Chiropractor, Mr B

Chiropractic Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC02228)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report discusses the care provided to a man by a chiropractor, when he attended a chiropractic clinic (the clinic) three times for treatment of hip pain in 2019.

2. The report highlights the importance of providing sufficient information to a patient about a procedure, so that the patient can give fully informed consent. It also highlights the importance of documentation.

Findings

3. The Deputy Commissioner found shortfalls in the care provided by the chiropractor, in particular the lack of information given prior to performing a lumbar spine manipulation and a cervical spine manipulation. The Deputy Commissioner considered that the man was unable to give fully informed consent to the procedures, and noted that to give informed consent, a patient must have all the information a reasonable consumer would expect in the circumstances, including the associated risks, possible side effects, and options available.

4. The Deputy Commissioner found that by failing to provide sufficient information, the chiropractor breached Right 6(2) of the Code. The lack of information meant that the man was unable to give his informed consent to the procedures and, accordingly, the Deputy Commissioner found that the chiropractor breached Right 7(1) of the Code. The Deputy Commissioner was also critical of the lack of safety-netting advice given.

5. The Deputy Commissioner considered that the chiropractor's record-keeping did not comply with professional standards, noting that only minimal patient history and visit history notations were recorded. As such, she found the chiropractor in breach of Right 4(2) of the Code.

6. Adverse comment was made about the clinic's lack of policies and procedures in place at the time of events.

Recommendations

7. The Deputy Commissioner recommended that the chiropractor apologise to the man for the failings identified; provide evidence of having attended an informed consent course and a documentation course; refamiliarise himself with the New Zealand Chiropractic Board's professional standards and code of ethics; undertake further training on the clinical issues raised in this case; and notify HDC when he has completed the diploma of orthopaedics for chiropractors that he commenced following these events.

8. The Deputy Commissioner recommended that the clinic arrange for a chiropractor recommended by the Chiropractic Board to review its cervical spine treatment policy and procedures and adverse event policy and procedures, and report back to the Chiropractic Board on whether the policies comply with accepted standards.

9. The Deputy Commissioner recommended that the Chiropractic Board consider undertaking a competence review of the chiropractor and asking him to arrange a mentor to review his

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informed consent processes and demonstrate to the Board that he is meeting accepted standards for management of neck pain.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him by Mr B at the clinic. The following issues were identified for investigation:

- *Whether Mr B provided Mr A with an appropriate standard of care from July 2019 to September 2019.*
- *Whether the clinic provided Mr A with an appropriate standard of care from July 2019 to September 2019.*

11. This report is the opinion of Deputy Commissioner Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner. The report is further to a provisional opinion from previous Deputy Commissioner Kevin Allan.

12. The parties directly involved in the investigation were

Mr A	Consumer
Mrs A	Consumer's wife
Mr B	Provider/chiropractor
Dr C	Provider/general practitioner (GP)
Dr D	Provider/neurologist

13. Further information was received from ACC.

14. Independent expert advice was obtained from chiropractor Tanja Glucina (Appendix A).

Information gathered during investigation

Introduction

15. This opinion relates to the services provided by chiropractor Mr B to Mr A in 2019. At the time of these events, Mr A was in his forties.

16. Mr B told HDC that he is a member of the Primary Spine Provider Network. He said that the clinic is a neuro-musculoskeletal practice focused on spine-related pain, and it utilises rehabilitation and performance training programmes to enhance the patient's quality of life.

17. Mr B stated that he is a sole practitioner and is the owner of the business. He is the sole director and majority shareholder of the clinic.

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18. Mr B was unable to provide any policies or procedures in force at the time of these events, but he provided the clinic's adverse event policy and procedure written in November 2019. He also said that the clinic has since put in place an informed consent policy and cervical spine treatment policy and procedures.

Cervical dystonia

19. Mr A has developed a rare neurological disorder called cervical dystonia, also known as spasmodic torticollis.[1] He believes the condition was caused by the treatment provided to him by Mr B.

20. Cervical dystonia is characterised by involuntary muscle contractions in the neck that cause abnormal movements and postures of the neck and head. The symptoms of cervical dystonia may begin slowly, and can involve any of the muscles of the neck. The severity of cervical dystonia can vary, but the disorder can cause significant pain, discomfort, and difficulty owing to the abnormal postures. The cause of cervical dystonia is unknown, although a genetic susceptibility is thought to underlie some cases.

First visit to Mr B 26 July 2019

21. Mr A stated that his first visit to Mr B was on 26 July 2019 for the treatment of hip pain. He said that at that time he was not experiencing neck pain, and he had no prior history of pain or injury to his neck. Mr A completed a form containing personal details indicating that his hip pain intensity was distressing and interfered with his concentration, with a pain level of 5/10. The Keele STarT Back Screening Tool[2] completed at this visit had "Disagree" selected for "I have had pain in the shoulder or neck at some time in the last 2 weeks", and the pain drawing indicated pain only in the hip/lower back.

22. Mr B stated that he discussed the risks of lumbar spine[3] manipulations and told Mr A that these risks were "very low". Mr B said that he included "stroke risks", and that he was "positive and reassuring". The clinical record for this appointment does not mention that any other risks relating to the lumbar spine were discussed, and there is no mention of risks of manipulating the cervical spine.[4]

23. Mr B's records for the visit are brief and include a number of acronyms and abbreviations. He told HDC that he performed orthopaedic examinations that included straight leg raise (SLR)/well leg raise (WLR) with dorsiflexion/with toe point, Laslett Cluster (hip thrust, spring test, compression, distraction) Posterior hip thrust, and "Compression and distraction of ilium to sacrum and sacrum spring test, reflexes of Patellar and Archilles". He agreed that there were probably aspects of the treatment that he did not write down.

[1] Torticollis is a problem involving the muscles of the neck, and it causes the head to tilt down.

[2] A screening tool used to assess patients with lower back pain.

[3] The lumbar region of the spine, more commonly known as the lower back, consists of five vertebrae labelled L1 through to L5. The lumbar region is situated between the thoracic (chest) region of the spine and the sacrum.

[4] The cervical spine, also known as the neck, is comprised of seven vertebral bodies (C1–C7) that make up the uppermost part of the spine. These vertebrae connect the spine to the skull.

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24. Mr B recorded: "adj [adjust] L5 R [right]".[5] There is no indication in Mr A's clinical records that Mr B manipulated Mr A's neck at this appointment.

Second visit to Mr B 14 August 2019

25. The clinical records for the visit on 14 August 2019 state that Mr A was feeling better and that he had driven a long distance to attend his daughter's birthday. The records state that Mr A was late for the appointment because he had attended an optometrist appointment as he was having trouble focusing his eyes and was considering getting "prisms"[6] in his spectacles. The notes include the statement: "Can you click my neck?" The notes record that Mr A had undergone physiotherapy for two years for neck and back pain, but he was not any better, and that he had trouble turning his head to the right, which had almost caused an accident at an intersection because he did not see a car coming, and he also had trouble driving at night, particularly with corners to the right.

26. Mr A told HDC that these records are incorrect, as the road trip was actually for his wife's birthday, which was on a different date. Mr A said that he was not having difficulty driving at the time of the appointment on 14 August 2019. He said that the difficulty with driving arose after the third appointment.

27. Mr A also stated that on 14 August 2019 he went with his wife to the optometrist with regard to *her* spectacles, not his, and he does not know what prisms are. He said that he does not recall discussing physiotherapy, and he had never had any treatment of his neck, other than that provided by Mr B.

