Exercise physiologist, Mr B

A Physiology Company

A Report by the

Health and Disability Commissioner

(Case 06HDC02887)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr B	Provider /Exercise physiologist
A physiology company	Provider/Exercise physiology company
Dr C	Orthopaedic surgeon
Dr D	Radiologist
Ms E	Health and Disability Consumer Advocate

Complaint

On 6 March 2006, the Commissioner received a complaint from Ms A about the services provided by exercise physiologist Mr B. The following issues were identified for investigation:

- *The adequacy and appropriateness of the care provided to Ms A by exercise physiologist Mr B from June 2004 onwards.*
- *The adequacy of Mr B's response to Ms A's complaints about the care he provided.*

An investigation was commenced on 15 May 2006.

Information reviewed

- Ms A's record of the exercise programme
- Information from Mr B
- Information from Ms A

Independent expert advice was obtained from Mr Duncan Reid, physiotherapist.

Information gathered during investigation

Background
In June 2004, Ms A, aged 42, referred herself to Mr B, an exercise physiologist at a physiology company. Ms A had been suffering from back pain for two years, and had previously been seen by a chiropractor, a physiotherapist, and an osteopath, but without any improvement in the pain.

Mr B describes himself as an exercise physiologist. He has a Bachelor of Physical Education degree and a Masters degree in science (exercise physiology/cardiac rehabilitation). He is the sole director and shareholder of a physiology company. The services Mr B provides include "goal orientated fitness and exercise programmes, lifestyle modification advice, nutrition advice, fitness testing, health and fitness talks and seminars, outdoor adventure trips, sport and fitness posters and illustrated exercise cards".

On 19 June 2004, Ms A was assessed by Mr B with a view to her commencing an exercise programme. He stated:

> "[Ms A] presented with a chronic lower back condition. Her limitations included not being able to do any house work or being able to go for a walk. Lifting baggage and passengers at her work … had also become a limitation. Assessment findings … included several postural imbalances, poor abdominal function and poor lifting technique. I also picked up a probable shorter right leg which could have been one of the sources of her symptoms and recommended a CT scan for leg length to confirm this with accuracy. [Ms A] chose to not follow up on this recommendation."

Ms A stated that she consulted her general practitioner about whether one of her legs was shorter than the other. The doctor advised that it was not necessary for her to have a CT scan if there was a minor difference in leg length.

In consultation with Ms A, Mr B planned an exercise programme. He stated:

> "One of the goals of the programme was to help [Ms A] be able to lift load at work (potentially up to 30kg) without putting her back at further risk. I initially supervised her for each session which was scheduled for an hour at a time. However, I always gave [Ms A] more time than this as she took time to learn how to perform the exercises correctly.
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> To help [Ms A] progress to being able to lift correctly I had to regress her to a lower level of this movement pattern. She began with a simple leg press exercise and over many weeks I gradually moved her to squatting with a ball behind her back against a wall, to squatting down onto a chair, to squatting without a chair, to front squats with load and then to lifting a 7.5kg bar which was placed on a box 30cm off the ground. [Ms A] gradually increased to lifting a total weight of 17.5kg.
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> …
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> I have the focus here of helping clients to independence following a more intensive supervised period. Often clients move on to doing a programme independently from home or back at their own gym. A few of my clients continue independently at this exercise clinic. [Ms A] chose this latter option."

Mr B added that as a result of his initial assessment, "it became apparent that [Ms A] did not know how to lift correctly".

In response to the provisional opinion, Ms A stated that she had never had the goal of lifting 30kg, and that she had not been required at work to lift baggage or passengers since 1999.

Ms A was provided with cards that described her exercise programme. At the end of each session, she would write down the exercises she had completed, and hand back the card.

Ms A was provided with no information leaflets that described the exercise programme.

In response to the provisional opinion, Mr B's lawyer provided a more detailed description of Ms A's exercise regime:

> "[Ms A] visited and was assessed by [Mr B] on 19 June 2004. [He] subsequently designed an exercise regime for [Ms A] and the first supervised session was held on 23 June 2004. A further 28 supervised sessions were then held between that date and 11 September 2004. Although supervised sessions are traditionally for one hour, [Mr B] advises that the sessions were frequently much longer than one hour, often lasting up to one and a half hours. [Ms A] was never charged any extra for the extra time spent.
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> By 11 September 2004 [Ms A] had progressed to the point where she could now exercise independently. To that end [Ms A] decided to continue to use the facilities at [the physiology company]. Up to and including her final visit in 2004, being the visit dated 23 December 2004, [Ms A] made 29 'unsupervised' visits to the clinic.
>
> From her 28 supervised sessions [Mr B] judged that [Ms A] could safely move to total independence. When [Ms A] went independent, she was given cards which described her exercise programme. She had been doing these exercises for six months. Furthermore, there are diagrams on the walls of the exercise clinic which illustrate the exercises, and there are staff constantly available to her if she had any queries."

13 January 2005

Ms A attended the gym on 13 January 2005, after an absence of almost three weeks from her previous exercise clinic appointment on 23 December 2004. She spoke to Mr B before she started exercising, and he gave her no new instructions regarding her exercise programme.

