Chiropractor, Dr A

Chiropractic Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC00174)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs B had been experiencing ongoing pain in her left leg. She had been to multiple specialists for treatment in the past. On a Wednesday in 2015 Mrs B saw Dr A at a chiropractic clinic (the Clinic) to seek treatment for the pain in her leg. Mrs B completed a patient information form where she recorded "constant pain down left leg". Dr A said that he would be able to help Mrs B and her pain could be resolved. During the appointment Mrs B became emotional because of the prospect that the pain, which previously she had been unable to get treated adequately, might finally be relieved.

2. Mrs B said that Dr A hugged her twice and kissed her on the cheek during the first consultation. Dr A said that he hugged Mrs B but did not kiss her.

3. A physical examination took place, which included taking Mrs B's blood pressure and pulse. Mrs B sat on the side of the bench, and Dr A sat on the bench facing her with his feet on either side of the bench, and took her blood pressure.

4. Dr A examined the front of Mrs B's neck in order to determine whether her thyroid gland was normal. He recorded in the patient notes that Mrs B might have a fluctuating thyroid function. Dr A discussed thyroxine and a gluten-free diet with Mrs B.

5. After the initial consultation, Mrs B asked Dr A for a summary of his findings. Dr A provided Mrs B with handouts about some of what was discussed, but no summary was supplied.

6. On Friday, Mrs B consulted with general practitioner Dr C to confirm Dr A's finding of a fluctuating thyroid and whether she should start taking thyroxine. Dr C advised Mrs B that she had an enlarged left thyroid lobe but thyroxine was not required, and that a coeliac screening could be performed for peace of mind if she wished.

7. On Friday, Mrs B attended a second consultation with Dr A, again unaccompanied. A foot scan was completed. A further appointment was made, which Mrs B later cancelled. Dr A telephoned Mrs B to follow up, and spoke with Mr B, who told him that Mrs B would have no further contact with Dr A.

Findings

8. By not providing a clear rationale for his assessment of a fluctuating thyroid, and not referring Mrs B to a doctor when he suspected she might have a dysfunctional thyroid, Dr A failed to provide services to Mrs B with reasonable care and skill and, accordingly, he breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

9. By not keeping adequate records of the services he provided to Mrs B, and failing to document all of his examination findings, Dr A did not provide services to Mrs B that

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

complied with the relevant professional standards and, therefore, he breached Right 4(2)[2] of the Code.

10. Adverse comment is made about not providing, on request, a written summary of the information Dr A provided, and the manner in which he communicated with and touched Mrs B.

11. Dr A's breaches of the Code were the result of individual decision-making and not errors attributable to the Clinic. Therefore, the Clinic did not breach the Code.

Recommendations

12. The Deputy Commissioner recommended that Dr A:

a) Undertake further training on documentation and referrals.

b) Reflect on his practice as a chiropractor and provide HDC with a written summary of his reflection and the changes to his practice, instigated as a result of this case.

c) Provide a written apology to Mrs B for his breaches of the Code.

Complaint and investigation

13. During 2015 the Commissioner received a complaint from Mrs B about the services provided to her by Dr A, a chiropractor practising at the Clinic.

14. An investigation was commenced. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs B by Dr A.*
- *The appropriateness of the care provided to Mrs B by the Clinic*.

15. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

16. The parties directly involved in the investigation were:

Dr A	Provider/chiropractor
The Clinic	Provider
Mrs B	Consumer/complainant
Mr B	Consumer's husband

17. Information was also received from Dr C, a general practitioner.

[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards."

18. Independent expert advice was obtained from chiropractor Mr Troy Dandy (**Appendix A**).

Information gathered during investigation

Wednesday— first consultation

19. On a Wednesday in 2015 Mrs B attended an initial consultation with Dr A at the Clinic for treatment of ongoing pain in her left leg. Dr A works from his own rooms and Mrs B told HDC that nobody else appeared to be there at the time. Dr A told HDC that normally he has a front desk assistant but, at that time, she was on leave.

20. Upon arrival at the Clinic, Mrs B completed a seven-page patient information form. This included general information about her medical history and a list of general health questions answered by circling "Yes" or "No".

21. Mrs B recorded on the form that her major complaint was chronic plantar fasciitis.[3] She wrote that she suffered from a "constant ache down [her] left leg". She said that Dr A talked about how chiropractic care could help alleviate pain.

22. Dr A noted in the patient notes:

> "Been to many people and has spent lots of money trying to get well. Discussion re injury and first treatment."

23. Dr A recorded that the pain in Mrs B's leg was seven out of 10, and could be up to 10 out of 10.[4] Mrs B said that Dr A confirmed that he was able to help her and could resolve the problem, and that this could be done within 10 sessions. She told HDC that she then started crying because of her relief at being advised that the condition, which she had experienced since 2011, could be resolved. Mrs B said:

> "I made it quite clear that I had been having a really difficult year and I had got upset during the consultation because I felt overwhelmed by the fact that he said that it would be an easy fix, to fix the plantar fasciitis; you know, a piece of cake."

24. Dr A conducted an examination to assess Mrs B's blood pressure, pulse and other observations. Dr A told HDC that he palpated Mrs B's spine and checked her sacroiliac joints,[5] and found that "she had really nice movement", which he found surprising in light of the extent of her pain.

[3] Plantar fasciitis involves pain and inflammation of a thick band of tissue, called the plantar fascia, which runs across the bottom of the foot and connects the heel bone to the toes.
[4] One being no pain and 10 being severe pain.
[5] The sacroiliac (SI) joints are formed by the connection of the sacrum and the right and left iliac bones (upper crest or "wings" of the pelvic girdle). The sacrum is the triangular-shaped bone in the lower part of the spine.

25. During the physical examination Dr A made a series of notes relating to the vertebrae of the spine. He recorded in the patient notes under a heading "Leg checks": "Joint pain in all areas. Patient has decreased pain on mobilisation. Patient happy walking up and down office."

Blood pressure

26. Dr A used a sphygmomanometer[6] to assess Mrs B's blood pressure. Mrs B indicated to HDC that she sat on one side of the bench with her feet almost touching the floor. She said that Dr A straddled the bench and sat facing her with the front of his body almost touching her side. She said that Dr A then rested her forearm on his thigh in order to use the sphygmomanometer. Mrs B said that she had never had her blood pressure taken that way previously.

