The Code for professional Practice for Chiropractors in Australia

Margaret Geitz o natboards /2010 09:46 PM

History: This message has been replied to.

To Whom It Concerns

In general, I agree with most of the this document. However, there are several areas of concern that affect me professionally and my ability / capacity to serve my community.

In regards to section 2.6. Where to begin... firstly it must be stated in my case (as I dare say in many other) I practice outside of a city in a coastal rural area. I therefore do practice truly as a Primary Care practitioner. This is important because I am frequently seeing a wide variety of complaints not limited to the spine. Given the sad state of NSW Health it would be smarter to diversify our skills as Primary Care Practitioner to better serve our community rather than restrict them further i.e. ragiograpghy of other body parts including shoulders, knee etc. We as Chiropractors (certainly those from RMIT) have been taught these skills are are capable of performing such diagnostics. This document does only mention spinal radiographs. Importantly as a Primary care provider I am the first person to pick up an unknown and unsuspected pathology by routinelt performing x-rays. Classic examples of this include undiagnosed cases of advanced osteoporosis,
spondylolisthesis, AS, various tumours, osteoarthritis (just to name some recent pathologies.) Remember we are serving the community and we working with a specific area of the body that most General practitioners will not be closely examining.
In particular 2.6.4 affects the basis of my chosen method of practice as a Chiropractor. I am utilise the methods taught and researched by Dr Deed Harrison as Chiropractic Biophysics (CBP). I do appreciate that there are a large number of Chiropractors who claim to be utilising this technique, thereby justifying the use of radiographs, but I frequently witness through the receipt of both their films from their patient and from comments from the patients themselves that the Chiropractor is not practising the technique in its entirety. The statement 2.6.4 underlies the entire premise of my technique. Without radiography, CBP would not be the clinically sound, predictable spinal rehabilitation method that it is today. May I suggest, that like your suggested method of CPD checks, audits are performed to verify the justification of radiographs. I my honest opinion, I have never regretted taking a single set of rediographs. They are invaluable in my clinical
decision making, especially in the identification for the need for care, the frequency of care and even in the cessation of care. This is invaluable information regardless of the age of the patient.

In regards 2.10 (specifically the last 2 paragraphs before 2.11). The second last paragraph is in complete contradiction for me as a CBP given the suggest alteration to the use of radiography in children. In CBP it is through the diagnostics of radiography that I am able to determine the frequency and necessity of care for children. It may come as a surprise to some, but it is possible to see spines that have had just as much structural damage and loss of structural integrity of an adult spine. Yes, I do agree that there is not a lot of clinical proof for this yet, but this is where the research will eventually come from. Just as with adults, when working with adults I can confirm clinically ans scientifically that I have achieved the desired outcomes of the treatment I have performed. The final paragraph is written in such a way that it basically implies Chiropractors who are treating children are manipulative, scare mongering business people, not

actually concerned, professional, well-educated individuals who are working with children and their families for their best interest. So many parents so my as a primary care practitioner often simply wanting more information due to the fact that they feel too rushed, pressured and ill-informed from tightly-scheduled GP. (This is most certainly the case in our rural town). Really it is about given information to parents for form their own opinion of what is best for their child.

Again, in regard to 2.11.2 by limiting my ability to use the diagnostic tool of x-ray as a CBP chiropractor I would agree that I would not have clinical and structural evidence of spinal changes that do need a specific and possible longer term treatment program. This is the beauty of the CBP method and the reason I have chosen to utilise. The detailed analysis of the normal spinal model through the use of the CBP line drawing method I am able to easily identify aberrant spinal alignment (outside of accepted spinal postures), structural instability and abnormal pathologies. By assessing this I have a specific treatment goal to both resolve these problems and to eliminate any particular presenting symptoms. The work is predictable and reliable when used correctly and in its entirety which includes Mirror Imaging adjusting, in-office spinal tractioning, exercising, anatomical heel lifts, and home tractioning. At all times in our office our patients can
utilise their freedom of choice not to receive this type of care.

In regard to CPD: I think there needs to be further clarification of if their is varying requirements for retired or semi-retired chiropractors i.e. less than 10 hours per week etc. Less then x hours per months (similar to insurance). In 3.4 how often will the Senior First Aid Certificate need to be renewed?

I appologise if this is not very clear. However I hope you do consider some of this changes before finalising this Code.

Thank you for your time.

Margaret Tay