Chiropractor, Mr B

A Chiropractic Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC02247)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr A, aged 46, had a history of back pain from various injuries and arthritis in his spine.

In late May 2007, Mr A sprained his lower back whilst lawn mowing, and sought treatment from chiropractor Mr B. Mr B proposed a treatment regime that involved treating both Mr A's injury and pre-injury symptoms. Mr B also provided Mr A with information that led him to believe that Mr B could alleviate his back pain. Mr A returned to see Mr B every two to four days and attended a total of eight visits over 18 days in June 2007. Mr A stated that the treatment sessions were very brief and he experienced little relief despite seeing Mr B regularly. At the final appointment, Mr B used a Pettibon Tendon Ligament Muscle Stimulator machine, which Mr A thought resembled a "Makita home handyman's jigsaw", to treat Mr A's spine. Mr A queried the validity of this and decided against returning to Mr B.

My investigation focused on whether Mr B appropriately assessed and treated Mr A and whether Mr B provided Mr A with adequate information regarding his treatments.

Complaint and investigation

On 18 February 2008, the Commissioner received Mr A's complaint against Mr B. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Mr B in 2007.*
- *The adequacy of information provided to Mr A by Mr B in 2007.*

The investigation commenced on 6 March 2008, and was delegated to Deputy Commissioner Rae Lamb. The parties directly involved in the investigation were:

• Mr A	Consumer
• Mr B	Provider/Chiropractor
• A Chiropractic Clinic	Mr B's employer

Information reviewed

Information from:

- Mr A
- Mr B
- Mr B's lawyer

- Ms D (Former Office Manager for the Clinic)

Mr A's clinical records from:
- Mr B
- A medical centre
- A radiology centre

Independent expert advice was obtained from Mr Bayne McKellow, and is attached as Appendix 1.

Information gathered during investigation

Background
Mr A, aged 46, had a history of back pain from various injuries and arthritis in his spine, and suffered from degenerative joint disease.

On 28 May 2007, Mr A slipped while mowing the lawn, and sprained his lower back. On 30 May 2007, he consulted his general practitioner (GP) who documented "no neurologic symptoms", and "pain worse while ROM [Range of Movements]". On examination, the GP noted "ROM: satisfactory" and that there was "mild tender[ness] on lower back beside the spine". In the ACC Injury Claim Form that the GP completed, he recorded his diagnosis as "lumbar sprain[1]" and assessed the severity of Mr A's injury as "minor". In addition to the Voltaren[2] the GP prescribed, Mr A requested that the GP to refer him to chiropractor Mr B. (A friend of Mr A had recommended Mr B on an earlier occasion.) However, as the GP was unable to locate Mr B's details from the computer, a referral was not made. Instead the GP advised Mr A to "find out if the institution is recognised by ACC" and to seek further medical advice if he did not experience any improvement. Following the consultation with the GP, Mr A made an appointment to see Mr B.

The Chiropractic Clinic
In 2007, the chiropractic clinic (the Clinic) operated as a chiropractic clinic and bio-mechanic[3] correction clinic. During the period under investigation, the Clinic employed Mr B as a chiropractor,[4] and Ms D as office manager. Mr B's responsibilities included assessing and treating patients, and completing patient records. He was also expected to assist the Clinic "in the promotion of the business of

[1] Lower back strain. "Lumbar" refers to the part of the back between the thorax and the pelvis.

[2] A non-steroidal anti-inflammatory drug taken to reduce inflammation and alleviate pain from conditions such as arthritis and acute injury.

[3] At no point during the investigation did Mr B explain what he meant by the term "biomechanics" nor did he provide any evidence of his qualification in this field.

[4] Mr B has not provided a copy of any employment agreement with the Clinic.

the company which subsequently resulted in various promotional material[s] issued by the business". As an office manager, Ms D was responsible for reception, booking appointments, and maintaining patient records including patient cards, X-ray reports and ACC forms.

Initial consultation: morning of 11 June 2007

On the morning of 11 June 2007, Mr A attended his first appointment with Mr B at the Clinic. Prior to the consultation, Mr A completed a confidential health questionnaire which contained a section asking patients to list all their "main symptoms/pain". Mr A ticked "backache" and "stiff neck/shoulder" (refer to Appendix 2). Mr B stated:

> "[Mr A] presented to our office on 11 June 07 where he completed our confidential health questionnaire in respect to the top third of the standard form a copy of which is attached. He was complaining of stiff neck in the upper left cervical region,[5] ach[ing] shoulders on both sides of the body at the trapezium, and low back ache concentrated at the fifth lumbar. While he reported having low back aches off and on for many years, this episode was brought on from a fall onto his left side in May 2007 while mowing lawns. He also stated he has been told previously he has degenerative joint disease, but was unsure as to the extent. He has had chiropractic and physio care in the past on a symptomatic basis for years."

It is unclear whether Mr B discussed with Mr A which symptoms were pre-existing, and which symptoms related to his lumbar injury.

Mr B then performed a clinical examination lasting approximately 20–30 minutes and described his findings to this Office as follows:

> "Orthopaedic and neurological tests were negative. There was tenderness described upon palpation in the upper cervical region, the trapezium (shoulders), the thoracic (mid back) at the 5–7 vertebra and the 9–10 vertebra, the fifth lumbar (low back). Altered biomechanics were noted at the 1st, 2nd, 5th, and 6th vertebral segments in the neck, the 1st, 2nd, 4th, 5-7th, 9-10th, and 12th vertebral segments in the mid back, the 2nd, 4th and 5th lumbar vertebral segments, the sacral iliac joints[6] and the symphysis pubis.[7]
>
> Also noted were altered biomechanics at the left gleno-humeral joint,[8] the right knee, both ankles and both wrists."

[5] Although Mr A believes that the cervical symptoms were the result of his injury on 28 May 2007, there is no mention of any cervical symptoms when Mr A consulted his GP on 30 May 2007.

[6] Sacroiliac joints are located at the bottom of the back. There is one on each side of the spine. They help make up the rear part of the pelvic girdle.

[7] Where the pelvic bones meet.

[8] Commonly known as the shoulder joint.

In light of the examination and Mr A's history of degenerative joint disease, Mr B advised that he needed to review Mr A's X-rays "for a proper assessment". Mr A mentioned that he had had X-rays taken in the previous year but was unsure of the date. In the section of Mr A's notes headed "Chief Complaint" Mr B documented "No access to X-rays. [Patient] unsure when they were taken, may have been longer than 6 months. Doesn't want to track down. Prefer to just get new ones." Mr B completed a referral form to a radiology centre in which he requested "full spine standing" X-rays and for the X-ray report to be sent to him.

Spinal X-rays
Later that morning, Mr A attended a radiology centre for spinal X-rays. The X-ray report stated:

> "**CERVICAL SPINE**
> Disc spaces C5/6 and 6/7 are narrowed. There are secondary degenerative changes with prominent osteophytes[9] at these levels. Calcifications posterior to the spinous processes of C6 & C7 are likely to represent previous avulsion fractures.
>
> **THORACIC SPINE**
> There are prominent osteophytes at the margins of the vertebral bodies at multiple levels.
>
> **LUMBAR SPINE**
> All of the disc spaces of the lumbar spine are narrowed and there are prominent osteophytes at all levels of the lumbar spine.
>
> **COMMENT: There are extensive degenerative changes.**"

A copy of the X-ray report was sent to Mr B.

Second consultation: afternoon of 11 June 2007
That afternoon, Mr A returned to Mr B with the X-ray films taken at the radiology centre as well as his X-rays films from a year earlier. Prior to reviewing the X-ray films, Mr A was shown a chiropractic DVD on back management, which he said "bordered on cultist". Mr A said that the contents of the DVD were akin to "converting someone into a religion" and that the DVD made strange claims that people could live up to 120 years if they did not have back problems. The DVD also claimed that back problems were the underlying source of many other problems.

During the investigation, Mr B was asked to provide a copy of the DVD to this Office. He advised that he no longer used this DVD in his practice and did not retain a copy. However, in an interview with Ms D, she stated that the DVD Mr A referred to was shown daily to clients during her tenure (from August 2006 until June 2008). Ms D

[9] Bone spurs that develop in areas of a degenerating joint. They are commonly associated with osteoarthritis.

also confirmed that the DVD claimed that a person could live longer if he/she did not have any back problems.

After Mr A had watched the DVD, Mr B reviewed and discussed Mr A's X-rays with him. Mr A recalls Mr B using a ballpoint pen to "draw numerous circles on [his] X-ray films". Mr B stated:

> "A thorough report of findings was conducted of approximately 30–40 minutes where the examination findings were explained and marked on a nerve function handout as to what specifically was causing his pain, his correct level of degenerative joint disease was marked on the degeneration page with the majority of the spine at a moderate to advanced stage of degeneration. He was explained how and why this occurs and what could and could not be done with it including extensive hand written notes on the back of the report of findings handout."

Mr B outlined the treatment options available. He explained to Mr A that he normally offered three options: Option A, B and D, but Option B — a corrective and prevention programme — was unsuitable for Mr A. Mr B did not explain why he considered Option B unsuitable for Mr A. At that time, Option A was a six-month "deep treatment program with guaranteed results". It involved "treating both the primary and secondary biomechanic pathologies" and required an upfront fee of $3,700. Interest-free finance was available to patients who chose Option A. Option D offered symptomatic relief and was a "pay as you go" program. Under this option, the cost of each treatment was $56 "minus ACC payments if any". Mr A was given a "Health Investment Worksheet" with information on the three options. Mr B also gave him printed information titled "[The Clinic] is Here For You", "Nerve Function", and "Phases of Progressive Spinal Degeneration" and a letter titled "[The Clinic] Advanced & Effective Solutions".[10] According to Mr B, he advised Mr A to "go home and consider the information" but apparently, Mr A "wanted to begin right away with Option D". In contrast, Mr A stated that he felt "pressure" and "inducement" to choose either Option A or Option D from "the way [Mr B] portrayed the alternatives". Mr A also stated:

> "I did not take out a loan or pay in advance [as] I was having what [Mr B] called 'symptom relief'. I believe I was denied the 'we can fix it treatment' [Option A] as I did not pay the thousands of dollars required."

That same afternoon, Mr B started Mr A on the Option D treatment, which Mr B described as follows:

> "Treatment was started [on 11 June 2007] with side posture adjustment excluded until [Mr A's] response to treatment could be ascertained. On the 11th of June a chiropractic adjustment was made to T10, T1, C5, C6, and L5

[10] Refer to Appendix 3 for the printed information Mr B provided Mr A.

> anterior to posterior drop. Left ileum posterior and inferior drop and a right anterior superior drop were applied. …"

Mr B's records show that Mr A paid a total of $56 for both consultations on 11 June 2007.

