EXECUTIVE SUMMARY- College of Massage Therapists of Ontario

Discipline Hearing Conducted January 25, July 21-22, 2010, February 7-11, May 2-3, 2011, October 4, 2012.

The Charges

The Registrant, Scott Spurrell, RMT, was charged with one count of incompetence and three counts of professional misconduct, namely that he:

(a) Treated or attempted to treat a condition beyond his competency;

(b) Contravened a standard of practice of the profession;

(c) Engaged in disgraceful, dishonourable or unprofessional conduct; and

(d) Was incompetent in the meaning of section 52(1) of the Health Professions Procedural Code.

The Plea

Mr. Spurrell entered a plea of not guilty to all of the allegations before a Panel of the Discipline Committee. The Registrant was represented by legal counsel throughout.

The Facts

Evidence was presented through the testimony of witnesses and documentary evidence adduced by both parties. The evidence adduced at the hearing disclosed that the client, K.O., was a married woman with one daughter. She was a former Olympic athlete who had qualified for the 1996 Olympics and the 2000 Olympics in the sport of judo. Since 2000, K.O. had been training for a career in mixed martial arts. A car accident on April 7, 2006, stopped her training. Up to that point, she was in supreme physical condition.

After the car accident, K.O. was taken to the hospital and subsequently released. Thereafter, she went to see her chiropractor, Dr. J. at the latter's clinic. Dr. J. referred K.O. for physiotherapy and to the Registrant for massage therapy. K.O. first saw the Registrant, Mr. Spurrell, in his office on May 10, 2006.

Altogether, K.O. attended at the Registrant's office on six separate occasions for treatment between May 10 and June 21, 2006. The allegations before the Panel relate to the events of the last attendance on June 21, 2006.

K.O.'s health history form indicated that her primary concerns were with hip, back, knees and tailbone pain with no mention of headaches as her primary concern. During the first five visits, the Registrant engaged in massage therapy. All visits were satisfactory, although the clinic notes indicated that K.O. was experiencing a left-sided headache that was gradually getting worse.

K.O. last saw the Registrant on June 21, 2006. She informed the Registrant that she was experiencing pounding headaches. In response, the Registrant advised K.O. that acupuncture could fix or cure her headaches. K.O. had had a previous bad experience with acupuncture and indicated that she would prefer not to receive it as a treatment.

In response, Mr. Spurrell indicated that he knew of a spot "that not too many people knew about", that was difficult to access, that would alleviate her headaches. When K.O. asked what the worst possible outcome was with acupuncture, the Registrant indicated that there was one instance where a client had died after inserting an acupuncture needle into his own neck. He said apart from that, the worst thing that could happen was a small hole in the lung, that it had happened to his own wife, and that it had required no medical attention and healed within eight weeks, and involved his wife's acupuncture instructor.

K.O. was informed that the needle would be inserted under the left clavicle, about halfway between the armpit and the center of her neck. Believing that the apex of the lung was below this insertion point, she gave her consent to the performance of acupuncture for her headaches.

Immediately upon the insertion of the needle into the chest wall, K.O. felt some pain and discomfort, but did not advise the Registrant. After the needle was removed, she assumed a prone position on the table and the Registrant performed acupuncture on her back and finished with a massage.

After leaving the clinic, K.O. testified that she started to feel a weird sensation in the insertion site on the chest. She mentioned this to her husband when she got home, along with symptoms including difficulty breathing, pain, and a rubbing or grinding sensation beneath her ribs.

After a rest, K.O. noted that her symptoms had worsened. As a result, she decided to stop at the Registrant's clinic to see the Registrant on her way to a movie with her daughter that evening.

At Dr. J.'s clinic, she saw the Registrant and told him that she thought she might have suffered a punctured lung and asked if she should go to the hospital or not. The Registrant told her that in his opinion, it was likely muscle strain, rather than a punctured lung, but that if she felt it was necessary to do so, she could go to the hospital. The Registrant also told K.O. that if the symptoms worsened, she should go right away. Relying upon the advice that she had not likely suffered from a punctured lung, K.O. went to the movies with her daughter and returned home that evening.

