background

All BAcC member practitioners are bound by a Code of Professional Conduct (Oct 2012) and a Code of Safe Practice (Oct 2010). The Codes are enforced by the BAcC's three Ethics Committees: the Investigating Committee (IC), Professional Conduct Committee (PCC) and Health Committee (HC). The committees are supported and administered by the Ethics Department of the BAcC.

Complaints are made by either member practitioners or their patients. The IC considers if there is a *prima facie* breach of the BAcC Codes; in other words, if there is a case to answer. The powers of the IC are explained in the BAcC Code of Disciplinary Procedures (Oct 2012); see Appendix 1.

The IC itself has no power to sanction a member through fines or disciplinary action. It can, however, refer a case to the PCC with a recommendation that the seriousness of the case may warrant temporary removal of the practitioner from the register pending consideration of the case by the PCC or Health Committee. The IC can also provide feedback to the practitioner and/or make recommendations for service improvements. These are not binding on the practitioner. Since 2008, the IC has been able to exercise its discretion not to refer a complaint to the PCC where it identifies minor infringements of the Code of Disciplinary Procedures.

The IC is made up of a lay (non-practitioner) majority, together with practitioner members, and is managed and supported by the Professional Conduct Officer, who heads the BAcC Ethics Department.

In 2013, the BAcC was accredited by the Professional Standards Authority for Health and Social Care under its Assured Voluntary Register Scheme.

2. Moderator role

My role as Moderator is set out in the BAcC Code of Disciplinary Procedures, Section 11. I have been appointed to review complaints made to the BAcC during the year in which the IC found no evidence of a breach of the Codes.

My role is to review those complaints in which the IC found no case to answer, describe how they were handled, and comment on the way they were handled in terms of communication and consistency. Where appropriate, I can make recommendations for improvements in the way complaints are handled by the IC. I also attend at least one meeting of the IC each year.

I did not attend a meeting of the IC in 2014. I attended a meeting in 2013 at which the discussion related to complaints covered in this report.

3. The BAcC complaints procedure

The complaints procedure sets out the steps in the complaints process, from the statement and supporting documents submitted by complainants through to the IC's decision. Practitioners complained of are required to provide a written response within 21 days of the BAcC requesting this. The IC then discusses the case at its next meeting, usually within one month.

The IC is entitled to ask for further information, including the complainant's comments on the practitioner's response, copies of the practitioner's notes and records, and a report from an independent Technical Assessor. The IC is also entitled to seek information and evidence from third parties and to seek advice from a lawyer or doctor. The IC then reviews any further information at its next scheduled meeting.

In 2013 the BAcC revised and republished its guide to its complaints procedure (Information for Complainants), which clearly explains the role of the IC, the procedure, and what is required to submit a complaint. This is sent to complainants and is also available on the BAcC website.

4. Complaints this year

In 2013, the IC found no breach of the Code of Professional Conduct and therefore no case to answer in three of the complaints made to it. These three were referred to me for consideration, along with one complaint carried over from 2012.

I refer to the cases by the number system used by the IC and have not included any reference to complainant or practitioner.

Case 5/2012
Issues: Diagnosis and outcome; consent; tranquility and luxury of surroundings; multi-clinics; health and safety; aftercare; adequacy of notes; others

Observations:
This complaint was complex and involved a great deal of evidence. It is always difficult to determine the cause of pain, and in this complaint the IC was unable to determine with certainty that the pain, which was not in question, had been caused by the treatment. I am confident that full consideration was given to all the evidence and that the basis for the IC's conclusion was explained clearly to both parties. The letters to both C and P were sensitively written and clear. I think it also would have been helpful had the IC, in its decision letters to C and P, set out in detail all the evidence it had considered. In particular, the IC could have confirmed to C that it had considered the expert report C had submitted.

I raised in my report last year the issue of consistency in the IC's approach to raising concerns about recording GP details. I note that the IC's approach taken to a breach of the Code of Professional Conduct – namely, the recording of a patient's GP details in the patient file – was different in this case than in a case last year (4/2012). In that case, the IC exercised its discretion not to refer this to the PCC. In this case, there is no mention of the IC exercising its discretion.

It is also not clear to me that the IC raised with P in this case – as it did in case 4/2012 – the expectations regarding aftercare. The Guide to Safe Practice advises that if a patient reports unexpected or worsening symptoms or is worried, practitioners should refer them to their GP for an assessment.

Case 1/2013
Issues: discrimination, unprofessional behavior, invasion of privacy

Observations:
The decision letter sent to C was comprehensive in setting out its findings under each of the complaint headings. It was also sensitive in conveying a decision that was likely to be disappointing to C. It would have been helpful had the letter to P also set out the findings in detail.

I note the response regarding the failure to record GP details on the patient notes. This is a breach of the Code, but it is one that the IC considers a minor infringement and responds to proportionately by reminding practitioners of the requirement. As in case 5/2012 above, there is no mention of the IC exercising its discretion not to refer this to the PCC.

I also note that in the response to the complaint sent by P to the BAcC, P notes that it is regrettable that P and C were not able to resolve the complaint in an amicable manner by talking to each other and listening to each other's point of view. P explained that she had already given C an apology for the unfortunate comment. I wonder if this case presented an opportunity to bring the parties together to discuss their different perceptions of what had taken place. As in case 4/2012 last year, this case raises the question as to whether the IC might play a useful role in helping parties to understand why a complaint has arisen and remedy some of the hurt that both parties feel.