27. Dr A told HDC that he agreed that he sat facing Mrs B at a 45 degree angle whilst she was sitting on the bench in order to take her blood pressure from her side. He added:

> "The sphygmomanometer unit used to do this is a portable unit that sits between myself and the patient. During my medical career I always sat in this position when using [the sphygmomanometer] as it is the easiest way to get a consistently replicated [measurement] while taking blood pressure bilaterally. I cannot understand why the patient believes this is unprofessional and I was totally unaware that this made her feel uncomfortable. In the many years practicing […] I have never had any patient comment or refer to this."

28. Dr A told HDC that Mrs B's arm was resting on her own thigh, and was not touching his thigh. Dr A then stood up, walked around to her other side, straddled the bench again, and took her blood pressure on the other arm. Mrs B stated:

> "So he is basically straddling the [bench] with his private parts facing towards me right up close with my arm resting on his leg and he did that on the left-hand side and then he did that on the right-hand side and made an observation that my blood pressure was significantly different on both sides … He said it was due to neurological imbalances that my blood pressure was different on both sides and that some adjustments would make it better aligned."

29. Dr A cannot recall whether he told Mrs B that her blood pressure on each arm was different; however, the clinical notes record that it was 140/80mmHg in her left arm, and 120/80mmHg in her right arm.

30. Dr A said that during the examination he talked to Mrs B about pain perception and joint proprioception,[7] and Mrs B became tearful. Dr A said that he reassured Mrs B that it was fine to cry, and that it was a normal response given her chronic ongoing pain. He told HDC that normally when a patient became distressed during a consultation, his front desk assistant would comfort the patient; however, at that time the assistant was on leave. Dr A said that he reached forward, put his arm around Mrs B's shoulder, patted her on the

[6] A device used to measure blood pressure.
[7] The unconscious perception of movement and spatial orientation arising from stimuli within the body.

back and gave her a little hug, similar in manner to when greeting someone. He told HDC that it was brief and purely instinctive as Mrs B was crying.

31. Dr A recorded in his patient notes: "Talks regarding pain perception, leg lengths, nerves and joints. Example given re. pain perception. Patient tearful — comforted by me. Reassured we would do our best to get her well and not to worry — people often cry."

32. Dr A then performed a manipulation through Mrs B's clothing, with her lying on her front.

Thyroid examination and diagnosis

Mrs B's account

33. Mrs B told HDC that Dr A then stood behind her as he examined the front of her neck in order to determine whether her thyroid gland[8] was normal. She said:

> "[Dr A] basically came behind me and said, 'I am just going to check your thyroid … it's your thyroid, dear', well actually he didn't even tell me he was going to check my thyroid, he was palpating it and then he came down like this [leaning down behind] and said, 'You have got a problem with your thyroid', hugging me and touching [his cheek against mine].
>
> …
>
> He was using terms of endearment with me."

34. Mrs B told HDC: "[Dr A] proceeded to cuddle me from behind and put his face up against mine and advised that I had an enlarged thyroid and that everything will be ok as we can get it sorted."

Dr A's account

35. Dr A stated that following the examination and assessment a discussion around thyroid functionality took place. Dr A said that this was because Mrs B had circled a number of issues that suggested to Dr A that her thyroid function was less than ideal.

36. Dr A said that Mrs B informed him that her mother and sister both had thyroid issues, and that her mother had had her thyroid removed and was on thyroxine.

37. Dr A told HDC that he explained to Mrs B how thyroid function affects metabolism, muscle and joint pain, and mood, and that it could compromise sexual relations between partners. He said that he explained that thyroid dysfunction could be a difficult condition to diagnose.

38. Dr A said that he sought Mrs B's consent to examine her thyroid by palpating it.[9] He told HDC that he stood on one side of the bench and, reaching over it, palpated Mrs B's neck as she sat facing away from him on the other side of the bench. He said:

[8] The thyroid is a large ductless gland located in the neck. The thyroid gland secretes hormones that regulate growth and development through the rate of metabolism.
[9] Touching the front and side area of the neck to feel the thyroid gland.

> "[I] found that her left lobe was slightly grainy and elevated. She asked if it was ok and I responded that it was slightly raised but that she would be fine. Taking my hands from her neck I then patted her shoulders from the side to reassure her. ***I never hugged her with my cheek against hers.***" (Emphasis in original.)

39. Dr A recorded in his patient notes: "Left thyroid lobe not major."

40. In response to my provisional opinion, Dr A said that, based on Mrs B's presenting symptoms and his clinical experience, he did not believe there was an acute problem warranting medical intervention. He said that there is a broad spectrum in thyroid dysfunction, and that Mrs B's slightly raised lobe was at the lower end of the spectrum. He said that he documented this as a reference to the need to monitor Mrs B's thyroid on an ongoing basis. Dr A said that dysfunction at the lower end of the spectrum does not automatically mean it is serious, but having it documented is helpful if subsequently it becomes more serious.

Advice given

41. Mrs B stated:

> "[Dr A] highly recommended that I commence supplementation with thyroxine that he would be providing in order to assist with losing weight, balancing my moods, improving my energy levels and increasing my affection towards my husband so as to not compromise our sexual relationship. He also stressed that I discontinue eating gluten and soy in order to assist with resolving my enlarged thyroid and diagnosed me as having non-coeliac gluten intolerance."[10]

42. Mrs B told HDC:

> "[Dr A] said 'It is OK, what we are going to do is we are going to give you thyroxine and the thyroxine will manage your enlarged thyroid. It is also going to help you to lose weight' and then he [motioned an hour glass shape with his hands] and said 'but you will keep your curves'.
>
> …
>
> He said I would be a much happier person, he queried whether when my husband gets home do I get agitated when I see him, like do I feel like I don't love him and said that if I took thyroxine I would fall in love with my husband again (not that at any point did I say I was out of love with my husband) and that my sex life would be improved by taking thyroxine.
>
> …
>
> He basically sold it like it was going to change my life, some magic potion."

43. Dr A denied suggesting to Mrs B that she take thyroxine. He told HDC:

[10] A syndrome in which patients develop a variety of intestinal and/or extra-intestinal symptoms that improve when gluten is removed from the diet. It may be diagnosed after coeliac disease and wheat allergy have been excluded.

