VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

ADMINISTRATIVE DIVISION

REVIEW AND REGULATION LIST VCAT REFERENCE NO. B112/2010

CATCHWORDS

Review and Regulation List – chiropractor – disciplinary proceedings – unorthodox treatment by a chiropractor – use of hyperbaric oxygen and Lokomat treatment for cerebral palsy, neurological conditions and several other complaints – allegations of failure to make proper assessment – failure to obtain informed consent and misleading and deceptive conduct – treatment plan – modifying treatment plan – monitoring outcomes and inadequate documentation – *Health Professions Registration Act* 2005 ss 3, 59(2)(9), 77 and 94

APPLICANT	Chiropractic Board of Australia
RESPONDENT	Dr Malcolm Hooper
WHERE HELD	Melbourne
BEFORE	Robert Davis, Presiding Member Dr B Draper, Member Dr J Waterhouse, Member
HEARING TYPE	Hearing
DATES OF HEARING	21, 23-25, 30-31 January, 1,4,6,8,11, 13-14, 20-22, 25, 27-28 February, 1,4,6,13-15, 25, 27-28 March, 3-5, 8-10, 17,22, 26 and 29 April, and 1 May 2013
DATE OF ORDER	4 June 2013
CITATION	Chiropractic Board of Australia v Hooper (Review and Regulation) [2013] VCAT 878

ORDER

1 Pursuant to s 77(1)(a) of the *Health Professions Registration Act 2005* (the Act):

(a) in relation to each of the Allegations 1, 3, 4, 5 and 8 of the Amended Final Notice of Allegations, the respondent has engaged in unprofessional conduct; and

(b) in relation to each of the Allegations 2, 6 and 7 of the Amended Final Notice of Allegations, the respondent has engaged in professional misconduct.

2. The proceeding is adjourned to a directions hearing on 12 June 2013 at 9.30 am for the purpose of making arrangements for the parties to be heard in relation to a determination to be made pursuant to s 77(4) of the Act.

3. Costs reserved.

Robert Davis
Presiding Member

APPEARANCES:

For Applicant	Dr I Freckelton SC
For Respondent	In person with Mr Little (non-practising lawyer)

REASONS FOR DECISION

1 This proceeding is a disciplinary hearing against Dr Malcolm Hooper, a registered chiropractor, which was referred to the Tribunal by a letter from the Chiropractic Board of Australia (the Board) dated 5 May 2010. The referral was made pursuant to s 59(2)(g) of the *Health Professions Registration Act* 2005 (the Act).

2 The allegations which we will refer to in detail below, concern the conduct of the respondent between August 2007 and May 2008 in relation to the respondent's treatment of a patient with cerebral palsy known, for the purposes of this proceeding, as 'QS'. The allegations also concern advertising on the respondent's website which advertising is alleged by the applicant to be misleading and deceptive. In relation to the treatment of QS and treatment advertised on the respondent's website, it is alleged by the applicant:

(a) That the respondent failed to undertake a proper clinical assessment of QS prior to recommending and undertaking hyperbaric oxygen treatment (HBOT) and Lokomat treatment for QS.

The Lokomat machine is a robotic walking device which supports the patient's body weight as the patient is harnessed into the Lokomat. Once the patient is harnessed into the Lokomat, the device moves the patient's legs through a normal gait cycle. Further, there are controls in relation to walking speed and it measures the body's response to the movement. The Lokomat machine also has its own computer which takes several readings in relation to each movement that the patient makes. Those readings can be printed out from the Lokomat computer.

(b) That the respondent failed to obtain informed consent from QS in relation to both the hyperbaric oxygen treatment and the Lokomat treatment.

(c) That the respondent failed to prepare a treatment plan or an adequate treatment plan in relation to treatment of QS for HBOT and Lokomat.

(d) That the respondent failed to modify the treatment plan (if it did exist) in relation to QS.

(e) That the respondent failed to clinically monitor or evaluate any measurable improvement in QS's condition (cerebral palsy) nor his suitability for stem cell therapy as a result of HBOT and/or Lokomat treatment.

(f) In recommending both the HBOT and Lokomat treatment the respondent misrepresented the likely effectiveness of such treatment in relation to cerebral palsy.

(g) In advertising treatment the respondent, in relation to the 30 named conditions, which the respondent alleged could be treated by HBOT, the respondent was misleading and deceptive about the effectiveness of that treatment; and

(h) The respondent failed to generate proper documentation in relation to the treatment of QS.

3 The particulars, which we have summarised above, are set out fully in the Amended Final Notice of Allegations [pp 16(a) to 16(g) Vol 1 Applicant's Tribunal Book] – which are fully reproduced in Appendix A to these reasons.

BACKGROUND

4 The respondent is a registered chiropractor. He graduated as a chiropractor in 1983 and completed a number of post graduate degrees including a Masters in clinical acupuncture. In 1995, the respondent opened a clinic in Collins Street, Melbourne, where he commenced treating patients with HBOT. Initially, the treatment for HBOT was confined to spinal patients but that widened to patients suffering neurological disorders, including stroke and spinal cord injury.

5 In 2006, the respondent introduced Lokomat to his practice. It was purchased for $750,000. The respondent said it was the only machine of its kind in Australia. Also, in 2005, the respondent incorporated power plate and vibrational training to assist patients with neurological disorders.

6 In May 2007, the respondent met the notifier QS. QS was born on 13 November 1976 and was 30 years of age when he first met the respondent. Unfortunately, QS was born with cerebral palsy. QS described his physical symptoms as follows:

> The physical symptoms I experience affect all four of my limbs. I use a motorised scooter to get around but can walk a limited distance using a walking stick, although I get tired easily.

QS's disability has prevented him from ever being employed. At all relevant times, both QS and his parents, with whom he lives, have been on disability pensions.

7 QS summarises his past treatment as follows:

> In the past I have had treatments including:
>
> (a) normal physiotherapy when I was young;
>
> (b) Massage therapy provided at my home by my mother;
>
> (c) treatment with Baclofen prescribed by Dr Rawicki, but I took myself off this medicine as it made me lazy; and
>
> (d) gym training sessions and swimming therapy.

Since June 2000, QS has been treated by his general practitioner Dr Alan Hodgson.

8 In about mid-2007, QS was desperate to improve the symptoms from which he was suffering as a result of cerebral palsy. He began searching the internet and found the site of the 'Steenblock Research Institute' (SRI) which was run by Dr David Steenblock who was located in California, USA, but refers patients to Mexico for umbilical cord stem cell treatment.

9 At paragraphs 10 and 11 of QS's witness statement, he describes part of the information that he was given by the SRI in the following terms:

> I was told that the Steenblock Research Institute had mainly done the stem cell treatment on young children but they were hoping to do some research into adult treatment. They informed me that it was likely that they would be able to do the treatment on me. They told me that the costs of the treatment would be about US$25,000 but they were aware of my financial situation and indicated that they may fund the treatment for me as the stem cell treatment on adults was still under research.
>
> After seeing the results of my CT scan, one of the staff or clinicians at the Steenblock Research Institute told me via email that it would be better to do hyperbaric oxygenation (HBO) treatment first before undertaking the stem cell treatment as this would activate the stem cells in my body and produce the best results. They recommended that I book into a place that does HBO in Melbourne and do a few hours of HBO treatment.

10 In QS's oral evidence [Transcript p 106], he stated:

> They (SRI) said maybe later on in life they would do stem cell therapy for adults and that we might be able to assist you in regard to the financial aspect of it.

11 Following the above conversation with a member of the SRI, QS searched the world-wide-web. He there found a site of 'HyperMED Neurorecovery Australia' (HyperMED) which was an organisation run by the respondent and of which he was the sole director. The respondent informed the Tribunal that there were in excess of 900 professional articles on the HyperMED website as well as some commentary and many testimonials.

12 QS looked at the website, and his feelings, after looking at the website, were summed up in paragraph 14 of his first witness statement, when he stated as follows:

> I was impressed with the information on the HyperMED website, which listed cerebral palsy on the home page of the website and linked through to information about HBO and Lokomat treatment for persons with cerebral palsy.

13 QS contacted the HyperMED organisation and he was sent some information by post about HBO and Lokomat treatment. The information stated that the hourly rate for HBO treatment was $140 per hour for the first 100 hours and then $100 per hour after the first 100 hours. The hourly rate for the use of the Lokomat machine was $220.

14 After making an appointment to visit the HyperMED centre, QS attended on 27 August 2007 when he met Dr Hooper. He also brought with him a CT scan. At page 6 of the respondent's witness statement dated 12 March 2013, he stated:

> The CT scan report identifies regions of old cerebral infarctions due to infantile stroke.

15 QS told Dr Hooper about his proposed stem cell treatment with the SRI. Dr Hooper told QS that he was a candidate for HBOT and that it would be of assistance in the treatment of his cerebral palsy. He said this was particularly so as QS had been active and his condition was less severe than others. Dr Hooper then recommended 140 to 150 hours of HBOT and 40 to 60 hours of Lokomat treatment. As QS by this stage trusted Dr Hooper, he accepted that recommendation. QS said it was during this consultation that Dr Hooper told QS about the Lokomat machine. During cross-examination, Dr Hooper maintained that QS, when he made contact with HyperMED, intended to have Lokomat treatment as well as HBOT for the purpose of preparing him for stem cell therapy. Dr Hooper said the other purpose for the treatment was to improve QS's functionality.

16 QS describes what he was told at paragraph 27 of his first witness statement:

> Dr Hooper also told me during this first consultation about the Lokomat machine. This is a machine which the body is connected to, you strap your legs into the machine and the body is supported by a harness. It is designed to move the patient's legs in the proper gait which then trains the mind to move the legs in the same gait pattern. Dr Hooper stated that the HBO treatment would assist with the Lokomat treatment because it makes the body relax and would make me ready for Lokomat treatment.

QS made it clear that he did not intend to have Lokomat treatment until he was persuaded during the first consultation. Dr Hooper denied this and said it was QS's intention, when he came to the clinic, to have Lokomat treatment.

17 At the time of the first consultation, QS had four hours of HBOT and one hour of Lokomat treatment for which he paid the cost, calculated on the basis of which we have already referred. In QS's oral evidence [Transcript p 107], he said the purpose of him having HBOT and Lokomat treatment at HyperMED was to get ready for stem cell therapy and better himself.

18 In his oral evidence [Transcript p 108] QS stated that Dr Hooper did not explain how stem cells would be activated by the proposed treatment. Further, QS stated:

> I understood what he (Dr Hooper) meant because of research from America and stuff. But when I went to HyperMED, I did not know – I knew he had a machine called the Lokomat but I did not think I will be actually using the machine.

19 It is apparent that Dr Hooper took some notes on 27 August 2007 and on the remaining periods, although the notes appear to be quite vague. Dr Freckelton accurately describes the notes [Transcript p 30, line 16] in the following terms:

> So you can see the clinical entries for the provision of treatment to QS starting on 27 August 2007, with some initial notes referring to discussion of a stem cell program, and his speech was intact and so on; he was born six weeks premature, legs popped out; reference to the initial payment of $280 for hyperbaric treatment, and so on. And then if you thumb through the succeeding pages, you will see short entries for treatment provided to QS as the weeks stretched into months, and you will see, for instance, entries for – I refer you to page 300, 8 November 2007. You can see there at the top of the page, 300, HBO 120-120. So 120 is 120 minutes and Loko 60, so he had an hour of Lokomat treatment on that day.

20 During the hearing, the applicant returned to the respondent the front page of the notes relating to QS that had been given to the respondent's investigator. That page contained the note: 'Adult Cerebral Palsy --- Stem Cell program – Dr David Steenblock'.

21 Also on 27 August 2007, Dr Hooper referred QS for an MRI of the full spine and brain. This MRI was performed on 6 September 2007.

22 At the first consultation, there was also discussion about the effects of Lokomat and HBO. At paragraph 31 of QS's witness statement, he described the discussion:

> Dr Hooper said the risks of HBO treatment were that I would get an ear ache and nothing else. I do not recall him talking about any likely effects of the HBO or Lokomat treatment or what it was going to accomplish for my cerebral palsy or for any future stem cell treatment. We also did not discuss how I would be able to tell if I was making progress from the HBO or Lokomat treatment, or whether he would review how I was going at any particular stage.

23 QS was concerned about his ability to pay for the treatment proposed by Dr Hooper. QS told Dr Hooper that both he and his parents were disability pensioners and he could not obtain any assistance to pay for the treatment and, as a result, he could not afford the cost. QS alleged Dr Hooper then suggested that he undertake fund raising, like some of Dr Hooper's other clients who were in the same position. (Dr Hooper said that QS had already set up his charity prior to the first consultation). QS then thought about whether he should undertake the course of treatment proposed by Dr Hooper for a couple of days; then he contacted Dr Hooper to inform him that he would try fund raising to pay for the treatment.

24 Some days after the MRI scan on 7 September 2007, QS had a further appointment with Dr Hooper who looked at the MRI report. It should be noted that QS received treatment from HyperMED on 28, 31 August, 1, 3 and 5 September 2007. Each time being prior to Dr Hooper seeing the

MRI. At paragraph 41 of QS's witness statement, he refers to what Dr Hooper told him about the MRI:

> Dr Hooper looked at the report and told me that I had a few spine problems which the HBO treatment would assist with. He said that I had brain stem problems which he said was the most concerning issue. He said that as you get older with cerebral palsy you might get Parkinson's disease and other problems like that. He said the HBO treatment would help lessen the chances of me getting such problems in the future.

Dr Hooper denied he told QS that he had brain stem problems or that he might get Parkinson's.

25 Subsequent to the above conversation, QS continued with the HBOT and Lokomat treatment, which he had already commenced. Such treatment included approximately 10 to 12 hours of HBOT a week and three to six hours of Lokomat treatment per week.

26 In or around November/December 2007, QS had completed 140 hours in the hyperbaric chamber and undertook Lokomat sessions between 13 September and 17 December on a weekly basis for three to four days per week.

27 After 17 December, QS alleged that he was troubled by his indebtedness to Dr Hooper and he wanted to stop treatment. However, Dr Hooper rang him on more than one occasion and persuaded him to continue with his treatment which then continued until 13 May 2008. By that time, QS had submitted to approximately 269 hours of HBOT and 79 hours of Lokomat treatment. It should be noted that some of the Lokomat treatment particularly after March 2008 was sponsored, that is, paid for by Dr Hooper's HyperMED clinic.

28 However, by 13 May 2008, QS owed the HyperMED clinic $44,825 after he had paid a sum of approximately $5000. That is, his total bill was approximately $50,000. His fund raising efforts had been spectacularly unsuccessful and he was concerned and worried as to how he would cover his indebtedness to the HyperMED clinic. In one discussion between QS and Dr Hooper, QS alleges that Dr Hooper told him that he should get his older brother to rob a bank to get the money that he owed him. Dr Hooper denies making this statement to QS. Subsequent to May 2007, QS received numerous requests for payment both verbally and in writing from Dr Hooper's HyperMED clinic.

29 In or about March 2008, when it was clear that indebtedness by QS was a real problem, QS made a video to help promote the HyperMED clinic and Lokomat treatment. In this video, which was tendered to the Tribunal, QS praised the Lokomat treatment and said that it was helpful and his condition had improved. Similar sentiments were expressed in a website set up by QS. However, QS said that he only made this video and website, and made the statements to which we have referred, as a result of his increasing

indebtedness to HyperMED clinic and his concern that he needed to raise money to make the payments for the treatment he had received. QS said it was wrong for him to say that his condition had improved. He did not in fact believe such a statement. QS also said that he regretted having made the video/website and co-operated in the promotion exercise with Dr Hooper. It is clear that Dr Hooper either wrote or assisted QS in writing the script for the video.

30 At paragraph 75 of QS's witness statement, he said as follows:

> I believe that the treatment had a placebo effect upon me. Because it was costing so much and I was committed to getting a benefit from it for myself and others suffering cerebral palsy, I really wanted to believe it was working. I now realise that by undertaking this costly treatment I have found myself without any real benefits to show and am unable to pay for the treatment I have received. I feel I was given false hopes and I wish I had never done it. I am embarrassed at having trusted Dr Hooper so unquestioningly and feel betrayed by him.

HyperMED Website

31 As previously stated, the HyperMED website contained many testimonials from past and current patients and over 900 articles in relation to a number of conditions which were treated by the HyperMED clinic. (It is noted that s 94(1)(c) of the *Health Practitioners Registration Act* 2005, made it an offence for a health practitioner to advertise using testimonials). In particular, the Tribunal has been referred to a section of the website headed 'Conditions Treated' with a long list of conditions under the words 'Disorders treatable with Hyperbaric Oxygen therapy (HBOT)'. We do not believe it is necessary to reproduce every condition in the list on the website, save and except that conditions 1-30 that are referred to in Allegation 7. 'Reducing risk of cancer cell mutation' (30) is not on the list of the website but appears elsewhere in the website. Those conditions are:

> (1) soft tissue musculoskeletal injuries; (2) fracture repair; (3) acute and chronic spinal instability; (4) facet dysfunction; (5) disc protrusion; (6) canal stenosis; (7) inflammatory arthritides; (8) spinal cord neuropathy due to crush and neurovascular degeneration; (9) paraplegia and quadriplegia due to incomplete neurovascular compression; (10) peripheral nerve injury and neuropathies; (11) cerebrovascular stroke; (12) multiple sclerosis; (13) multi-infarct dementia; (14) cerebral palsy; (15) Parkinson's disease; (16) Alzheimer's disease; (17) Autism; (18) epilepsy due to hypoxia; (19) coronary heart disease; (20) heart insufficiency (post-surgical); (21) heart contractile dysfunction; (22) acute and chronic arterial insufficiency; (23) gastric and duodenal ulcers; (24) hepatitis; (25) diabetes; (26) lung abscess; (27) pulmonary embolism (as an adjunct to surgery); (28) complications of pregnancy (including gestational diabetes, eclampsia, heart disease, placental hypoxia, foetal

hypoxia and congenital disease of the neonate); (29) infertility; and (30) reducing risk of cancer cell mutation.

The evidence in relation to Allegation 7 of Dr Bennett, who is a specialist in HBOT and is director of the Hyperbaric Oxygen Unit at the Prince of Wales Hospital, Sydney, and Dr Millar, who is a specialist in hyperbaric medicine and was director of the Hyperbaric Oxygen Unit at The Alfred Hospital for 12 years, is accurately and conveniently set out in a table which is Appendix B hereof. The appendix also accurately extracts parts of Dr Hooper's evidence. The table was prepared by the applicant. The respondent refers to Dr Bennett's table as 'cryptic'. In our view, this description is wrong. The table is clear and informative. Dr Millar by and large, with a few subtle distinctions, agreed with its contents. We accept both Dr Bennett and Dr Millar have thorough knowledge and experience about the likely outcomes from the use of HBOT in relation to the areas referred to in paragraph 31 hereof.

32 The website has links to each of the conditions referred to under disorders treatable by Hyperbaric Oxygen. At the bottom of the list of conditions that are treated by Hyperbaric Oxygen, the following text appears:

> Many patients and their families recognize their lack of improvement and are often referred to us as 'the last hope'. Due to the severity of their disability and their failure to improve with conventional therapies, most patients hope that the use of Hyperbaric Oxygenation together with assertive physical therapy will produce better results.
>
> Orthopaedic and Neurological disorders are our prime focus, given the fact that approximately 20-30% of the body's consumption of Oxygen occurs within 3-5% of the body mass – the brain and spinal cord. These structures are extremely sensitive to oxygen deficiency, and can have the most dramatic result with the use of HBOT (Jain 1995).
>
> Hyperbaric Medicine is used as an 'adjunctive therapy'. HBOT is used in conjunction with other forms of aggressive treatment recommended by the patient's Doctor, to promote stabilization and repair. The purpose of Hyperbaric Oxygenation (HBOT) is to repair tissue that is severely damaged because of inadequate blood supply.
>
> - HBOT improves the immune system mechanisms with an increase in lymphocyte (white blood cell) production, promoting fibroblast replication and collagen production, repairing disc and supporting ligaments.
> - HBOT accelerates body defence mechanisms enabling the patient to overcome chronic infections and viral conditions inhibiting immune system function. This is extremely important in spinal surgery patients where delayed wound healing due to poor vascular compliance leads to further serious complications. The incidence of post surgical scarring, adhesions and predisposition to infection is dramatically reduced with HBOT.
>
> In the United States of America, England, Europe and Asia, HBOT is used routinely to promote accelerated healing including pre and post

operative procedures. It is used to reduce secondary complications including infections, and to promote functional rehabilitation. HBOT significantly reduces the length of post-surgical rehabilitation care and hospitalisation, which reduces costs (Jain 1995).

Hyperbaric Medicine is not a 'cure all' but has been clearly demonstrated to dramatically increase immune capabilities, assisting patients with problems ranging from simple delayed wound healing to complex disabilities and impairment.

- HBOT is non-invasive, it is not a surgical procedure.
- HBOT is safe. Unlike many other forms of treatment and surgical procedures, HBOT has few side effects, and almost none of any lasting nature.
- HBOT works extremely well with other forms of physical therapies and or requisite medications. It enhances the effectiveness of both traditional and complimentary therapies.

33 None of the 30 conditions (referred to in paragraph 31 of these reasons) listed on the HyperMED website are recognised as suitable for HBOT by the peak bodies for HBOT in Australia, USA and Europe. Those peak bodies are Australian and New Zealand Hyperbaric Medicine Group (ANZHMG), Australia and New Zealand Special Interest Group for Diving and Hyperbaric Medicine (ANZSIGDHM), Undersea and Hyperbaric Medicine Society (UHMS) and European Consensus Conference on Hyperbaric Medicine [Applicant's Tribunal Book pp 770(a) – 770(u)].

34 There are likewise, many articles on the website relating to Lokomat treatment. Further, the website contains some commentary and a number of newsletters that have been published by HyperMED, which largely consist of abstracts of various articles that have been published on topics relating to conditions which are treated at HyperMED.

35 There is also a great deal of material on the website from a textbook by Professor Jain relating to mainstream and complimentary treatment of neurological disorders allegedly treated by Hyperbaric Medicine. It is noted that the list of conditions suitable for HBOT on the website referred to in paragraph 31 hereof is reproduced from Professor Jain's textbook.

36 Dr Ian Millar commented on Jain's text in the following terms, [Transcript p 433]:

> K.K. Jain is – produces a – a well referenced textbook that, although many would not regard some of its conclusions or some of its chapters as mainstream, it is a very useful reference to – in that it has been well referenced and well written so that it presents a good reference source for the literature related to some of the conditions which don't appear in the – if you like, the more mainstream text such as Thom or the Kinwall textbook.

> … Jain's textbook includes a coverage of both, if you like, orthodox and unorthodox, so it's a – it is a useful textbook to have on you – on one's shelf, I believe.

37 Dr Bennett appeared to have less regard for Jain's work. Dr Bennett denied Jain's textbook was authoritative because there were many propositions in the textbook which Dr Bennett and the majority of his colleagues would not concur [Transcript pp 1087/8]. Likewise, Dr Churchyard, neurologist, stated that none of the neurological conditions referred to in paragraph 31 hereof, were suitable for treatment by HBOT.

38 A number of points are self-evident from Jain's text book in relation to Chapter 21, 'HBO in the management of Cerebral Palsy'. Reference is made to the Montgomery et al study in 1999. That study gave some hope for the benefits of HBOT for cerebral palsy and led to the Collet study. The respondent, inter alia, relied on the Montgomery study and parts of the Collet study to support his view of the benefits of HBOT for cerebral palsy. However, it is clear from Jain's writings that there were flaws in the Montgomery study. They are:

(a) there was a lack of placebo control;

(b) two different hyperbaric protocols had been applied;

(c) the assessment tools utilised had inherent variations; and

(d) the children involved in the study experienced rapid regression of neurological gain after they stopped treatment.

39 Both the Montgomery et al and Collet et al studies relate to children. Drs Bennett, Millar and Churchyard made it clear that it is inappropriate to extrapolate from children's studies to the situation of adults in respect of cerebral palsy and its treatment by hyperbaric oxygen. Surprisingly, against the weight of this strong evidence, Dr Hooper refused to agree to the above proposition. He preferred to rely on his 17 years 'experience with dealing with many patients under the banner of cerebral palsy, I have my own observations and my own viewpoints' [Transcript p 1735]. This is in spite of Dr Hooper having only treated two adult cerebral palsy patients (other than QS). He relied on anecdotal evidence from those patients as to any benefits they may have achieved from HBOT in relation to their cerebral palsy condition, this is not strong evidence and unreliable [Dr Millar's evidence Transcript 409].

40 Dr Hooper appears to treat the writings in Jain's textbook as some form of 'holy grail'. He said that his clinical experience supports the use of HBOT for many of his patients in a hopeless state [Transcript 1737].

He also said he relied on a textbook by Professor Zhang 'Hyperbaric and Neurological Disorders'. We gained the impression that Dr Hooper's support for Professor Jain's writings may come from the fact that the writings supported his practices. It is indeed surprising that he paid such homage to Professor Jain while relegating the views of eminent doctors

such as Drs Millar, Bennett and Churchyard and the peak HOB professional bodies to be unimportant.

41 Another of Jain's articles 'Effect of Hyperbaric Oxygen on Spasticity and Stroke Patients' referred to the effect of HBOT at 1.5 ATA (atmospheres of pressure) on spasticity of stroke in relation to observations of 21 patients undergoing rehabilitation. In this observation, the patients served as their own controls. It was concluded in the article that, 'HBO reduced spasticity in all the patients, an effect that was more marked than that of physical therapy, hyperbaric air, or 100% Normobaric air'.

However, it is clear that this particular article was of a very small number of patients who were providing their own controls and thus, it statistically did not provide much evidence for the conclusion drawn by Professor Jain.

42 Another article referred to on the website was what was known as the 'McGill Pilot Study'. This study was limited to 25 subjects comprising 10 girls and 15 boys who were diagnosed with spastic diplegia. The study eventually concluded that there was some hope of treatment but, 'further research is definitely required to ascertain the potential of this treatment (hyperbaric oxygen) for children with cerebral palsy'. There was also reference made on the website to a University of Texas Galveston Research Study performed under the direction of Dr Kevin Barrett who is Professor of Hyperbaric Medicine at that University. The study investigated the effects of HBOT with paediatric cerebral palsy. 'The objective of the study was to determine if 1.5 ATA Hyperbaric Oxygen Therapy can ameliorate the neurological deficits associated with paediatric cerebral palsy'. This study concluded that:

> Hyperbaric Oxygen Therapy effected improvement in tests of gross motor and fine motor function and decreased spasticity as measured by the modified Ashworth Spasticity Scale in patients with chronic cerebral palsy. Functional reorganisation in the visual cortex is suggested by the reappearance of visual evoked potentials.

43 However, it is noted that this study only included five children whose average age was 41.8 months. The above reference to books and articles is in no way a complete reference to all the articles that appeared on the HyperMED website. It is but a small sample that we believe demonstrates the type of articles that appear on such websites.

44 Referring to the type and volume of articles that appear on the HyperMED website, Professor Dodd, who is Professor of Physiotherapy at Latrobe University, made comments in relation to the articles in relation to Lokomat treatment. We believe those comments that she made in relation to Lokomat treatment are equally applicable to the articles that appear in relation to HBOT. While being cross-examined, Professor Dodd made the following comment [Transcript p 851 ff]:

> As I suggested to Dr Hooper, there are a lot of articles on the website and particularly in the clinical research areas, in fact so many articles

> that I thought – I would think a lay person would find it very difficult to sift through such information and at the moment in that area there actually is no analysis or no – any other information to help a lay person, and presumably the website is mostly for lay people to actually look at the effectiveness of treatments that are provided by HyperMED that they – that there is no information there to help them understand what these papers are actually saying and so there are so many papers there including, interestingly enough, some negative papers …
>
> Even for me it was hard to go through every single paper because there is so much information there. For a lay person I think what they would do is look at it and, to tell you the truth, I think they would go, 'There's a lot of papers. This must be a good thing,' is what I think people would probably do.

45 We accept what Professor Dodd has said about the website, and we are of the opinion that even an intelligent lay person, such as QS, would be likely to gain the impression that Professor Dodd has referred to.

46 Even though the use of testimonials for advertising has been illegal for use by registered chiropractors for a long period of time, Dr Hooper continued the publication of testimonials on the HyperMED website until after he was forced to undertake, in May 2011, to stop using them. Dr Hooper would not concede that the testimonials were on the website for advertising or commercial purposes. Instead he maintained that the testimonials provided a forum for his patients to be contacted and to speak. In our view, it is most unlikely that the testimonials were on the website for the sole purpose stated by Dr Hooper as it was him or his organisation that placed the testimonials on the site, not the individual patients who had made the testimonials. Further, there was no chat room or the like on the site. Thus we find the testimonials were placed on the internet in order to attract clients to HyperMED.

A strong body of evidence contradicts the use of HBOT for cerebral palsy patients

47 Dr Millar was asked by Dr Freckelton, counsel for the applicant, why HBOT is not provided for the most part to either children or adults with cerebral palsy [Transcript p 414]. Dr Millar stated:

> I think there was some interest some years ago, when the first clinical trials about hyperbaric oxygen brain injury started to come out, and some of the case series of hyperbaric oxygen in cerebral palsy specifically were first published, but the subsequent research that has been done, and the more critical evaluation of evidence that has occurred in the last five or 10 years has led people to believe that at the moment, there is not a case for hyperbaric oxygen to be considered as supported by evidence for cerebral palsy.