28. The clinical records for the 14 August appointment set out the examinations undertaken, and state that the findings were discussed, including what the tests were for. The records noted that if the changes with Mr A's eye movements did not improve with exercises, Mr B would suggest that something was wrong with Mr A's neck. Mr A was advised to buy the Focus Builder app to help with his eye movements. The records state that Mr B adjusted Mr A's lumbar/sacral area, thoracic area, and lower C6/7.[7]

29. Mr B told HDC: "[Mr A] came into the room and during the introduction asked if I would click his neck?" Mr B said that he asked Mr A why, and Mr A mentioned physiotherapy and neck pain symptoms. Mr B stated that based on his assessment, he thought that the best option for treatment with the lowest risk was to adjust Mr A's lower cervical levels C6/7. Mr B stated: "[Mrs A] may have been present at the second visit as she was moving back and forth between treatment room and children." He later said that when Mr A asked to have his neck clicked, "[Mrs A] was standing beside [Mr A] at the time".

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[5] The L5 vertebra is located in the spinal column of the lumbar (lower back) region inferior to the L4 vertebra and superior to the sacrum.

[6] Prism correction is used in eyeglasses for some people with diplopia, or double vision. The prism is intended to align the two images, so that only one image is seen.

[7] The C6–C7 spinal motion segment bears the primary load from the weight of the head, and provides support to the lower part of the neck. The lower end of this motion segment articulates with the first vertebra of the thoracic spine (T1).

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30. Mr A told ACC that he did not request neck manipulation as, up until this point, the pain had been in his pelvic/lower back area. Mr A told HDC that he mentioned to Mr B at this appointment that he had neck pain with relation to tiredness when he spent a long period at his computer, and Mr B said that he would "adjust" Mr A's neck. Mr A stated: "[I]t wasn't explained to me in any detail what this would involve."

31. Mr B said that typically he asks whether the person has had their neck adjusted previously, and the risks discussion focuses on the risk of stroke. He stated: "This I did on the initial visit and it is the key point of my consent form. I usually inform the patient that they may experience pain or discomfort and to contact me." The "Terms of Acceptance and Consent to Treatment" form states:

> "Chiropractors, Medical doctors, and Physical therapists using manual therapy treatments for patients with neck problems such as yours are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause stroke, sometimes with serious neurological injury. The chances of this happening are extremely remote, approximately 1 per 1 million treatments."

32. In another statement to HDC, Mr B said that after he had stood and turned to go out of the room to the reception area, Mr A asked about his neck. Mr B said that he replied: "[W]e can look and see what is happening." Mr B stated that he interpreted Mr A's comment as meaning that he wanted him to assess and manipulate his cervical spine "as he had done previously". As stated above, there is no evidence that Mr B had manipulated Mr A's cervical spine previously.

Mrs A's account

33. Mr A's wife, Mrs A, told HDC that she accompanied her husband to his three chiropractic treatment sessions. She said that initially Mr A visited Mr B because of a hip issue, and did not raise neck issues with him.

34. Mrs A said that she and their children also received manipulation and treatment from Mr B. She stated that Mr B did not manipulate Mr A's neck at the first consultation, and she cannot recall whether the neck manipulation occurred during the second or the third consultation.

35. Mrs A told HDC that Mr B did not provide any explanation or ask for permission to undertake neck manipulation, and he did not ask Mr A for his consent. Mrs A said that at the appointment when Mr B manipulated Mr A's neck, they were accompanied by their children. She stated that she was present when Mr B manipulated Mr A's neck initially, and that following Mr A's neck manipulation, the rest of the family was asked to go to another room, and Mr B and Mr A remained in the treatment room for around an hour.

Third visit to Mr B 4 September 2019

36. Mr B told HDC that he cannot recall whether at the third visit he asked Mr A whether he would like his neck adjusted, or whether Mr A asked him to do so.

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37. The clinical records state that at the visit on 4 September 2019, Mr A was "feeling OK but neck is strange was checking text & [phone] hold down to left!!". Mr B recorded that he asked Mr A why he was holding his phone like that, and he replied that otherwise he could not see, and that this had started about a week ago and may have worsened since the last visit.

38. Mr A said that he does not recall any difficulty operating his telephone on this date.

39. Mr B stated that he did more testing and training, as the tests also double as exercises. He said that Mr A told him that he would be seated for eight to ten hours per day, with a centrally placed screen and two screens placed to the left of each other. Mr B told Mr A in a letter, which was provided to HDC:

> "I had a gut feeling that something unusual was at play, and considering the prisms, difficulty with head movement to the right, holding your mobile the way you did I was thinking of Cranial 4 Nerve Palsy, Supra Nuclear Palsy or a disruption of your perception of Subjective Visual Vertical. That is why I wanted the following appointment the next week."

40. Mr A told ACC that the tests were completed satisfactorily, and Mr B did not alert him to any issues arising from the tests.

41. Mr B told HDC that he performed lumbar spine palpation and lumbar adjustment. He said that he performed a cervical assessment and adjusted C6/7 on the right side, and also performed a lower cervical/thoracic adjustment. Mr A stated that when his neck was manipulated during the treatment he experienced pain. He said that he told Mr B that his sight had blacked out temporarily and he felt a little dizzy. Mr A stated that Mr B replied that he would be all right from then on. In contrast, Mr B told HDC that if that had happened, he would have stopped the appointment immediately and would not have charged for the appointment.

42. Mr A stated that his wife was present at the appointment. However, Mr B stated that Mrs A was present initially, but he did not adjust Mr A in front of her or the children, as he wanted to repeat the same tests he had done on the second visit, to establish any change in Mr A's condition. Mr A told ACC that Mr B asked him to stay after his wife left the room as he wanted to perform the visual vertical test, but he did not say why he wanted to do so.

43. Mr B said that as he knew that it was going to take some time, he suggested that Mrs A and the children go to the gym area, as that was the only place where she could sit down and the children could play. He stated that at the end of the appointment Mr A asked to have his neck treated and, at that time, only he and Mr A were in the room.

Deterioration of condition

44. Mr A text messaged Mr B the following day and thanked him for the treatment. Mr A told HDC that his cervical dystonia symptoms did not develop instantaneously, but his condition deteriorated over the following days, so he cancelled his appointment with Mr B that was scheduled for 9 September 2019, as he wanted to seek the advice of his GP.

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45. On 11 September 2019, Mr A consulted GP Dr C at a medical centre. Dr C recorded that Mr A had suffered a "neck sprain" after having been "manipulated by chiropractor for lower back pain … now has spasm and locking of rotation to [right]". The recorded plan was to refer Mr A for physiotherapy, for him to wear a neck brace at night, and for him to use pain-killers.

46. On 26 September 2019, Mr A sent a text message to Mr B saying that he was having difficulty driving because of neck spasms, and that his head was turning involuntarily, which had almost caused an accident. Mr A said that Mr B tried to call him back and left a voicemail saying: "I guess it's one of my learning curve."

47. The medical centre's records of 30 September 2019 note that Mr A had developed some involuntary movements of his neck and a headache. Mr A's head was tending to twitch to the left side, and he had "spasms ++" on the right side of his neck. The notes state: "? Injury post manipulation." On 17 October 2019, Dr C referred Mr A to the district health board's neurology service.

