Physiotherapist, Mr B

A Report by the

Health and Disability Commissioner

(Case 01HDC03073)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaint

The consumer, Mr A, complained about the services he received from Mr B, a physiotherapist. Mr A's complaint is summarised as follows:

On 26 January 2001 Mr A consulted Mr B, physiotherapist, about a pinched nerve in his lower back. Mr A is concerned about the standard of physiotherapy treatment that he received from Mr B and alleges that Mr B failed to:

- *adequately assess his injury or symptoms;*
- *relieve the pain of the pinched nerve in his lower back;*
- *advise him about why he 'cracked' his spine as he felt that Mr B failed to adequately explain the treatment to him prior to performing it;*
- *advise him that in order not to exacerbate his condition, he should lie down and not sit up at all once he got home after the treatment;*
- *enquire or provide any follow-up care or advice to him after the treatment; and*
- *adequately treat his condition as he ended up being worse off following the treatment than what he was prior to consulting Mr B.*

Investigation process

The complaint was received on 12 March 2001 and an investigation was commenced on 27 June 2001. Information was obtained from:

Mr A	Consumer / Complainant
Mr B	Provider / Physiotherapist
Mrs C	Complainant's wife
Mrs D	Physiotherapist
Dr E	General Practitioner
Dr F	General Practitioner
Mr G	Physiotherapist

Independent expert advice was obtained from Mr Duncan Reid, Senior Lecturer, School of Physiotherapy, Auckland University of Technology.

Information gathered during investigation

Background

On 20 January 2001, Mr A fell off a stool while he was painting. Mr A experienced pain in his lower back, which later radiated to the left buttock and leg. By the next day, Mr A no longer felt any pain in his back, but he continued to experience pain in his left leg. Because of the pain, Mr A had difficulty in sitting or standing still but he felt better when

walking or lying down. Mr A felt that the pain symptoms in his leg were similar to those he experienced after a previous injury in September 2000.

In September 2000 Mr A injured himself while working on a friend's deck and as a result experienced pain in his left leg when standing. He was diagnosed by a physiotherapist as suffering from a pinched nerve. Whenever the pain in his left leg got too bad, Mr A would take time off work and rest until his leg improved. Mr A took Tilcotil, an anti-inflammatory, for the pain as required.

Mr A did not see a doctor immediately after his fall in January 2001, as he concluded that the injury was a recurrence of the pinched nerve he experienced the previous year. He continued working in his job as a welder and took Tilcotil for the ongoing pain. However, Mr A's symptoms became slightly worse over the following week, and he consulted Mr B, a local physiotherapist.

Assessment of injury
On 26 January 2001, Mrs C telephoned Mr B's clinic to make an appointment on behalf of her husband. She spoke to Mrs D, a qualified physiotherapist who practises with her husband at the Physiotherapy Clinic.

Mrs C recalled that she informed Mrs D that her husband had suffered a pinched nerve and experienced considerable pain in his left leg in September the previous year. She told Mrs D that Mr A was experiencing similar symptoms again, after falling from a stool, but this time with pain moving from his lower back to his left leg. She said that her husband had experienced a pinched nerve "like he'd had last year". Mrs C requested an urgent appointment for her husband.

Mrs D's recollection of the conversation is as follows:

> "A woman wanted to make an urgent appointment for her husband who she described as in considerable pain after stepping/falling awkwardly from a stepladder. The woman described the pain and the cause in detail as being located in the man's lower back and going into his buttock on the right, felt mostly over the sacroiliacal joint."

(The sacroiliac joint (SI joint) is located between the sacrum, which is the triangular bone just below the lumbar vertebrae, and iliac bone, the expansive superior portion of the hip bone.)

Mr A consulted Mr B after work that same day. Mrs C did not accompany him. Mr A recalled that his consultation with Mr B began without any questioning or discussion about his condition. Mr A was concerned at the lack of discussion and asked Mr B if he knew why he was there. Mr B replied that Mrs C had told his wife (Mrs D) that Mr A was suffering from a pinched nerve. Mr A then took it upon himself to inform Mr B of the details of his condition.

Mr B recalled that when Mr A arrived at his clinic, he was visibly in pain with a typical posture of acute lower back pain. Mr B said to Mr A words to the effect, "Let's start with this immediately and have a look at your back. Where is most of the pain?" Mr A then provided Mr B with the same information his wife had told Mrs D (see above).

Mr B commented that he asked Mr A if there was pain radiating into his leg and that he was told by Mr A the area affected only his right buttock. However, Mr A recalled advising Mr B that he also had pain at the top of his left thigh.

Mr B also stated that he asked Mr A if he had suffered similar pains before and that Mr A told him about his previous injury in September resulting in a pinched nerve for which he had received physiotherapy treatment. Mr A denied that Mr B asked him directly about his previous injury.

Mr B advised me that he proceeded to treat Mr A with a standard assessment recommended by the New Zealand Association for Musculoskeletal Medicine. Mr B recalled that he asked Mr A to lift one leg at a time to check the normal "drop" of the SI joint. He also found that the right SI joint was blocked towards the tested direction using the "Stork" test. Furthermore, the right pelvis was being pulled up by lumbar muscle spasm. Mr B then checked all other levels of the spine and found that the right-sided pattern was present in the rest of the spine.

Mr B concluded that the right SI joint was blocked in its movements but that the left SI joint was mobile and painful when palpated (hyper mobility). He also observed that there was palpable swelling over the level of the fourth and fifth vertebrae, which he thought could be a sprain of either the soft tissues, the disc or both. Mr B commented to Mr A that his upper spine and neck showed a pattern that is often associated with headaches. Mr A assured him that he seldom suffered from headaches.