48 Dr Millar was then asked about a study by Collet et al, 'Hyperbaric Oxygen for children with cerebral palsy: a randomised multi-centre trial' which was

published in the Lancet Medical Journal in 2001. Dr Millar agreed that the Collet study was a reference relating to children rather than adults. He then stated that the aim of the Collet study was resolving an issue that was becoming very political about resourcing for the provisions of hyperbaric oxygen for cerebral palsy. He then stated:

> my understanding is that Collet was appointed to the trial group as an independent senior research person to strengthen the study group. The study enrolled … 111 patients, into – in the age three to 12 years, to receive a randomly-selected hyperbaric oxygen or pressurisation in the chamber just with air. This is actually a problem in scientific sense that's inherent in hyperbaric medicine, in that in clinical research, ideally, you would like to give a true placebo, something that looks, tastes, seems identical to the active treatment, but which has no clinical effect whatsoever; the classic sugar pill, if you like, against the active drug. But there is no equivalent of the harmless gelatine capsule and an active drug with hyperbaric medicine. You have to choose to either put the control patients in the hyperbaric chamber, which does expose them to something that is not normal, so they do get exposed to some degree of pressure, they do get driven from their home to the clinic, they have the whole two/three hours experience of coming, interacting with people, going through a treatment, which is not, of course, what you would normally do with your day, and it doesn't happen once, it happens many times over a course of treatments. The alternative is that you don't put the control group patients into the chamber, you just leave them at home and don't bring them in at all; you just bring them in three months/six months later to do their assessment. But then, of course, the study is not blinded, and it's open to the biases of different interpretation, different behaviours between the patients who actually came in each day for their treatment, and the patients who were left at home. The closest anyone has come is using the lowest possible pressure so that the air in the chamber, from the patient who was not receiving active treatment, the control group, is as close to normal atmospheric as possible. And for a condition where the outset is totally objective, like the physical size of a wound, or something like that, that's probably very good, but in a condition like a neurological condition, particularly cerebral palsy in children, where there is a tendency for natural improvement as the child grows up and does develop, because, after all, cerebral palsy children do improve their capability and skills as they grow older, and abilities. So the control group, bringing them in each day to the chamber was providing a significant stimulation to them each day. But it did ensure that the study was free from one of the major biases, which is whether the patient and the child themselves knew that they were getting the active treatment or the sham. As a result, this is a study that is relied on quite strongly; it sits very highly, probably second from the top level of that evidence hierarchy I was asked to summarise before, as a blinded randomised control trial. And the outcome of this study in summary was that it did show some improvements, which are small, but I am advised are relevant and

> significant to those involved in the cerebral palsy field, but those improvements were identical statistically in the group that received the sham control treatment and the active hyperbaric treatment. So the interpretation of this Collet study has been varied. Most people agree that it demonstrates there's no justification for putting children into a hyperbaric chamber for cerebral palsy because the risks and costs associated with that, and that if there is some acceleration of their development available, it could be much more easily provided by either just the stimulating environment, or a small increase in oxygen for the 45 minutes to two hours, depending on what dose you believe in as a practitioner, which could be done with a face mask or nasal prong administration very easily. Now, of those two theories of why it might have produced some benefit, nearly all the expert opinions that I read lean towards it being a participation effect or the stimulation effect of people attending and going through this quite unusual experience of coming to the hospital, having expert paediatric neurologists assess them, interacting with hospital staff, travelling each day, something special happening in their life, and then each day culminating with actually going in the chamber, having to adjust your ears to the pressure change, the noise, the sound, the whole environment and this has been a stimulating environment for them, and therefore has assisted their development. But because there was no difference between the outcomes in the control sham treatment group and the active hyperbaric treatment group, the consensus is that you therefore have proof of lack of effect of hyperbaric oxygen specifically, even though the children did benefit from the participation.

49 In Dr Millar's written evidence [Tribunal Book p 660], he makes it clear that:

> It is not reasonable for any adult cerebral palsy patient to expect any significant improvement. To the best of my knowledge, this opinion would be shared by all of my colleagues working in hospital based hyperbaric chambers around Australia.

50 Dr Millar [Transcript p 416] elaborated on this statement by saying that his opinion was principally based on the Collet study and a number of other studies which have produced very similar results in slightly related areas like autism and brain injury. He also stated that hyperbaric oxygen treatment is less likely to work with adults than children with brain injury. He stated:

> The general awareness of the general principle that neurological recovery, neuroplasticity, in other words the ability of the brain to adapt and develop change and repair itself, is much stronger in children, particularly children under three or four years old, than it is in adults. So as a general principle, with respect to brain recovery particularly or brain response to treatment, we have in clinical medicine demonstrated that you can get improvements pretty much until the day you die but it's harder and you get less improvement the older you get. So that you would expect that any improvement was

> less likely in an adult with stable neurological situation than it would be in a child. So if the best clinical research has said that there's no net benefit in a child, you would expect less benefit than that in an adult.

51 The view expressed by Dr Millar, by and large, was accepted by both Dr Bennett and Dr Churchyard, an experienced neurologist, who gave evidence in this proceeding.

52 As previously stated, Dr Churchyard was of the view that HBOT was not helpful in treating adults with neurological problems, including cerebral palsy.

53 Dr Marois gave evidence by telephone from Montreal Canada. He is a medical doctor specialising in physical medicine and rehabilitation, paediatrics and that children with cerebral palsy is his main practice. He believes HBOT can ameliorate conditions such as cerebral palsy. He stated that HBOT can revive certain parts of the brain (cells). He stated that HBOT can cause revival of adult brain cells as well as those of children. He stated [Transcript pp 2102/3]:

> I have young adults that …, are 22, 24, 25 years old, and they were – they tried a treatment --- I've seen change even that late, so even with adults --- we have not seen that money (many), probably just about 20.

54 In order to conclude that HBOT had benefited cerebral palsy patients, Dr Marois relied, in part, on evidence produced by a scan known as a SPECT scan. However, when Dr Millar gave evidence, he suggested SPECT scans were of little or no value. He stated [Transcript 545]:

> … SPECT scans proved to have virtually no correlation with clinical benefit, so the fact that the SPECT scan was suggested to show an improvement in brain blood flow and metabolism didn't seem to be of particular relevance as an outcome or as a measure or dose of therapy or anything else. So the particular use of SPECT scans --- has died away in favour of – the most recent developments are functional MRI's. And SPECT scans have fallen out of favour in general.

55 Dr Marois gave evidence that originally the Collet study was to have 3 groups, the 3rd group being not exposed to hyperbaric pressure, however this group was not proceeded with. At Transcript 2100, Dr Marois when commenting on not proceeding with the use of the 3rd group, stated:

> Unfortunately, when the government decided to subsidise the research they … we decided the … to rule (out) the control group.

This was seen by the respondent as political interference. On behalf of the respondent, Mr Little stated, at [125] of his submissions:

> It's the critical case relied upon by the applicant to show the 'charlatan style' nature of the respondent's sham treatments, the Collet study morphed into a form of political football with the Canadian government appointing its own man. Collet, a non-research scientist to control the trial and its publishing conclusions. The evidence of

> Marois the Senior Clinician, noted the government appointed Collet changed the design methodology which led to the controversy by removing the actual control group, which was to be the third group, cerebral palsy clinical trial precedent, the politics of that government intervention with scientific trial method.

This is an example of the respondent making submissions that do not accord with the evidence and making assumptions which the evidence did not permit.

56 The respondent's witness, Dr Stoller, agreed that just because HBOT works on children with neurological problems, it would not necessarily work on adults. At [Transcript p 2050] he stated:

> … because therapy (HBOT) works on one age group doesn't mean it's going to work the same in another age group …
>
> … you have described neuroplasticity, which is very present in young children, five and under, and there's no question that the sooner you can treat such an assault to the brain the greater the possibility of improving the results from having so treated. So you will not get argument from me on that point.

The respondent submitted that the respondent's witnesses should be preferred to those of the applicant because:

(a) Dr Steenblock had had clinical experience in using HBOT to prepare patient for stem cell therapy;

(b) they had clinical or research experience using HBOT (Drs Steenblock, Stoller, Marois and Patritti);

(c) they have had clinical experience treating or researching using HBOT in respect of various medical conditions referred to in Allegation 7 (Drs Steenblock, Stoller and Ewer); and

(d) Dr Carda failed to publish outcomes or findings relating to Lokomat.

Drs Millar, Bennett, Churchyard and Carda are widely respected in their various fields. Drs Millar and Bennett are members of the peak HBOT bodies both in Australia and USA. Dr Churchyard has practised as a neurologist for many years and displayed a thorough understanding of neurological matters. Dr Carda was an expert in physical medicine and has used and thoroughly understood the Lokomat. The respondent's witnesses appeared less reliable and did not belong to peak professional bodies. They were, by and large, champions and/or enthusiasts for their cause. Further, the professional bodies to which they belonged were fringe bodies of which comment is made elsewhere herein. Further, their assertions were based on evidence on the second and third bottom layers of the evidence hierarchy. It is also suggested by the respondent that Dr Millar's evidence is coloured because his Alfred Hospital HBO chamber is in competition with HyperMED. This submission is not supported by the evidence and was not squarely put to Dr Millar in cross-examination.

57 The conclusion in the Collet study has had a number of detractors. They argue that, over a longer period of time, there was a greater difference between the sham group and the group that actually received hyperbaric oxygen. Further, they say that the sham group received 1.3 ATA which is likely to have had a positive effect on those children. Supporting this view is Dr Stoller and Dr Marois. In relation to these two individuals, Dr Millar, asserted that they both appear to be convinced to the benefits of hyperbaric oxygen and it is therefore clear that their views are subject to bias. Dr Millar stated that neither Dr Stoller nor Dr Marois appear to be independent, neutral experts on the subject of whether hyperbaric oxygen is or is not appropriate for the management of cerebral palsy, given their publications and practice patterns. We agree with Dr Millar's comments.

58 There was evidence called by the applicant which strongly suggested that neither stem cell therapy by itself nor stem cell therapy with HBOT would assist a patient suffering from cerebral palsy. Dr Churchyard [Transcript p 785] made the following points:

(a) There is no evidence for cerebral palsy or any other neurological disorder that stem cell therapy is efficacious. There have been no trials.

(b) There is no evidence that hyperbaric oxygen therapy would activate stem cells. And, as I said, there's no evidence that stem cell therapy of whatever type has any effect on any neurological disorder.

(c) There is no potential to use activated stem cells from other parts of the body (eg behind the knee) to assist the brain. It would be very difficult to see how an activated stem cell could cross the blood-brain barrier.

59 Dr Hooper also relied on a paper by Senechal, Larivee, Richard and Marois published in the journal of American Physicians and Surgeons, Winter 2007 edition. Dr Millar dismissed this article on the basis that it was published by a 'politically active group advocating against what is seen as government interference in US medical practice, with specific campaigns against the current "Obama Care" arrangements and supporting what would generally be considered right-wing views on personal responsibility'. Dr Hooper also relied on writings by Professor Thoms to demonstrate a stem cell shower once the stem cells became activated they remained for a considerable period of time. (Professor Thoms using animal research concluded that HBOT mobilized stem cells by increasing synthesis of the nitric oxide molecules in the bone marrow which in turn triggered enzymes that encourage cell release). Dr Hooper said that the showers would be likely to assist cerebral palsy sufferers and QS in his treatment at SRI. Dr Millar pointed out that animal research could not be relied upon when it came to neurological problems in humans, because the animal brain was very different to that of humans. We agree with Dr Millar's views.

60 Dr Hooper relied on his clinical experience for treating adult cerebral palsy patients with HBOT. Prior to QS becoming Dr Hooper's patient, Dr Hooper had treated two other adults with cerebral palsy. He described these patients at p 1581 of the Transcript. He referred to patient "S", a 30 year old man with cerebral palsy. Patient "S" had a disc problem in his cervical spine. He was treated for the disc problem with HBOT. After the HBOT, "S" found there was improvement in his mobility, balance, circulation, speech and spasticity. Dr Hooper also referred to Patient "C" [Transcript p 1585]. "C" was a 63-64 year old woman with cerebral palsy who came to Dr Hooper complaining of a very sore neck. After HBOT, she had what Dr Hooper described as good changes in her balance, gait and involuntary reflexes. The difficulty is neither of these patients was able to demonstrate any change as a result of HBOT by any objective standard. Further, they were single patients in a non-controlled situation. At best, these two patients are a very small number and anecdotal. At Transcript 409, Dr Millar stated that while anecdotal impressions are sometimes useful, they are a very unreliable guide to what the truth will turn out to be.

61 It is also noted that the premier hyperbaric body in the world, being the Underwater Hyperbaric Medical Society (UHMS) of the United States, does not support the use of hyperbaric treatment for cerebral palsy. The view is shared by ANZHMG, ANZSIGAHM and the European consensus. We realise that there are other less well known organisations in the world that do give such support, but we accept the evidence of Dr Millar that they are but fringe organisations. One of those bodies is the International Hyperbaric Medical Association (IHMA) of which Dr Stoller, a physician from the USA, is President. It was clear from answers Dr Stoller gave in cross-examination that IHMA was established to promote the use of HBOT and secure government funding for that treatment. Further, Dr Stoller agreed that UHMS 'is the primary source of hyperbaric medicine physiology worldwide' [Transcript p 2033]. Given these circumstances, we accept that the hyperbaric use for treatment of cerebral palsy in children or adults is certainly not mainstream medicine. And, as far as adults are concerned, it is less likely to be efficacious. However, having said that, it still may be in the future after further trials, that there may be some proof that hyperbaric treatment for cerebral palsy is a proper treatment. This is not to say that if a patient is apprised of mainstream views, treatment of HBOT should be withheld. Having taken this view, we have formed the view that Dr Hooper should have emphasised to QS prior to the commencement of treatment, that there is a large body of respected evidence which would suggest that hyperbaric treatment would not be of assistance to him. This was neither emphasised to QS verbally nor in writing, nor evident on the Hyperbaric website save for the odd reference contrary to the use of HBOT.

Efficaciousness of Lokomat treatment

62 Like with HBOT, there is controversy over whether Lokomat treatment for cerebral palsy sufferers is appropriate. There also appears to be a strong body of evidence that would suggest that even if the Lokomat treatment is appropriate, a warning should be given to patients that there is a strong body of evidence which suggests that it is inappropriate.

63 At paragraph 50 of the respondent's first written statement, he refers to the rationale for the use of Lokomat treatment with cerebral palsy patients. He there states:

> There can be dominant learned non-use nerve cells which Lokomat and HBOT can assist. The recommendation was based on the opinion that HBOT acts as a catalyst effectively fuelling the body and brain to then enable the effects and benefits of Lokomat to be greater realised. As referred to in an article from the journal of the American Heart Association …. 'Lokomat training improves daily stepping activity and gait efficiency in individuals post-stroke, who have reached a 'plateau' in recovery'. Since CP is in effect caused as a result of infantile stroke, this article was relevant. The HBOT is done first to fuel the body to assist in the Lokomat.
>
> MNS is used whilst on the Lokomat and helps with the process neuroplasticity, being the ability of the brain and the spinal cord to re-learn in functionality. In conjunction, these help improve the re-training, specifically reduction of spasticity, gait, posture (therefore reducing back pain) and long term spinal functionality.

64 The treatment pursued with QS on the Lokomat by Dr Hooper was initially many hours of what Dr Hooper described as 'air-walking', that is, his feet were not touching the treadmill. He was then lowered to the treadmill where his toes would touch the treadmill and eventually his heel would touch the treadmill and he would walk in a toe to heel motion. That is, walk on the treadmill of the Lokomat machine.

65 Dr Hodgson, QS's GP, gave evidence that since 2004, QS's overground walking had improved considerably, and while that improvement continued during the treatment QS had with Dr Hooper, in Dr Hodgson's view, that improvement would have continued with or without Dr Hooper's treatment. Dr Hodgson stated [Transcript p 300]:

> It was my opinion then, and still is today, that I believe his (QS) improvement was due to his perseverance and practice, and not due to any outside influence.

66 Dr Hooper relied on a large amount of data that the Lokomat's computers produced in order to demonstrate the advantage of the Lokomat treatment to QS, and also showing QS's progress particularly in relation to gait movement, and range of movement generally, the distance that he was able to walk on the Lokomat and the force and speed that he was able to walk with.

67 Dr Carda who gave evidence from Switzerland, is a specialist in physical medicine, rehabilitation with a special interest in neurological rehabilitation and the holder of a PhD in neuro-rehabilitation, said that the Lokomat data is of little use in assessing the patient. Because, to use lay person's terms, it is the machine that is doing the work and not the patient. It was suggested by both Dr Carda and Professor Dodd that the proper way to assess the patient in QS's position, was by testing his ability with overground walking, that is, walking without the benefit of the machine. In an exchange between Dr Freckelton and Dr Carda, Dr Freckelton asked [Transcript p 876]:

> By your having looked at the patient records and at the statistical data printed out from the Lokomat, and that the summary provided by Dr Hooper, are you able to tell anything about whether the patient has improved, deteriorated or stayed the same during approximately 70 sessions on the Lokomat?

Dr Carda answered:

> That's to say the data is … that varies during the time, but this does not mean that the patient has varied during the time. That's the main problem with L walk data. So we can – data can vary because we train the patient differently, but they don't say anything about what the patient does. That would remain a rehabilitation … a modification.

Dr Carda also said that his experiences with the Lokomat were quite disappointing and that he does not use the machine any more.

68 In Dr Carda's witness statement dated 16 October 2012, he makes the point that the data printout from the Lokomat was:

> not pertinent to measure any improvement in patient gait …. Furthermore, there is no way to understand from such a report if the treadmill speed, angular speed of joints and unloading has improved due to the patient's amelioration or only are due to different choice of the operator.
>
> LWALK parameters that are presented here can be used to improve the set up and to provide a feed-back to the practitioner during treatment, but they have never been accepted as an outcome measure or to show the patient's improvement, at least in scientific literature …
>
> LWALK parameters are not an adequate measure of muscle tone reduction …
>
> Lokomat's software has a feature (L-STIFF) that is aimed to measure muscle stiffness but this measurement is not currently validated in both clinical practice and research …
>
> So, saying that the L-WALK parameters one may measure an improvement in muscle spasticity is, to my knowledge, misleading.
>
> Improvement in the Notifier's gait could have been easily measured with commonly accepted measure of gait function: gait speed (for example measuring speed with the 10 metre walking test) and with measures of participation …

> In my opinion, to assess the improvement with Lokomat therapy, a clinician should utilise clinical and instrumental measures first. Lokomat data can be utilised as a complementary measure but they are not enough for an appropriate judgement.

69 Dr Hooper also relied on a number of written works to support the use of Lokomat treatment. It is impractical for us to deal with each of the works that the respondent relied upon. However, we will deal with the most important.

70 Dr Hooper referred us to an article entitled 'Robotic-Assisted Treadmill Therapy Improved Walking and Standing Performance in Children and Adolescents with Cerebral Palsy' by Ingo Borggraefe et al published in the official journal of the European Paediatric Neurology Society. At p 501 of the article, it was stated:

> In summary, robotic assisted treadmill therapy was easily performed in an outpatient setting in 20 patients with cerebral palsy without any undesirable side effects and results in improved standing and walking performance. The improvement in gait parameters indicates that the paradigm of task specific learning is adaptable to children with CP (cerebral palsy) secondary to congenital brain injury who have never learned a normal physiological gait pattern. Appreciable change in motor performance after participation in a relatively short program of robotic assisted treadmill therapy can be achieved. The severity of motor impairment affects the treatment outcome.

71 Dr Carda made the following comment in relation to Borggraefe's article:

(a) The group that participated in the study to which the article referred was a relatively small group of 20 people without a control group.

Dr Carda suggested that this meant that the article had a big bias because a lot of therapies that work well in studies with evidence from the group but when 'we use a control group the treatment does not work'.

(b) The patients had different ability prior to the treatment being commenced.

Dr Carda said in relation to this point, 'it means that patients in group 1 or 2 are patients that walk. They walk without aid or without crutches or some aid but usually they don't. … Function measure of 1 inches. Group 3 and 4 are patients that each rely mainly … wheelchairs and they can, in the Group 3, sticks for walking in groups and in Group 4 they are usually in wheelchairs or … patients'. [Transcript p 1241].

(c) there was a short training period of only three weeks.

(d) there was no follow up.

72 Further, it should be noted that the patients referred to in the article were children and not adults. And as we have previously mentioned in relation to HBOT, with a neurological problem such as cerebral palsy, there is a big

difference between children and adults. That is, adults are far less likely to react positively to treatment than children. The same applies to Lokomat treatment. At Transcript 623, Dr Hooper was cross-examining Professor Dodd as to whether reasoning applied to children in the Lokomat treatment would also apply to adults. Professor Dodd answered:

> I would be cautious. As I said to you before, I believe that there could be some capacity to have some motor learning, but this – these are individuals, adults with cerebral palsy, who have had the condition since birth. They have never known how to move in a normal way. Their systems that they require for function have had to develop in the context of that abnormality, and therefore the ability to change all of those symptoms using the treatment when they are 30 odd, I would take with a great deal of caution. There's a possibility of improving somebody a little. I am not sure how much. It depends on how severe they are.

Later, in relation to a question from Dr Waterhouse, where problems have been caused by stroke, and whether the results may be variable based on the location of the stroke and the part of the brain that has been damaged. Professor Dodd stated:

> And that was my point about the different sorts of cerebral palsy and the different ways that it expresses itself. And with a brain damage they can [sic] sensory problems, all sorts of problems, not just motor problems.

73 The respondent referred to a study by Andreas Mayr, 'Blinded Randomised Control, study of gait rehabilitation in stroke' published in 2007. The conclusion of the paper stated as follows:

> Despite the small number of patients, the present data suggest that the Lokomat robotic assistive device provides innovative possibilities for gait training in stroke rehabilitation while eliminating prolonged repetitive movements in a nonergonomic position on the part of the physical therapist.

74 It is clear from the article itself [p 313], that there are considerable limitations to the study. It is there written:

> Limitations of the Lokomat become evident in later stages of rehabilitation. Movements required for functional walking depend on interactions between perception and motor ability, as well as between the individual task, and environment. The Lokomat cannot provide the variable environments and movement patterns necessary for adaptation to daily living. Early application of Lokomat training can only rehearse a mechanical pattern, as a prerequisite for independent walking.

75 In commenting on the above quotation, Dr Carda stated [Transcript p 1243]:

> It says that one of the problem with such is written is that you train a patient in an environment that is not natural, because walking is not

> only moving the legs, but is knowing where we have to go – knowing what we have to do. This tends to differ … to different … balancing … moving the legs is a … that is not walking.

76 The respondent also relied on an article by Benjamin Patritti published in 2010 in the American Academy of Physical Medicine and Rehabilitation. The name of the article was 'Robotic Gait Training in an Adult with Cerebral Palsy: A Case Report'. Dr Patritti also gave evidence before the Tribunal. In the extract at the commencement of the article it is stated:

> This case study reports on the outcomes of a 6-week intervention of robotic-assisted gait training administered to a 52-year-old woman with right hemiplegia attributable to CP. Improvements were noted in balance, walking speed, and time to negotiate stairs at post training and follow-up. Gait analysis showed an increase in step length and a reduction in the period of double support. In conclusion, robotic-assisted gait training may be beneficial in enhancing locomotor function in adults with CP.

77 The difficulty with this study was pointed out by Professor Dodd in that it was only one subject and the subject may have improved with on-ground walking training in any event. Further, Professor Dodd stated that the subject of the study was suffering right hemiplegia which meant that her cerebral palsy affected only the right side of her body. She also made the point that people with hemiplegia walk reasonably well, 'because of course they have one very good functioning part of their body so they're – there's very different sorts of cerebral palsy. This is a very specific sort of cerebral palsy. So the point is that this is a single study and therefore it's hard to generalise it from it. It's also not a blinded study'. [Transcript p 562].

78 In the end, Professor Dodd concluded that the article was no more than theory.

79 Thus, it would seem that it is very difficult for any clinician to recommend Lokomat treatment to somebody in QS's position, without pointing out to that person that various considerable doubt as to whether such treatment would, in any way, be advantageous and that person may be better off spending the time and effort in training in overground walking with the assistance of crutches, stick or frame rather than Lokomat treatment.

Informed Consent

80 We are satisfied that QS did not give any consent to the treatment in writing. (The respondent suggested the signed consent form may have been removed from his file). In relation to oral consent, there were discussions between QS and Dr Hooper about the nature of the treatment and QS had done his own research as well as research on the HyperMED website. 'Informed Consent' is referred to in the Chiropractors Registration Board of Victoria Standards and Practice Code of Professional Conduct October 2007. That code refers to 'Informed Consent' in the following terms:

Informed Consent

Informed consent supports an open, patient-centered approach. Consent is defined as legal permission to proceed with an agreed course of action. Consent is granted by a legally competent adult for themselves, or as a parent or guardian. Informed consent requires that the person consenting receives all the information that a reasonable person in the same circumstances would require in order to make a decision, including alternative options and having the practitioner respond to any reasonable requests for additional information regarding the matter.

If the patient is unable to give informed consent, appropriate steps must be taken to have a guardian appointed for the patient in accordance with current legislation. For further information, refer to the Boards code on *Informed Consent.*

A Practitioner should:

a) Content themselves that the person consenting understands the information presented. Language and literacy barriers must be addressed.

b) Ensure that no duress is employed in the consent process.

c) Obtain consent verbally or preferably in writing. There should be documented evidence of such consent for chiropractic services.

d) Honour the right of the patient either to consent, or refuse to consent, to participate in chiropractic services.

e) Provide adequate information on the specific nature of the services being provided, both initially, and on an on-going basis. The practitioner, before commencing examination or treatment, should ensure that the patient understands to a reasonable level and appreciates:

- The purpose of any testing/assessment, and how the results will be used, prior to its administration.
- The nature and purpose of the treatment/service to be provided.
- The expected benefits and limitations of the treatment/service.
- The material effects, risks and side effects of the treatment service.
- Any alternative treatment or courses of action that might reasonably be considered.
- The likely consequences of not undertaking the treatment/service.

f) Comply with relevant current legislation, and adhere to the principles of informed consent for all chiropractic services provided to the patient.

81 In relation to paragraph (e), Professor Terrett who is a chiropractor, having practised for many years and is an Associate Professor at RMIT University, described the word 'adequate' as used in paragraph (e) of the Code set out above to mean that the information is understandable by the patient for the purpose of making decisions on whether to have treatment or whether to continue the treatment. '"Adequate" to me seems to imply that the patient understands'.

82 Further, Professor Terrett also said that the practitioner must use language which the patient understands.

83 Dr Freckelton asked Dr Terrett what information the patient should have in non-mainstream treatments. Dr Freckelton asked Dr Terrett [Transcript p 1445]:

> In the patient's decision-making about whether or not to have the treatment, what kind of information do they need to be armed with in order to make that informed decision, if it's non-mainstream: right out of the ordinary area of chiropractic services?

Dr Terrett responded:

> Well, the person may find the treatment offensive. There's lots of reasons why a patient might choose not to have the treatment because of the nature of the treatment. It might be offensive and offend them for some reason. It might be too expensive. It might be too painful. Some people might say, 'I choose not to have that treatment because it is painful. Can you provide some other form of treatment?'. The nature of the treatment might be the person says, 'This is a very very gentle approach, but it will require twice the number of visits'. The person needs to know the nature of the treatment so again, they can make that decision: 'I either choose to have the treatment, or I choose not to have the treatment'.

84 In relation to the benefits that a patient should expect to receive from the treatment, Dr Terrett said [Transcript p 1445 ff]:

> To be truly informed consent, the patient should be given information like the practitioner might say, 'In cases that I have had similar to this', or, 'In cases similar to yours which have been published in the literature, it has been found that with this treatment, you know, large percentage of the people have a good response and because you're part of that group, I will expect that we will give you a short trial and that – expect that you have should a reasonable result here'.
>
> …
>
> But a patient can still consent to a treatment knowing that there is no strong evidence for that treatment, but that should be disclosed to the patient if that is the case.

85 On being asked by Dr Freckelton what kind of consent is there if that kind of information is not imparted to the patient, Dr Terrett said:

> Then it is not fully informed consent.

> … people can only make informed consent if they have access to enough information on which to make a decision to give their consent.

86 Then, Dr Freckelton asked Dr Terrett a number of questions about ethical matters [Transcript pp 1446 and 1447]. Those questions and answers are as follows:

> On the ethical principles? --- Well, the patient – in that particular case, the practitioner involved will be making over-claims for the treatment, which is not borne out by evidence.
>
> Why does that matter? --- Because a patient is a vulnerable person who can be taken advantage of if they're not given truthful information. We're talking about a person whose – ill people are vulnerable to be taken advantage of and therefore they have to be given truthful information.
>
> What if they've got conditions like multiple sclerosis or Parkinson's or cerebral palsy or hepatitis, diabetes; where do they fit in the spectrum? You've just been referring to vulnerabilities ---? --- Well, a lot of these people are desperate and a lot – if you've got multiple sclerosis or Parkinson's disease, a lot of these people are desperate because medicine doesn't offer much. Either they've got multiple sclerosis and they've been given no hope or they're not responding any longer to the Parkinson's disease – to their medication, rather. A lot of these people look for somebody, anybody who offers hope, and so they are vulnerable people to all sort of suggestions, all sorts of ---
>
> And so if they're given hope on the basis of an – of the creation of an unreasonable expectation of beneficial treatment, what are the ethical principles involved then? --- If they have been given unrealistic expectation ---
>
> Yes? --- then they they're making decision not based on all the evidence or reasonable evidence, and therefore they can't give truly informed consent.
>
> And what's the view of the chiropractic profession about a practitioner who facilitates that form of decision-making by a patient? --- Well, once again?
>
> What is the view of the chiropractic profession about a practitioner who facilitates the making of decisions to submit to treatment by a patient when they have been given unrealistic expectations about the likelihood of a positive outcome to the treatment?
>
> …
>
> …Thank you? --- I can't give a comment on behalf of the whole chiropractic profession, but it certainly – it would be seen by most practitioners, I think, that it would be something that would certainly bring the profession into disrepute and certainly wouldn't be encouraged.

