Chiropractor, Mr A

A Report by the

Deputy Health and Disability Commissioner

Case 11HDC00231

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Executive summary

1. This report is about the appropriateness of the chiropractic care provided to Ms B (aged 48 years at the time) by a registered chiropractor, Mr A.

Background

2. Ms B had an eight-month history of lower back and leg pain and sought treatment from Mr A on 18, 21, 23 and 25 February 2011.

3. At the consultation on 18 February, Mr A diagnosed Ms B with right hip bursitis, left sacroiliac joint bursitis, cervical bursitis, and possible pseudo-sciatic symptoms. Mr A also manipulated Ms B's lower back.

4. At the consultation on 21 February, Mr A performed a technique called "urtication",[1] which involved applying a piece of stinging nettle to various parts of Ms B's body including her abdomen.[2] Mr A did not ask permission to undo the top button of Ms B's trousers in order to apply the stinging nettle to her abdomen.

5. Ms B attended two further appointments on 23 February and 25 February. At one of these appointments Mr A performed a Periosteal Sensitivity test on Ms B, which involved the application of pressure to Ms B's clavicle and shin bones. Mr A also performed a Poison Point test.

6. Ms B stated that she was "beside herself" when she left the consultation on 23 February 2011. Ms B attended an appointment with a nurse later that day and advised the nurse that Mr A had pinched her nipples.

7. Mr A did not adequately explain to Ms B the risks and benefits of the procedure and how it would be performed.

8. On 25 February, Ms B returned for another appointment. During this appointment Mr A performed further manipulations of Ms B's neck.

9. An orthopaedic surgeon subsequently diagnosed Ms B with a disc prolapse.

Decision

10. Mr A's initial assessment of Ms B was inappropriate and inadequate. Mr A did not have sufficient clinical rationale for his diagnoses of Ms B's condition, nor is there evidence that he gave adequate consideration to whether Ms B had a potential disc prolapse despite her clinical presentation indicating that he ought to have done so. Accordingly, Mr A breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[3]

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[1] Mr A has used two different spellings of "urtication" in his submissions to HDC. For the purpose of consistency, "urtication" will be spelt as above throughout this report.

[2] Mr A explained that urtication "is a healing system for the body's acupressure reflexer, using a small piece of stinging nettle to stimulate the area involved".

[3] Right 4(1) of the Code provides: "Every consumer has the right to have services provided with reasonable care and skill."

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11. The treatments that Mr A provided to Ms B were not clinically appropriate in light of Ms B's reported symptoms of lower back and leg pain. Mr A's clinical rationale for manipulating Ms B's cervical spine on 23 February was flawed, and his decisions to perform urtication, a Periosteal Sensitivity test, and a Poison Point test were not clinically indicated. Mr A therefore breached Right 4(1) of the Code by failing to provide Ms B with services with reasonable care and skill.

12. Mr A had a duty to inform Ms B about her condition, to explain that the techniques he was proposing to use were unorthodox, and to provide information about the validity and efficacy of those techniques, as well as the location of the proposed treatment. Mr A breached Right 6(1) of the Code for failing to provide Ms B with information that a reasonable consumer, in Ms B's circumstances, would expect to receive.[4] Because Ms B did not receive sufficient information, she was not in a position to provide informed consent to the unorthodox chiropractic techniques. Accordingly, Mr A also breached Right 7(1) of the Code.[5]

13. By not keeping clear, legible and full records of the services he provided to Ms B, Mr A failed to comply with his professional obligations and, accordingly, breached Right 4(2) of the Code.[6]

14. Mr A will be referred to the Chiropractic Board of New Zealand.

Complaint and investigation

15. The Commissioner received a complaint from Ms B about the services provided by chiropractor Mr A. The following issue was identified for investigation:

    The appropriateness of the care provided to Ms B by Mr A in February 2011.

16. An investigation was commenced on 4 August 2011. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

17. The parties directly involved in the investigation were:

Mr A	Provider/Chiropractor
Ms B	Consumer/complainant
Mr C	Mr A's counsel
Mr D	Chiropractor
Mr E	Chiropractor

[4] Right 6(1) of the Code provides: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive…"
[5] Right 7(1) of the Code provides: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."
[6] Right 4(2) of the Code provides: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Mr F	Chiropractor
Mr G	Chiropractor

18. Independent expert advice was obtained from chiropractor Bayne McKellow (attached as **Appendix A**).

Information gathered during investigation

18 February 2011 — first consultation

19. On 18 February 2011, Ms B consulted chiropractor Mr A at a chiropractic centre for treatment of her ongoing lower back and leg pain, which was caused by an accident that had occurred eight months previously.

20. Upon arrival, Ms B completed a Patient Information form and a Health History form. On the Patient Information form, Ms B documented that her major complaint and symptoms were "[p]inched nerve sciatica"[7] and that the pain in her leg rated seven out of ten (one being no pain and ten being severe pain). On the Health History form, Ms B recorded that she suffered from headaches, shoulder, leg and arm pain, and nausea.

21. Mr A documented in the patient notes that Ms B had previously sought treatment for her condition from an osteopath and a physiotherapist, but despite receiving such treatments, there had been little change in her condition.

22. Ms B advised HDC that Mr A began by manipulating her spine in two different places. She stated that he told her that she had "dysfunctional hips and problems in [her] back" but he did not explain to her what "dysfunctional hips" meant in relation to her condition, or provide her with any details about the treatment he was providing. Ms B also stated that Mr A told her that he would be able to "fix" her condition in two weeks.

23. Mr A denied that he said he could "fix" Ms B's back in two weeks; rather, he advised HDC that he would have told Ms B that he would reassess her after six visits, or before if indicated.

24. Mr A advised HDC that during his initial assessment he noted that Ms B was complaining of pain in her left buttock and associated left leg pain, with pain occasionally present on the right side of her lower back. Mr A stated that he conducted a physical examination and found "[r]estriction in [c]ervical[8] range of rotation and lateral flexion to the right, and lumbar lateral flexion to the right and rotation to the right".

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[7] Pinched nerve sciatica refers to pain, tingling and/or numbness down the leg caused by entrapment or pinching of the sciatic nerve.

[8] The cervical spine refers to the neck section of the spine (the first seven vertebrae that run down from the base of the skull).

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25. Mr A advised that, following his examination, he concluded that Ms B had sacroiliac joint and hip joint dysfunction based on a positive right Faber-Patrick test[9] and a positive left Gaenslens test[10] at the level of the second sacral vertebra.[11] He stated that palpation showed that Ms B was tender over the left sacroiliac joint,[12] that she had a "[p]ositive [c]ervical elliptical motion", and that her fifth lumbar vertebra was fixated.[13] This meant that when Mr A tested Ms B's spinal range of motion, she had some restrictions in her lower back and neck. These clinical findings were documented in the notes.

26. Mr A said he also used orthopaedic tests, such as the bilateral and unilateral leg raise, which measure the tension or irritation of the sciatic nerve. Mr A stated that the results of the orthopaedic tests were negative. However, there is no record of the results in the clinical notes.

27. Mr A completed an assessment form which lists the ranges of motion for the cervical, thoracic[14] and lumbar spines. However, he limited his documentation of Ms B's lumbar spine assessment to only positive or restricted results. Mr A stated: "Due to previous forms I have used in the past, I only indicated positive results and not normal results of the lumbar range of motion and orthopaedic testing."

28. Mr A recorded in the notes that the differential diagnoses were the following:

"1. Right Hip Bursitis[15]
2. Left Sacroiliac Joint Bursitis
3. Cervical Bursitis
4. Possible Pseudo-Sciatic symptoms due to a dysfunctional left sacroiliac joint. Lumbar sprain/strain as the original injury."