Mr B recalled that after this initial assessment, he fully explained his findings to Mr A. Mr B advised me that it is always his practice to discuss his findings with each patient after assessment, and to explain treatment options before commencing treatment. Mr B provided copies of the clinical notes for the consultation as evidence of the process of informed consent. The form has three boxes which are headed: "Treatment explained", "Patient instruction/education" and "Treatment approved by patient". I note that all three boxes are ticked. Mr B also commented that the whole assessment can be done within a reasonably short period of time.

Mr A described his recollection of the assessment he was given, in his letter of complaint dated 7 March 2001: "He asked me to tilt first my left leg and then my right in front of me whilst standing. He felt my back and commented: 'I bet you get a lot of headaches,' to which I replied that I very seldom get a headache." After the assessment was completed Mr A recalled that Mr B "did not explain anything at all" to him, and proceeded with his treatment, without discussion.

Treatment provided

Mr B advised me that he gently mobilised the primary locks that he had found during the assessment. He was particularly careful and kept the velocity of mobilisation as low as possible, because Mr A might have previously suffered a disc prolapse. These mobilisations are done with the patient lying on his side and using gentle rocking/shaking. Mr B advised me that he then:

> "proceeded with gentle mobilisation of the Thoracic spine and rib joints with the patient prone. (This is definitely not a position to mobilise the lumbar spine.) I recall that

some of the right lower ribs released without much pressure, actually still in the 'testing' stage but with the cracking sound associated with some joint releases.

I continued by checking the cervical spine movements but found that the right-sided pattern had been mainly caused by T [thoracic vertebrae joint] 12/L [Level] 1 and L2/3 blockages.

I checked the SI joint movements again after the mobilisation and found that both joints moved freely and fully. The right pelvis half had dropped back to a normal level position, which I hoped would take at least part of the pressure off from the L4/5 disc and sprained tissues.

The swelling over L4/5 and the left SI joint were treated using Interferential Therapy, an electric treatment current that works particularly well to release swelling in sprained tissues and joints. The treatment time with this modality was fifteen minutes, as demanded by our treatment protocol.

I kept the possibility of a disc bulge in mind but decided to wait with a detailed assessment for this option, when the pain would be a less limiting factor. There was no clear sciatica but sufficient nerve pain into the right buttock to be suspect."

Mr A's recollection of the treatment he received is as follows:

"He then laid me on my side and rocked me gently a couple of times and once strongly on each side. I then had to lay on my stomach and he pressed down on my lower spine and cracked it 3 times. Then he placed electric pads on and left me for 5 minutes with electric current surging on my lower spine. At no time was gentle manipulation or massage applied."

Mr B commented that Mr A said he felt good after he stood up from the treatment table. Mr A advised me that he does not recall saying this to Mr B, although he may have said something like "it feels a bit better". Mr A advised me that after receiving treatment from Mr B he "did not feel worse" or better.

Mr B advised me that he warned Mr A of the possibility of "afterpain", which can occur after the release of spinal locks, and that he could possibly experience recurrent pain in the SI joints. He also warned Mr A against prolonged sitting as this puts undue pressure on the SI joints. Mr A was told to lie down for a while and then walk around again during the rest of the day, to allow the sprained tissues to settle further. Mr A was to increase the level of his walking over the weekend, if possible. Mr B considered that it was too early to recommend Mr A commence an exercise programme as the pain was too acute. A follow-up appointment for Mr A was made for Tuesday 30 January at 4.30pm, which Mr A did not attend.

Mr A cannot recall Mr B "saying anything like that" or "warning" him "about anything". Mr A recalled that Mr B just told him to return and see him again on Tuesday.

Mr B's complete clinical notes for the consultation of 26 January 2001 state:

> "Pain (radiating) to left lateral thigh after falling/stepping from a little stepladder. Right pain lower back. Right SI joint (Sacro-Iliac joint) blocked both tests but left pressure pain SI. Swelling palpable L4/5. Mobilised T12/L1, L2/L3. Felt good when leaving. Warned against after pain."

(Mr B has not provided me with a separate clinical assessment form.)

Events after treatment
After the consultation Mr A drove home and sat down to rest for the evening. When he went to bed, he felt "very, very sore". This was confirmed by Mrs C. Mr A recalled that he spent the night "in a lot of pain" and that the pain "woke [him] during the night too, that's how bad it was". Mr A advised me:

> "When I awoke the following morning I was in agony and unable to move. I had no choice but to stay in bed and hope this would not continue for long but the pain became unbearable. I could not stand, walk or sit and the only position that even slightly relieved the pain was to lay on my back with my legs curled up on my chest. The following morning [Sunday 28 January 2001] my wife called the doctor on duty [Dr E, who was on call for the Medical Centre] who administered Pethidine and advised taking Panadol and Codeine for the pain and to continue with the anti-inflammatories."

Dr E wrote a medical certificate for Mr A, and Mr A took two weeks' leave.

Mrs C advised that on Monday 29 January 2001 she telephoned the doctor on call for the Medical Centre to see whether Mr A could increase the dosage of Tilcotil and codeine tablets because of her husband's extreme pain. Mrs C said that the on-call doctor told her that Mr A could increase the Tilcotil up to two times a day and the codeine up to two tablets three times a day. (The on-call doctor has no recollection or written record of this conversation.) Mr A said that a neighbour also gave them some Paradex tablets (also an analgesic) on 29 January 2001, which helped to relieve the pain a lot more. Mr A was able to obtain some sleep for the first time in several days.

On Tuesday (30 January) Mrs C telephoned and spoke to Mrs D about her husband's condition. Mrs D offered the use of a pair of crutches, which Mrs C collected the same day. Mr A, however, advised me that the crutches were of no help whatsoever as he could not "even stand never mind walk".