About halfway through her programme, Ms A felt a sudden sharp pain across her back, and she fell to the ground. After a few minutes of resting on the ground, she "very gingerly" went to see Mr B in his office. He applied some "deep heat" gel to her

back but, according to Ms A, he did not provide her with any advice. Ms A stated that she wrote down on the card in pencil the exercises she had performed on that day prior to the injury, and went home. Her shift was due to commence after the exercise clinic but, because of her back pain, she was unable to go to work. A copy of her personnel record confirms that she was off sick on 13 January 2005.

Mr B does not recall the incident when Ms A injured her back. Mr B stated that "if he had received a complaint … which indicated that something was significantly different he believes he would have both noted it and recalled the event". The clinic's computerised appointment system records that Ms A did not attend on 13 January 2005 (the record states "meeting not held"), and shows Ms A's first attendance at the exercise clinic after the Christmas and New Year break as being on 14 February 2005.

Mr B stated:

> "The timing of this complaint followed a holiday that [Ms A] had just been on. Unfortunately, [Ms A] chose to lift the weight that she was lifting prior to her holiday. Ideally she should have made a decision to reduce the weight as she would have lost some conditioning while she was away."

Mr B stated that he did not provide Ms A with any advice about reducing the weights to be lifted, as he expected that she would have asked staff about this issue before commencing the lifts.

In response to the provisional opinion, Mr B accepts Ms A's account of the injury that occurred, but he is "certain that he would have said something to the effect that Ms A should wait to see if the pain settled and if it did not then she should seek medical assistance". He added that although he would have been aware of the programmes he was supervising, "unsupervised attendance was an entirely different matter".

Subsequent events

Ms A attended the gym again on 14 February 2005, and managed to complete only a portion of her exercise programme. The card she completed after the exercises indicates that she performed a reduced set of exercises. She recalls that Mr B was not present. Ms A stated that on this subsequent attendance, she rubbed out the exercises that she had performed on 13 January, and substituted the exercises she performed on 14 February.

The clinical record for Ms A's next appointment on 23 February 2005 states:

> "Check exercises that may be aggravating back. Felt sore after [14 February 2005] session, but cycling and aquajogging makes it feel good."

As Ms A still had back pain and had started to develop weakness in her legs, her orthopaedic surgeon, Dr C, arranged for an MRI to be performed privately. She telephoned Mr B to arrange an appointment to discuss the events, and attended the clinic on 15 March 2005. Mr B recorded in Ms A's clinical record:

> "Meeting — came to discuss an exacerbation of lower back pain. I advised to take a break from the programme until symptoms subsided or seek further medical advice if needed. I realised at the time that [Ms A] had a period of no resistance training recently as she had been on holiday. She went back to doing her programme independently … when this incident happened and unfortunately chose herself to return to the similar load and volume that she had done 8 weeks prior to her break. Three staff were on duty at the time to provide advice if requested … This is in contrast to a supervised session where a client pays to be supervised for an hours session."

Ms A recalls that during the meeting she told Mr B about the pain and the developing weakness in her legs, and "he sat there and said little".

In response to the provisional opinion, Mr B's lawyer stated:

> "At the meeting with Ms A on 15 March 2005 [Mr B] says he started to panic. He appreciated that he had not responded to [Ms A] appropriately. It was at this point that, for [Mr B], and no doubt for [Ms A], the issue started to spin out of hand."

The MRI was performed on 30 March 2005. The report by radiologist Dr D concluded:

> "Localised moderately advanced L4/5 disc degeneration with central disc protrusion. No neural impingement."

In May 2005, Ms A attended a physiotherapist, where she received treatment including Pilates. She still performs exercises as advised by the physiotherapist, and regularly attends aqua-jogging and goes walking. Surgery is not currently planned.

Complaints

On 18 June 2005, Ms A wrote to Mr B, enclosing a copy of her MRI report. She wrote:

> "The orthopaedic surgeon says this is a fresh injury and the cause of the new leg pain I now have. I mentioned this to you the last time we spoke. Although my symptoms have improved, my situation is the worst it has ever been. Apart from my original back pain I now have spinal pain close to the tail bone, pain in the

> right hip, and as I said new leg pain with tingling in my feet. All this is leading to my question about dead lifts and exercise where lifting of weights is required. Why perform an exercise where you run the risk of further injury especially with someone who has a weakened back to start with? Perhaps I hadn't applied my abdominals at the time I don't know, but what a price to pay for a bit of inattention. That injury was and still is a real setback for me. I tried very hard to achieve a good outcome over the six months I attended [the physiology company]. There must surely be other exercises that would achieve the same thing that are safe for people rehabilitating. I certainly cannot function 'normally' at all, this includes at work. I no longer know where to turn.
>
> Look forward to your comments."

In his response to the provisional opinion, Mr B's lawyer stated:

> "When [Ms A] wrote to [Mr B] on 18 June 2005 he was simply incapable of responding. In fact the letter was giving him an opportunity to address the situation with [Ms A]. Instead he reacted most inappropriately and simply did not respond at all. He just worried about it but could not act."