29. Mr A believes that his assessment of Ms B, as recorded in the notes, was sufficiently detailed to justify the above diagnoses. He advised that the orthopaedic tests were used to determine the structural and functional integrity of the joints, and that in Ms B's case, the findings indicated spinal stress in her lower lumbar and cervical spine, as well as joint irritation, including dysfunction in her left sacroiliac joint, right hip joint and cervical spine. He explained that this was the cause of Ms B's lumbar pain. He stated:

[9] The Faber-Patrick test is an orthopedic test to evaluate hip pain.
[10] The Gaenslen's test is an orthopedic test used to assess sacroiliac joint dysfunction.
[11] The sacrum refers to the large triangular bone at the bottom of the spine. It is made up of five fused vertebrae designated S1–S5 starting at the top.
[12] The sacroiliac joint is the joint between the last section of the spine, the sacrum, and the pelvis.
[13] The lumbar spine is the section of the spine in the lower back area. It is made up of five vertebrae running down from the thoracic spine. They are designated L1–L5 starting at the top.
[14] The thoracic spine refers to the section of spine below the neck in the chest/thoracic region. It is made up of 12 vertebrae running down from the cervical spine.
[15] Bursitis is the inflammation of a bursa, which is a fluid-filled sac located between the tendon and bone in some joints of the body.

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> "Any of the three area[s] of involvement ie: cervical joint dysfunction, hip joint dysfunction and sacroiliac joint dysfunction can have an effect on the lumbar spine. This is due to cervical meningial tension, sacrolumbar ligament weakness and postural distortions and gait imbalance due to right hip dysfunction (bursitis)."

30. In his response to the provisional opinion, Mr A stated:

> "In complex patient profiles there are sometimes more than one diagnosis or one diagnosis and multiple body areas which can stress/[a]ffect the primary diagnostic area."

31. Mr A advised HDC that he explained to Ms B that her pain and symptoms were aggravated by the orthopaedic findings of "Bursitis/Dysfunction" of the left hip and right sacroiliac joint. He stated in response to the provisional opinion that he seldom uses the term "dysfunctional hips".

32. Mr A stated that he explained that treatment options included spinal adjustment to the fifth lumbar and sixth cervical vertebrae, and that he recommended the use of "urtication" for the treatment of Ms B's bursitis. Mr A documented in the patient notes: "Urt proc for Rt Hip & HSO exp".[16]

33. Mr A explained to HDC that urtication involves the application of a piece of stinging nettle to stimulate the body's acupressure points to aid healing. He said he chose urtication to treat Ms B's pain, which was associated with the diagnosed bursitis, because of her lack of response to osteopathic and physiotherapy treatments. He stated that he chose to utilise cervical spinal manipulation in conjunction with urtication because he considered that Ms B's cervical spine dysfunction was causing spinal pressure and resultant weakness of her lumbar support muscles which, in turn, contributed to her lumbar pain.

21 February 2011 — second consultation

34. Mr A advised HDC that during the consultation with Ms B on 21 February 2011, he again explained the urtication procedure for treatment of her left sacroiliac and right hip bursitis, and indicated the points on her body that would be treated, which included her "McBurney's point". Mr A said that the McBurney's point is an acupressure point located in the mid-line between the belly-button and the top of the right hip.

35. In his response to the provisional opinion, Mr A advised HDC that he thoroughly explained the procedure to Ms B and indicated the "body point" prior to commencing treatment. The notes record that Mr A obtained Ms B's verbal consent to conduct the urtication procedure on her McBurney's point, as well as her right hip, left big toe and left sacroiliac joint. Mr A also documented that he conducted, for a second time, the right Faber-Patrick test and Gaenslen's test to assess Ms B's "progress". Mr A documented that the results of both tests were negative.

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[16] Mr A advised HDC that the shorthand used in the entry dated 18 January 2011 means the following: "Urtication procedure for right hip and right sacroiliac joint explained".

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36. Mr A advised that because Ms B was wearing high-waisted trousers, he needed to unbutton the top of her trousers to access her McBurney's point. Mr A explained that he unbuttoned Ms B's trousers while she was lying on the treatment table and momentarily placed a piece of stinging nettle on her McBurney's point. He stated that after he conducted the urtication procedure, Ms B fastened the button of her trousers and nothing further was said.

37. In contrast, Ms B said that Mr A advised her that he was going to use a stinging nettle to fix her dysfunctional hips, and then proceeded to unbutton her shorts,[17] without asking for her consent to do so. Ms B does not recall Mr A providing her with any further explanation about the procedure. Ms B stated:

> "My pubic area was not exposed, BUT never in my entire life have I had a professional just remove clothing without first asking if I could do it first."

38. Ms B stated that Mr A then applied the stinging nettle to her abdomen and rubbed it around. She believes that Mr A also applied the stinging nettle to her forehead. Ms B said that Mr A also manipulated the middle part of her spine during the appointment.

39. Mr A accepts that although he obtained Ms B's informed consent to apply a piece of stinging nettle to her abdomen, he did not specifically obtain her consent to unbutton her trousers, and says that it would have been prudent for him to have done so. In his written response to Ms B's complaint, Mr A apologised for failing to obtain her consent to undo her trousers.

23 and 25 February 2011 — third and fourth consultations

40. There is dispute as to what happened at the consultations on 23 and 25 February.

Ms B's account

41. Ms B initially told HDC that during the consultation on 23 February 2011, Mr A manipulated the upper part of her neck while she was lying on the treatment table, fully clothed, wearing a heavy material bra and a cotton top. Ms B stated that after Mr A completed the spinal manipulations, he said his treatments were "the best in the country or the world". She stated that Mr A was "very hard to understand". Ms B advised that although she had "switched off a bit", she recalled that Mr A then either asked her, "Can I squeeze your nipples?" or said, "I'm going to squeeze your nipples", and told her that it would stimulate her nerve endings. Ms B advised HDC that she agreed, not realising what Mr A had meant. She stated that Mr A then pinched her nipples using his thumb and forefinger:

> "I was [lying] on the table with my arms across my waist, when he mumbles something about nipples and nerve endings. He then says, 'Can I pinch your nipples?' Or something to that effect… I said 'Sure whatever'. How stupid am I? It never occurred to me that he meant pinching my nipples, so while he was

[17] Ms B is clear that she was wearing shorts during this appointment and, when it was put to her that Mr A recalls that she was wearing jeans, Ms B considered this unlikely as it was summer. In any event, Ms B agrees that whatever she was wearing would have been high waisted, covering her navel, requiring Mr A to undo the button and zip.

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standing over me, he pinched 1,2,3,4 times and told me it had something to do with nerve endings. He's supposed to be a professional so who am I to second guess him? I kept thinking, 'This isn't right'".

42. In a later conversation with an HDC investigator, Ms B said that she may have been sitting on the treatment bed rather than lying down. She recalled that she was looking at Mr A's face, trying to understand what he was saying to her, when Mr A pinched one of her nipples. She stated that at this point, she was taken by surprise and looked down to see what he was doing. She recalled that Mr A then pinched her nipples three more times, twice on each nipple. The pinching of each nipple was very brief, with each pinch being only one second.

43. Ms B advised HDC that just before she left the consultation, Mr A told her that he needed to check her bones, and then pinched her collar bone and shin. Ms B does not recall Mr A providing her with any explanation prior to performing the procedure. She recalled that the pinching was painful and that Mr A commented, "We will fix that next time." Ms B does not recall Mr A ever explaining the Poison Point test[18] and believes that she would remember if he had used such a term.