Mr B provided the following comment:

> "On Tuesday, 30 January, we received a phone call from [Mrs C] who cancelled the appointment for her husband. She said that he had become sore on Saturday and had to stay in bed. [Mrs D], who answered the phone, offered for [Mrs C] to come and pick up a pair of crutches to aid [Mr A] with walking around. She also asked during this phone call if he had seen a doctor over the weekend and if he had appropriate painkillers. She offered for [Mr A] to come back for a follow-up treatment at a later stage when he was more mobile.

> [Mrs C] did pick the crutches up but returned them the next day (Wednesday) because [Mr A] did not want to use crutches. While she was there in person my wife and I enquired after [Mr A] as we were both puzzled and concerned. She advised that [Mr A] had felt good on Friday afternoon after the treatment and went to do 'things'. When asked what these 'things' were, she said 'The things he does in his shed and in town.' She said the next day (Saturday) he was still feeling good and had done some more 'things'. Later in the morning he felt pain coming on and felt the need to sit down. The pain got worse during the afternoon and evening. On Sunday morning he was unable to get out of bed.
>
> I enquired why he would do all this work and sitting against my advice, and she said that she had heard the advice that I gave her husband and could only say that he 'would do his own thing'. We thanked her for her honesty."

Mr B recorded the following information in his clinical notes:

> "30/01/01 (from phone call) Saturday more pain and stayed in bed. This morning still pain. Wife phoned, will come and collect crutches.
>
> 31/01/01 [W]ife returned elbow sticks, he didn't want them, could walk around bed, didn't want another appointment. Wife told: felt very good on Friday and did 'things'. [F]elt good Saturday morning and did some more 'things'. Pain increased over Saturday, bad in evening. [C]ame on over morning."

Mrs C advised me that she did not recall commenting to Mr and Mrs D that her husband felt good after the treatment. She said that Mr B:

> "asked how [Mr A] was going and I told him about [Mr A] being in agony the next day after he had seen him [Saturday 27 January 2001], and that he had had to go back to bed by lunchtime because of the pain.
>
> I don't think I would have told [Mr B] that [Mr A] was good when he hadn't been able to walk or stand.
>
> I only told [Mr B] about [Mr A] trying to do some gardening on Saturday morning, that [Mr A] had woken up in agony, and that by lunchtime he had to go back to bed because of the pain.
>
> I would not have said anything [to Mr B or Mrs D] about [Mr A] going out to do things in his shed or in town because we couldn't go to town between the Saturday when he woke up in agony or the Wednesday when I returned the crutches to [Mr B], because [Mr A] couldn't sit, stand or walk – he could barely lie down or crawl along the floor."

Mrs C also commented that she cannot understand why Mr B maintained that she "heard" him advise her husband about not sitting after the treatment, as she did not accompany him to the appointment on 26 January 2001. She alleged that when she returned the crutches, Mr B asked her whether "[Mr A] had sat down at all on the evening of the treatment". Mrs C advised Mr B her husband did sit down for the rest of the evening after the treatment and

that Mr B then said to her: "Oh dear, I should have told him not to sit down and to only lie down. But he looked fine when he left here."

Mr A advised that on Wednesday 31 January 2001 he could not stand, sit or walk and could only lie on his back with his legs bent. His general practitioner, Dr F, visited him at home and confirmed that he had a pinched nerve. Dr F told him to keep taking the pain relief and anti-inflammatories. Mr A maintains that Dr F noted that he had no reflex in his left ankle, but decided that a hospital admittance was not necessary as he appeared to have normal bowel and bladder function.

On Friday 2 February 2001 Mr A visited another local physiotherapist, who provided him with acupuncture and gentle exercise and manipulation therapy. After this treatment, Mr A was "in slightly more pain again that evening and for the next two days".

On Wednesday 7 February 2001 Dr F visited Mr A again at home and signed him off work for a further two weeks. By this time, Mr A had slightly more lift in his left leg although still no flex in his left ankle. Dr F advised Mr A that he needed to have a CT scan. An appointment with a specialist (identity not advised) was arranged for 19 March 2001. Dr F also referred Mr A to Mr G, a physiotherapist.

A week later Mr A experienced a very slight improvement in his overall condition. He took amitriptyline, which resulted in an improved sleep pattern. (Mr A had a small quantity of amitriptyline at home left over from a previous prescription.) On Friday 16 February 2001 Mr A consulted Mr G. Mrs C noticed that her husband's condition improved after the treatment as he could lift his sore left leg a bit higher the next day and could move around a little better. Mr G advised me that the treatment he provided to Mr A was resting flexion treatment and nerve root stretch combined with anti-inflammatory drugs. Mr A received treatment from Mr G on three other occasions: 22 February, 2 and 6 March 2001.

Mr B advised me that on 28 February 2001, Mr A telephoned and told Mrs D that her husband had treated him four weeks ago for a trapped sciatic nerve and had cracked his back while he was lying on his stomach. Mr A said this had caused the problem to become considerably worse and that he was still unable to go to work. Mrs D told her husband that Mr A said he should not "crunch other people because it makes it [the pinched nerve] a lot worse".

Mr A advised me that by 7 March 2001, he "had been off work and on ACC for almost six weeks and was only just starting to walk further than the length of [their] house". (ACC advised me that the standard ACC claim form was drafted by Mr B, and that there was no subsequent medical misadventure claim.) Mr A advised me that he feels Mr B:

> "needs to be made aware of the need to take time to establish how an injury occurred and what the symptoms are. He also needs to concentrate on the problem at hand and to tackle other perceived irregularities in the skeleton later. **Never** to forget to inform the patient of any requirements ie. not to sit down."