Subsequent consultations: 13–25 June 2007

Two days later, on 13 June 2007, Mr A attended another consultation with Mr B. Mr B's records show that over 18 days in June 2007, Mr A returned to see Mr B every two to four days, and attended a total of eight visits. Mr A paid $32 for each of his subsequent consultations as part of the fee was covered by ACC. At no point during the course of his treatment did Mr B contact Mr A's GP to discuss the treatment plan.

Mr A commented that unlike the physiotherapists and chiropractors he had previously consulted, Mr B did not display the same degree of professionalism. Specifically, Mr A alleged that Mr B did not pay sufficient attention to his back pain. There was little discussion about the severity of Mr A's pain during the treatment sessions, and Mr B did not enquire how he was progressing and managing on a day-to-day basis.

Mr A also stated that he received "little or no benefit" from seeing Mr B, and described the treatments as brief "crunch, crunch, crunch" sessions. Except for the first two treatments on the morning and afternoon of 11 June 2007, the subsequent visits lasted no longer than approximately three minutes each. Mr A stated that "on one occasion, it was less than a minute from walking in the room — I actually timed it". The short duration of the treatment was also confirmed by Ms D, who stated that sessions with Mr B usually lasted between 3 and 10 minutes, and that many clients had complained about his charges. During the investigation, Mr B was asked to provide this Office with copies of his appointment diary showing Mr A's visits. Mr B said he did not retain a copy of his appointment diary and could not provide the information.

Mr B described the treatments he provided to Mr A between 13 and 25 June 2007 as follows:

> "… On the 13th no change in symptoms was reported, a L2 drop and a L5 anterior to posterior drop was applied with no pelvic adjustment. On the 15th the low back ache remained and the technique was switched to a gentle side posture as it had been ascertained that at this point that it could be tried safely. Right iliopsoas[11] tightness was found and corrected. A right ileum posterior and inferior and a left anterior and superior was found and adjusted using a gentle side posture, along with an anterior to posterior L5 drop. On the 25th the same adjustment was applied along with an explanation that significant scar

[11] The term "iliopsoas" refers to the combination of three muscles in the thigh — psoas major, psoas minor and iliacus. The iliopsoas is important for standing, walking and running, and is the strongest of the hip flexors.

> tissue is in the area and that it needs to be realigned with a machine called a PTLMS [Pettibon Tendon Ligament Muscle Stimulator]. …"

Mr B documented in his treatment notes of 25 June 2007, "too much scar tissue needs PTLMS". In contrast, Mr A stated that Mr B did not provide any explanation about the PTLMS during the appointment on 25 June 2007, or subsequently.

Pettibon Tendon Ligament Muscle Stimulator (PTLMS)

The Pettibon Tendon Ligament Muscle Stimulator (PTLMS) is a machine that "removes muscle splinting" and "increases blood flow".[12] It is manufactured by Pettibon System Incorporated (Pettibon), an organisation based in the United States of America. According to Pettibon's product catalogue,[13] PTLMS is "used during the acute phase of care for pain control and enhanced metabolic function for regeneration of the injured para-vertebral soft tissue". The catalogue claims that the PTLMS "works amazingly fast with significant results".

Final consultation: 29 June 2007

On 29 June 2007, Mr A attended his eighth and final consultation with Mr B. During this appointment, Mr B used the PTLMS on Mr A, but according to Mr A, Mr B provided no explanation before using it. Mr A recalls:

> "On my last visit, [Mr B] walked into the room with an open sports bag. In the bag was a home handyman type electrical jig saw (minus the cutting blade) which he plugged into the power socket. I have spent 4 years as a carpenter & the balance of my working life has been in engineering. I know what it was — a Makita[14] as memory serves. After a cursory click or 2 of my spine, [Mr B] turned it on & ran it up my spine. Using home handyman power tools on a patient?!"

Mr B acknowledged that the equipment used during this consultation looked similar to a jig saw. He explained to this Office:

> "On [Mr A's] last treatment gentle side posture was used on the Right P-I and Left A-S found. Transverse ligament massage was applied using a 'PTLMS' (Pettibon Tendon, Ligament, Muscle Stimulator) to realign scar tissue. It does look similar to a jig saw. It is a therapeutic health care device that is specifically made for Dr Pettibon by Makita."

Mr A queried the validity of the equipment used and decided against further treatments with Mr B. Instead, Mr A returned to his GP for analgesia and anti-inflammatory prescriptions to manage his pain. It is unclear whether Mr A formally informed Mr B of his decision to discontinue treatment. Mr B posted a "symptom care" letter to Mr A on 9 July 2007.

[12] See also Mr McKellow's advice on pages 25–26 for further information on the PTLMS.

[13] Refer to *www.pettibonsystem.com/products*.

[14] Makita is a company based in the USA that produces a range of industrial power tools.

Other matters

Clinical records
As part of the investigation, Mr B was asked to provide copies of his clinical records of Mr A's care. Initially, Mr B's lawyer stated that his client "ha[d] not retained a copy of the written material that was provided to Mr A" and requested this Office to liaise with Mr A for the information.

Mr A confirmed that he did not hold any of the information Mr B was seeking, and this was relayed to Mr B's lawyer. The lawyer was also asked why his client had not kept copies of his patients' treatment notes.

Mr B subsequently stated:

> "In reality, I have retained a copy of the original format used with [Mr A]. However, if [Mr A] had retained a copy himself, you would have seen directly from him the thoroughness of the information provided to [Mr A] by [the Clinic] not only the text, but also the extensive hand written notes. Due to space constraints, we only keep one example of the original paperwork on file, and have shorthand notes on each individual's treatment card as to the specifics of the case."

The clinical records concerning Mr A that Mr B provided this Office comprised a Confidential Health Questionnaire, one-page notes recording physical examination findings and Mr A's chief complaint, along with progress notes documenting the care provided at each consultation, and the fee paid.[15] It is unclear whether Mr B retained copies of the ACC form and the referral for X-ray form he completed on 11 June 2007 as they were not provided to this Office. During the interview with Ms D, she commented that Mr B did not have a good system for storing patient records.

Independent advice to Commissioner

Independent expert advice was obtained from Mr Bayne McKellow, a chiropractor, and is attached as Appendix 1.

[15] Refer to Appendix 2 for copies of Mr B's clinical records.

Responses to provisional opinion

Responses to my provisional opinion were received from the following parties:

Mr A
Mr A confirmed that the information gathered in the report is accurate.

Ms D
Ms D confirmed that the information gathered in the report is accurate.

Mr B and the Clinic
Mr B's lawyer responded on behalf of Mr B and the Clinic. He stated:

> "My clients do not accept the findings of the HDC and indeed it is apparent from the report that you have dismissed the number of … observations and assertions that [Mr B] has made in his response to date to your office.
>
> My clients are concerned that the report does not accept the explanations that you have received, or given them the appropriate consideration.
>
> Accordingly they reject the accuracy of the report and the conclusions that you have made.
>
> … [M]y clients consider that much of the opinion that has been provided by other persons to HDC have been taken as fact without question and that the opinion offered by the Chiropractor Mr McKellow has been given without knowledge or understanding.
>
> My clients also observed inconsistencies and factual errors in the report and that the statements by my clients have been misinterpreted.[16]
>
> …"

The lawyer did not reply to a request for details of his concerns and a further opportunity to respond.

[16] Details of these were not specified in the lawyer's response.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

(a) An explanation of his or her condition;

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

Other relevant standards

The New Zealand Chiropractic Board *Code of Ethics and Standards of Practice.* (Refer to Appendix 1 for a discussion of these standards.)

Opinion: Breach — Mr B

Information about condition
Mr A had a history of back pain from various injuries and arthritis in his spine. He also suffered from degenerative joint disease. On 30 May 2007, he sustained a minor lumbar sprain whilst lawn mowing, and decided to seek treatment from Mr B.

Mr A first consulted Mr B on the morning of 11 June 2007. In addition to his symptoms of low back ache from the injury a fortnight earlier, Mr A also complained of a stiff neck in the upper cervical region, and pain on both sides of his shoulders. It is probable that the cervical symptoms pre-dated Mr A's injury on 28 May 2007 given

his medical history. My expert chiropractor, Mr Bayne McKellow, commented that "it is not unusual when some patients present with injury for them to also request information or assistance for other injury or conditions that they have sustained or suffer from". In such instances, "it is important for the chiropractor to determine what component applies to the accident claim and what component is not injury related". However, there is no indication that Mr B did so nor did he explain to Mr A that it would be inappropriate for him to treat Mr A's pre-injury symptoms under ACC. Instead, Mr A was asked to list all his "main symptoms/pain" on the Confidential Health Questionnaire he completed. Not surprisingly, he ticked both "backache" and "stiff neck/shoulder" since there was nothing on the questionnaire directing Mr A to list only the symptoms related to his accident. Furthermore, there were no notes in Mr B's treatment records stating that Mr A was receiving treatment under ACC.

Mr B's failure to ascertain the exact nature of Mr A's injury symptoms meant that Mr A did not receive accurate and appropriate information about his lumbar sprain. Rather, as my expert has advised, Mr B appears to have exaggerated the severity of Mr A's symptoms by merging Mr A's lumbar injury with his existing cervical symptoms and offering a combined management protocol. In light of the symptoms Mr A listed, Mr B examined Mr A's entire spine, shoulders, knees, ankles and wrists. Mr B then advised the need to review Mr A's spinal X-ray films and referred him for full spinal X-rays despite a lack of rationale in the initial consultation or treatment records to justify this.

That same afternoon, after showing Mr A a chiropractic DVD on back management and reviewing his X-rays (which showed degenerative change in his lumbar spine), Mr B discussed two treatment options with him — Option A and Option D. Option A was a six-month "deep treatment program with guaranteed results" requiring an upfront fee of $3,700. However, there is no indication that Mr B discussed with Mr A the details of the guarantee, nor were any details outlined in the Health Investment Worksheet Mr B provided to Mr A. Given that this was only Mr A's second session with Mr B (which in many ways was an extension of Mr A's first visit earlier that day), Mr McKellow advised that it was premature to discuss long-term treatment at this stage. It would also have been good practice for Mr B to have contacted Mr A's GP to discuss why Mr A needed care beyond what was reasonably expected for an acute lower back injury. Although Mr B did outline Option D (which Mr A selected), I share my advisor's view that the choices offered were "inappropriate for Mr A's presenting symptoms". Mr B should have considered the current model for managing lower back pain and offered Mr A other choices including waiting to see if it resolved; anti-inflammatories and analgesia and manipulation; and heat treatment. However, there is no indication that Mr B did this.