87 We also refer to the statement by Professor Dodd referred to above where she says that it would be difficult for any lay person to understand the

articles on the HyperMED website and QS did not have a proper appreciation or knowledge about the facts that the Lokomat would not give him the benefit promised by the respondent or that there was a strong body of opinion that did not support the use of the Lokomat for adult cerebral palsy.

Adequacy of Notes, Assessment and Monitoring Treatment and Modification of Treatment

88 The notes prepared by the respondent or his organisation have dates of each of the attendances of QS and states the number of minutes that QS spent on each apparatus on those particular attendances. They refer to some initial discussions and occasionally a comment. For example, in August 2007, it said:

> 1st day Loko. Doing well. Coping the speed. Spasticity present in both legs – body structure arhythmical.

There are then a few other comments spasmodically through the notes. For example, in around October 2007, it states:

> Had a chat with QS regarding his financial support. Parents and uncles are wealthy but don't want to support him. Don't know how he will bring up-to-date!!

On 18 October 2007, there is another comment:

> Observation: Moving his legs better and QS said he has more fluidity now than before after doing Lokomat.

In November 2007, there is a further note about payments as there is in December 2007 and a further note about that between February and March 2008.

89 In relation to the records, on 31 August 2010, Assoc Professor Ebrall, who worked at RMIT University stated [Tribunal Book p 926]:

> In my opinion the records of QS as provided to me do not meet a reasonable test of being an appropriate patient record expected of a registered chiropractor.

90 Professor Terrett said [Transcript p 1448] that most chiropractic practitioners have good records and agreed with Dr Freckelton that there is an obligation to generate such records, generic irrespective of the particular kind of treatment and modality being provided.

91 Dr Hooper, to a large extent, relied on conversations he had with QS, but it is somewhat unclear because of lack of written records as to what extent those conversations were.

92 What is clear is that the notes written at the HyperMED clinic were very sparse indeed. It is impossible to determine from those notes as to what the initial assessment of QS was, what if any was the supervision of his treatment, whether there was a treatment plan and whether at any time the treatment was modified. Save and except that between November 2007 and

January 2008, when QS had completed the treatment first flagged in relation to both HBOT and Lokomat treatment, further treatments were prescribed by Dr Hooper. However, it does not appear that any real assessment took place at that time.

93 In initially assessing QS, Dr Hooper was given the benefit of a number of medical reports that QS had in his possession from the Children's Hospital from a number of years previous and also two reports of Dr Rawicki, the neurologist. He was also given the CT scan that Dr Hodgson ordered for inspection by the SRI. Dr Hooper did not believe that the CT scan was adequate and thus ordered an MRI scan. However, he treated QS for approximately two weeks before seeing the results of that scan. Dr Millar and Dr Churchyard expressed the view that an MRI scan was not useful in assessing a cerebral palsy patient's suitability for HBOT.

94 The applicant makes some criticism of Dr Hooper for not contacting QS's health practitioners, in particular Dr Hodgson, the GP. However, at paragraph 7 of Professor Terrett's witness statement, he states:

> In my opinion and based on the information provided to me, Dr Hooper, as a registered chiropractor, did not need to have communicated with the Notifier's treating health practitioner/s prior to or during the course of treatment.

That appears to be a definitive statement.

95 QS initially saw Dr Hooper as a result of a conversation he had had with the SRI who had told him that hyperbaric oxygen would be good to stimulate his stem cells. It is noted that given these circumstances, it is somewhat surprising that Dr Hooper did not contact Dr Steenblock or one of his employees in order to ascertain what exactly was required. Further, it is mystifying to understand how stem cell therapy could have been useful at this particular time bearing in mind that it was unclear when and if at all QS would have attended the Steenblock institute. Dr Millar noted that stem cells that become activated as a result of HBOT only remain active for a relatively short period of hours, and occasionally a few days. However, he did say that HBOT can make the bone marrow more amenable to stimulation for stem cells.

96 Dr Bennett's oral evidence is similar to Dr Millar. He made the following points [Transcript p 953 ff]:

(a) … there is no indication that I am aware of that the mechanism of activated stem cells getting into the brain and helping to repair an injury that may have been present for 20, 30 or 40 years is a likely one to be true; …

(b) … once given hyperbaric, there is a short period where the number of stem cells is (active) (the short period is hours to days) …

(c) So intervening within that short window might have no logic to it, but after that period the stem cell shower, if you will, has

> subsided and the stem cells are residing elsewhere or re-accumulated in the bone marrow and any introduction at that point would seem to be influenced by the hyperbaric …

97 Dr Hooper denied there was only a short window of opportunity to transfuse stem cells after QS's own stem cells were activated. However, Dr Hooper's own witness, Dr Ewer, a specialist in physical medicine from New Zealand, only went so far as to say: 'there were effects of stem cell production and new cell growth up to 28 days following the treatment …' [Transcript p 2122]. In cross-examination, when asked about a 25 patient study where there had been stem cell therapy subsequent to HBOT, Dr Ewer said the time between the HBOT and stem cell therapy was '… 2 or 3 days' [Transcript p 2127].

98 Dr Hooper said in evidence that he had no responsibility to tell QS when he was ready for stem cell therapy in spite of treating him in order to prepare him for that treatment and later to improve his functionality. Further, he said he would not tell a patient to stop treatment unless that patient was non-compliant. He said it is up to the patient (including QS) when to stop. This would even be the case if there was no improvement in the patient's condition. In other words, the lay patient was meant to know when it was appropriate to stop the treatment or the treatment had completed its purpose [Transcript p 1709 ff].

99 While there were conversations as to QS's progress with Dr Hooper, there does not appear to be any suggestion that Dr Hooper tried QS out on overground walking. One would have thought that such a trial was important in order to assess the success or otherwise of treatment given. Nor does Dr Hooper appear to have performed any objective assessment either before or during the treatment. Dr Hooper said he observed QS in his rooms.

100 Also in relation to the question of notes, Professor Ebrall, a chiropractor, criticised Dr Hooper for not recording subjective findings, objective findings, assessment and plans (SOAP). At p 925 of his statement, the Professor stated:

> I am provided with what may be considered as a contemporaneous record of practitioner/patient interaction but find it is not in the expected format of SOAP notes notwithstanding the printed words Subjective, Objective Assessment and Plans as a header. I find there is very little subjective opinion from the patient, very few objective findings of the practitioner, some notes that may be accepted as documenting a clinical action or therapeutic intervention, and no real plan of how to better move forward.

101 Further, Professor Ebrall noted that there is no record of the technical parameters of the hyperbaric treatment.

102 Professor Ebrall commented on what the Chiropractic Board would consider proper as an assessment in the following terms [p 925 of his statement]:

> Precedent is established through previous findings of the Chiropractors Registration Board of Victoria that the conduct of chiropractic practice requires a history of the patient complaint, a record of the physical assessment of the patient including vital signs and a systems review, a working diagnosis, a management plan, and a contemporaneous record of practitioner/patient interaction, typically in the form of SOAP notes where a subjective opinion from the patient is recorded, the objective findings of the practitioner are recorded, an action or therapeutic intervention is documented, and a plan to move forward is recorded.

103 The respondent relied on Dr Millar's evidence at Transcript 682 and, in particular, Dr Millar agreeing that when his patients attend for HBOT (at the Alfred Hospital) it is not normal to take SOAP notes on every occasion. Dr Hooper, commenting on the notes taken for HBOT patients at the Alfred Hospital stated, at Transcript 628:

> The notes are often construed by the habits of the institution in the formats in which you record them. … Notes vary between very brief and just say, 'Hyperbaric treatment occurred on this day', though to a more detailed note if there is a complication, a concern, a more formal assessment of the patient. So notes may go anywhere from a few words, not dissimilar to what's present on your progress notes (HyperMED progress notes), only in our case electronically, through to perhaps half a page or a page of writing depending on the situation. But the latter would be comparatively rare. It is mostly a few lines or a few sentences only.

104 HyperMED is a different institution to the Alfred Hospital. HyperMED like most chiropractic clinics are primary healthcare providers. That is, usually, there has been no formal referral from a medical doctor or other practitioner. Patients tend to come off the street. Because of this factor, in our view, the notes that a chiropractor using the modalities engaged in by Dr Hooper need to be far more detailed in line with what has been described by Professor Ebrall above. This is particularly so when the treatment given is different from the tried and proven treatment normally given by chiropractors.

105 Professor Dodd commented on what she teaches her students in regard to taking notes. She agreed that her students were not taught to take SOAP notes on each and every occasion but they were taught, 'that they need to take notes and review'. Professor Dodd also stated that SOAP notes should be taken as a review.

106 At Transcript 625, Professor Dodd was asked by Dr Hooper:

> So in between commencement of the therapy for hydrotherapy and perhaps at an allocated time of reassessing patients are SOAP notes … required on each time the patient is attending?

To that question, Professor Dodd answered:

> We would teach our students that that would be the best practice.

107 Having regard to all these matters, we accept the views stated above and it is clear that while SOAP notes may not be required for every attendance of a patient, at a chiropractic clinic, where the treatment performed is unusual, as in this case, they are required initially and at regular reviews. Such notes were not taken.

108 In relation to the question of monitoring, Professor Terrett described Dr Hooper's documentation as poor. Professor Terrett said [p 951 of the applicant's Tribunal Book]:

> This [monitoring] could be as simple as asking the patient to grade their pain and or disability out of '10' when they first presented and tell them that '0' is pain and disability free; and have the patient tell us what their level of pain or disability is on each day. This could be recorded as a number out of 10, or marked by the patient on a Visual Analogue Scale (VAS).
>
> Another tool to monitor improvement is the Roland Morris Questionnaire, or the Modified Roland Morris Questionnaire (RM-18).
>
> It has been shown that these correlate well to the physical dimension of spinal problems (but do not compare well with the psychosocial dimensions). Research has shown this to be as valid as the lengthier Sickness-Index-Profile.
>
> In the clinical notes there are comments which suggest the Notifier was improving ('progressing well', 'moving his legs better', 'more flexibility now than before after doing Lokomat', 'doing well', 'spasticity less').
>
> Dr Hooper did mention that it would be the Notifier's feedback (as well as Lokomat information) that would be used to determine improvement, and these comments suggest clinical improvement.
>
> This is still poorly documented.

109 Further, Professor Terrett commented [at p 953 of the applicant's Tribunal Book], that the material provided to him did not show any measurable improvement in the Notifier's condition.

110 And further, Professor Terrett commented [at Transcript p 954] on the risks of failing to monitor a patient's condition during treatment, when he stated:

> Failure to monitor a patient during a course of treatment may lead to the practitioner being unaware that:

- The patient's condition is actually getting worse.
- Some new signs and symptoms may have appeared.
- Some other event has occurred in the patient's life which may affect the patient's condition; and/or
- The patient's condition is unchanged (not benefitting from treatment).

111 Professor Terrett also noted [p 955 of the applicant's Tribunal Book] that:

> The clinical notes do not describe:
>
> - The Notifier's disability.
> - Whether some limbs more than others (sic).
> - Whether the Notifier has involuntary movements.
> - Whether the Notifier has any intellectual disability.
> - Whether the Notifier has joint contractures.
> - Whether the Notifier has pain.
> - All these matters would seem to appear to be missing from the notes prepared by the HyperMED clinic.

112 All these matters would seem to appear to be missing from the notes prepared by the HyperMED clinic.

Evidence of Dr Perkoulidis

113 Dr Perkoulidis was called on behalf of the respondent to give evidence before the Tribunal. He stated that he had practised as a chiropractor for many years since 1983 but in the last few years he let his registration lapse due to illness. He is now in the process of seeking re-registration. He also has specialisation as a Fellow of the Australian College of Chiropractors and he is a certified chiropractic orthopaedist. Further, he has a diploma of medical education from the University of Dundee in Scotland Medical School. He is a former member of the Chiropractic Board of Victoria, serving in the 1990s.

114 Dr Perkoulidis' evidence was supportive of the respondent and he said that the respondent had done nothing wrong. He stated that a proper clinical assessment had been made of QS, and there had been a proper and adequate treatment plan as a result of that assessment. He also said that Dr Hooper had obtained proper informed consent from QS in relation to the treatment obtained for the Lokomat and HBOT. He deposed to the fact that a proper treatment plan had been prepared and that QS had been properly and adequately monitored. Dr Perkoulidis also stated that there was no obligation on Dr Hooper to inform QS or any other patient of other views as to the correctness or otherwise of the treatment that was being given by Dr Hooper. Dr Perkoulidis also referred to a number of matters on the respondent's website and said that they were all proper matters and gave

any potential patient a proper view of the efficacy of treatment that that patient may receive. In particular, Dr Perkoulidis said that the medical conditions referred to on the website whereby it was stated they could be treated by HBOT and Lokomat treatment were not, in any way misleading, or misrepresentative. Also, Dr Perkoulidis said that the file kept by Dr Hooper was quite proper and adequate.

115 In coming to the above conclusions, Dr Perkoulidis was full of praise for Dr Hooper, and condemned the applicant for commencing these proceedings. Dr Perkoulidis stated [Transcript p 1501]:

> Based on my experience as a board member, I find it highly irregular that this matter has even appeared before a tribunal. It's based on my experience that as a board member we would have reviewed the complaint, then considered whether investigations were necessary, and evaluated the nature of the complaint with respect to inviting the doctor and having a little mediation conference and finding out the basis of what these complaints were. My experience as a board member and a judicial member finds this – these proceedings highly irregular with respect to the board. I consider that mediation would have resulted in a more than adequate resolution of the entire matter, particularly when the complaint is basically about a patient not wanting to pay fees. So I find that a mediation conference would have saved the board a lot of time and expense and money, and if I was on the board and this sort of matter appeared before me, I would have debated it and voted against any form of prosecution, which I find highly irregular.

116 Dr Perkoulidis suggested [Transcript p 1503] that in Australia there was a continuing bias and phobia against the chiropractic profession by the medical profession with anything that may be medical. He said that in America they were a more 'enlightened species'.

117 Dr Perkoulidis stated [Transcript p 1504]:

> I find nothing whatsoever in Dr Hooper's practice that could be considered unreasonable at all. In fact, the nature of the patients and treatments that he was affording, he should be commended for his service to society, not anything else but that.

118 Dr Perkoulidis also stated that QS's complaint was spurious and misleading because of the circumstances in which it came about.

119 Dr Freckelton asked Dr Perkoulidis [Transcript p 1511]:

> I suggest to you, sir, that you are a complete advocate for Dr Hooper. What do you say about that? …
>
> I suggest to you sir, that you are trying to diminish my evidence because I am answering in a manner which doesn't suit the prosecution and you are trying to diminish the value of my evidence by thinking I'm some sort of devotee of Dr Hooper or complete and utter mindless supporter of him.

> And you deny that, do you? …
>
> Well, obviously, sir, I do otherwise I wouldn't be putting it to you, would I, in that way.

120 The manner in which Dr Perkoulidis gave his evidence was that of a complete advocate for Dr Hooper. It appeared to us by both the manner that Dr Perkoulidis gave his evidence and the contents of his evidence, that he was prepared to say anything that he thought would assist Dr Hooper. We did not gain the impression that Dr Perkoulidis was, in any way, an impartial expert, in fact, we gained the impression that he was totally biased in support of the respondent's case. We thus formed the view that Dr Perkoulidis' evidence was of no assistance to us in determining the issues that were before the Tribunal. This being the situation, we put Dr Perkoulidis' evidence to one side.

Evidence of Dr David Steenblock

121 Dr David Steenblock, who has been referred to earlier, gave evidence by telephone from the USA. He stated that he was an osteopathic physician practising in California. He commenced his evidence by confirming that his written report dated 1 October 2012 and the summary of his evidence, which was in the respondent's Tribunal Book, were true and correct. Both documents had reference to QS and the conversations QS had with Dr Steenblock. Those conversations were set out in some detail in the documents to which we have referred. However, in examination in chief by Dr Hooper when he was asked about these conversations, Dr Steenblock said: 'I really have no recollection of his [QS] conversation with me'. We took the view that this was an extraordinary statement bearing in mind that it was only in October 2012 that Dr Steenblock prepared his witness statement, and January 2013 in which the summary of evidence was prepared. Further, Dr Steenblock said that he did not have his notes or 'chart' as he put it, in relation to QS. Even though we appreciate that Dr Steenblock had just moved premises, we find it extraordinary that when he knew he was giving evidence in this matter that he would not have had the notes before him.

122 Dr Steenblock was asked by Dr Hooper the purpose of providing HBOT coupled with stem cell therapies. Dr Steenblock stated [Transcript p 1384]:

> Well, prior to hyperbaric, it activates stem cells, so that means it causes an increased amount of oxidated stress on those cells which causes the cells to have an internal signal that tells them internally that they have been slightly damaged and with that slight damage, it is enough to trigger their replication, and so by doing this treatment, we're inducing the cells to go into a cell cycle and start to proliferate and so as they start to proliferate, they become much more active and much more able to penetrate into the tissues and repair the tissues. After the stem cells have been given, the hyperbaric has been shown to enhance the angiogenesis and enhance the ability of the new blood

> vessels to grow out of the pre-existing capillaries and blood vessels into the ischemic penumbra.

123 Dr Steenblock also indicated that 35% of his patients were stroke victims. (Dr Hooper contended that QS's condition was as a result of a stroke caused in utero).

124 Dr Steenblock also gave detailed evidence of the use of hyperbaric oxygen in the USA in general and by him in particular.

125 Dr Hooper's examination in chief continued for the morning, although such examination in chief was punctuated by difficulties with the telephone line.

126 Soon after Dr Freckelton commenced his cross-examination, questions were asked of Dr Steenblock about difficulties relating to disciplinary proceedings he had had with his osteopathic association in California. He became quite agitated with these questions and began to demand from Dr Freckelton where he obtained his information. A number of questions were asked by Dr Steenblock of Dr Freckelton in that regard. At that point, the Tribunal warned Dr Steenblock that it was not his position to be asking questions of counsel for the applicant. Dr Steenblock then replied [Transcript p 1865]:

> I'm here – listen I'm volunteering. I'm not being paid one cent for this whole thing, and to be lied to about this kind of thing and not being able to talk is craziness, and why should I even put up with you folks at all, really. …
>
> Unless you're civil to me, there is no reason for me to continue this conversation. You are not being civil.

The Tribunal then said:

> There has been questions asked so far Dr Steenblock. The questions have certainly not been anything but civil, I would not have thought, and you're able to answer those questions, how you want to answer?

To which Dr Steenblock replied:

> Well, I've just been told I'm a liar.

Soon after the above exchange, Dr Steenblock put down the telephone. The matter was stood down for a short while to enable Dr Hooper to persuade Dr Steenblock to re-engage on the telephone, however Dr Hooper did not have any success.

As a result, the applicant, through its counsel, was not able to test the evidence of Dr Steenblock by cross-examination.

127 As a result of:

(a) the applicant's inability to test Dr Steenblock's evidence by cross-examination, and

(b) the fact that Dr Steenblock was unable to recall any conversations with QS, in spite of the fact that he had that day deposed to the fact

> that his written evidence was true and correct, which evidence included reference to such conversations;

Dr Steenblock's evidence should be treated with circumspection, and where it conflicts with other evidence that has veracity, that evidence should be accepted in preference to that of Dr Steenblock.

Credibility of respondent

128 Continually while the respondent was being cross-examined, or facing a question from the Tribunal, the respondent answered questions he wanted to answer rather than what was put to him. This happened on a number occasions in spite of several warnings by the Tribunal. We gained the impression that the respondent's conduct occurred in an attempt to avoid answering the question or to answer the question in a way that was helpful to the respondent's case.

129 Dr Hooper is a bankrupt and is still involved in bankruptcy proceedings seeking an annulment. He was being asked questions [Transcript p 1663] whether he had transferred shares in Melbourne Hyperbaric Pty Ltd to his wife. He replied:

> To the best of my knowledge, I would say no, I haven't transferred any shares across to my wife.

130 Later, Dr Freckelton showed the respondent a copy document from the Australian Securities and Investment Commission which showed that on 15 August 2012 the respondent's shares in that company had decreased to nil while the respondent's wife's shares in the company had increased from 1 to 2. The original of the document was purportedly signed by the respondent on 12 February 2013 whereby he certified that, 'the information in this form is true and complete'. On being asked to comment on the transfer of his share, the respondent said: 'I was the sole director of the company originally'. In our view, the respondent was trying to avoid answering the question that was put to him for reasons best known to himself.

131 During the hearing, the respondent made serious unsubstantiated allegations. In particular, Dr Hooper suggested that QS may be involved in criminality because Dr Hooper theorised that QS was accepting services from HyperMED while not intending to pay for such services [Transcript p 67]. This is a very serious allegation to make. There appears to be no substance to this allegation whatsoever.

132 Dr Hooper also suggested that the applicant was biased against him in favour of medical practitioners. In his opening address to the Tribunal, Dr Hooper posed rhetorical questions [Transcript p 69):

> Is the Board biased against Dr Hooper? Is the Board biased against me because he is different in his scope of practice? I have been practising – Dr Hooper, third party – I believe that that's acceptable in legal circles – Dr Hooper has been practising hyperbaric since 1996,

> surely ample time for the Board and its changing members over the years to visit and inspect the first non-hospital-based facility using the merits of hyperbaric in the treatment and management specifically for patients with complex neurological and orthopaedic conditions.

133 Dr Hooper stated as follows [Transcript p 71]:

> The real issue may be a concerned [sic] attempt to establish a precedent to disallow chiropractors from engaging in the said treatment (HBOT and Lokomat) so that medicine will maintain a monopoly, as well as continuing to limit and control the scope of practice of chiropractors and other healthcare professions.
>
> Political medicine wants to own the exclusive right to dispense and control the hyperbaric and Lokomat. Medicine wants to dominate the other professions and this trial of myself, I would suggest, is a cunning example of it being by using the Chiropractic Board to do its dirty work. Political medicine and its friends and advocates will use every legal tactic to destroy, to humiliate, to bankrupt and to eliminate Dr Hooper and the operation of HyperMED.

Dr Hooper then went on to criticise Dr Freckelton for his alleged personal support of the anti-chiropractic forces in relation to HBOT and Lokomat. It seems likely that Dr Hooper feels persecuted and attempts to blame others for his predicament. There is little or no evidence to support his allegations. It is an attempt by the respondent to absolve himself from responsibility for his actions.

134 Dr Hooper agreed [Transcript p 1666], that he believed there was a concerted attempt to establish a precedent to disallow chiropractors from engaging in the treatment of HBOT and Lokomat. When asked about whether Dr Hooper thought there was a conspiracy, he stated:

> I believe there are very, very strong forces of work there. Correct.

135 Dr Hooper was then asked who the parties were to the conspiracy and he suggested the national law. At that point we interrupted him and ordered him to answer the question. After further prompting from Dr Freckelton, Dr Hooper said:

> I believe that there is a very strong opposition for non-hospital based chambers not to flourish, nor exist.

Again, the Tribunal interrupted and ordered Dr Hooper to answer the question 'who are the parties to the conspiracy'. After the question had been put again by Dr Freckelton, Dr Hooper stated:

> The broader aspect of political medicine is a broad umbrella, and that was the reference that I was making.

136 It was then put to Dr Hooper that QS was a party to the conspiracy and he said:

> I certainly have no doubt that Mr QS, the notifier, is part to this process to avoid his debt.

On being asked again, who were the parties to the conspiracy, Dr Hooper then referred to political medicine, drug-orientated medicine and pharmaceutical companies. The Tribunal again ordered Dr Hooper to answer the question and say who were the conspirators. This pattern then continued for some time but Dr Hooper continued to refuse to name names. On suggestions from Dr Freckelton, he agreed that Dr Freckelton might be a conspirator, as well as elements within AHPRA, and elements within the Victorian Government Solicitor's Office.

137 We gained the impression from the respondent's refusal to answer questions as to who were his alleged conspirators that he was willing to make unsubstantiated allegations but not willing to back them up with any facts. In fact we believe he probably had no facts whatsoever to support those allegations.

138 When being cross-examined Dr Hooper was asked a general question about presenting to QS a balanced view from literature and peer-reviewed journals about the likely effectiveness or otherwise of HBOT and Lokomat treatment for cerebral palsy. Dr Hooper said he did give a balanced view and referred QS to two chapters in Professor Jain's book and a copy of the information pack [Transcript 1758]. He was then asked further questions relating to information given to QS. Dr Hooper's answer referred to his website and discussion with QS. However, it was not until Dr Hooper was asked 'Did you tell the notifier that the treatment you were proposing … is not advocated by a significant percentage of qualified practitioners in this country?' that Dr Hooper answered 'Yes' [Transcript 1759]. However, when it was pointed out that there was no such statement in the progress notes Dr Hooper agreed that he did not tell QS that the treatment was not advocated by those referred to. He then said he misunderstood the question. However, later on, the same page of Transcript [1759], Dr Hooper said that he did provide QS with a balanced view. We do not accept that Dr Hooper told QS that the proposed treatment was not advocated by a significant percentage of qualified practitioners in this country. Further, in an untitled document given to the Tribunal, as part of Dr Hooper's submission which was in chart form, dealing with Allegation 6, Dr Hooper referred to his answer saying that he did inform QS of the contrary opinions held, but failed to mention the other evidence to which we have referred. At page 21 of the same document, the respondent refers to Transcript 1761 and notes he told QS that treatment was not mainstream. However, the Transcript shows that when giving evidence Dr Hooper prevaricated as to how he told him the treatment was not mainstream and does not answer the question as to telling QS how long the upstream effect of the stem cells would last. [See Transcript 1763].

139 Taking all these matters into account, we have formed the view that Dr Hooper is a man who, on several occasions, attempted when giving evidence to deflect the real issues in the case to other matters which really were not in issue. We take this to mean that he had no real answer to many

of the allegations that were put against him. Also he was willing to make serious allegations against others when there was little or no substance to those allegations.

140 It is surprising that Dr Hooper did not know, or if he did know, did not tell QS, that the stimulation of stem cells that QS received from the HBOT would only be short lived. Dr Hooper [Transcript p 1706] was asked:

> Do you agree with what the witness (Dr Bennett) said in respect of treatment of a cerebral palsy patient with stem cell therapy, namely that your activation, to the extent you succeed in it, is going to last a short time – days, or at most weeks? --- I agree with Dr Bennett's response of the effect of the stem cells on vascular growth factors which is ---

Then, Dr Hooper was asked [Transcript p 1707]:

> I suggest to you that the ethical response for a practitioner such as yourself, with some level of knowledge about hyperbaric oxygen and some level of knowledge about stem cell therapy, would have either been to decline hyperbaric treatment for QS or to warn him that the treatment you were giving to him was utterly speculative and experimental; what do you say about that? --- I disagree.

141 When giving evidence the respondent would not acknowledge activated stem cells had a short active life. Nonetheless, in our view, QS should have been at least alerted to the fact that many experienced practitioners in the field of HBOT (e.g. Drs Bennett and Millar) believe that there was a very limited life for activated stem cells and, as such, having treatment prior to any arrangement being made for the stem cell therapy was very questionable and problematic. As a practitioner in HBOT, the respondent should have known stem cells have a short active life, or at least known there was a respected body of mainstream opinion holding that view. This fact should have been communicated by Dr Hooper to QS prior to him commencing treatment.

Credibility of QS

142 In QS's evidence, he stated that he received no lasting benefit from the treatment he received from HyperMED. Dr Hooper submitted that QS's past conduct suggested that this statement was untrue. The past conduct referred to was:

(a) QS made a video saying how he had benefitted from the treatment given by the respondent and, in particular, the Lokomat.

(b) QS had a website that continued until well after he stopped treatment at HyperMED, which website lauded the benefits of the treatment he had received from HyperMED.

(c) QS knew all there was to know about the HyperMED treatment as he had made a study of the website and was sent an information pack by HyperMED.

Further, he had a lengthy conversation with Dr Hooper on his first visit to HyperMED on 27 August 2007 as well as a tour of the facility and speaking to other employees at the facility. We refer to p 168 of the Transcript where QS was asked what he was seeking from the treatment and QS stated:

> It would get my stem cells in my knees more activated and hopefully getting – getting the stem cells from my knees injected into my spinal cord or my brain or whatever if they found suitable for my condition.

143 When these propositions were put to QS, he stated that he made the video and the website because he was indebted to the HyperMED clinic and he felt an obligation to try and raise the money. Further, while he was having the treatment, he thought he was receiving benefit from such treatment. However, now he realises such benefit was no more than wanting the treatment to be successful because he was costing a lot of money. It was what was referred to by Dr Millar and Dr Bennett as the participation or Hawthorne effect. QS said in fact that there had been no lasting effect from the treatment. Dr Marois denied the concept of the participation effect but as Dr Marois appeared to be a champion for the use of HBOT for people with cerebral palsy, we prefer the evidence of Drs Millar and Dr Bennett, in any event what they said appeared more logical.

144 Dr Hooper also put that QS's website continued for long after he had stopped attending the HyperMED clinic and after he had notified the applicant in relation to his complaint. QS said that this was because he had difficulty removing the material from the website, and he needed a friend who set the website up for him in order to remove the material.