44. Ms B said that when she left Mr A's consultation room following the assessment of 23 February she was "beside herself".

45. Later that day, Ms B rang her general practitioner (GP). He was not available so Ms B attended a consultation with the practice nurse, and told her what had happened that day.

46. The practice nurse said that Ms B asked her to record her account in her patient notes. She recorded:

> "Came in to see nurse as needed to discuss whether the care of a chiropractor she saw today at 10.00 was acceptable.
>
> Saw chiropractor on Friday and again today for sciatica and neck problem.
>
> Today part way through consult he asked if he could squeeze her nipples as part of a check of nerve ends. [Ms B] was surprised but initially said yes. He did it twice. When got home started to think about why that would be needed and if appropriate. Started to feel it was all wrong, something only a partner should be able to do.
>
> Came to discuss as did not know if she was over reacting.
>
> Have told her I have no knowledge of the treatment/diagnosis technique being used on anyone else.
>
> Could check with Chiropractor Body re the practice.

[18] See paragraph 54 for an explanation of the Poison Point test.

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> Have asked [Ms B] what she would like to do from here. Does not at this stage wish to lay formal complaint but would like it recorded.
>
> Suggest if attends next appoint as planned Friday she takes a chaperone…"

47. Ms B returned to see Mr A for a fourth appointment on 25 February 2011 without taking a support person or chaperone. Ms B stated to HDC that she went back because she trusts everyone, and did not think a professional would do anything inappropriate, and she wanted her back "fixed".

48. Ms B believes that during this appointment, Mr A manipulated her cervical spine. She does not recall Mr A explaining to her why he needed to manipulate her cervical spine but understood that it had something to do with her sciatica. Ms B could not recall any more details of this appointment.

Mr A's account

49. Mr A advised that during the consultation on 23 February 2011, he gave Ms B an explanation of cervical bursitis and then obtained her consent to perform urtication to an acupressure point on her forehead. He advised that he also retested Ms B's cervical range of motion and found that the "circular range of motion was negative or unrestricted". Mr A documented:

> "Pt suffers from depression Exp Urt Cervical B. Pt/Perm. Urt forehead. Cervical RDM Circ ∅"[19]

50. Mr A advised HDC that at the consultation on 25 February he manipulated Ms B's first cervical vertebra and noted that she had an uncomfortable reaction to the manipulation. When interviewed by HDC, Mr A described Ms B's reaction as a "fleeting, uncomfortable sensation". He explained that this was a "red flag". He said it is very rare for a patient to experience this kind of reaction to spinal manipulation and, in his experience, it was due to "periosteal sensitivity",[20] which indicated "spinal nerve interference". He advised that possible causes of periosteal sensitivity include "nutritional issues, vitamin D deficiency, exposure to cigarette smoke, osteoporosis, 'leaky bowel syndrome', corticosteroid therapy, other medications, and old age". Mr A stated that he did not attempt to elicit any more clinical history from Ms B at the consultation, as he believed his initial Patient Information form was sufficiently comprehensive.

51. Mr A stated that if periosteal sensitivity is present, cervical spine manipulation is contraindicated and extreme caution is needed when manipulating other areas of the spine, so he tested Ms B for periosteal sensitivity.

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[19] Mr A advised HDC that the shorthand used in the entry dated 23 January 2011 means the following: "Patient suffers from depression. Explained urtication for cervical bursa. Patient permission. Urtication forehead. Post-tested cervical range of motion. Circular negative."

[20] Sensitivity of the tissue that surrounds the bones. In response to the provisional opinion, Mr A's counsel submitted an email from Mr E. Mr E advised that the term "periosteal sensitivity" was "coined" by Mr A.

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52. Mr A advised that the Periosteal Sensitivity test involves applying pressure in a pinching type fashion to the middle of the clavicle and tibia bone. He stated that Ms B showed a positive response to the Periosteal Sensitivity test. He said that there are many causes of periosteal sensitivity, some of which, as a chiropractor, he is unable to test because they involve investigations such as X-ray and blood tests. He advised HDC that he decided to focus on whether Ms B's problem was caused by a "systemic poison issue", which he says is most commonly caused by faeces being absorbed into the blood. This is known as "leaky bowel".

53. Mr A stated that he then proceeded to use the Total Body Modification (TBM) test called the Poison Point test[21] to test for leaky bowel. Mr A advised that TBM is a chiropractic technique that is "taught at undergraduate and postgraduate seminars".[22]

54. Mr A demonstrated to HDC investigators how he conducts the Poison Point test. The test involves the patient standing in front of the practitioner fully clothed, and the practitioner applying his or her little finger in a knife-edge fashion against the patient's nipple for approximately one second while pushing down against the patient's opposite arm, which is in an outstretched position of about 90 percent flexion. Mr A said that the pressure he applies to the chest area is very light, and that he is primarily interested in the resistance of the opposite arm. The test is then repeated on the opposite side.

55. When HDC questioned where exactly he was touching in relation to the breast and nipple, Mr A stated that his hand was positioned "right across the nipple. It has to be right across the chest, and I didn't really push."

56. Mr A said that the Poison Point test is used for diagnosis and treatment. He stated that, in Ms B's case, after the Periosteal Sensitivity test was positive, he used the Poison Point test as a diagnostic tool in order to increase his clinical understanding of the cause of her periosteal sensitivity. Mr A said that he obtained Ms B's informed consent to touch her breasts to perform the Poison Point test, and recorded this in Ms B's notes. Mr A advised HDC:

> "I would have said 'She's got periosteal sensitivity', which is a systemic issue which could be due to many things and one of the things that will be relatively common would be that I could test for was poison point… The poison point test [involved] hand across the chest wall-breast, across the nipple, I test the muscle, if it goes weak there's issues with the poison point."

57. Mr A said that he would have used "ninety per cent" of those words to explain the treatment procedure. He also stated that it "may have been possible" that he also told her that the test involved touching "in the vicinity of [her] nipples or something along those lines by way of description of where the contact would be made". However, in response to the provisional opinion, Mr A stated: "I did not talk about Ms B's breasts

[21] Mr E advised that the Poison Point test is "mandatory at the end of a treatment or TBM session and is taught and re-inforced [sic] in all Modules".

[22] Mr E advised that TBM has been taught in Australia for over 20 years and that there are several hundred chiropractors who use the technique.

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nor did I touch her in that area." Mr A denied pinching Ms B's nipples, and said he would have had no way of knowing exactly where Ms B's nipples were through her top and bra. Mr A clarified that the test involves "the edge of the hand being across the breast in the area of the nipple … and that the precise location [of the nipple] cannot be, and does not need to be, ascertained for the test".

58. Mr A said that the Poison Point test for Ms B was positive, and he briefly discussed this with her, advising that she could possibly have "leaky bowel". Mr A stated that he sent Ms B away with no management plan as he intended to think about how he would manage her condition before her next visit.

59. Mr A advised in his response to the provisional opinion:

> "[Ms B] expressed some reservations to [Mr A] after the toggle recoil adjustment on the 25th Feb 2011, this was due to sensitivity to the adjustment. Hence the extra time checking for a solution to a complex problem."

60. Mr A advised HDC that during the consultation on 25 February Ms B did not raise any concerns in relation to the Poison Point test. The receptionist said that Ms B did not express any concerns as she was leaving.

61. Mr A documented the following in the patient notes:

> "ASRT Pt had uncomfortable reaction to adj. Test shin & clavicle comp test ⊕ Very sensitive & pressure. Test TBM Poison Point. Possible Leaky Bowel. Both procedures explained and PT/Perm given."[23]

Complaint

62. On 28 February 2011, Ms B attended a consultation with her GP, who documented the following:

> "[C]hat about sexual molesting from Chiropractor; stressed; has written complaint."