> "I explained the role of thyroxine in the body to her and told her that the medical treatment for Hypo Thyroid dysfunction was to give the patient thyroxine but that Functional Practitioners like myself used vitamins, diet and exercise to support thyroid function. At no stage did I suggest or even raise with the patient that she should start taking thyroxine or that I would prescribe thyroxine to her. Chiropractors are not allowed to prescribe drugs to patients. I have never prescribed any drugs to a patient and never tried to get any patient to take thyroxine."

44. Dr A told HDC that he did not talk about the side effects of taking thyroxine. He said that he explained to Mrs B that a lack of thyroxine affects perception, and that "it affects relationships even to the level that it can affect people's sexual relationships".

45. Mrs B told HDC that it was not clear how Dr A proposed to prescribe thyroxine; however, she gained the clear impression that he was going to supply it. She said: "He didn't specify but the implication to me was that he had it there at his premises and was going to give it to me once I consulted my husband."

46. Dr A told HDC that there was a discussion about the fact that Mrs B's mother had had her thyroid removed, and that her sister had thyroid problems. He said that he explained to Mrs B that she was "likely to have suffered the effects of a fluctuating thyroid for some years given her familial history of thyroid dysfunction and that it was possible that this was a factor in her depression". Dr A told HDC that he told Mrs B that she could reduce the metabolic load on her thyroid, adrenal and gastrointestinal system by removing gluten and, to a lesser degree, soy from her diet.[11]

47. Mrs B told HDC that her mother and sister both suffer from an enlarged thyroid and take thyroxine. Mrs B said that the apparent diagnosis of enlarged thyroid without performing any other tests shocked her but, because of her family history, did not surprise her.

48. Mrs B stated:

> "When I asked [Dr A] why my general practitioner had never diagnosed this in the past, he advised me that it's because they wouldn't have undertaken the same practical examination that he did and that they wouldn't have been testing my blood correctly due to only observing Thyroid Stimulating Hormone levels and not specifically T4 & T3[12] to uncover the problem with my enlarged thyroid."

49. Dr A told HDC that, in his opinion, any thyroid dysfunction was not presenting to a sufficient degree to warrant referring Mrs B to a medical practitioner. He said that the reasons why he did not refer Mrs B to a medical practitioner at the time of the initial consultation were:

a) patients usually open up and provide more information about thyroid dysfunction over time, after four to six sessions, and he was still forming a working diagnosis;

b) other healthcare professionals had not "resolved the pain";

[11] It is within the scope of practice for a chiropractor to provide dietary advice (see Scope of Practice — Chiropractor, paragraph 2, below).
[12] The thyroid hormones.

c) the prescription medication Mrs B was taking might "mask the most obvious" symptoms of thyroid dysfunction; and

d) Mrs B denied other symptoms commonly associated with thyroid dysfunction.

50. Dr A told HDC that "many GPs don't do an initial physical exam/palpation of the thyroid as [he] had just done but rely on blood tests to make a diagnosis". He said that in the past he has referred patients who have presented with potentially serious thyroid problems to their GP.

51. Dr A submitted:

> "While [I] had [my] strong suspicions, [I] had not yet definitively diagnosed thyroid dysfunction. [I] needed more consultative presentations to do this. Given the initial information provided by [Mrs B], and the elevated lobe, [I] believed that it possibly pointed towards thyroid dysfunction. [I] did NOT diagnose Hypothyroidism nor state this to the patient."

Request: summary of information

52. Mrs B said that at the end of the consultation she asked Dr A if he would provide a summary of his findings so she could give it to her husband. Dr A said to Mrs B that he did not have time to prepare a summary at that stage. Dr A told HDC that he believed that Mrs B wanted follow-up information about the thyroid dysfunction, so he gave her some handouts with general information about the thyroid gland and a gluten-free diet.

53. Dr A told HDC that he provided Mrs B with an article he had written about gluten, and a pamphlet on thyroid and adrenal health. He said that he told Mrs B that her husband or mother would be welcome to accompany her to the next visit and listen to the information imparted. Dr A said he also told Mrs B that Mr B would be welcome to give him a call if he wished, and he would answer any questions Mr B might have.

54. Dr A's clinical notes state that information was provided "re. gluten and thyroid adrenal health". In response to my provisional report, Dr A stated that as Mrs B was coming back for a further consultation a few days later it was his intention to give a more complete summary after the next consultation. Dr A said that he did not feel that there was any more information (other than the generic handouts) to give to Mrs B at that stage without a further consultation. He said that if the second consultation had been scheduled for several days or even a week later, he would have summarised his findings and forwarded them to Mrs B.

Conclusion of consultation

55. A further appointment was discussed. Dr A stated:

> "I said to [Mrs B] that I realised we had covered a lot of information today and that at our next visit I would like to scan her feet to assess whether she had any plantar vault changes that are common in Plantar Fasciitis and lower leg and back pain. The scan would be at no charge to her so she didn't have to worry about any costs. [Mrs B] seemed happy with that and in general."

56. After the consultation, Dr A filled in another sheet. In the section titled "Key Case Notes" he circled "Yellow Flags"[13] and noted the following yellow flag:

> "Prolonged sciatic nerve entrapment/irritation."

Under the heading "Clinical Impression", Dr A noted:

> "Right sided sciatic nerve involvement multiple level joint and left foot pronation. ? fluctuating thyroid function."

57. Mrs B said that at the end of the consultation, as she was departing the Clinic, Dr A "hugged [her] and kissed [her] on the cheek". On this point Dr A said: "I did not hug the patient or kiss her goodbye on the cheek. I cannot understand why she has said this." Mrs B said that this "may have been [Dr A's] way of showing empathy", but she found the actions unprofessional and inappropriate, and subsequently she felt degraded and upset. She said: "I feel as though I am currently experiencing elevated stress levels due to my encounter with [Dr A] as I continue to have disturbing flashbacks to the initial consultation and I feel degraded and upset."

58. Dr A told HDC:

> "[Mrs B] had also received some Chiropractic adjustments from me during the consultation to which she stated the pain felt much better. She appeared really happy following the consultation in the reception area. At no stage did [Mrs B] raise any concerns about the care she had received."

59. Mrs B supplied HDC with a transcript of text messages that she sent to her sister immediately after the consultation, which refer to a discussion with Dr A about thyroid functioning and thyroxine. The messages are consistent with her account of Dr A's conversation with her regarding thyroid functioning and thyroxine.