Regarding the treatment that he provided to Mr A, Mr B believes he:

- performed an appropriate and adequate assessment of Mr A's complaints
- gave Mr A ample information about his findings during the assessment. He would have explained the findings of his assessment or the offered treatment or possible outcomes of the treatment to Mr A
- gave Mr A appropriate and adequate treatment for his lower back complaint, performed with due professional consideration and skill, following the current professional guidelines for the treatment of acute back pain and only after Mr A gave him permission to do so
- treated Mr A without being rushed, and for an appropriate length of time (the consultation time was just over 35 minutes)
- gave Mr A proper advice for the management of his condition during the consultation
- gave due care to Mr A once he heard that his back problems had been exacerbated over the weekend by means of advice and by offering crutches and the option of further treatment.

Mr B advised me that he and his wife have had a lengthy discussion about Mr A's complaint in regard to their procedures and practices and have decided that there is no reason for them to change their treatment protocol or the way in which their patients are informed of the findings during assessment and treatment. They are satisfied that the advice given to Mr A was sound. Mr B feels that the complaint has occurred "due to a breakdown of communication". He advised me that he is "sorry that such a breakdown in communication occurred and that [Mr A] has been in such discomfort".

Independent advice to Commissioner

I obtained independent advice from Mr Duncan Reid, physiotherapist, who included with his advice an example of a "Clinical Assessment Form" (see Appendix II, p.16). My advisor's report is set out below:

"**Re: Complaint file CO1AKLO3O73**

Before answering the questions you have specifically asked me I would like to comment that there are obviously two quite different accounts of the events that took place on January 26th 2001 from the patient's point of view and from the therapist's point of view. However I will give my opinion with the information provided.

Questions to be answered:

1. **Did [Mr B] adequately assess [Mr A's] injury?**

[Mr B] appears to have gained the information about [Mr A's] condition from two sources, his receptionist and very briefly from the patient himself. A normal examination would entail a lengthy subjective examination ascertaining the exact cause,

nature and behaviour of the patient's symptoms of the symptoms followed by a thorough physical examination checking for major 'red flags' or precautions? Neither of these things appear to have taken place.

2. **Did the therapy relieve the pinched nerve?** Yes but only temporarily.

3. **Was [Mr A] advised about why his spine was cracked?** In [Mr A's] opinion no, and in [Mr B's], yes.

4. **Was [Mr A] given advice about not exacerbating the condition?** As with the above question, no according to [Mr A] and yes according to [Mr B].

5. **Did [Mr B] enquire about follow up care or advise after treating him?** This answer is the same as the above two questions. However, [Mr A] was asked to make another appointment at which other advice and treatment could have been given. He chose not to keep the second appointment as a result of the initial treatment.

6. **Was the treatment adequate given the outcome was poor?** To answer this leads into the second page of questions you have provided.

What specific standards apply to the provision of treatment and were they followed?

The New Zealand Society of Physiotherapists (NZSP) and the New Zealand Private Physiotherapists Association (NZPPA) both have guidelines on the expected standard of care. (See Appendix I for copies of expected standard of care guidelines.) [Mr B] is a member of both these organisations (see CV).

As stated above, a patient should expect to have an interview to establish the history of the complaint, the nature of the pain, whether the pain is behaving in a chemical way (inflammatory) or mechanical way, past history, and questions about safety issues eg medications, pins and needles numbness etc that may indicate more serious pathology.

Next a physical examination would take place. This may be brief if the patient is in considerable pain but would still have to cover active range of movement, relevant passive movement tests to appropriate joints and special tests such as Straight leg raise, strength and sensation testing of the lower limb in this case.

Looking at the notes that have been provided by [Mr B] there is minimal evidence of the depth of interview and tests carried out. Given that the subsequent pathology was damage to the intervertebral disc then the special tests would need to be carefully carried out and documented to ascertain the status of the disc and the surrounding nerve tissue. The history [Mr A] gives in his account of events and the intensity of the pain would also indicate a need for caution.

Following the assessment an explanation to the patient of the possible reason for the pain and the treatment plan would be standard practice. The possible time frame for the problem to resolve and the setting of goals in conjunction with the patient would follow

next (see Appendix I). Again from the notes there are no goals stated although there is a tick box that the treatment was explained. [Mr A] does not recall any explanation, goals being mentioned or consent being gained following the receipt of appropriate information.

Appropriateness of treatment

Given the acute nature of the pain caution would be required. The Accident Compensation Acute Low Back Pain Guidelines (1997) recommend that the management of acute pain should follow these steps:

1st visit, thorough assessment, check for any red flags (Straight leg raise, strength sensation of the lower limb), if yes, refer back to Doctor or specialist.

If no, give advice to stay active, continue normal activities, take medication and if other contraindications are clear manipulation may help in the first month.

It is not possible from [Mr B's] notes to see if a full neurological examination was undertaken although active straight leg raise in standing was tested. Manipulation i.e. the 'crack' appears to have been used but again there are discrepancies between the patient and [Mr B] as to how much force was used in this technique. Given there is the possibility that a disc injury was a likely pathology, if no red flags were present manipulation was a possible treatment option. If red flags were present then manipulation was not a good option as it may stress the annulus of the disc in a rotation technique as described. Alternative treatments to the ones given by [Mr B] could have included patient generated extension exercises as described by McKenzie (McKenzie, 1981), advice on rest positions for an acute disc such as lying supine with the knees flexed for periods of time and appropriate medications as per the ACC Acute Low back pain guidelines. Electrotherapy in the form of Interferential as given by [Mr B] following the manipulation was also an option.