145 Other patients of HyperMED gave evidence that QS told them that HBOT and Lokomat had significantly improved his condition. In particular, his balance, spasticity and circulation had improved. The respondent submitted that QS's conduct in continuing to attempt to raise money stating he had benefitted from the treatment meant he was either dishonest or he had in fact benefitted from the treatment. However, this submission does not take account of the participation or Hawthorne effect that the treatment had on QS and the obligation that QS felt to pay the debt.

146 It is also notable that QS was never asked in cross-examination whether he had been told of the extensive and mainstream views that HBOT and Lokomat would not assist cerebral palsy and that stem cell therapy had not been developed to such an extent that it was likely to work in adult cerebral palsy patients. It seems clear that QS was never given such information by Dr Hooper.

147 Dr Hooper submitted that QS made the notification to the applicant to avoid paying his debt to HyperMED. Even though QS was cross-examined at length, we did not gain this impression and the evidence does not support this submission.

Conclusion as to credibility of Dr Hooper and QS

148 QS's association with HyperMED was motivated by his desire to better himself for a long time and he had been searching for avenues to help his condition, something even his general practitioner was supportive of. Part of that process involved searching the internet where he came across information on the use of stem cell therapy. He has obviously looked at many international sites, but chose to contact SRI and clearly had correspondence with them. He was advised to search for somewhere in Australia that could provide him with HBOT, which is where he came into contact with HyperMED.

149 From this website the amount of information on it clearly persuaded him that this was a place for him. Coupled with his keen desire for help, and the enthusiasm generated by his search, and that at the HyperMED clinic, he was, in effect, primed up, in a positive and optimistic frame of mind. In many ways, this would account for the participation or Hawthorne effect so-often mentioned throughout the hearing. QS was keen to pursue fundraising to pay the costs of his treatment knowing full-well he did not have any money for it.

150 At this stage, it is clear to us that Dr Hooper had an even greater duty of care with QS as he was a vulnerable patient and his enthusiasm for treatment and financial position should have alerted him to providing better advice as to the delivery of care from the outset. This, Dr Hooper failed to do.

151 In relation to QS, while there was inconsistent conduct and past statements by QS in relation to his present views relative to the treatment, we are of the opinion that such conduct and statements are explainable. That is, at the time that previous inconsistent statements were made, QS was under an enormous amount of pressure to pay the large amount of money that was owed by him to HyperMED. Further, at the time of the video and website, he was having what has been described as a participation effect. In relation to statements QS made to other patients of HyperMED, it seems likely that these statements arose as a result of the participation or Hawthorne effect that the treatment was having on QS. We accept that is likely given the circumstances of this case.

152 In relation to Dr Hooper, we gained the impression that he was willing to make serious and unsubstantiated allegations in order to assist his case. Further, we are of the view that there was at best, a considerable amount of carelessness on Dr Hooper's part in not ensuring that QS was obtaining some benefit from the treatment. It is not good enough for a health professional to say that if his patient believed he was not getting benefit from the treatment, the patient would stop coming. That is unacceptable. Thus, where there is a conflict between the evidence of QS and Dr Hooper we prefer the evidence of QS. In particular, we do not accept that Dr Hooper told QS that using HBOT to treat cerebral palsy and enlivening

stem cells was not mainstream and how long the enlivened stem cells would last.

Relevant Legislative Provisions

153 "Professional misconduct" in s 3 of the Act means:

> ***professional misconduct*** includes
>
> (a) unprofessional conduct of a health practitioner, where the conduct involves a substantial or consistent failure to reach or maintain a reasonable standard of competence and diligence; and
>
> (b) conduct that violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency; and
>
> (c) conduct of a health practitioner, whether occurring in connection with the practice of the health practitioner's health profession or occurring otherwise than in connection with the practice of a health profession, that would, if established, justify a finding that the practitioner is not of good character or is otherwise not a fit and proper person to engage in the practice of that health profession;

154 "Unprofessional conduct" in s 3 of the Act means:

> ***Unprofessional conduct*** includes
>
> (a) conduct of a health practitioner occurring in connection with the practice of the practitioner's health profession that is of a lesser standard than a member of the public or the health practitioner's peers are entitled to expect of a reasonably competent health practitioner of that kind;
>
> (b) professional performance which is of a lesser standard than that which the registered health practitioner's peers might reasonably expect of a registered health practitioner;
>
> …
>
> (d) providing a person with health services of the kind that are excessive, unnecessary or not reasonably required for that person's well-being;

155 The applicant has requested that the Tribunal find that there has been professional misconduct by the respondent in relation to each of the allegations that are made against him.

156 The relevant provision is to be found in s 77(1) and (2) of the *Health Professions Registration Act* 2005 –

> **77 Determinations of VCAT**
>
> (1) After it has completed a hearing under this Division in relation to an application in respect of a health practitioner VCAT may make a finding as to whether or not –

(a) the health practitioner has engaged in unprofessional conduct or professional misconduct; or

(b) the health practitioner's ability to practise as a health practitioner is affected; or

(c) the health practitioner's performance has been unsatisfactory; or

(d) the health practitioner is not of good character.

(2) VCAT may find a practitioner has engaged in unprofessional conduct even though the application alleged professional misconduct.

Onus and Standard of Proof

157 Both parties agree that the applicant has the onus of proof in this proceeding. That onus is to be discharged to the standard of 'on the balance of probabilities'.

158 In a proceeding such as the present one, it is necessary that the onus of proof be discharged with an exactness of evidence. This matter was discussed in the often cited case of *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 363 when Dixon J stated as follows:

> When in a civil proceeding a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues … But consistent with this opinion weight is given to the presumption of innocence and exactness of proof is expected.

At page 361, his Honour stated:

> The truth is that when the law requires proof of any fact, the Tribunal must feel an actual persuasion of its occurrence or existence before it can be found.

159 In relation to the standard of proof, both parties also cited s 140 of the *Evidence Act 2008* (Vic). That section relevantly provides:

1. In a civil proceeding, the court must find the case of party proved if it is satisfied that the case has been proved on the balance of probabilities.
2. Without limiting the matters that the court may take into account in deciding whether it is so satisfied, it is to take into account –

   (a) the nature of the cause of action or defence; and

   (b) the nature of the subject matter of the proceeding; and

   (c) the gravity of the matters alleged.

160 While this Tribunal is not bound by the rules of evidence (*Victorian Civil and Administrative Tribunal Act 1998* s 98(1)(b)), it is desirable that they should be applied where practicable. Dr Freckelton referred to a number of authorities which suggested that there were subtle distinctions between the

matters referred to in the *Briginshaw* case and s 140 of the *Evidence Act*. However, Dr Freckelton, in our view, has correctly summarised the position when he stated, at paragraph 11 of his submissions:

> What is most important is that the Tribunal scrutinise the evidence with considerable care, having regard to the seriousness of the allegations and the important consequences to a practitioner should the allegations be found proved. (*Psychology Board of Australia v Van Megchelen* [2013] VCAT 328 at [62]-[65] per Judge Jenkins VP and Members Crawford and Manning.

We will adopt this approach.

161 Dr Hooper referred to a number of cases from the USA regarding the standard of proof. He referred to *James v Board of Dental Excessiveness* (1985) 172 Cal App 3rd 1069, 1105 which referred to 'clear and convincing proof of reasonable certainty'. He also referred to 'High probability of the existence of evidence' – *People v Mabini* (2001) 92 Cal App 4th 654, 662 and *Ettinger v Board of Medical Quality Assurances* (1982) 139 Cal App 3rd 853 at 856 wherein it was stated 'Clear and convincing (evidence) requires a finding of high probability'. (The evidence must be) 'so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind'.

162 This Tribunal is, as are Courts in this country, bound by decisions of the High Court of Australia. The *Briginshaw* principle has been accepted law in Australia for over 80 years. Therefore, where there is a difference between the *Briginshaw* principle and the USA authorities we will follow the *Briginshaw* principle.

Different from normal chiropractic disciplinary proceedings

163 Dr Reggars was subpoenaed by the respondent to give evidence in this proceeding. He stated that he has been practising as a chiropractor for 40 years. He has also a master degree from Macquarie University. He was also chairman of the Chiropractors Registration Board for many years and his appointment as chairman ceased on or about 30 June 2009. Dr Reggars said that, as chairman of the Chiropractors Registration Board of Victoria, he had a reasonable knowledge of what was happening in the profession. Further, he said, to his knowledge, Dr Hooper was the only chiropractor that he was aware of that was practising in the field of hyperbaric medicine. He further said that he had never heard of the Lokomat until he read about it in an article that was submitted to him by the Board. He agreed that the practice of hyperbaric medicine and Lokomat were not commonplace for chiropractors in Victoria [see Transcript 2377].

164 There are also a number of matters that are very different in this case to what is faced by chiropractors normally practising in Victoria or Australia.

165 In our view, there are also a number of matters peculiar to this proceeding that make the facts that we are dealing with here very different from the

commonplace matters that a chiropractor would normally have to deal with. Those matters are:

(a) The vulnerability of QS. While we accept that QS was intelligent and did a considerable amount of homework in order to improve his position and make his disability more bearable, that does not in any way reduce his vulnerability in relation to people that may offer to help him. At paragraph 52 of the applicant's submissions, Dr Freckelton has correctly described the vulnerability of QS:

> QS has limited education. He has never had paid employment. He has suffered from depression and made two suicide attempts. He has visual dyslexia which impairs his ability to read. He has gastric reflux and a range of spinal problems. He has limited capacity for ambulation and has long been dependent upon walking sticks and a motorised scooter. However, he passionately aspires and works toward a normal life. As Dr Hodgson put it, 'he is struggling with a difficult situation. But determined and coping'.

(b) The treatment prescribed by the respondent and underwent by QS was both lengthy and costly. The treatment given to QS by HyperMED lasted from August 2007 to May 2008. In that time, QS made several visits to the HyperMED clinic often as much as 5 times per week. Those visits would entail QS using the train to travel from his home to the city and then using his wheelchair to go from the train station to the respondent's practice in Collins Street. This was an enormous undertaking by QS and it is unsurprising that he said, in about December 2007, that he felt very tired. The treatment was also extremely costly. It has already been mentioned that the total cost of the treatment was just under $50,000. This is in spite of some of the sessions that QS underwent at the HyperMED clinic being 'sponsored'. It would be most unusual indeed for patients of chiropractors throughout Victoria to have to endure the commitment and cost that befell QS with HBO/Lokomat treatment by HyperMED.

(c) HBOT was very controversial and unorthodox in so far as chiropractors were concerned. In so far the controversial aspect of the treatment is concerned, it is clear from as what we have said above that the recognised view of the UHMS, the European conference, ANZHMG and Australian Special Interest Group in Diving and Hyperbaric Medicine (ANZSIGDHM), that this treatment is not recognised by these peak bodies for cerebral palsy or any of the conditions referred to in paragraph 31 hereof. On the other hand, there are some bodies which Dr Millar described as fringe bodies that recommend this treatment for cerebral palsy and a number of other conditions referred to in paragraph 31 hereof. The respondent submitted, that as there were many chiropractic clinics in the United States practising in hyperbaric medicine and other hyperbaric medicine clinics that were performing HBOT for cerebral palsy and

the conditions referred to in paragraph 31 hereof, that the treatment of hyperbaric medicine for cerebral palsy and other conditions was in fact the mainstream. We do not accept this submission as the bodies that promote the use of hyperbaric medicine to assist in cerebral palsy and the other conditions referred to are largely fringe bodies. We accept that Dr Millar had to say about this matter. Further, we do not believe that adding up the number of people who practise in hyperbaric medicine in the world or the USA and working out whether more of those people give treatment for the conditions we have referred to are determinative of whether the mainstream view is that the treatment is proper for those conditions. To ascertain the mainstream view, one must look at not only the quality of persons that propose a certain view but also their teachings and publications. For those that do not support using hyperbaric medicine for cerebral palsy and those conditions to which we have referred, they have been involved in peer review articles and trials such as the Collet et al study. Further, the proponents of the view that there is insufficient evidence to recommend hyperbaric treatment for cerebral palsy and the conditions referred to are people with unblemished records who are regarded very highly in their profession such as Dr Millar and Dr Bennett. Thus, we form the view, that practising HBOT for cerebral palsy patients or with the complaints referred to in paragraph 31 hereof, is not mainstream medicine.

166 We consider this situation very different from the usual work of chiropractors in this country. Chiropractors in Australia practise on the basis of acquired knowledge over many years of joint experience. The usual work of chiropractors, such as adjustments, is a proven field of treatment modality and, in our view, cannot be compared with the type of treatment that was given by HyperMED. When a patient enters the door of a chiropractor's surgery in this country, the patient will generally know what he or she is seeking and will have a reasonable idea of the course that the chiropractor will follow in performing treatment. The patient will also know that the effects of that treatment will be reviewed regularly by the chiropractor in discussion with the patient to see if the treatment has been effective for the particular complaint that the chiropractor is treating. This stands in stark contrast to the practise of Dr Hooper who left it to the patient to decide when to cease treatment. A patient of a chiropractor usually has a good idea of the treatment goals. This is because of the very nature of the treatment, the patient will know precisely what he or she is trying to achieve. If it is something outside that area, the chiropractor will inform the patient otherwise. Here, the goals of the treatment were unclear, the highest that they can be put was the amelioration of QS's cerebral palsy symptoms and preparation for stem cell therapy.

167 While we accept that treatments given by chiropractors are not always based on science, in our view, it is inappropriate to compare that type of

treatment with the treatment offered at HyperMED. We say this because of the matters we have articulated above. On the other hand, a patient entering the HyperMED clinic will be in quite a different situation. While we appreciate that hyperbaric oxygen has been used for many of the treatments discussed since the 1980's, in our view, the success of that treatment has not been established to anywhere near the same extent as the success of the chiropractic treatment has been so established. It should be noted, that we are not saying that the treatment for the conditions referred to offered by HyperMED will not work. What we are saying is that the treatment is so controversial at this stage that a different modus operandi vis a vis informing the patient needs to be adopted to that which is adopted in normal chiropractic practice.

168 The respondent has submitted that this is a test case. In our view, this is not a test case, but is a case very much concerned with and decided on its own particular facts. The issue in this proceeding is whether, as the result of the respondent's conduct, all or any of the 8 allegations that are made against him are proved by the applicant. This is not a test case for other members of the profession. It is not even a test case to determine whether the 30 conditions referred to in paragraph 31 were treatable by hyperbaric medicine. The issue in relation to Allegation 7 is whether Dr Hooper engaged in false and misleading advertising on the website in relation to those 30 conditions. There have been a number of cases already decided by this Tribunal in relation to health practitioners performing treatment that is outside what is normally performed by their colleagues. There is nothing new about the Tribunal deciding these matters. See *Traill v Medical Practitioners Board* [2006] VCAT 1920 and *Chinese Medical Registration Board of Victoria v Ghaffurian* [2012] VCAT 478. We thus conclude that any matters that are found in this case do not necessarily apply to chiropractors practising in Victoria or Australia within the normal manner that the chiropractors so practise.

Allegation 1: Alleged Failure to Make Proper Clinical Assessment

169 Allegation 1 alleges that the respondent failed to undertake or direct a proper clinical assessment before embarking on hyperbaric and Lokomat treatment of QS. In relation to the question of using HBOT to stimulate stem cell growth and activity, the following points are made:

(a) We refer to and repeat paragraphs 95 to 97 hereof in that Dr Steenblock or his SRI should have been contacted to find out when and if stem cell therapy was to take place.

(b) An important matter Dr Hooper should have considered was what QS was requesting of the respondent and what the notifier was expecting to achieve from the treatment being offered. Dr Hooper further should have discussed the amount of treatment that it would have been necessary in order to have the stem cells activated to the required level prior to the SRI stem cell therapy rather than just fixing on a number of

treatments without explanation. In relation to the question of the treatment for QS's improvement in functionality because of his cerebral palsy, there was no discussion as to what was trying to be achieved as a result of HBOT and Lokomat treatment. Further, there was no objective examination. For example, there was no six minute or ten metre walking tests suggested by Dr Carda, that is, because the tests were not performed, it was impossible to obtain an objective measurement as to the notifier's starting point before the commencement of treatment. There was not even a description taken from QS as to his difficulties he was suffering on a scale of one to ten. Thus, it does appear that there was no proper objective tests performed prior to commencing treating so that the notifier could be properly assessed. The respondent submitted that, 'the applicant has failed to produce any evidence from 26 percent of the transcript devoted to its HBOT practitioners' (sic). (See [107]). Instead it is forced to rely upon its chiropractors, Ebrall, Terrett and its neurologist, Churchyard. In our view, this submission misses the point. What is important, is the practitioner finding out and stating precisely what is to be achieved and the best way of achieving it and obtaining some objective measurements in relation to QS.

170 The respondent also said that QS informed Dr Hooper when he first came to the HyperMED clinic of such information had been obtained from the HyperMED website in particular and from other websites on the world wide web, including that of SRI. Dr Hooper also referred to the information pack that had been sent out to the applicant and newsletters prepared by HyperMED. He quoted from QS's evidence at Transcript 158, where he said, 'I felt quite informed, but I actually should have researched myself regarding the source of that information.' He also referred to the fact that SRI had supplied a video to QS about stem cell therapy. Dr Hooper also referred to the fact that he had taken QS through two chapters of Jain's book.

171 In our view, the respondent's submissions place far too much emphasis on what QS may have found out prior to the first consultation. What is important is the actual assessment that should have been made. We agree with Dr Freckelton's submission, that the respondent, 'failed to undertake or direct a proper clinical assessment before embarking upon lengthy and expensive hyperbaric and Lokomat treatment for QS.' We also agree with Dr Churchyard when he said that the MRI scan which was performed at the direction of Dr Hooper upon the notifier, was unlikely to yield information of any particular assistance in relation to the proposed treatment of QS. In any event, QS attended the sessions at HyperMED on 29 August, 1, 3 and 5 September 2007, which sessions all happened prior to the MRI being performed.

172 We note that Dr Hooper was provided with historical material about QS's previous treatments, however, that material, apart from the CT scan, showed little other than QS was previously treated with Baclofen.

173 Dr Freckelton submitted that the respondent's progress notes do not show any more than a 'short clinical history was obtained and an MRI proposed'. It is also noted, that the front cover of the notes refer to 'Adult cerebral palsy … stem cell program – David Steenblock'. In spite of this scant information, it is clear that the respondent proposed that QS receive 'hundred and fifty plus' hyperbaric oxygen treatment and 'forty-sixty plus' Lokomat treatment. There was also discussion about QS fundraising. It is thus clear, that the notes kept by HyperMED do not in fact show what assessment was made, if any, of QS prior to commencing treatment. In Dr Ebrall's witness statement of 31 August 2012, he observed that QS had not been provided with a working diagnosis or management plan and the records of practitioner-patient interaction was not in the accepted format.

174 It is also noted that Mr Islam, an unregistered doctor in Australia but whom was registered in Pakistan and employed by HyperMED, had an initial conversation with QS. In that conversation, it is clear that he knew nothing about preparation for stem cell therapy and he believed that the purpose of treatment at HyperMED was because 'he [QS] want to get better, and he wants to walk better; and that kind of thing.' [See Transcript 1897].

175 Further, the initial notations made in August 2007 do not make it clear what Dr Hooper thought he was trying to achieve. As Dr Freckelton put it, at paragraph 121 of his submissions:

> Regardless of what Dr Hooper was seeking to accomplish, this should have been identified clearly with QS and properly recorded. This should have been:
>
> (a) realistically achievable therapeutic goals;
>
> (b) ongoing monitoring of the efficacy of the therapeutic intervention(s) by clinical examination and/or use of established measures of function;
>
> (c) define end points of acute and intensive treatment;
>
> (d) transition of a maintenance treatment phase once maximum possible function has achieved.
>
> See report of Dr Churchyard, 11 February 2010. ATB 688, that is, as Dr Churchyard said, Dr Hooper appears not to have systematically or prospectively attempted objectively to assess QS's condition at the outset or thereafter.

176 Dr Terrett made it clear that prior to commencing treatment, in addition to a proper history being taken, there should have been a physical examination conducted. Failure to do so, he said, falls short of what is reasonably expected by a registered health practitioner. We agree with this comment,

particularly in relation to this particular instance where the treatment given was so unusual in Victoria. Thus, we find Allegation 1 has been made out.

Determination pursuant to s 77(1) of the Act in relation to Allegation 1

177 Section 77(1)(a) provides that we may make findings as to whether or not Dr Hooper has engaged 'unprofessional conduct or professional misconduct'. Dr Freckelton, for the purpose of Allegation 1, has submitted that we should find that Dr Hooper has engaged in professional misconduct. Definitions of professional misconduct and unprofessional conduct have been provided by the Act and are reproduced in these Reasons at paragraphs 154 and 157 inclusive. Subsections (a) and (b) of the definition of professional misconduct in s 3 of the Act are a restatement of the common law definition of professional misconduct. In *Myers v Elman* (1940) AC 282 at 288 to 289, Viscount Maugham in House of Lords found that professional misconduct was to:

> Have been properly defined as conduct which would reasonably be regarded as disgraceful or dishonourable by solicitors of good repute and competency.

178 In *Re Solicitor* (1960) VR 617 at 622 Deane J held that, 'misconduct' 'in a professional capacity' pursuant to s.15 of the *Legal Profession Act* 1958 (VRC) bore the same meaning as described in *Myer v Elman* in respect of professional misconduct. In *Magrath v Medical Board* (unreported) Supreme Court of Victoria 1 November 1976, Eames J noted that judicial interpretation of the expression 'professional misconduct' was that the words, 'comprised conduct which was more than mere professional incompetence, or mere deficiencies in professional practice, but would encompass conduct which included 'deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner'. This was a quotation from Kirby P in *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 at 200.

179 The test has also been referred to by Mandy J in *Campbell v Dental Board of Victoria* (1999) VSC 13 at [23]-[24] where his Honour followed a formulation of the Queensland Full Court in *Adamson v Queensland Law Society Inc* (1990) 1 Qd R 498 at 507. It was there stated:

> The test to be applied is whether the conduct violates or falls short of, a substantial degree, the standard of professional conduct observed or approved by members of the profession of good repute and competency.

180 'Unprofessional conduct', as defined in s 3 of the Act, is 'a smaller hurdle' or less serious than the conduct referred to in 'professional misconduct'. The definition refers to the reasonable standards of the community and professional peers of good repute and competence. In *Vissenga v Medical Practitioners Board of Victoria* [2004] VCAT 1044 at [33] the then President, Morris J, stated:

> I wish to repeat the words of paragraph (a) and (b) of the definition of unprofessional conduct. In both 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 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 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 sufficiently serious to warrant intervention by those charged with acting on behalf of the state.

181 The provision of HBOT and Lokomat treatment is very unusual in Australia as opposed to the United States, Japan, China and Russia. We have already noted that this is a most unusual case involving a chiropractor practising in Australia. By that we mean that there are either no other or but a handful of chiropractors who practise in the same field as did Dr Hooper.

182 In our view, it is inappropriate, when making a determination, to take into account the views of chiropractors practising in another country, such as the United States, for example, Dr Stoller. As Dr Freckelton has pointed out, those chiropractors are avowedly 'part of groups which are lobbying for change and perspectives other than those which are standard.'

183 Dr Freckelton submitted that because of the unusual nature of the treatment that Dr Hooper, as a chiropractor, was giving, the appropriate view in relation to that required by s 3 in relation to professional misconduct and unprofessional conduct was hyperbaric practitioners of good repute in mainstream, highly regarded associations such as ANZHMG, ANZSIGDHM, and in the United States, UHMS and in Europe, the consensus of the European Committee for Hyperbaric Medicine. We believe this submission is going too far in that it excludes the views of chiropractors in Australia, however, because of the nature of this particular proceeding, which we have explained earlier, it is appropriate that these bodies' views should be taken into account and given strong weight.

184 Taking these matters into account, we have formed the view that the conduct of Dr Hooper in so far as it relates to failing to make a proper assessment, is not conduct of sufficient seriousness as to be considered 'professional misconduct'. We believe it is too extreme to describe this conduct as 'disgraceful or dishonourable' as referred to in *Myers v Elman* (supra). The real vice in this proceeding was the failure to do a proper assessment led to QS not being provided with a working diagnosis or management plan and that the record of practitioner-patient interaction was not in the expected format. (See evidence of Dr Ebrall referred to above.) We also agree that a proper assessment should have been done prior to treatment commencing and this was not done. However, we do not believe that such failure amounts to professional misconduct.

185 We are of the view that the failure to do a proper assessment, is of a lesser standard than that which might reasonably be expected of a registered chiropractor by the public or by the peers of Dr Hooper be they other chiropractors in Australia or members of the peak organisations that we have referred above. We also note, that in relation to the provision of Lokomat treatment, the fact that no objective assessment was made prior to the commencement of any treatment, made it impossible to objectively gauge any benefit that QS may have received from treatment. Again, we are of the view that this would be of such a character that it would not be acceptable by members of the public in relation to a chiropractor or his fellow members of the profession. Given these circumstances, we find that the applicant, in failing to assess QS at all or in a proper manner, has engaged in unprofessional conduct within the meaning of s 77(1)(a) of the Act. We have considered other possible determinations provided in s 77(1) but do not believe they are appropriate in these circumstances.

Allegation 2: Failure to Obtain Informed Consent

186 In relation to this issue, we refer to paragraphs 80 to 87 inclusive and repeat the contents of those paragraphs. We also refer to and repeat the matters concerning the efficacy of HBOT and the Lokomat which are to be found in paragraphs 47 to 79 inclusive hereof.

187 Before commencing a discussion of this topic, we wish to make it clear that we are not of the view that either HBOT or Lokomat treatment for the conditions described in paragraph 31 hereof should be prohibited. The issue is that the treatments that were offered by HyperMED to QS were not mainstream and, as a result, special attention should have been given in relation to discussions about the possible effects that those treatments would have had on QS. We have discussed this issue above. Further, the treatment HBOT and Lokomat treatment are treatments are not normally used by chiropractors in Australia. Bearing all these matters in mind, what should QS have been told by Dr Hooper and his associates in order for him to have given informed consent to the treatment?

188 As previously mentioned, Dr Hooper relied on the fact that the chiropractic profession in Australia conducts evidence based practice and therefore scientific proof of efficacy is not required. However, as we have previously said, this is a special case because of the reasons stated above. Put simply, because there is great controversy in relation to HBOT for patients with cerebral palsy, its ability to stimulate stem cell growth and, for the use of a Lokomat of such patients, the treatment offered by HyperMED falls into a completely different category of treatment than offered by other chiropractors in Australia. This puts a greater onus on the practitioner than one who is simply doing an adjustment that may take a few treatments. This is in stark contrast to the amount of treatments and the cost of such treatments that QS had with HyperMED.

189 It is insufficient for a chiropractor to just give written material, even though that written material may not all be in favour of the treatment. It does not matter whether that written material is in the form of a website or an information pack sent to a potential patient. In this particular instance, the material on the respondent's website was like a 'huge forest' where persons such as QS would be likely to lose their way, we refer to and accept the comments of Professor Dodd referred to in paragraph 44 of these Reasons. We also note, that QS was an extremely vulnerable person who was desperate to improve his position.

190 Because of all these factors, it was extremely important and proper that Dr Hooper should have ensured that QS had a full understanding, not only of the treatment that was to take place, but of the views of mainstream hyperbaric practitioners and peak professional bodies that the treatment for cerebral palsy was not recommended by those practitioners and particular bodies and, in fact, they did not believe such treatment was efficacious. This fact was never properly explained to QS by Dr Hooper.

191 Further, in relation to Lokomat treatment, it was never explained by Dr Hooper to QS that there was a firm body of evidence which would suggest that the Lokomat treatment, would not advance QS's cause any more than practising in overground walking like he had been doing since 2004.

192 It is the responsibility of the practitioner to ensure that the patient has given suitable consent. The High Court in *Rogers v Whitaker* (1992) 175 CLR 497 at [14]-[16] stated:

> The choice as to whether a patient will submit to medical treatment is, in reality, meaningless unless it is made on the basis of relevant information. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of practitioner alone or, for that matter, of the medical profession … except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment … Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for the purpose having regard to the patient's apprehended capacity to understand the information …
>
> A doctor has a duty to warn a patient of a medical risk inherent in the proposed treatment; the risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably aware that the particular patient if warned of the risk, would be likely to attach significance to it.

193 The Tribunal, in *Medical Board v Laska* [2011] VCAT 1888 at [29], made it clear that the practitioner has an obligation to:

> Not only explain to the patient what he was doing and why he was doing it; he needed to ensure that she fully understood and was thereby giving her informed consent to the examination. Silence is not sufficient or adequate 'cue' to proceed.

194 In this instance, it is insufficient for Dr Hooper, after having formed the view that QS was a knowledgeable and intelligent man, that he knew all the pros and cons of receiving the treatment, as well as the strong views expressed by peak bodies and respected practitioners against the efficacy of such treatment or the questionable efficacy of such treatment. The fact that QS was not only vulnerable but displayed that vulnerability should have put Dr Hooper on notice that contrary views needed to be explained to QS very carefully and those explanations needed to be noted in the progress notes. In Dr Hooper's defence, he relied heavily on the fact that QS knew that there was some doubt as to the efficacy of the treatment by the fact that he told Dr Hooper that he was 'a good guinea pig' [see Transcript page 150]. This statement should have immediately sent signals to Dr Hooper as to the vulnerability of QS. Instead, Dr Hooper took this statement to mean that QS was aware of the experimental nature of the treatment. What Dr Hooper did not explain to QS and what was necessary to be explained was that the treatment that was being offered had many detractors, including mainstream medicine and people of high repute. It matters not that others believed the treatment was most efficacious, for example, Dr Stoller and Dr Marois. Dr Terrett, at page 7 of his witness statement of 4 August 2012, and at Transcript 2149, made it clear what a practitioner must tell a patient in order for consent to be informed. He stated:

> It can only be Informed Consent if the practitioner has explained to the patient:
>
> - the diagnosis;
> - the proposed treatment;
> - the benefits of treatment;
> - the likely duration of treatment;
> - any real or material risks of the treatment;
> - the likely costs of treatment, and other possible costs (eg, X-rays);
> - likely consequences of treatment;
> - the patient has the opportunity to ask the practitioner any questions they may have about the diagnosis, the proposed treatment and/or possible complications of the proposed treatment.

