Inappropriate technique used by chiropractor to treat back pain and sciatica
(03HDC00910, 9 December 2003)

Chiropractor ~ Standard of care ~ Explanation of condition ~ Information about treatment options ~ Rights 4(1), 4(2), 6(1)(b)

A female patient complained that a chiropractor did not take an adequate medical history or conduct a sufficiently thorough examination prior to commencing treatment for her pain arising from a sciatic nerve problem, and treated her inappropriately by using excessive force on her back. Another aspect of the complaint was that the chiropractor failed to provide her with information about the nature or cause of her condition or the treatment options available.

The Commissioner held that the chiropractor breached Right 4(1) by failing to take an adequate history before commencing treatment. He failed to elicit important details regarding the patient's presenting complaint and her hereditary susceptibility to spinal degeneration, a matter of clinical importance when determining treatment protocols.

The chiropractor also breached Right 4(1) by omitting to perform an adequate examination in order to establish a clinical diagnosis prior to initiating treatment.

The chiropractor breached Right 6(1)(b) by failing to provide information that the patient could reasonably have expected to receive about treatment options, including a discussion of the proposed treatment and an explanation and demonstration of the use of the chiropractic equipment.

The chiropractor also breached Right 4(1) by failing to provide services with reasonable care and skill in using excessive force and an inappropriate technique when applying pressure to the patient's back. There is no known technique that would require a chiropractor to leap off the ground when applying pressure to a patient's spine. A patient should not experience pain if the chiropractor adopts the correct treatment technique.

Finally, the chiropractor breached Right 4(2), as his record-keeping failed to comply with professional standards. His records could not have been interpreted by his colleagues, and did not include a description of all procedures performed on the patient. Thus they did not allow for effective continuity of patient care.