1. **GENERAL COMMENT**

Concern is expressed at the marked inconsistencies and discrepancies between this Board's requirements for chiropractors and those of Boards of other professions. More particularly, I note the somewhat onerous requirements of the CBA which place unfair restrictions on professional primary contact practitioners whose role it is to heal, educate, and inform patients when requested and where necessary and which are out of step and peculiar to this proposed Code.

2. ADEQUATE ACCESS TO ENSURE EXPECTED STANDARD DIAGNOSIS

The new Code states that a primary role and responsibility of chiropractors is "ensuring that the diagnosis is relevant, justifiable, and based in sound clinical reasoning" (Page 3 2.1 be) While diagnosis is essential, it is acutely handicapped by the fact that chiropractors are strictly limited in their ability to access legitimate diagnostic services. This includes radiological (MRI, UP/SO, CT) and specialists. Such restraints severely limit the diagnostic acuity, ability and accuracy, akin to having one hand tied behind one's back. Yet the new National Code demands the highest diagnostic standards. It is incumbent upon the Board to ensure that chiropractors have appropriate access to such diagnostic facilities to ensure the highest possible standards of patient care.

I note that under the Code's clause *4.2 Use of diagnostic tools, test and procedures...* it is required that practitioners employ

***"(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.."* As such, it is critical for the Board to ensure that registrants under its jurisdiction have access to all appropriate diagnostic facilities.**

3. UNQUALIFIED/UNDERQUALIFIED PRACTISE

The primary contradiction and weakness for all the professions' requirements under the new legislation, in that *any* person may conduct medical or chiropractic (or other) procedures even if not registered, as long as they do not claim to be a member of one of the registered professions. Such a situation defies the legislated purpose of registration.

It should be fundamental that all medical practitioners and other professionals who practise spinal manipulation (SMUT) be required to be trained in the science and technique of SMUT to the same level of proficiency as those professions who specialise in-depth in the field of the manipulative sciences.

4. SPECIALISTS LISTINGS

- Specialist registration for some areas of chiropractic where formal extended qualifications have been obtained, is one which should be addressed and accepted for those recognised specialties. I submit that this is another weakness in the proposed Code.

Such a move would encourage higher standards.

Such recognition is consistent with medicine and dentistry.

5 TITLE 'Dr'

5. Use of the title 'Dr' with professional nomination, has been recognised and accepted by, and to, the chiropractic profession for over 100 years. [1,2] The Victorian Branch of the AMAX has accepted this situation in a letter to the CAA(Vic).

NSW and Queensland have been out-of-step with world-wide acceptance of this title.

6. <u>INFORMED CONSENT</u>

To imply that chiropractors perform high risk skeletal manipulation procedures is inconsistent with the scientific evidence[3] – a requirement in other parts of the Code.

This comment both outrageous and ill-informed.

While the medical literature is somewhat creative with such claims, the papers ignore the true situation which is substantiated in the published literature, including the medical literature.

The chiropractic profession has always been concerned that such claims may be seen as adverse events and a danger to patients, despite the millions of manipulative procedures performed daily without incident. However the claim has been proven to not be plausible. Proper studies have now been conducted and an analysis of the literature undermines what can only be classed as prejudicial, uninformed and ignorance in such claims which grossly distort the true picture.

Attention is drawn to a number of relatively recent papers that have researched the topic.[3-7] A population-based case-control and case-crossover study of the risk of vertebrobasilar stroke and chiropractic care, it appears that any relationship could be temporal, and no more prevalent that for patients attending medical practitioners.[3]

Cassidy J et al.[3] – *"The authors also documented only a handful of stroke cases following chiropractic cervical manipulation in a massive study population spanning nearly 100,000,000 person-years. Even more impressive, the data suggest that while spinal manipulation may increase the risk of an embolism in those with a VAD in progress, which can then lead to a stroke,* ***the association between the stroke and the office visit was no higher in patients who seek the care of a chiropractor than in patients who seek the care of a general physician****."*

Terrett AGJ.[4] – Points out the false accusations made against chiropractors when other professions had been associated with apparent incidents. This paper in particular shows the prejudicial bias and distortion created in the medical literature.