195 Dr Freckelton correctly suggested that the practitioner had an obligation to inform the patient of other treatment options. In support of this submission he referred to the Chiropractors Registration Board of Victoria's Standards and Practice Code – 'Codes of Professional Conduct'. In this regard, Dr Hooper relied on the evidence of Dr Stoller that the use of oxygen masks rather than HBOT could produce a benefit at far less cost [Transcript p 2055], Professor Dodd also said overground walking would be just as beneficial (if not more so as a partial bodyweight system such as the Lokomat) [see Transcript 564].

196 Taking these matters into account, Professor Terrett was of the view that informed consent from QS had not been obtained by Dr Hooper in this regard [see Transcript 2118].

197 The question of the strength of the evidence supporting the proposed treatment was referred to by Dr Millar at Transcript 409. He stated that:

> It's a critical part of informed consent that patients … are made aware of the level of evidence supporting the proposed treatment.

He said it was a fundamental part of obtaining informed consent from a patient that they be alerted to the level of evidence supporting the treatment and if it is an unproven therapy, they be informed of this:

> If it is not a reasonable therapy then of course I don't believe it should be offered to them, and if it is truly experimental then it should – I think everyone, at least in my peer group would agree, should actually be approved by a properly constituted ethics committee as being a human research ethics-approved research exposure. So depending on just how experimental or speculative the therapy is, it would range between informed consent with the patient clearly told that this was speculative, you know commonly applied perhaps but speculative therapy, through to should only be provided as the ethics-approved research exposure, depending on just how speculative it was.

198 Dr Millar also referred to the fact that the cost and effort on the part of the patient should be discussed by the practitioner, which would allow the patient the greatest possible information about the risks and benefits of the treatment and the reason that recommendations were made or not made. [See Transcript 951].

199 Dr Churchyard was of a similar view to Dr Millar. At Transcript 1407, Dr Churchyard stated:

> My view would be for any health practitioner, from whatever discipline, dealing with the patient, that whatever cause, that they should ensure informed consent which would include, when discussing any treatment option, a realistic assessment of the evidence base and hopefully be able to give patients an estimate of the likelihood of success. I think, also, in chronic neurological disorders – and this is a fundamental tenant of practice – that it's very important that treatment not be open-ended, that patients are to be given defined treatment goals, and there is some sort or schedule, if I might put it

> that way, for the treatment's efficacy to be evaluated and a decision made at that time whether or not there will be any benefit to the patient in continuing treatment thereafter.

200 It is noted, that Dr Hooper made several criticisms of Dr Churchyard, including the fact that Dr Hooper believed Dr Churchyard's evidence was contradictory and that Dr Churchyard had no experience in either hyperbaric or stem cell therapy. In our view, the areas in which Dr Churchyard was considered by Dr Hooper to be contradictory, were minimal, and can easily be explained by the lengthy cross-examination that was put to him and the different context in which questions were put. Further, Dr Churchyard is a distinguished neurologist of many years experience. He thus has a good understanding of the workings of the brain and what treatments may or may not be beneficial for neurological conditions. A doctor like Dr Churchyard does not have to practise in a particular modality of treatment, in order to know the likely efficacy of such treatment.

201 Professor Dodd, at Transcript 1407, suggested that a practitioner should be very careful and give correct information to patients who are contemplating treatment when the efficacy of the treatment had not been scientifically established. She stated the practitioner should:

> Say this is a very early treatment, it is based on a theory which had got some, you know, people thinking this was a useful thing to do, and that it was something that might be useful, but I would be really clear about what usefulness that might be … You would have to be very careful about what your claims were about something like that. But I think the most important thing is to agree to tell the person that, you know, the evidence, is very weak. There's not a lot of evidence at the moment. This is almost experimental, actually. It's almost experimental kind of treatment at this point, and tell them how much it will cost and how much time it would take, and we're not sure about what outcomes might be. Therefore if they wanted to participate, they could, but I would be very anxious about doing a lot of treatment, you know, without having quite clear outcomes I was going to measure and clear times when I was going to measure them.

202 Dr Marois agreed that, in 2007/2008, it was necessary to inform a patient with cerebral palsy with a balanced view of the prospects of success and the state of scientific literature at the time which did not categorise it (HBOT) as a recognised therapy.

203 The respondent launched an attack on the credibility of Dr Millar's evidence in so far as it related to informed consent and other matters. Dr Hooper contrasted different evidence given by Dr Millar and concluded it was inconsistent. At paragraph 109 of the respondent's submissions it is stated:

> The second area of informed consent was testimony from Dr Millar where he contradicted his testimony from the previous day's

> testimony to swing the scales back in favour of the applicant. The respondent refers to paragraph 134 [Transcript page 951] where Dr Millar indicates a practitioner should politely decline treatment for cerebral palsy patients, contrasts his page 778 earlier 'toss of the coin' statement.

204 On researching these references, we find this submission difficult to understand. At Transcript page 778, Dr Millar, after indicating he would defend his ability to give hyperbaric treatment to conditions that are not on the Medicare funding list, stated:

> And the same philosophy is probably why I ended up concluding in my earlier statement that if I was asked whether hyperbaric oxygen should be banned for cerebral palsy or multiple sclerosis I would be quite equivocally placed and possibly could even toss a coin because I would feel torn between the public purse and the evidence of the clinical practice.

However, the statement at Transcript page 951 attributed to Dr Millar appears to be made by Dr Bennett. Dr Bennett there says:

> Leaving aside the possibility of offering other forms of treatment (other than HBOT) and assistance and referral, the correct course for this hyperbaric position is to politely and regrettably decline treatment on that basis.

Thus, the statement with a slightly different emphasis to that quoted by Dr Millar, seems to be made by Dr Bennett.

205 At paragraph 20 of Dr Freckelton's reply submissions, he comments the tossing of the coin reference and by Dr Millar and the alleged banning reference by Dr Millar but, in fact, from Dr Bennett. Dr Freckelton stated:

> … the reference to tossing a coin relates to the banning, the prescribing absolutely, of hyperbaric treatment for cerebral palsy and multiple sclerosis. Dr Millar's tentative ethical position, as it is for giving hyperbaric oxygen for conditions not on various lists, is that it ought to be allowed but only engaged when amongst other things, properly informed consent is obtained (depending on sufficient furnishing of relevant information) and, for instance, when a properly controlled and designed clinical experiment is conducted. The position that Dr Millar was advocating tossing a coin or was so unsure that his professional views rested upon the 'toss of a coin' is a complete distortion of his words and a failure to have regard to the context.

We agree with this statement of Dr Freckelton.

206 The respondent also referred to the fact that the code of conduct did not require practitioners to practise in evidence-based modalities of treatment. However, we agree with Dr Freckelton that the code of conduct is, a 'broad-based document endeavouring to give ethical guidance to chiropractors, and clearly identifying what is required for obtaining informed consent. The codes do not descend into every specific detail.'

207 As we have stated previously, this proceeding revolves around very unusual conduct for a chiropractor. Therefore, different rules apply in a situation like this as to when a chiropractor would be practising the normal everyday modalities that chiropractors use for treatment. We thus agree with what Dr Freckelton has stated at paragraph 205 of his submissions that:

> … treatment for cerebral palsy to an adult with the condition who is desirous of improving his circumstances, it was his (Dr Hooper's) responsibility to provide information to enable the patient to engage in lengthy and extensive treatment which, objectively, was unlikely to provide him any significant benefit.

208 For the above reasons, we have concluded that the respondent failed to obtain proper informed consent pursuant to Allegation 2 for the treatment administered by Dr Hooper to QS between August 2007 and May 2008.

Determination in Relation to Allegation 2

209 Dr Freckelton has submitted, that we should make a determination in relation to Allegation 2, pursuant to s 77(1)(d), that Dr Hooper is not of 'good character'. That does not, of course, preclude us from making a determination that Dr Hooper's conduct was professional misconduct or unprofessional conduct. That is, we, subject to proper principles, are able to make a determination that Dr Hooper is not of good character, has engaged in professional misconduct or has engaged in unprofessional conduct. It is noted that s 77(1) provides for a number of other determinations which we do not believe are appropriate in this proceeding.

210 In relation to both professional misconduct and unprofessional conduct, we have discussed the law in relation to those matters in relation to Allegation 1 hereof and, as a result, it is not necessary to repeat the same.

211 The concept of good character is not one which bears some special or technical meaning; rather, the words are used in their ordinary meaning. See *Healthcare Complaints Commission v Karalasingham* (2007) NSWCA 267 at [45]. Further, whether a person is of good character or otherwise is a question of fact rather than law. It is an evaluation of the given question being undertaken in the context in which the question is raised under the legislation. See *Smith v Director-General of Transport* (2004) WASCA 64 at [24]. Thus, one must consider the statutory purpose for which assessment of character is required. That is, the character in so far as it is relevant to the function for which a person is registered or to be registered. See, by way of example, *Re B* [1981] 2 NSWLR 327 at 394-395. This principle was demonstrated by a statement from Walsh JA in *Ex parte Tziniolis; re Medical Practitioners Act* (1967) 1 NSWR 357 at 358-359 where it was stated:

> [W]e are entitled to enquire into what may be described as personal misconduct; as distinct from professional misconduct; in determining this case whether or not the applicant is a man of good character, whilst recognising that there may be some kind of conduct deserving

> of disapproval which have little or no bearing on the question of whether or not it is shown that an applicant for registration as a medical practitioner is a person of good character.

In the same case Holmes JA stated at 301:

> 'good character' is not a summation of acts alone but relates rather to the quality of a person. The quality is to be judged by acts and motives, that is to say, behaviour and mental and emotional situations accompanying that behaviour. However, character cannot always be estimated by the evidence from which the inference of good character or not good character can be drawn.

212 It is also clear, that character is not just clinical capacity of a practitioner. In *Bannister v Walton* (unreported) NSWC Court of Appeal 30 April 2002, Mahoney stated:

> Clinical capacity is by no means the only consideration to which regard is to be held in determining whether a person is appropriate to practise medicine. It is necessary that the public be protected against those who, though having the appropriate skills do not have the character for the opportunities and privileges which the right of practice gives.

213 In *McBride v Walton* (1994) NSWCA 199 the New South Wales Court of Appeal (Handley and Powell JJA) approved the following factors as relevant to the question of determining 'good character':

(a) whether the misconduct can be satisfactorily explained as an error of judgment rather than a defect of character;

(b) the intrinsic seriousness of misconduct and its relevance to practising medicine;

(c) whether the misconduct should be viewed as an isolated episode or whether it is characteristic of the practitioner;

(d) any motivation which may have given rise to the proven episode of misconduct;

(e) underlying qualities of character shown by other acts of misconduct; and

(f) whether the practitioner's conduct after the proven episode of misconduct demonstrates that public and professional confidence may be reposed in him to uphold and observe high standards required of a medical practitioner.

214 In this particular instance, we view Dr Hooper's conduct as an error of judgment rather than a defect in character. While we agree that Dr Hooper was running a business and undoubtedly trying to maximise his profits, on the other hand, we are of the view that he truly believed and believes that the treatment he was offering would be effectual and was a panacea for not only cerebral palsy but for other matters described in his website. The treatment being offered was not likely to have serious side effects or adverse physical effects on QS, save and except for the huge commitment

that QS put into the treatment and the exhaustion which followed and the huge financial commitment which he made and which ultimately he became very worried about when he could not meet such commitment. The offering of HBOT and Lokomat treatment by HyperMED was clearly not isolated episodes. The giving of that treatment for cerebral palsy and/or neurological complaints, was part of HyperMED's business. However, we do not believe that the giving of such treatment, in fact, reflects on the character of Dr Hooper, save and except that he is 'true believer' in the treatment that was being given.

215 In relation to the question of motivation for giving the treatment, clearly Dr Hooper's motivation was that of running his business and, quite possibly, curing his patients.

216 In relation to Dr Hooper's underlying qualities of character shown by other acts of misconduct, it should be noted that, apart from the allegations that have been presented to us here, no other misconduct has been alleged against Dr Hooper. We also note, that a number of his patients have given testimonials that they were very happy with the treatment he gave. However, the issue that we are concerned with here is informed consent. That being the case, we do not hold the view that this shows any matter of underlying character by which we could make a finding of bad character. However, we are concerned that Dr Hooper has operated his practice in a blinkered sort of way, refusing to accept legitimate criticism in relation to his conduct. Further, when things have gone wrong, he has been inclined to blame others, for example, in his opening submissions, he has blamed QS for his bankruptcy and has accused the applicant and its solicitors and counsel of having improper motives in bringing this application. He also believes that has been singled out for 'persecution'. All that is a flaw in the respondent's character.

217 In relation to the question of whether Dr Hooper's conduct, after the conduct which we have found to be not proper, may demonstrate or affect public and professional confidence in him. We are of the view that, as in relation to Dr Hooper's conduct, it is likely to have a devastating effect into the public's view as to whether he is able to give proper professional advice in an unbiased type of manner which is in the patient's best interest. We are of the view that, certainly at the present time, he would be unable to observe the high standards that would be expected of him in the chiropractic profession. Further, his conduct is likely to bring the whole chiropractic profession into disrepute and adversely affect the positive results that the profession has achieved in its hard fought battle to become a legitimate health provider in Australia.

218 Having made the above findings, we are nonetheless of the opinion, that the respondent's conduct, in failing to obtain proper informed consent from QS, is not sufficient conduct to make a finding pursuant to s 77(1)(d) of the Act.

219 The next question is whether a finding should be made of 'professional misconduct' as a result of Dr Hooper's failure to obtain proper informed consent from QS. Dr Hooper knew, or should have known, that it was necessary to obtain proper informed consent, being a vulnerable person, before he embarked upon costly and lengthy treatment. He also knew, or should have known, that the treatment he was providing, both in HBOT and Lokomat, was treatment that was not accepted by the mainstream bodies for hyperbaric medicine and that, those that were like-minded with Dr Hooper, were complete advocates for the cause of such treatment, and were performing the treatment, not only without proper evidence, but without proper clinical results from that treatment, particularly in the community which Dr Hooper was operating in, that is, Victoria.

220 In our view, taking into account the matters that we have discussed, Dr Hooper's conduct 'violates or falls short of, to a substantial degree, the standard of professional conduct observed by members of the profession of good repute or competency.'

221 In our view, the conduct of Dr Hooper in relation to this Allegation, is such that it comes within what Priestley JA stated in *Qidwai v Brown* (1984) 1 NSWLR 100 at 105 as to be such that the 'practitioner was in such breach of the written or unwritten rules of the profession as would reasonably incur the strong reprobation of the professional brethren of good repute and competence.'

222 We also believe that this conduct comes within what Kirby P described in *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 at 200 that it included:

> A deliberate departure from accepted standards or such serious negligence as, although not deliberate to portray indifference and an abuse of privilege which accompany registration …

It also comes within what Mandy J described in *Campbell v Dental Board of Victoria* referred to above.

223 In our view, the professional peers of Dr Hooper in Victoria would conclude that Dr Hooper's conduct in relation to Allegation 2 is a matter of serious impropriety. Therefore we conclude that Dr Hooper's conduct in relation to Allegation 2 is professional misconduct within the definition of s 3 of the Act and within the meaning of s 77(1)(a) of the Act. Having concluded that Dr Hooper's conduct was professional misconduct within the meaning of s 3 of the Act, we do not have to consider whether Dr Hooper's conduct was unprofessional conduct. We have considered determinations provided in s 77(1)(b) and (e) of the Act and do not believe they are appropriate in this instance.

224 Before leaving this allegation, it is desirable we say something of the evidence presented to us by the respondent concerning Allegation 2. The evidence from QS suggests that he was given or possessed a broad understanding of HBOT and Lokomat therapy from both his own research and from whatever told to him by Dr Hooper. The extract from the

Transcript also refers to Dr Hooper showing QS diagrams which Dr Hooper suggests come from Jain's book. There is also evidence in relation to fundraising and 'base line' approximates of the amount of treatment and costs. Further, Dr Hooper also refers to the fact that if QS was 'offered a miracle he would take it'. The evidence of Dr Terrett is referred to but, in our view, does not take the matter any further than what we have already discussed. Many quotations related to Dr Terrett's view of the Codes of Conduct. In our view, none of these matters take the issue before us any further and do not alter either the view we have taken of the evidence about or the use to which the evidence should be made. In particular, the evidence does not touch on whether QS was informed of contradictory views held by peak professional bodies or respected mainstream practitioners relating to HBOT and Lokomat treatment.

Allegation 3: Failure to Prepare a Treatment Plan

225 It would appear that the purpose of the treatment given by HyperMED to QS was to prepare QS for stem cell therapy at SRI and to make him more functional.

226 Professor Dodd, in her report of 18 January 2010 at paragraph 8, commented on the appropriateness of a treatment plan for a Lokomat provider. She stated:

> It would be appropriate and very common practice for providers of Lokomat treatment to prepare a treatment plan prior to the commencement of treatment. The plan should include at least the following:
>
> 1. Specific agreed and measurable goals of treatment for the person with CP (cerebral palsy), that are realistic and based on scientific evidence of the potential benefits of such program.
> 2. Information about how the goals of treatment will be measured and evaluated (ie, what the objective and substantive outcome measures to evaluate progress will be).
> 3. When and how often the goals will be formally measured – so setting formalised review dates.
> 4. Based on scientific literature, an agreed plan of approximately the intensity and duration of treatment that is anticipated to be needed to achieve the agreed specific measurable goals.
> 5. Details of the treatment intervention proposed for implementation.

227 In relation to hyperbaric treatment, Dr Millar made the following comment about a treatment plan. [See Transcript 958]:

> I think in respect of hyperbaric and in respect of treatment plans in general, it's extremely important from both a practitioner and patient and the patient's family often – that the treatment plan is clearly understood between the practitioners and the patient. And there are multiple reasons why this is so. It is often only in the development of

> a comprehensive treatment plant that the full impact on the individual concerned may become obvious. For example, from our own practice in hyperbaric, it is not uncommon for a patient to … – to express the desire to have the hyperbaric treatment and to understand that it might involve more than one treatment, but when full explanation of the time taken each day and the number of hours that they will have to be at the hospital and so forth that they can modify their decision about to have at all or delay treatment. So a plan is essential in the patient's understanding what their committing to. Hyperbaric, … its great disadvantage is the time taken to produce its therapeutic effects. It's – there are very very few things we treat that respond quickly. So it's very important for the – from the patient's point of view to understand as much as possible what they are signing up for. From the practitioner's point of view it is very important to have a clear idea from your experience and knowledge of the literature what number of treatments or time under pressure or whichever you want to express it, what are critical times.

228 Dr Hooper maintains there was an adequate treatment plan. Reference was made that there were to be 140+ hours of hyperbaric treatment and 60+ hours Lokomat treatment to be provided. Also he says that the patient had a full understanding of what was to be achieved by the treatment, namely, preparedness for stem cell therapy and a better functionality.

229 It is noted that Dr Ebrall, in his report of 31 August 2010, observed that there was 'no real plan' in Dr Hooper's records. There was no 'management plan by the chiropractor that proposes the frequency duration of the treatment and the desired milestones'. In a similar vein, Dr Terrett observed, in his report of 4 August 2012 at page 11, that the ordinary indicia of a treatment plan in this instance are wholly lacking. We agree with the observations of both Dr Ebrall and Dr Terrett.

230 In Dr Hooper's submissions, under the heading of Allegation 3, he referred to the fact that there were computer-generated notes. The notes he was referring to were those documents that were generated from the Lokomat. We find it difficult to understand how those documents could have been a treatment plan, when they were produced after the treatment had commenced. In any event, it does appear from the evidence of Dr Carda, that the notes do not give an indication of how the patient is performing. They, in fact, indicate what the machine is doing. Dr Hooper also relies heavily on the evidence of Dr Perkoulidis. However, we have already made comment in relation to his evidence.

231 In conclusion, we agree with the comments made by Dr Freckelton in his submissions when he stated, at paragraph 133:

> What was sought to be achieved is simply a matter of conjecture. What would be the mark of success or failure are not identified – either in respect of the necessary improvement of the patient's condition or symptomatology or his readiness for stem cell treatment.

232 We also agree with the comment that Freckelton made at paragraph 139 of his submissions where he states:

> The tactic of failing to formulate and communicate a treatment plan to QS deprived the patient of the ability to ask relevant questions and to understand informedly the purpose and objectives of treatment. In turn this impacted fundamentally upon QS's capacity to make a considered decision about the expensive treatment which Dr Hooper proposed that he submit.

233 Dr Hooper referred to what he called a treatment plan being contained in the information sent to QS prior to his first visit to HyperMED. He also referred to the fact that QS had three stages of treatment being 'the start phase', 'intensive phase' and 'consideration of pursuing stem cells overseas'. Dr Hooper suggested there was an opportunity for QS to discuss the treatment going forward when the cost of the HBOT was reduced after QS had completed 100 hours. In our view, none of the matters together or individually referred to by Dr Hooper were sufficient to constitute a treatment plan. We refer to matters discussed above as to what a treatment plan should contain and the way QS's treatment plan (if there was one), was lacking. We do not believe the issues raised by Dr Hooper take the matter any further.

234 Thus, we find Allegation 3 has been made out.

235 Dr Freckelton has submitted that we make a determination pursuant to s 77(1)(a) that Dr Hooper has engaged in 'professional misconduct' in relation to Allegation 3. In making a determination in relation to this particular Allegation, we believe that the same principles and matters apply as we have referred to pursuant to Allegation 1. Having formed that opinion, we determine that the respondent, Dr Hooper, has engaged in unprofessional conduct pursuant to s 77(1)(a) of the Act. We have set out the law and considerations relating to unprofessional conduct in dealing with Allegation 1 hereof. In relation to unprofessional conduct we are of the view that similar facts and law apply to Allegation 3 as to Allegation 1. We do not believe the other determinations referred to in s 77(1) are applicable to Allegation 3.

Allegation 4: Failure to Modify Treatment Plan

236 A number of the expert witnesses gave evidence that it is necessary to monitor and review a treatment plan to identify whether its objectives are being met. In order to do this, the treatment plan needs to be reviewed at various intervals to ensure that it is fulfilling worthwhile therapeutic objectives and not open-ended. Further, the practitioner needs to inform him or herself of whether the objectives in the initial treatment plan are being accomplished or otherwise.

237 In Professor Terrett's report of 4 August 2012, he explained when a treatment plan may require review and when it will require review. In relation to the former, he stated that it may require review if:

- the patient has improved more quickly than was initially thought;
- the patient has reacted badly to previous treatment;
- the patient has not responded as well as initially hoped; or
- if there has been any events which have occurred since the previous treatment.

In relation to when the plan will be required to be reviewed, he stated:

- the patient does not respond to treatment more quickly than was initially thought;
- the patient does have any adverse reaction to the treatment; or
- the patient does not have any benefit from the treatment.

238 The importance of monitoring progress was referred to by Professor Dodd in her report of 18 January 2010 at paragraph 9, where she stated:

> Monitoring progress and potential improvement is critical. Research suggests that the effects of the treatment vary from individual to individual and needs to be tailored and adjusted to the need and responses of the individual throughout the course of treatment …

239 In the same paragraph of the same report, Professor Dodd said that monitoring should entail:

- indication of valid and reliable objective outcome measures relevant to the specific goals of treatment;
- subjective evaluation from the patient of their perceptions about progress;
- agreed timelines of when formal systematic measurement of the agreed outcome measures will take place;
- there should also be less formal monitoring of progress throughout each treatment session, and from session to session but between the formal treatment reviews;
- in this instance the only indication of modification of the treatment plan is merely that the treatment was extended, in the sense of more sessions being determined upon by Dr Hooper on or about 16 November 2007.

240 Dr Hooper relies on the Lokomat printout notes as showing that he changed the treatment plan and the treatment as it went along. However, in our view, those notes do not show any real monitoring of the treatment at all. What they show is different settings on the machine. It does not show the patient being evaluated. It does not show whether the patient has made improvement that justifies the treatment continuing. In fact, it does not really show that the patient has made improvement. What the notes show is that the machine settings have been altered. But, when one looks at the

overall treatment of the machine settings, such as Exhibit J, which is a document prepared by Dr Hooper, being a summary of some of the machine notes, it indicates that there is no real change in the patient's progress.

241 Dr Hooper's progress notes also point the fact that, in November, there was a decision to continue with more of both hyperbaric and Lokomat treatments. However, the notes do not say on what basis this decision was made.

242 Further, it is clear from Dr Hooper's own evidence, that he was not properly monitoring the HBOT. At pages 1710 and 1711 of the Transcript, that Dr Hooper would not tell a patient to stop treatment unless the patient was non-compliant. It is quite unsatisfactory that the decision whether to stop or continue treatment should be left to the patient alone.

243 At paragraph 145 of Dr Freckelton's submissions, he quotes from Professor Dodd as to part of the risk of not monitoring outcomes. The Professor states:

> The risk of failing to monitor progress and potential improvement mostly surrounds delivery of potentially ineffective treatment to the patient – so wasting time and finances. There is also the risk of not progressing the treatment parameters appropriate to obtain the optimal result.

244 Dr Carda, in his report of 16 October 2012 page 4, indicates the matters that should have been taken into account in considering whether a treatment plan should have been modified. He identified the following matters:

> Improvement in Notifier's gait could have been easily measured with commonly accepted measures of gait function as: gait speed for example measuring the speed with a ten metre walking test, cadence, step length, endurance (for example with a six minute walking test) and with measures of participating (for example, with WHS or the Canadian Occupational Performance Measure; Mayo-Portland Ability Inventory). Three-D gait analysis is another reliable tool to assess slight improvements at the level of patients ability that are hard to believe clinically. Another measure that could have been used is Gross Motor Function Classification System.
>
> So, a clinician that wants to show improvement in patients gait with Lokomat should utilise one or more of these instruments.

245 Dr Hooper relied on conversations between doctors with foreign, but no Australian registration and the notifier. He also relied on some of the patient's self-reporting. As we have discussed earlier, the self-reporting of a patient is very unreliable, because of the participation or Hawthorne effect. That is, the patient is paying a lot of money and going to a lot of trouble to participate in the treatment and therefore is anxious for success and believes that is success in the treatment, even if, objectively, there is none. In our view QS's conversations with the HyperMED clinicians were no more than self reporting.

246 We agree with the statement made by Dr Freckelton at paragraph 148 of his submissions. He there stated:

> There is no indication of whether QS had met any treatment objectives in terms of improvement of his symptomatology of cerebral palsy or whether and if so, how he had been readied for stem cell treatment. In fact there is no reference whatsoever to his readiness for stem cell treatment anywhere in the clinical file save that there have been discussions about stem cell treatment on 27 August.

247 Thus we conclude, that Allegation 4 has been made out.

248 As with Allegations 1 and 3, Dr Freckelton submitted that we should determine in relation to Allegation 4, that Dr Hooper has engaged in 'professional misconduct'. However, as with Allegations 1 and 3, we believe the same considerations apply here as they applied there. We have set out the law and considerations in what we have written about Allegation 1, relating to unprofessional conduct and we are of the view that the same considerations apply to Allegation 4. We do not believe other determinations referred to in s 77(1) of the Act are appropriate for Allegation 4. Therefore, we determine that the respondent has engaged in unprofessional conduct. (Basically the same facts apply here as there).

Allegation 5: Failure to Monitor Outcomes

249 The matters in relation to this Allegation are not dissimilar to those discussed in relation to Allegation 4. In paragraph 48 of QS's statement of 16 June 2010, he referred to matters relevant to monitoring of outcomes. He said there were few consultations between himself and Dr Hooper, 'he would talk to me from time-to-time while I was on the Lokomat machine but he did not undertake any tests to record any improvement in my condition. At no stage did Dr Hooper physically examine me in relation to my progress or my functionality.'

250 The respondent relied on the evidence of QS at Transcript 205 where QS agreed that he talked to Dr Lu, Dr Tooraj and Mr Islam that they knew the protocols and they were not pressurising him. The doctors referred to were unregistered doctors in the State of Victoria or Australia. Dr Hooper also relied on the fact that QS agreed that each of those 'doctors' instructed QS in what to do and they were familiar with his problems. However, it was admitted by Mr Islam in his evidence, that he was unaware that QS was being prepared for stem cell therapy. The other 'doctors' did not give evidence.

251 Dr Freckelton also relied on the evidence of Dr Terrett at Transcript 1414. After Dr Terrett had indicated that the only treatment plan he could determine was 120 hours of HBOT and a number of hours of Lokomat treatment, Dr Terrett was asked by Dr Freckelton: 'Would that kind of an indication meet the standard criteria for a treatment plan provided by a chiropractor?' Dr Terrett answered:

> I think there should be – with a treatment plan that is so long, you would normally expect periodic revision of – or reassessment of the patient's condition and they are responding to treatment before you complete 120 hours of or 200 hours of treatment. So I don't think that – would be normal practice. Amongst many practitioners that I know who have long, extended treatment plans with some patients, I have heard it suggested that after 12 visits, there is reassessment on the twelfth visit.

Apart from extending the hours for HBOT and Lokomat treatment in November of 2007 there does not appear to have been any reassessment of QS at all. In fact, as it has already been mentioned, Dr Hooper believed QS should continue treatment until he stopped.