During the eighth and final visit on 29 June 2007, Mr B used a PTLMS machine to realign the scar tissue in Mr A's spine. According to Mr B, he had explained to Mr A during the previous appointment (on 25 June 2007) that he would be using this machine, and had documented the need for PTLMS in his treatment notes. In contrast, Mr A stated that he did not receive any information about the PTLMS machine from

Mr B. Regardless of any explanation from Mr B, it appears from Mr A's complaint that he remained unclear about the benefits of the PTLMS, and queried Mr B's decision to use "home handyman power tools on a patient". This suggests that Mr B may not have provided Mr A with adequate information about the PTLMS.

Overall, I consider that Mr B did not provide Mr A with adequate information about his condition and treatment options, and breached Right 6(1) of the Code. Mr B does not accept this finding but has offered no further information in response to it.

Standard of care

Based on his review of Mr B's clinical records, Mr McKellow advised that Mr B's clinical assessments and examination "fail[ed] to meet the standard required of a chiropractor".

The clinical examination that Mr B performed lacked specific details about Mr A's injury, and appeared to be standardised for all patients. Mr McKellow noted that Mr B's treatment notes failed to differentiate left from right, and areas in the spine and limbs, and Mr McKellow was able to decipher the meaning of Mr B's notes only from reading a letter he sent to the Commissioner during the investigation. Although Mr B assessed that Mr A had "altered mechanics" at several areas of his spine, left glenohumeral joint, right knee, and both ankles and wrists, Mr B failed to explain what "altered biomechanics" entailed. Mr McKellow was severely critical of Mr B's clinical examination and the documentation of it, which was "vague and of no clinical value". It also lacked important detail to enable the formulation of an adequate treatment plan.

Based on the information Mr B recorded, there was insufficient justification for ordering an X-ray at the initial consultation. Should X-rays have been deemed necessary, Mr McKellow advised that this should have been limited to the lumbar spine and possibly the pelvis. Instead, Mr B ordered full spinal X-rays, which was not medically necessary and was excessive for investigating a lower back sprain. Although Mr McKellow confirmed (from reviewing the original X-ray films) that there were degenerative changes in Mr A's lumbar spine, he stated that "this finding is not unusual and does not necessarily indicate a causal relationship for acute lower back pain or the necessity for prolonged care without first following the protocols for supportive care".

Furthermore, Mr B failed to assess Mr A's cervical risks by omitting to document an adequate case history before examining Mr A's entire spine. Mr McKellow advised that "where the cervical spine is assessed, there are recommended protocols for its examination" in order to minimise the risk of accidents during the clinical examination. Mr B's omission in this regard was a severe departure from accepted practice.

Accordingly, I consider that Mr B's clinical care was inappropriate and breached Rights 4(1) and 4(2) of the Code. Once again Mr B rejects my finding but he has not provided any additional information to persuade me to take a different view.

Documentation
Health professionals are required to document accurately and fully a patient's symptoms and the findings from any examination conducted. They should also document adequately the details of their discussions including any information provided on treatment options.

As discussed above, Mr B's documentation of Mr A's care was poor — a finding Mr B rejects. Mr McKellow commented that Mr B's documentation was "noteworthy for its brevity". It did not include salient information regarding Mr A's presenting symptoms, and lacked detail to "enable formulation of an appropriate treatment plan". The treatment notes were also "silent on a management protocol or plan for handling [Mr A's] injury and/or condition" and "failed to establish medical necessity" for the treatment Mr B proposed.

I am concerned by Mr B's standard of record-keeping. Any provider of health services should know that adequate documentation is an important aspect of providing good care. Evidence of this fundamental standard is found in many sources. For instance, Standard 4.6 of the Standards of Practice as found in the Chiropractic Board of New Zealand Code of Ethics fully sets out the documentation requirements of a chiropractor. These include:

- Retention of all records, including X-rays being kept for a minimum of 10 years;
- Records of consultations should include brief notes about the subjective comments made by the patient along with the Chiropractor's observations, examination findings recorded, all procedures performed on the patient, date of next follow up visit;
- Records must be capable of interpretation by colleagues.

Furthermore, the introduction to the Standards New Zealand publication *Health Records*[17] states:

> "Health Records are a method by which providers and health and disability services communicate with each other. They are therefore an important factor in providing quality and continuity of care. The health record is also the primary document for recording care. An accurate health record is necessary to support informed and co-ordinated decision-making, evaluation of care provided, achievement of effective health outcomes and retrieval of data for management, audit and medico-legal reference."

[17] NZS 8253:2002.

Along with the deficiencies discussed above, Mr B also failed to store Mr A's clinical records appropriately. It appears that he does not appreciate the importance of keeping a full copy of his treatment records, and I am not persuaded by his explanation that it was owing to space constraints. In my view, it seems more than coincidental that the information this Office requested was exactly the information that Mr B chose not to retain.

I conclude that Mr B's standard of record-keeping breached Right 4(2) of the Code, and was a severe departure from expected standards.

Opinion: Breach — The Clinic

Vicarious liability
During the period under investigation, Mr B was an employee of the Clinic. (I have concluded that Mr B was an employee of the Clinic based on his representation to that effect.) Under section 72 of the Health and Disability Commissioner Act 1994 ("the Act"), an employer is liable for acts or omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

There is no indication that the Clinic exercised any authority over Mr B's actions in over-servicing Mr A's lumbar sprain. On the contrary, the Clinic devised various "educational" materials for distribution to patients which Mr McKellow viewed as "promotional in nature, tailored to direct choice towards option A of the Health Investment Worksheet". He also commented that the materials were designed to guide Mr A into a "one size fits all" system of management rather than to assist Mr A to understand and decide upon immediate options available for managing his acute lower back pain. In addition, the Clinic did not have adequate systems in place to ensure that patient records were filed appropriately and safely.

In my view, the Clinic failed to take reasonably practicable steps to prevent Mr B from breaching Rights 4 and 6 of the Code. Therefore, the Clinic is vicariously liable for Mr B's actions.

Referral to Director of Proceedings

As discussed above, Mr B's care, record-keeping, and the information he provided Mr A amount to breaches of the Code, and highlight significant concerns. Furthermore, this is the second occasion where Mr B has breached the Code, and I note that similar deficiencies in his standard of care, record-keeping, and the adequacy of information provided to patients are identified in another opinion. In addition, my expert, Mr

McKellow, noted in several parts of his report that Mr B departed severely from an appropriate standard of care. Therefore, I have referred Mr B to the Director of Proceedings in accordance with section 45(2) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Other comments

Communication of treatment options
Mr A and Mr B differ in their perceptions about Mr A's decision to choose treatment under Option D (during the second session on 11 June 2007). According to Mr B, he discussed Options A and D with Mr A, provided him with written information and advised him to "go home and consider the information". However, Mr A apparently "wanted to begin right away" and was started on option D treatment that same day. In contrast, Mr A stated that he felt pressured to choose one of the two treatment options from "the way [Mr B] portrayed the alternatives". However, owing to the cost of Option A, Mr A selected Option D, which he understood was an inferior treatment regime.

The New Zealand Chiropractic Board's Code of Ethics states that "a chiropractor must not leave a patient feeling pressurised or coerced into entering a contracted treatment plan".[18] The right of a consumer to be free from exploitation and coercion is also affirmed in Right 2 of the Code. Although Mr A did not enter into any contracted treatment plan, I am concerned that he felt "pressured" to make a decision within the same appointment, and chose a cheaper treatment plan. I take this opportunity to remind Mr B of his obligations under the Code, and recommend that he review his manner of communication with his clients, in particular when he discusses treatment options.

Mr B's qualification and registration
Although Mr B made several references to "biomechanics" in his documentation and observations of Mr A's condition, at no point did Mr B explain what biomechanics entailed nor provide any evidence of his training and qualification in this area. Although Mr B was requested to provide me with clarification, he has not done so to date.

Mr B is no longer registered as a chiropractor. He should be very careful not to undertake any activities restricted to registered chiropractors under the Health Practitioners Competence Assurance Act 2003.[19] He should also inform his clients

[18] Section 3.1.13j.

[19] As a non-registered chiropractor, Mr B is not allowed to refer patients for X-ray or to undertake cervical manipulation.

that he is not a registered chiropractor and outline what (if any) formal qualifications he holds in biomechanics. As an unregistered practitioner, he is still subject to the Code.

ACC
Mr McKellow advised that Mr B's documentation failed to comply with ACC's requirements as the documents do not contain the information needed to make an appropriate assessment of Mr A's presenting symptoms, nor do they contain sufficient detail to determine the appropriate clinical interventions. I have drawn this to the attention of ACC.

The Advice Notice sent out by the Chiropractic Board in June 2007[20] stated that ACC covers care only for a clearly defined injury based on clinical judgement, rather than corrective care beyond which the immediate injury has been managed. In addition, the *Code of Ethics* prohibits a chiropractor from having any additional form of contract with a patient covered under ACC. As Mr McKellow noted, the treatment regime Mr B recommended did not differentiate between injury and symptom management. There is no evidence that Mr B made any attempts to notify ACC that he was also treating Mr A's cervical symptoms, by completing an ACC32 Request for Additional Treatment form.[21]

Recommendations

I recommend that Mr B:

- apologise to Mr A for breaching the Code of Health and Disability Services Consumers' Rights. The written apology is to be forwarded to this Office by 25 March 2009 for sending to Mr A;
- comprehensively review his clinical practice;
- reflect on the inadequate and inaccurate information he provided Mr A and provide written confirmation by 25 March 2009 that he will provide clients with more appropriate information in the future.

I recommend that the Clinic:

- review its system of storing patient records, and advise me by **25 March 2009** of what actions it has taken.

[20] Refer to Appendix 4.

[21] A practitioner is entitled to invoice ACC $19 along with any fee for treatment/consultation provided on the same day upon completion of the ACC32 form.

Follow-up actions

- Mr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the New Zealand Chiropractic Board, the Ministry of Health, and ACC.

- A copy of this report, with details identifying the parties removed except the expert who advised on this case (Mr McKellow), will be sent to the New Zealand Chiropractors' Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addenda

The chiropractor was referred to the Director of Proceedings. The Director decided not to issue proceedings.

Appendix 1 — Independent advice to Commissioner

The following expert advice was obtained from Mr Bayne McKellow:

"I have been asked to review and comment on the following:

1. *Please comment generally on the standard of care provided by [Mr B] to [Mr A]*.

The standard of care, as evidenced by the provided documentation, fails to meet the required standard expected of a chiropractor.

The recorded clinical information does not meet the minimum requirements of ACC[22] (Providing reports and claimant notes to ACC Clinical records) or the standard expected by the Chiropractic Board Code of Ethics and Standards of Practice (Page 13).

Documentation

[Mr A's] file comprises:

- health questionnaire (page 00012 HDC file)
- physical exam-X-ray report (page 00012 and 00013)
- chief complaint notes (page 00013 HDC file)
- daily chart notes (page 00014 HDC file)

All four components do not provide the necessary information to make an appropriate assessment of [Mr A's] presenting symptoms, or provide sufficient detail to determine appropriate clinical interventions.