63. Ms B made a complaint to HDC. She told HDC that she was initially reluctant to complain but does not want anyone else to experience similar events. She said she has found it hard to forget the events and feels that the incident was "offensive". Subsequently she has had an MRI scan and was diagnosed with disc prolapse by an orthopaedic surgeon.

Comment and additional evidence from Mr A

64. Mr A considers that all the assessments and procedures he performed on Ms B were adequately explained to her, and that she was given the opportunity to decline any of the proposed techniques. Mr A stated that Ms B raised no concerns at any stage.

[23] Mr A advised HDC that the shorthand used in the entry dated 25 February 2011 means the following: "Atlas superior right toggle. Patient had uncomfortable reaction to adjustment. Test shin and clavicle compression test positive. Very sensitive to pressure. Test TBM [Total Body Modification] poison point positive. Possible leaky bowel. Both procedures explained and patient permission given." "Atlas superior right toggle" refers to a manipulation technique to the first cervical vertebra.

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65. Mr A acknowledged that the Poison Point test involves the touching of a "traditionally sensitive area" and, in light of this, he should have allowed Ms B time to think about the procedure before proceeding with it. He stated that he should also have ensured that the receptionist was present if Ms B decided to proceed with the Poison Point test after signing a consent form.

66. Mr A advised HDC that he will now always ensure that when treating any sensitive area, the patient is provided with relevant information and given a day to decide whether to consent to the procedure. In response to the provisional opinion, Mr A added:

> "The TBM test is not regarded as being particularly sensitive … The test does not involve any removal of clothing though the edge of one hand is pressed against the chest wall at the approximate position of the nipples."

67. Mr A has also developed additional consent forms for patients to sign prior to proceeding with treatment of a sensitive or intimate area. Mr A advised HDC that he has decided not to perform the Poison Point test in the future.

68. Mr A provided HDC with a statement from chiropractor Mr D, to support his clinical management of Ms B. Mr D stated:

> "TBM (Total Body Modification) technique is a well accepted low force Chiropractic Technique. The founder […] Dr Victor Franks has presented in NZ and Australia. The technique has been taught in 34 countries around the world where Chiropractic is practiced and there are a number of practitioner using the technique both here and in Australia. While I am not a TBM practitioner I am well aware of it as a technique within the spectrum of Chiropractic techniques and would not describe it as unconventional. It is an alternative but accepted technique within the broader scope of Chiropractic practice."

69. Mr D said that Mr A's decision to utilise TBM technique on Ms B was reasonable in the circumstances given her lack of response to previous treatments, and that Mr A had conducted a standard examination before proceeding.

70. In relation to the urtication technique, Mr D advised: "I was not familiar with the term [urtication], however I was able to find a paper in [a] peer reviewed journal regarding the use of this procedure." Mr A provided HDC with an article entitled "Urtication for Musculoskeletal Pain?" by physiotherapist Les Alford.[24] The article discusses one person's experience in the use of urtication for the treatment of lower back pain. The article states that today urtication is not commonly used for musculoskeletal pain.

[24] Published in *Pain Medicine* (Volume 9, Number 7, 2008).

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Response to provisional opinion

Ms B

71. Ms B's response to the provisional opinion has been incorporated into this opinion where relevant.

Mr A's comments

72. Mr A's comments, and those made by his counsel, Mr C, are summarised below and incorporated into this opinion where relevant. Mr A also provided a number of references to journal articles and opinions to support his submissions.

Expert advisor

73. Mr C submitted that my expert advisor, Mr Bayne McKellow, was not appropriately trained to advise on the care Mr A provided. Mr C stated that Mr A is trained in, and practises, specific techniques, for example TBM, and therefore the expert commenting on Mr A's standard of care needs to be familiar with these techniques. Mr C submitted that given that Mr McKellow is unfamiliar with the techniques utilised by Mr A, he lacks sufficient understanding to comment on the care Mr A provided.

Mr A's assessment and use of chiropractic techniques

74. In relation to the provisional finding that Mr A did not give sufficient consideration to whether Ms B had a disc prolapse, Mr C submitted that this would have been an unreasonable diagnosis for Mr A to make. Mr C stated that Ms B was diagnosed as having a disc prolapse only following an MRI scan. He said that Ms B had previously attended an osteopath and a physiotherapist for the same problem, and that similarly they did not diagnose the disc prolapse.

75. Mr A reiterated his view that his decision to manipulate Ms B's cervical spine was clinically justified. He stated:

> "I find from clinical experience, the upper cervical toggle recoil manipulation can have a positive effect on the lumbar spine/sciatica symptoms in some cases."

76. Furthermore, Mr A stated:

> "[I] would be confident a positive [Faber] Patrick Test and positive [Gaenslen's] Test would be a positive examination finding. [I] determined, with a history of 28 visits in the preceding eight months, including three different practitioners, a correct management plan could look at other factors which may be relevant to this case. Contributing factors as assessed and indicated by orthopaedic testing and range of motion testing were treated."

77. Mr A submitted that there are many chiropractic techniques that can be used by a chiropractor, and that there are many practitioners in New Zealand and Australia who use TBM.

Mr A's credibility

78. Mr C submitted that given the inconsistencies in Ms B's evidence it should not be relied upon. Furthermore, Mr C submitted that Mr A's evidence has been consistent

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throughout HDC's investigation. For example, Mr A has always accepted that he did not obtain informed consent to undo Ms B's button on her trousers, and offered an apology in his statement to HDC for his failure to do so. Mr C therefore stated: "For [Mr A] to so readily admit to one transgression yet steadfastly deny the allegation of another does not make sense if the latter were true." Mr C further commented that it appears that Ms B made the complaint only after having been urged to by her GP. Mr C stated that it "appears there is some history between this particular GP and [Mr A]".

79. Mr C stated that Mr A has always been clear that the Poison Point test involves the hand being placed across the patient's chest wall in line with the nipple, and that Mr A does not push on the nipple, and he never pinched Ms B's nipples. Mr C submitted:

> "[Mr A] has been totally consistent throughout that he never pinched [Ms B's] nipples. Indeed he is clear that on the third visit he did not touch [Ms B] through her clothing anywhere near her breasts. It is submitted that in choosing to prefer [Ms B's] evidence HDC appears to be ignoring the possibility that someone whose story is incredibly inconsistent, may have believed something happened which in fact did not."

80. Furthermore, Mr C submitted:

> "While [Mr A's] techniques may not always be entirely mainstream there is nothing whatsoever in an extremely long career to suggest that he would act in a way that would be considered of a sexual nature with a patient. It also defies belief that if the touching was of such a sexual nature the patient would choose of her own volition to go back to the same practitioner two days later and further to go back without anyone else present in the room having apparently been advised to do so."

Standards

81. New Zealand Chiropractic Board *Code of Ethics and Standards of Practice* (2004)

"3 Chiropractor's Relationships

3.1 Relationship with Patients (General)

…

3.1.6 A Chiropractor must not over-service a patient. It is the responsibility of the Chiropractor to treat the patient only while Chiropractic can be shown to be of benefit and clinically justified. Care that is not clinically justified constitutes over-servicing.