Emergency Department review

48. On 21 October 2019, Mr A presented to the Emergency Department at the public hospital with involuntary dystonic movements of his neck. The discharge summary from a house surgeon states that Mr A reported a six-week history of neck and scalp pain following neck manipulation by a chiropractor, with no preceding trauma to his neck. The discharge summary notes that Mr A reported a sudden onset of left-sided neck pain, and that one week later he developed involuntary twisting/jerking head movements towards the left side. The house surgeon recorded her impression of dystonia, and discharged Mr A back to his GP for a trial of treatment with procyclidine.[8]

Neurology review

49. Mr A was referred to a neurologist, Dr D. On 6 November 2019, Dr D reported to Dr C:

> "[On examination] [t]here is variable extent of leftward torticollis with jerky movement superimposed and elevation of the left shoulder. [Mr A] demonstrates a sensory gest — placing his fingers on his chin or his forehead, so the head then can adopt a more neutral position. When he lies down, the movement is less obvious and it disappears when he is asleep. No cervical muscle asymmetry/hypertrophy, as yet."

50. Dr D noted that Mr A was taking two anticholinergics,[9] and said that there was little other useful medical therapy available. Dr D suggested that Mr A trial Botox treatment.

ACC

51. Dr C lodged an ACC injury claim form requesting cover for the neck injuries caused to Mr A by Mr B's treatment.

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[8] A medication used to help decrease muscle stiffness, sweating, and the production of saliva.

[9] A medication used to block the action of a neurotransmitter (a chemical messenger in the brain called acetylcholine), to stop involuntary muscle movements.

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52. On 7 February 2020, ACC declined cover. It said that its medical advisor considered that the clinical notes and history were not consistent with Mr A sustaining cervical dystonia/torticollis at the time of treatment. Mr A has applied for a review of the decision.

Response to provisional decision

Mr A

53. Mr A was provided with the "information gathered" section of the provisional report, but did not wish to provide any comment.

Mr B

54. Mr B was provided with the opportunity to respond to the provisional report. He commented on the provisional recommendations and provided information on further training he has sought. The recommendations made have been altered accordingly.

Opinion: Mr B — breach

Introduction

55. This opinion relates to the chiropractic care Mr B provided to Mr A in August and September 2019. Mr A subsequently developed cervical dystonia, which is a rare and distressing condition.

56. Mr A believes that the cause of the cervical dystonia was the chiropractic treatment he received. It is not the role of this Office to determine causation, and accordingly this opinion considers whether Mr A gave informed consent for the treatment provided by Mr B and whether the treatment was of an appropriate standard, but it does not consider whether the treatment Mr B provided caused Mr A's cervical dystonia.

Informed consent — breach

57. Right 6(2) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to the information that a reasonable consumer in that consumer's circumstances needs to make an informed choice and give informed consent. Right 6(1) of the Code states that the information expected includes an explanation of the consumer's condition and the options available, and an assessment of the expected risks, side effects, benefits, and costs of each option. Consumers should also be informed of the results of tests and procedures.

Lumbar spine manipulations

58. Mr A's first visit to Mr B was on 26 July 2019, at which time Mr A complained of hip pain. Mr B recorded that he had adjusted "L5 R [right]" in Mr A's lumbar region. Mr B said that he discussed lumbar spine manipulations, and told Mr A that the risks were "very low", and mentioned "stroke risks".

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59. My expert advisor, chiropractor Tanja Glucina, advised that this discussion was insufficient, as Mr B did not mention what the risks of lumbar spine manipulations are, apart from mentioning stroke risks.[10]

60. I agree. I consider that the information provided to Mr A at this visit was not sufficient for Mr A to be in a position to give informed consent to lumbar spine manipulation.

Cervical spine manipulation

61. The records for Mr A's second visit to Mr B, on 14 August 2019, refer to Mr A having asked Mr B to "click" his neck. Mr A said that he had not requested neck manipulation previously, as until this point, the pain had been in his pelvic and lower back areas. However, at this appointment, he told Mr B that he had neck pain when he was tired after spending a long time doing computer coding, and Mr B said that he would "adjust" Mr A's neck. Mr A stated: "It wasn't explained to me in any detail what this would involve." Mrs A also said that Mr B did not explain what was involved or ask for permission to do neck manipulation, and he did not ask Mr A for his consent.

62. Mr B has given differing accounts of the interaction between himself and Mr A at the appointment on 14 August 2019. In his initial statement, Mr B told HDC that at the introduction of the appointment Mr A had requested that he (Mr B) click his neck. In a subsequent statement, Mr B said that Mr A made the request as he was about to leave the appointment[11].

63. Mr B stated that he thought the best option for treatment was to adjust Mr A's lower cervical levels C6/7.

64. Mr B said that typically he would ask a person whether they had had their neck adjusted previously, and the risk discussion would focus on the risk of stroke. He stated that he had that discussion with Mr A during the initial visit. However, I note that during the initial visit the focus was on lumbar spine manipulation, because Mr A had attended for treatment of hip pain. This is supported by the information Mr A provided in the pain diagram and screening tool. I do not accept that cervical spine manipulation was discussed at the first consultation.

65. Ms Glucina considers that if the patient specifically asked the chiropractor to check their neck, that could imply consent. I accept that this may be the case if the patient has been fully informed about the procedure previously; however, in this case there is no evidence in the

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[10] See: "What Are the Risks of Spinal Manipulation?" *Am Fam Physician*. 2002 Oct 15; 66(8):1531. Approximately one half of patients who undergo spinal manipulation have mild to moderate undesirable effects; these include local discomfort (occurred in 53% of patients in one series of 4,712 patients); headache (12%); tiredness (11%); and radiating discomfort (10%). Most (74%) of these reactions resolved within one day. Serious adverse consequences, including death, were reported in a number of cases. Cerebrovascular accidents, with permanent neurological sequelae, were most often reported. Other serious events occurring after spinal manipulation included dislocation, vertebral fracture, disk herniation progressing to cauda equina syndrome (occurring after lumbar manipulation), and vertebrobasilar accidents (occurring after rotational cervical treatment).

[11] Mr B later clarified that Mr A requested Mr B click his neck both at the start of the second visit, and at the end of the third visit.

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clinical records that Mr B discussed — either prior to or at this appointment — the factors required by Right 6 of the Code with regard to cervical spine manipulation.

66. Regarding whether Mr B should have discussed the risk of cervical dystonia resulting from cervical spine manipulation, I note Ms Glucina's advice that cervical dystonia is rare and there is little evidence of a causal connection. In my view, given the rarity of the condition, it would not be expected that Mr B would discuss this with Mr A.

67. Ms Glucina provided me with the NZ Chiropractic Informed Consent form, which sets out the risks that should be discussed for chiropractic adjustment (see Appendix A).[12] There is no evidence that these issues were discussed other than the mention of stroke. I agree with my expert that Mr B's informed consent processes were inadequate. Ms Glucina considers that written consent was required. I accept that written consent would be helpful to provide clarity, but I note that Right 7(6) of the Code provides that the circumstances when consent must be in writing include if the procedure is experimental or if there is significant risk of adverse effects on the consumer. Otherwise, verbal consent would be sufficient. In any event, whether the consent is written or verbal, the key when it comes to informed consent is ensuring that the consumer has received the information that a reasonable consumer would expect in the circumstances and, as set out above, I do not consider that this occurred.

Conclusions

68. Mr B failed to provide Mr A with sufficient information regarding lumbar spine manipulations and cervical spine manipulations. Consequently, I find that Mr B breached Right 6(2) of the Code. As a result, Mr A was not in a position to give informed consent and, accordingly, Mr B also breached Right 7(1) of the Code.