Mr B explained that during this period, he was distracted by a major family illness.

Mr B did not contact Ms A in response to her first letter of complaint. On 8 September 2005, she wrote again to Mr B:

> "Over two months ago I wrote to you outlining the further health problems I have had this year since performing a deadlift at [the physiology company] in January. I have had no reply to this letter so have redirected it to you along with the result of my MRI.
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> …
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> I have had no follow up enquiry from you and have now lost all that I had achieved in terms of a fitness level.
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> A reply would be appreciated."

Mr B did not contact Ms A in response to her second letter of complaint. Ms A then approached Ms E, Health and Disability Consumer Advocate. Ms E wrote to Mr B on 5 December 2005, setting out Ms A's concerns, and in addition asking why he had not responded to her earlier questions.

As Mr B did not respond to her letter of complaint, Ms E telephoned Mr B twice on 16 January 2006 requesting that he contact her. Mr B did not reply to Ms E's telephone calls, so she wrote on 18 January 2006, quoting Right 10 of the Code of Health and Disability Services Consumers' Rights, which sets out a consumer's right to complain. Ms E ended her letter by requesting Mr B's response.

On 23 February 2006, as Mr B had still not been in contact with Ms E or Ms A, Ms E wrote to the Commissioner, formally referring Ms A's complaint.

Mr B accepts that he failed to respond to the letters and communications from Ms A and Ms E:

> "I have never had a formal complaint against me before and I knew the answers I had would not be good enough for [Ms A]. She was a challenge to work [with] and I had to give a lot of my patience and extra time along the way. So due to a heavily demanding occupation and not having the answers that I knew [Ms A] wanted, I did procrastinate."

In response to the provisional opinion, Ms A stated:

> "I was only a challenge because his exercises did not work … I would have loved to have [Mr B] cure my back pain."

Mr B stated that the physiology company did not have a complaints procedure at the time of Ms A's injury. A complaints procedure has now been introduced.

Independent advice to Commissioner

The following expert advice was obtained from Mr Duncan Reid, senior lecturer in physiotherapy:

> "Professional Expert Advice for the Health and Disability Commissioner
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> Case 06/02887 17th June 2006
>
> I, Duncan Reid, Physiotherapist, Auckland, have been asked to provide an opinion on case number 06/02887. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I also declare that there is no conflict of interest in this case. I do not know [Ms A] the complainant, and although I have heard of [Mr B], the health provider, I do not personally know him, nor have I had any professional contact with him.
>
> **Expert Qualifications**
> Duncan Reid, Master of Health Science (Hons), Postgraduate Diploma Health Science (Manipulative Physiotherapy), Diploma Manipulative Therapy, Diploma Physiotherapy, Bachelor of Science (Physiology).
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> I have been a practicing Musculoskeletal Physiotherapist for 25 years. I am currently Head of the Division of Rehabilitation and Occupation Studies at AUT. I

am a senior lecturer in the School of Physiotherapy. I teach both undergraduate and post-graduate Musculoskeletal Physiotherapy papers. I teach on a second year Physiotherapy paper, Exercise Physiology and Prescription and therefore have knowledge of relevant exercise programmes for special populations such as low back pain. I coordinate the Musculoskeletal Physiotherapy paper in the MHSc Programme at AUT. I have a special interest in the management of spinal pain and rehabilitation and have lectured and published nationally and internationally in this area. Hence, I have the required skills and expertise to comment on the treatment and management of low back pain.

Purpose of this report: To provide independent expert advice about whether [Mr B], exercise physiologist, provided an appropriate standard of care to [Ms A].

Background: [Ms A] attended [Mr B] with a 2-year history of back pain, and commenced a programme of exercise rehabilitation in June 2004. This commenced with supervised exercise, and progressed to a self-managed exercise programme, with [Ms A] attending [Mr B's] clinic.

Following the 2004/5 Christmas and New Year holiday period, [Ms A] attended the clinic. She returned to the same programme that had been in place prior to her holiday. Midway through the programme, she experienced sudden back pain, and was unable to go on with the exercise.

Over the next few weeks, [Ms A] developed further symptoms, including leg weakness, and an MRI taken on 30 March 2004 stated:

'Localised moderately advanced L4/5 disc degeneration with central disc protrusion. No neural impingement.'

Complaint
The adequacy and appropriateness of the care provided to [Ms A] by exercise physiologist [Mr B] from June 2004 onwards.

The adequacy of [Mr B's] response to [Ms A's] complaints about the care he provided.

Expert Advice Required
Please comment generally on the standard of care provided by [Mr B].

What professional standards are relevant in this case? Were these standards met?

If not answered above, please provide the following advice, giving reason for your views:

1. Please comment on the exercise programme planned for [Ms A] by [Mr B].

2. Please comment on the assessments made prior to the commencement of [Ms A's] exercise programme.

3. Should there have been re-assessments of the programme during the period from June 2004 to January 2005?

4. When [Ms A] attended the clinic after the holiday period, should she have been advised to adjust her exercise programme? If so, whose responsibility was this?