…

3.2.3 Sexual transgression includes *any* touching of a patient that is of a sexual nature, other than behaviour described in sexual connection, including but not exclusively:

— inappropriate touching of breasts or genitals …"

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…

4.0 Case Management

4.1 Adequate case management

Adequate care management relies on performing a logical sequence of actions, each one based on prior information, making clinical decisions from data obtained, forming a management plan, evaluating progress, providing advice and informing the patient about lifestyle issues that impact on the care delivered. Record keeping of all these steps should be maintained …

4.6 Records

…

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

1. Date of each consultation
2. Brief notes about the subjective comments made by the patient or guardian, along with the Chiropractor's observations
3. Examination findings recorded
4. Informed choice/consent obtained
5. All procedures performed on the patient
6. Significant concerns the Chiropractor may have about the findings or the patient's progress
7. Advice given to the patient
8. Patient non-compliance with the Chiropractor's instructions
9. Date of the next follow-up visit."

Expert advisor

82. On a number of occasions Mr C has raised concerns about the suitability of Mr McKellow to provide advice on this case, submitting that it is important for Mr A's actions to be evaluated by someone who practises TBM.

83. Mr A is a chiropractor and is therefore required to comply with the New Zealand Chiropractic Board *Code of Ethics and Standards of Practice* (2004). Mr McKellow is an experienced chiropractor and suitably qualified to provide advice on the standard of care provided by Mr A. On 20 March 2012, the New Zealand Chiropractic Board confirmed to HDC that it supports Mr McKellow being an expert advisor in this case. Accordingly, I consider that Mr McKellow is suitably qualified to give expert advice on this complaint.

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Opinion: Breach — Mr A

Appropriateness and adequacy of initial assessment and diagnosis

84. On 18 February 2011, Ms B presented to Mr A with ongoing lower back and leg pain. Mr A assessed Ms B's cervical and lumbar spine. He recorded that her left sacroiliac joint was tender, her fifth lumbar vertebra was fixated, and that her responses to the Faber-Patrick and Gaenslen's orthopaedic tests were positive. Following these assessments, Mr A diagnosed Ms B with right hip bursitis, left sacroiliac joint bursitis, cervical bursitis, lumbar strain and possible pseudo-sciatica due to left hip dysfunction.

85. Mr McKellow stated that Mr A's documented clinical findings do not support the diagnoses of hip bursitis, left sacroiliac joint bursitis, or cervical bursitis and that there were no documented clinical findings to indicate that the cervical spine was contributing to Ms B's lower back and leg pain. Furthermore, Mr McKellow advised that persistent and ongoing lower back pain, especially with symptoms of referred pain such as sciatica, which Ms B presented with, would require consideration of potential disc prolapse, particularly in light of her failure to respond to orthopaedic and physiotherapy treatments. Mr McKellow advised:

> "It is well understood that persistent ongoing lower back pain, especially with any degree of radicular symptoms, requires consideration for potential disc injury. This would be considered part of the basic investigation for management of [Ms B's] presenting complaint, especially given her failure to respond under previous treatment providers."

86. I note Mr A's submission that the disc prolapse was picked up only after an MRI was conducted, and that it was not diagnosed previously by the other health professionals who saw Ms B. However, I remain of the view that Mr A's initial assessment of Ms B was inappropriate and inadequate. Mr A did not have sufficient clinical rationale for his diagnoses of Ms B's condition, and there is no evidence that Mr A gave adequate consideration to whether Ms B had a potential disc prolapse despite her clinical presentation indicating that he ought to have done so.

87. Therefore, I find that Mr A breached Right 4(1) of the Code by failing to provide Ms B with services with reasonable care and skill.

Appropriateness of treatment

Mainstream and unorthodox chiropractic techniques

88. Chiropractic care is concerned with the assessment, treatment and rehabilitation of conditions related to the spine, non-spinal articulations (joints) and the neuro-musculoskeletal system.[25]

89. The ACC *Chiropractic Treatment Profiles* (2003) is a guideline for accepted assessment and treatment protocols for various presenting problems. It states that

[25] New Zealand Chiropractic Board *Code of Ethics and Standards of Practice* (2004).

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treatment of lower back pain may also include mobilisation, pain management, exercise prescription, and ergonomic advice.

90. The New Zealand Chiropractic Board *Code of Ethics and Standards of Practice* (2004) states that in the process of delivering chiropractic care, the chiropractor may do the following:

> "[U]tilise adjunctive or supportive procedures and advice including by way of example but not by way of limitation: myofascial trigger point therapy and other soft tissue techniques, application of heat/ice, taping, bracing, stretching, strengthening exercises, dietary advice, nutritional supplementation, ergonomic assessment and guidance, psycho-social support, physiological therapeutics (e.g. ultrasound) and other healthful living practices."

91. Mr A provided submissions from chiropractors Mr E and Mr D. Mr D advised that TBM is a "well accepted low force Chiropractic Technique". Mr E advised that TBM has been taught in Australia for over 20 years, and that there are several hundred chiropractors who use the technique. Mr E advised that Mr A "coined the term periosteal sensitivity" to describe a patient's adverse reaction to spinal manipulation.

92. Mr D stated that he is not familiar with the term "urtication" but was able to find an article about the technique in a peer-reviewed journal. Mr A provided references to articles relating to urtication for the use of chronic pain, including chronic back pain.

93. In contrast, my expert advisor, chiropractor Bayne McKellow, does not consider that urtication, the Poison Point test or the Periosteal Sensitivity test fall within mainstream chiropractic practice. Mr McKellow considers that urtication is "unconventional", commenting that he has been unable to find any reference to it being used in chiropractic management of sciatic pain. Mr McKellow commented that the article "Urtication for Musculoskeletal Pain" describes urtication as "unorthodox". He advised that the Periosteal Sensitivity and Poison Point tests "do not reside within mainstream chiropractic procedures".

94. In my view, Mr A performed both mainstream chiropractic techniques, such as spinal manipulation, and unorthodox chiropractic techniques, such as urtication, the Periosteal Sensitivity test, and the Poison Point test, to treat Ms B's lower back and leg pain. My next consideration is whether or not the chiropractic techniques that Mr A performed on Ms B were clinically indicated in light of her presentation.

Cervical spine manipulation

95. During the consultation on 18 February, Mr A manipulated Ms B's lower back. Mr McKellow advised that this was appropriate.

96. During the appointments of 23 and 25 February, Mr A treated Ms B for cervical bursitis by manipulating her cervical spine. Mr A explained that manipulation of Ms B's cervical spine was indicated because she had restricted cervical range of motion, causing spinal pressure, and resultant weakness of her lumbar support muscles. Mr A provided a supporting statement from chiropractor Mr F, in which he referred to research linking the cervical spine and pelvis. Furthermore, Mr A submitted that he

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had previously experienced positive results using upper cervical manipulation in the treatment of lumbar/sciatic pain.

97. Mr McKellow advised that "[m]anipulation of the cervical spine for a presenting lower back injury requires strong clinical indicators to justify any early implementation of the procedure". He commented that the clinical rationale for Mr A's decision to manipulate Ms B's cervical spine was unclear, given that there was no clinical finding to indicate that her cervical spine was contributing to her lower back and leg pain.

Urtication

98. During the consultation of 21 February, Mr A performed urtication to treat Ms B's sacroiliac and hip bursitis. On 23 February, he used urtication to treat her cervical bursitis. Mr A advised that he used this technique because of Ms B's lack of response to osteopathic and physiotherapy treatments.

99. In response to the provisional opinion, Mr A submitted that urtication should be considered a complementary alternative medicine and that, regardless of whether it is commonly used, it is still a valid treatment for pain relief. Mr A referred to a number of studies that reviewed the use of urtication in the treatment of chronic pain.[26] Mr A stated:

> "The use of urtication has to be taken in the light of a chronic problem which has failed to resolve with repeated spinal manipulation, physiotherapy and medical intervention."