Record-keeping — breach

69. Mr B's clinical records are a series of handwritten notes, some of which are illegible. It is not evident when the notes were made or whether they have been amended, and it is not possible to conduct an audit trail of notes of this nature. Mr A and Mr B both agree that Mr B did not make the notes at the time of the consultations. Mr A has disputed the accuracy of some of the notes and has pointed out that on occasion the notes refer to incidents that had yet to occur, such as his road trip.

70. Ms Glucina was critical that Mr B recorded minimal patient history and minimal visit history notations. She was also concerned that he did not record a differential diagnosis, and she noted that it is normal practice to make notations where appropriate for subjective and objective findings, the treatments delivered, and the post-treatment findings. She stated that the notes made on 26 July 2019 were a moderate departure from accepted standards of practice.

[12] The NZ Chiropractic Informed Consent document states: "Other uncommon risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). In extremely rare circumstances, patients may present to a chiropractor whilst in the process of having a vertebral artery dissection, which may lead to a stroke (1 in 5.85 million). These symptoms can be difficult to detect despite our thorough assessment according to best practice."

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71. Ms Glucina advised that the clinical notes from the consultation on 14 August 2019 are more thorough with regard to the physical examination and general assessment performed, but do not specifically state what chiropractic treatment was performed, such as the vertebral level and technique, and the reasons why Mr B manipulated the lumbar and cervical regions. Ms Glucina considers that the clinical notes on 14 August 2019 were a moderate to severe departure from accepted practice.

Conclusions

72. The New Zealand Chiropractic Board's document "Competency Based Professional Standards for Chiropractors"[13] states that a chiropractor should obtain and record the patient's history in a structured manner, and the patient's clinical presentation and history should be explored appropriately and the findings recorded. In my view, Mr B's record-keeping did not comply with professional standards. Accordingly, I find that Mr B breached Right 4(2) of the Code.

Quality of care — adverse comment

73. Ms Glucina advised me that the services provided by Mr B on 26 July 2019 were acceptable. She said that with regard to the appointment on 14 August 2019, the assessments appear to have been more thorough. However, as there is no record of what chiropractic treatment was performed, or why the treatment was performed, it is not possible to determine whether the treatment was of an acceptable standard.

74. Ms Glucina said that on 4 September 2019 Mr A's cervical spine testing showed no improvement and his symptoms had worsened. She advised that the most appropriate approach would have been to "wait and see", rather than to adjust Mr A at this appointment. Ms Glucina stated: "What I would do in this instance, is not adjust here and wait to see how things were going next visit." She said that if the physical examination findings had showed strongly that treatment of this area would be clinically beneficial, then a non-manual low force treatment approach, such as an activator, would have been advised. Ms Glucina considers it a departure from accepted standards of practice to have manipulated Mr A's cervical spine on this date, but she also noted that there was nothing glaringly obvious that contraindicated the care provided. Mr B stated that he thought that Mr A's presentation on 4 September 2019 was unusual. Ms Glucina advised me that this impression reinforces her comments that Mr B should not have applied further treatment at that visit.

75. Mr A stated that when his neck was manipulated during the treatment on 4 September 2019, he experienced pain. He said that he told Mr B that his sight had blacked out temporarily and he felt a little dizzy, and Mr B replied that he would be all right from then on. In contrast, Mr B told HDC that if that had happened, he would have stopped the appointment immediately and would not have charged for the appointment. There is no reference to this issue in the records and, consequently, I am unable to make a finding as to which account is correct.

76. Ms Glucina also advised that Mr B should have provided safety-netting advice that if Mr A's symptoms got worse, he should seek medical advice. I am critical that Mr B adjusted Mr A on

[13] See Appendix B.

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4 September 2019 and failed to provide safety-netting advice. However, I accept Ms Glucina's advice that the clinical picture at that time did not show any "red flags".

Opinion: The chiropractic clinic — adverse comment

77. As a healthcare provider, the clinic is responsible for providing services in accordance with the Code. Mr B is the sole director of the clinic, and he provides his services through this company. At the time of these events, the company had no policies or procedures in place.

78. I consider that Mr B's inadequate record-keeping and failure to obtain informed consent from Mr A were individual failings. However, I am critical that the company did not have an adverse event management policy, informed consent policy, or requirements regarding record-keeping. Since these events, the company has developed an informed consent policy and cervical spine treatment policy and procedures.

Changes made since events

79. Mr B told HDC that he has enrolled in an informed consent course and reviewed several articles on the subject. He said that the articles he reviewed outlined what informed consent should include, what it means when a consumer signs a consent form, and implied consent.

80. Mr B stated that he now uses a programme that converts speech to text for patient visit notes. He reported to HDC that this allows for more detailed documentation.

81. Mr B said that he has also reformatted his initial consultation notes to integrate the obtaining of informed consent prior to the physical examination. He stated that after finalising the examination, treatment, and frequency of visits, a patient signature is obtained to complete the paperwork and to proceed to the treatment interventions.

Recommendations

82. I recommend that within three weeks of the date of this opinion, Mr B apologise to Mr A for the failings identified in the opinion. The apology is to be sent to HDC for forwarding to Mr A.

83. I recommend that within six months of the date of this opinion, Mr B:

    a) Provide evidence of having attended an informed consent course (such as ChiroCredit's "Ethics for Professionals 105 — Informed consent", or "Risk 107 — The informed consent process and how to avoid malpractice actions").

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b) Provide evidence of having attended a documentation course (such as ChiroCredit's "Documentation 197 — The clinical and written documentation process").

c) Refamiliarise himself with the New Zealand Chiropractic Board's "Competency Based Professional Standards for Chiropractors" and the Board's "Code of Ethics".

d) Undertake further professional development training on the clinical issues raised in this case.

84. Mr B has indicated that he has commenced a qualification in orthopaedics for chiropractors. I recommend that Mr B report back to HDC with his completion certificate at the end of the course.

85. I recommend that within six months of the date of this opinion, the clinic arrange for a chiropractor recommended by the Chiropractic Board to review its cervical spine treatment policy and procedures and adverse event policy and procedures, and report back to the Chiropractic Board on whether these policies comply with accepted standards.

86. I recommend that the Chiropractic Board consider undertaking a competence review of Mr B and consider my expert advisor's recommendation that Mr B arrange a mentor to review his informed consent processes and provide evidence to the Board that he is meeting accepted standards for management of neck pain, and advise HDC of the outcome of its considerations.