Licht PB, et al.[5] Concluded *"It appears that the risk of cerebrovascular accidents after cervical manipulation is low, considering the enormous number of treatments given each year, and very much lower than the risk of serious complications associated with generally accepted surgery. Provided there is a solid indication for cervical manipulation, we believe that the risk involved is acceptably low and that the fear of serious complications is greatly exaggerated."*

The AMA statement assumes that all medical procedures and drugs are safer.[8,11] While medical iatrogenic figures in Australia are strangely and severely inconsistent with those from overseas (US, UK), greater significance and accuracy would place such claims in perspective.

There is supportive evidence in the literature questioning the distortion of any risk factor associated with SMT. Other comments, including those of medical doctors

It is noted that other professions who employ SMT do not have the same obligation to utilise Informed Consent.

7. EVIDENCED BASED PRACTICE.

In relation to evidence based chiropractic, I would like to draw your attention to some of the *medical* evidence which supports the role of SMT in areas apart from musculoskeletal conditions.[17,18] The attached appendix cites primarily European medical papers where attitudes appear to be different and somewhat contradictory to papers published in English.

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ADDENDUM

In their paper, Dabbs and Lauretti found that the relative risk of non-steroidal anti-inflammatory drugs (NSAIDS) have a risk factor of several hundred times more than spinal manipulative therapy.(3) They found that the rate of death from gastrointestinal bleeding (including bleeding abdominal ulcers) is 0.04% - 160-times greater than neck manipulation (.04% -v- .00025%). The risk of a non-fatal stroke from manipulation is 0.001%, and from NSAIDS 0.4% - a difference of 400-times. [8]

"Even if risk estimates are better quantified, however, the fundamental issue remains not consent for risk but demonstration of benefit: in the absence of randomised controlled trial evidence demonstrating the efficacy of cervical manipulation, the best current evidence suggests that the small risk of dissection and stroke outweighs the benefit of this treatment modality for patients with acute neck pain."[12] (Williams)

Myler calculated the rate of fatal stroke after cervical manipulation at 0.00025%, while the rate of deaths from stroke in the general population was 0.00057% - more than double the rate of the manipulated patients.[13]

Each year some 37,000 Australians suffer a stroke, that is more than 100 on each day of the year. Of these patients, 12,000 die, while another 12,000 are permanently disabled. This is a mortality rate of 70 per 100,000 population. Some 20% of stroke patients - 7,400, have diabetes, which can be a predisposing factor.[14,15]
Each day, some 25 Australians experience a spontaneous transient ischaemic attack.[16] Based on a population of 19,000,000 this is a rate of 1:760,000.[9]

MANOEUVRES ASSOCIATED WITH CVA'S

FOR WHICH SIGNED CONSENT IS GENERALLY NOT REQUIRED.

Calisthenics
Yoga
Overhead work
Neck extension during radiography
Neck extension for a bleeding nose
Turning the head while driving a vehicle
Archery
Wrestling
Emergency resuscitation
Star gazing
Sleeping position
Swimming
Rap dancing
Fitness exercise
Beauty parlour stroke
Tai Chi

OTHER
Childbirth/Pregnancy
Surgeon or anaesthetist during surgery

Source: Terrett AGJ. Malpractice avoidance for chiropractors 1. Vertebrobasilar stroke following manipulation. Des Moines, IA: National Chiropractic Mutual Insurance Company, 1996.

VOLUNTARY RISKS

Voluntary Risk	RISK OF DEATH /PERSON/YEAR
Smoking: 20 cigarettes/day	1 in 200
Drinking: 1 bottle of wine/day	1 in 13,300
Soccer, football	1 in 25,500
Automobile racing	1 in 1,000
Automobile driving (United Kingdom)	1 in 5,900
Motorcycling	1 in 50
Rock climbing	1 in 7,150
Taking contraceptive pills	1 in 5,000
Power boating	1 in 5,900
Canoeing	1 in 100,000
Horse racing	1 in 740
Amateur boxing	1 in 2 million
Professional boxing	1 in 14,300
Skiing	1 in 4,350
Pregnancy (United Kingdom)	1 in 4,350
Abortion: legal <12 wk	1 in 50,000
Abortion: legal >14 wk	1 in 5,000

Source: Dinman BD. The reality and acceptance of risk. *Journal of the American Medical Association* 1980; 244 (11): 1226-1228.

Respectfully submitted,

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