Reason for Presenting For Treatment

[Mr A] attended to [Mr B's] office, on referral from his General Practitioner, on 11 June 2007 for treatment of an acute lower back injury (Read Code S572.)

He completed a brief health questionnaire during his first office visit. This identified [Mr A] also experienced cervical pain.

There are no further annotations in the case history regarding nature of pain, severity, duration or aetiology that would establish a causal link of [Mr A's] cervical symptoms to his lower back injury claim.

[22] http://www.acc.co.nz/for-providers/responsibilities-performance/WCMZ002226?ssSourceNodeId=3931&ssSourceSiteId=1494.

Injury and Non Injury Management

It is pertinent to know if the cervical symptoms were part of the injury sustained by [Mr A] on 28 May 2007,[23] as he received onward examination (x-ray) for his cervical and thoracic spine. This was ordered under the ACC injury number — TB75099 as evidenced in the radiological report (page 00016 HDC File).

If the cervical symptoms were related to the injury [Mr A] sustained, [Mr B] should have notified ACC of the additional injury by completing an ACC32 form.

It is not unusual when some patients present with injury for them to also request information or assistance for other injury or conditions that they have sustained or suffer from. When these instances occur, it is important for the chiropractor to clearly determine what component applies to the accident claim and what component is not in/unrelated. This needs to be clearly explained to the patient as it relates not only to management, but also when ACC coverage ceases.

In [Mr A's] case notes there is no evidence of differentiation between the management of injury and non injury components. There appears to have been an attempt to merge the lumbar injury and the cervical symptoms together and offer a combined management protocol.

Early presentation of a long term treatment contract carries the potential to blur differentiation between acute injury management and treatment for non injury conditions.

[Mr A] was presented with an option plan, along with a five page letter, intimating the optimal management plan was a contract suggesting long term care. (Option A — HDC file page 00024). This offers a specific guarantee, but details of that guarantee were not attached.

The Chiropractic Board is specific about offering guarantees in its Code of Ethics (3.1.8)

> 3.1.8 A Chiropractor should give an evaluation, to the patient or a person who has care for the patient, of the patient's condition and expected progress based on the patient case history and assessment. Furthermore, the Chiropractor should only act on up-to-date information and not exaggerate the efficacy of his or her services or give specific guarantees regarding the results to be obtained from Chiropractic.

While merging the lower back injury and the cervical condition [Mr B] appears to have exaggerated the severity of [Mr A's] symptoms by suggesting an option for long term care.

[23] Although Mr A believes that his cervical symptoms were caused by his injury on 28 May 2007, there is no indication that Mr A had discussed his cervical symptoms with his GP during the consultation on 30 May 2007.

The Chiropractic Board is specific about this in its Code of Ethics (3.1.7).

3.1.7 A Chiropractor must not overstate or exaggerate the seriousness of a patient's condition.

I am mindful that [Mr A] presented for acute lower back pain under the ACC scheme. Remedial or maintenance type care should be addressed after the acute injury has resolved and [Mr A] had returned to his pre-injury status.

[Mr A's] treatment notes are silent on a management protocol or plan for handling his injury and/or condition.

Appropriate documentation is an expected competency.

Injury Management in New Zealand

The normal procedure for injury management under Accident Compensation is to assess the injury and if further treatment is necessary, treat the injury. If after a specified period (in the Chiropractic Profession — evidenced by Treatment Profiles further care is deemed necessary, approval is sought from ACC using an ARC32 — Request for Prior Approval of Treatment. This same form is used to report additional injuries to an existing claim for ACC to consider coverage. (Main menu>Treatment Guides>Musculoskeletal>ACC 2324 ACC32).

The case notes [Mr B] has provided, would not in my opinion provide sufficient detail to enable this form to be completed to the required standard for ACC to provide authorisation for additional treatment, or addition of further injury to his existing claim.

[Mr B's] case notes for [Mr A's] injury fail to establish medical necessity.

Managing Acute Lower Back Pain

Acute lower back pain has been reviewed extensively by the Accident Compensation Corporation and there are multidisciplinary guidelines to assist health providers in determining "best practice diagnosis and treatment protocols.[24] They were initially published in 1995 and the current edition was published in October 2004. Chiropractors have received these guidelines from ACC, and they are available from the ACC website.

Guidelines (Treatment Profiles)[25] to assist management of specific injuries are printed for the chiropractic profession. These are consensus documents on "best

[24] New Zealand Acute Low Back Pain Guide — January 1997 edition, revised May 1999. These have been updated and the current version published in October 2004 is available at http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/internet/wcm002131.pdf.

[25] http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providersdocuments/internet/dis_ctrn093423.pdf.

practice" procedures is one of these. The Treatment Profiles were published in 2003.

In accepting [Mr A] as a patient under ACC, [Mr B] was expected to conform to conditions he agreed with ACC when registering as a Treatment Provider.[26]

Eligibility for treatment costs

ACC can only pay you for treatment costs related to personal injury covered by the ACC scheme. The treatment you provide must also:

- be for the purpose of restoring the claimant's health to the maximum extent practicable.
- be necessary and appropriate, match the quality required, be given the appropriate number of times.
- be given at the appropriate time and place.
- normally be provided by your type of treatment provider.
- be provided after ACC has agreed to the treatment (unless it's acute treatment, public health acute services, or your contract states you don't need prior approval.

The appropriate best practice management of acute lower back pain are evidenced from these disciplinary guidelines.[27]

The current clinical model (multidisciplinary) for acute lower back pain is to offer initial passive care (treatment provider initiated), then patient participation in active care (patient initiated) if necessary. This is to assist with self management, and reduce or eliminate ongoing reliance upon a treatment provider. (Practitioner dependency.) Obviously dependency is not in a patient's best interest.

Often a blend of this model occurs. Frequently, after initial treatment, the patient is prescribed home based care (usually exercises) while receiving ongoing care/supervision from a treatment provider/chiropractor. Long term care (contracted or otherwise) without establishing medical necessity, is not considered acceptable clinical practice, or in the patient's best interests.

Pay As You Go V Long Term Contract

[Mr B], by offering long term care, without establishing medical/chiropractic necessity, invites the potential to over service. (Code of Ethics 3.1.6)

[Mr A] avoided this when opting to pay for services as they were received, and terminating care when he recognised his injury was failing to respond under [Mr B's] treatment.

[26] http://www.acc.co.nz/for-providers/responsibilities-performance/index.htm.

[27] http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/internet/wcxm002131_.pdf — pages 6–6.

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.

Pay as you go (fee per office visit) is the default payment method followed by the majority of chiropractors in New Zealand.

It allows for cessation of treatment when medical/chiropractic maximum improvement has been attained. Contracted care has the potential to obscure the point when maximum improvement has been attained.

If not covered above, please answer the following questions and include reasons for your view:

2. *Please comment on the standard of [Mr B's] clinical assessments/examinations of [Mr A] between 11 and 29 June 2007.*

The recorded documentation that evidences the clinical assessment/examinations fails to meet the standard required of a chiropractor.

This standard, published on the Chiropractic Board website [28] is appended.

Summary

There is insufficient documented information to warrant ordering x-ray examination at the initial consultation. Further information in the daily chart notes that would indicate necessity for this examination is also absent.

The degree of variance from accepted practice is dual:

Ordering of an x-ray when not clinically evidenced (Lumbar) — Moderate disapproval. Ordering inappropriate region for x-ray examination and not clinically evidenced (Cervical and Thoracic) — Severe disapproval.

The clinical examination, in the format recorded, lacks the necessary specificity and detail to enable formulation of an appropriate treatment plan.

The degree of variance from accepted practice is — Severe disapproval

Failure to adequately assess cervical risk, by not recording an adequate case history, prior to provocative examination procedure.

Degree of variance from accepted practice — Extremely severe.

X-Ray

[28] http://www.chiropracticboard.org.nz/Site/code_of_ethics.aspx.

[Mr B] has failed to demonstrate justification — one of the three components essential to a Radiation Quality Assurance Plan and part of the NRL 06 requirement for Chiropractic X-rays.

There is a lack of documentation to support referral for further x-rays.

[Mr A] had received previous x-ray examination. While it is recorded that he did not want to access (track them down)[29] and they may have been over 6 months old, there is no entry in the daily clinical notes why [Mr B] considered it necessary to repeat this examination so early in the management of [Mr A's] acute lower back pain

Inappropriate x-ray examination

X-ray examination included the entire spine. There is lack of rationale presented in the initial consultation or daily notes to justify full spine x-ray examination for [Mr A's] referral injury — acute lower back pain.

The physical examination is equally silent on providing supporting clinical information that could justify this decision.

In [Mr A's] case, should x-rays have been deemed necessary, the appropriate requirement was for lumbar spine x-rays, and possibly pelvis. Radiological examination beyond the injury site was not medically necessary and becomes a subsidy by ACC for management of non-injury conditions.

[Mr B] outsourced his x-ray requirements in this instance. Outsourcing does not relieve him of the responsibility of determining the appropriateness of a particular examination. Indeed, there is an increased requirement, when outsourcing, to order appropriately as it is unreasonable to expect the radiologist or radiographer to assess each case from the limited information available on a referral form.

[Mr A's] x-rays do demonstrate degenerative change in the lumbar spine. This finding is not unusual and does not necessarily indicate a causal relationship for acute lower back pain or the necessity for prolonged care without first following the protocols for supportive care.

I am unable to locate any reference in published peer reviewed literature that suggests long term care will change the nature, alter the progress of lumbar disc degeneration, or provide immunity to degenerative change.[30]

[29] Page 00013 HDC file hand written notes at bottom of page.

[30] Page 00021 HDC File — line 1 & 2 — Correction and prevention stops and prevents Spinal degeneration.

Summary — there is insufficient documented information to warrant x-ray examination at the initial consultation. Further information in the daily chart notes that would indicate necessity for this examination is also absent.

Clinical examination

Clinical examination is recorded on page 00012 of the HDC file under physical exam/x-ray report.

The listed tests relate to the cervical, thoracic, and lumbar spine, along with neurological examination. All have been marked with a dash presumably indicating that they were negative. Where required, they are not differentiated left from right. Their recording lacks specificity and appears to be standardised for all patients.

Handwritten notes on the file annotating C1, C2 and other spinal and extremity areas are not differentiated. Clarification of their meaning relies upon reading [Mr B's] letter to the Commissioner. (That the annotations mean tenderness in those regions noted.) There are no further descriptors.