Follow up advice

As stated, the ACC Acute Low Back Pain Guidelines recommend remaining active within the limits of the pain. As with most acute injuries, some injuries require short periods of rest to allow acute symptoms to settle. In the case of an acute sciatica with the potential for a distorted annulus rest in an unweighted position and to avoid prolonged flexion such as sitting, or bending would be commonly applied advice (Nachemson, 1987). There is no indication in the notes written by [Mr B] as to the nature of the advice he may or may not have given [Mr A]. As [Mr A's] wife did not accompany him to the appointment there is no way of corroborating the advice.

Other matters relevant to the case

One question often asked is: Is there a causal link between the treatment given and the worsening of the symptoms? In other words did the treatment itself make the patient worse or was there something the patient did after the treatment took place that made it worse?

In answering this question it appears from the information given that although [Mr A] was possibly a little better after treatment he deteriorated later that day. After a troubled night's sleep he was much worse upon waking. This is not uncommon with disc injuries as the disc hydrates over night and subsequently swells. The increased pressure in the disc would aggravate a damaged annular wall (Adams, Dolan, & Hutton, 1987; Adams & Hutton, 1983). This would also make weight bearing difficult. These are problems [Mr A] faced the morning after treatment and add weight to the disc injury hypothesis. With this in mind the treatment being a rotation technique may well have further weakened the annular wall to the extent that the symptoms were much worse following treatment (Huijbregts, 1998).

It appears from [Mr A's] transcript that he was too sore to have done anything else at home himself to aggravate the symptoms.

Also looking at the report of the subsequent Physiotherapist [Mr A] saw, [Mr G], who has performed many of the required examination tests, the following objective signs are found; pain in weight bearing, straight leg raise 30% on left, reduced ankle reflex and reduced calf strength and bulk. These are all signs consistent with a disc prolapse. Given this information there is a strong possibility of a casual link between treatment and the worsening of symptoms.

Finally, [Mr B] goes to great length to state that he has an ISO 9002 accredited practice. The standard of his note taking with obvious brevity, lack of body chart and lack of patient goals are below what one would expect to gain this sort of accreditation.

In summary:

– [Mr A] received a very cursory examination prior to his treatment.

– He was not actively involved in any goal setting with regard to his treatment and was not clearly informed of his treatment options and outcomes.

– The standard of note taking is not of the required standard as expected by the NZSP and the NZPPA.

– There were enough significant signs and symptoms from the history to warrant caution on the initial treatment and alternative treatment options may have been more appropriate given the outcome.

Relevant References:

Accident Compensation Corporation and National Health Committee (1997) The New Zealand Acute Low Back Pain Guide. Ministry of Health Publication.

Adams, M., Dolan, P., & Hutton, W. (1987). Diurnal variations on the stresses on the lumbar spine. *Spine, 12,* 130–137.

Adams, M. & Hutton, W. (1983). The effect of posture on the fluid content of lumbar intervertebral discs. *Spine, 8(6),* 665–671.

Huijbregts, P. (1998). Fact and Fiction of Disc Reduction: A literature review. *Journal of Manual and Manipulative Therapy* 6(3), 137–143.

McKenzie, R. (1981). *The Lumbar Spine. Mechanical Diagnosis and Therapy.* Waikanae, New Zealand: Spinal Publications.

Nachemson, A. (1987). Lumbar Intradical Pressure. In Jayson, M. (Ed), *The Lumbar Spine and Back Pain* (3rd ed.). Edinburgh: Churchill Livingstone.

Attached Appendices:

1. NZPPA guidelines for documentation of patient clinical records relevant areas highlighted.

2. Copy of sample examination recording sheet – Clinical Assessment form D Reid 2001.

Appendix 1 from N2PBA Accreditation Manual Section on Clinical Notes

		CIRCLE the score that applies
2.3	**The Physiotherapy process applied is documented in a permanent legible clinical record.**	**7 6 5 4 3 2 1**
2.3.1	The service ensures compliance for the minimum requirements for the content of clinical records. These include: • An assessment; • Measurable goals for management; • A plan for physiotherapy; • A dated notation for each physiotherapy appointment; • Evidence of re-evaluation; • A discharge plan and/or summary. ***Guidance:*** *Assessment will include the relevant history, subjective and objective findings as well as functional deficits.* *Goals for treatment will be identified, documented and evaluated in partnership with the client.* *Any changes in the plan are noted following documentation of the initial plan.* *A description of the interventions used is noted including modalities used, dosage and location of application where applicable.* *Any warning given re potential adverse reactions or complications is recorded.* *A discharge summary is on every record and copies of discharge letters are included where they apply.* *Communications between the therapist and others involved in the client's care are noted. This may include other health professionals, referring sources, third parties e.g. insurers.* *Where integrated records are a policy of a larger organisation, the physiotherapy entries must comply with policies and procedures of that organisation but must also include the above as relevant.* *Abbreviations and terminology frequently used in clinical records should be documented. It should reflect common usage.*	**7 6 5 4 3 2 1**
2.3.2	All entries on the clinical record are signed and dated and comply with the policies and procedures laid down for clinical records. ***Guidance:*** *The initial assessment, plan and interventions are signed and dated. Any changes made to the physiotherapy plan are signed and dated as are entries indicating warnings given, adverse responses, communications (including telephone calls, other verbal communications, faxes and e-mails) with the client or others involved in care.*	**7 6 5 4 3 2 1**

