Regarding the Consultation Draft Code of Conduct for Chiropractors
Released by the Chiropractic Board of Australia on 7th May 2010

Circulated for comment by my colleagues

Preamble
It is an absolute deception to imply that a principle aim of registration is protecting patients from harm when virtually all involved have for some five decades ignored Illiches warning about iatrogenesis and the published articles about the iatrogenic epidemic.

The true extent of iatrogenesis should be common knowledge within health related government departments, yet no governments collect and publish data about the full extent of iatrogenesis. That is why researchers use medical data about the incidence of permanent harm or death.

John Archer's 1995 book, *Bad Medicine*[i] was based upon **some** of the medical data about iatrogenesis. I phoned John and suggested that his estimates of about 50,000 iatrogenic deaths and 750,000 permanent injuries per year in Australia were excessive. He told me he stood by his interpretation of the medical data.

US researchers, including three MDs and a PhD, used a framework of categories of iatrogenesis in which to sort **all** of the available jumbled medical data into an orderly way of portraying the full picture of the entire spectrum of their iatrogenic epidemic. "The most stunning statistic, however, is that the total number of deaths caused by conventional medicine is an astounding 783,936 per year. It is now evident that the American medical system is the leading cause of death and injury in the US."[ii]

The rate of harm arising from chiropractic care pales when compared to iatrogenic risk

The architects of the codes/regulations rightly propose that: "Chiropractors have a duty to make the care of patients their first concern.' Chiropractors have a responsibility to contribute to the effectiveness and efficacy of the health care system. Minimising risk to patients is a fundamental component to practice.

Recognition by researchers the medical system is as a or the leading cause of death and injury obliges the architects of the codes/regulations to ensure registrants minimise risk to patients by informing them about the iatrogenic epidemic.

For the protection of the patients and chiropractors the codes/regulations must recognise and respond to rather than ignore the extent of medical harm within the health care system.

Page 3 Chiropractors have a responsibility to recognise and work within the limits of their competence and scope of practice. The meaning of the term 'chiropractic' seems to some degree to be whatever the chiropractor decides her/his area of interest is. Without criticism; my highly regarded neighbouring colleagues use a poultice and manipulate using a ball. I visited 2 chiropractors, neither examined or manipulated/adjusted my spine, one prescribed massage, the other prescribed minerals and vitamins.

My point is that in the marketplace there is no uniform scope of practice. Who is to say when a chiropractor is practising or is not practising "chiropractic'.

No legal Australia wide definition of chiropractic and an unlimited scope of practice may pose a danger for patients. That risk raises the question should the codes/regulations define both 'chiropractic' and the chiropractor's scope of practice.

Page 3 Chiropractors should be committed to safety and quality in health care. (The Australian Commission of Safety and Quality in Health Care etc. According to my inquiries with the Australian Commission of Safety and Quality in Health Care they have no idea of the number of patients who are either permanently harmed or died due to medical treatment as distinct from their disorder or what Australia's annual iatrogenic toll is. They use the term "sentinel event" whose definition and subsequent figures bear no relationship even to media figures about the iatrogenic toll which point to, 18,000 5,000 and 4,5000 iatrogenic deaths per year.

Page 3 2.1 b) ensuring that the diagnosis is relevant, justifiable and based on sound clinical reasoning.
For decades limited exclusions under the medical Act restricted the practise of chiropractic. Diagnosing and/or claiming to treat named disorders raised the spectre of the possibility of chiropractors being charged with practicing medicine without a license. Registered chiropractors have who have practised for decades without any formal tertiary level training in clinical diagnosis and whose mode of practice does not include diagnosing. . The codes/regulations need to accommodate to that.

There is a need for clarification with regard to the outer perimeters of what the codes/regulations will require registrants to be able to diagnose and equally importantly, what diagnoses are we precluded from making? The codes/regulations need to include that clarification for the protection of the patients and chiropractors.

Page 4 o) practising in accordance with the current and accepted evidence base of the chiropractic profession, including clinical outcomes. I see the call to confine chiropractic for only 'evidence based' chiropractic as a massive threat to patient and practice well being.

