Dr B

A Report by the
Health and Disability Commissioner

(Case 03HDC00910)

Parties involved

Mrs A	Consumer
Dr B	Provider/chiropractor
Dr C	General practitioner
Ms D	Physiotherapist

Complaint

On 20 January 2003 the Commissioner received a complaint from Mrs A about Dr B. The complaint was summarised as follows:

On 8 March 2002, Dr B did not provide services of an appropriate standard to Mrs A, in that he:

- *did not take an adequate medical history prior to starting treatment;*
- *did not conduct a sufficient examination prior to starting treatment;*
- *inappropriately treated Mrs A and, in particular, used excessive force on Mrs A's back.*

On 8 March 2002, Dr B did not provide Mrs A with information about:

- *the nature or cause of her condition;*
- *the options for treating her condition.*

An investigation was commenced on 29 April 2003.

Information reviewed

- File note detailing Mrs A's complaint, dated 24 March 2003.
- Letter of notification, dated 29 April 2003.
- ACC documentation, including:
  - ACC claim decision, dated 11 December 2002
  - Independent advice from a chiropractor, received by ACC on 27 September 2002
  - Expert advice from Dr James Burt, chiropractor, dated 19 August 2002
  - Clinical notes from Ms D, physiotherapist, received by ACC on 15 July 2002
  - Response to information request from Dr C, general practitioner, dated 16 May 2002
  - Letter of response from Dr B, to ACC's Medical Misadventure Unit, received on 14 May 2002
  - Dr B's clinical notes, received by ACC on 14 May 2002

Independent expert advice was obtained from Dr James Burt, chiropractor.

Information gathered during investigation

During the course of my investigation I reviewed information from Dr B, Mrs A, the Accident Compensation Corporation (ACC) and the New Zealand Chiropractic Board (NZCB). I also sought independent expert advice from Dr James Burt, chiropractor.

I note that Dr B and Mrs A have provided very different summaries of their consultation. However, I consider that, for the most part, this reflects a difference in emphasis rather than a conflict of evidence. A summary of the information I have considered in forming my opinion is set out below.

Background
Mrs A began having neck pain in January 2002. She consulted her general practitioner, Dr C, who advised her to see a physiotherapist or chiropractor. Mrs A initially saw a physiotherapist, Ms D. However, as she was able to provide only short-term relief, Mrs A made an appointment to see Dr B on 8 March 2002.

Dr B's summary of events
In response to my request for information about this complaint, Dr B relied on the information he had previously provided to the ACC. This consisted of a letter, dated 6 May 2002, which outlined his consultation with Mrs A and his clinical notes of the consultation.

Dr B states that, at the appointment, Mrs A complained of continuous mid-back pain and lower back stiffness. She also complained of: pain and numbness in her right leg; stiffness in her neck; difficulty walking and getting out of a car; digestive and sleep disturbances; tiredness and low energy. She told him that she had a total knee joint replacement, her tonsils had been removed, and that she was taking iron supplements for anaemia. Apparently, Mrs A looked worried and tense.

Examination revealed tenderness between Mrs A's T1 and T3 vertebrae, especially over the right rhomboid muscles. Her mid-back was stiff and painful on bending and she had only 20% flexion. Mrs A showed pain and difficulty with bending. She had a "left short leg" and weakness in her quadriceps.

Dr B diagnosed a thoracic sprain/strain with pain, segmental dysfunction and hypokinesalgia. His treatment consisted of chiropractic adjustments with a low-force activator to the T1-4 vertebrae, traction and Nimmo point work.

Following treatment, he advised Mrs A to restrict her movement and reduce sitting and walking to a minimum. He also told her to take salt baths to relieve her muscular tension

and pain. Further, that she "might want to look into" making some lifestyle changes. Particular reference was made to posture and diet. He advised her to return for treatment the following week.

Mrs A's statement of events
Mrs A states that when she first saw Dr B she complained of pain from a sciatic nerve problem, which needed relief. His response was to enquire into how she was going to pay for the treatment. According to Mrs A, he was not interested in her medical history and continually interrupted her when she tried to volunteer it. Additionally, he did not make any enquiries that would elicit this information.