5. Are there any aspects of the care provided that you consider warrant additional comment?

If, in answering any of the above questions, you believe that [Mr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

Answers to questions

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

The following is first a chronological summary of the events.

[Mr B] first consulted with [Ms A] on the 19/6/04. [Ms A] was self-referred to [Mr B's] business [the physiology company]. [Mr B] is an Exercise Physiologist, with an interest in Exercise Rehabilitation.

In the notes provided by [Mr B], at the initial consultation a medical history was taken outlining the main complaint [Ms A] has, a 2-year history of low back pain. This pain was mainly on the lower back and radiates to the front of the pelvis and groin, behind the right knee and sometimes to the left knee. The pain was rated between one and seven on the visual analogue scale. The pain was aggravated by standing still, bending backwards, lifting baggage at work and bending forwards. Her main limitations were work related lifting, house work and lifting. Following the history taking, [Ms A] was physically assessed and the main findings were several imbalances including an increased anterior tilt of the pelvis, some instability in the pelvis, poor control of the abdominal and gluteal muscles,

hyperextension of the knees, tightness of the calf muscles, iliotibial bands and the hip flexors. A potential leg length difference was also noted. The overall impression from [Mr B] was a sacroiliac joint dysfunction and general postural dysfunction. He felt these were good indications for an exercise programme. Following the physical examination, an exercise programme was initiated.

In the notes provided by [Mr B] the exercise programme begun on the 21/6/04 consisted of the following seven exercises.

- Leg Press
- Pull-ups
- Prone Glut lifts
- Prone Scapular retractions
- Knee Transverse abdominus (TVA) exercises
- Lower body rotations and side lifts
- Pelvic tilt exercises

All exercises were preceded with a warm up and stretching exercises. [Ms A] was initially supervised with the exercises and attended 3 times per week at [the physiology company] gym.

On the 17/7/04 [Ms A] was progressed to the following exercises.

- Front Squats
- Total gym pull ups
- Prone Cobra
- Gym Ball Woodchops
- Pelvic tilts

On the 23/7/04 the following exercises were introduced.

- Deadlifts
- Supine lateral ball rolls
- Kneeling horse stance leg lifts
- Kneeling on a gym ball
- Side lifts.

From the notes provided it seems these last exercises were then continued through until the Christmas break on the 20/12/04. There is then a break and the final session undertaken as stated in [Mr B's] notes on the [14 February 2005]. It was during this last session [which [Ms A] states was her penultimate session, on 13 February 2005] that during the dead lift activity that [Ms A] states she felt a sharp pain in the back. She was unsupervised at the time. [Mrs A] states in her recorded phone conversation with the HDC office (25/05/06) that she went to see [Mr B] in his office immediately after that event and that he applied some deep heat, but made no other comment and took no further action. Since that event, [Ms A's]

pain increased and subsequently progressed further into the legs. She was seen by Orthopaedic surgeon [Mr C] who ordered a MRI scan. This revealed a central annular tear with a broad based disc protrusion (report [Dr D] 01/04/05).

Despite letters from [Ms A] and her advocate [Ms E], outlining the new injury, [Mr B] did not respond to the questions asked about the appropriateness of the dead lift exercise.

Standard of Care

In the initial dealing with [Ms A] the standard [of] care seems appropriate, consent for treatment was gained, a relevant history was taken, an assessment undertaken and an exercise programme prescribed. Initially [Ms A] was supervised in her exercises and then encouraged to be more independent. This is appropriate, as patients with low back pain should be encouraged to take greater self-control and management of the problem.

The exercises were initially progressed as [Ms A] became familiar with them but over the latter part of the exercise programme did not seem to change greatly. In his report to the Accident Compensation Corporation (ACC) on 29/08/04 Mr B states that [Ms A] had had a reduction of symptoms and had an increased work tolerance. [Ms A] disputes this and in her statement to the HDC (25/05/06), felt she had not made any improvement with the programme over the six months of attending the gym. While this is in dispute, some measurable change should have taken place after six months. In terms of the standard of care there is nothing in Mr B's notes to indicate what objective changes had taken place, for example a reduction in the pain as measured by the VAS [visual analogue scale]. Other forms of measurement such as the Oswestry or Roland Morris disability questionnaires could also have been used to measure the changes in pain and function. These types of functional questionnaire are useful with chronic LBP patients to objectify the improvement. There is no evidence of [Mr B] using such measures in his notes.

Once [Ms A] had re-injured her back, [Mr B's] care was not of the required standard. He should have undertaken a further assessment of the problem and referred her back to her GP, with the possible suggestion of an Orthopaedic referral. Patients with acute back pain and radiating leg pain, including changes in the neurological signs (weakness in the limbs) are considered to have potential red flags as outlined in the ACC Acute Low Back Guide (ACC, 2003) and require onward referral. [Mr B] neither reassessed nor referred [Ms A] back to her GP for further evaluation. Not answering her letters is also professionally inappropriate. [Mr B] has defended his actions in his email to the HDC (06/06/06) stating that [Ms A] was a challenge to work with and that he did not have the answers [Ms A] wanted. This does not seem an appropriate answer when clearly [Ms A] has incurred an injury while under [Mr B's] care. Collectively, these actions (or rather lack of them) are a significant departure from the expected standard of care.

