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## **Chiropractic Acquitted in Canada**

### **Patient's Death after Manipulation Not Attributed to DC**

By Editorial Staff

On February 3, 1998, 20-year-old Laurie Jean Mathiason, accompanied by her boyfriend, went to her chiropractor in Saskatoon, Saskatchewan, Canada for acute neck pain. She was a regular chiropractic patient with a chiropractic history of 23 adjustments. Having felt no relief from the Feb. 3rd adjustment, Ms. Mathiason came back to her chiropractor again the next day. Shortly after a lateral adjustment at C5, she expressed an uneasy feeling and passed out, showing signs of neurologic disorder.

The chiropractor immediately called the emergency number and the patient was taken to the Royal University Hospital. She was generally nonresponsive and found with a transectional tear of the left vertebral artery. Ms. Mathiason was put on life support, but was pronounced dead on February 5th. Her family offered her body for organ donations.

This was the first time in the 103-year history of chiropractic in Canada that a patient had died after a chiropractic adjustment. At this point, the obvious question was asked: Did the chiropractic adjustment cause the young woman's death?

The family was of course extremely upset, and blamed the chiropractor. The Canadian media carried the story with all of the emotionally charged quotes and comments. Would this be the first stain on chiropractic's perfect record in Canada? An inquest began.

The jury heard the case on September 8-11. Among those testifying were:

Adrian Grice, MSc, DC -- Dr. Grice spoke on the quality of chiropractic education.

David Cassidy, DC, MSc, PhD -- Dr. Cassidy explained the findings in the field of chiropractic research.

Paul Pelloso, MD -- Dr. Pelloso, a practicing rheumatologist and researcher, provided additional assurance to the jury regarding the safety of chiropractic.

Murray Katz, MD -- A long-time nemesis of chiropractic, Dr. Katz' testimony didn't seem to carry much weight with the jury.

The most damning testimony before the jury was that Ms. Mathiason had a history of self-manipulation; her DC had warned her about the danger of adjusting herself.

After four days of testimony, the jury found that Ms. Mathiason died of a "traumatic rupture of the left vertebral artery." The jury did not conclude that her death was the result of chiropractic manipulation.

During the course of the inquest, the jury heard testimony regarding the lack of federal funding for chiropractic research, especially in regards to cervical manipulation. This prompted the jury to make several recommendations:

1. We recommend that the ministries of health of Canada immediately allocate funds for, and implement the following studies:

A) to determine the incidence of strokes associated with cervical spinal manipulation;

B) to determine the benefits and harmful effects that are associated with single and multiple cervical spinal manipulations;

C) to pursue the development of effective screening tests that will identify patients who are at high risk of adverse complications when receiving cervical spinal manipulations;

2. We recommend that the ministries of health in Canada:

A) develop a prototype patient and family medical history form which elicits pertinent health data prior to chiropractic treatment. The administrative assistant at the clinic will ensure that the requested information be fully provided on the form at the patients initial visit. The chiropractor will verify and discuss all pertinent information on the form and explain to all patients his/her particular expertise before proceeding with treatment.

B) collaborate with chiropractic associations to ensure that the contents of the consent for treatment

form be discussed by the chiropractor and the patient at the initial visit;

C) in collaboration with chiropractic associations, ensure that literature indicating the risk of strokes and other inherent risks associated with chiropractic treatment be visible and available in the reception area of every chiropractic facility;

D) after development of the screening test(s) referred to in recommendation 1.C, ensure that such test(s) be made mandatory before administering cervical spinal manipulation;

E) increase communication and collaboration among all specialties in health care to maximize benefits and minimize risks inherent in cervical spinal manipulation treatments;

From the beginning of this case the Canadian Chiropractic Protective Association (CCPA), the organization that handles malpractice claims, and the Canadian Chiropractic Association (CCA) were intimately involved. From media management to the more detailed aspects of the inquest, both organizations were extremely persistent in their efforts to protect the chiropractor involved and the profession at large.

The jury's recommendations, which some DCs may look at as being too intrusive, point to the growing advocacy of health consumers to question the safety and efficacy of various treatments, medical or otherwise.

The story of Laurie Jean Mathiason is a tragic one, but the jury could not fault the chiropractor nor the safety of the chiropractic adjustment.



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