In his letter to the Commissioner on page 00010 [Mr B] further indicates that "there were altered biomechanics" at several areas of the spine, left glenohumeral joint, right knee and both ankles and wrists. Further detail defining the altered biomechanical disadvantages noted during [Mr A's] examination, are absent. Besides not being entered into the clinical examination as such, the diagnosis is vague and of no clinical value.

Summary — the clinical examination, in the format recorded, lacks sufficient specificity and detail to enable formulation of an adequate treatment plan.

(If applicable) What further assessments/investigations should [Mr B] have initiated?

As recorded, the clinical examination for lower back, thoracic and cervical spine was inadequate.

Lower Back Examination

Inclusion of further information in the clinical examination would have facilitated measurable goals and more accurate assessment. This is fundamental to competent examination.

Cervical Spine

Failure to adequately assess cervical risk, by not recording an adequate case history prior to provocative examination procedure. Degree of variance from accepted practice — extremely severe.

Where the cervical spine is assessed, there are recommended protocols for its examination. This is to minimise the risk of accident during examination for serious conditions such as Vertebral Basilar Insufficiency/Vertebral Artery Disease (VBI/VAS) as well as accident during treatment.

These protocols would not be the domain of this report, except for [Mr B] recording examination of the cervical spine (although [Mr A] presented with lower back pain) without documenting an adequate case history. This was important to assess the appropriateness to perform provocative cervical tests. (Maignes — HDC File page 00012 — Physical exam)

A good publication relating to this issue of vertebral ischemia/stroke is the Risk Management III Module offered by the Chiropractic and Osteopathic College of Australasia (COCA).The protocols are not an industry standard and may possibly only be utilised by those who accessed the COCA website and downloaded them.

http://www.coca.com.au/education/riskmanagementlll.asp

I have appended the file (Risk Management III) to this report, (please note that copyright has not been determined.)

Further commentary on the latest research in relation to this rare but significant clinical risk can be accessed at
http://www.coca.com.au/newsletter/2008/mar0801a.htm

A DVD of a lecture by Dr G Glum of Life West Chiropractic College on the subject of stroke and manipulation is included. This DVD was distributed to all New Zealand Chiropractors in 2006 by the New Zealand College of Chiropractic.

A PowerPoint presentation of the above lecture is also included.

3. *Please advise on the appropriateness of the equipment [Mr B] used to treat [Mr A] on 29 June 2007.*

Summary

The use of a PTLMS is within normal practice parameters. [Mr B] documented in the daily chart notes on 25 June 2008, his impression that its use was required.

[Mr B] used a massage type machine on [Mr A] on 29 June 2007.

This machine is called a Pettibon Tendon Ligament Muscle Stimulator (PTLMS).

http://www.pettibonsystem.com/products/Pettibon_Product_Catalog.pdf

It is usually used as a mechanical massager prior to manipulation. Used appropriately it is considered by many chiropractors to be a useful adjunct prior to chiropractic treatment. It is a powered unit with rechargeable batteries. If used

when plugged into the mains power, a residual current device should be employed as a precaution.

[Mr B] states in his letter of 8 April 2008 (HDC File 00010 para 4) that he discussed the necessity to use the device.

Reading [Mr A's] letter of 12 February 2008 (HDC File 00002 paras 4 & 5) he does not appear to have understood the necessity for its application, as explained by [Mr B].

Summary — the use of a PTLMS is within normal practice parameters. [Mr B] documented in the daily chart notes on 25 June 2008, his impression that its use was required.

4. *Please comment on the adequacy of information [Mr B] provided to [Mr A] between 11 and 29 June 2007.*

Summary

The overall impression of the "educational" material given to [Mr A] by [Mr B] suggests it is designed to guide [Mr A] into a standard 'one size fits all' type system of management rather than information to help [Mr A] understand and decide upon the immediate options available for management of his acute lower back pain.

[Mr B] provided the following information:

Written

- [The Clinic] is Here For You (HOC File 00017 to 00021)
- Nerve Function (HDC File 00022)
- Phases of Progressive Spinal Degeneration (HDC File 00023)
- Health Investment Worksheet (HDC File 00024)
- '[The Clinic]' Advanced & Effective Solutions letter (HDC File 00025)

[The Clinic] is Here For You (HDC File 00017 to 00021)

This publication does not provide information that would assist [Mr A] to make an informed choice for managing his lower back.

The document appears promotional in nature, tailored to direct choice towards option A of the Health Investment Worksheet. It does little to inform [Mr A] about his presenting symptoms (acute lower back pain).

Nerve Function

This sheet has the appearance of a remake of a chart that has been in circulation within the chiropractic profession for many years.

First public comment on its educational suitability was in the report of the Commission of Inquiry into Chiropractic (1979).

Overall, the Commission was a positive document for chiropractic, but did identify specific areas of concern. One of these was CHIROPRACTIC PAMPHLETS. Comments about the 'Nerve Chart' made by the Commission are still pertinent today. (Comments of the Commission)

22. Attached to the letter was what was described as a 'Chart of the Nerve System (Your Health Source)' 'There is a diagram of the spine, with each vertebra labelled. Various disorders are identified on the chart as being related to 'pressure on, or interference with' nerves associated with the labelled vertebrae. Hence the reader is able to see from the chart that attention to vertebra 8D will have some connection with his leukaemia or hiccoughs, whereas attention to vertebra 3C may relate to his acne or pimples. Attention to vertebra 11 may relate to his hernia. At the foot of the chart the reader is told that:

Only the commonest conditions and diseases are listed above. It is suggested that you consult your Chiropractor in regard to anything not found on the chart.

23. We must add that according to the evidence of some chiropractors who appeared as witnesses no modern chiropractor could possibly take such a chart seriously. *That does not surprise us. We doubt whether many members of the public would take it seriously, but the danger to credulous people needs no emphasis.*

The spine chart used by [Mr B] is sourced from BackTalk Systems[31].

https://www. backtalksystems.com/index. html

Phases of Progressive Spinal Degeneration

This information sheet portrays 5 x-rays of the cervical spine, outlining three 'phases' of degeneration. Their descriptors may not necessarily be accurate in all cases presenting to a chiropractor's office and would need clarification on a case by case basis.

[31] https://www.backtalksystems.com/index.html.

Investment Worksheet

This worksheet offers "choices" for treatment in [Mr B's] office. It offers specific guarantee which is not detailed further, and as mentioned previously in this report, probably contravenes the Chiropractic Board Code of Ethics. (Code of Ethics (3.1.8))

Informed choice means making choices from realistic proposals. Management of acute lower back pain offers a number of choices. This does not include long term treatment. It is premature to discuss long term treatment at the early stage of acute injury management.

[Mr A] appears to have been given choices, but inappropriate choices for his presenting symptoms.

The current model for managing lower back pain would proffer the following choices for [Mr A]:

- Leave it alone and see if it will resolve over 2–3 weeks
- Manipulation or physical medicine intervention
- Anti-inflammatory (NSAID5) and pain relief
- Combination of NSAIDs and physical medicine/manipulation
- Palliative care such as heat

If [Mr A] required longer term management

- Home based exercise
- Cognitive behavioural therapy where appropriate
- Promotion of self management to reduce practitioner dependency

If [Mr A's] pain became chronic, ACC has pain intervention strategies such as supervised exercise and multidisciplinary programmes.

If he relapsed, supportive care (which has specific protocols) could also be considered as an option.

Visual

[Mr A] was shown a DVD. In his letter (HDC File 00002) he is of the opinion the DVD was inappropriate. He appears to refer to a DVD that was specific to [Mr B] — 'He showed me a DVD that I would say bordered on cultist. *The gist of which was that he knew far more than other practitioners & used a mix of all treatments & therapies to produce a miracle cure'.*

In the conversation notes by [the HDC investigator] (document numbered 00004) paragraph 5 [Mr A] is recorded as saying … *made some strange claims that a person could live up to 120 years if they did not have problems with their back.*

[Mr B] states in his reply to Rae Lamb (HDC File 00011) paragraph 6 'I believe the video [Mr A] viewed was the Chiropractic "report of findings" video from back talk systems. I no longer use that video and do not have a copy to provide you.'

https://www.backtalksystems.com/index.html.

I have reviewed the website of Backtalk Systems Inc. The 'report of findings' DVD is listed and a three minute preview is available. I have viewed this.

I am uncertain whether [Mr A] and [Mr B] are talking about the same DVD. [Mr A] leaves the impression that [Mr B] participated in the video he saw. The BackTalk DVD appears — from the limited 3 minute preview, to be more generic.

[Mr B] initially states that he showed [Mr A] the BackTalk Report of Findings video (HDC File Page 00010 Para 3) but on page 00011 Para 6 is uncertain about the exact video he showed [Mr B]. *...I believe the video [Mr A] viewed was the Chiropractic 'report of findings' video from back talk systems.*

Maybe [Mr A] is not referring to the same DVD that [Mr B] is referencing.

I am unable to comment further on the visual information (DVD) viewed by [Mr A].

5. *Should [Mr B] have contacted [Mr A's] doctor to discuss his plan of treatment?*

Yes. The necessity occurred once [Mr B] ordered referral x-ray examination that exceeded the region of injury.

[Mr B], by suggesting long term contractual care, indicated medical need that exceeded the reason for referral. His obligation was to contact [Mr A's] GP to discuss why [Mr A] required care beyond that reasonably expected for acute lower back pain injury.

Short term care would not necessitate communication unless there was lack of progress, additional concerns or complication arising during treatment.

6. *Was [Mr B's] documentation of an appropriate standard?*

This has been answered previously. [Mr B's] documentation is noteworthy for its brevity. Its degree of variance from an acceptable minimum standard is severe.

7. *Are there any aspects of the care provided by [Mr B] that you consider warrant additional comment?*

[Mr A] attended [Mr B] for 8 office visits over 18 days. [Mr A] abandoned care after he failed to feel any progress, and felt uncomfortable with [Mr B's] treatment procedures. He states (HDC File 00002) that *'only on the first two visits did the entire treatment last longer than 3 minutes. On one occasion it was less than a minute from walking in the room — I actually timed it.'*

Three minutes allows insufficient time for competent assessment, treatment and documentation. [Mr B's] appointment book, for the days [Mr A] attended, would require inspection[32] to determine if the appointments were indeed that brief. If so, it may also account for the brief entries observed in [Mr A's] daily progress notes.

New Zealand Acute Low Back Pain Guide

Pages 6–8. The full guidelines can be viewed at:

http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/internet/wcm002131.pdf.

Or at the associated file wcm002131.pdf.

These guidelines recommend the following approach:

At the initial assessment the critical role for health providers is to screen for Red Flags. These may indicate serious disease (not always confined to the back) that can cause back pain. If Red Flags are present, referral for specialist management should be considered.