60. Mrs B says that when she told her family what Dr A had advised her about her thyroid, they were "horrified" that a chiropractor had made a diagnosis without a scan being done.

61. Dr A said that he telephoned Mrs B that evening to see how she was doing. There is a further note in Dr A's patient records: "Patient phoned in evening […]. Has been tired and pain returned. To be seen Wednesday.[14] Foot scan to be done then."

Friday — consultation with Dr C

62. On Friday, Mrs B consulted her general practitioner (GP), Dr C, to confirm whether Dr A's diagnosis of "enlarged thyroid" was correct.

63. Dr C' patient notes record: "Told by her chiropractor … that she has an under-active thyroid and coeliac disease[15] … wants her to start taking thyroxine to treat this." Dr C

[13] Ranging from red, orange, yellow, blue and black, clinical flags and psychosocial flags help to identify possible indicators of serious pathology or, in the case of psychosocial flags, serious social issues with the patient. Red represents a higher level of seriousness than yellow.
[14] Mrs B did not have an appointment for the following Wednesday.
[15] A disease in which the small intestine is hypersensitive to gluten, leading to difficulty in digesting food.

noted: "Enlarged left lobe of thyroid — no overt nodules", "minor abdominal upset when she eats", and "coeliac disease is unlikely … tissue diagnosis represents the 'gold standard' for diagnosis of coeliac disease". Dr C advised Mrs B not to commence taking thyroxine and, if she wished, undergo a coeliac screening "for peace of mind".

Friday — second consultation with Dr A

64. Also on Friday, Mrs B attended a second consultation with Dr A. She said that she returned because the first treatment had helped her pain, but the pain had returned. She did not take a support person with her.

65. The second appointment was quite brief. Dr A told HDC that the consultation consisted of "structural adjusting, talking about how she had been, what her pain levels had been like and then we did the foot scan". Dr A carried out a foot scan using an electronic scanning machine to calculate Mrs B's foot arches. He noted:

> "Patient remains in pain. Right leg very sore at times. Initial relief claimed then pain returned. Patient looking more relaxed today. Foot scan completed, summary given to Patient [being an article Dr A had written about gluten, and a pamphlet on thyroid and adrenal health] … Benefits of foot levelers [orthotics] explained. No charge for scan. Patient moving freely but unsure as to any posture change. To be seen Monday […]."

66. Dr A did not examine Mrs B's thyroid at this consultation. He told HDC:

> "[Mrs B] seemed happy at the end of her visit but was unsure if her treatment that day had changed her pain level. At no stage did she raise any issue of concern regarding this visit or the previous visit."

67. Mrs B told HDC: "[Dr A] made me book in another appointment while I was there." Dr A told HDC: "[W]e rescheduled another appointment" at the end of the initial appointment when [Mrs B] was leaving [the Clinic].[16]

68. Dr A said that Mrs B "seemed fine throughout and no mention was made of feeling anxious or uncomfortable at either this or the previous consultation".

69. Dr A did not provide Mrs B with a summary of the consultations at or after this consultation.

Changes made

70. Dr A said that he will take more care with patients' understanding of his scope of chiropractic practice and "assure patient receipt of clinical notes upon request".

Policies

71. The Clinic said that it "works by standard operating procedures as provided by the Profession". These were listed as being Code of Conduct[17] and Scope of Practice,[18] and copies were enclosed with Dr A's response to the complaint.

[16] This next appointment is scheduled in the clinical notes for Monday.
[17] New Zealand Chiropractic Board Code of Ethics (adopted February 2013).

Response to provisional opinion

72. Mrs B confirmed that she had read and considered the "information gathered" section of the provisional report and had nothing further to add.

73. Dr A's and the Clinic's responses to the "information gathered" section of the report have been incorporated into the opinion where appropriate.

74. Dr A said that the consultations stopped after the second consultation, so "the basis for him to be able to measure" Mrs B's thyroid for increased dysfunction, seriousness or fluctuation was taken away. He said that he would have referred Mrs B to a GP if her thyroid dysfunction had increased in seriousness during the three days between the first and second consultation, or had fluctuated from his initial finding.

75. Dr A said that his note "fluctuating thyroid" meant that potentially there was a thyroid issue over many years, but it was not presenting to any serious degree at the time of the "two consultations over four days". If it had been diagnosed as serious, he said that he would have used the medical terms hypo- or hyper-thyroidism.

76. Dr A said that he has reflected on the provisional opinion in respect of how he took Mrs B's blood pressure, and has purchased an automated mechanical cuff for taking blood pressure, which sits beside the patient; this circumvents his need to sit near the patient to complete the task.

77. Dr A said that he has trained extensively at postgraduate level in endocrinological medicine and thyroid dysfunction, and that his qualifications differentiate him from other practitioners. Dr A submitted that Mrs B first presented on a Friday, and the next appointment was the following Monday, with the weekend between the appointments.

78. Dr A said that in future he will refer a patient to a GP if he makes any finding of thyroid dysfunction, or the possibility of such, and not rely on forming his own clinical opinion over time.

Relevant professional standards

79. The New Zealand Chiropractic Board *Competency Based Professional Standards for Chiropractors* (2010) states:

> "***5. Patient Assessment***
> **5.1 Obtains and records patient history**
> 5.1.3 History-taking is approached in a structured manner.
> 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.

[18] New Zealand Chiropractic Board Scope of Practice Chiropractor (effective 2004).

5.2 Performs an appropriate physical examination

5.2.5 Patient modesty and comfort is considered and provided for.

5.2.9 All examination data is recorded in writing.

6. Case Management

6.1 Establishes differential and working diagnosis (clinical impression) from the information acquired

Where a chiropractor accepts a patient for chiropractic management:

…

6.1.2 Based on the differential diagnosis or clinical impression, a decision is taken to:

a) accept responsibility for chiropractic management of the patient;

b) seek consultation and/or participation in care with another health care provider;

c) refer all further patient evaluation and/or care to another health care provider.

6.2 Collaborates or refers as necessary to obtain expert opinion

6.2.1. Referral is based on clinical justification.

7. Planning of Patient Care

7.1.8 Professional and personal limitations necessitating referral or other action are taken into account when developing or modifying a management plan.

