

Discipline Case Summary

Allisyn Camche, Licence # 1437

Accusation of treatment causing a pneumothorax to occur, failure to recognize and respond to the adverse event, and failure to obtain informed consent appropriately.

A written complaint numbered 2023.1 was initiated against the Member. The complaint indicated that the Complainant had sustained a pneumothorax secondary to a dry needling treatment that had occurred on November 11, 2022 and that the Member disclosed possible other pneumothorax incidents to the Complainant at their follow-up.

The complaint was thoroughly investigated by the Professional Conduct Committee (PCC) and the investigation found that the Member was utilizing Gokavi Transverse Technique (GTT) at the upper fiber trapezius and levator scapulae when the Complainant began to experience chest pain and shortness of breath. The Member did not instruct the Complainant to seek medical attention nor did she educate the Complainant regarding the potential signs or symptoms of a pneumothorax. The Complainant sought medical attention and diagnostics the following day, which confirmed the pneumothorax.

The investigation also found an issue with the informed consent provided to this Complainant as the signed consent form for receiving GTT was dated in July 2021 with the Complainant's first needling appointment occurring November 2022 with no review of the consent form. The consent obtained would not be considered informed as there was no discussion regarding the possible risks of adverse events from this treatment, such as a pneumothorax. There was no contact between the Member and the Complainant until a follow-up appointment in December, during which the Member disclosed to

the Complainant that she had had a similar experience with another, unnamed client, a few weeks following.

As a result of the investigation, the PCC concluded that the events that occurred would likely constitute professional misconduct as this term is defined in section 23 of the Act, on the grounds that the Member:

1. failed to recognize the adverse event (a pneumothorax) and subsequently failed to provide appropriate adverse event management to the client; and
2. did not obtain informed consent in a timely or comprehensive manner for the procedure and failed to detail the potential risks to the client.

The Member provided an undertaking to resolve the complaint by a Resolution Agreement. Under the terms of the Agreement, the Member acknowledged that her actions constituted professional misconduct as defined in *The Physical Therapists Act, 1998* and agreed to the following resolution:

1. a formal reprimand to be retained on her record;
2. an essay to be submitted to the PCC regarding the application of dry-needling theory and the safety requirements associated with this specialized procedure, totaling 1500 words;
3. five supervised mentorship hours with an SCPT-accredited provider of dry-needling to review and demonstrate techniques, surface anatomy, and safety procedures; and
4. a fine of \$1000.00 to be paid to SCPT.

On behalf of the Professional Conduct Committee members:

Jen Aberhart (Chair) - Recused

Amanda Paterson

Emad Abdelmasseh

Moir Stoll

Bonnie Yake

Christopher Sarsons