2. What professional standards are relevant in this case? Were these standards met?

In terms of standards, Exercise Physiologists do not fall under the Health [Practitioners] Competence Assurance Act. However, Sport and Exercise Science New Zealand (SESNZ) does have a category of Membership called Musculoskeletal Exercise Rehabilitation. If [Mr B] is a member of SESNZ and of this subgroup then there are a set of competencies outlined in the accreditation programme (See www.sportscience.org.nz). These competencies are based on the Health [Practitioners] Competence Assurance Act. One of these competencies is communication and under section 1b the document states that all practitioners must adequately inform participants about the activities they are undertaking and provide feedback during and at the conclusion of all sessions. It is apparent Mr B did not meet this competency.

In the same document under specific competencies Section C Safety and Prevention, the document states that the practitioner must monitor symptoms during a course of treatment, and demonstrate safety principles in weight lifting techniques (eg spotting and dangerous lifts). In the case of [Ms A], the dead lift could have been deemed a lift that required some attention due to its potential for harm. While [Ms A] had done this lift many times before, following her break, the lift could have required supervision. As [Mr B] did not supervise the lift or monitor the symptoms, he did not adhere to this competency.

3. Please comment on the exercise programme planned for [Ms A] by [Mr B].

The exercise programme instituted by [Mr B] was generally appropriate for a patient with chronic low back pain. His basic premise was to increase the functional stability of the lumbo-pelvic region, improve her flexibility and increase her ability to lift at work. The exercises described above were all aimed at achieving this. As quoted by [Mr B] in his letter of 4/05/06 he based the programme on the work of McGill (2002). A number of the exercises prescribed such as the Knee Transverse abdominus (TVA) exercises, Kneeling horse stance leg lifts and the side lifts are recommended by McGill (2001, 1999).

The exercise that appears to have caused the greatest problem is the dead lift. If this is performed as shown in the picture supplied by [Mr B] in his letter of 4/05/06, then there should be only a small chance of this being pain provoking. Cholewicki McGill, & Norman (1991) have demonstrated that if the lumbar spine is maintained in extended or lordotic position during heavy lifts that in well trained individuals, they can lift up to 18 times their body weight. However there are two assumptions that also have to go with this, firstly that the lumbar lordosis is well maintained and secondly that the lumbar discs are normal. A normal disc can withstand these normal vertical compression forces.

[Ms A] did not have normal discs as demonstrated in the MRI findings. The report from [Dr D] on 01/04/05 indicates she has moderately advanced L4/5 disc degeneration. A degenerative disc may not be able to tolerate increased vertical loading. If [Mr B] had had this information, he may have modified this exercise or not given it at all.

The second requirement to have a good lordotic posture during the lift is something that [Ms A] may have been instructed to do at the outset of the programme. As she was not explicitly supervised on the day she injured her back it is possible she did not have ideal posture. If the spine was in a flexed position during this lift, then this would be a possible mechanism to tear the annulus. Adams and Hutton (1982) have demonstrated that hyper-flexion is harmful to the annulus of the disc. [Ms A] is also in the age group where disc injury is common (25–45 yrs of age). This is another risk factor.

While [Mr B] states there were staff around in the gym at the time [Ms A] did the lift, it is not clear if any of these staff were actually watching her. Given that [Ms A] had returned from holiday, it would have been prudent for [Mr B] to have reviewed the programme, see if there had been any deterioration in her condition, reset the target weights, and review the technique. In terms of standards of care, given the chronic nature of [Ms A's] pain, a review and re-evaluation of the programme would have been appropriate. The inability to monitor the lift is a moderate deviation from the expected standard of care.

4. Please comment on the assessments made prior to the commencement of [Ms A's] exercise programme.

[Mr B] provides ample evidence of the actual changes to the exercise programme. While there is an initial status report to ACC (29/08/04) on a range of areas there is no evidence of any other assessment that indicate these parameters have improved. There is no evidence that there has been a measurable change in the intensity of the low back pain, the flexibility of [Ms A's] limbs or the functional activities she could or could not do following the programme. There clearly should have been frequent evaluation of these factors documented in the initial report, on a more regular basis. Not monitoring the programme and recording appropriate changes in the status of these variables is a moderate deviation from the normal standard.

5. When [Ms A] attended the clinic after the holiday period, should she have been advised to adjust her exercise programme? If so, whose responsibility was this?

Yes, [Ms A] should have been advised to adjust her programme after a period of time away from the Gym and it was [Mr B's] responsibility to reassess [Ms A] and set new targets. Not reassessing the programme is significant deviation from the normal standard of care.