8. Implementation and Provision of Care

8.1.13 Records relevant information including progress or adverse effects of management choices.

8.2 Referral of patients

8.2.1 Referral is consistent with clinical indications, management plan, physical, physiological, psychological, psycho-social characteristics, cultural considerations and physical habits."

80. The New Zealand Chiropractic Board — *Code of Ethics* (February 2013) states:

"***3. Chiropractor's Interactions***

3.1.1 Interactions with Patients — General

…

3.1.1.6 A chiropractor must not over-service a patient. Management of a patient must be appropriate and clinically justified.

…

3.1.1.13 Chiropractic care should be based on true patient need and tailored to meet a particular patient's needs and goals.

3.1.1.14 A chiropractor must not leave a patient feeling pressured or coerced into chiropractic care."

81. The *New Zealand Chiropractic Board — Scope of Practice — Chiropractor* (2004) states:

"2. In the process of delivering chiropractic care, a chiropractor may:

- Utilise adjunctive or supportive procedures and advice including by way of example but not by way of limitation … dietary advice, nutritional supplementation … and other healthful living practices."

Opinion: Dr A

Thyroid assessment and diagnosis — Breach

82. On a Wednesday in 2015, Mrs B sought treatment from Dr A regarding ongoing pain in her left leg. Dr A conducted a physical examination and performed a spinal manipulation.

83. Mrs B told Dr A that she had a family history of thyroid issues, and provided her medical history in the patient questionnaire. Consequently, Dr A examined Mrs B's thyroid gland by palpating her neck. He told HDC that he found that her left thyroid lobe was "slightly grainy and elevated" and "slightly raised". In the patient notes he recorded, "Left thyroid lobe not major" and "? fluctuating thyroid function". Dr A explained to Mrs B that it was likely she had suffered the effects of a fluctuating thyroid for some years, and that it was possible that this was a factor in her depression. Dr A also told HDC that, in his opinion, any thyroid dysfunction was not presenting to a significant degree to warrant referring Mrs B to a medical practitioner, and that, while he had strong suspicions, he had not definitively diagnosed thyroid dysfunction and needed more consultations to do this.

84. Dr A said that he did not believe there was an acute problem warranting medical intervention at the time, and that Mrs B's thyroid dysfunction was at the "lower end of the spectrum". He said that if his diagnosis had been of a more serious nature, he would have used the medical terms hypo- or hyper-thyroidism in the notes. Dr A said he knew he would see Mrs B in three days' time and, had the condition increased in seriousness by the time of that appointment, he would have referred Mrs B to a GP.

85. Dr A did not examine Mrs B's thyroid at the next appointment, which was on Friday.

86. My expert advisor, chiropractor Mr Troy Dandy, advised me that it was reasonable and appropriate for Dr A to have examined Mrs B's thyroid; moreover, observation and palpation of the thyroid tissue is not uncommon within a chiropractic health centre, and falls within the chiropractic scope of practice. However, Mr Dandy advised further:

> "[W]here a patient is not under concurrent treatment from a medical practitioner for thyroid dysfunction or a suspected thyroid problem, a chiropractor should refer the patient to their medical practitioner."

87. Mr Dandy stated:

> "While [Dr A] may have had the best of intentions, he appears to have focused to a significant degree on [Mrs B's] thyroid function during the clinical encounter. It should be stated that chiropractors are generally not experts in thyroid or endocrine function per se … a medical practitioner or specialist is considerably better placed to assess and manage thyroid dysfunction, most certainly and at the least in a concurrent fashion."

88. In response to the provisional opinion, Dr A said that he has trained extensively at postgraduate level in endocrinological medicine and thyroid dysfunction, and that his qualifications differentiate him from other chiropractors.

89. Mr Dandy also observed that Dr A "has not provided any clear rationale for arriving at this assessment of a fluctuating thyroid". Mr Dandy advised me that Dr A's failure to refer Mrs B to her medical practitioner or other medical specialist for further assessment regarding her suspected thyroid dysfunction represents a moderate departure from accepted standards.

90. The New Zealand Chiropractic Board Competency Based Professional Standards for Chiropractors Competency Standard 6.2 states that a chiropractor should "collaborate or refer as necessary to obtain expert opinion", and that "referral is based on clinical justification". Competency Standard 8.2 states that referral to another healthcare provider should be consistent with clinical indications and, among other factors, "psycho-social characteristics", such as family history.

91. In my view, if Dr A suspected that Mrs B had a dysfunctional thyroid, he should have referred her to a medical practitioner. I acknowledge that Dr A submitted that he was working towards a diagnosis. However, Mrs B told Dr A that she had a family history of thyroid dysfunction, and Dr A's initial assessment had found that Mrs B's left thyroid lobe was "slightly raised" and "possibly pointed to thyroid dysfunction". Moreover, Dr A had "strong suspicions" of thyroid dysfunction, although he had not "definitively diagnosed" such a condition.

92. I am critical that Dr A did not provide a clear rationale for his assessment of a fluctuating thyroid. I also consider that Dr A's finding that Mrs B possibly had a dysfunctional thyroid, combined with the information discussed between the parties and his awareness of Mrs B's family history of the condition, presented sufficient clinical justification for him to advise Mrs B to consult her GP so that the issue could be looked into further.

93. By not providing a clear rationale for his assessment of a fluctuating thyroid, and not referring Mrs B to a doctor when he suspected she might have a dysfunctional thyroid, Dr A failed to provide services to Mrs B with reasonable care and skill and, accordingly, he breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Documentation of thyroid examination — Breach

94. With regard to the thyroid examination, Dr A recorded: "? fluctuating thyroid function" and "left thyroid lobe not major". There is no documented record in Dr A's clinical notes of the thyroid examination or of a differential diagnosis.

95. Mr Dandy was critical that there is no documented rationale for the working diagnosis of a fluctuating thyroid. Paragraph 5.1.7 of the New Zealand Chiropractic Board Competency Based Professional Standards for Chiropractors states that the patient's clinical presentation and history should be explored appropriately and findings recorded. Paragraph 5.2 states that a chiropractor should record "all examination data" gained from the physical examination of the patient. It is a fundamental requirement of good clinical

practice that a healthcare provider keep clear and accurate records of the care provided, and it is a requirement of chiropractic practice.