Standard	Criteria	Expected
3.6	The standard of physiotherapy given reflects current physiotherapy practice and ethics and is based on agreed goals leading to measurable outcomes.	Ethical principles and guidelines are known and complied with. Continuous re-evaluations reflects monitoring of services. Treatment given demonstrates compliance with the competency requirements of the Physiotherapy Board of New Zealand and a copy of "Requirements for Registration" is available in the practice.
3.7	The client receives treatment documented in a completed, legible clinical record.	There is a clinical record for every client recorded in the appointment book for all treatment dates, including domiciliary visits. Records may be held off site (e.g. private hospital), if appropriate measures are taken to ensure they are secure and the H.I.P.C. is met.
3.8	A comprehensive clinical record for each client is maintained according to specified policies and procedures. It shall contain:	
	• an assessment	Includes history, subjective and objective information, related test findings and assessment form attached if used. Assessment is legibly signed by the assessor.
	• measurable goals of treatment	These are identified, documented and evaluated, in partnership with the client and/or carer.
	• a clearly stated plan for the course of treatment.	The initial plan for treatment is recorded. Any change in plan is clearly recorded, dated and signed.
	• a dated notation of treatment given for each appointment.	The actual treatment given is recorded. Modalities have dose/location of application recorded. Any warning re potential adverse reaction is recorded.
	• evidence of periodic review	Entry of review (e.g. SOAP notes) each time the client attends for treatment.
	• discharge planning and summary (including outcome measures) is completed in liaison with client and referrer as necessary.	Discharge summary is on every record. Information resulting from measurement of outcomes is incorporated in quality assurance documentation throughout the practice. There is evidence of communication between therapist, the referring doctor and appropriate others (e.g. case manager) when this has occurred. Copies of discharge letters are with the clinical record if appropriate. There is a signed and dated entry of verbal communication.

Standard	Criteria	Expected
3.9	The initial assessment and treatment plan is signed and further signed if there is a change of therapist and/or a change in treatment plan.	All documentation of treatment is to be completed according to written policy and procedures.
3.10	Consultation or a second opinion is available and documented when sought. The client is made aware of the availability of a second opinion.	Written policy for this, and when sought, is documented (even telephone calls).
3.11	There is a written procedure for consultation/referral to other health, social, educational and vocational community agencies. These agencies are listed.	List of agencies, i.e. health, social, educational and vocational recorded with contact person, if possible, and telephone numbers. If a local publication is used, this must be recorded in the policy and must be current (produced within the last three years). Procedure for referral is documented, including how to refer on. Policy re non-disclosure of information to third party without consent is available.
3.12	Written consent from clients will be obtained where students are involved in the provision of services. The treatment will be overseen by a registered physiotherapist.	Client wishes must be considered, and there must be assurance that a high standard of care is provided and the student is adequately supervised. Evidence of periodic review of the patient by the supervising physiotherapist is documented. Treatment without a registered physiotherapist in attendance may only be given when the physiotherapist has established the proficiency of practice by the student, and when the registered physiotherapist is in the same physical location.
3.13	When non practice personnel are visiting the practice, clients are informed of their presence and consent is gained by the practice physiotherapist before any intervention with the client is observed.	A written policy and procedure guides the activities of individuals who wish to spend time observing the practice of physiotherapy.(This will apply to other physiotherapists, persons on work experience and prospective physiotherapy students). At all times, clients wishes will be accepted, and non practice personnel must comply with practice policies, and agree to be bound by client and practice confidentiality requirements.

Appendix II Example of Patient Assessment Sheet.

AUT School of Physiotherapy

Clinical Assessment Form

Name _____ **DOB** _____

Date _____ **Occupation** _____

C/O _____

CHx _____

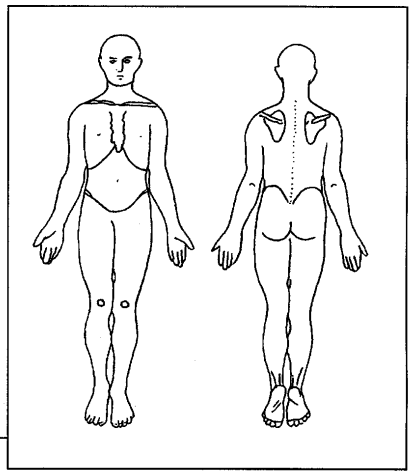
_____

_____

PHx/Rx _____

_____

_____



Pain type Const/Int **Night pain Const/Int**

Aggravating factors _____

_____

Easing factors _____

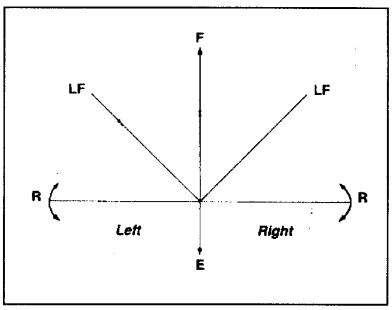
_____

Special Questions **Cough/Sneeze** **Meds** _____

Xray Yes/No **General Health** _____

Vertebral Artery Yes/No

Physical Examination



AROM _____

PROM _____

Acc _____

Resisted _____

Palpation _____

Neurological **SLR/Slump/ULTT** _____

Contraindications _____

Diagnosis _____

Pt Ed **I.C** **Signature**

Goals _____

Plan _____

D Reid/Assess/MT/2001

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.

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 –

…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: Breach

Right 4(1)

In my opinion Mr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable skill and care. In Mr A's case, this means he was entitled to receive a detailed assessment of his injury, and treatment of an appropriate standard. In my opinion, neither occurred.

Assessment of Mr A's injury
Mr A alleged that his consultation of 26 January 2001 with Mr B began without any questioning about his condition. When Mr A queried this approach, he was told by Mr B that his wife, Mrs D, had informed him of what was wrong with Mr A, following her telephone conversation with Mrs C. Mr A then described his condition to Mr B himself, without any prompting. He informed Mr B that his leg was very sore, and that he was suffering from a pinched nerve.