Dr B told Mrs A to lie on the table, face down. He then used a "plunger" [here Mrs A refers to an Activator adjusting instrument; a low-force, high-speed mechanism for adjusting vertebrae] on her back several times, prior to twisting and pulling her legs. After completing these ministrations he moved to her middle-back area. Subsequently Dr B "leapt-up", obviously leaving the ground, and landed on her back. Mrs A yelled out, in pain. She states that it felt as if Dr B had sat on her, and that the contact made with her back was definitely larger than could be made with hands. Nonetheless, she was not able to describe exactly what Dr B did because she was lying prostrate. Dr B repeated this manoeuvre and Mrs A exclaimed, "You're not going to do that again!" He replied, "That was enough for today." Mrs A states that his treatment was extremely painful; it made her yell, and brought tears to her eyes. She felt that if he had jumped on her again she "would not have been getting up at all".

Mrs A was then informed that she required treatment three to four times weekly. Dr B further recommended that she make lifestyle changes, but did not specify how. He advised Mrs A to make an appointment for the following day. Mrs A decided against another appointment.

Mrs A states that the entire appointment lasted about ten minutes and certainly no more than 15.

General practitioner's notes
Almost four weeks later, on 4 April 2002, Mrs A visited her general practitioner, Dr C. Dr C's notes from this consultation recount Mrs A's experience at that appointment as follows:

> "[Mrs A] … was not happy with the RX [prescription] she received. He was not interested in her history and constantly interrupted her. She said he placed her face down on the table, lifted her L [left] arm and then sat down heavily on the middle of her back. He did that twice. She felt severe pain on both occasions and refused to allow him to do it again."

In June and July 2002, Mrs A visited another country. While she was there she had trouble with her balance, which led to her spending time in hospital. She was advised that she had a pinched nerve in her neck, which was likely to have been caused by a hit or jolt to her central body, and that the vertebrae were compressed.

ACC decision

ACC declined Mrs A's claim on the basis that she had not suffered personal injury but, at most, an exacerbation of pre-existing back pain.

Independent advice to Commissioner

The following expert advice was obtained from Dr James Burt, chiropractor:

"**On the basis of Dr [B's] records, did he:**

– Take an adequate medical history?

A review of the clinical records presented by Dr [B] ('the Chiropractor') fail to elicit adequate information in respect of the presenting complaints of 'right sciatica to knee and pain at centre back'.

The importance of a medical/health history is to ascertain information from the patient that will give the practitioner a picture of the person who has consulted him/her. They will then conduct an examination on the regional area of complaint.

An important family history of spinal degeneration has been missed. This is of clinical importance in determining treatment protocols.

– Conduct an adequate examination prior to beginning treatment?

The examination conducted by the Chiropractor was inadequate. He has failed to perform an examination of a standard that would allow him, from the information recorded, [to] establish a clinical diagnosis prior to beginning treatment.

His letter dated 6 May 2002 to the Medical Misadventure Unit under 'Examination' records information that an examination was performed in the area of the presenting complaints. I am unable to find this information revealed in this letter on the clinical file that I have examined to the extent that he has stated.

– Accepting that Dr [B] leapt off the ground while applying pressure to Mrs [A's] back, and that Mrs [A] had to tell him to stop due to the extreme pain, did Dr [B] use excess force in providing treatment?

There is no known technique to the writer of this report that would require a Chiropractor to leap off the ground when applying pressure to a patient's spine.

When adjusting a spinal area the Chiropractor is trained in a manner that would allow him to apply the correct amount of pressure to relieve the subluxation complex that the patient had presented with.

NB: On 8 March 2002 the patient file records a 'pressure twist' as part of the treatment on that day. I cannot assume to know what this means. Possibly this is the recording of the treatment that Mrs [A] describes as 'pulling her legs and leaping onto her back'.

– Did Dr [B] provide treatment to the appropriate area of Mrs [A's] back?

When the patient presented for treatment she identified her reasons for coming to the [city] Chiropractic Clinic. She stated that she was interested in 'help with specific problems [and] in addition interested in becoming healthier and staying healthier instead of allowing her problems to reoccur'. She described her complaints as 'pain in centre back and sciatica in right leg extending to the knee for which she underwent massage at Xmas and physio on [her] neck'.