6. Are there any aspects of the care provided that you consider warrant additional comment?

One further aspect that warrants some comment is that of diagnosis. The term chronic low back is not a diagnosis and while explicit diagnosis in chronic cases is not always possible, a working diagnosis is useful. As [Mr B] is not a Doctor or health professional who would have the competency to make a diagnosis, it may have been prudent for [Mr B] to contact [Ms A's] GP to get the most current working diagnosis before prescribing the exercise programme. While I have stated that the exercise programme was appropriate to stabilise the lumbo pelvic region, that is on the assumption that this was the diagnosis, an unstable sacroiliac joint. Ms A had evidence of consistent central lumbar pain radiating to both legs. This is not consistent with sacroiliac joint dysfunction and based on the work of Laslett, Aprill and McDonald et al (2006) patients with a loss of lumbar extension and pain that centralises to the lumbar spine with repeated lumbar extension have a high probability of having discogenic pain. The prevalence of chronic back pain patients in this study with discogenic pain was 35%. Therefore, the more likely diagnosis of [Ms A's] LBP is a disc lesion, not a sacroiliac instability. This diagnosis may have required a modification to the exercise programme.

In summary, while the overall exercise programme seemed appropriate, the overall management, with a lack of relevant reviews and documented outcomes, and the monitoring of the exercise programme after a period of time off, was less than optimal. The management of [Ms A's] acute episode of pain following the lifting exercise in particular was not of the appropriate standard of care.

References

ACC. (2003). *New Zealand Acute Low Back Pain Guide*. Wellington.

Adams, M., & Hutton, W. (1982). Prolapsed Intervertebral disc. A hyperflexion injury. *Spine, 7*(3), 184–191.

Cholewicki, J., McGill, S., & Norman, R. (1991). Lumbar Spine loads during the lifting of extremely heavy weights. *Medicine and Science in Sports and Exercise, 10*(2), 245–256.

Laslett, M., Aprill, C., McDonald, B., & Oberg, B. (2006). Clinical predictors of lumbar provocation discography: a study of clinical predictors of lumbar provocation discography. *European Spine Journal*.

McGill, S. (2002). *Low Back Disorders: Evidence-Based prevention and treatment*: Human Kinetics.

McGill, S., Childs, A., & Liebenson, C. (1999). Endurance times for low back stabilisation: clinical targets for testing and training from a normal database. *Archives of Physical Medicine and Rehabilitation, 80*(8), 941–944.

Sport and Exercise Science NZ Accreditation Document
http://www.sportscience.org.nz/sess/accreditation/MSExerciseRehabJuly2005.pdf
"

Response to provisional opinion

Presenting symptomology
In response to Mr Reid's advice that Ms A's presenting symptomology would have suggested a disc lesion rather than sacroiliac instability, Mr B stated:

> "My training through [the institute] did provide me with skills to get 'indications' for the source of a problem as a means to help design an appropriate exercise programme. As reported in the Commissioner's report, I am not a health professional and therefore should not diagnose. This has always been known to me and in [Ms A's] case my focus was on her biomechanics and imbalances affecting this. In [Ms A's] case I had much stronger indications that a sacroiliac joint dysfunction was at least a big part of the problem. If a disc issue was present at the time it was not [obviously] based on her symptoms and my measurement findings.
>
> Firstly her symptoms were lower back pain, pain in the front of the pelvis and pain mainly behind the right knee. Pain in front of the pelvis occurred before the back pain started. It was tender behind the right knee specifically and not further up. There was no radiating pain down the buttock or right hamstring."

Reassessment of back pain
Mr B's lawyer stated:

> "Mr Reid is critical of the fact that there was no evidence of 'frequent evaluation' of the intensity of low back pain, the flexibility of [Ms A's] limbs or the functional activities she could or could not do following the programme. That observation fails to have regard for the fact that [Mr B] was indeed carrying out that exact evaluation each time [Ms A] came for supervised treatment. She was in fact making very good progress, and reporting a reduction of her back pain and self-evidently there was increased flexibility of movement. The monitoring only ceased at a point where [Ms A], and encouraged by [Mr B], elected to end the supervised programme."

Supervision of exercise
Mr B's lawyer stated:

> "Mr Reid appears to assume that [Ms A's] continued attendance at [the physiology company] was under a supervised programme. That is just not the case. At issue, perhaps, is whether or not there was some residual obligation on [Mr B] to continue to supervise even though that was completely contrary to the arrangement. Put another way, [Ms A] could not contract to have access to the apparatus on the clear understanding that there would not be supervision, on the one hand, and yet expect an element of supervision on the other.
>
> What this case has raised is the complicated issue of whether or not [Mr B] can allow access to the apparatus for the purpose of people continuing their exercise regime on an unsupervised basis, but without retaining some residual responsibility. Can he allow use of the apparatus if he may not be present, staff may not necessarily even know the person's history, and there is no intention of monitoring them[?] He has addressed this with the introduction of a new Protocol …
>
> This [protocol] requires the client to acknowledge the extent of their responsibility for the management of their programmes if continued on the '10 trip' basis. That includes advising staff prior to commencement of a session of:
>
> 1. A change in physical condition where that has arisen since the last programme attendance, and
>
> 2. Advising of the fact that the programme has not been carried out for a period of greater than two weeks.
>
> …
>
> The latter point is important, because [Mr B] has clients who, for example, will attend sporadically at his clinic but who are in fact attending other gyms more convenient to them at times, or are carrying out their programmes at home. [Mr B] will have no idea what these clients have been doing or when they have been doing it. The normal practice is that they are taught to be sensible and to make conservative judgements with their programmes. This is part of teaching self-reliance and safe management of the injury or condition. As noted, in 20 years there has never been an issue arising such as this. [Mr B] does accept that [Ms A] did not understand that she had to ease herself back into the programme after an absence from it of some weeks."