100. Mr McKellow commented that urtication is an unorthodox pain management treatment not usually performed in chiropractic practices. In his view, urtication is not a generally accepted procedure for the management of lower back injury involving sciatic pain.

Periosteal Sensitivity and Poison Point tests

101. Mr A claims that he performed the Periosteal Sensitivity and Poison Point tests during the fourth consultation on 25 February 2011, as supported by the clinical notes. While Ms B acknowledged to HDC that she is unclear about the sequence of events, she believes that the tests were performed at the third consultation on 23 February. Ms B's account is consistent with her earlier statement to the practice nurse on 23 February. I consider that it is unnecessary for me to determine at which consultation the tests were performed.

102. Mr A explained that it is very rare for a patient to have an adverse reaction to cervical manipulation, and that Ms B's reaction was because of periosteal sensitivity. Mr A advised that as Ms B tested positive for periosteal sensitivity, he decided to investigate leaky bowel as one possible cause by using the Poison Point test.

---

[26] Randall, C, Dickens, A, White, A, Sanders, H, Fox, M, and Campbell, J, "Nettle sting for chronic knee pain: A randomized controlled pilot study", *Complementary Therapies in Medicine* (2008), 16, 66–72; Larkin, M, "Nettles take the sting out of arthritis pain", *The Lancet*, 251 (6491), 146–147; White, A, Randall, C, and Harding, G, "Patient consensus on mode of use of nettle sting for musculoskeletal pain", *Complementary Therapies in Medicine* (2011), 19, 179–186.

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103. Mr McKellow advised that "[r]eaction to cervical manipulation is not uncommon". He said that the validity and efficacy of the Periosteal Sensitivity and Poison Point tests would be viewed with a "considerable degree of scepticism". Mr McKellow concluded that the tests were not clinically indicated in Ms B's case.

104. There are significant discrepancies between Mr A's and Ms B's descriptions of how the Poison Point test was performed. Ms B stated that while she was either lying or sitting on the treatment table fully clothed Mr A pinched her nipples through her clothing four consecutive times, twice on each nipple, using his thumb and forefinger.

105. In contrast, Mr A advised that the test involved Ms B standing in front of him fully clothed and him applying his little finger in a knife-edge fashion against Ms B's breast for approximately one second. He then repeated this on the opposite side. I am unable to reach a conclusion about how the Poison Point test was actually performed, and therefore cannot make a finding about the nature of the touching.

Conclusion

106. Mr McKellow advised me that Mr A's clinical management of Ms B's lower back and leg pain represents a moderate departure from accepted standards. I agree.

107. The New Zealand Chiropractic Board *Code of Ethics and Standards of Practice* (2004) at paragraph 3.1.6 provides:

> "A Chiropractor must not over-service a patient. It is the responsibility of the Chiropractor to treat the patient only while Chiropractic can be shown to be of benefit and clinically justified. Care that is not clinically justified constitutes over-servicing."

108. Paragraph 4.1 provides:

> "Adequate care management relies on performing a logical sequence of actions, each one based on prior information, making clinical decisions from data obtained, forming a management plan, evaluating progress…"

109. I remain of the view that Mr A's treatment was not clinically appropriate in light of Ms B's reported symptoms. In my view, Mr A's clinical rationale for manipulating Ms B's cervical spine was flawed, and there was no clinical indication for Mr A to perform the Periosteal Sensitivity test or Poison Point test. As stated in the *Code of Ethics and Standards of Practice*, treatment that is not clinically justified constitutes "over-servicing", which is ethically inappropriate. Accordingly, I find that Mr A breached Right 4(1) of the Code by failing to provide Ms B with services with reasonable care and skill.

Information and consent

110. Under Right 6(1) of the Code, Mr A had a duty to provide Ms B with information that a reasonable consumer, in Ms B's circumstances, would expect to receive, including an explanation of her condition, treatment options, the purpose for which the treatment techniques were used, and their risks and benefits.

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111. Ms B advised that at the first consultation, Mr A manipulated her spine and told her that she had "dysfunctional hips"; however, he did not explain to her what "dysfunctional hips" meant in relation to her overall condition or why manipulation of her back was necessary to treat her dysfunctional hips.

112. Ms B recalled that, at the consultation of 21 February, the only information she received from Mr A about urtication was that it involved the use of a piece of stinging nettle to fix her dysfunctional hips. Ms B advised that she was not told any other information about the technique, including that Mr A would unbutton her trousers.

113. Mr A stated that he did inform Ms B about urtication and that her McBurney's point would be treated. However, he accepted that he did not seek Ms B's consent to unbutton her trousers.

114. Mr A advised that at the fourth consultation, he fully informed Ms B of his intention to perform the Poison Point test because she had periosteal sensitivity, and said that she consented to the procedure. Mr A submitted that he was clear about what the Poison Point test entails. He documented in the notes: "Both procedures explained and Pt/perm given."

115. In contrast, although Ms B agrees that Mr A did talk to her about the Poison Point test, and that she consented, Ms B did not have a clear understanding of how the Poison Point test was to be performed. Ms B said that she was told something about "nipples and nerve endings" and was asked "something along the lines of "can I pinch your nipples?". Ms B said that she was taken by surprise when Mr A touched her breasts. Mr A stated in response to the provisional opinion that he never talked about nerve endings, nor did he talk about Ms B's breasts.

116. In my view, a reasonable consumer in Ms B's circumstances would expect to receive adequate information about his or her condition. Although Mr A advised Ms B that his assessment was that she had bursitis and joint dysfunction, I do not consider that Mr A provided her with an adequate explanation about what this meant.

117. I accept the view of Mr McKellow that urtication, Periosteal Sensitivity and Poison Point testing are unorthodox chiropractic techniques. If a provider proposes to use an unorthodox technique, a reasonable consumer in Ms B's circumstances would also expect to be informed about whether the technique is supported by evidence-based literature, its risks and benefits, and how the test is to be performed. Information about unorthodox techniques is particularly important where there is a lack of evidence to determine their validity and efficacy. A reasonable consumer would also expect to be informed about the overall safety of the technique before giving consent. As stated in a previous HDC opinion,[27] "Providers who do not adequately explain the services being provided run the risk of making the consumer feel confused and uncomfortable".

118. I accept that Mr A took some steps to explain to Ms B the procedure of urtication, the Periosteal Sensitivity test and the Poison Point test. I also acknowledge that Mr A

[27] Refer to opinion 06HDC09882.

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documented in the patient records that he explained the tests to Ms B. However, on balance, I remain of the view that Mr A did not advise Ms B that the tests were unorthodox chiropractic techniques. He also did not provide Ms B with information about whether the validity and efficacy of the techniques were supported by evidence-based literature, or with sufficient information about why the unorthodox techniques were clinically indicated in relation to her condition.

119. Accordingly, I find that Mr A breached Right 6(1) of the Code for failing to provide Ms B with information that a reasonable consumer, in Ms B's circumstances, would expect to receive. As Ms B did not receive sufficient information, she was not in a position to provide informed consent to the unorthodox chiropractic techniques. Accordingly, I also find that Mr A breached Right 7(1) of the Code.

Documentation

120. Legible and accurate documentation of services provided is important to quality and continuity of care. Paragraph 4.6.3 of the *Code of Ethics and Standards of Practice* states that a chiropractor must keep a record of the initial case history, examination information and patient's progress. Furthermore, it states that "[r]ecords must be capable of being interpreted by the Chiropractor's colleagues".

