2014 Report from the Independent Complaints Moderator for BAcC

This report is my third one as Independent Moderator of complaints for the British Acupuncture Council (BAcC). It covers the period 1 January – 31 December 2014 under the following headings:

1. Background

The BAcC is a membership body and a professional regulator accredited by the Professional Standards Authority for Health and Social Care under its Assured Voluntary Register Scheme. 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 about a practitioner who is a member of the BAcC can be made by a member of the general public, professional regulator, patient, fellow practitioner or member of any committee or employee of the BAcC. 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).

The IC itself has no power to sanction a member through fines or disciplinary action. It can, however, refer a case to the PCC, and it can recommend that the seriousness of the issues warrants temporary removal of the practitioner from the register pending consideration of the case by the PCC or Health Committee. The IC can also decide there is no case to answer. Since 2008, the IC has been able to exercise its discretion not to refer a complaint to the PCC where it identifies minor breaches of the Codes. In some cases the IC will provide feedback to the practitioner and/or make recommendations for service improvements. These are not binding on the practitioner

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.

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 in which the IC found no case to answer.

My role is to review those complaints, 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, although I did not attend a meeting of the IC in 2014.

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.

Complainants are to be informed of the IC's decision within 14 days of the meeting at which the decision was made.

A 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, is sent to complainants and is also available on the BAcC website.

4. Complaints this year

In 2014, the IC found no case to answer in two of the complaints made to it. These two were referred to me for consideration, along with one complaint that was made in 2014 but not considered by the IC until 2015. I will include the latter case in my 2015 report next year.

I refer to the cases by the number system used by the IC. I provide a brief description of the issues only, and do not include any names of the complainant (referred to as 'C') or the practitioner ('P'), in order to protect the anonymity of individuals involved.

Case 2/2014
Issues: Termination of treatment by patient

The complaint in this case concerned the suggestion made by the practitioner (P) that the complainant (C) should seek counseling and that she would not continue treatment unless C did so. C took this to be a form of 'blackmail' and terminated the treatment, subsequently raising a complaint with the BAcC.

Twice after submitting the complaint, C withdrew it, then reinstated it. The complaint, and P's response and file notes, were considered by the IC, which decided that there was no evidence of a breach of the Code and that P had acted professionally. The IC dismissed the case.

Observations:

This was a case requiring some sensitivity, given the issues involved. C was dealt with fairly and P was offered the support that the BAcC offers to its members.

I am concerned, however, that the IC did not see in the practitioner's submission any notes of what P said to the patient regarding counseling. As this was the crux of the complaint made, it would have been logical for the IC to want to see such evidence. The only mention of counseling in the evidence submitted by the practitioner is by C, in an email sent by C to P on the day C terminated the treatment. It is not likely this would have changed the outcome, unless the way P made the suggestion was considered to be unprofessional. After all, P was carrying out her duty of care according to the Code of Professional Conduct (para 4): to 'encourage patients promptly to seek other forms of medical treatment if you feel that acupuncture is no longer the most appropriate means of treating their problems.' It is, however, a potential breach of the case notes requirements in the Code (para 7), which state that case notes should include any information and advice given to the patient.

In addition, the patient history notes submitted by the practitioner do not include any details of the patient's GP, which is also a requirement under the Code (para 7). Both omissions in the patient notes appear to be breaches of the Code, therefore, and so I believe the IC should have made explicit that it was using its discretion not to refer the case to the PCC (which it has done in the past with similar breaches).

I would also like to have seen evidence of the follow-up suggested by the IC – namely, to take forward guidance for practitioners on sharing social media with patients. It may be that this was actioned, but nothing was included in the case file outlining what follow-up took place and the outcomes, if any, of that follow-up.

Case 3/2014
Issues: patient management; adverse effects of treatment

In this case, C complained, via her husband, of adverse effects caused by excessive use of acupuncture administered by P.

There was a great deal of evidence to consider in this case, and in particular evidence of the treatment provided. After first considering the complaint, the IC decided to send C the response from P and invite comments from C, and at the same time to request any further medical information available from C.

The IC then considered the case again, along with the response (no further medical information had been sent). The IC took the view that it was not possible to determine the full truth because of conflicts in the evidence sent by C and P, and it was therefore difficult to draw conclusions. The IC noted that it could be argued that the number of treatments seemed excessive, but it was C who insisted on that number of treatments and it was clear it was not done for P's financial gain. The IC also noted that it could have been argued that P should have referred C to another practitioner sooner. However, the IC decided that P had not breached the Code of Professional Conduct, and there was no evidence that C's worsening condition had been caused by the treatment.