Follow-up after injury
Mr B's lawyer stated:

> "Mr Reid concludes that 'Once [Ms A] had re-injured her back, [Mr B's] care was not of the required standard.' [Mr B] acknowledges that he should have followed up with [Ms A], and, that the follow up needed to entail reassessment at least to the extent of ascertaining whether [Ms A] could resume an exercise regime in some form or other, or whether she needed GP evaluation."

Professional standards
Mr B has considered the professional standard referred to by Mr Reid. Mr B stated through his lawyer:

> "Mr Duncan Reid has advised you that Exercise Physiologists do not fall under the Health (Practitioners) Competence Assurance Act. He raised the question of whether or not [Mr B] was a member of Sport and Exercise New Zealand. The answer to that is 'no'. However, [Mr B] takes the view that he should not seek to shelter behind an obscure argument as to whether or not particular standards apply to him. He accepts that those standards ought to apply to him and he also unreservedly accepts that by his failure to act the result is [a] very serious breach of those standards."

Response to complaint
Mr B accepts that he failed to respond appropriately to Ms A's complaint. In an apology to Ms A, he stated:

> "Yours is the first complaint I have ever had to manage in nearly 20 years of being in the business of exercise physiologist. Unfortunately, I suffer from a real difficulty in coping with conflict in relationships. It is a serious problem for me. I try to avoid the conflict and tend to try and pretend that it is not happening.
>
> …
>
> By the time you had got to have the MRI scan your injury was already looming large for me as a significant issue. I was worrying about it but could not see a way of appropriately addressing it. Then, and to make matters worse, as you wrote to me I just further retreated into a shell. You must have felt very neglected and betrayed by me, as well as feeling utterly let down. I am mortified about that and just cannot apologise to you enough.
>
> …

[Ms A], again I must apologise for having let you down in such an abysmal way. I cannot turn back the clock on my actions. I wish that I could. I am proud of the fact that I have helped and assisted so many people over 20 years. But I feel, in relation to my management of you and your case, that I have let you down very very badly indeed. I really do not know how I can make amends in a meaningful way. I am happy to give you a full refund of all the fees you have paid to me since you commenced seeing me. I would also be willing to meet with you to apologise in person."

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.

RIGHT 10
Right to Complain

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

…

(6) Every provider, unless an employee of a provider, must have a complaints procedure …

Health and Disability Commissioner Act 1994

The following definition in the Health and Disability Commissioner Act 1994 is applicable to this complaint:

3. Definition of "health care provider" —

In this Act, unless the context otherwise requires, the term "health care provider" means —

…

(k) Any other person who provides, or holds himself or herself or itself out as providing health services to the public or to any section of the public, whether or not any charge is made for those services.

Opinion: Breach — Mr B and the physiology company

Mr B is not a registered health practitioner. He is not a member of Sport and Exercise Science New Zealand, which has an accreditation programme as well as a Code of Ethics. However, he is a health care provider, offering rehabilitative exercise to people with lower back pain and other problems. Consequently, he is obliged to abide by the Code of Health and Disability Services Consumers' Rights (the Code).

Under Right 4(1) of the Code, Mr B was required to provide physiology services to Ms A with reasonable care and skill. When she approached Mr B with concerns about the injury sustained during an exercise clinic, under Right 10(3) Mr B was required to facilitate the fair, simple, speedy, and efficient resolution of her complaint. In addition, in accordance with Right 10(6), the physiology company, of which Mr B was the sole director and shareholder, was required to have a complaints procedure in place.

For the reasons given below, in my view Mr B breached Rights 4(1) and 10(3) of the Code. By failing to have a complaints procedure, the physiology company also breached Right 10(6) of the Code.

Exercise programme

Assessments
My independent physiotherapy advisor, Mr Duncan Reid — who, although not a direct peer of Mr B, is able to provide general advice on the appropriateness of exercise physiotherapy services — advised that the exercise programme instituted by Mr B in June 2004 was "generally appropriate for a patient with chronic low back pain".

Mr B was required to review the efficacy of the programme that he had planned, and alter it to meet Ms A's needs. Apart from the ACC Activity Based Programme Initial Report of 19 June 2004, there was no further reassessment of Ms A's back pain or whether the programme prescribed was helping. Mr Reid criticised Mr B's failure to monitor Ms A's programme:

> "Not monitoring the programme and recording appropriate changes in the status of these variables is a moderate deviation from the normal standard."

In response to the provisional opinion, Mr B stated that there was continual reassessment of Ms A's programme while she was supervised in her exercise programme, but there is no documented evidence of this. I consider that Mr Reid's criticism is still appropriate.