With the above information in mind, it would be logical for the Chiropractor to have examined the areas of complaint prior to the commencement of treatment. This did not occur to an adequate standard. There are no satisfactory clinical findings recorded. The area that the patient received treatment was at level T1-T4 utilising an Activator Adjusting Instrument and a 'pressure twist'. (An assumption is made that this is a correction to the thoracic spine at a non-specific level utilising the thenar eminence of the hands in combination with a twisting action and simultaneous downwards pressure.)

The patient did present with centre back pain and treatment was afforded to that area. No treatment was administered to the lumbar spine for the sciatic condition. How the Chiropractor determined that treatment to that area was appropriate cannot be established, as there is not enough information in the file to make any assumptions.

– Information:
– Did Dr [B] provide Mrs [A] with the information that she could reasonably expect to receive from a Chiropractor, including information about:
– The nature and cause of her condition?

The Chiropractor in my opinion never obtained from the patient at the time of the medical history and examination procedure enough information to be able to impart to the patient information in respect of her presenting conditions. He never recorded that Mrs [A] suffered from a family history of spinal degeneration. From the patient's perspective the fact that she had an ongoing problem with the sciatic nerve and that she had previous treatment from another health practitioner should have led the Chiropractor to set out a protocol for the patient that would allow her an opportunity to make a decision on the type of care that was available.

He should have discussed with her his method of treatment and how he intended to approach her condition. As he was using the Activator Adjusting Instrument on the thoracic spine he should have explained to the patient the process by which the Activator operates and demonstrated this to her.

It is normal for a Chiropractor to explain to the patient the clinical finding of the examination and utilising a spinal replica give an explanation as to how that treatment will be administered.

It is then up to the patient armed with that information to make a decision whether that is the type of treatment that she would accept and then consent to that treatment.

It would appear from the information in the clinical file that no information was provid[ed] to the patient prior to treatment.

– Record keeping:
– Are Dr [B's] records of an acceptable standard?

The records that I have reviewed in respect of Mrs [A] do not meet the minimum Standards.

There has been an overall failure to keep records that graph a procedure within his clinic that would allow a continuation of care.

– Other matters:

There would appear to be a communication breakdown between the patient and the Chiropractor. From her comments in communications with the Commissioner's office and with ACC she has stated that he said she would have to 'make lifestyle changes, but did not say how' and he has stated, 'should restrict her sitting and walking periods and advised her to take salt baths to relieve muscular tension'. While there is no evidence that either was said, it often occurs during a consultation where additional information is imparted to patients without a record being made of the conversation. While this may not on the surface appear to be good practice this does occur.

The patient has stated that she was told that she would need to see the Chiropractor three to four times a week. I have elicited from the clinical notes on 5 August 2002 that the patient was to be seen next week for a re-assessment of subluxations. This would lead me to the conclusion that no determination on a treatment plan had been finalised, only that the mode of treatment was to utilise the Activator procedures.

– Conclusion:

Dr [B] has failed to meet the Standards. I would view his conduct with moderate disapproval at the high end of the scale.

I would like to see that Dr [B] be given an opportunity to review his clinical procedures and have the Board appoint a Chiropractor to review his procedures to ensure that they comply with the Standards."

Additional advice

In a subsequent telephone conversation with my investigation staff Dr Burt reiterated that, to his knowledge, no chiropractic technique required a practitioner to leap off the ground, and doubted that it occurred. He confirmed that if a practitioner did leave the ground while applying pressure to a patient's spine, then this would indicate the use of excessive force. Dr Burt also stated that no patient should experience pain during the course of treatment, if the correct technique was adopted.

Response to Provisional Opinion

Dr [B] did not respond to my provisional opinion and advised me that he does not intend to continue practising as a chiropractor.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 6

Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Professional standards

The New Zealand Chiropractic Board's "Standards of Practice" (the Standards) state:

2.1 All chiropractors should conform to a minimum standard in recording the health history (see 3.0 below) of new patients and a record of the patient's progress while under chiropractic care.

3.1 A health history should include the following information:

…

2. history of past and present health, and family history

4.6.3 In addition to the initial case history and examination information, a Chiropractor should keep a record of patients' progress. Records must be capable of being interpreted by the Chiropractor's colleagues, and should include:

…

2. Brief notes about the subjective comments made by the patient … along with the Chiropractor's observations

3. examination findings recorded

4. informed choice/consent obtained

5. all procedures performed on the patient

...