252 Dr Hooper's progress notes do not reveal any record of testing QS in respect of cerebral palsy symptoms generally or his readiness for stem cell treatment. This indicates that it is unlikely that there was proper monitoring of the outcome of any treatment which QS received.

253 The necessity for monitoring treatment, was emphasised by a number of the witnesses who gave evidence for the applicant:

(a) In his report of 11 February 2010, at page 5, Dr Millar noted that the patient's progress should always be monitored on a continuing basis. He stated, that the failure to monitor treatment has the potential for the unnecessary continuation of either completed or futile treatment, or a result of important issues being overlooked or an alternative treatment foregone.

(b) In his report of 6 April 2011, Dr Bennett stated that it was 'universal practice' in medically run (HBO) chambers to assess the patient each day after therapy to ensure there was no problems with the therapy.

Save for the occasional comment in the notes that QS was feeling better, there does not appear to be any clinical assessment undertaken by HyperMED to monitor QS's progress.

(c) At Transcript 1417, Dr Terrett stated that he had reviewed the progress notes and there was an absence of any objective measures availed of by Dr Hooper. Dr Terrett stated he could find no base lines recorded with respect to symptoms such as spasticity, range of movement, involuntary movement or pain, no attempts to objectify improvement, no questions as to how QS was feeling on one day compared with the previous day and no reference to measurements for improving gait.

254 In dealing with Allegation 4, we have already dealt with the tests that Dr Carda said could be implemented in order to objectively assess whether QS had made any improvement or otherwise during treatment. Professor Dodd and Dr Patritti also referred to such tests.

255 It is also noted, that both Professor Dodd and Dr Carda were unable to discern any improvement or otherwise from the Lokomat information.

They suggested it was all over the place. Dr Carda stated, in his report of 16 October 2012, at page 963 of the applicant's tribunal book:

> There is no way to understand from the Lokomat printouts that the treadmill speed, angular speed of joints and unloading has improved due to the patient's amelioration or only are due to a different choice of operator.

256 We accept the views of the experts referred to above and as such we find that Allegation 5 has been made out.

257 Dr Freckelton submitted, as with Allegations 1, 2 and 4 that we should determine that the respondent engaged in professional misconduct in relation to Allegation 5. We believe, that the matters we have set out in Allegation 1, also reflect matters in Allegation 5 as to reasons why we should determine that Dr Hooper engaged in unprofessional conduct rather than professional misconduct. We have set out the law and considerations in what we have written about Allegation 1, relating to unprofessional conduct and we are of the view that the same considerations apply to Allegation 5. We do not believe other determinations referred to in s 77(1) of the Act are appropriate for Allegation 4. Under those circumstances, we determine that Dr Hooper has engaged in unprofessional conduct.

Allegation 6: Misrepresentation of Likely Effectiveness of Treatment

258 At Transcript 2451, Dr Freckelton referred to the basis of Allegation 6. He stated:

> The allegation relates to misrepresentation about likely effectiveness, which in itself postulates a contrast between what was communicated and reality. It appears that QS was given to understand that it was worthwhile to submit to hyperbaric oxygen treatment and Lokomat treatment, either to better his symptomatology of cerebral palsy and/or to get him ready for stem cell treatment overseas. The evidence before you is that the organisations to which reference is made in paragraph 170 ANZHMG, ANZSIGDHM, UHMS and European Committee for Hyperbaric Medicine 7th Consensus Conference of 2004, after due consideration, have omitted cerebral palsy from the list of conditions which can constructively be treatment with hyperbaric oxygen treatment. We say that places a heavy onus on anyone suggesting to the contrary, to communicate clearly with a patient or potential patient what they are doing, why they are proposing to do it and what the bases are of their proposed treatment.

We do not take this statement to mean Dr Freckelton suggest that there should be a reversal of the onus of proof.

Hyperbaric Oxygen Treatment or Symptoms of Adult Cerebral Palsy

259 It has already been stated, that the International Hyperbaric Association, which promotes HBOT for neurological conditions, is largely a funding organisation.

260 Dr Hooper submitted that the chiropractic profession is not bound by scientific efficacy. At paragraph 134 of his submissions, it is stated:

> The bar, for 'standard of scientific efficacy' embodied in the allegations of this case, is based upon concepts foreign to the working knowledge of practitioners, foreign to the words of the old codes of conduct, and foreign to the new codes of conduct of the fourteen registered health professions, including the medical profession.

261 As we have previously stated, the practice of hyperbaric medicine and, for that matter, Lokomat treatment, is not common or usual amongst chiropractors in Victoria or Australia. Therefore, this particular instance, is something different from normal chiropractic practice.

262 It is not suggested, that Dr Hooper should be prohibited from performing the treatment that he did in relation to QS, what is suggested, is that Dr Hooper should have informed QS of the mainstream views, including those of the peak organisations of Australia, Europe and the United States to which we have already referred. Put differently, a balanced view needed to be given. We agree with Dr Freckelton's comments at paragraphs 179 and 180 of his submissions where he stated:

> Dr Hooper appears to want to prioritise his own clinical experience over scientific literature. First, this is illogical in the particular instance as he has conceded that before QS he had only had two other adult patients with cerebral palsy [see Transcript 1742].
>
> In terms of experience of others, Dr Hooper is vague, maintaining that other persons, who for the most he does not want to name, have also had positive experiences of such treatment. They do not include Dr Marois who is a paediatrician. Significantly, whoever these practitioners are, by 2007/2008 they had not communicated their allegedly positive experience in peer review journals.

263 Dr Hooper relied on the evidence of Dr Terrett at 1423 where Dr Terrett said:

> There is no requirement of any health practitioner, that I know of, to provide scientific evidence for efficiency of their treatment.

However, that does not mean that a practitioner should not inform a patient of other views contrary to the treatment particularly in a case such as the treatment in this proceeding which is rare in the chiropractic profession and where there is mainstream views which are completely contrary to the treatment being performed. Again, at Transcript 1424 and 1425, Dr Terrett agreed that there was no need to tell the patient whether the treatment is novel or mainstream. However, we find that that is not the position with this particular treatment nor with Lokomat treatment which, is unusual for a chiropractor as we have already stated.

264 Dr Hooper also relied on the writings of Jain in the fourth edition of his book published in 2004. We have already dealt above with the comments of Dr Millar and Dr Bennett in relation to this book. We find that this book,

by and large, is not mainstream view and is insufficient to establish Dr Hooper's position. We make these findings on the reasons discussed in paragraphs 35 to 41 inclusive hereof. We note that Dr Steenblock, was supportive of Jain's writings, however, we place little reliance on his evidence for the reasons already stated, including that he did not make himself available for full cross-examination.

265 Dr Hooper also relied on Dr Marois, the co-author of the Collet Study published in the Lancet to suggest that the Collet Study did not exclude the use of HBOT for cerebral palsy for the reasons we have discussed above.

266 In relation to the view of Dr Marois, Dr Freckelton has correctly noted, at paragraph 192 of his submissions, that Dr Marois has never publicly published a repudiation of his role in the Lancet article. We take this to mean that there may be some question over Dr Marois' views.

267 In relation to Dr Stoller, we note that he appeared to misrepresent Dr Marois' views altogether. He stated that the article in the Lancet was published without Dr Marois' consent or knowledge. This did not appear to be correct from the evidence of Dr Marois.

268 We do not intend, nor do we need, to decide the question of whether HBOT can assist patients with cerebral palsy. What we are required to decide is whether there has been misrepresentation by Dr Hooper in relation to the offering of HBOT for cerebral palsy. The material provided by Dr Hooper in his website and other materials given to QS, as well as conversations held between QS and Dr Hooper, all suggested that HBOT would be of assistance to ameliorate his symptoms of cerebral palsy and to help in the preparation for stem cell therapy. Dr Hooper did not give a balanced view. To give a balanced view, Dr Hooper was obliged to inform QS, in clear and unequivocal terms, of the large body of evidence which suggests that HBOT would not assist ameliorating QS's symptoms in relation to his cerebral palsy. This should have been stated verbally and discussed with QS. It was completely insufficient for Dr Hooper to say that there were contrary views on his website. We refer to the statement by Professor Dodd in relation to the interpretation of that website by a lay person. See paragraph 44 hereof.

269 In our view, Dr Hooper acted quite improperly and, in fact, misrepresented to QS that the treatment would assist ameliorating his symptoms of cerebral palsy. Dr Hooper had a responsibility to provide material information within his knowledge or which should have been in his knowledge, which would have delivered a balanced view as to the likely success of the treatment he was providing or seeking to provide.

270 It is no answer, as Dr Hooper would have us believe, to say that he referred to and went through Jain's writings with QS. Jain's writings do not give the whole picture in relation to the treatment of cerebral palsy or many other conditions which Dr Hooper alleges it is suitable to treat. Jain's writings do

no more than support Dr Hooper's case for supplying the treatment. They do not provide a balanced view.

271 Dr Hooper also relies on the code of ethics of chiropractors as not precluding the treatment he gave. However, as we have already stated, the code of ethics do not, in principal, and do not, in fact, descend into every particular specific of the chiropractor's obligation. As Dr Freckelton said, 'The essential obligations of practitioners was set out in the code and Dr Hooper failed to comply with it by failing to communicate to QS the realities about the provision of hyperbaric oxygen therapy to an adult with cerebral palsy.'

Hyperbaric Oxygen Treatment to Ready QS for Stem Cell Therapy

272 It seems clear that, at least in part, HBOT was given to QS to ready him for stem cell therapy. A number of matters that we have dealt with in relation to HBOT for improving QS's functionality also apply to stem cell therapy and we not intend to repeat the same.

273 Dr Hooper relied on the evidence of Dr Steenblock to suggest that it was useful to use HBOT in preparation for stem cell therapy. We have already made comment on Dr Steenblock's evidence, and do not intend to repeat the same except to say that we not accept his evidence as reliable for the reasons we have given. Further, it is clear, on the evidence, that Dr Steenblock in 2007 had not used stem cell therapy for adult patients with cerebral palsy. He did that much later.

274 We agree with Dr Freckelton that there has been no satisfactory evidence adduced to the Tribunal that there was any convincing prospect of success of the stem cell therapy which QS hoped to undertake. This should have been explained to QS in some detail. It was not.

275 Dr Freckelton gave a number of examples of the proper attitude an ethical medical practitioner would adopt when somebody like QS, with cerebral palsy, talked about stem cell therapy. He referred to:

(a) Dr Rawicki, a neurologist, who had previously treated QS. Dr Rawicki stated:

> Stem cells for therapeutic (or even reasonable experimental) use for people with CP or other significant neurological impairments are still a pipe dream. I doubt very much that either you or I will see such use.' (See file note of Dr Hodgson, Exhibit 9).

(b) In Dr Churchyard's evidence, he stated, Transcript 785:

> There is no evidence that hyperbaric oxygen therapy would activate stem cells and … there is no evidence that stem cell therapy of whatever type has any effect on any neurological disorder.

276 Dr Churchyard also stated at Transcript 816 that the fundamental characteristic of cerebral palsy, whose evidence is 'rock solid' and several centuries old is that 'initial insult to baby or infant's brain is an acute insult,

presumably, in most cases, and then after that, the brain has to deal with whatever way with the residual permanent damage'.

277 Dr Hooper made considerable criticism of Dr Churchyard that he was not an expert in stem cell therapy and that there were inconsistencies in his evidence. Dr Hooper also referred to the ischemic penumbra which is the area around the brain that has been affected by the neurological disorder. He said that that area has cells that do not work but are not dead and that those cells can be activated by HBOT and stem cell therapy. As previously said, it is not for us to determine the controversy of stem cell therapy or HBOT in relation to cerebral palsy or any other condition, but what is clear from Dr Churchyard's evidence and others is that there is a considerable body of learned mainstream opinion which is clear that stem cell therapy will not assist a patient such as QS with cerebral palsy. QS should have been informed of these views. Not informing QS of these views, in our view, was a misrepresentation. For a discussion of this evidence, reference should be had to what we have said above, in particular from paragraphs 47ff of these reasons.

278 We would add to what Dr Freckelton has stated, that there is also an obligation to inform any patient or potential patient, of the views of the organisations referred to above, which are mainstream organisations as there is in relation to mainstream views about Lokomat treatment.

279 Dr Freckelton then continued, at Transcript 2452:

> In this instance, the overwhelming preponderance of literature is not in favour of the treatment of cerebral palsy symptomatology with either hyperbaric oxygen or Lokomat treatment. And there isn't any substance which is supportive of treating a person with this condition, who's an adult, to ready them for stem cell treatment. This means that it is incumbent upon a person, nonetheless, determined to provide such therapy to **let the patient know what they are submitting to**. **In other words, what the state of the literature is. What the state of conventional approach is … That it's unsupported by the relevant professional organisations and by most health practitioners working in the field in Australia or in western countries. That it is not supportively the subject of publications in international respective peer review journals.** That, in essence, it's a novel, non mainstream, speculative and experimental treatment. (Emphasis supplied).

280 Dr Hooper theorised that QS's cerebral palsy was caused by a stroke in utero. He suggested there was evidence to support this theory, relying on the CT and MRI. However, the European Conference material at page 770N of the applicant's Tribunal Book suggests clearly that neither cerebral palsy nor stroke are acceptable conditions for HBOT (stroke being level D evidence and cerebral palsy, multiple sclerosis being Level F, F being the lowest level of evidence). Anything less than level 'C' evidence is not acceptable.

281 As has been discussed earlier, the view of the mainstream professional organisations to which we referred are not accepted by Dr Hooper and a number of the witnesses that he called, including Dr Steenblock, Dr Stoller and Dr Marois, although Dr Stoller did say that UHMS was the peak organisation. That does not mean that Dr Hooper was not obliged to inform QS of those views.

Lokomat Treatment to Treat QS for Cerebral Palsy or its Symptoms

282 We have already dealt with the efficaciousness of the Lokomat treatment in paragraphs 62ff hereof. Like with the HBOT, it was incumbent upon Dr Hooper to inform QS of the strong view of others that the Lokomat treatment was not efficacious for his condition or that other treatments, such as, overground walking would be just as beneficial. It is noted, that of course, overground walking would be far less expensive than the Lokomat treatment. Further, it could be done at home, without the need for daily trips from the applicant's home to Dr Hooper's rooms. Further, we accept, that there are limited studies on the effect of the Lokomat. Professor Dodd commented at Tribunal Book 709, and her report on 18 January 2010, that, 'because of the relatively small amount of literature in this area (Lokomat training) and the low methodological quality of existing studies, further high quality research needs to be completed before it can be confidently concluded that PBWSTT (partial body weight support treadmill training) has a beneficial effect on the activity and participation of children with CP.' Therefore, even though there may have been some difficulty in Dr Hooper referring to the literature available in 2007, it was incumbent upon him to know and to tell QS that there was little known about this treatment and that further studies were required. He did not do so. It is insufficient for him to rely on material produced by the Hacoma (the manufacturer of the Lokomat). The material is not independent. It is promotional.

283 Professor Dodd also made it clear that it was the view of most mainstream healthcare providers, that as people with cerebral palsy (CP) got older, physical therapy intervention had less impact on changing the underlying impairment associated with CP. (See report of Professor Dodd, 18 January 2010, ATB 709) and Transcript 559.

284 All the matters which we have discussed, in our view, made it incumbent upon the healthcare provider, Dr Hooper, to inform QS that there was doubt as to whether the Lokomat would be able to better his condition or symptoms of cerebral palsy. He could well have referred to the fact that there was little information about these matters and, at the moment, it was very much an untested field. He also should have informed QS that it was possible that practising overground walking at home, which he had been doing since 2004, could have a similar effect to the Lokomat treatment.

285 In relation to the matter of stem cell therapy, Dr Freckelton correctly makes the point that there was, "no peer review scholarly literature which would have justified Dr Hooper in encouraging QS to believe that hyperbaric

oxygenation or Lokomat treatment had a realistic prospect of readying QS for stem cell treatment".

286 The clinical file makes no reference to when QS would be likely to be ready for stem cell therapy or if he would be ready for stem cell therapy at all. Dr Hooper should have pointed out to QS that there were many variables in relation to being able to be ready for stem cell therapy and he should have pointed out those variables, for example, when was it proposed for the stem cell therapy to take place? Or was the stem cell therapy to take place at all? We agree with Dr Freckelton's comments at paragraph 238ff of his submission:

> It was incumbent upon Dr Hooper, if he had a bona fide belief that hyperbaric oxygen treatment or Lokomat treatment had some potential to assist with stem cell therapy, to explain to QS how that would be so (explaining that such views were idiosyncratic, unrepresentative of what most other reputable practitioners, in Australia and other comparable countries thought, and that peer review, scholarly literature did not support his views as yet), how he would measure such readiness, when he thought QS would be ready and how he would liaise with, for instance Dr Steenblock, to coordinate the provision of their therapies so as to maximise the prospects of their success. The clinical file makes it clear that no measurements were undertaken. In fact, it may well be that such assessment was not feasible, thereby rendering the whole concept of stem cell readying by way of activation or otherwise, dubious in the extreme and a licence for open ended provision of therapy. …
>
> All these considerations suggest that the representations of Dr Hooper to QS about his provision of hyperbaric oxygen treatment and Lokomat treatment, in so far as they related to readying QS for overseas stem cell treatment, were misrepresentations about the prospect of there being or any significant progress towards that objective. As with other representations, to which reference has previously made, they were not characterised by any or any ethical qualifications by reference to the position of most practitioners, the state of scientific/medical knowledge at the time and the absence of any sound evidence as to the likely efficacy, that should have been provided.

287 As a result of the above considerations, we conclude that Allegation 6 has been made out.

288 As with Allegation 2, Dr Freckelton has submitted, that pursuant to s 77(1)(d) of the Act, we should determine that Dr Hooper is not of good character. However, in line with the considerations that we have discussed in relation to Allegation 2, we are of the view that the proper determination is that there has been professional misconduct in relation to Allegation 6. In coming to this view, we refer to what we have written about the law and the facts relating to Allegations 1 and 2. We are of the view that similar facts apply to Allegation 6 as to we applied to Allegation 2. We do not

believe other determinations referred to in s 77(1) of the Act are appropriate for Allegation 6.

Allegation 7: Misleading and Deceptive Advertising

289 Section 94(1) of the Act relevantly reads as follows:

> A person must not advertise a regulated health service or a business providing regulated health service in a manner which –
>
> (a) is or is intended to be false, misleading or deceptive …

There is then a criminal penalty provided for such conduct.

290 In relation to matters concerning Allegation 7, we refer to paragraph 31ff of these Reasons. Further, in relation to the evidence of Dr Bennett and Dr Millar in relation to Allegation 7, we refer to Appendix A and B hereof.

291 We note that Dr Steenblock, at Transcript 1856 and 1857, gave evidence as to the 30 conditions referred to in Allegation 7, and he maintained that those 30 conditions could be benefitted by treatment with HBOT, except for condition 27 (pulmonary embolism) which he said that would not benefit and he said he had no experience in relation to infertility and cancer mutation. We have already made comments about Dr Steenblock's evidence and, because of the comments we have already made, where there is a conflict between the evidence of Dr Steenblock and Dr Bennett and Dr Millar, we prefer the evidence of Dr Millar and Dr Bennett.

292 Having said what we have stated above, in our view, it would not make any difference, if Dr Steenblock's evidence was accepted as having some veracity. We accept that there are many practitioners in the United States and elsewhere, that would hold similar views to Dr Steenblock, or the author Jain, on the basis that all the 30 conditions referred to in Allegation 7 are treatable by HBOT. But, like other matters we have discussed, that does not make those views mainstream. These are very similar matters to what has been discussed in Allegation 6 and, to some extent, in Allegation 2. Like there, we conclude here, that the views expressed by Drs Bennett and Millar are the mainstream views. They are the views held by the peak bodies in Australia and New Zealand, USA and the European Conference. Therefore, like other matters, in advertising treatment, it is incumbent upon the practitioner to make these contrary views abundantly clear in such advertising. Dr Hooper has not done this. While we agree that there are some articles in the 900 articles on HyperMED website that do give contrary views to the majority of the articles therein and the views expressed by Dr Hooper, those articles would not be immediately apparent to anyone reading the website. We again refer to the view put forward by Professor Dodd referred to at paragraph 44 of these reasons.

293 It is not unusual for a practitioner advertising that they can cure or ameliorate certain conditions with particular modalities of treatment, which conditions either cannot be cured or ameliorated to which there is a large body of evidence which would suggest that there may be some doubt as

they can be cured or improved have been before the Tribunal. In a number of those cases, the conduct of the practitioner has been found to be false, misleading or deceptive. See *Hassad v Dental Practice Board of Victoria* [2007] VCAT 2489; *Dental Board of Australia v Paino* [2010] VCAT 1998.

294 At paragraphs 257 and 258 of Dr Freckelton's submissions, he gave a correct and a well-referenced overview as to the meaning of the words 'false', 'misleading' and 'deceptive'. He there stated:

> The meaning of 'false' is 'contrary to fact'; it does not require knowledge on the part of the person making the representation.
>
> The meaning of 'misleading' and 'deceptive' overlap but are probably not the same, although it has been suggested that they are tautologous. The meaning that they share is to 'lead into error'. To establish the language used by the practitioner must convey a misrepresentation. A misleading representation must induce or be capable of inducing error. If it is proven that there was an intention to mislead this may make it more likely that advertising was deceptive, but intent is not an essential element. Whether or not a representation is misleading is a question of fact to be determined by reference to the context and the surrounding facts and circumstances. Generally the question to be asked is what is a reasonable person of the class to which the representation is directed, would reasonably understand from the representation.
>
> A prediction can constitute a representation but the fact alone that a representation as a future matter does not come to pass does not necessarily make it false.
>
> Deception has been held to involve some degree of moral turpitude, trickery, craft and guile and typical but not essential elements.

295 The decision of the Victorian Court of Appeal in *Noone, Director of Consumer Affairs Victoria v Operational Smile (Australia) Inc* (2012) VSCA 91 relates to matters of representation in a health matter. An assertion by the clinic concerned involved 'the claim that Hope Clinic adopted an integrated approach to treatment of chronic illness combining state of the art medical technology with alternative therapy; the explicit description of Hope Clinic therapies as the best scientific complimentary medicine, the obesity scientific names ascribed to the therapies offered by the Hope Clinic, such as 'photodynamic therapy', 'haltmicrowave therapy', 'oxygen therapy' and 'Biolife electrotherapy'. At paragraph 60 of the decision the court stated that:

> A statement is misleading or deceptive or likely to mislead or deceive within the meaning of s 9 of the FTA if there is a real and not remote possibility be it more or less than a chance of 50%, of the statement leading into error the readers at which it is directed. Given that the website was not aimed at highly educated class in the community, but at the widest possible range of ordinary readers, I consider that the statement that the Hope Clinic therapies were peer reviewed and

> published methods for cancer treatment, in the context in which they appeared, and undoubtedly gives rise to that possibility.

296 In this particular instance, the HyperMED website was read by general members of the community not with specific intelligence, but which frequently, like QS, were very sick people. Those people were desperate for a cure or an amelioration of their complaint. They would frequently grab at anything where there was any possibility of their position being improved. Therefore it was very important that the website make it abundantly clear, in the clearest possible terms, that there may have been contrary views to those propounded by the practitioner. Those contrary views should be given at least equal importance to those of the practitioner. It is our view that it is the responsibility of a practitioner to enable the patient to understand where the treatment sits in relation to scholarly views contained in the literature. In *Traill v Medical Practitioners Board* [2006] VCAT 1920, the practitioner had administered hyperthermia and microwave treatment, which the Tribunal found were not proven treatments for cancer. And that the failure to disclose this information to patients meant that the consent that they had given was not informed. It found that, in recommending and administering unproven treatments to patients, failing to inform them adequately of the proposed treatments, wrongly characterising infusions as chemotherapy and charging them on that basis, as well as charging excessive fees for treatment, Dr Traill's 'conduct represented a deliberate and sustained departure from accepted standards and portrayed indifference and an abuse of privileges which accompany registration'. See [114].

297 The case of *Medical Board of Queensland and Tarvydas* [2010] QCAT 246 concerned a practitioner with some similarities to the present situation. The proceeding concerned a medical practitioner who had provided stem cell treatment to a patient with adhesive arachnoiditis. It found that he held out to prospective patients 'the hope of relief they were not getting from conventional medical treatment. He told them he was conducting a trial and that his treatment would stimulate the growth of the stem cells and revitalise them'. At [7]. The Tribunal found that the practitioner had:

> Failed to assess and monitor his patient's condition. He provided no information about his treatment, conventional options, and the risks associated with both. He made no attempt to obtain informed consent. His cavalier disregard for core requirements of patient care fundamentally challenges his professionalism. At [21].

298 The case *Chinese Medical Registration Board v Ghaffurian* [2012] VCAT 478 is a very useful guide as to misleading and deceptive representations by a practitioner. In that case, the practitioner was found to have engaged in professional misconduct in the provision of light therapy DMSO injection of high dose vitamin C, and use of the BICOM Bioscience Machine and DISRESONANCE Electronic Energy Machine as treatment to a patient

with sarcoidosis and high blood pressure. The Tribunal found [68-72] that Mr Ghaffurian induced the patient:

> To undertake a range of treatments outside the scope of Chinese medicine about which there is little if any scientific evidence to support their efficacy. He failed to enable her to either give or withhold informed consent based on advice from him about either issue.
>
> When his patient raised the issue that she did not perceive light therapy to be providing a benefit, without clinical justification he induced her to continue saying if she stopped her health would deteriorate. His desperate patient agreed to continue. …
>
> When he offered stem cell therapy, he attempted to introduce the Notifier to accept the therapy by in part providing her with a testimonial from someone described as a nurse.
>
> Mr Ghaffurian also failed to in any sense keep adequate medical records of his treatment of the Notifier. This in itself is a serious departure from accepted standards and a threat to the welfare of the patient should the treating practitioner be unable to recall the treatment provided or for some reason become unavailable to provide treatment.
>
> Further, he failed to provide any reasonable form of documentation and or labelling with respect to herbal mixtures he gave the Notifier.

As part of its findings that Mr Ghaffurian engaged in professional misconduct by providing excessive, unnecessary, incompetent and clinically unjustified treatment, also found that 'Mr Ghaffurian failed to advise the Notifier that light therapy DMSO and Biocom BIORESONANCE Machine are not part of Chinese medicine and are not scientifically proven'.

299 The Tribunal found Mr Ghaffurian had engaged in professional misconduct by making misleading and deceptive representations that created in his patient an unreasonable expectation that his treatment would be beneficial.

300 The respondent sought to distinguish *Ghaffurian's* case from the present on the basis that the proceeding related to traditional Chinese medicine. This distinction is not to the point as that the issues and propositions that we are concerned with in that case relate to health professions generally.

301 The Tribunal, in *Ghaffurian's* case concluded that the practitioner engaged in professional misconduct in failing to obtain informed consent for his patient by failing:

> To advise her that while he thought she may derive benefit, his opinion is supported with scant if any credible scientific evidence. Further, he failed to advise her of potential risks of treatment. Therefore, he failed to obtain informed consent. Also, we note, Mr Ghaffurian failed to record any consent given by the Notifier.
>
> In particular, with respect to the Notifier, Mr Ghaffurian:

- failed to explain the likely outcomes, advantages, disadvantages, side effects, risks and alternatives to the 'light therapy';
- failed to explain the likely outcomes, advantages and disadvantages, side effects, risks and alternatives of the vitamin C injections;
- incorrectly informed her that there were no known side effects from vitamin C injections;
- failed to explain the likely outcomes, advantages, disadvantages, side effects, risks and alternatives of animal stem cell therapy;
- failed to explain that animal stem cell therapy is experimental;
- failed to explain the likely outcomes, advantages, disadvantages, side effects, dangers, risks and alternatives of the DIMETHYL SULFOXIDE solution (DMSO) which prescribed; and
- refused to answer the Notifier's questions about the contents of her Chinese medical prescription.

302 The Tribunal also found [129-130] that Mr Ghaffurian engaged in professional misconduct by creating an unreasonable expectation that his treatment would be beneficial to the patients by what he published on the web, including, by advertising the BICOM BIORESONANCE Machine on the website … which:

- Incorrectly suggests the machine is specially effective for treatment of allergic illness such as rash, asthma and hayfever, acute and chronic inflammation of gastric mucosa, rheumatic disease, disease of internal organs/migraine all sorts of pains, injuries/scar interference fields, problems of the teeth/jaw region;
- Inaccurately stated the machine could treat 'almost all illnesses … with varying results'; and
- Misrepresented that the machine could successfully treat depression, irritable bowel syndrome, eczema, bloating, fertility issues, weight loss, arthritis, back pain, candidia, allergies, fatigue, acne and cholesterol and blood pressure.

303 It found that asserting that he merely republished information provided to him, does not justify his actions. This is similar to the present situation, where Dr Hooper published on his website material from the Jain textbook.

304 As previously referred to, Dr Hooper asserted that his website was not advertising but was for the purpose of a forum. We have already rejected this proposition. In our view, looking at the website as a whole, and in particular, the 30 matters referred to in Allegation 7, the material was

published on the website for the purpose of attracting customers and/or patients to the HyperMED clinic, that is, advertising. The treatments were referred to in order to attract people like QS who had very serious conditions and were desperate to find some amelioration or relief from their symptoms. To put it simply, to attract vulnerable people.