Follow-up actions

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

88. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to ACC, the Neurological Association of New Zealand, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from chiropractor Tanja Glucina:

"**Tanja Glucina BSc (Psych), BSc (Chiro), BHSc (Hons; first class), PhD Candidate**

Agreement

I Tanja Glucina have been asked to provide an opinion to the Commissioner on case number C19HDC02228, and agree that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and Experience

Qualifications
2019–current PhD Candidate from the Auckland University of Technology

2020 In final year of a National Certificate in Adult Education and Learning at the Southern Institute of Technology

2016 Bachelor in Health Science (Honours: First Class) from the Auckland University of Technology

2000 BSC in Chiropractic from the New Zealand College of Chiropractic (NZCC)

1998 BSc in Psychology from the University of Auckland

Experience
2020 Research fellow at the Centre for Chiropractic Research and Course

Coordinator at the New Zealand College of Chiropractic

2018 HDC Independent advisor

2017 NZCC Professional Practice — Professional Communications Year 1 & 2 Lecturer

2016–2019 NZCC Chiropractic Centre Research Department Operations Manager and Lecturer

2012 NZ Chiropractic Board Foreign Entry Examiner

2007–2014 NZCC Examiner: Clinical Conference, Entrance and Exit examinations

2007 NZCC — Clinic Conference 3 and Pathology Lecturer

2006–2016 NZCCC Chiropractic Centre — Case History and Clinic Supervisor

2003–Current Locum and private practice experience in New Zealand. Owner and Practitioner at Creating Wellness Family Chiropractic Centre

2001–2003 Associate and locum in Australia

Instructions from Commissioner

At the end of July 2020, I received an email asking whether I would be interested in being an Independent advisor for the HDC for a case involving a chiropractor, his patient

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and various other medical professionals. I advised that I [have] no conflict of interest with any of the above mentioned parties.

Thereafter via email I received a letter dated 3 August 2020 that outlined the complaint of [Mr A]/[Mr B]. Enclosed were also the letter of complaint, responses, clinical notes, text messages and clinical records.

I was asked to review the documentation and advise whether I considered the care provided to [Mr A] by [Mr B] was reasonable in the circumstances and why. Below are the itemised considerations stated to which I will give my responses to and comment on.

1. The adequacy of the care provided to [Mr A] on 26 July 2019. In particular, please comment on whether [Mr B] provided [Mr A] with sufficient information on the risks and benefits of lumbar spine manipulations.

For the case C19HDC02228, the adequacy of the care provided in my opinion could be improved. [Mr B] has recorded minimal patient history and minimal visit history notations. No differential diagnosis is present. For a patient visit, it is normal practice to make notations where appropriate for subjective and objective findings, the treatments delivered and then post-treatment findings.

I consider that [Mr B's] notes of [Mr A's] chief complaint (from [Mr B's] response to HDC 16/12/19) on the initial consultation form were a moderate departure from standards of practice.

I consider that the clinical notes taken for this visit (from [Mr B's] clinical notes), to be a moderate departure from standards of practice.

I believe that peers would also consider both the initial consultation and patient visit notes to be a moderate departure from accepted standards of practice.

I recommend [Mr B] to familiarise, upskill and implement the Competency Based Professional Standards for Chiropractors directed by the NZ Chiropractic Board especially the sections —

5. Patient Assessment,

5.1 Obtains and records patient history,

5.2 Performs an appropriate physical examination,

6. Case Management

6.1 Establishes differential and working diagnosis (clinical impression) from the information acquired, Collaborates or refers as necessary to obtain expert opinion and

7. Planning of Patient Care.

This could be in the form of online modules, mentoring etc.

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In my view discussing the risks of lumbar spine manipulation as ‘very low’ to [Mr A] (from [Mr B’s] response to HDC 16/12/19), is insufficient in that it does not actually mention what the risks are.

I would consider this to be a moderate departure from accepted practice as that stated by the NZ Chiropractic Board.

From the perspective of practitioners/peers I believe this would be considered a mild departure from accepted practice as these types of risks are considered low and hence may be glossed over/not always fully mentioned.

I would recommend that [Mr B] ‘upskill’ his knowledge on informed consent, standards of practice and code of ethics. This could be in the form of online modules, mentoring etc.

[Mr B] further stated that he discussed ‘stroke risks’. Whilst it is not entirely clear what this means, it is appropriate and accepted standard of practice to do so. In this way I do not believe this is a departure from accepted practice.

2. The adequacy of the care provided to [Mr A] on 14 August 2019.

The clinical notes (from [Mr B’s] clinical notes), state that [Mr A] asked [Mr B] to check (or click, I am unsure of the spelling) his neck. As this then becomes a difference of opinion between both [Mr B] and [Mr A], I do not believe I can comment as to whose perspective is true. However, I do believe that practitioners in the field would consider that a patient specifically asking for a chiropractor to check their neck could imply consent.

The clinical notes (from [Mr B’s] clinical notes and from [Mr B’s] response to HDC 16/12/19) for this visit seem more thorough for the physical exam and general assessments performed. However, the clinical notes do not specifically tell me what chiropractic treatment was actually performed (e.g. the vertebral level and technique used and what led [Mr B] to manipulate there) in both the lumbar and cervical region.

In this way I consider this part of the clinical notes to be a moderate to severe departure from accepted practice.

I would consider that peers/practitioners would consider this a moderate departure from accepted practice.

I recommend that [Mr B] records more thorough treatment notes on what chiropractic care was actually performed.

3. The adequacy of the care provided to [Mr A] on 4 September 2019. In particular, please comment on whether it was reasonable for [Mr B] to manipulate [Mr A’s] neck (or any other part of his body) in the circumstances. As a part of your analysis, please address the following issues:

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

a. Whether the cervical spine testing [Mr B] performed was appropriate in the circumstances, and whether [Mr B] should have withheld treatment based on the results of these tests.
In my opinion, given the cervical spine testing showed no improvement, and given that symptoms had gotten worse (see from [Mr B's] clinical notes, [Mr B's] approach to HDC and [Mr B's] responses to [Mr A] 14/1/20), a 'wait and see approach' would be most appropriate. What I would do in this instance, is not adjust here and wait to see how things were going next visit. However, if the physical exam findings strongly showed that this area for treatment would be clinically beneficial, a non-manual low force treatment approach, such as an activator would be advised.

I consider this to be a mild to moderate departure from accepted standards of practice as personally I would err on the side of caution.

I believe that peers would consider this a very mild departure from accepted standards of practice as there was nothing glaringly obvious that contraindicated care. However, a lower force approach would be accepted.

I recommend that [Mr B] upskills on contraindications to manual manipulation through reading research, attending conferences etc.

It is noteworthy that cervical dystonia is rare and its prevalence is considered to be approximately 0.3% of the population (see Jankovic, J., Tsui, J., & Bergeron, C. (2007). Prevalence of cervical dystonia and spasmodic torticollis in the United States general population. Parkinsonism & related disorders, 13(7), 411–416.). I was unable to source any research where chiropractic care had specifically resulted in cervical dystonia. The research that was present was focused on how chiropractic care had helped people with this condition:

Viehmann, M., Weise, D., Brähler, E., Reichel, G., Classen, J., & Baum, P. (2014). Complementary/alternative medicine and physiotherapy usage in German cervical dystonia patients. Basal Ganglia, 4(2), 55–59.

Kukurin, G. W. (2004). Reduction of cervical dystonia after an extended course of chiropractic manipulation: a case report. Journal of manipulative and physiological therapeutics, 27(6), 421–426.

b. Whether [Mr B's] account of how he obtained [Mr A's] consent to manipulate his neck met or departed from accepted practice.
As I have stated above: The clinical notes (from [Mr B's] clinical notes), state that [Mr A] asked [Mr B] to check (or click, I am unsure of the spelling) his neck. As this then becomes a difference of opinion between both [Mr B] and [Mr A], I do not believe I can comment as to whose perspective is true. However, I do believe that practitioners in the field would consider that a patient specifically asking for a chiropractor to check their neck could imply consent.

[Mr B] stated (see [Mr B's] response to HDC) that '5. I can't recall if I asked him if he would like me assess and adjustment his neck or if he asked me to'.