The letter to P explaining the IC's decision made a number of recommendations. One relates to a patient putting pressure on a practitioner to continue treatment, which the IC noted should be seen as a 'red flag' issue and should prompt a practitioner to reconsider their relationship with that patient. The other recommendation was that the practitioner might have benefited from discussing the case with a colleague or supervisor as part of her continuing professional development.

Observations:

I have no concerns about the decision made by the IC in this case. I do have a few points to raise about other aspects of the way the case was handled.

A small but not insignificant point is that the case file does not include evidence that P had C sign a copy of the self-treatment form for moxa treatment at home, as required by the Code of Safe Practice (para 13). This omission is potentially a breach of the Code, and therefore the IC should have stated it was using its discretion not to refer the case to the PCC, and the omission should have been noted to P in the decision letter.

The reference to 'red flag' issues, and how practitioners are expected to identify these and respond to them, could have been explained in the letter to P. It's unclear to me where either the Code of Professional Conduct or the Code of Safe Practice mentions pressure from patients to continue treatment and advise practitioners what to do about this.

My final points on this case are ones of delay and courtesy. It is disappointing to see that following the decision letter to C, C's husband contacted the BAcC several times to express his view that the investigation had been inadequate. I understand that it would be inappropriate for the BAcC to engage in discussions about the case with either party once the IC's decision has been sent out. However, there was a month delay in sending a response to C's husband; he had contacted the BAcC on 6 October, twice by phone, and then by letter later in October, and did not get a response until 6 November. In my view the BAcC should have responded earlier, and at the least its response on 6 November should have included an apology for the delay.

5. Recommendations

I have no overall concerns about the IC's decisions in the two cases in 2014 in which it identified no case to answer and which I considered. My primary concern is that where a breach is identified, and the IC has decided to exercise its discretion not to refer the case to the PCC (because the failure is not considered significant in the overall context), this should be stated explicitly and feedback should be given to the practitioner.

Below are my recommendations for the IC to consider.

5.a. Timescales

The procedure now requires that complainants are informed of a decision within 14 days of the meeting at which the decision is made. In my view it would be good practice for the IC to ensure that parties to a complaint are notified of the IC's decision as soon as possible, and preferably no later than one week. The parties will have known the date of the meeting and

will no doubt be eager to know the IC's decision. I suggest that consideration be given to reducing the timescale for decisions to be sent to the parties.

It is important that any follow-up correspondence, while not encouraging debate or discussion of the decision, should be promptly acknowledged. In one of the two cases this year there was a delay in acknowledging and responding to post-decision correspondence.

5.b. Breaches of case notes requirements

When considering a case, the IC has in the past noted when an aspect of a practitioner's record-keeping does not comply with the Code of Professional Conduct. This has been true in particular of the requirement to record a patient's GP details, which has been a concern in cases from previous years. Where a P has failed to record the GP details in the patient notes, the IC has to decide whether the failure warrants referral to the PCC or use its discretion not to refer the case.

This year, in one case it appeared that the practitioner had not recorded the patient's GP details in the medical notes, contrary to the Code of Professional Conduct. I also note that no information was included about what advice the practitioner gave to the patient, which I understand is also a requirement of the Code. In the other case, the practitioner appeared to have failed to obtain the patient's signature on a form for self-administered treatment (Code of Safe Practice).

I recommend that the IC ensure that it takes a consistent approach to noting failures to comply with the requirements of the professional codes. It is for the IC to decide whether or not such failures justify a referral to the PCC or simply a reminder to the practitioner (and this has not always been consistent the past). However, the IC should be consistent about recording when it is exercising its discretion not to refer such a breach to the PCC, and a standard admonishment/reminder should be given to the practitioner in each case.

Last year I suggested that, 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.

5.c. Further guidance

One case this year identified the need for further guidance on practitioners' use of social media and sharing social media with patients. I have not seen anything on the follow-up action and I recommend that guidance should be produced, as indicated by the IC.

The other case involved suspected adverse effects of treatment. Last year I noted that 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. I recommended that the IC could suggest that the BAcC produce guidance for practitioners on how to respond appropriately and sympathetically to complaints about adverse effects without compromising the issue of liability.

Two years ago 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.d. Improvements

I commented in my report last year on the progress that has been made in being more proactive in updating complainants and in providing more information for complainants about timescales. I am pleased that this appears to be continuing.

It would also be useful to know if the IC has taken forward the recommendation, made in my first report, 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 2014.

Margaret Doyle
Moderator, BAcC
December 2015