Case 2/2013
Issues: unclean premises, poor customer service, violation of privacy

Observations:
Once again the issue of failing to comply with the Code's requirement (para 7) to record GP details in patient notes was identified. The approach in this case differs from the approach taken in the previous two cases this year, in that the IC considered referring the issue to the PCC and explicitly stated that it exercised its discretion not to refer the breach to the PCC. Although I do not question that decision (the exercise of its discretion is a decision for the IC to take), I do wonder if the approach was inconsistent with that taken in other cases in which this issue arises. On the other hand, I note that in this case the IC had a number of concerns in addition to noting the failure to record GP details, and it might be that it took this slightly different approach in light of all the circumstances.

I also note that there were a number of unexplained delays in the handling of this complaint. The complaint was received in January, and the IC considered the two options in early March. It appears there was no IC meeting in April, and the complaint was considered in May. The technical assessor was briefed in July, and the decision on the complaint was reached at the IC's meeting in September. I note that the parties were kept informed, which is important. Nevertheless, it is unclear why it took nearly two months to decide on which option to progress, and then a further two months to brief the technical assessor.

I wonder if in this case, as in the previous one, the IC might have explored whether there was the possibility of bringing the parties together. Particularly where there is a long-standing relationship between patient and practitioner, this can be helpful.

4/2013
Issues: Pain following treatment

Observations:
The case was a difficult one to determine because of the lack of evidence. The IC determined that the treatment was not unreasonable. Its letters to both C and P were clear, and the letters to C specifically sympathised with the fact that he was experiencing pain,

I note that again the issue of failure to comply with para 7 of the Code of Professional Conduct. The IC does not appear to have explicitly stated that it was exercising its discretion not to refer this breach to the PCC.

5. Recommendations

I have no overall concerns about the IC's handling of the three cases in 2013, and the case carried over from 2012, in which it identified no case to answer and which I considered. The correspondence is clear and sensitive, and apart from one case (2/2013), there were no unexplained delays in the IC's consideration of the complaints.

Below are recommendations for the IC to consider.

5.a.Consistency

The only concern about consistency relates to the issue of failure to record GP details in patient notes. This is a breach of para 7 of the Code of Professional Conduct, but it is generally considered by the IC to be a minor infringement and therefore the IC can exercise discretion as to whether or not to refer the breach to the PCC.

In all cases where this arose, the IC noted the failure and advised the practitioner accordingly; this was consistent. The IC was not consistent about recording when it was exercising its discretion not to refer such a breach to the PCC, and in one case it did consider doing so, presumably because it had a number of concerns about the practitioner, but in the end did not. I think it should be made more explicit when the IC is exercising this discretion, and a standard admonishment/reminder should be given to the practitioner in each case.

Given the frequency with which this issue arises in complaints, it might be worth the IC considering whether the BAcC should produce a reminder to practitioners and a model patient note template containing the entry for GP details.

In two cases there was an allegation of poor treatment resulting in pain after treatment, and in such cases the IC must also ensure that practitioners have carried out their duty of care regarding after care – specifically, referring the patient to their GP for an assessment. The expectations of practitioners regarding suspected adverse effects of treatment are set out in the Guide to Safe Practice, and they include advice to send patients to their GP and to make a note of the incident in the patient file, specifying any points and aftercare provided. I did not see that in the cases involving pain after treatment, the IC reminded practitioners of this expectation.

5.b. Facilitating meetings and apologies

The only other recommendation is one relating to the IC's possible role in facilitating responses from practitioners subject to complaints. In two cases, it appeared that circumstances indicated that a meeting might be helpful between the parties – one because the practitioner expressed regret that this hadn't happened and one because of a long-standing patient-practitioner relationship. Both involved an unfortunate comment from the practitioner rather than an allegation of unsafe practice. I am aware that the IC is concerned to be clear about its role in investigating and deciding cases and might be concerned that such a facilitation role would blur the boundaries of its remit. However, the Code of Disciplinary Procedures (at 2.3(e)) does give the IC the power to recommend mediation if the IC believes the allegation or complaint is such that the parties would be better advised to deal with the issue by way of mediation rather than disciplinary proceedings.

In addition, the Guide to Safe Practice (p34) is potentially confusing about how practitioners are expected to respond to suspected adverse effects. It advises that insurers will oppose any unqualified acceptance of liability as part of a conciliation process. Perhaps the IC could suggest that the BAcC could advise practitioners on how to respond appropriately and sympathetically to complaints about adverse effects without compromising the issue of liability.

Last year I recommended that the BAcC consider devising guidance for practitioners on making meaningful apologies – I have not yet seen this but I understand it is in progress.

5.c. Improvements

In my last report I recommended that the IC could be more proactive at updating complainants. I note that this is happening now regularly. In addition, the standard letter to complainants explains about the timescales for the IC"s consideration and its meetings. These are both useful improvements.

It would also be useful to know if the IC has taken forward the recommendation to set out in writing what follow up it undertakes, including any confirmation to the complainant that its recommendations have been implemented.

Thank you for the opportunity to consider the work of the IC in 2013.

Margaret Doyle
Moderator, BAcC

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