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Whilst there is doubt in this statement, it does also show that this area of patient consent is weak in [Mr B's] clinical practice. In [Mr B's] response to HDC 16/12/19, [Mr B] comments that his normal practice is to always ask his patients if they have had their neck adjusted before, and that he focusses his patient discussions on stroke risks and musculoskeletal pain/discomfort. As we cannot be sure that this happened with [Mr A], it is difficult to comment on. In the notes from [Mr A] he states that (See [Mr B's] responses to [Mr A] 14/1/20), he 'wasn't aware that I was going to be receiving neck manipulation, as you didn't fully explain what "adjusting" my neck involved'. Based on this, overall:

I would consider this to be a moderate departure from accepted practice as one needs full consent of the process and the risks involved.

From the perspective of practitioners/peers I believe this would be considered a moderate departure from accepted practice.

I would strongly recommend that [Mr B] 'upskill' and implement his knowledge on informed consent, standards of practice and code of ethics in each visit.

c. The adequacy of the safety netting advice provided to [Mr A], including whether [Mr B] should have referred [Mr A] to another health provider at this time.
Based on the documentation provided, I believe that [Mr B] should have advised [Mr A] that if his symptomology worsened after that visit, that he should seek medical help. However, I do not believe that the clinical picture at that time showed any major red flags. Hence, I do not believe that this would contradict any standards of practice or that an immediate referral was indicated.

It was noteworthy that [Mr B] (see [Mr B's] further response and updated consent form 27/2/20), stated that he 'requested we have a following appointment the next Wednesday to review his presentation as referral to appropriate specialist was looking likely (I didn't tell him that though)'. Whilst this is not against any standards of practice, I personally would not have chosen to manually adjust [Mr A], at that time.

With respect to the specific cervical testing that [Mr B] was using, it was stated (see [Mr B's] response to HDC) that 'I was distracted as I had not seen this type of response before'. This could imply that if he was unsure, he should have investigated this further and erred on the side of caution. Further to this, (see [Mr B's] further response and updated consent form 27/2/20), [Mr B] stated that he thought that the patient presentation on visit 3 had 'an unusual progression'. This adds to my previous comments that it may have been a better outcome if [Mr B] had not applied further treatment on that visit.

4. The appropriateness of the advice [Mr B] provided to [Mr A] in communications that took place subsequent to 4 September 2019.

In my view [Mr B] was professional and open to communication with [Mr A] following the 4/9/19 visit.

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5. The adequacy of [Mr B's] clinical documentation and record keeping, particularly with regards to obtaining patient consent and discussing the risks and benefits of treatment. Please also comment on the updated consent form provided by [Mr B] in response to this complaint.

As already noted above, I believe that:

[Mr B's] clinical documentation and record keeping need improvement and more structure. More thorough notes on the patient's chief complaint and history (e.g. location, onset, quality, etc.) additional complaints, physical exam findings, treatments performed etc, are required.

I recommend that his patient visit to visit documentation be improved in way of better structure etc.

[Mr B] needs upskilling and/or mentoring on obtaining patient consent and what true informed consent is.

The updated consent form is adequate and is a good reflection of the general standard of practice.

6. In his response to [Mr A] received 14 January 2020, [Mr B] states 'I have downloaded and will implement the Canadian Chiropractic Guidelines for cervical spine treatment'. Please advise on the appropriateness of this step, and whether there are any other remedial measures you would recommend to [Mr B] to improve his practices.

The Canadian chiropractic guidelines for cervical spine treatment is an evidence based approach. In this way, this is an appropriate resource to follow. Additional research that I suggest for [Mr B] include:

1. Bryans, R., Decina, P., Descarreaux, M., Duranleau, M., Marcoux, H., Potter, B., ... & White, E. (2014). Evidence-based guidelines for the chiropractic treatment of adults with neck pain. Journal of Manipulative and Physiological Therapeutics, 37(1), 42–63.
2. Whalen, W., Farabaugh, R. J., Hawk, C., Minkalis, A. L., Lauretti, W., Crivelli, L. S., ... & Walters, S. A. (2019). Best-practice recommendations for chiropractic management of patients with neck pain. Journal of Manipulative and Physiological Therapeutics.

It could be recommended that [Mr B] get asked to submit evidence of where he has followed these guidelines to the NZ chiropractic board yearly for two to three years. This could ensure that these guidelines are being implemented in everyday practice.

7. Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.

Overall, I recommend that [Mr B] improve his clinical notes and documentation, informed consent and patient consent procedures. [Mr B] has already taken the

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impetus to upskill in his consent and initial consultation forms which is to be commended. However, I do believe that he needs to implement a better visit to visit structure/process for note taking and treatment being delivered. I also recommend that [Mr B] is asked to attend a low force, non-manual chiropractic technique seminar to be able to care for people with other approaches when clinically warranted.

Final comments

I hope that this report provides further insight from a chiropractor's perspective. Please do not hesitate to contact me if deemed necessary.

Kind regards

Dr Tanja Glucina Dated: 21/08/2020"

The following further advice was received on 30 November 2020:

"Independent Advisors Report
Tanja Glucina BSc (Psych), BSc (Chiro), BHSc (Hons; first class), PhD Candidate

Agreement

I, Tanja Glucina have been asked to provide an opinion to the Commissioner on case number C19HDC02228, and agree that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Original Instructions from Commissioner

- At the end of July 2020, I received an email asking whether I would be interested in being an Independent advisor for the HDC for a case involving a chiropractor, his patient and various other medical professionals. I advised that I have no conflict of interest with any of the above mentioned parties.
- Thereafter via email I received a letter dated 3 August 2020 that outlined the complaint of [Mr A]/[Mr B]. Enclosed were also the letter of complaint, responses, clinical notes, text messages and clinical records.

Recent Instructions from Commissioner

- I have since received a number of clinical notes and email additions from 16 November–24 November

I was asked to review the documentation and advise whether any information has caused me to assess the conclusions drawn in my initial advice. Below are the itemised considerations stated to which I will give my responses to and comment on.

1. The adequacy of the care provided to [Mr A] on 26 July 2019. In particular, please comment on whether [Mr B] provided [Mr A] with sufficient information on the risks and benefits of lumbar spine manipulations.

Based on [the clinic] Response: I uphold my initial advice.

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For the case C19HDC02228, the adequacy of the care provided in my opinion could seem acceptable given the information required on what was delivered/said additional to the original information received. However, more detailed notes are needed. The new system of voice to text note taking should help to address this.

I uphold my initial recommendation that [Mr B] familiarise, upskill and implement the Competency Based Professional Standards for Chiropractors directed by the NZ Chiropractic Board especially 6.1 Establishes differential and working diagnosis (clinical impression) from the information acquired, Collaborates or refers as necessary to obtain expert opinion and 7. Planning of Patient Care. This could be in the form of online modules, mentoring etc.

In my view discussing the risks of lumbar spine manipulation as 'very low' to [Mr A] (from [Mr B's] response to HDC 16/12/19), is insufficient in that it does not actually mention what the risks are.

- Based on the new information changing the context, I amend my original view of a moderate departure from accepted practice as that stated by the NZ Chiropractic Board to being a mild deviation from accepted standard of practice. I do still believe that even if very low, the patient needs to know what risks may present with lumbar/pelvis adjusting.
- I previously recommended that [Mr B] 'upskill' his knowledge on informed consent, standards of practice and code of ethics. From the information provided, it appears he has undertaken this adequately.