305 Like in *Gurfurian's* case, here it is no answer that the material on the website is extracted out of the Jain textbook. The material was a representation by Dr Hooper and published by HyperMED of the facts asserted. Therefore, it was incumbent upon Dr Hooper to ensure that the representations contained sufficient information for people to be able to judge whether or not they desired the treatment. That is, the website should have contained clear information that the treatment and results claimed by HyperMED, were thought by a large section of the medical community and in fact mainstream medicine to be non-efficacious. No such statements were made.

306 It is clear from the evidence of Dr Millar, Dr Bennett and Dr Churchyard that there is considerable doubt as to the efficaciousness of the treatment in relation to the 30 named conditions.

307 In relation to the neurological conditions, Dr Churchyard stated, without reservation, at Transcript 784:

> I would not consider any of these treatments – any of these conditions – likely to respond to hyperbaric oxygen nor on the basis of my reading and my experience as a clinician nor is there any evidence that hyperbaric oxygen would have efficacy with these conditions.

308 Again, Dr Hooper relied upon evidence of Dr Terrett, Transcript 1423:

> There is no requirement of any health practitioner, that I know of, to provide scientific evidence of efficacy of their treatment.

309 The evidence in this regard of Dr Terrett is not to the point. First, because, as we have previously stated, this is a different situation from everyday chiropractic treatment. Secondly, the complaint by the Board is not that Dr Hooper failed to state the scientific efficacy of the treatment, but that he failed to warn patients, or prospective patients, searching the website that there was a strong body of evidence which was from mainstream medicine, that believed this treatment was not efficacious for the 30 conditions referred to.

310 Dr Hooper also relied on Dr Terrett's evidence that the Board's complaint in regard to this matter was not covered by the Chiropractic Codes of Conduct. However, as Dr Freckelton has pointed out, the Codes of Conduct do not cover every situation. The Act itself forbids misleading and deceptive conduct (5.94(1)(a)).

311 Dr Hooper also relied on his third witness statement at 5 to the effect that:

> Hyperbaric oxygen was incorporated into treatment protocols during 1996; in excess of 80,000 separate chamber sessions have been performed without incident.

Again, this is not to the point. The fact is, that, as people were not warned and informed of the strong body of evidence holding contrary views to the efficacy of the treatment offered by Dr Hooper, they were clearly misled into believing that the treatment was efficacious without question. That does not necessarily mean that Dr Hooper was saying that the treatment, in all cases, would be beneficial. It means that he was neglecting to tell people who read the website that experienced medical practitioners did not believe there was efficaciousness in the treatment and, more particularly, the three peak organisations to which we have referred did not recommend hyperbaric treatment for those 30 conditions referred to on the website.

312 We accept Dr Freckelton's submission that:

> The evidence establishes in respect of the conditions that it was misleading and deceptive, on a fair reading of the representations, and placing them in fair context, for it to be represented that the 30 'conditions' were 'also' treated. This could only have been conveyed to the reader that such conditions could be treated with reasonable prospect of a positive outcome to the provision of treatment. … A reasonable prospect of a positive outcome from such treatment did not exist in respect of all or at least the overwhelming majority of the conditions.

313 At paragraph 284 of Dr Freckelton's submissions, he sets out, in clear terms, what should have been included in HyperMED's website in order for it not to be misleading and deceptive:

> … Dr Hooper would have needed to present a balanced view of the effectiveness of hyperbaric oxygen treatment for the (30) conditions. Such a balance could only have been achieved by incorporation of a clear statement about the real status of his claims, namely that such treatment was not conventionally used in Australia and western countries with a comparable health service culture between 2007 and 2008 in treating such conditions. Nor was such treatment for this wide number of conditions advocated by qualified health practitioners practising in such countries in hyperbaric medicine or by four organisations to which reference had previously been made. Nor did medical and scientific evidence support the effectiveness of his representations in respect of either hyperbaric or Lokomat treatment. Nor did in internationally respect peer review journals establish that substantive benefits would be provided by such treatment for the 30 conditions.

Dr Hooper made the point that the current editor of UHMS Journal supports the use of HBOT for neurological conditions. However, Dr Millar, who is a Board member of the UHMS, made it clear that the editor did not represent the view of UHMS.

314 Thus, we determine that Allegation 7 has been made out. In relation to a determination in this matter, like Allegations 2 and 6, Dr Freckelton has requested that we determine that Dr Hooper is not of good character pursuant to s 77(1)(d). However, for the reasons given in relation to Allegation 2, which, for the purpose of determinations, is very similar to the similar present, we determine that the respondent has engaged in professional misconduct in relation to Allegation 7. In coming to this view, we refer to what we have written about the law and the facts relating to Allegations 1 and 2. We are of the view that similar facts apply to Allegation 7 as to we applied to Allegation 2. We do not believe other determinations referred to in s 77(1) of the Act are appropriate for Allegation 7.

Allegation 8: Inadequate Clinical File

315 In relation to this issue, we refer to paragraphs 88 to 92 inclusive hereof and, 100 to 107 inclusive hereof. In relation to the clinical file, Dr Hooper relied on the fact that the file contained a diagnosis of QS condition, that is, cerebral palsy, and that part of the outcome of treatment was for preparation of stem cell therapy. He also stated that the chiropractics Code of Conduct did not require notes of greater extent than what he had. However, we have made the point repeatedly in these Reasons, that the matters that Dr Hooper was concerned with in treating QS were somewhat very different from the normal practice of a chiropractor. Dr Hooper also made reference to the Lokomat computer print out notes which he said were part of the file. However, we have already made reference to the comments which we accept that were made by Dr Carda in relation to those notes. That is, briefly, those notes do not really reflect the condition of the patient but the setting of the machine.

316 Dr Terrett gave evidence that it is the obligation of a registered practitioner to generate proper clinical records, irrespective of the particular kind of treatment or modality provided. Both Dr Terrett and Dr Ebrall were of the opinion that Dr Hooper's clinical file does not meet the test of being an appropriate patient record expected of a registered chiropractor. See Transcript 1448 and Exhibit N ATB 955.

317 There were a number of clinical deficiencies observed in the file:

(a) Dr Terrett said, in his witness statement, at ATB 938:

> It would be expected for an average chiropractor demonstrating reasonable care that such a history (the 8 point history) would be documented in the clinical notes.

(b) Dr Terrett stated that basic components of a physical examination were missing [see Transcript 1412]. He said that an assessment of the patient's clinical problems can consist of three steps, being taken a clinical history, performing a physical examination and formulating a working diagnosis hypothesis as the cause and nature of the patient's condition. See Exhibit N, page 938 ATB. There was no

history or physical examination of QS noted in the file. Dr Terrett identified the following omissions from Dr Hooper's clinical notes:

- The notifier's disability.
- Whether some limbs (were affected by QS's condition) more than others.
- Whether the notifier had involuntary movements.
- Whether the notifier had any intellectual disability.
- Whether the notifier had joint contractures.
- Whether the notifier has pain.

318 Professor Ebrall, in his report, (Exhibit L at p 10) stated that the notes did not provide a working diagnosis based on Dr Hooper's assessment of QS; nor could he identify a management plan that proposes the frequency and duration of treatment or desired milestones, nor was there a signed consent form.

319 Dr Hooper made a rare concession, at Transcript 1764, that there was no notation of QS's suitability or otherwise for HBOT or Lokomat treatment.

320 Dr Freckelton correctly makes the point that:

> There is nothing in the clinical notes as to what advice Dr Hooper provided QS, based on QS's personal medical circumstances as to the risks, options, disadvantages, limitations, contraindications or side effects of hyperbaric oxygen therapy or Lokomat therapy for QS; nor was there any written response by QS to that advice.

321 Further, the file does not contain any reason why further treatment was necessary or details of QS's clinical progress, or lack thereof. There were no records of communication between Dr Hooper or HyperMED staff with QS other than practitioners notation about QS's treatment; it was submitted on behalf of Dr Hooper that he performed an examination of QS which he referred to as the Valsalva's manoeuvre, however, that does not appear to be noted in the notes. It was also said by Dr Hooper that it was unnecessary to make notes as to the advantages and disadvantages of the kind of treatment because the patient had been given a handbook. Dr Hooper said the handbook was similar to the Alfred Hospital Protocols. In our view, Dr Hooper's clinic was very different from the Alfred Hospital. At the Alfred Hospital, it is very likely that a patient would have been referred to the hospital with a referral from a medical practitioner who is the primary healthcare provider. In Dr Hooper's case, he was the primary healthcare provider, therefore, it is very important that conversations between the patient and the provider be noted, which Dr Hooper failed to do.

322 Dr Hooper also asked QS whether he recalled instructions given by one of the practitioners at the clinic to QS in regard to the use of the hyperbaric chamber. QS did recall some instructions being given and the nature of

those instructions. However, it is very important that those instructions be noted. They were not.

323 Dr Hooper also relied on the Lokomat printout and said that formed part of his clinical file. In our view, not only are the Lokomat print outs inadequate for the clinical file for the reasons stated by Dr Carda in his evidence, but, it is unlikely those notes would be able to be interpreted by another practitioner who may take over QS's treatment.

324 Dr Hooper also relied on several matters that QS was told as to the use of the Lokomat. However, in our view, that does not take the matter further as they do not appear in Dr Hooper's clinical file.

325 Dr Hooper also relied on the answers QS gave in cross-examination in relation to questions that were asked as to his suitability for treatment. See Transcript 221. Those questions appeared, apparently, in an ABC report. In our view, an ABC report is not part of a clinical file.

326 Dr Hooper also refers to many conversations that were had with QS and he maintains that those conversations fulfil the requirements referred to in the particulars to Allegation 8. However, as we have said, in relation to other specific matters, the matters do not appear in the notes.

327 Taking all the evidence together in relation to Allegation 8, we have formed the view that Allegation 8 has been made out. Dr Freckelton has submitted that we should determine that Dr Hooper has engaged in professional misconduct in relation to Allegation 8. However, in our view, Allegation 8 falls into the same category as Allegations 1, 3, 4 and 5. For the reasons we have stated in Allegation 1, we find that the matters concerned in Allegation 8 constitute unprofessional conduct by Dr Hooper. We have set out the law and considerations in what we have written about unprofessional conduct in dealing with Allegation 1, relating to unprofessional conduct and we are of the view that the same facts of law apply to Allegation 7. We do not believe other determinations referred to in s 77(1) of the Act are appropriate for Allegation 7.

Other Matters

Submissions of Respondent

328 Submissions made by Dr Hooper or on Dr Hooper's behalf by Mr Little were difficult to follow. Frequently, they did no more than quote lengthy passages from the Transcript, apparently inviting attention to inconsistencies which the respondent perceived. It was not clear to us what point the respondent was seeking to make thereby.

329 The respondent made lengthy additional submissions relating to:

(a) attacking the motivation and general conduct of the proceedings on behalf of the applicant. The respondent alleged the applicant incited hostile media coverage against Dr Hooper;

(b) the applicant caused difficulties with the renewal of Dr Hooper's 2012 registration as a chiropractor;

(c) reference to writings from those involved with the applicant, including senior counsel, which writings did not relate to the proceeding;

(d) matters which occurred in directions hearings and preliminary issues that did not bear directly upon issues before the Tribunal;

(e) complaints about the rulings of the Tribunal;

(f) misplaced understanding of the importance of scientific efficacy to the proceedings;

(g) issues of conspiracy with bodies such as 'The Friends of Science';

(h) the position of Chinese medicine in Victoria;

(i) trying to draw a distinction between the Notice of Allegations and matters raised by QS in his notification to the respondent; and

(j) suggesting a conspiracy amongst those involved on the applicant's side of the proceeding.

None of these matters bear on the merits of this proceeding. It is unsurprising the evidence in this proceeding would not have enabled us to make findings on these submissions even if they were relevant. Noting these facts, we put these submissions to one side as irrelevant.

330 In the respondent's submissions, Dr Freckelton was taken to task in relation to a reference, 'Saint Freckelton' had made to the story of Sampson in the Book of Judges. Mr Little referred to the Book of Hebrews, while there was some reference to Sampson in the Book of Hebrews, it does not support the proposition that 'Sampson is going to rule with Christ'. There was also reference to the 'Book of Hope', however we are not aware of such book appearing in either the Old or New Testament of the Bible. We are unaware of that work (Book of Hope) and no reference was given in relation thereto (other than it was mentioned on the internet).

The Proceeding

331 This proceeding commenced in May 2010 and has occupied many days before the Tribunal. Dr Freckelton has prepared a document entitled, "A Short History of the Litigation" which we have reproduced as Appendix "C". Insofar as we can ascertain, the document is true and correct save and except that the hearing went for one further day after 29 April 2013, ie 1 May 2013. It is noted that the proceeding took an excessive amount of time as a consequence of the failure of the respondent to take directions on both time wasting and irrelevance of many of his arguments. There was also clearly a lack of understanding of the process of examination in chief and cross-examination procedures, which led to the frustration of Dr Hooper not being able to enter information into his examination in chief that he intended to rely on. All of this has also increased the costs to the

Chiropractors Registration Board, a comment made on many occasions by Dr Freckelton, which included the phenomenal amount of material required to be photocopied and the many volumes of material potentially to be read and used during the proceedings. This was further exacerbated by the frequent failed challenges to the constitution of the Panel itself, and the perception of bias.

Receipt of Material by Tribunal Member

332 Subsequent to the hearing of this proceeding concluding, Dr Waterhouse (a panel member of the Tribunal) received and email from HyperMED on or about 6 May 2013. The email contained a series of brochures and a research paper. We find the sending of such material to a member of the Tribunal, while the proceeding is being considered, to be both surprising and unorthodox. No leave was given by the Tribunal to file further material after the hearing concluded. Therefore, we will not take account of the material received by Dr Waterhouse. The normal way for any party to file material with the Tribunal is to file it through the Registry, not to send it by email to an individual member of the Tribunal.

CONCLUSION

333 As a result of the findings we have made above, in relation to Allegations 1, 3, 4, 5 and 8, we determine, pursuant to s 77(1) of the Act, that the respondent has engaged in unprofessional conduct. In relation to Allegations 2, 6 and 7, for the reasons stated above, we find that the respondent has engaged in professional misconduct. We intend to list this proceeding for a directions hearing so arrangements can be made to determine the appropriate order to be made pursuant to s 77(4) of the Act.

Robert Davis
Presiding Member

APPENDIX A
AMENDED FINAL NOTICE OF ALLEGATIONS
27 February 2013

Failure to Make a Proper Assessment

1. On 27 August 2007, Dr Malcolm Hooper failed to undertake or direct that a proper clinical assessment be undertaken prior to recommending that his patient, QS, undertake costly treatment in the form of more than 150 hours of hyperbaric oxygenation (HBO) treatment (which by 13 May 2008 totalled approximately 230 hours) and approximately 40-60 hours of Lokomat treatment (which by 13 May 2008 totalled approximately 70 hours).

PARTICULARS

(a) On 27 August 2007, QS attended Dr Hooper's HyperMED Neurorecovery Australia Clinic at Level 13, 15 Collins Street, Melbourne and sought HBO treatment, including in preparation for possible future overseas stem cell treatment of cerebral palsy.

(b) On 27 August 2007, Dr Hooper conducted an initial consultation with QS.

(c) Dr Hooper's clinical notes from the initial consultation on 27 August 2007 do not record that he undertook a physical examination and proper assessment of QS prior to him commencing HBO and/or Lokomat treatment.

(d) The cost per hour for undertaking HBO treatment at HyperMED was between $100-$150 per hour and the cost of undertaking Lokomat treatment at HyperMED was $220 per hour.

(e) On 27 August 2007, QS commenced HBO treatment and undertook two hours of HBO treatment at HyperMED following the initial consultation with Dr Hooper.

(f) On 27 August 2007, Dr Hooper recommended during the consultation with QS that he undergo an MRI scan, whose results were communicated to Dr Hooper on 7 September 2007.

(g) Between 29 August 2007 and 5 September 2007, prior to QS submitting to an MRI scan and Dr Hooper receiving the results of the MRI scan on 7 September 2007, QS undertook the following treatment at HyperMED:

(i) 2 hours of HBO treatment and 1 hour of Lokomat treatment on 29 August 2007;

(ii) 4 hours of HBO treatment on 1 September 2007;

(iii) 2 hours of HBO treatment and 1 hour of Lokomat treatment on 3 September 2007;

(iv) 2 hours of HBO treatment and 1 hour of Lokomat treatment on 5 September 2007.

(h) Dr Hooper failed prior to the commencement of HBO and Lokomat treatment to consult or communicate with QS's treating health practitioners in relation to his condition (cerebral palsy), his symptomatology and his general health.

Failure to Obtain Informed Consent

2. Prior to commencing HBO and Lokomat treatment on 27 and 29 August 2007, respectively, Dr Hooper failed to obtain informed consent, or sufficiently informed consent, from QS in relation to undertaking the costly HBO and Lokomat treatment which he recommended.

PARTICULARS

(a) Dr Hooper failed to advise QS prior to the commencement of either the HBO or the Lokomat treatment what were its advantages, disadvantages or contra-indications.

(b) Dr Hooper failed to advise QS prior to the commencement of either the HBO or the Lokomat treatment what were its limitations for his condition (cerebral palsy), symptomatology, or readiness for stem cell treatment for cerebral palsy.

(c) Dr Hooper failed to advise QS prior to the commencement of either the HBO or the Lokomat treatment what were its likely outcomes (including what permanent or temporary improvements in his condition (cerebral palsy), symptomatology or state of his stem cells could reasonably be expected.

(d) Dr Hooper failed to advise QS of any options other than the HBO and/or the Lokomat treatment which he might consider, rather than submission to and expenditure on HBO and Lokomat treatment.

(e) Dr Hooper failed to advise QS of risks that could arise in the course of the provision of the HBO and/or the Lokomat treatment.

(f) Dr Hooper's clinical notes between 27 August 2007 and 13 May 2008 do not record that he discussed with or advised QS in respect of those issues set out in paragraphs (a) to (e) above.

Failure to Prepare and Modify Treatment Plan

3. On or around 27 August 2007 and 13 May 2008, Dr Hooper failed to prepare a treatment plan, or adequate treatment plan, for QS which set out the planned recommended HBO and Lokomat treatment, and/or how and when such treatment would be periodically reviewed and/or assessed in order to clinically evaluate any improvements or progress (or lack thereof) by reference to the contrast (if any) as assessed by Dr Hooper between QS's initial presentation and any later presentation in his condition (cerebral palsy), symptomatology or the state of his stem cells.

PARTICULARS

(a) Prior to the provision of HBO and Lokomat treatment to QS, Dr Hooper did not discuss a treatment plan with QS, including, for example, an end point to treatment or degree of improvement (including what permanent or temporary improvements in his condition, symptomatology or state of his stem cells could reasonably be expected) that were sought to be attained through the recommended HBO and/or Lokomat treatment.

(b) Dr Hooper allowed QS to commence undertaking, costly HBO and/or Lokomat treatment in the absence of a treatment plan, or adequate treatment plan.

(c) Dr Hooper's clinical notes on or around 27 August 2007 do not provide a record of a treatment plan, or adequate treatment plan, in respect of those issues set out in paragraphs (a) and (b) above.

4. Between 27 August 2007 and 13 May 2008, Dr Hooper failed to modify and/or properly modify any treatment plan which did exist for QS to set out the planned recommended further HBO and/or Lokomat treatment and how and when such treatment would be periodically reviewed in order to clinically evaluate any improvements or progress (or lack thereof) by reference to the contrast (if any) as assessed by Dr Hooper between QS's initial presentation and any later presentation in his condition (cerebral palsy), symptomatology or state of his stem cells.

PARTICULARS

(a) During the provision of HBO and/or Lokomat treatment to QS Dr Hooper did not discuss a treatment plan with QS, including, for example, an end point to treatment or degree of improvement (including what permanent or temporary improvements in his

condition, symptomatology or state of his stem cells could reasonably be expected) that were sought to be attained through the recommended HBO and/or Lokomat treatment.

(b) Dr Hooper allowed QS to continue undertaking costly HBO and Lokomat treatment in the absence of modifications or proper modifications to any treatment plan.

(c) Dr Hooper's clinical notes between 27 August 2007 and 13 May 2008 do not provide a record of modifications to a treatment plan in respect of those issues set out in paragraphs (a) and (b) above.

Failure to Monitor Outcomes

5. Between 27 August 2007 and 13 May 2008, Dr Hooper failed to clinically monitor or evaluate any measurable improvements (or otherwise) in QS's condition (cerebral palsy), symptomatology or state of his stem cells or readiness for stem cell therapy for cerebral palsy cells attributable to the HBO treatment and/or Lokomat treatment provided to him

PARTICULARS

(a) During the HBO and Lokomat treatment, Dr Hooper did not conduct ongoing clinical evaluation of any measurable improvements (or otherwise) in QS's condition, symptomatology or state of his stem cells or his readiness for stem cell treatment for cerebral palsy attributable to the HBO and/or Lokomat treatment provided.

(b) Dr Hooper continued to allow QS to undertake costly HBO treatment and Lokomat treatment in the absence of any measurable improvements or progress (or lack thereof) in QS's condition, symptomatology or state of his stem cells or readiness for stem cell treatment for cerebral palsy.

(c) Dr Hooper failed to keep adequate and detailed records of any clinical observations as to improvements or progress (or lack thereof) in QS's condition (ie cerebral palsy), symptomatology or state of his stem cells or readiness for stem cell treatment for cerebral palsy attributable to the HBO treatment and/or Lokomat treatment provided.

Misrepresentation of Likely Efficacy of Treatment

6. In recommending the provision of HBO and/or Lokomat treatment by his clinic HyperMED to QS, Dr Hooper misrepresented the likely effectiveness of HBO and/or Lokomat treatment in relation to cerebral palsy either generally or for the purpose of QS undertaking possible future overseas stem cell treatment of his cerebral palsy.

PARTICULARS

(a) In recommending such treatment to QS, Dr Hooper did not provide a balanced view as to the effectiveness of such treatment in relation to cerebral palsy, including a statement that such treatment is not conventionally used in Australia and/or in Western countries with a comparable health service culture in treating cerebral palsy or readying persons for stem cell treatment for cerebral palsy.

(b) Dr Hooper did not disclose to QS that such treatment in relation to cerebral palsy or readiness for stem cell treatment for cerebral palsy is not advocated by a significant percentage of qualified registered medical practitioners or medical representative organisations in Australia.

(c) Dr Hooper's recommendation of such treatment to QS did not set out the health risks associated with such treatment.

(d) Dr Hooper did not disclose to QS that available medical and scientific evidence published in internationally respected peer reviewed journals does not support the effectiveness of treatment of cerebral palsy or its symptomatology either generally or for the purpose of preparation for stem cell treatment with the use of HBO and/or Lokomat treatment.

(e) Dr Hooper did not disclose to QS that HBO and/or Lokomat treatment for adults with cerebral palsy is novel and non-mainstream.

(f) Dr Hooper did not disclose to QS that HBO treatment was not appropriate for the treatment of adults with cerebral palsy or its symptomatology in that, in spite of its expense, it has not been proved to provide specific and/or lasting benefit to the patient.

(g) Dr Hooper did not disclose to QS the outcomes or improvements that could reasonably be expected from the provision of HBO and/or Lokomat treatment in preparing QS for future stem cell treatment.

Misleading and Deceptive Advertising

7. In promoting the provision of HBO and/or Lokomat treatment by his HyperMED clinic on its website (http://www.hypermed.com.au/) in relation to numerous listed medical conditions (namely (1) soft tissue musculoskeletal injuries; (2) fracture repair; (3) acute and chronic spinal instability; (4) facet dysfunction; (5) disc protrusion; (6) canal stenosis; (7) inflammatory arthritides; (8) spinal cord neuropathy due to crush and

neurovascular degeneration; (9) paraplegia and quadriplegia due to incomplete neurovascular compression; (10) peripheral nerve injury and neuropathies; (11) cerebrovascular stroke; (12) multiple sclerosis; (13) multi-infarct dementia; (14) cerebral palsy; (15) Parkinson's disease; (16) Alzheimer's disease; (17) Autism; (18) epilepsy due to hypoxia; (19) coronary heart disease; (20) heart insufficiency (post-surgical); (21) heart contractile dysfunction; (22) acute and chronic arterial insufficiency, (23) gastric and duodenal ulcers; (24) hepatitis; (25) diabetes; (26) lung abscess; (27) pulmonary embolism (as an adjunct to surgery); (28) complications of pregnancy (including gestational diabetes, eclampsia, heart disease, placental hypoxia, foetal hypoxia and congenital disease of the neonate); (29) infertility; and (30) reducing risk of cancer cell mutation) between 27 August 2007 and 3 March 2010, Dr Hooper engaged in advertising that was misleading and deceptive in that he invited inaccurate inferences to be drawn by potential patients about the effectiveness of such treatment in relation to those listed conditions.

PARTICULARS

(a) Dr Hooper did not provide a balanced view of the effectiveness of HBO and/or Lokomat treatment in relation to the listed medical conditions, including a statement that such treatment is not conventionally used in Australia and/or Western countries with a comparable health service culture in treating such medical conditions.

(b) Dr Hooper did not disclose that HBO and/or Lokomat treatment in relation to the listed medical conditions is not advocated by qualified registered medical practitioners or medical representative organisations in Australia.

(c) Dr Hooper's HyperMED advertising and literature did not disclose that available medical and scientific evidence does not support the effectiveness of treatment for the listed medical conditions with the use of HBO and/or Lokomat treatment.

(d) Dr Hooper's HyperMED advertising and literature did not disclose that HBO treatment is not appropriate for the treatment of the listed medical conditions in that no medical or scientific evidence published in internationally respected peer reviewed journals exists to demonstrate it provides substantive benefits.

Inadequate Clinical File

8. Between 27 August 2007 and 13 May 2008, Dr Hooper failed in his professional responsibilities by generating seriously inadequate clinical documentation in relation to the provision of costly HBO and Lokomat treatment to QS, including making a record in QS's clinical notes of:

(a) QS's medical history;

(b) any physical examination and proper assessment of QS (if there was any) prior to him commencing HBO and Lokomat treatment;

(c) QS's current symptomatology and level of spasticity at the commencement of treatment;

(d) QS's suitability for treatment;
advice provided by Dr Hooper to QS (if there was any) as to risks, options, advantages, disadvantages, contra-indications, limitations, or side-effects of the proposed treatment for his condition, symptomatology or state of his stem cells or readiness for stem cell treatment for cerebral palsy;

(e) questions and issues raised by QS with Dr Hooper as to the HBO and/or Lokomat treatment;

(f) treatment planning (if there was any), including likely outcomes or improvements (including what permanent or temporary improvements in QS's condition, symptomatology or state of his stem cells or readiness for stem cell treatment for cerebral palsy could be expected) from the treatment to be provided and/or treatment goals;

(g) treatment actually provided;

(h) QS's response to the HBO and/or Lokomat treatment as clinically evaluated by Dr Hooper and/or HyperMed staff;

(i) any clinical progress in or improvement from treatment;

(j) reasons for the need for further treatment; and

(k) communications between him and his patient about significant matters arising during the course of provision of treatment (other than moneys owed).