121. Although Mr A recorded his consultations with Ms B, his notes are frequently illegible. Furthermore, Mr A has documented the results of only a few tests, as he recorded only positive test findings. This is not acceptable. As Mr McKellow advised, "[t]he recording of negative clinical findings is an important process in helping document how a clinical impression was determined". In response to the provisional opinion, Mr A accepted that his documentation on this occasion could have been of a higher standard, and he has addressed this in his procedures.

122. By not keeping clear, legible and full records of the services he provided to Ms B, including the failure to document all examination findings, Mr A failed to comply with his professional obligations. Accordingly, I find that Mr A breached Right 4(2) of the Code in this regard.

Recommendations

123. I recommend that Mr A provide a written apology to Ms B. The apology is to be sent to this Office by **25 June 2013** for forwarding to Ms B.

124. I propose to refer Mr A to the Chiropractic Board of New Zealand, and recommend that the Board conduct a competency review of Mr A.

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Follow-up actions

125.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Chiropractic Board and the New Zealand College of Chiropractic. They will be advised of Mr A's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent chiropractic advice: Bayne McKellow

"I have been asked to provide advice on case number 11/00231.

I am a practising chiropractor in Greenmeadows, Hawkes Bay, registered in 1972 and hold a current annual practising certificate.

- I graduated from Palmer College of Chiropractic on March 31, 1972 with the degree of Doctor of Chiropractic and a Certificate in X-ray proficiency.
- I gained Chiropractic Claims Review and Independent Examination Certification in December1999, from Texas Chiropractic College.
- I gained the International Chiropractic Sport Science Diploma (ICSSD) in December 2001 from the Federation Internationale de Chiropractique du Sport.
- Past president, New Zealand Chiropractors' Association.
- Certified Practising Member (CPM) of the Chiropractic & Osteopathic College of Australasia (COCA).
- Fellowship status (FCC) of the College of Chiropractors (UK) 2008.
- Chiropractic Board (Registration — Entrance Competencies) Examiner 2008–2010.

[At this point Mr McKellow outlines the information provided to him by HDC. This has been removed for the sake of brevity.]

STANDARD OF CARE PROVIDED BY [MR A]

When considering the standard of care the following Standards or Guidelines were consulted:

- Chiropractic Board — Code of Ethics and Standards of Practice
- Acute Low Back Pain Guidelines 1999 and 2004 editions
- Chiropractic Treatment Profiles 2003 (NZCA/ACC joint initiative)
  - Low Back Pain (Low back Pain, Acute Lumbar pain, Lumbago) — Read Code N142. Page 9–11.
  - Sciatica — Read Code N143. Page 13–14
  - Sprain Sacroiliac joints — Read Code S561. Page 15–17
  - Definition of treatment profiles[1] (Page 115)
- ACC Treatment Provider Handbook 2011
  - Clinical records pages 26–28
  - Payment criteria Page 81

[1] ACC Treatment Provider Handbook 2011 Page 115 — Definition of Treatment Profiles

The Chiropractic Board Code of Ethics and Standards of Practice sets the minimum standards expected of a chiropractor when managing a patient's chiropractic care, including ethical responsibilities and minimum clinical standards.

Acute Low Back Guidelines October 2004 — is a multidisciplinary consensus guideline. The expert panel included: a Consumers' representative, Pain specialist, Rheumatologist, Physiotherapist, Clinical Psychologist, Rehabilitation Medicine Physician, Orthopaedic Surgeon, General Practitioner, Musculoskeletal Pain Specialist, Chiropractor and representative from Faculty and Society of Occupational Medicine.

The guideline offers recommendations based on evidence grading using the SIGN (Scottish Intercollegiate Guidelines Network) grading system that is recommended by the New Zealand Guidelines Group.

Chiropractic Treatment Profiles 2003

The profiles are a consensus of opinion as to what is considered appropriate and common current practice.

They are to help encourage common accepted standards and should be seen as a step to developing evidence based best practice guidelines. (P3)

It is not a rigid, prescriptive document. Its advice is flexible, so that treatment providers can make clinical judgements according to individual patient circumstances.

ACC Treatment Provider Handbook 2011

The ACC Treatment Provider Handbook clearly explains a Treatment Provider's responsibilities when managing and billing the Accident Compensation Corporation.

STANDARD OF CARE PROVIDED BY [MR A]

What standard of care could [Ms B] reasonably expect when visiting a chiropractor for management of her lower back injury and left leg pain?

My opinion is determined by what [Mr A] recorded as his clinical findings and not his retrospective recollections of clinical examination findings he failed to document in [Ms B's] clinical file at the time of examination.

The recording of negative clinical findings is an important process in helping document how a clinical impression was determined[2].

[Mr A] accepted [Ms B] for injury management relating to an accepted ACC claim. ([xx] — Strain lower back).

([Ms B] also had injured her neck in May 2010 and this was registered under claim [xx]).

ACC has reimbursed [Mr A] for lower back injury management under claim [xx] — Strain lower back.

The responsibilities of practitioners under the Accident Compensation Act are clearly detailed in the Treatment Providers Handbook.

In my opinion, [Mr A] failed to meet the standard required of a treatment provider when managing an ACC compensable lower back injury.

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[2] Chiropractic Board — Standards of Practice — 4.1 & 4.6.3

His clinical notes do not demonstrate his clinical management was:[3]

- necessary and appropriate
- of the quality required

Considering [Ms B's] presenting symptoms, what was necessary and appropriate process during examination and treatment delivery?

[Mr A] clearly identified, in his opinion, a possible cause of [Ms B's] continuing pain. A preliminary diagnosis of left sacroiliac joint "bursitis" and possible pseudo sciatica was underpinned by positive orthopaedic findings during examination (+ve Fabere Patrick and Ganes Lands (Gaenslands). Manipulative care administered to the lower back/pelvis provided on the first office visit (18/02/2011) **was appropriate.**

The rationale to proceed further and manipulate her lower cervical spine is unclear. There are no clinical findings to indicate her lower cervical spine was a contributing factor for the management of her lower back injury/leg pain.

I also comment on the unconventional pain management procedure called urtication. I have been unable to find any information in the indexed literature that relates chiropractic management of sciatica with this procedure. [Mr D], in his letter of support for [Mr A], references an observational case study by a physiotherapist where a patient self-administered (or husband administered) stinging nettle for assistance in her pain management. The article itself describes the procedure as unorthodox.

On her initial office visit [Ms B] completed a Health Questionnaire identifying **her major complaint and symptoms as** "pinched nerve sciatica". She was requested to indicate on a pain diagram where she was experiencing pain and circle the degree of pain from 1–10. Her only indications were left gluteal (buttock) pain which she rated as 7/10 on a numeric pain scale.

She also completed a Health History section where she was asked to indicate any symptoms experienced in the last 6 months.

This type of Health History is frequently used in many chiropractors' offices to gather general background health information in a systemised and orderly manner.

While the questionnaire provides background information for [Mr A] when considering her presenting symptoms, completion of a Health Questionnaire, **does not**, in itself, confer consent to a broader treatment regime beyond the presenting complaint.

Neither manipulation of [Ms B's] cervical spine nor urtication follow the generally accepted procedures for management of lower back injury involving sciatic type pain.[4]

On 23 February 2011, [Mr A] indicated in his initial response to the Commissioner that he explained and treated [Ms B] for cervical "bursitis". There are no further entries. I note the differing versions of the clinical encounter on February 23 2011.

On 25 February 2011 [Ms B] again attended [Mr A]. On this occasion she received a toggle recoil adjustment/manipulation to the first cervical vertebra. (C1 or Atlas

[3] ACC Treatment Provider Handbook 2011 — Invoicing and payments — Page 81.