Mr A considered that the consultation he received from Mr B was hurried and inadequate. In his opinion, Mr B was only interested in completing the consultation as quickly as possible.

In contrast, Mr B alleged that he began questioning Mr A about the pain he was experiencing, and was told the same information by Mr A as had been conveyed to him earlier by his wife; that is, that Mr A was currently experiencing pain in his lower back and right buttock. However, Mr B described this in the medical notes as "pain (radiating) to left lateral thigh after falling/stepping from a little stepladder. Right pain lower back." Therefore, Mr B was aware that Mr A had pain radiating into his left leg.

My advisor commented that an appropriately detailed interview would cover the history of the complaint, the nature of the pain, whether the pain was behaving in a chemical or mechanical way, past history, and questions about safety issues, medications, pins and needles, numbness, etc that may indicate a more serious pathology. None of the information provided to me establishes that an appropriately detailed interview of this nature actually occurred.

Mr B's comment, "Let's start this immediately and have a look at your back. Where is most of the pain?" suggested that Mr B was anxious to alleviate Mr A's pain. However, prompt treatment should not be at the expense of a careful and considered approach.

Mr B obtained the information about Mr A's condition from two sources: Mrs D (his receptionist/wife) and (briefly) Mr A himself. He appears to have accepted the accuracy of the second-hand information he was provided with at face value, together with a brief discussion with his client, instead of a comprehensive interview, which is appropriate when treating a new patient.

Mr B maintained that his physical assessment of Mr A was conducted in a manner consistent with the standard assessment recommended by the New Zealand Association for Musculoskeletal Medicine. I note that Mr B comments that this assessment can be done in a reasonably short period of time. Mr A recalled the physical assessment as follows:

> "He asked me first to tilt my left leg and then my right in front of me whilst standing. He then felt my back and commented: 'I bet you get a lot of headaches.'"

The consultation notes Mr B provided do not detail the nature of the tests carried out during the consultation, and state: "Right SI joint blocked both tests but left pressure pain SI. Swelling palpable L4/5." I note that Mr B provides a more detailed description of the tests carried out in his letter of response, but there remains little evidence that a sufficiently detailed assessment occurred.

My advisor stated that while the examination may be brief if the patient is in considerable pain, the examination should still cover active range of movement, relevant passive movement tests to appropriate joints and special tests such as straight leg raise, and strength and sensation testing of the lower limb. He commented that a normal examination would entail a lengthy subjective examination ascertaining the exact cause, nature and behaviour of the patient's symptoms followed by a thorough physical examination checking for major red flags or precautions. Given that the subsequent diagnosis was damage to the intervertebral disc, the special tests would need to be carefully carried out and documented to ascertain the status of the disc and the surrounding nerve tissue. My advisor concluded that neither a lengthy subjective interview nor a thorough physical

examination appear to have occurred and that in his opinion Mr A received a "very cursory examination prior to his treatment".

I acknowledge that brevity of notes may indicate, in some circumstances, that there was nothing of particular significance to record. However, given the comments from Mr B about the short length of the consultation, together with Mr A's concern about the speed of the consultation, and the paucity of documentation, I am satisfied that the physical assessment was too brief for an initial visit of this nature.

I am guided by the independent advice I have received. Following a careful review of the available information, I am satisfied that Mr B did not provide services to Mr A with sufficient care and skill. Mr B breached Right 4(1) of the Code by inadequately assessing Mr A's injury. He failed to provide Mr A with an adequate subjective interview, and to provide him with a sufficiently detailed physical assessment, prior to treatment.

Treatment of Mr A's injury
Mr A does not know why Mr B "cracked" his spine. He considers that the treatment had no relevance to his trapped nerve and failed to relieve the pain he experienced. He believes that Mr B simply cracked his spine because he thought it needed doing.

My advisor stated that "[m]anipulation i.e. the 'crack' appears to have been used" and that this was a possible treatment option if no "red flags" were present. However, if red flags were present then manipulation was not a good option as it may stress the annulus of the disc through a rotation technique. In this situation alternative treatments may have been an option and/or a referral back to a doctor or specialist in the case of a suspected serious disc injury.

Mr A alleged that the treatment that Mr B provided exacerbated his condition. After the consultation with Mr B, he went home to rest for the evening. Although Mr A was possibly a little better after the treatment, he deteriorated later that day. He was feeling very sore when he went to bed, and after a troubled night's sleep awoke the next morning in agony. He had to remain in bed as he was unable to stand, walk, or sit, and the only position that slightly relieved his pain was to curl his legs towards his chest.

My advisor stated that this pattern is not uncommon with disc injuries as the disc hydrates overnight and subsequently swells. The increased pressure in the disc would aggravate a damaged annular wall. This would also make weight bearing difficult. These are problems Mr A faced the morning after treatment and point to his having suffered a disc injury. The rotational technique treatment Mr B performed may well have exacerbated Mr A's condition with the result that his symptoms were much worse following the treatment. My advisor noted that it appears from Mr A's comments that he was too sore to have done anything else at home to aggravate the symptoms. He also advised that "there were enough significant signs and symptoms from the history to warrant caution on the initial treatment and alternative treatment options may have been more appropriate given the outcome".

Mr B commented that he kept the possibility of a disc bulge in mind but decided to wait until the pain was a less limiting factor, for a detailed assessment of this option. However, it is apparent that in these circumstances more conservative treatment options were

appropriate. Without a detailed assessment, Mr B could not have known whether manipulation was contra-indicated.

