Stroke a rare complication of neck manipulation by osteopath (02HDC11987, 10 December 2003)

Osteopath ~ Stroke ~ Information about risks of therapy ~ Rare complications ~ Follow-up care ~ Record-keeping ~ Rights 4(1), 6(1)(b)

A man complained about the services provided by two osteopaths. The complaint alleged that the first osteopath: (a) manipulated the man's neck, which caused a bilateral vertebral artery dissection; (b) failed to appreciate the seriousness of symptoms the man developed following the manipulation; (c) did not refer him for urgent specialist assessment following the development of complications; and (d) did not provide him with information about potential risks of the manipulation before commencing treatment. The second osteopath: (a) failed to appreciate the seriousness of symptoms the patient developed following the manipulation; (b) did not refer him for urgent specialist assessment following the development of complications; (c) did not ensure that an appropriate follow-up management plan was in place; and (d) did not provide him with information about possible risks and further complications. The patient made a complete recovery from his stroke.

The Commissioner held that the first osteopath did not breach Right 6(1)(b) by not advising the patient of the remote possibility of a stroke. There was nothing to indicate that a neck manipulation was contraindicated or that the patient had any condition that predisposed him to a stroke. Although the consequences of a stroke for an active and otherwise healthy man are potentially severe, a stroke risk of 1 in 100,000 neck manipulations is sufficiently remote that there is no legal duty on a provider to disclose it.

Further, the first osteopath did not breach Right 4(1) because: (a) the pre-treatment assessment undertaken met professional standards; (b) even though the neck manipulation was likely to have caused the patient's stroke, there was nothing to indicate that the technique used was performed incorrectly or that the adverse outcome could have been predicted; and (c) there was no evidence that the first osteopath failed to appreciate the seriousness of the patient's symptoms, as he responded appropriately by initially attempting to make the patient more comfortable and, when this failed, seeking assistance and advice.

The second osteopath breached Right 4(1) because he failed to appreciate the seriousness of the patient's symptoms and did not refer him to hospital for urgent specialist assessment. The notes made by the second osteopath in respect of his involvement in the patient's management were barely adequate.