[4] Chiropractic Treatment Profiles 2003 — N143. Low back Pain, N143 Sciatica, N561 Sacroiliac Joint strain.

vertebra). It was her adverse reaction to this manipulation that led [Mr A] to conclude that, in his clinical experience, it possibly related to sensitivity or sensitive skeletal bones and concluded that she suffered from periosteal sensitivity.

Reaction to cervical manipulation is not uncommon. Well documented recent research has been conducted into predictive factors.[5]

The test used by [Mr A] for periosteal sensitivity assessment involved applying light pressure over the clavicle and anterior tibia. [Mr A] attributes "periosteal sensitivity" to spinal nerve interference, cortisone/steroid use, leaky bowel or nutritional issues.

A further procedure employed by [Mr A] to "double check" for leaky bowel was a TBM (Total Body Modification) "poison point" procedure.

Both the "periosteal sensitivity" assessment procedure and "poison point" procedure do not reside within mainstream chiropractic procedures. I am unable to access any research or information that determines validity or specificity/sensitivity of the "Periosteal sensitivity" pinch test, or the TBM poison point procedure. The only references available are notes/diagrams supplied by [Mr A] from a TBM manual.

In my opinion the efficacy of the poison points procedures remains unsubstantiated.

Further reference detailing the specificity and sensitivity of these unorthodox test procedures (periosteal sensitivity and poison point) is required before they can be considered reliable diagnostic indicators.

I opine that — **The overall standard of care provided by [Mr A] relating to the management of [Ms B's] injury to her lower back/leg pain fell below the standard a member of the public could reasonably expect from a registered chiropractor. Specifically, after the second office visit, chiropractic care was not administered [and did not] address her lower back or left leg pain.**

Apart from the manipulation of the sacroiliac joints, which would gain the approval of his peers, the alternative procedures of assessment and treatment would be viewed by many of his colleagues with a considerable degree of scepticism.

Specifically:

The adequacy of [Mr A's] initial assessment.

Incomplete documentation limits accurate comment. [Mr A] has indicated that he only records positive findings but maintains he performed other orthopaedic evaluations but did not record them as they did not elicit a positive test response.

However, his recording of normal findings for cervical range of movements, simply confuses the issue as to what tests were performed, and what was or was not documented as negative or normal.

Given [Ms B's] indications on the pain diagram, [Mr A] proposed a logical preliminary diagnosis of sacroiliac involvement to explain her lower back/left leg pain.

[5] Predictors of Adverse Events Following Chiropractic Care for Patients with Neck Pain — Rubinstein, Leboeuf-Yde, Knol, Koekkoek, Pfeifle and van Tulder.

[Mr A's] rationale for his diagnosis

The clinical findings, as documented, do not support the diagnosis of hip bursitis, left sacroiliac joint bursitis, or cervical bursitis. The term bursitis appears to have been used in a very general and non specific manner.

[Mr G] offers an explanation in his correspondence to [Mr A] (P75) for bursitis in the pelvic region.

I am unable to explain [Mr A's] rationale for his diagnoses as there is insufficient recorded clinical information.

[Mr A's] subsequent treatment

Manipulation for [Ms B's] lower back pain is appropriate.

Urtication is an unorthodox pain management procedure and would not usually be performed in chiropractic practices.

Manipulation of the cervical spine for a presenting lower back injury requires strong clinical indicators to justify any early implementation of the procedure. [Mr A's] clinical documents are silent in this regard apart from range of motion evaluation.

[Mr A's] rationale that [Ms B] had "periosteal sensitivity following the cervical adjustment.

Periosteal sensitivity refers to abnormal sensations felt at the outer surface of bones and joints.

Some other possible causes are:

Systemic Lupus erythematosus,
Dermatomyositis,
Polymyositis,
Systemic sclerosis,
Wegener's granulomatosis,
Rheumatoid arthritis,
Osteoarthritis,
Gout,
Pseudogout,
Osteomyelitis,
Duptutyrens contracture,
Mucopolysaccharidoses.

[Mr A] attributes "periosteal sensitivity" to spinal nerve interference, cortisone/steroid use, leaky bowel or nutritional issues.

A percentage of patients experience symptoms or reactions after manipulation, as mentioned earlier in this report. I am unable to comment on [Ms B's] reaction as the documentation simply records reaction to the upper cervical adjustment without further detail. I note that she did not react to earlier manipulation of her sacroiliac joint or lower cervical spine.

I am unable to reference the test for periosteal sensitivity as performed by [Mr A] in any indexed peer reviewed literature. Hence there is no available data about its reliability or sensitivity/specificity.

[Mr A's] rationale for his subsequent assessment of [Ms B's] "poison point".

[Mr A] used the "poison point" to help him confirm or verify his findings of periosteal sensitivity, and suspicion of leaky bowel syndrome.

Leaky gut syndrome is a commonly accepted diagnosis by alternative health practitioners, but remains a questionable diagnosis within mainstream medicine.

Alternative health practitioners usually confirm this syndrome by one of two tests — a urinary indicans test or a PEG test (polyethelyeneGlycol). These are frequently used tests by natural medicine practitioners.

The "poison point procedure" does not appear on any literature search for "leaky gut syndrome" or similar, and the only reference is that supplied by [Mr A].

As mentioned earlier, while leaky bowel syndrome has not been embraced by allopathic medicine, it is well documented by naturopathic medicine. Lack of embrace from allopathic medicine does not mean that the concept is without merit. (Chronic fatigue and fibromyalgia being examples of late embrace.)

The "poison point procedure" appears to have been used for similar reasons that the Urinary Indicans or PEG test would be employed to determine intestinal/bowel health.

The poison point test procedure lacks any evidence of validity. It is incumbent for [Mr A] to produce evidence that supports this procedure.

I am mindful that the process started with manipulation of the upper cervical spine (rationale for this intervention is not documented) and the subsequent reaction [Ms B] experienced.

The adequacy of [Mr A's] documentation, particularly in relation to the recording of his assessment findings.

[Mr A's] documentation does not meet the recommended standard requested by ACC or the Chiropractic Board.

In my initial assessment of this complaint I opined that the documentation was not adequate, documented examination findings were minimal and did not support the diagnoses concluded by [Mr A] (cervical, hip and sacroiliac bursitis). After reviewing additional comment provided by [Mr A], I am still of the same opinion.

Failure to record negative examination findings is a departure from the expected standard of documentation required of chiropractors.

Any other comment you wish to make

[Ms B] presented for treatment of an injury to her lower back. While there possibly may have been other health issues, it was [Mr A's] responsibility to address her presenting complaint of lower back and leg pain and formulate an adequate management plan.

ACC is very specific on management of injury claims. It rarely compensates for health or non-injury related treatments. There is nothing in [Ms B's] clinical notes that suggests that her cervical spine was either causal or secondary to her lower back injury. The assumption of "periosteal sensitivity" remains unsubstantiated.

The poison point procedure also remains unsubstantiated.

It is well understood that persistent on going lower back pain, especially with any degree of radicular symptoms, requires consideration for potential disc injury. This would be considered part of the basic investigation for management of [Ms B's] presenting complaint, especially given her failure to respond under previous treatment providers.

Without adequate investigation, appropriate management appears to have been supplanted by more ethereal diagnostic and treatment procedures.

The absence of accurate and legible documentation would make it difficult for a colleague to provide continuing care for [Ms B] without reverting to a basic preliminary workup to obtain an appropriate clinical impression."

Additional expert advice — 24 May 2012

Mr McKellow advised that, in his view, Mr A's departure from accepted standard would be viewed as moderate.