96. I agree with Mr Dandy. There is a lack of documentation of Dr A's assessment of Mrs B's thyroid function. By not keeping adequate records of the services he provided to Mrs B, and failing to document all of his examination findings, Dr A did not provide services to Mrs B that complied with the New Zealand Chiropractic Board Competency Based Professional Standards for Chiropractors and, therefore, he also breached Right 4(2) of the Code.

Failure to provide written summary — Adverse comment

97. Mrs B said that Dr A did not provide her with a written summary of his findings, and instead gave her "generic handouts". Dr A said that he "simply didn't have time" to provide notes then and there, but he gave Mrs B some handouts to read about gluten and thyroid and adrenal health, and told her that her husband and mother were welcome to accompany her at the next appointment. Dr A said that he would have been able to provide a "fuller and more complete summary" after the next consultation. However, Dr A did not send Mrs B a summary after the second appointment, and no subsequent appointment occurred.

98. Every consumer is entitled to receive, on request, a written summary of the information provided. It is not expected that information is provided "on the spot"; however, a copy of the information imparted or a summary of key discussions that took place should be provided to the patient in reasonable time.

99. It appears that a substantial amount of information was imparted to Mrs B; indeed, Dr A acknowledged this to Mrs B. Much of the information went beyond what Mrs B had consulted Dr A for, her plantar fasciitis. Mrs B wanted a summary of the information and findings provided to take away and consider later. Dr A did not provide a summary to Mrs B of all of the information discussed, or his findings.

100. Consumers have the right to be fully informed, not only for patient well-being and quality of service, but also so that relevant information may be available to third parties such as other healthcare providers. This is particularly so where extensive or new information is provided, as in this case. Commonly consumers want to consider information further after a consultation, and have the right to receive a written summary of the information given to them, if requested.

101. I note that Dr A says that he will now ensure that he provides patients with the information discussed upon request, even if it is sent after the patient is seen.

Other issues — Adverse comment

102. I have a number of concerns about the manner in which Dr A interacted with Mrs B. The consultations took place in Dr A's rooms and there was no one else present.

103. Mrs B described two instances in which she claims Dr A made inappropriate physical contact with her.

104. Mrs B said that Dr A hugged her and kissed her on the cheek at the end of the consultation. She accepted that this may have been Dr A's way of showing empathy; however, she found the actions unprofessional and inappropriate.

105. Dr A said that at no stage did he kiss Mrs B. However, he accepted that he hugged Mrs B and patted her on the shoulders, and said that this was an attempt to comfort Mrs B when she appeared tearful and upset during the examination.

106. Mrs B told HDC that when Dr A took her blood pressure, she sat on one side of the table with her feet almost touching the floor while Dr A straddled the table and sat facing her with the front of his body almost touching her side. She said that Dr A then rested her forearm on his thigh with "his private parts facing towards me right up close …"

107. Dr A agreed that he sat facing Mrs B at a 45 degree angle, but said that the sphygmomanometer was between him and Mrs B, and that Mrs B's arm was resting on her own thigh and was not touching his thigh.

108. Mr Dandy advised that to have taken Mrs B's blood pressure "sitting open-legged adjacent to the patient while straddling the patient bench is inappropriate and detracts from the patient's dignity". Mr Dandy commented that there are alternative ways to position the sphygmomanometer and the patient. Mr Dandy also noted that if Dr A was concerned about obtaining a consistent blood pressure, he should have considered the confounding effects of unwanted physical contact or unusual positioning on a patient's blood pressure.

109. Mrs B was also concerned about aspects of Dr A's communication with her.

110. In my view, Dr A should reflect on the manner in which he speaks to and touches clients. Dr A should consider the technique he uses when assessing blood pressure, and should confine his touching of clients to that required for chiropractic treatment. In my view, touching of any kind that is beyond the scope of clinical care is not appropriate and should be avoided. I note that Dr A said that he has reflected on the technique he uses when assessing blood pressure and has purchased an automated mechanical cuff for taking blood pressure, which sits beside the patient; this circumvents his need to sit near the patient to complete the task.

Opinion: The Clinic — No breach

111. Dr A is a director and shareholder of the Clinic. The Clinic is a healthcare provider and an employing authority for the purposes of the Health and Disability Commissioner Act 1994. As such, it may be held directly liable for the care provided to Mrs B, and it may be held vicariously liable for any actions or omissions of its employees and/or agents who are found to be in breach of the Code.

112. In my view, Dr A's errors were the result of individual decision-making. Accordingly, I find that the Clinic did not breach the Code.

Recommendations

113. I recommend that Dr A:

a) Provide a written apology to Mrs B for his breaches of the Code. The apology is to be sent to HDC within three weeks from the date of this report, for forwarding to Mrs B.

b) Undertake further training on documentation and referrals and provide evidence of having attended the training, and the content, within three months of the date of this report.

c) Reflect on his practice as a chiropractor and provide HDC with a written summary of his reflection and the changes to his practice, instigated as a result of this case, within three weeks of the date of this report.

Follow-up actions

114. A copy of this report with details identifying the parties removed (except the expert who advised on this case) will be sent to the New Zealand Chiropractic Board and the district health board, and they will be advised of Dr A's name.

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

Appendix A: Independent advice to the Deputy Commissioner

The following expert advice was obtained from chiropractor Mr Troy Dandy:

"I am a practising chiropractor of 15 years' experience. My professional qualifications include BSc (Human Physiology; Pharmacology), BSc (Chiropractic), LLB (Hons) and my opinion on the Complaint is provided in that context.

You have requested my advice on a number of aspects regarding the Complaint to enable the Health and Disability Commissioner (the 'Commissioner') to determine, on the information available, if there are concerns about the care provided by chiropractor [Dr A], which may require further action.

EXECUTIVE SUMMARY:

On review of the materials provided, I do have concerns about the care [Dr A] provided to [Mrs B] and believe [Dr A's] clinical management in some aspects of this case reflects a **moderate** departure from accepted standards of practice. Collectively I view the instances of deficient care as isolated lapses and there is no evidence presented which suggests they represent a wider systemic competency issue.

BACKGROUND: *(as provided by the Commissioner by letter[…])*

'[Mrs B] attended a consultation with [Dr A] for chronic plantar fasciitis in her left leg.

