Care provided by chiropractor to woman with leg pain (15HDC00174, 29 June 2016)

Chiropractor ~ Chiropractic clinic ~ Referral ~ Thyroid ~ Rights 4(1), 4(2)

A woman went to a chiropractor as she had been experiencing ongoing pain in her leg. She had unsuccessfully seen multiple specialists for treatment in the past. The woman completed a patient information form where she recorded "constant pain down left leg". The chiropractor said that he would be able to help, and the pain could be resolved.

During the consultation the woman became emotional because of the prospect that the pain, which she had been unable to get adequately treated previously, might finally be relieved. The woman said the chiropractor hugged her twice and kissed her on the cheek. The chiropractor said he hugged her in an attempt to comfort her but did not kiss her.

The chiropractor conducted a physical examination which included taking the woman's blood pressure and pulse. The woman sat on the side of the bench and the chiropractor sat on the bench facing her with his feet on either side of the bench and took her blood pressure. He also examined the front of the woman's neck to determine whether her thyroid gland was normal. The chiropractor recorded in the patient notes that the woman might have a fluctuating thyroid function, and discussed thyroxine and a gluten-free diet with her.

At the end of the consultation the woman asked the chiropractor for a summary of his findings. The chiropractor provided her with handouts about some of what was discussed, but no summary was supplied.

The woman consulted her general practitioner (GP) to confirm whether the chiropractor's finding of a fluctuating thyroid was correct. The GP advised the woman that she had an enlarged left thyroid lobe but thyroxine was not required.

The woman attended a second consultation with the chiropractor and a foot scan was completed. A further appointment was made, which the woman later cancelled.

By not providing clear rationale for his assessment of a fluctuating thyroid and not referring the woman to a doctor when he suspected she may have had a dysfunctional thyroid, the chiropractor failed to provide services to the woman with reasonable care and skill and, accordingly, breached Right 4(1).

By not keeping adequate records of the services he provided, and failing to document all of his examination findings, the chiropractor did not provide services that complied with relevant professional standards and, therefore, breached Right 4(2).

Adverse comment is made about not providing a written summary of the information discussed at the consultation, and the manner in which the chiropractor communicated with and touched the woman.

The Deputy Commissioner recommended that the chiropractor undertake further training on documentation and referrals; 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; and provide a written apology for his breaches of the Code.