The following morning, when the symptoms had worsened, K.O. went by herself to the local hospital in Hamilton and was seen in the Emergency Department. X-rays indicated that she had suffered a small 10% left pneumothorax. She was released by the hospital with instructions to return immediately if the severity of the symptoms increased. Later that afternoon, when the symptoms worsened further, she returned to the hospital. By then she was experiencing difficulty breathing. A medical examination determined that K.O.'s left lung had collapsed and a chest tube was inserted. She remained in the hospital from June 22 through July 2, inclusive.

Following her release from hospital, K.O. has been left with 55% function in her left lung and other difficulties.

Evidence disclosed further that the following day K.O.'s husband received a telephone call from the Registrant who seemed quite concerned and apologetic for what had happened. K.O.'s husband declined the Registrant's offer of a visit to the hospital.

In addition to K.O., the prosecution called three expert witnesses: Dr. Shaf Keshavjee, former Chief of Thoracic Surgery, and now Surgeon in Chief, at the University Health Network; Dr. Fred Hui, a medical doctor who practices integrated medicine, including acupuncture; and, Dr. Linda Rapson, a medical doctor with more than 30 years of experience in acupuncture.

In summary, Dr. Keshavjee explained the mechanics of a pneumothorax (collapsed lung) and went on to opine that needling of the subclavius muscle was a potentially dangerous undertaking in respect of which a clinician had to have a very good reason to proceed to treat the area. He testified further that a pneumothorax could only be diagnosed by chest x-ray and that a clinician undertaking acupuncture with a needle could not determine when the needle had passed through the superior muscles into the subclavius or below. Dr. Keshavjee was of the opinion that K.O.'s pneumothorax was caused by acupuncture of the subclavius muscle. Dr. Keshavjee was also critical of the Registrant's advice given to K.O. upon her return to the clinic on the evening following the procedure. He opined that it was unacceptable for a patient to be given an option whether to attend a hospital or not. K.O. should have been told to go right away as her symptoms were consistent with a pneumothorax. He said that the classic symptoms of a pneumothorax included pain, a dull ache, and a grinding sensation, all signs and symptoms presented by K.O. upon her return to the clinic. Dr. Keshavjee rejected the suggestion that K.O. had suffered from a spontaneous pneumothorax as suggested by defence counsel.

Dr. Hui also opined that inserting a needle into the subclavius muscle was a very high risk procedure, given the anatomy of the veins, arteries and muscles in that area of the body. He confirmed that a clinician cannot tell if a needle had protruded beyond the subclavius and punctured a structure, including the lung, beneath it.

Dr. Hui testified that an acupuncturist does not needle the subclavius muscle in order to treat headaches, and that there are many other relevant acupuncture points that could be used that are not as dangerous. It was Dr. Hui's opinion that the acupuncture treatment was the cause of K.O.'s pneumothorax. Dr. Hui also confirmed that there was nothing in the Registrant's treatment notes to suggest any clinical indication for the provision of acupuncture to the subclavius muscle.

Dr. Hui testified that the Registrant should have been aware of symptoms and the possibility of having caused a pneumothorax. In his opinion, when a client presents with symptoms approximating a pneumothorax, the client ought to be sent to the emergency department to be assessed. In his opinion, the Registrant fell below the standard of practice expected of a massage therapist practicing acupuncture within his scope of practice. Dr. Hui also rejected the suggestion that K.O.'s pneumothorax was spontaneous. Dr. Hui also testified that the departures from an appropriate standard of practice were substantial enough that the Registrant's practice ought to be restricted insofar as acupuncturing of the subclavius is concerned.

The College's last expert witness, Dr. Linda Rapson, also confirmed that it was hard to know when a needle had gone through the subclavius into the tissue or lung beneath, and that needling the apex of the lung is dangerous and requires a significant clinical justification. The only way to rule out a pneumothorax is with an x-ray, and physical symptoms of a pneumothorax included chest pain, a grinding sensation, and shortness of breath. She confirmed that any of these symptoms would have to be investigated by x-ray and that any patient presenting with those symptoms should be informed that the condition could be serious, and that they ought to attend a public hospital. Dr. Rapson testified that the only clinical indication for needling the subclavius would be if the person presented with a specific pain pattern as indicated in a classic acupuncture text, Travell's. She also testified that there were other acupuncture spots that should be attempted first, and that needling the subclavius should only be a last resort.