7. advice given to the patient …

Opinion: Breach – Dr B

Medical history
Having reviewed Dr B's clinical notes and his statement to ACC, my expert considered that the history taken by Dr B failed to elicit important details regarding Mrs A's presenting complaint and hereditary susceptibility to spinal degeneration. This finding is supported by Mrs A's assertion that Dr B neglected to make any enquiries into her medical history. It is also supported by the duration of the consultation, which Mrs A claims to have been less than 15 minutes in total. I am satisfied that Dr B did not take an adequate medical history prior to beginning treatment. In my view, this amounts to a failure to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

Initial examination and diagnosis
In statements made to my investigation staff, Mrs A asserted that Dr B did not perform an examination prior to initiating treatment. She claimed that he neglected to inform her of any diagnosis upon which the proposed treatment was based. I note the comments made by my expert advisor:

> "The examination conducted by the Chiropractor was inadequate. He has failed to perform an examination of a standard that would allow him, from the information recorded, [to] establish a clinical diagnosis prior to beginning treatment."

Dr B's response to the ACC contains examination details that were not apparent in his clinical notes. According to Dr B, his examination of Mrs A revealed that she was tender between her T1 and T3 vertebrae, especially over the right rhomboid muscles. She had a stiff mid-back, which was painful to flex, and her flexion was only 20%. He recalled that Mrs A exhibited pain and difficulty with bending.

I consider that the contemporaneous clinical records made by Dr B are more likely to be an accurate record of his examination than a response to the ACC written two months after the event. I accept the comments of my expert advisor that, on the basis of these records, Dr B's examination was inadequate and would not have allowed him to establish a clinical diagnosis prior to initiating treatment. In my view, these omissions constitute a failure to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

Information about treatment options
Prior to beginning treatment, Dr B should have discussed his intended treatment with Mrs A. This should have included explaining and demonstrating the use of the Activator adjusting instrument. Mrs A said that she did not receive any such explanation or demonstration. Dr B has provided no evidence that he gave Mrs A any information prior to treatment. In my opinion, Dr B did not provide Mrs A with the information she could reasonably have expected to receive about the options for treatment and thus breached Right 6(1) of the Code.

Treatment
Mrs A stated that, prior to experiencing substantial pressure on her back, she observed Dr B's feet leave the ground. Subsequently, she experienced considerable pain. I note that Dr B was provided with a copy of Mrs A's complaint letter in formulating his response to the ACC. He did not directly dispute her version of events. Therefore, I accept that Dr B's feet left the ground while providing treatment to Mrs A.

My expert advisor noted that a chiropractor leaving the ground while providing treatment indicates the use of excessive force. Further, that no patient should experience pain if a chiropractor adopts a correct treatment technique. On the basis of the evidence provided, I consider that Dr B used excessive force and inappropriate technique in treating Mrs A. Thus, in my view, Dr B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Record keeping
Section 4.6.3 of the Chiropractic Standards of Practice requires practitioners to keep records that are "capable of being interpreted by the Chiropractor's colleagues and should include … all procedures performed on the patient". My advisor noted:

> "On 8 March 2002 the patient file records a 'pressure twist' as part of the treatment on that day. I cannot assume to know what this means. Possibly this is the recording of the treatment that Mrs [A] describes as 'pulling her legs and leaping onto her back'."

In my opinion Dr B did not meet the minimum requirements of the Standards. His fellow practitioner, Dr Burt, was unable to interpret his notes regarding the procedures performed on Mrs A. Dr Burt also noted that "there had been an overall failure to keep records that … would allow a continuation of care". In my opinion, Dr B failed to comply with professional standards and breached Right 4(2) of the Code in this respect.

Follow-up actions

Review of practice
I recommend that Dr B review his practice in light of this report.

Copies of report to Chiropractic Board and ACC
A copy of this report will be sent to the New Zealand Chiropractic Board and the Accident Compensation Corporation.

Copies of report for educational purposes
A copy of this report, with identifying details removed, will be sent to the New Zealand Chiropractic Board and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.