See a sample of two cases unlikely to be ever evidence based
http://www.youtube.com/watch?v=PDHHFFNbAlQ&feature=channel
http://www.youtube.com/watch?v=D4DcoJ3SWqI

This regulation would give the Sceptics great opportunity to use our literature as a basis for legal complaints against chiropractors. A page of advertising for the current spine care week includes *flattening of the skull, poor sleep, unexplained crying, frequent colds, colic, inability to settle, middle ear infections, reflux, constipation wind flatulence, eczema, scoliosis, poor posture, bed wetting, migraine, recurrent infections, growing pains, ADHD/ADD asthma* etc etc. How many of those publically implied/claimed clinic outcomes are evidence based?

Page 4 2.6 d) …. and not providing unnecessary services." There is a very grave need to clearly define *'unnecessary services*', what is the criteria for deciding that and who decides what is or is not; 'unnecessary service'?.

A common sequence in my practice is an initial nine visits over a three week trial period and then a review visit. My chiropractor uses about three visits. In both instances, if there is inadequate improvement, the patient's care is usually terminated. Most of my patients are maintenance patients on once in three weekly visits. Some chiropractors do not subscribe to maintenance programs, while some get adjusted frequently throughout our careers.

Page 4 2.6 e) …. if a patient poses a risk to health and safety, the patient should not be denied care, if reasonable steps can be taken to keep chiropractors and their staff safe. For years, I have asked my adult patients to only send me patients whom they like. I forewarn my

patients that if they send me someone who I could not warm up to if I was cremated with them, I will send them some where else. Registration should compel chiropractors to adjust patients who pose 'a risk to health and safety".

Page 4 2.7 Treating patients in emergencies.
The codes/regulations should not legally compel chiropractors to treat patients in emergencies.

I am a chiropractor who locates and adjusts subluxations, I can perform basic first aid. I am not qualified to treat many/most emergencies.

Page 4 3.2 Partnership e) too long to type ; providing information and advice to the best of the chiropractors ability and according to the stated needs of the patient. Yet under page 4 of the Guidelines for advertising 5 e) we are not allowed to compare different regulated health professions. F) claim that the services provided by a particular regulated health profession are better or safer than others.

In our day to day practice, there are occasions when we need to compare the safety of chiropractic to the risk of medical harm. A common example being perceived unnecessary spinal surgery and comparing medicine's cost and risks to those of locating and adjusting subluxations. Chiropractic patients are often on prescribed high risk drugs, the code/regulations need to clarify if registrants share a duty of care to explain to patients about these risks.

Page 5 Effective Communication
Both h). and i) seem to be quotes from a big institution's rule book and should be removed.

h). Making sure, where ever possible, that arrangements are made to meet the specific language, cultural and communication needs of patients and being aware of how these needs effect understanding.

"..arrangements are made to meet the specific language, cultural and communication needs of patients .." What are those arrangements for solo chiropractic practices where the norm is seeing a diverse range of patients speaking different languages?

i). "becoming familiar with, and using wherever necessary, qualified language interpreters and cultural interpreters .." who pays for this service? What is wrong with the time honoured practice of using non-qualified members of their own families as language interpreters and cultural interpreters?

Confidentiality and privacy

e). where relevant, being aware that there are complex issues relating to genetic information and seeking appropriate advice about disclosure of such information. This appears to impose information from a medical setting upon a chiropractic setting. It should be removed.

Page 6
Informed Consent
b). an explanation of the current treatment recommended, its likely direction, expected benefits and cost, any alternative (s) to the proposed care and their relative risks/benefits as well as the likely consequences of no care. That happens in a typical

report of findings visit, except that this code obliges the chiropractor to detail expected benefits and cost of **any** alternative (s) etc. Massage, yoga, physiotherapy, drugs, surgery and on and on "any alternative (s) to the proposed care and their relative risks/benefits as well as the likely consequences" should be deleted.

Page 8
3.13 Ending a professional relationship.

The code should not mandate that the chiropractor must facilitate arrangements for the continuing care of the patient, including passing on relevant clinical information. In over forty years thousands of patients have come and gone without me facilitating arrangements for the continuing care of those patients, including passing on relevant clinical information.

In the normal flow of practice, patients want to know if theirs is a subluxation related disorder, chiropractors provide a trial period to find that out. Occasionally, if theirs proves not to be a subluxation related disorder, chiropractic care is terminated. It is then up to the patient to choose and pursue what other option (s) the patient subsequently follows.

3.14 Personal relationships.

Good practice recognises that providing care to close friends, work colleagues and family members can be inappropriate because of a lack of objectivity, possible discontinuity of care and risks to the chiropractor or patient.