Patient assessment

The health provider must take a careful and thorough history to identify:

- The history of the acute episode
- Activities that may be associated with pain
- Any Red Flags — The risk factors for serious disease (see page 8) How limiting the symptoms are
- If there have been similar episodes before
- Any factors that might limit recovery and an early return to usual activities, including paid work (this includes assessing possible Yellow Flags)
- The level of activity required to resume usual activities — (this includes taking a history of the demands of the patient's work, recreation and daily living activities).

[32] During the investigation, Mr B was asked to provide copies of his appointment diary but he claimed that he had not retained this information.

The clinical examination should identify any relevant abnormal neurological signs and assess the degree of functional limitation caused by the pain.

The history may indicate the need for a more extensive general clinical examination, particularly if Red Flags for serious or systemic disease (such as cancer) are suspected.

Investigations

Investigations in the first 4–6 weeks do not provide clinical benefit unless there are Red Flags present. Radiological investigations (X-rays and CT scans) carry the risk of potential harm from radiation-related effects and should be avoided if not required for diagnosis or management. Red Flag pathology may lie outside the lumbar region and so may not be detected with radiology.

Red Flags

Features of Cauda Equina Syndrome include some or all of: urinary retention, faecal incontinence, widespread neurological symptoms and signs in the lower limb, including gait abnormality, saddle area numbness and a lax anal sphincter.

Cauda Equina Syndrome is a medical emergency and requires urgent hospital referral.

Other Red Flags include:

Significant trauma

Weight loss

History of cancer

Fever

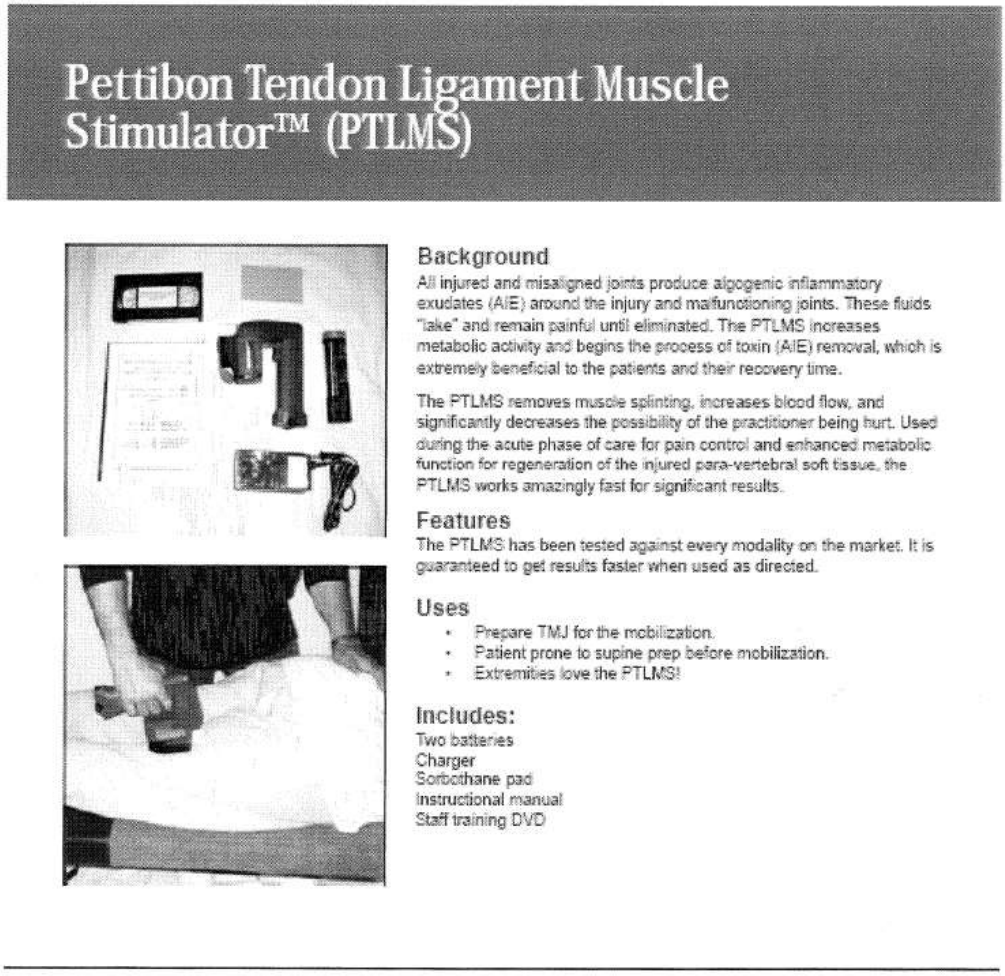
Intravenous drug use

Steroid use

Patient over 50 years

Severe, unremitting night-time pain

Pain that gets worse when lying down



Pettibon Tendon Ligament Muscle Stimulator™ (PTLMS)

Background

All injured and misaligned joints produce algogenic inflammatory exudates (AIE) around the injury and malfunctioning joints. These fluids "lake" and remain painful until eliminated. The PTLMS increases metabolic activity and begins the process of toxin (AIE) removal, which is extremely beneficial to the patients and their recovery time.

The PTLMS removes muscle splinting, increases blood flow, and significantly decreases the possibility of the practitioner being hurt. Used during the acute phase of care for pain control and enhanced metabolic function for regeneration of the injured para-vertebral soft tissue, the PTLMS works amazingly fast for significant results.

Features

The PTLMS has been tested against every modality on the market. It is guaranteed to get results faster when used as directed.

Uses

- Prepare TMJ for the mobilization.
- Patient prone to supine prep before mobilization.
- Extremities love the PTLMS!

Includes:

Two batteries
Charger
Sorbothane pad
Instructional manual
Staff training DVD

Providing reports and claimant notes to ACC

Clinical records/claimant notes

Please make sure you keep full and accurate claimant notes. Their quality may be very important for claimants whose ACC cover is contested or if ACC audits your practice. We do not pay for treatment if clinical records do not demonstrate the appropriateness of care.

Each profession has its own standards for good clinical notes but the information should include:

- diagnosis
- care plan
- progress towards outcome

Your notes should:

- clearly demonstrate that you conducted each consultation with appropriate levels of skill and care
- record the main reason for the claimant's visit (when the consultation involves more than one condition). If the main reason is a non-ACC covered injury or medical condition, you should not charge us for a casual enquiry about a past injury
- be legible
- be written at the time of the consultation or shortly afterwards
- have any later notes appropriately dated and signed off

For injuries, please note:

- details of the accident
- how the injury happened (including its mechanism if appropriate) symptoms
- the injury's clinical significance any previous history of relevant problems
- clinical examination findings
- a diagnosis and treatment plan.

Your follow-up consultation should include assessing the results of the previous treatment.

We often assess clinical records to make sure that:

- there is a clinical record for each treatment claimed
- the clinical record meets professional standards of documentation
- an appropriate clinical reason has been documented to justify visit and ongoing treatment
- the treatment given is in line with current acceptable treatment numbers, frequency and quality.

Sprain Lumbar Spine

Read Code: S572.

Number of treatments: 14

Triggers: 18

Key Points

- Psychosocial factors may influence recovery
- There is usually no pain below the knee
- Refer to sciatic protocols if there is pain below the knee
- A good case history is important
- **Special considerations**
- Any previous episodes of LBP
- The patient's age Regional pain syndrome
- Keeping mobile helps in recovery
- Manipulation is contraindicated if there is joint effusion or active joint infla

History

- Identify any Red/Yellow Flags and Blue/Black Flags where possible:
- Black Flags require possible OSH review
- Blue Flags should be considered throughout any treatment
- Work or sport injury
- Contributing factors can be leg length inequality, muscle imbalance or excessive foot probation
- Better/Worse and provoking factors
- Pain type and distribution
- Previous history and management
- Current management, including investigations
- Any change to activity and ADLs
- Significant trauma
- Use an outcomes measurement where appropriate
- Determine the progress goals
- History may include immediate and transitory pain, followed by pain-free intervals
- The condition usually presents with stiffness, decreased mobility and muscle spasm, with variable pain increasing on muscle resistance
- The patient may have difficult arising from supine or seated positions.

➢ RED FLAG

For potentially serious conditions:

➢ Features of C**au**da Equina syndro (especially urinary retention, l neurological symptoms and signs, anaesthesia) — **this requires**

very urgent referral

- ➢ Significant trauma
- ➢ Weight loss
- ➢ History of cancer
- ➢ Fever
- ➢ Intravenous drug use
- ➢ Steroid use
- ➢ Patient aged over 50 years
- ➢ Severe, unremitting night pai
- ➢ Pain that gets worse when pa lying down

❖ **YELLOW FLAG:**

Psychosocial factors that increase the developing or perpetuating long disability and work loss associated w back pain:

- ❖ Attitudes and beliefs about b pain
- ❖ Behaviours
- ❖ Compensation issues
- ❖ Diagnostic and treatment issues
- ❖ Emotions
- ❖ Family
- ❖ Work

Examinations

- Exclude neurological complications
- Posture – antalgia
- Gait
- Palpation – spasm, tenderness and joint fixation
- ROM and pain response in active and passive modes
- Test to appraise IVD, mechanical LBP, sprain, SI lesion, myofascitis, sciatica, Red Flags including fracture
- Lower extremity pulses
- Most orthopaedic tests are benign
- The patient may have reversal of lordosis owing to multifidis spasm

Differential diagnosis

- Nerve rot pain/radiation
- Red Flags
- Cauda Equina syndrome – requires immediate referral
- Exacerbation of chronic LBP
- Facet syndrome with pain referred to groin
- Myofascial pain syndrome
- Inflammatory diseases, eg AS
- Contributing structural factors – spondylolisthesis, pseudoarthroses, facet trophism etc Muscle tears in hamstring
- Hip
- Lumbar instability
- Metastatoc lesions Facet trophism

Investigations

- If pain remains after I month, consider further investigation X-ray
- If X-raying within the first 4 weeks, document the rationale
- If Red Flags are present, refer for further investigation (CBC, ESRICRP)

Complications

- Secondary gain
- Stenosis
- Neurological involvement
- Chronic LBP or history of repetitive injury
- Underlying pathology
- Work/home environment, including stress

Treatment/Rehabilitation/Management

Acute:

- Encourage and advise the patient to remain mobile

- Explain the nature of lower back sprain to reassure and allay fears of
- incapacity
- Pain management
- Manipulation
- Mobilisation
- Exercises to tolerance
- Short-term SIJ or lumbar support
- ADL advice
- Home care advice

Sub-acute:

- Pain management
- Ergonomic advice for when at home/work, lifting, sitting, sleeping etc
- Continue advice on maintaining mobility and modified AI)Ls
- Exercises for centralisation, strength, stabilisation and mobility
- Encourage self management
- Approximate healing periods are:

– mild sprain — 1-4 weeks

– moderate sprain — 1-12 months

- Severe strains or sprains may require surgical intervention

Referral

- Refer to GP for:

– TOW

– **Cauda Equina syndrome**

– **spinal pathology**

– **nerve root pain that has failed to improve after 4 weeks**

– **home help if necessary (you may also need to involve the patient's ACC case manager)**

– **if Yellow Flags dominate or affect return to work, requiring a psychologist or vocational management**

- **Refer to occupational therapist for 05Ff review**
- Refer to physiotherapist for TENS, other forms of electrical stimulation, lumbar traction, acupuncture
- Refer to X-ray if not available on-site
- Liaise with the patient's employer

Back Talk — Report of Findings video

Your Report of Findings VHS/DVD

Bring your practice into the 21st Century

By using a state-of-the-art patient education

Video that's short, to the point, and

Communicates the most contemporary model

Of chiropractic.