APPENDIX B

TABLE OF EVIDENCE IN RELATION TO ALLEGATION 7

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
(1)	**Soft tissue muscoskeletal injury**	"approximately 5 per cent"	"there are a number of randomised control trials looking at muscle injury and they're universally unsupportive of hyperbaric oxygen much to the surprise of most of us, to be honest." "The two randomised control trials looking at soft tissue - actual soft tissue injuries, one in the knee and one in the ankle, both of - neither of those suggested a definitive benefit from hyperbaric, so it's somewhat unhopeful and all that was there in 2007 as far as I'm aware."	20 Feb 2013 Page 962 lines 5-20	"It's a very broad category, but I think there is some evidence that some conditions that would fall within that category would be treatable. Many others would not."	1 Mar 2013 Page 1346 lines 37 - 39
(2)	**Fracture repair**	"Less than one per cent"	"There's very little evidence and that's not a routinely accepted indication and we've done a Cochrane review on that as well."	20 Feb 2013 Page 962 line 37	"I don't believe there is sufficient evidence to support that. There are some small animal trials that suggest fracture repair in small bones in small animals may be accelerated and possibly better in quality, but, to my knowledge, no evidence that this applies to humans at all, so not something we would recommend or expect to see benefit from necessarily in humans." "It's very difficult to extrapolate, and it quite often leads to incorrect conclusions if you extrapolate from rodents and small animal research to humans with	1 Mar 2013 Page 1346 lines 41-45 Page 1347 lines 1-8

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
					neurological conditions"	
(3)	**Acute and chronic spinal instability**	"I've listed that as under 3, 4, 5 and 6 including facet joint dysfunction, disc protrusion and canal stenosis I've said is approximately 50 per cent of the patients attending."	"For the next few items I can't find any data at all, aid to prosthesis, acute and chronic spinal instability - I don't if you want me to go through each of the individually, but they're all, as far as I'm aware, data-free areas."	20 Feb 2013 Page 962 lines 42-45	"I don't believe there's any evidence nor any expectation that there would be any change to a mechanical/structural situation affecting the spinal column"	1 Mar 2013 Page 1347 lines 11-13
(4)	**Facet dysfunction**	"I've listed that as under 3, 4, 5 and 6 including facet joint dysfunction, disc protrusion and canal stenosis I've said is approximately 50 per cent of the patients attending."	Dr Freckelton: "So that includes osteoporosis, facet dysfunction, disc protrusion, canal stenosis, post-surgical instability, degenerative joint disease, inflammatory arthritides?" Prof Bennett: "Yes, all of those."	20 Feb 2013 Page 963 lines 1-3	"I don't believe so. I don't believe there's any evidence nor any expectation that there would be any change to a mechanical/structural situation affecting the spinal column."	1 Mar 2013 Page 1347 line 15
(5)	**Disc protrusion**	"I've listed that as under 3, 4, 5 and 6 including facet joint dysfunction, disc protrusion and canal stenosis I've said is approximately 50 per cent of the patients attending."	Dr Freckelton: "So that includes osteoporosis, facet dysfunction, disc protrusion, canal stenosis, post-surgical instability, degenerative joint disease, inflammatory arthritides?" Prof Bennett: "Yes, all of those."	20 Feb 2013 Page 963 lines 1-3	"There's certainly no evidence I've seen. Mechanistically there is some possibility but its speculation only."	1 Mar 2013 Page 1347 lines 17-18
(6)	**Canal stenosis**	Yes - "I've listed that as under 3, 4, 5 and 6 including facet joint dysfunction, disc protrusion and canal stenosis I've said is approximately 50 per cent of the patients attending."	Dr Freckelton: "So that includes osteoporosis, facet dysfunction, disc protrusion, canal stenosis, post-surgical instability, degenerative joint disease, inflammatory arthritides?" Prof Bennett: "Yes, all of those."	20 Feb 2013 Page 963 lines 1-3	"No. That would - that's my first comment. No reason why one would expect any change to any structural problem with a spinal column."	1 Mar 2013 Page 1347 line 20-21
(7)	**Inflammatory**	"I've said yes, but I haven't	Dr Freckelton: "So that includes	20 Feb	"No literature but clinical experience of a	1 Mar

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
	arthritides	put a percentage because its in the true sense of inflammatory arthritis it's actually quite minimal as far as attending at HyperMED."	osteoporosis, facet dysfunction, disc protrusion, canal stenosis, post-surgical instability, degenerative joint disease, inflammatory arthritides?" Prof Bennett: "Yes, all of those. Arthritides, yes. Good to go."	2013 Page 963 lines 1-3	number of people, including myself, would suggest that there's maybe some temporary ameliorative effect which goes away as soon as treatment is finished and which is an occasionally observed side effect for treatment for other conditions and therefore not a treatment as such, but some people have observed temporary reduction in symptoms during treatments but no net change. So that's a clinical observation but no evidence that I'm aware of otherwise."	2013 Page 1347 lines 23-29
(8)	**Spinal cord neuropathy due to crush and neurovascular degeneration**	"Spinal cord injury, including 8 and 9, neuropathy due to crush and neurovascular paraplegia and quadriplegia due to incomplete neurovascular compression I've stated is approximately 50 per cent"	"These are all theoretically interesting uses for hyperbaric, but, as far as I'm aware, there's nothing but theory and for peripheral nerve injury there's some data, but it's not conclusive." "We don't have evidence to support the fact that oxygen therapy will make any difference to the outcome in those things, but there are some hopeful indications in there that await to be provide and some where there is absolutely no data at all."	20 Feb 2013 Page 963 lines 7-9 lines 14-16	"I believe there's some evidence that hyperbaric oxygen may have some effect in the very acute situation. If I remember correctly, the prime window was in the order of four to six hours…but in a number of centres which tried to implement this clinically, they failed to see beneficial results so research didn't proceed any further…at the time period you're talking about that there's no evidence of practically deliverable treatment with any - within any time window and certainly not outside of a major trauma receiving hospital and it proved impractical to hit that time window."	1 Mar 2013 Page 1347 lines 32-40
(9)	**Paraplegia, quadriplegia due to incomplete neurovascular compression**	"Spinal cord injury, including 8 and 9, neuropathy due to crush and neurovascular paraplegia and quadriplegia due to incomplete neurovascular compression I've stated is	"These are all theoretically interesting uses for hyperbaric, but, as far as I'm aware, there's nothing but theory and for peripheral nerve injury there's some data, but it's not conclusive." "We don't have evidence to support	20 Feb 2013 Page 963 lines 7-9 lines 14-16	"Not aware of any good data. I am aware of some centres that have undertaken treatments and feel that there may be some acceleration in resolution or some affinity with physiotherapy done under hyperbaric conditions during a subacute phase of several days to weeks after treatment, but not	1 Mar 2013 Page 1347 lines 43-47

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
		approximately 50%"	the fact that oxygen therapy will make any difference to the outcome in those things, but there are some hopeful indications in there that await to be provide and some where there is absolutely no data at all."		aware of any convincing literature, but I am aware of centres in Europe that have supported that indication." "I would not offer them [a patient] treatment in that situation in my practice. I would suggest that there's some very limited speculative suggestions that there might be some benefit there, but that we were not in a position to provide a trial of treatment."	Page 1348 lines 4-7
(10)	**Peripheral nerve injury and neuropathies**	"one per cent"	"These are all theoretically interesting uses for hyperbaric, but, as far as I'm aware, there's nothing but theory and for peripheral nerve injury there's some data, but it's not conclusive." "We don't have evidence to support the fact that oxygen therapy will make any difference to the outcome in those things, but there are some hopeful indications in there that await to be provide and some where there is absolutely no data at all."	20 Feb 2013 Page 963 lines 9-10 lines 14-16	*Peripheral nerve injury:* "some animal data to suggest there may be improved rates of healing and, possibly, also, quality of healing, but no human clinical data" *Neuropathy:* I'm not aware of any evidence of good response for the – what's conventionally referred to in that sense. However, there are regular observations of side effects of treatment for diabetic patients who often have neuropathy of some minor degrees of improvement in function. There are also some results noted in trials of hyperbaric oxygen where they – although it has not been the primary outcome of the study, there has been some improvement in autonomic and small nerve function. So there's possibly some small effect present there in – demonstrated in several clinical trials that have quite good methodology, and it has appeared as a side effect, not as a primary	1 Mar 2013 Page 1348 lines 15-26

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
					reason for doing treatment, but the effect does appear to be there to a very limited degree. It's not clear whether it provides any long-term benefit to the patient and, therefore, as far as I'm aware, it's not offered clinically, but there may be something there."	
(11)	**Cerebrovascular stroke**	"Stroke, 15 per cent"	<u>*Regarding acute stroke:*</u> "People in the acute period after developing signs of a stroke may well be a useful target for hyperbaric oxygen therapy." "Acute would truly mean within 24 hours." "There have been three randomised control trials attempting to show that, that that - you know, that demonstrates, I think, the interest the field has taken in that area. They all have some failings, it must be said, but none of them showed any useful benefit to patients." <u>*Regarding chronic stroke:*</u> "The chronic treatment of stroke is much more controversial." "There has been one piece of work on what we might call subacute strokes, not - talking about months after the stroke rather than	20 Feb 2013 Page 963 lines 39-42 line 15 20 Feb 2013 Page 964 lines 2-8	"There is some promise in acute stroke trials, less so in the chronic stage." "I don't think you could say that at the time period you're talking about there was a body of evidence, although there had been some previous interest in that area."	1 Mar 2013 Page 1348 lines 37-47 page 1349 lines 3-5

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
			years, there was some evidence of benefit, but it wasn't considered clinically significant."			
(12)	**Multiple Sclerosis**	"MS, 1 per cent"	"there are now something like 13 or 14 randomised control trials and when one puts them all together it's pretty clear that hyperbaric has no meaningful effect on the course of the disease or on the function or ability of the individuals. So we get an answer. If people are advocating treating something as common as multiple sclerosis with hyperbaric oxygen, a case report here and there is not sufficient." "MS is a condition where it's widely accepted that the evidence is overwhelmingly that hyperbaric makes no difference – no better, no worse." "This is one of the conditions, chronic neurological conditions, where we have pretty good evidence that hyperbaric does not work."	20 Feb 2013 Page 973 lines 31-35 21 Feb 2013 page 1062 lines 24-25 page 977, lines 43-45	"It was clearly put away that there is no major therapeutic effect and that all the benefits were things that were discussed early, participation effect, healthy survivor effect and so on, so that despite all the promise, it disappeared completely off the therapeutic radar." "So there were practitioners at the time including some of the people who went on to become proponents for cerebral palsy – Philip James of the UK, for instance, was one such person – who were believers on mechanistic grounds in this once a week or so therapy, that it provided something that was of value for the neurological system. But that has fallen into general disrepute."	31 Jan 2013 Page 456 lines 8-11 lines 15-20
(13)	**Multi-infarct dementia**	"Multi-infarct dementia is blank because it's not something that is treated at HyperMED"	"I'm not aware of any evidence in that area."	20 Feb 2013 Page 964 line 29	"I'm not aware of any evidence of benefit in that field, no"	1 Mar 2013 Page 1349 line 26
(14)	**Cerebral Palsy**	"Yes, being approximately 5 per cent"	Dr Freckelton: "From your knowledge of the literature, is there a proper basis for provision of	20 Feb 2013 Page 945, lines 23-25	"most of us would now say that, well, on the basis of the evidence that's out there, we're	31 Jan 13 Page 452 Lines 39-

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
			hyperbaric therapy to an adult with cerebral palsy? Professor Bennett: "No, I'm not aware of any rational basis for doing so." "My knowledge of the evidence surrounding the use of hyperbaric oxygen therapy in the treatment of cerebral palsy in adults would lead me to conclude that there is no purpose in treatment, and I would not be persuaded to offer treatment."	Page 945, lines 38-41	sufficiently convinced that there's nothing really big there, that we don't want to get into this and use our energy." "No. The control trial in children and the degree of benefit seen in less well controlled studies and uncontrolled studies suggests that there's no difference in the outcomes between hyperbaric oxygen and low pressure air. And the benefits seen in the trials are consistent with a broad range of research related effect which can be, I suppose, generally summarised as various types of placebo effects."	44 1 Mar 2013 Page 1349 lines 32-37
(15)	**Parkinson's disease**	"Yes, but however, one patient. I had one patient in my last 15 - well 17 years of using hyperbaric - is only to one patient, it happened to be my auntie who I treated for Parkinson's disease for about five to six years."	"I'm not aware of any substantial evidence at all. There may be a case or two around, but it doesn't immediately come to mind. I don't think that is a reasonable thing to treat with hyperbaric."	20 Feb 2013 Page 978 lines 1-3	"No, no expectation of benefits especially from hyperbaric oxygen" "The placebo effect in Parkinson's disease is very, very powerful. But in Parkinson's it appears to be about – I'm informed about twice as powerful as in many other conditions."	1 Mar 2013 Page 1349 lines 41-47 Page 1350 lines 1-9
(16)	**Alzheimer's disease, degenerative motor neuron disorders, amyotrophic lateral sclerosis**	"No patients"	"No."	20 Feb 2013 Page 978 line 5	"No evidence that I'm aware of and no reason to expect benefit."	1 Mar 2013 Page 1350 lines 14-15
(17)	**Autism**	"Approximately 5 per cent"	"In 2007, there was relatively little evidence around." "I think that trial does raise the possibility	20 Feb 2013 Page 975 lines 36-45 Page 976 lines 1-12	"no reason to expect benefit at that particular time." "There was a study that – a randomised controlled study in autism that suggested	1 Mar 2013 Page 1350 lines 17-26

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
			that there may be a beneficial effect, but it's highly controversial. I've disputed the findings significantly of that trial. However, it is a small RCT that raised the level of evidence in support of autism from the previous few case reports. So of itself, that was interesting but not sufficient to convince us this was a good routine treatment, and subsequent evidence has suggested that was the appropriate."		the possibility of some benefit but which has since been countered by a better one. Mechanistically, I wouldn't have had any expectation of improvement other than as a result of a placebo effect on behaviour or in changes, but there was a study, and as I sort of said, I can't remember the date, but it might have fallen around about the end of that period that we're talking about which seemed to suggest some benefit, even though there were some problems and biases with the study and that have subsequently been corrected in subsequent studies."	
(18)	**epilepsy due to hypoxia**	"Nothing for epilepsy"	"That would be very controversial as hyperbaric oxygen can cause fitting. In fact, it's one of the reasons we occasionally have to decline treatment if people are – have epilepsy and it's very poorly controlled by their medication. We advise them that we're likely to make their condition worse." "As far as I'm aware, there's no evidence that you can treat the underlying cause" "I'm not aware of any evidence that the cause of the epilepsy will make any difference, and I'm certainly not aware of any evidence that hyperbaric should be used to treat epilepsy. I've never read such a case."	20 Feb 2013 Page 976 lines 22-31 Page 977, lines 15-18	"Not aware of any benefit. I'm aware – I came across or had a look at the titles of the paper in Dr Hooper's response document, but I'm not aware of any convincing data or – and, indeed, there is a concern that epilepsy may be – well, that epilepsy is a risk factor for oxygen administration, and epileptics may actually have seizures whilst receiving hyperbaric oxygen, so reasons not to treat and – with hyperbaric oxygen because of risks that may be associated with it."	1 Mar 2013 Page 1350 lines 30-36

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
(19)	**Coronary heart disease (angina pectoris, myocardial ischemia)**	"heart disease, heart insufficiency, heart contractile function, acute and chronic arterial insufficiency, duodenal and gastric ulcers, none"	"There's a suite of randomised controlled trials that altogether add up to a confusing picture, and it's certainly not true that coronary heart disease is a routine - well, infarct, rather, that people suffering a heart attack should be treated. There are those who advocate it, but I'm not aware of anywhere where that is done in the acute phase, and there's very little evidence in the more chronic phase.?	20 Feb 2013 Page 965 lines 6-12	"some evidence of potential and some clinical trials undertaken in association of - with acute hospital treatment of myocardial infraction in the first few hours…but not aware of any evidence for benefit in the post-acute stage, so other than in the - that very acute stage and certainly not established practice because of the high risk that such patients happen."	1 Mar 2013 Page 1350 lines 38-46 Page 1351 lines 1-2
(20)	**Heart Insufficiency (post surgical)**	"heart disease, heart insufficiency, heart contractile function, acute and chronic arterial insufficiency, duodenal and gastric ulcers, none"	"There's no data that I know of, apart from a case report, for that."	20 Feb 2013 Page 965 lines 14-15	"Not entirely clear to me what that refers to as a concept, and I'm not aware of any evidence that was suggest treatability." "there is indeed some evidence that hyperbaric oxygen might reduce postsurgical cardiac dysfunction, but to represent that as a condition that could be provided in a clinic I believe would be suggesting to the patient that if they had problems after surgery, they could possibly be treated, and that's certainly not the case to my mind."	1 Mar 2013 Page 1351 lines 4-13
(21)	**Heart contractile dysfunction**	"heart disease, heart insufficiency, heart contractile function, acute and chronic arterial insufficiency, duodenal and gastric ulcers, none"	Dr Freckelton: "The same thing with heart contractile dysfunction?" Professor Bennett: "Indeed, yes. Similar. Very much the same kind of thing."	20 Feb 2013 Page 965 lines 17-18	"some theoretical benefit for acute benefit but only in that contractile dysfunction after surgery, after acute surgery, so no data and no evidence, no reason to suggest it's a useful treatment once that situation is established."	1 Mar 2013 Page 1351 lines 17-19
(22)	**Acute and chronic arterial insufficiency**	"heart disease, heart insufficiency, heart	"This is an example of an indication which is - it's hard to pin down the exact	20 Feb 2013 Page 966	"In the acute phase possibly as an adjunct to surgical repair in an impatient [sic] hospital	1 Mar 2013 Page 1351 lines

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
		contractile function, acute and chronic arterial insufficiency, duodenal and gastric ulcers, none"	meaning. I've put speculative only there and, you know, that's perhaps even being generous." "Our common response is that hyperbaric oxygen can do nothing to improve blood supply because of blockages in the larger arteries of the body. What we can do is assist in growing new capillaries, the micro-vasculature, but someone with a physical blockage to an artery is not amenable to treatment with hyperbaric oxygen except in very few circumstances and where there's no other recourse through surgery or some other procedure to clear those arteries. So taking that to be what the term means, it's not a hopeful indication."	lines 29-41	surgical setting, but not of any value in a clinical outpatient situation and lots of pretty solid experience to suggest that any improvements seen whilst you're in the chamber in vascular insufficiency doesn't actually produce any lasting benefit…if you have had vascular insufficiency and then had it surgically corrected, then hyperbaric oxygen in conjunction with the surgical correction is generally considered to be quite a useful treatment and although the controlled trial evidence is weak, it's fairly well established clinical practice to utilize hyperbaric oxygen in wounds associated with corrected vascular insufficiency or partially corrected vascular insufficiency."	21-31
(23)	**Gastric and duodenal ulcers**	"heart disease, heart insufficiency, heart contractile function, acute and chronic arterial insufficiency, duodenal and gastric ulcers, none"	"No evidence that I know of in that area at all."	20 Feb 2013 Page 971 lines 11-12	"I believe the answer is "no", although I understand there has been some use of hyperbaric oxygen in eastern Europe and Russia for these conditions, however that has essentially been superseded by effective drug therapy that has managed to actually not quite eliminate but almost eliminate surgical treatment which used to be required frequently"	1 Mar 2013 Page 1351 lines 41-47
(24)	**Hepatitis**	"hepatitis, I've had one patient which was in the last 12 months"	"No – well, no evidence in 2007"	20 Feb 2013 Page 974 lines 1-5	"No evidence of benefit. I believe that most people would take that word to imply either immune or, more likely, infective hepatitis, and some people might take both, and neither of those, I believe, have	1 Mar 2013 Page 1352 lines 11-14

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
					anything evidence of evidence – for benefit."	
(25)	**All stages of diabetes**	"Then 25, diabetes, certainly there are many, many patients attending with a range of different problems, but not specifically for their diabetic condition"	"Diabetes itself, no."	20 Feb 2013 Page 974 line 7	"I don't think there is any evidence of benefit for diabetes. It would be inappropriate to make my – that statement, because I think most people would read that as a treatment for the diabetes condition itself. Hyperbaric oxygen – oxygen is routinely used, and there's some evidence to supports its use, for some of the complications of diabetes, particularly…skin ulceration, but not for the diabetes itself."	1 Mar 2013 Page 1352 lines 16-22
(26)	**Lung abscess**	"Lung abscess, no patients"	"I'm not aware of any evidence so I think the answer to that is no."	20 Feb 2013 Page 974 line 9	"some theoretical attraction to the idea of using hyperbaric oxygen with certain particular bacteria, but no evidence of benefit, and I'm not aware of anyone around the world using it, so I think it would be inappropriate to make the statement."	1 Mar 2013 Page 1352 lines 24-27
(27)	**Pulmonary embolism (as an adjunct to surgery)**	"Pulmonary embolism, no patients"	"No".	20 Feb 2013 Page 974 line 11	"I think that's quite inappropriate. A pulmonary embolism is very much an inpatient hospital condition, and to suggest hyperbaric oxygen would be a benefit would be very inappropriate. I'm not aware of any evidence of benefit or mechanistic reason why one would expect benefit, and it would potentially complicate the surgical management of the condition in a way that could be dangerous."	1 Mar 2013 Page 1352 lines 29-34
(28)	**Complications of pregnancy including:** **1. Gestational Diabetes**	"pregnancy complications, no patients"	There is no published evidence of which I'm aware that supports the routine use of any of these obstetric indications." "So for example, in Russia if a woman	20 Feb 2013 Page 974 lines 13-24	"But in general, I would say there's no evidence or basis to suggest treatment is useful, except in one – well, there's two specific areas; one is that there is practice that's understood - understood	

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
	2. Eclampsia **3. Heart disease** **4. Placental hypoxia** **5. foetal hypoxia** **6. congenital heart disease of the neonate**		who was had a miscarriage before shows signs of having a miscarriage a second time, they will be put in the hyperbaric chamber, but we have absolutely no figures from them despite many attempts to get them to see whether that reduces the chance of the miscarriage going through. It's an unfortunate situation but at the moment in Australia, New Zealand, the US, Europe none of those are routine indications. There is virtually no evidence on which to go good or bad."		- I understand has been used in Russia, of having a birthing suite inside a hyperbaric chamber, so that high-risk pregnancies can be delivered in that situation, with the idea that, if the baby becomes distressed and acutely lacking oxygen, the hyperbaric oxygen can be used as a temporary bridge, just while the baby is delivered, so in a very high-tech, complex acute-care arrangement, that actually does make some sense, even though there's limited published – publicisation of that, and it's not a practice that has been spread elsewhere in the world, to my knowledge, but it does have some rationale. There are also several conditions of newborns, particularly necrotising eterocolitis, which may respond – that's an acute vascular insufficiency of the bowel with bacterial overgrowth, and proceeds to cause most of the bowel to die, and there's some suggestions – some observational reports out of a small number of areas, that there may be some value in that condition, but with the exception of those two particular subsets, there's no evidence. So particularly no evidence for placenta insufficiency, that I'm aware of, or any reason I would expect that, other than in that acute rescue situation, I may suggest – I mentioned in Russia, and no reason to expect a congenital abnormality to improve in any way."	
(29)	**Infertility**	"infertility, no patients attending	"An experimental indication…the potential harm,	28 Feb 2013	"I think there actually is some reasonable suggestion that there	1 Mar 2013

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
		specifically for that."	particularly to a developing embryo or foetus, so I think to suggest that hyperbaric is a commonly accepted or routine treatment that improves those problems is not one that can be sustained."	Page 1339 lines 8-11	may be benefit. There's a Croatian group that have produced some results which were sufficiently promising to interest the IVF and infertility treatment practitioners… so although it's not good clinical evidence that would support funding or routine use, there was actually some intriguing suggestions of benefit." Dr Freckelton: "At the relevant time frame was it accurate or proper to say fertility was treatable by HBOT?" Dr Millar: "As a statement in isolation, I believe no."	Page 1355, lines 11-21
(30)	**reducing risk of cancer cell mutation**	"Reducing the risk of cancer cell mutation, I've said about there were about five per cent of patients attending with cancer, but it's in combination with their chemotherapy, their radiation therapy, and certainly not attending specifically with the anticipation that it's going to cure them of the cancer."	"I think as a statement of pathophysiology, it's not unreasonable, because I believe the word "may" is in there, and there was certainly some conjecture in that time period that that may be the case. I'm certainly not aware of good evidence from clinical trials to suggest one way or the other whether that is true…the conclusion drawn by Feldmeier is, I think, one that would be widely accepted, and that is that we have no evidence that hyperbaric speeds up the growth of tumours, and no good evidence that it slows down the growth of tumours, or evidence that the growth of tumours is prevented in the first place. So I think it is an unreasonable statement to make as a purpose for treating people with hyperbaric oxygen."	28 Feb 2013 Page 1339 lines 15-45 and page 1340 lines 1-11	"I think the body of opinion is exactly the opposite, that there was a substantial concern that it might increase the risk of cancer mutation." "So I think it would be quite inappropriate to make that statement at that time…the view is now that - fairly strongly that in most cancers hyperbaric oxygen is probably neutral and we don't have to worry about it too much. But it's not an active therapeutic. So the statement that it has any - or at the time had any role in preventing or minimising cancer mutation, I think is quite incorrect."	1 Mar 2013 Page 1355 lines 27-40

No.	Condition	Dr Hooper's opinion, including percentage of patients treated at HyperMED (transcript p 1622-3, lines 43ff)	Professor Bennett's opinion	Transcript reference (Professor Bennett)	Dr Millar's opinion	Transcript reference (Dr Millar)
			Dr Freckelton: "Between those same years, was there evidence suggestive of hyperbaric oxygen being of assistance in treating breast cancer, gastric cancer, or prostate cancer, or bowel cancer?" Prof Bennett: "Using hyperbaric oxygen of itself, I think that's an unreasonable statement, and there's little or no evidence of which I'm aware to support that."			

APPENDIX C

A Short History of the Litigation

27 August 2007 to 13 May 2008	Treatment received by the Notifier, which is in part the subject of the referral to VCAT
9 March 2010 and 8 April 2010	Chiropractors Board of Victoria decision to refer the Respondent's conduct to VCAT
5 May 2010	Board referral to VCAT with original "Notice of Allegations"
10 December 2010	Matter listed for a 10 Day hearing commencing on 11 April 2011 before **Lambrick DP** and **Members Drinkwater and El Moussalli** with the Respondent represented by Mr Kewley (VCAT Day 1)
11 April 2011	Application by the Respondent for reconstitution of VCAT on the basis of apprehended bias (VCAT Day 2)
13 April 2011	**Lambrick DP** refused the application for reconstitution: *Chiropractic Board of Australia v Hooper* [2011] VCAT 641 (VCAT Day 3)
20 April 2011	Matter listed before **Ross J** with the Respondent represented by Mr P Holdenson QC and Mr B Murphy of counsel; matter adjourned (VCAT Day 4)
29 June 2011	Matter listed for a 12 VCAT Day hearing: • 26 October 2011 for 5 VCAT Days; • 11 November 2011 for 3 VCAT Days; and • 19 December 2011 for 4 VCAT Days (VCAT Day 5)
1 September 2011	**Ross J** reconstituted the Tribunal (VCAT Day 6)
11 October 2011	Compulsory conference with the Respondent represented by Mr M Titshall QC and Mr B Murphy (VCAT Day 7)

13 October 2011	Compulsory conference concluded with proposed agreed findings and determinations filed by Mr Titshall QC before **Justice Ross P** (VCAT Day 8)
24 October 2011	Hearing before **Lambrick DP and Members Waterhouse and Draper** in relation to findings and determinations (VCAT Day 9)
31 October 2011	The Respondent informed VCAT that he wished to withdraw from the proposed agreed findings and determinations
14 November 2011	VCAT hearing regarding the Applicant's objection to the Respondent's withdrawal of agreement (VCAT Day 10)
19 December 2011	**Lambrick DP** ruled that the Respondent was permitted to withdraw his agreement: *Chiropractic Board of Australia v Hooper* [2011] VCAT 2400 (VCAT Day 11)
22 December 2011	Directions hearing before **Lambrick DP** resulting in procedural orders being made (VCAT Day 12)
23 February 2012	Directions hearing before **Lambrick DP**, in which the Respondent foreshadowed the making of a strike-out application, procedural orders made (VCAT Day 13)
1 May 2012	Strike out hearing brought by the Respondent before **Lambrick DP and Members Draper and Waterhouse** (VCAT Day 14)
25 June 2012	**Lambrick DP and Members Draper and Waterhouse** dismissed the Respondent's strike out application: *Chiropractic Board of Australia v Hooper* [2012] VCAT 1042 (VCAT Day 15)
7 August 2012	Directions hearing before **Judge Hicks** with the Applicant represented by Ms Kummrow in relation to the Respondent's applications pursuant to ss 81 and 104 of the VCAT Act

	(VCAT Day 16)
13 August 2012	Directions hearing before **Judge Hicks** with discussion about allegations and further applications made by the Respondent pursuant to ss 81 and 104 of the VCAT Act (VCAT Day 17)
29 August 2012	Further Directions hearing and orders made by **Judge Hicks** (VCAT Day 18)
5 September 2012	Further Directions hearing before **Davis SM** and procedural orders and 15 VCAT Day hearing to commence 8 October confirmed. (VCAT Day 19)
2 October 2012	Further Directions hearing before **Davis SM**. Matter set down for hearing commencing 21 January 2013, for a period of 30 VCAT Days, with every Friday to be a lay VCAT Day**.** **(**VCAT Day 20)
3 October 2012	The Respondent sought written reasons from Davis SM
15 October 2012	Final Notice of Allegations filed and served
22 October 2012	Written reasons declined by Davis SM under s117 of the VCAT Act on the basis that the hearing did not include final orders
22 October 2012	Further procedural orders made in chambers by Davis SM, permitting Final Notice to be filed and allowing strike out application to be filed by 8 November 2012 (VCAT Day 21)
8 November 2012	Application to have Final Notice set aside, filed by the Respondent in VCAT
8 November 2012	Originating Motion of the Respondent filed in the Supreme Court
22 November 2012	Referral by **Zammit AJ** under Rule 77.04 of the Supreme Court Rules of the Respondent's application for leave to appeal to a judge of the Practice Court

23 November 2012	Letter from Respondent to Applicant's lawyers foreshadowing an application for leave to appeal the orders of Judge Hicks to the Court of Appeal
27 November 2012	Respondent's unsuccessful application for leave to appeal before **Habersberger J**; costs awarded against the Respondent [**the 1st costs award**]
21 December 2012	Respondent's strike out application before **Davis SM** dismissed: costs awarded against the Respondent in favour of the Applicant, Dr Sipser & Dr Pyke(VCAT Day 22) [**the 2nd, 3rd & 4th costs awards**]
21 January 2013	30 VCAT Day VCAT hearing commenced before **Davis SM and Members Waterhouse and Draper,** with every Tuesday being a lay VCAT Day (VCAT Day 23).
14 February 2013	Respondent made application for reconstitution of Tribunal. Application dismissed. (VCAT Day 37)
14 February 2013	Respondent made further request for reconstitution to VCAT President
18-19 February 2013	Reconstitution hearing after 13 days before **Judge Macnamara V-P** declined and costs awarded against the Respondent: *Chiropractic Board of Australia v Hooper* [2013] VCAT 236 (VCAT Days 38-39) [**the 5th costs award**]
9-10 April 2013	On 33rd-34th days of the trial hearing, the Respondent made application for reconstitution of Tribunal on the ground of bias. The application was declined by **Davis SM**. (VCAT days 58-59)
	Respondent made request for reconstitution to the President.
12 April 2013	Reconstitution hearing before **Garde J** (VCAT day 60)

15 April 2013	Garde J declined reconstitution and costs awarded against Respondent: *Hooper v Chiropractors Board of Australia* [2013] VCAT (VCAT day 61) [**the 6th costs award**]
17 April	Hearing resumed before Tribunal (VCAT day 62)
22 April 2013	Evidence before the Tribunal with costs awarded against the Respondent in favour of Dr Reggars (VCAT day 63) [**the 7th costs award]**
26- 29 April*	Final submissions (VCAT days 64 and 65)

*(Hearing continued on 1 May 2013)