2. The adequacy of the care provided to [Mr A] on 14 August 2019.

I uphold this initial recommendation: The clinical notes (from [Mr B's] clinical notes), state that [Mr A] asked [Mr B] to check (or click, I am unsure of the spelling) his neck. As this then becomes a difference of opinion between both [Mr B] and [Mr A], I do not believe I can comment as to whose perspective is true. However, I do believe that practitioners in the field would consider that a patient specifically asking for a chiropractor to check their neck could imply consent.

From the original recommendation on the clinical notes, it seems that the new information provided is more robust which offers more insight into what was performed and why. I still recommend [Mr B] to continue to record as much information on the findings of the areas that are to be treated, as well as the treatments provided.

- I recommend that [Mr B] records more thorough treatment notes on what chiropractic care was actually performed.

3. The adequacy of the care provided to [Mr A] on 4 September 2019. In particular, please comment on whether it was reasonable for [Mr B] to manipulate [Mr A's] neck (or any other part of his body) in the circumstances. As a part of your analysis, please address the following issues:

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a. Whether the cervical spine testing [Mr B] performed was appropriate in the circumstances, and whether [Mr B] should have withheld treatment based on the results of these tests.
I uphold this opinion, given the cervical spine testing showed no improvement, and given that symptoms had gotten worse (see from [Mr B's] clinical notes, [Mr B's] approach to HDC and [Mr B's] responses to [Mr A] 14/1/20), a 'wait and see approach' would be most appropriate. What I would do in this instance, is not adjust here and wait to see how things were going next visit. However, if the physical exam findings strongly showed that this area for treatment would be clinically beneficial, a non-manual low force treatment approach, such as an activator would be advised.

- I consider this to be a mild to moderate departure from accepted standards of practice as personally I would err on the side of caution.
- I believe that peers would consider this a very mild departure from accepted standards of practice as there was nothing glaringly obvious that contraindicated care. However, a lower force approach would be accepted.
- I recommend that [Mr B] upskills on contraindications to manual manipulation through reading research, attending conferences etc.

It is noteworthy that cervical dystonia is rare and its prevalence is considered to be approximately 0.3% of the population (see Jankovic, J., Tsui, J., & Bergeron, C. (2007). Prevalence of cervical dystonia and spasmodic torticollis in the United States general population. Parkinsonism & related disorders, 13(7), 411–416.). I was unable to source any research where chiropractic care had specifically resulted in cervical dystonia. The research that was present was focused on how chiropractic care had helped people with this condition:

Viehmann, M., Weise, D., Brähler, E., Reichel, G., Classen, J., & Baum, P. (2014). Complementary/alternative medicine and physiotherapy usage in German cervical dystonia patients. Basal Ganglia, 4(2), 55–59. Kukurin, G. W. (2004). Reduction of cervical dystonia after an extended course of chiropractic manipulation: a case report. Journal of manipulative and physiological therapeutics, 27(6), 421–426.

b. *Whether [Mr B's] account of how he obtained [Mr A's] consent to manipulate his neck met or departed from accepted practice.*
As I have stated above: The clinical notes (from [Mr B's] clinical notes), state that [Mr A] asked [Mr B] to check (or click, I am unsure of the spelling) his neck. As this then becomes a difference of opinion between both [Mr B] and [Mr A], I do not believe I can comment as to whose perspective is true. However, I do believe that practitioners in the field would consider that a patient specifically asking for a chiropractor to check their neck could imply consent.

Based on the new information provided by [Mr B] as to how he came about adjusting [Mr A], it appears that [Mr A] implied that he wanted to be adjusted. Based on [Mr B's] additional notes on page 8 'as I explained on the first visit regarding stroke risks and muscular factors, as well as the second visit prior to the cervical adjustment, that you may experience stiffness and soreness, perhaps I should have been more insistent with

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his acknowledgement that he understood', I am satisfied that if this conversation took place that there was some level of verbal informed consent provided.

- This would be a mild to moderate deviation from accepted standard of practice as written consent would need to be evidenced. However, there (sic) practice as one needs full consent of the process and the risks involved.
- From the information provided, I feel satisfied that [Mr B] has upskilled and is implementing his knowledge on informed consent, standards of practice and code of ethics in each visit.

c. The adequacy of the safety netting advice provided to [Mr A], including whether [Mr B] should have referred [Mr A] to another health provider at this time.

I uphold this recommendation: Based on the documentation provided, I believe that [Mr B] should have advised [Mr A] that if his symptomology worsened after that visit, that he should seek medical help. However, I do not believe that the clinical picture at that time showed any major red flags. Hence, I do not believe this would contradict any standards of practice or that an immediate referral was indicated.

4. The appropriateness of the advice [Mr B] provided to [Mr A] in communications that took place subsequent to 4 September 2019.

I uphold this recommendation: In my view [Mr B] was professional and open to communication with [Mr A] following the 4/9/19 visit.

5. The adequacy of [Mr B's] clinical documentation and record keeping, particularly with regards to obtaining patient consent and discussing the risks and benefits of treatment. Please also comment on the updated consent form provided by [Mr B] in response to this complaint.

Please note the following:

- [Mr B's] clinical documentation and record keeping need improvement and more structure. More thorough notes on the patient's chief complaint and history (e.g. location, onset, quality, etc.) additional complaints, physical exam findings, treatments performed etc, are required — Based on the new information provided, I believe this has been undertaken.
- I recommend that his patient visit to visit documentation be improved in way of better structure etc. — Based on the new information provided, I believe this has been undertaken.
- [Mr B] needs upskilling and/or mentoring on obtaining patient consent and what true informed consent is. — Based on the new information provided, I believe this has been undertaken.
- The updated consent form is adequate and is a good reflection of the general standard of practice. — Based on the new information provided, I believe this has been undertaken.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

6. In his response to [Mr A] received 14 January 2020, [Mr B] states 'I have downloaded and will implement the Canadian Chiropractic Guidelines for cervical spine treatment'. Please advise on the appropriateness of this step, and whether there are any other remedial measures you would recommend to [Mr B] to improve his practices.

I uphold the recommendation below:

The Canadian chiropractic guidelines for cervical spine treatment is an evidence based approach. In this way, this is an appropriate resource to follow. Additional research that I suggest for [Mr B] includes:

Bryans, R., Decina, P., Descarreaux, M., Duranleau, M., Marcoux, H., Potter, B., ... & White, E. (2014). Evidence-based guidelines for the chiropractic treatment of adults with neck pain. Journal of Manipulative and Physiological Therapeutics, 37(1), 42–63. Whalen, W., Farabaugh, R. J., Hawk, C., Minkalis, A. L., Lauretti, W., Crivelli, L. S., ... & Walters, S. A. (2019). Best-practice recommendations for chiropractic management of patients with neck pain. Journal of Manipulative and Physiological Therapeutics.

It could be recommended that [Mr B] get asked to submit evidence of where he has followed these guidelines to the NZ chiropractic board yearly for two to three years. This could ensure that these guidelines are being implemented in everyday practice.

7. Any other matters in this case that you consider warrant comment or amount to a departure from the standard of care/accepted practice.

Overall, based on my previous recommendations, I am satisfied that [Mr B] has improved his clinical notes and documentation, informed consent and patient consent procedures. [Mr B] has already taken the impetus to upskill in his consent and initial consultation forms which is to be commended. It also appears that [Mr B] has implemented a better visit to visit structure/process for note taking and treatment being delivered. [Mr B] has stated in the new notes supplied that he does use an Activator/low force approach hence it appears he may have some adequacy of knowledge here.