Dr. Rapson also confirmed that there were no clinical justifications on the face of the clinical record or in the evidence justifying the treatment of the subclavius with acupuncture to alleviate symptoms of a headache. Like the other experts, she also rejected the suggestion that K.O. had suffered from a spontaneous pneumothorax. In Dr. Rapson's opinion, the Registrant fell below the standard of practice for an acupuncturist by not choosing a safe or effective acupuncture point. He also fell below the standard of practice in failing to refer K.O. to the hospital upon presentation at the clinic the evening of the procedure.

The Registrant's Case

Four witnesses were called on behalf of the Registrant. Dr. David Salanki, DC, a chiropractor with training in acupuncture, was called initially as an expert witness. The Panel ultimately ruled that Dr. Salanki could only testify on facts surrounding McMaster University's Acupuncture Program and the subject of informed consent as taught at McMaster. His credentials as an "expert witness" were rejected by the Panel. Dr. Salanki testified that the McMaster Program taught its students that the subclavius was an appropriate insertion point and that McMaster teaches that it is totally outside of the pleural structures. With respect to the application of subclavius acupuncture for treatment of a headache, he testified that tight shoulders may be one cause of a headache and that there was an association between muscles involving the shoulder girdle and headaches that could be therapeutically treated by acupuncture.

Dr. Salanki testified that students of the McMaster program were instructed about the risks of a pneumothorax involving clients receiving acupuncture. He confirmed that the McMaster Program instructs students to refer clients out to hospital in cases of suspected pneumothorax. Under cross-examination, Dr. Salanki testified that good recordkeeping is taught to all students in the McMaster

Program and that students are also taught that there are anatomical variations to musculature of different people.

Christopher O'Connor, RMT, was called as an expert witness, but after a *voir dire,* the Panel ruled that Mr. O'Connor could only give expert opinion on the issue of treatment for shoulder dysfunction as an RMT/acupuncturist. While Mr. O'Connor testified that constant pounding headaches could be associated with the acupuncture points engaged in by the Registrant, under cross-examination, he agreed that many aspects of the Registrant's assessment and evaluation were missing from the clinical records. Most particularly, he noted that there was nothing in the treatment notes of the relevant date to demonstrate that the left should girdle was an issue. There was no indication or notation of any range of motion testing or palpation of the subject area. As he said, the hypothetical scenario provided to him by the Registrant's counsel did not match the actual case history or treatment notes prepared by the Registrant in this case. Mr. O'Connor also testified that he was not aware that there was a special spot in the chest that only a few acupuncturists knew about for the treatment of headaches.

The next defence witness was the Registrant. He testified that he completed the McMaster Program in 2004 and that throughout the course of his involvement with K.O. on June 21, he followed the instruction he received at the McMaster Program, one recognized by the College. He testified that he could not clearly recall everything that he said to K.O. or why he made the clinical notes that he did. He said that he had some recollection of the events, but not all.

After reviewing the events surrounding the first five visits, he testified that at the time of K.O.'s visit to the clinic on June 21, 2006, his treatment note showed that neck pain was increasing and headaches were pounding. He testified that with respect to the June 21st interaction, his memory of the day was limited and he remembered certain things better than others. He denied that his goal of treatment that day was treating headaches, testifying that he was treating "K.O. as a whole" to encompass everything that was going on with her. He pointed to a note in his clinical records indicating "anterior position" and testified that there were a number of reasons for that presentation, including the pectoralis major, the pectoralis minor, and the subclavius muscles. His plan was to release the chronic shortened position of these muscles and thereby improve the shoulder girdle function. He testified that it was his opinion that the left-sided neck pain was causing her headaches. The purpose of the acupuncture in that location, he testified, was to help relax those muscle groups.

Mr. Spurrell acknowledged that the purpose of his treatment notes was to record pertinent information.

The Registrant testified that when K.O. returned to the clinic the evening of the last visit, she asked him if she had a punctured lung. The Registrant told K.O. that given her pain and the nature of the treatment, it was more likely due to a muscle spasm, and that his clinical impression was that it was not a pneumothorax. He confirmed also that he told K.O. that if she felt she should go to the hospital right away, then she should, and that if she got worse, then she should go immediately. The Registrant testified that the complaint of "grinding in the chest" did not raise any red flags in the context of a possible pneumothorax. He was not aware that it was a classic symptom of a pneumothorax.

Under cross-examination, the Registrant agreed that a pneumothorax could be fatal and, with reluctance, agreed that K.O. did not go to the hospital that evening was because of the advice that he gave. He reluctantly agreed that she would have gone to the hospital had he advised her to do so.