… the basis of [Mrs B's] complaint is that [Dr A]:

- exhibited levels of physical contact outside clinical requirements;
- inappropriately diagnosed abnormal thyroid function;
- inaccurately recommended thyroxine;
- failed to provide a written account of consultations;
- performed a scan of [Mrs B's] feet but did not charge for it, on the basis that she would purchase orthotics for $530; and
- became upset and 'pushy' when [Mrs B] tried to end the clinical relationship.

[Dr A] strongly denies the accusation of inappropriate physical contact, and provides a different account of the consultation and interactions.'

In giving my opinion, I have reviewed the following materials supplied by you in your correspondence dated 19 May 2015:

- Cover letter from the Commissioner dated 19 May 2015;
- Copy of [Mrs B's] letter of complaint dated […];
- Copy of [Dr A's] letter of response to the complaint dated 22 March 2015; and
- Copy of [Mrs B's] clinical records from [Dr A] covering the period […].

REQUEST:

You have requested my opinion with respect to:

1. Based on [Mrs B's] presentation, what examination, assessment and history taking would you expect?
2. Was it reasonable to explore thyroid functions?
3. Please describe the usual process for examining the thyroid.
4. Based on [Dr A's] notes and response, was the treatment provided reasonable?

For each question, you have asked me to further detail:

a) What is the standard of care/accepted practice?
b) If there has been departure from the standard of care or accepted practice, how significant a departure do you consider it is?
c) How would it be viewed by your peers?

OPINION:

1. Based on [Mrs B's] presentation, what examination, assessment and history taking would you expect?

[Mrs B's] presentation in this case is not atypical and represents a fairly common set of symptoms that a chiropractor might encounter in practice. On [Mrs B's] first visit [on Wednesday] she reported the following symptoms including:

- chronic plantar fasciitis *(presumably left sided)*
- constant entire left leg ache including iliotibial band
- arm or leg weakness *(unclear on the clinical records as to which)*
- arm or leg muscle stiffness *(unclear on the clinical records as to which)*
- shortness of breath on exertion
- cramp-like pain in either leg when walking
- heart misses beats
- is easily depressed
- suffers stress
- has difficulty concentrating
- has poor balance
- occasional poor sleep
- suffers fatigue
- suffers joint pain which is worse at night
- suffers from muscle and joint stiffness
- recent weight change

Clinical examination, assessment and history taking in this instance should include the following elements (in general accordance with sections 5.1 and 5.2 of the New Zealand Chiropractic Board Competency-Based Professional Standards for Chiropractors ('Competency Standards')):

1.1 Health history

- consent

- record of current symptoms and complaints
- history of surgery
- current medications
- history of illnesses
- history of trauma
- family health history

1.2 Physical examination
To a large extent the health history and patient questionnaire dictate the extent of the physical examination required. In this case it could be expected that a chiropractor would undertake a physical examination including the following aspects as a minimum:

- consent
- overall appearance
- vital signs — blood pressure check, heart rate, pulses, respiration assessment
- weight measurement
- heart auscultation
- posture and gait
- palpation of neck, mid-back, low-back and pelvis (and adjacent tissues) including range of motion assessment
- palpation of legs, ankles and feet (and adjacent tissues) including range of motion assessment
- orthopaedic tests
- neurological assessment including muscle strength tests, muscle stretch reflexes and sensation (upper and lower extremity)
- plain film radiographs

1.a) *What is the standard of care/accepted practice?*

The accepted standard of care includes the items outlined in items 1.1 and 1.2 above. On the information provided in the circumstances [Dr A] has largely met this standard of care.

1.b) *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?*

N/A.

1.c) *How would it be viewed by your peers?*

N/A.

2. Was it reasonable to explore thyroid functions?

[Dr A] states in his letter [of] response […] that '… the patient had circled a number of issues that suggested her thyroid function was less than ideal' but then failed to outline what they were specifically. On review of the clinical records, no reference to thyroid appearance, familial history, examination findings or function can be located.

According to the accounts of both [Mrs B] and [Dr A], it appears that [Mrs B's] thyroid function was however discussed in some detail by both parties during the initial consultation. In that context and as [Mrs B's] family history of thyroid dysfunction was made clear, assessment of [Mrs B's] thyroid is a reasonable and appropriate step to take, or alternatively referral to her medical practitioner to investigate and manage. Observation and palpation of the thyroid tissue is a not uncommon practice within a chiropractic health centre, and falls within the chiropractic scope of practise (http://www.chiropracticboard.org.nz/Publications/Scopes-Of-Practice/).

2.a) *What is the standard of care/accepted practice?*

In the case of thyroid disease, a chiropractor may investigate, examine and manage within professional chiropractic boundaries utilising the patient's health history, physical examination, special tests, and applicable interventions, the nature of that condition. In the case where that patient is not under concurrent treatment from a medical practitioner for thyroid dysfunction or a suspected thyroid problem, a chiropractor should refer the patient to their medical practitioner or other medical specialist for assessment, diagnosis, management, pharmacological or other treatment intervention for that condition. A medical practitioner or specialist is generally best placed to manage such a suspected thyroid problem.

[Dr A] does not appear to have made any clinical diagnosis or provided rationale in his clinical records to reflect the 'fluctuating thyroid' condition he discusses in his response letter.

2.b) *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?*

In the case where [Dr A] suspected [Mrs B] had a dysfunctional thyroid, he should have referred her to her medical practitioner or medical specialist for further assessment, diagnosis, and management where applicable. This omission would indicate a **moderate departure** from accepted standards of practice.

2.c) *How would it be viewed by your peers?*

This departure from accepted standards would likely be viewed with some degree of consternation by the wider chiropractic profession.

3. Describe the usual process for examining a thyroid.

The standard process for thyroid examination following informed consent is to proceed to undertake a targeted thyroid health questionnaire, visual examination and then physically palpate the thyroid tissue. Visual examination is typically done from an anterior viewpoint facing the patient, and palpation by hand can be made from a number of positions, either the same anterior position or alternatively from a posterior position standing directly behind a seated patient, or from an adjacent position alongside the patient when he or she is lying supine. A patient may be asked to swallow to assess the symmetry of thyroid elevation with this motion.

3.a) *What is the standard of care/accepted practice?*

The accepted standard of care includes the items outlined in item 3 above. On the information provided in the circumstances [Dr A] has largely met this standard of care as to the examination although it should be stated that there appears to be no documented record of the thyroid examination or a differential diagnosis occurring in his clinical records. This is a breach of section 5.2.9 of the Competency Standards and could be considered a **moderate departure** from accepted practices.