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Appendix 2

CONFIDENTIAL HEALTH QUESTIONNAIRE

ame (please print)

ss

d Birth

Age 72

Female Married

ber of Children 1

ication Unemployed

rred by DF

sultation date 11/8/07

at is your main symptoms/pain?

Please tick as applicable

- Backache
- Pain between shoulder
- Spinal curvature
- Stiff neck/shoulder
- Headaches
- Neuralgia/Numbness
- Other – include any previous/current medical problem

- Asthma/Hay Fever/Sinus
- Allergies
- Nausea/Dizziness
- Tumours
- Weight loss
- Bowel/Bladder

Name of Medical Practitioner

SURGERY? Yes ☐ No ☑

If yes, please give kind and date

ARE YOU TAKING ANY MEDICATION?

Yes ☑ No ☐

If so what Arthritis – 6 months

WHAT PREVIOUS TREATMENT HAVE YOU RECEIVED?

PHYSIO, CHIRO

HOW LONG HAS IT BEEN SINCE YOU HAVE HAD:

Complete physical exam. 6 MONTHS

Heart exam. "

Blood Pressure check 3 MONTHS

Chiropractic X-Rays 6 MONTHS

Signed

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Physical Exam – X-RAY REPORT

NAME _____ PHONE.HM _____

ADDRESS _____ WK _____

_____ DATE _____

OCCUPATION _____ AGE _____ MALE/~~FEMALE~~

CHIEF COMPLAINT:

			Sharp	Ache	Lt	Rt
NP	☑		☐	☐	☐	☐
MBP	☑		☐	☐	☐	☐
LBP	☑		☐	☐	☐	☐
H	Lt ☐	Rt ☐				
W	Lt ☐	Rt ☐				
K	Lt ☐	Rt ☐				
A	Lt ☐	Rt ☐				

Fatigue ☒

Bilat Trap Ache ☒

Tight Between Shoulders ☐

Res. le part of (d) symptom care 2xwk 7 wks 1/wk work up as feeling better

DATE			Phase I II III — SUBSEQUENT VISITS AND FINDINGS (L4, L5 large space ... rt sciatica)	Spineshape & Stability	ACE	ACCOUNT RECORD		
Day	Mo	Yr				Charge	Paid	Balance
11	6	07	Exam. Sent for X Rays, Pictures taken			66	56	[illegible]
11	6	07	ROF A, d, X ~~[illegible]~~			~~Pd~~		
			Lt PI drop, Rt AS drop, L5 ant drop T12, T11, C5, C6.			Pd	—	—
13	6	07	L2 P-A drop, L2 drop, Rt illiosois,			32	32	0
15	6	07	Rt PI, LBA, switch to SP, Rt illiosois, L5 Ant drop,			32	32	0
18	6	07	Rt PI, L2 BP, LAS, Rt illiosois			32	32	0
22	6	07	Rt PI, LAS, Rt illiosois, L5 Ant			32	32	0
25	6	07	SA too much scar tissue needs PTL45			32	32	0
29	6	07	SA, PTL MS LB			32	32	0
			Sympt care letter posted 9/7/7					

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Appendix 3

Welcome, this very important letter will help you to understand what we are about, how your body works, what has happened to it, and what can be done to fix it.

Mission: is here with a very special purpose. We are here to improve the Health, Vitality and longevity for as many people as possible.

We provide truthful, integrity based free information on the most effective treatment course for an individuals health problems.

The Nature of Health: Your body is designed to live in great health by the very nature of the way it was designed. You see, the nervous system controls every cell of your body; it's how you and your body communicate. Nerve impulses flow from the brain, down the spinal cord, out of the spine to every tissue, organ, muscle and skin area of your body. Impulses sent back to the brain confirm that the body is working as it should.

This is how life is maintained, with thousands of these **"Vital"** feedback cycles and corrections happening every second. This is called

Life Causes Injuries to your body:

(Bone)
(Picture)

Many things can cause the moving bones of the spine to lose their normal motion or position. This can irritate the sensitive nerve roots that branch off the spinal cord to provide life to the organs and tissues of your body. This changes the communication between the brain and the body affecting "Homeostasis". This happens where the nerve exits the spinal column between the spinal joints, this is where the nervous system is very susceptible to injury.

What Happens & Why Our Bodies Deteriorate:

Most of the time when the spinal joints lock or lose their normal motion you don't feel the alteration in biomechanics and often have no pain from it. If you do feel anything, it may just be a little ache that goes away after a couple of days. This is because the nervous system fatigues and has decreased its function level.

The most common reason people don't live at their potential for Health, Vitality and Longevity is because; it is easy to inaccurately think that when there is no pain that there is no problem. This mind set leads to a health care approach called Symptom care. **Symptom care does not stop, nor does it prevent spinal degeneration.** Joints left without proper motion deteriorate faster and shut down your body early. This early deterioration from a symptom care mind set is the reason for the multiple health problems that are common as we age. Most health care is geared for symptom care and because of this people have more and more health problems the older they get.

This degeneration process you have going on in your body is developing from and into a type of arthritis called osteoarthritis. (See chart for the stage of development you are currently at.)

96% of all arthritis is osteoarthritis. Billions of people in the world suffer needlessly as this **preventable** arthritis slowly shuts down their body and life. **Osteoarthritis in the spine slowly shuts down the "Vital" flow of information between the brain and the body, decreasing homeostasis.**

effective until surgery is the only option. While surgery has it place, it is a last resort with consequences that even surgeons like to avoid. Surgery becomes the best option when there are no other choices. The worse the damage is, the fewer choices you have. Like symptom care it does not stop the deterioration process and often becomes one of many surgeries as your body continues to deteriorate.

Stopping the pain, healing and recovery:
The treatment is usually painless and its healing ability normally starts immediately. It is usual to feel worse at first as the body heals. The aches and soreness after the first treatment are from the joints coming alive and the discs getting pumped full of nutrients. This releases the toxins they have been unable to get rid of for months and often years the joints have been locked and deteriorating. This achy ness is usually only after the first treatment. This will start clearing along with the pain, which may have brought you to our office for help. Most people are feeling 80% better within 2-4 weeks depending on the severity of the pain and the stability of your spine. The soft tissue damage takes 8 weeks once the cause of the damage is removed. Nerve damage may take 3-6 months to heal depending on the severity of the damage, even though you usually feel better much sooner.

Whether you stop your treatment when you are out of pain (symptom care) or go on to do correction and prevention the treatment starts the same, to get you out of pain as soon as possible. With symptom care you determine your treatment based on how you feel. Let us know if this is what you want to do, we will write it on your card and just wait for you to call us once you are out of pain. We have people that choose this and we respect their choice since they now have been informed of the long term consequences of this type of approach. We will do the very best possible care and is usually the most effective symptom care possible. If another form of treatment will relieve your symptom faster we will refer you to that person or treatment. We are here for you, respect your choice and enjoy helping you when we can.

Living At Your Best = Correction and Prevention: This is where you go through life not knowing the health problems you otherwise would have had. Correction and prevention will stabilize your spine to the strongest and most stable configuration possible. Preventative health care is the best health care possible. Correction and prevention is the only way to stop and prevent osteoarthritis, so you can live at your potential for Health, Vitality and Longevity.

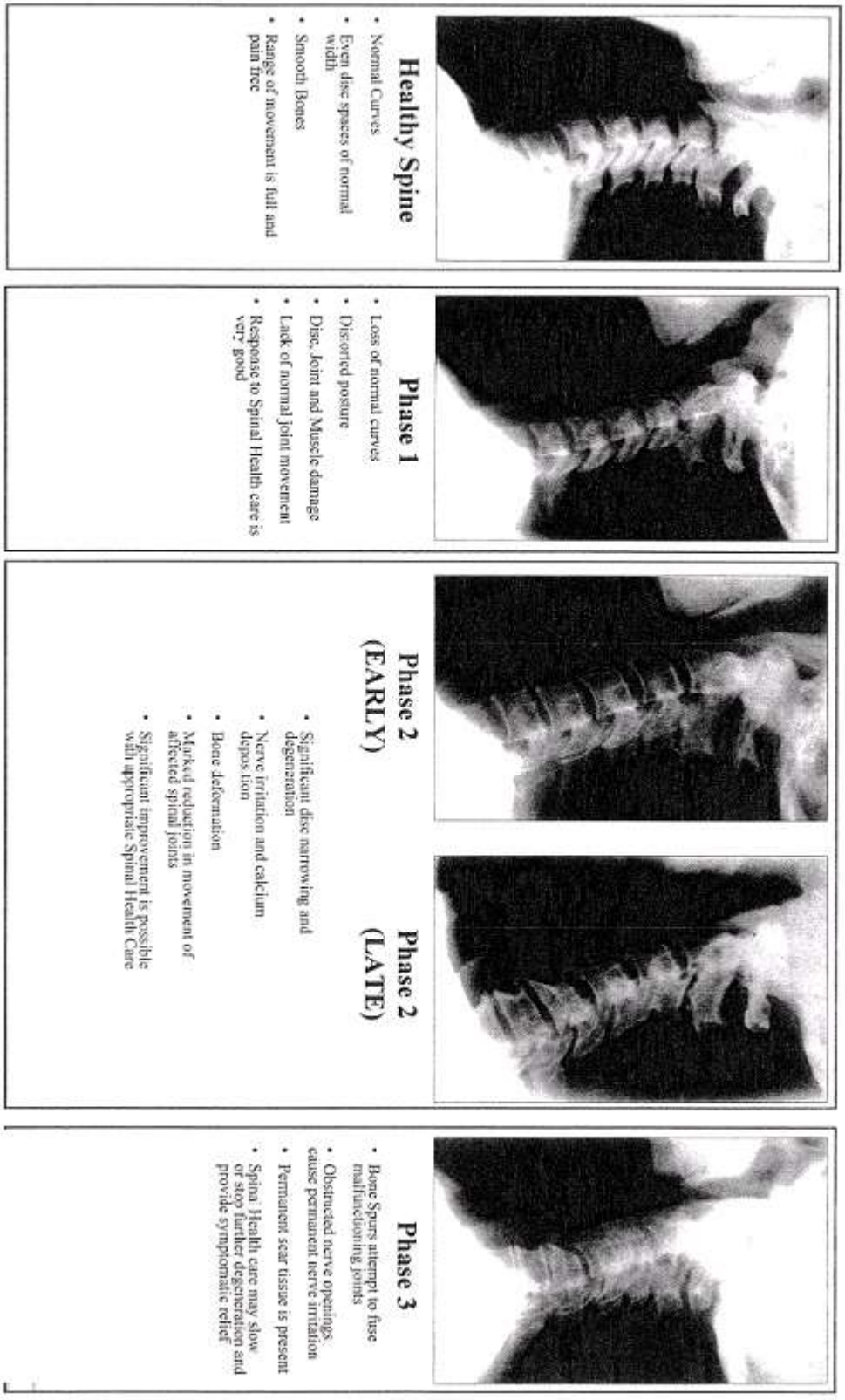
Different from symptom care: Correction and prevention stops and prevents Spinal degeneration by increasing nutrients and oxygen to the spinal vertebral discs and maintaining proper nutrient absorption. This prevents spinal degeneration because the vertebral disc (the spacer for the nerve opening) stays alive by getting food and oxygen from the surrounding tissue.