The Registrant agreed that he told K.O. that he knew a spot that others did not treat, and that it was an unusual spot. While agreeing that there was a difference between a pounding headache and a constant pounding headache, it would not have made a difference in the treatment that he undertook. Anatomically, the Registrant disagreed that the subclavius was located over the apex of the lung, but under cross-examination, reluctantly agreed that the lung did extend above the clavicle and that part of the subclavius lies over the apex of the lung.

The Registrant also agreed that there was nothing in his clinical notes to justify why he provided acupuncture to the various points that he did. He agreed that, with the gift of hindsight, he made a mistake by not telling K.O. to go to the hospital directly.

The last witness called on the Registrant's behalf was Dr. Alejandro Claraco, a medical doctor trained in Spain but not holding a valid Ontario registration. Dr. Claraco runs the McMaster Acupuncture Program that Mr. Spurrell attended. Dr. Claraco was not qualified as an expert witness in the case, but was only permitted to testify about what students in the McMaster Program were taught. Dr. Claraco testified that there is no risk of a pneumothorax when needling the subclavius, if it is done correctly. He also confirmed that students are taught about the risks of puncturing the pleura and about the signs and symptoms of pneumothorax. He testified that all patients were expected to know the signs and symptoms, including a grinding sensation, so as to recognize the symptoms of pneumothorax when presented.

The Finding of Guilty

After lengthy deliberations, the Panel of the Discipline Committee found the Registrant guilty of treating a condition beyond his competency, failing to maintain professional standards, and disgraceful, dishonourable or unprofessional conduct.

The count of treating the condition beyond his competency dealt with the manner in which the Registrant advised K.O. upon her return to the clinic on the evening following the June 21 treatment. Despite the fact that K.O. expressly asked the Registrant if she had sustained a pneumothorax, K.O. told her that it was most likely a muscle spasm, that it was not a pneumothorax, and left it up to her as to whether or not to go to the hospital. The Panel found that the only way to diagnose a pneumothorax was to have an x-ray, consistent with the testimony of Drs. Keshavjee, Rapson, Hui and Claraco. The Panel found further, that by informing K.O. that she had a muscle spasm and did not have a pneumothorax, and by leaving the decision to K.O. as to whether or not she should go to the hospital, the Registrant was guilty of treating a condition beyond his competency, including by communicating a diagnosis (muscle strain and not pneumothorax) in circumstances where it was foreseeable that K.O. would rely upon that advice. Accordingly, the Panel found the Registrant guilty of count one.

With respect to the allegation of incompetence, the Panel concluded that while the evidence met the first two of three components of incompetence (namely that it related to the professional care of the patient and a lack of knowledge, skill or judgment, or disregard of the welfare of the patient) the evidence was not such as to justify a finding that the incompetence was sufficiently serious as to demonstrate that the Registrant was unfit to continue to practice or that the Registrant's practice should be restricted. They did not see that there was a pattern of conduct rather than a single episode. The Panel felt that the Registrant had learned from the incident and was unlikely to repeat the conduct.

With respect to count three, breaching standards, the Panel concluded that K.O. had suffered a pneumothorax as a result of the acupuncture of the subclavius muscle. Further, relying upon the testimony of the Registrant's own witnesses, namely Dr. Claraco and Mr. O'Connor, RMT, the panel accepted that if the procedure had been done properly, there would have been no possibility of an accidental puncture of the pleura. As such, they concluded that the procedure was improperly performed. The Panel concluded that the decision to needle the subclavius required compelling clinical indications for which, on the facts of this case, there was no evidence. Further, the Registrant's notes did not support his treatment decision or the clinical findings that he testified to. As a result, the standard of practice was breached.

With respect to the advice that the Registrant gave to K.O. upon her return to the clinic, they felt that the advice was inappropriate and that in the absence of an ability to diagnose a pneumothorax (in the absence of x-rays), he should have told K.O. to attend the hospital immediately.

Finally, because of the findings on counts one and three, given the evidence, the Panel was satisfied that Registrants of the profession would reasonably regard this type of behavior to be disgraceful, dishonourable and unprofessional.