3.b) *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?*

The absence of documented examination information in [Mrs B's] clinical records regarding the thyroid examination is a **moderate departure** from accepted standards of practice.

3.c) *How would it be viewed by your peers?*

This departure from accepted standards would likely be viewed with some degree of consternation by the wider chiropractic profession.

4. Based on [Dr A's] notes and response, was the treatment provided reasonable?

[Mrs B] presented at [Dr A's] practice primarily for what she described as plantar fasciitis and a left leg ache issue. While [Dr A] may have had the best of intentions, he appears to have focused to a significant degree on [Mrs B's] thyroid function during the clinical encounter. It should be stated that chiropractors are generally not experts in thyroid or endocrine function per se, and even with additional training and qualifications in these areas as [Dr A] claims to have done (and which for the record have not been assessed for credibility or recognition here), a medical practitioner or specialist is considerably better placed to assess and manage thyroid dysfunction, most certainly and at the least in a concurrent fashion.

Reflecting on the basis of [Mrs B's] complaint as below, I make the following comments regarding the allegations that [Dr A]:

- *exhibited levels of physical contact outside clinical requirements;*

Given the conflicting views, this cannot be determined due to the lack of an independent objective reference point.

- *inappropriately diagnosed abnormal thyroid function;*

Although absent from [Mrs B's] clinical records, [Dr A] claims that [Mrs B] has '… suffered the effects of a fluctuating thyroid for some years' and demonstrated '[a slightly grainy and elevated left lobe]' in his response letter. He has not provided any clear rationale for arriving at this assessment of a fluctuating thyroid however.

- *inaccurately recommended thyroxine;*

Given the conflicting views, this cannot be determined due to the lack of an independent objective reference point.

- *failed to provide a written account of consultations;*

[Dr A] states in his response letter that he did not have time immediately following the first consultation to provide a written summary of the things he had talked about to [Mrs B]. While this is understandable at the time, [Dr A] should reflect on his obligations to provide effective communication to patients under the HDC Code of Health and Disability Services Consumers' Rights regulation 1996, and this may necessitate written reports in many instances. Where he is requested to provide a written summary, he could have considered mailing or emailing a summary in the days following the appointment, or having a report ready for [Mrs B's] next visit.

- *performed a scan of [Mrs B's] feet but did not charge for it, on the basis that she would purchase orthotics for $530; and*

Given the conflicting views, this cannot be determined due to the lack of an independent objective reference point.

- *became upset and 'pushy' when [Mrs B] tried to end the clinical relationship*.

Given the conflicting views, this cannot be clearly determined due to the lack of an independent objective reference point. Certainly a health practitioner should make an effort to understand why a patient is having treatment compliance issues. The difficulty comes however when a patient feels that he or she is being unduly pressured to return to care against their wishes. [Dr A] should reflect on the nature and degree of his post-consultation calling practices in this context.

4.a) *What is the standard of care/accepted practice?*

As discussed in items 1–3 above, the standard of care required by chiropractors is relatively clear and well established. [Dr A's] clinical practice has fallen below the required standard in a number of instances by a moderate degree.

It should be mentioned also that there appears to be a number of areas where the accounts of [Mrs B] and [Dr A] conflict as to their take on the facts. I would encourage [Dr A] to closely examine and reflect upon these areas and consider where he might be able to improve his clinical practices and communication to avoid such conflict in future.

4.b) *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?*

I have summarised the areas where [Dr A] has fallen below the accepted standard of practice below:

1. In the case where [Dr A] suspected [Mrs B] had a dysfunctional thyroid, he should have referred her back to her medical practitioner or other medical specialist for further assessment, diagnosis, and management where applicable. This omission would indicate a **moderate departure** from accepted standards of practice.

2. The absence of documented examination information in [Mrs B's] clinical records regarding the thyroid examination is a **moderate departure** from accepted standards of practice.

4.c) *How would it be viewed by your peers?*

Collectively, these departures from accepted standards would likely be viewed with some degree of consternation by the wider chiropractic profession.

Troy Dandy"

Further advice was sought from Mr Dandy:

"I have reviewed the transcript of [Dr A's] interview thank you.

In answer to your question, as to whether it was within bounds for [Dr A] to 'educate her about how she could reduce the metabolic load on her thyroid adrenal and gastrointestinal system by taking gluten and to a lesser degree soy from her diet' I make the following comments:

It is within the scope of practice for a chiropractor to:

'2. In the process of delivering chiropractic care, a chiropractor may:

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

[Source: Chiropractic Board — Scope of Practice — http://www.chiropracticboard.org.nz/Portals/12/Scope%20of%20Practice%20-%202010.pdf]

This would confirm that it is professionally acceptable for [Dr A] to provide dietary advice to his clients where appropriate.

Assessment of the quality of that dietary advice would be a separate consideration of the relevant accepted standards of practice against the facts of the case."

Further advice was sought from Mr Dandy:

"1. *Was it appropriate for [Dr A] to take [Mrs B's] blood pressure in the way described?*

Based on the information provided, I have concerns regarding how [Dr A] positioned himself while assessing [Mrs B's] blood pressure. To do so in a way sitting open-legged adjacent to the patient while straddling the patient bench is inappropriate and detracts from the patient's dignity. **Such procedures represent a moderate departure from accepted standards of practice.**

Comments:
Regardless of [Dr A's] previous practices, there are a number of alternative means to position both the blood pressure machine and patient to avoid this sort of outcome. If [Dr A] is concerned about obtaining a consistent blood pressure reading as he states,

he may wish to consider the confounding effects on blood pressure of unwanted physical contact or provocative positioning.

[Dr A] should be reminded that the onus is on him to ensure clear communication and that there is no misinterpretation by the patient of his clinical practices. He should clearly avoid any sort of unnecessary positioning which exposes his groin region to the patient. Patient dignity and comfort are important requirements emphasised in Right 3 of the Code of Health & Disability Services Consumers' Rights.

2. *Are [the Clinic's] policies adequate?*

There are no professional requirements for a chiropractor to maintain policies in their practice for patient care per se. Certainly policies can be useful both from a clinical and business perspective, but currently neither the Chiropractic Board nor the Health & Disability Commissioner (to my knowledge) require them."