Submission to the Chiropractic Board of Australia

Regarding the Consultation Draft Code of Conduct for Chiropractors

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PREAMBLE

Registration Travesties.

Registration is about ensuring the delivery of safe treatment.

Implying that a principle aim of registration is protecting patients from harm is a dangerous and cruel deception. During the five decades since Illiche's warned about iatrogenesis published articles have warned of the iatrogenic epidemic.

The true extent of iatrogenesis should be common knowledge within health related government departments, yet internationally, no governments collect and publish data about the entire extent of the full spectrum of iatrogenesis. That is why researchers use medicine's own the medical literature to guesstimate rates of medical permanent harm or death.

John Archer's 1995 book, *Bad Medicine is* 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[i] 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]

According to the BMJ July 17 1999 "Studies in Australia, Israel, the United Kingdom and elsewhere suggest levels of error and hazard in patient care that are no lower than in America."

If interpretations of the medical literature are close to being correct, over decades registered and licensed medical providers appear to have initiated an iatrogenic epidemic whose collective magnitude dwarfs all of the fatalities incurred by serving men and women in Australia's defence forces in all of the wars in which Australia has been a combatant, without any adequate public forewarning from medical or chiropractic registration Boards, medical and chiropractic associations, the mainstream media or the government.

The sponsors of Australia's medical system Australia's Government can be trusted to adequately forewarn potential victims of iatrogenic harm.

My correspondence to various government departments established that no government department, including the Australian Bureau of Statistics accurately defines the number of victims of the total spectrum of iatrogenesis. The spokeswoman for the federal Minister for health echoed the Australian Bureau of Statistics (ABS) data suggesting **259** deaths a year. Prime Minister Rudd's government inquiry into public health stated that there are **4550** in-hospital deaths due to medical mistakes in Australia annually, a difference of 1756.76% from the ABS figure of **259** deaths a year. Australia's true total iatrogenic toll is unknown and unknowable

I know that governments remain ignorant of the true magnitude of iatrogenesis and that they fail to forewarn and so protect a vast number of future potential victims of iatrogenic harm. Seen in a worldwide context over decades, this is an incomprehensible level of wrongdoing. It would please me greatly if the reader can disprove that position.

Registration is about ensuring the delivery of effective treatment.

Australia's 1977 Webb Report noted the following sequence of events; the majority of new patients attending chiropractors shared a history of failed medical treatment, later they sought chiropractic care for the same disorder. Quoting Webb ", the majority of whom report high levels of satisfaction with treatment they received."

Over decades millions of public patients have shifted to chiropractic care, by 2010, majority refers to millions of patients. Currently, some half of Australia's 22 million population use public health and so are denied direct access to Medicare funded chiropractic care. It is probable that a similar number of public patients as compared to private patients share subluxation related disorders for which Chiropractic is, and Medicine is not the appropriate care.

Within public health, and with regard to subluxation related disorders, registration serves as an anticompetitive device permitting the substitution of ineffective, potentially dangerous medical services for comparatively safe and effective chiropractic care.

The codes/regulations need to recognise that chiropractors who locate and adjust subluxations share a professional obligation to oppose the continuing containment of chiropractic so that those public patients who have subluxation related disorders may have direct access to Medicare funded chiropractic care.

Regarding chiropractic philosophy, why many chiropractors do what we do.

Belief systems may lose currency, truths are everlasting. My truths include both Universal intelligence and Innate intelligence. I am proud to be a chiropractor, I use its terminology and subscribe to its philosophy.

Allopathically inclined chiropractors abandon both chiropractic philosophy and its the terminology.

That is their free choice, but they should not misuse their authority of the Board to exclude chiropractic philosophy and its the terminology while imposing upon all chiropractors medical thinking, terminology and procedures in a perilous hybrid between chiropractic and medicine.

The code of conduct should be about ensuring patients receive safe, effective and cost effective care. Instead the code is unnecessarily cluttered with relatively low priority motherhood statements while ignoring two crucial key issues
1)Probably millions of public patients who have subluxation related disorders are denied direct access to Medicare funded chiropractic care by government imposed anti-competitive trading arrangements; i.e. containment.
2) Ignoring and not incorporating the public domain recognition that there is an iatrogenic epidemic.

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 (repeat of words with the same meaning) of the health care system. Minimising risk to patients is a fundamental component to practice.

Chiropractors share a duty to make the care of patients their first concern, to contribute to the effectiveness and safety of health care system and to minimise risk. How are we to do that if we are expected to ignore what authors refer to as an iatrogenic 'epidemic'?

Because of containment chiropractors cannot contribute toward the safety and success of Australia's public "health care system". The Board needs to define the term "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.

With no uniform national legislated chiropractic scope of practice academics have redefined 'chiropractic' to a degree that there is no recognisable way that anyone can define when a chiropractor is practising or is not practising "chiropractic, there is no legally defined 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 segments of the iatrogenic toll which point to, 18,000 5,000 and 4,500 iatrogenic deaths per year.

In relationship to both the iatrogenic epidemic and containment of chiropractic the code needs to define how chiropractors should be committed to safety and quality in health care.

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. In response chiropractors developed modes of practise which do not include diagnosing. Registered chiropractors of that era have practised for decades without any formal tertiary level training in clinical diagnosis. The codes/regulations must accommodate to that segment of the profession.

Both for the protection of the patients and the new legal obligations imposed upon chiropractors by this section of the code the outer perimeter of what disorders all registrants must be able to diagnose and equally importantly, what disorders all registrants must not diagnose must be defined.

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." Who is qualified to arbitrarily define "necessary service" and 'unnecessary service'? 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. Registration should **not** legally 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 medical emergencies. If chiropractors are to be legally obliged to treat emergencies, then the codes/regulations should clearly define the terms 'treat' and 'emergency'.

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. Once again; 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. For example when the stated needs of the patient have been 1) medically to have spinal surgery 2) from the chiropractor's viewpoint, locating and

adjusting subluxations may make surgery unnecessary. The code/regulations need to clarify if registrants do or do not share a legal duty of care to explain iatrogenic risks to patients.

Page 5 Effective Communication

Both the following 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 relative risk/benefits of **any** alternative (s) etc: massage, yoga, physiotherapy, drugs, surgery and on and on; "as well as the likely consequences".

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.

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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.

Which profession's "good practice" recognises that? This paragraph sounds as if it has a medical origin. Where is the chiropractic evidence underwriting this claim? In my experience, such claims are utterly unfounded.

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.
As mentioned above, 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/many chiropractors are not qualified to diagnose, do not claim to do so and judging by their decades of satisfactory practise, do not need to do so. The proposed code places a legal requirement that all chiropractors must 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.

That requirement should be deleted.

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

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

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 the patient 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. When one reflects upon the codes fatal flaws, such as the

recognition of iatrogenic harm, this requirement exemplifies overly stringent regulation about relative trivia. 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 do not provide adequate clear unbiased information regarding the risk-benefit ratio of repeated vaccinations. Growing distrust causes patients to ask advice from chiropractors.

Along with the foregoing I remain seriously concerned about the areas in the codes/regulations that are still in effect and that were mentioned in my previous submission.

Michael McKibbin DC

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[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.htmii