This "vital" disc absorbs its oxygen and food through maintaining proper motion. The disc cannot survive on the nutrients it is limited to, anytime it is left without proper motion. This occurs regardless if you feel pain from it or not. This is why correction and prevention is based on your condition and not on how you are feeling. To succeed in stopping and preventing degeneration it is important for you understand this. You must be consistent with your correction and prevention and stop chasing after the whims of how you feel. In doing this you will not only feel your best, you will live at your potential for Health, Vitality and Longevity. You will have your best possible quality of life, and maintain the ability to function at the highest possible level as you age.

(Spinal Osteoarthritis and degeneration is: thinning of the disc, the opening becoming smaller with sharp bony spurs that grow into the opening choking off and shutting down the nerves.) **Thus, preventing osteoarthritis ensures the nervous system and homeostasis is maintained at a high function level, the individual maintains a high function level, and the highest possible quality of life results with increased health, vitality and longevity through the years.**

A Word on Costs: Studies show that preventative health care is not only the best from of health care; it is also the least expensive by a 10 to 1 ratio. For every dollar you spend on correction and prevention, it would have cost you 10 times more on crisis care through the years following a symptom care approach. Correction and prevention is an investment that saves you money by being the most cost effective approach. Living longer, going through life knowing less health problems, keeping the ability to move, live and play, as well as maintaining independence much longer in your life are benefits so great that they are immeasurable.

What ever you decide we will do our best for you. If you have questions please ask. We are here for you.



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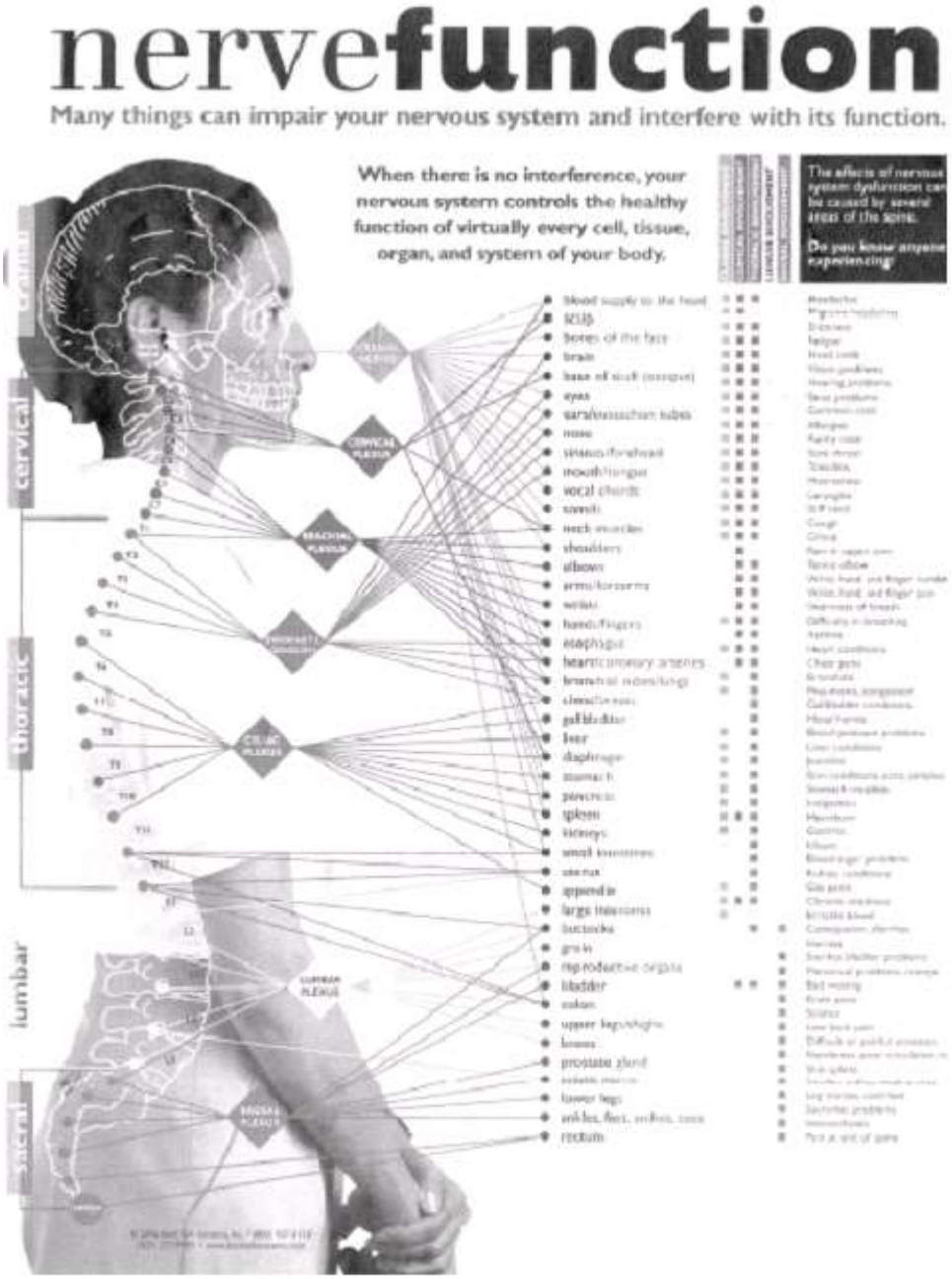

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Appendix 4

New Zealand Chiropractic Board

To: **Registered Chiropractors**

From: **Chiropractic Board**

Date **June 2007**

Subject **Advice notice**

Introduction

A decision of the High Court dated 27 July 2006 in the matter of D Blackbourn vs. The Chiropractic Board has significance for all practicing chiropractors. The full decision of the High Court can be found of the Chiropractic Board's website www.chiropracticboard.org.nz (complaints/hearings).

The Board received a series of complaints from a patient of the defendant. In summary, these complaints can be outlined as follows:

1. The patient was required to pay an up-front lump sum payment of $3000.00 for twelve months chiropractic care where a predetermined treatment programme of that nature was not warranted generally and or in terms of the patient's presentation.
2. A reasonable system or policy for refund was not in place in circumstances where all of the treatment was not given or required.
3. A refund did not occur in a timely manner.
4. Informed consent regarding options for chiropractic care and payment was not given adequately.
5. There was a failure to keep adequate notes; in particular the recording of subjective and objective findings and there was a failure to follow-up courses of action and recommendations.
6. The patient was required to claim ACC payments directly rather than the chiropractor making the claim on the patient's behalf
7. The patient was not advised that they would be required to make ACC claims directly.

As a result of these complaints, a Board disciplinary hearing was held and Dr D. Blackbourn was found guilty of professional misconduct and ordered to pay a fine and a share of costs. A finding of 'professional misconduct' is a significant deviation from accepted behaviour.

The decision of the Board was appealed. The High Court found in favour of the Board and awarded further costs.

It is noteworthy that courts in Victoria and South Australia have made similar decisions in similar cases. The significance of this is that precedents have now been set for what can be considered reasonable practice behaviour of chiropractors in these matters.

Implications for chiropractors

Practitioners who choose to practice outside this advice and the regulations within the Standards of Practice and Code of Ethics, Scope of Practice and relevant legislation will find it very difficult to withstand the scrutiny of a competence review or Professional Conduct Committee.

Julian White
Chairman

1. A requirement that practitioners who recommend a patient pay an up-front lump sum payment for a predetermined length of care demonstrate acceptable clinical justification for this. This includes the type of care provided, any x-rays or subsequent x-rays taken and methods for gauging patient progress. The patient's clinical records must clearly outline the reasoning behind the decisions made. There must be clear evidence of decision-making applied to each individual patient. A 'one-size-fits-all' approach to patient management is unacceptable.

2. A requirement for a clearly outlined refund policy to accommodate an interruption to the initial recommendation. Patients must be made fully aware of this prior to accepting a programme of care. At no stage will the patient be liable to pay more than the initial amount. Any refund must be made promptly upon request and shall not include administrative or bank charges.

3. The requirement for a clear process of informed consent. This should cover options regarding fees and chiropractic care. Patients must be advised that it is not usual practice for chiropractors to recommend extended periods (eg. twelve months) of care with pre-payment so that the patient can reasonably choose an alternative provider. It is not sufficient to offer the patient payment options for an extended programme without indicating that there are other options for care. For example acute care only. The practitioner must be able to clearly demonstrate that the patient has been made fully aware of these matters in a manner that is easily understood.

4. The requirement for chiropractors to maintain adequate patient records as set out in the Board's *Standards of Practice and Code of Ethics* a copy of which is available on the Board's website. These must be adhered to under all circumstances. There is no distinction between 'acute' care, 'wellness' care, 'maintenance' care, 'corrective' care or any other type of care. Every patient interaction must conform to the published standards.

The Board advises practitioners to 'bulk bill' ACC for all fees and request a co-payment from the patient where applicable. Please note that ACC covers care only for a clearly defined injury based upon the clinical judgement of the practitioner. ACC does not cover 'corrective' care or care beyond where the immediacy of the injury has been managed. Treatment Profile recommendations for injury code visit numbers are not automatic. For example, a patient suffering from a lower back sprain (s572.) treatment profile recommended 16 visits does not mean that all patients with this injury are automatically entitled to 16 visits. Clinical judgement must be utilised to discern the appropriate care for each patient.