In my experience, such claims are utterly unfounded.

This paragraph sounds as if it has a medical origin. Where is the chiropractic evidence underwriting this claim? Which profession's "good practice" recognises that?

What research proved that providing care to close friends, work colleagues and family members can be inappropriate because of:
A lack of objectivity, My objective, locate and adjust the subluxations is the same for every one.

Discontinuity of care.
During the decades of a chiropractor's practice of the thousands of patients she/he will see most will discontinue care, long term continuity of care such as lifetime chiropractic care is an exception.

What is the basis for the claim that the provision of chiropractic care to "close friends, work colleagues and family members can be inappropriate because of risks to the chiropractor or patient"? What unique risks does this rule apply to?

4.2 Use of diagnostic tools, test, and procedures

As mentioned above, Board members should know that some chiropractors are not qualified to diagnose, do not claim to do so and do not need to do so. The proposed code places a legal requirement that all chiropractors to perform:

a) a full and thorough assessment of patients using tools, tests and procedures that are appropriate for the gathering of information necessary to form a diagnosis etc.

Requiring that, without very explicit strict guidelines may well endanger both patient and chiropractor.

Two must answer questions arise:

1) What medical conditions are all of Australia's practising chiropractors going to be legally required to diagnose?
2) What medical conditions are all of Australia's practising chiropractors not going to be legally required to diagnose?

5 Working with other practitioners

Whose liability is it when a chiropractor's referral to a medical practitioner exposes a patient to iatrogenic harm? A medical referral may take the patient from comparatively low level risk chiropractic to the risk of being a victim in the iatrogenic epidemic.

6 Working within the health care system.

The wording of this section is very poor, it would have greater relationship to the profession's reality to word it as follows.

Good practice involves:
a) fully understanding the anticompetitive structure and function of public health, its various trade barriers and their adverse effects upon those who should be chiropractic patients.
b) Upholding the right of public patients to gain direct Medicare funded access to chiropractic care.
c) Opposing the current biased allocation of health resources and supporting their equitable allocation.
d) Understanding that denial of those public patients who have subluxation related disorders to appropriate chiropractic care while exposing them to the risks of inappropriate medical treatment betrays patient and public interests.
For a) see http://www.attadalechiropractic.com/News-And-Views/Articles-of-Interest/Pages/Do%20You%20Sense%20that%20Something%20is%20Amiss.aspx

Minimising risk

Risk is inherent to health care. True, iatrogenesis appears to be a or the leading cause of permanent harm and death. Iatrogenic harm is evidenced in our practices far more often than any harm from chiropractic.

If it is the intent of the codes/regulations to minimise risk they should at this point give recognition to a chiropractor's responsibility to be on the lookout for iatrogenesis

such as the report of bleeding from the rectum due to anti-inflamatories, or muscle wasting coincidental to taking cholesterol lowering medication.

9.4 Health records

a) keeping accurate records that report relevant details of …. medication … What medications must a chiropractor record? This requirement needs to be exquisitely specific.

9.12 Financial and commercial dealings

b) …. If token gifts (flowers and chocolates) are accepted making a file note or informing a colleague. This exemplifies overly stringent regulation, its inclusion contrasts to no inclusion of more urgent matters.

c) not pressuring patients or their families to make donations to other people of organisations. ASRF?

Please delete b) and c)

Ensuring chiropractor health

d) understanding the principles of immunisation against communicable diseases.

Patient safety may be best served if the codes/regulations require registrants to understanding the principles of immunisation against communicable diseases as well as understanding vaccination risks.

Medicine, government and the media provide inadequate clear unbiased information regarding the risk-benefit ratio of repeated vaccinations. Growing distrust causes patients to ask advice from chiropractors.

Conclusion:

The codes are cluttered with motherhood statements while completely avoiding two key issues

1)Anti-competitive arrangements that are central to virtually no provision of chiropractic care within public health endanger those public patients who have subluxation related disorders.

2) Ignoring the public domain recognition that there is an iatrogenic epidemic and not incorporating that into the codes/regulations.

My thanks for a very interesting read

Michael McKibbin DC

[i] Archer, John. Bad Medicine: How Safe Is Modern Medicine. Simon and Schuster Australia, East Roseville, NSW. 1995. P184

[ii] Le Magazine March 2004; As We See It, Dangerous Medicine http://www.lef.org/magazine/mag2004/mar2004_awsi_01.htm