Injury
There is some dispute about the day on which Ms A's injury occurred: she states that it happened on 13 January 2005, and Mr B cannot recall when it occurred. The documentation provided by both parties is also contradictory. Mr B's notes suggest that Ms A did not attend the gym on 13 January but on 14 February, but the evidence confirms that she took sick leave from work later on 13 January.

What is clear is that Ms A returned to the exercise clinic after a break of three to four weeks over the Christmas and New Year period. She stated that she spoke with Mr B prior to commencing the programme, but he did not advise her to alter her programme. (Mr B does not recall this conversation.) At no time did Mr B advise Ms A that her exercise programme needed to be altered because she had taken a break. Ms A proceeded with her programme, and was unsupervised. The injury to Ms A's back occurred midway through her exercise routine.

Mr Reid commented that the deadlift "could have been deemed a lift that required some attention due to its potential for harm". Mr Reid also identified Ms A's age as a further risk factor for disc injuries. He advised:

> "Given that [Ms A] had returned from holiday, it would have been prudent for [Mr B] to have reviewed the programme, see if there had been any deterioration in her condition, reset the target weights, and review the technique. In terms of standards of care, given the chronic nature of [Ms A's] pain, a review and re-evaluation of the programme would have been appropriate. The inability to monitor the lift is a moderate deviation from the expected standard of care."

Post-injury
Ms A recalls talking with Mr B in his office immediately after she injured her back. In contrast, Mr B does not recall Ms A coming to him immediately after her injury, although he does accept that the injury occurred at the clinic.

Ms A described how she returned to the exercise clinic on 14 February to perform a reduced set of exercises. These are recorded on the card she completed at the end of each appointment.

On the balance of probabilities, I find it is probable that Ms A's injury occurred on 13 January, as she described, and that her failure to complete the exercise card somehow resulted in the computerised record stating that she did not attend on that day. I therefore accept that she probably did speak to Mr B both before she started her programme that day and immediately after the injury. Accordingly, having been made aware of Ms A's injury, he was required to respond appropriately. However, there is no evidence that Mr B responded in any way. He did not refer her to another health

professional, and there is no evidence that he made a record of the injury at the time. Mr Reid advised:

> "Once [Ms A] had re-injured her back, [Mr B's] care was not of the required standard. He should have undertaken a further assessment of the problem and referred her back to her GP, with the possible suggestion of an Orthopaedic referral. Patients with acute back pain and radiating leg pain, including changes in the neurological signs (weakness in the limbs) are considered to have potential red flags as outlined in the ACC Acute Low Back Guide (ACC, 2003) and require onward referral. [Mr B] neither reassessed nor referred [Ms A] back to her GP for further evaluation."

Summary
Mr B failed to reassess Ms A's back pain during the course of her programme (June 2004 to February 2005), and failed to alter Ms A's exercise programme or provide supervision when she returned from a break, even though he knew that she would have "lost some conditioning". As I accept that Ms A spoke to Mr B prior to commencing her exercise programme, this was an ideal opportunity to review her programme.

In his responses, Mr B indicated that Ms A "should have made a decision to reduce the weight", and that he would have expected her to ask staff about this issue prior to commencing her exercise programme. However, Ms A was unaware of the need to discuss this issue with the staff at the clinic. In my view, Mr B cannot lay the blame on Ms A for her injury. Mr B also failed to respond appropriately to the injury that occurred on 13 January 2005 as he did not refer Ms A to another practitioner, such as her general practitioner.

Even though Ms A had progressed to exercising without supervision, Mr B had not provided her with sufficient information to do this safely.

For the above reasons, Mr B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Response to complaints
Following a meeting in March 2005 to discuss the injury incurred during the exercise clinic, Ms A sent Mr B two letters explaining her concern about her exercise programme and injury, and seeking a response. Having received no response from Mr B, Ms A approached the Health and Disability Consumers Advocacy Service. However, despite two letters and two telephone calls from an advocate, Mr B still did not contact either Ms A or the advocate, Ms E.

Mr B also delayed responding to enquiries from my Office. In his response once the investigation commenced, Mr B admitted that he had not responded to the letters and telephone calls from Ms A and her advocate because he had a demanding job and he did not have the answers that he knew Ms A wanted.

I agree with Mr Reid's advice that Mr B's failure to respond to Ms A's letters was "professionally inappropriate". In my view, Mr B's reasons for not responding to Ms A's questions and complaints are wholly inadequate. In response to the provisional opinion, Mr B has belatedly explained the reasons for his failure to respond. His explanation and his fulsome apology explain, but do not excuse, his behaviour. By failing to respond to contact by Ms A and her advocate, Mr B did not facilitate the speedy resolution of Ms A's complaint, and therefore breached Right 10(3) of the Code.

It is a requirement of the Code that the physiology company should have had a complaints procedure; at the time of Ms A's injury in January 2005 there was no such procedure. Accordingly, the physiology company (with Mr B as the sole director and shareholder) breached Right 10(6) of the Code.

Follow-up actions

- A copy of this report, with details identifying the parties removed, but identifying Mr B, will be sent to Sport and Exercise Science New Zealand and the American College of Sports Medicine.

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

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.