My advisor stated that Mr G (the physiotherapist Mr A subsequently consulted) performed many of the required examination tests that were not performed by Mr B. Mr G found the following objective signs when performing the tests on Mr A: pain in weight bearing, straight leg raise 30% on left, reduced ankle reflex and reduced calf strength and bulk. My advisor stated that these are all signs consistent with a disc prolapse and are indicative of a strong possibility of a causal link between the treatment provided by Mr B and the worsening of Mr A's symptoms.

There is no specific evidence to verify exactly what occurred, in particular with regard to the exact nature and velocity of thoracic spine mobilisations. However, I am satisfied that Mr B did not proceed with sufficient caution prior to manipulation, and that alternative treatment options may have been more appropriate.

I am guided by the independent advice I have received. Following a careful review of the available information, I am satisfied that treatment was not provided with reasonable care and skill. In my opinion, Mr B breached Right 4(1) of the Code by failing to provide Mr A with appropriate treatment for his condition.

Right 6(1)(b)

Right 6(1)(b) of the Code states that every consumer has the right to an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option. In my opinion Mr B breached Right 6(1)(b) of the Code in relation to the following matters.

Lack of explanation about the treatment
Mr A advised me that he does not recall Mr B explaining "anything at all" to him about the treatment. Mr A does not recall any explanation or goals being specified nor his giving consent. Furthermore, as noted above, Mr A does not know why Mr B "cracked" his spine.

In contrast Mr B alleges that he explained the findings of his assessment to Mr A. He advised that it is always his practice to explain his findings to his patients after assessment, then to discuss any proposed treatment. Mr B points to his clinical notes as evidence of the process of informed consent. I note that these notes do not provide specific evidence as to the nature of the discussion, but simply indicate that a box headed "treatment explained" has been ticked. In his response to me dated 21 August 2001, Mr B does not elaborate or provide any specific information that the possible risks or benefits of the proposed treatment were discussed. There is no evidence that he considered or discussed any of the alternative treatment options.

My advisor stated that it would be standard practice following the assessment for an explanation to be given to the patient of the possible reason for the pain and the treatment plan. The possible time frame for the problem to resolve and the setting of goals in conjunction with the patient would follow next. There are no goals stated in Mr B's notes, although there is a ticked box stating that the treatment was explained. My advisor's view

is that Mr A was not actively involved in any goal setting with regard to his treatment, nor was he clearly informed of his treatment options and outcomes. I agree.

Having regard to Mr A's evidence, the failure to conduct a comprehensive assessment, brevity of documentation, the failure to specify treatment goals, and the lack of explanation by Mr B in his response, I am satisfied that Mr B did not properly explain the treatment options.

Accordingly, in my opinion Mr B breached Right 6(1)(b) of the Code, by not sufficiently discussing the proposed treatment.

Lack of follow-up advice after treatment
Mr A alleged that Mr B omitted to tell him that in order not to exacerbate his condition, he should lie down and not sit up at all, once he got home after the treatment. Mr B did not tell him of the possibility of further pain, and only advised him to return and see him again the following Tuesday (30 January 2001). Mrs C also told me that when she returned a pair of crutches to Mr B on Wednesday 31 January 2001, Mr B then said, "Oh dear, I should have told him not to sit down and to only lie down."

In contrast, Mr B advised that he informed Mr A of the possibility of further pain, and that he warned him against prolonged sitting. He told Mr A to lie down for a while and then walk around again during the rest of the day to allow the sprained tissue to settle further. Mr B maintained that he told Mr A to increase the walking over the weekend if possible. Mr B's medical notes state: "Warned against after pain." I note that he considers that it was too early for Mr A to commence an exercise programme, because of the acute nature of the pain.

My advisor commented that the ACC Acute Low Back Pain Guidelines recommend remaining active within the limits of the pain. As with most acute injuries, some injuries require short periods of rest to allow acute symptoms to settle. For an acute sciatica with the potential for a distorted annulus, rest in an unweighted position and avoiding prolonged flexion such as sitting or bending, would be commonly applied advice.

Mr B's clinical notes do not indicate the nature of the advice given to Mr A. However, the advice he alleged (in his response of 21 August 2001) that he provided to Mr A appears to be generally consistent with that recommended by my advisor. There is no reason to prefer Mr A's evidence over Mr B's on this matter, and I am unable to substantiate what was said by either party. I am unable therefore to conclude that Mr B failed to provide appropriate follow-up advice to Mr A and have accordingly decided to take no further action in relation to this aspect of Mr A's complaint.

Other comment

The standard of Mr B's clinical notes were not specifically under investigation. However, a consistent theme throughout this investigation has been the brevity and inadequacy of Mr B's clinical notes. My advisor stated that Mr B went to great length to state that he has an ISO 9002 accredited practice. However, his standard of note taking – with obvious brevity, lack of body chart and lack of patient goals – are below what one would expect to gain such accreditation. My advisor also noted that Mr B's note taking is not of the required standard as expected by the New Zealand Society of Physiotherapists and the New Zealand Private Physiotherapists Association. Although I do not propose to take any further action regarding the standard of clinical notes, I draw this matter to Mr B's attention and remind him of the importance of comprehensive and accurate documentation.

Actions

I recommend that Mr B take the following actions:

- Provide a letter of apology to Mr A. This letter of apology should be sent to the Commissioner and will be forwarded to Mr A.
- Review his current practice in light of this report, and the Accident Compensation Acute Low Back Pain Guidelines (1997) regarding the management of acute pain.
- Improve the quality and standard of his clinical note taking.

Other actions

- A copy of this opinion will be sent to the Physiotherapy Board of New Zealand.
- A copy of this opinion, with identifying features removed, will be sent to the New Zealand Society of Physiotherapists and the New Zealand Private Physiotherapists Association, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.