Appropriateness of Policies and Procedures and Final comments:

It seems as though the original gaps in procedures and policies have been either improved or where there was lack of information, sufficient information has been provided. Due to the differing views of who was and wasn't in the treatment room, and what was and wasn't stated, I am unable to comment on the credibility of the information provided by all parties.

I hope that this report provides further insight from a chiropractor's perspective. Please do not hesitate to contact me if deemed necessary.

Kind regards

Dr Tanja Glucina Dated: 30/11/2020"

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The following further advice was received from Dr Glucina:

"Additional Independent Advisor's Report

Tanja Glucina-Russell BSc (Psych), BSc (Chiro), BHSc (Hons; first class), Cert TT, PhD (Cand)

[Mr A] 19HDC02228

Most recent instructions from Associate Commissioner

- Further to previous reports and emails for the above aforementioned case, I received an email on the 14th April requesting further advice on the following:
  - Further to the advice you have provided regarding this matter could you please advise what information a chiropractor should give to a client about the following matters:
    * The risks of lumbar manipulation
    * The risks of cervical manipulation
    * The treatment options available other than manipulation
    * The risk of stroke
- I responded to this via email on the 16th April, to gain more clarification as to the level of depth required for this advice, whether this was specific to this case only and to what age group this information was to be based on.
- In response, I received an email requesting general guidance as to what would be expected (perhaps regarding clients in this age group) — not advice relating specifically to this case.

My Advice:

I will use the NZ Chiropractic Board Competency Based Standards documents: https://www.chiropracticboard.org.nz/wp-content/uploads/2020/03/Competency-Based-Standards-2010.pdf to discuss my views. The following sections relate to informed consent:

5.1.1 Obtains informed consent from the patient or authorised person as outlined in the Board's Code of Ethics and Standards of Practice document.

8.1.2 The nature and implications of all chiropractic procedures to be used are communicated.

8.1.4 Obtains patient acknowledgement and consent.

➢ It is my advice that all chiropractors MUST gain informed consent.

➢ From our NZ Chiropractic board, informed consent is stated to not have to be written, hence can be verbal. Informed consent is known to need to include information on risks of manipulation and stroke.

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- At the New Zealand College of Chiropractic, informed consent is discussed verbally and documented in written form. I have attached the form currently used at the College. Of course, not all NZ chiropractors have qualified from NZ, however informed consent is an international concern and acknowledged at all colleges that I am aware of. I believe this informed consent document covers all the necessary information about stroke and risks of manipulation.

- For chiropractors who have graduated many years ago, informed consent has been discussed at many seminars, AGMs, Continuing Professional Development symposiums and suchlike over the years. Hence, it is my belief that there is no reason why a chiropractor would not be aware of what informed consent is and what it entails.

- In relation to alternative treatment options, I think it is up to the individual chiropractor to ascertain to what they level they may or may not discuss this. Personally, I would often verbally mention to my patients that they had a number of choices, e.g. do nothing, see another health provider such as a physiotherapist, take pain relief or try chiropractic … however, often this would depend on the case.

Final comments

In general chiropractic practice, when there is no obvious red flags for concern in a case presentation, practitioners should in my opinion discuss and obtain informed consent — at the very least this should be verbal and recorded in patient notes. This informed consent should discuss the risks of manipulation, stroke etc. A chiropractor may spend a brief amount of time discussing alternative options if they choose. However, like in most healthcare professions that I have encountered (from medical care, dentistry, massage, physiotherapy), alternatives are rarely discussed.

Kind regards

Dr Tanja Glucina Dated: 30/4/2021

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

INFORMED CONSENT

Chiropractic care is one of the safest forms of health care available. However, health care practitioners are required to inform patients of any possible risk, no matter how rare or slight.

Some people may experience some mild soreness for 24–48 hours after their adjustments.[1,2] This is a normal sign of change, as may occur after exercise or stretching.[1,2]

Other uncommon risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000).[3]

In extremely rare circumstances, patients may present to a chiropractor whilst in the process of having a vertebral artery dissection, which may lead to a stroke (1 in 5.85 million).[4] These symptoms can be difficult to detect despite our thorough assessment according to best practice.

Chiropractic experience consistently demonstrates unexpected improvement in people's lives. One study indicated that 23% of people experience improvement in some other aspect of their health.[5] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% in their circulatory system/heart;
- 14% in their eyes/vision.[5]

If you have any questions relating to the care you are about to receive, please discuss this with your intern or one of the Chiropractic Centre Mentors.

I, , confirm that I have received and understood the information given to me regarding my case, the proposed care and the implications and that I hereby give consent to chiropractic care.

I understand that this is a training facility and that I will receive chiropractic services from an intern under the supervision of a registered chiropractor.

In the case of chiropractic services being rendered to a minor, or a patient who is recognised to have diminished intellectual capacity, this consent is to be signed by either a parent or legal guardian.

Signature: ____Date:

References

1. Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A & Thurnherr T. Side effects of chiropractic treatment: a prospective study. J Manipulative Physiol Ther. 1997;20(8):511–515.
2. Senstad O, Leboeuf-Yde C & Borchgrevink C. Frequency and characteristics of side effects of spinal manipulative therapy. Spine. 1997;22(4):435–440.
3. Dvorak J & Orelli F. How dangerous is manipulation to the cervical spine? Manual Medicine. 1985;2: 1–4.
4. Haldeman S, Carey P, Townsend M, Papadopoulos C. Arterial dissections following cervical manipulation: the chiropractic experience. Can. Med. Assoc. J. 2001;165(7):905–906.
5. Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A & Thurnherr T. The types and frequency of improved non-musculoskeletal symptoms reported after chiropractic spinal manipulative therapy. J Manipulative Physiol Ther 1999;22(9):559–564."

Appendix B: Relevant standards

The New Zealand Chiropractic Board document "Code of Ethics" (2015) states:

> "Informed consent from the patient, or authorised person, must be obtained before commencing chiropractic management. The process of obtaining informed consent must comply with the Code of Health and Disability Services Consumers' Rights 1996, particularly Rights 5, 6 and 7."

The New Zealand Chiropractic Board document "Competency-Based Professional Standards for Chiropractors" (2010) states:

"Patient Assessment

5.1 Obtains and records patient history

5.1.1 Obtains informed consent from the patient or authorised person as outlined in the Board's Code of Ethics and Standards of Practice document.

5.1.2 Patient apprehension, physical discomfort, disability, and signs of mental disorder is acknowledged.

5.1.3 History-taking is approached in a structured manner.

5.1.4 Verbal and non-verbal communication is delivered in an appropriate manner.

5.1.5 Questions are asked in a clear, concise, purposeful and organised manner. They are appropriately directed and redirected to obtain a substantial history, using open, non-leading questions, verbal and non-verbal techniques; probing elicits more explicit information by seeking clarification, extension or accuracy.

5.1.6 The patient's verbal and non-verbal responses are recognised, actively listened to, and recorded.

5.1.7 The patient's clinical presentation and history is appropriately explored and findings recorded.

5.1.8 Factors (including psychosocial factors) which may explain the patient's presentation are recognised and considered.

5.1.9 The significance of the history is discussed with the patient or other appropriate party.

5.1.10 Patients with a different ethnic, cultural or linguistic background to the practitioner are recognised and supported in order to obtain a history and other clinical data.

5.1.11 Silence during delayed responses is allowed for."

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