The Sentencing Phase

The Panel reconvened on October 4, 2012, for the Penalty Hearing. During the sentencing phase, the Registrant testified that he was truly sorry for what he had done and that he had made serious errors for which he accepted responsibility. He acknowledged that he did not complete his treatment notes appropriately and failed to recognize K.O.'s condition when she returned to the clinic, and should have sent her to the hospital. He testified about the financial stress that he had experienced, and that he had taken over 400 hours of anatomy and physiology training since the date of the events riving rise to the allegations.

After hearing submissions of both prosecution counsel and the Registrant's counsel, the Panel imposed the following penalty:

1. It required the Registrant to appear before the Panel to be reprimanded;

2. It directed the Registrar to suspend the Registrant's Certificate of Registration for 12 months;

3. It directed that 5 months of the 12-month suspension would be remitted if the Registrant complied with the following terms and conditions within 7 months;

4. It directed the Registrar to impose the following terms, conditions and limitations on the Registrant's Certificate:

    a. The Registrant was to be restricted for performing acupuncture until he satisfied the terms, conditions and limitations set out in paragraph 5;

    b. Notwithstanding the foregoing provision, the Registrant was restricted indefinitely from performing acupuncture in the area of the subclavius muscle;

5. It directed the Registrar to impose the following terms and conditions on the Registrant's Certificate of Registration:

    a. The Registrant was required to attend 8 hours of in-person mentoring in relation to the practice of acupuncture, including various terms and conditions associated therewith;

    b. The Registrant was required to take two online courses, including the College's Online Recordkeeping Course, and the College's Professionalism Workshop;

6. The Registrant was ordered to pay the costs of the College in the amount of $10,000 in 24 equal monthly installments;

7. In the event that the Registrant failed to pay the imposed costs, the Registrant's suspension would remain indefinitely until such arrears and payments were fully made, or until the College's costs of $10,000 were paid in full.

During the course of its reasons for imposing the penalty that it did, the Panel noted that this was the College's first case where a Registrant had been harmed by an RMT and that a pneumothorax was a serious and potentially life-threatening injury. It noted that had the Registrant recognized the symptoms of a pneumothorax and referred K.O. to the hospital on the evening of the treatment, the Panel would have considered a lighter period of suspension. The Panel agreed to remit five months of the sentence, provided that the Registrant met the terms and conditions of his order because the Panel recognized that the Registrant had taken responsibility for his mistakes. It noted that the Registrant had paid a high price, both with stress to him and his family. As it said:

> The suspension sends a strong message to the profession that the College takes client safety very seriously. The public is also protected while the Registrant is suspended and re-educated.

No further anatomy-related educational terms and conditions were imposed because the Panel accepted that the Registrant had taken sufficient further training in anatomy since the incident and needed nothing further in that regard. It also pointed out the rigorous nature of the mentoring program imposed, including the requirement to take two online courses.

With respect to the indefinite restriction on the Registrant's needling of the subclavius, the panel noted that the expert testimony of Drs. Hui, Rapson and Keshavjee confirmed that needling in the area of the subclavius was dangerous, no matter how carefully the procedure was done, and that there was always a risk of pneumothorax. The experts also stated that there were other safer ways to treat the subclavius then by doing acupuncture. The Panel noted:

> The Registrant is not restricted from treating the subclavius, as he can use massage therapy techniques, osteopathic techniques that he has studied, and active release techniques. This ensures that the public can be treated but safety is not jeopardized.

The Panel concluded by noting that the Registrant "behaved inappropriately and his actions necessitated an investigation and a subsequent Discipline Hearing. These are costly proceedings."

The Appeal

Following the decision of the Discipline Panel, the Registrant appealed both the finding of guilty and the sentence imposed to the Ontario Divisional Court. The appeal was heard on May 8, 2013. On June 19, 2013, the Divisional Court released unanimous reasons dismissing both appeals. It ordered the Registrant to pay the costs of the appeal in the amount of $8,814.00 to the College.

Case Comment

This is the first case in which the Discipline Committee of the College has dealt with a treatment that caused physical harm to a Registered Massage Therapist's client. The Panel of the Discipline Committee made it clear that public safety is its paramount concern. The College will vigorously pursue Registrants who cause their clients harm and will request that significant restrictions on the Registrant's practice be imposed in an effort to fulfill its mandate of protecting the public interest. The decision also makes clear the importance of keeping accurate and complete records. Finally, Registrants are reminded that it is important to recognize the limitations on scope of practice and to refer clients to appropriate health professionals where conditions merit medical intervention.