



The peak body representing chiropractors

Consultation Paper on Proposed Registration Arrangements for the National Registration and Accreditation Scheme

Submission to the Australian Health Ministers' Advisory Council
Practitioner Regulation Subcommittee of the
Health Workforce Principal Committee

from the

Chiropractors' Association of Australia (National) Limited

The peak body representing Chiropractors

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The Chiropractors' Association of Australia (National) Limited's (CAA) submission has provided comments on the proposals of the Australian Health Ministers' Advisory Council Practitioner Regulation Subcommittee of the Health Workforce Principal Committee, relating to Proposed Registration Arrangements.

The CAA has also provided comment in regard to the question of whether or not spinal manipulation generally, or cervical manipulation, specifically should be a restricted act within the proposed new legislation. CAA's comments on this can be found in two separate documents as appendices to this submission:

Appendix I: CAA submission proposing restricted practice of spinal manipulation

Appendix II: Key points of the CAA submission proposing restricted practice of spinal manipulation

The CAA has restricted comment to specific proposals within the proposed Registration Arrangements consultation paper. Other chiropractic groups have responded in more detail to some proposals especially where they are more informed about the ramifications of the proposals. It is recommended that the following submissions be read in conjunction with this submission from the CAA:

- Submission from The Council on Chiropractic Education (Australasia)
- Submission from the Combined Chiropractic Registration Boards

Proposal 2.1: It is proposed that the registration provisions be framed in a way that:

- a. reflects the wording and intent of the IGA
- b. builds on the best aspects of State and Territory schemes, rather than the lowest common denominator or replicating one existing registration scheme, and facilitates a smooth transition to the national arrangements
- c. enables a robust system that is designed to protect the public
- d. is the least restrictive law necessary to achieve the policy objectives, and includes legislated restrictions on practice only where the benefits to the community as a whole outweigh the costs, and there is no other more responsive method of achieving these benefits, and
- e. facilitates the transparent, accountable, efficient, effective and fair operation of the scheme.

In order to move from multiple profession-specific legislative schemes to a single national scheme for all the regulated professions, general (rather than profession-specific) language will be required in legislation to describe the practitioners, the

professions, the boards and their functions, etc. Terms such as 'responsible board', 'registered health practitioner' and 'regulated profession' are used in this paper, and may require definition in the legislation.

At the outset the CAA agrees that the legislation supporting the new national registration and accreditation scheme should be based on the safety of the public being paramount and that high quality care be encouraged.

The CAA supports the above proposal. It believes that terms such as 'responsible board', 'registered health practitioner' and 'regulated profession' **will** require definition in the legislation.

Proposal 4.1.1: It is proposed that the legislation require applications for registration to be made to the responsible board, and that an application must be:

- in a form approved by the responsible board
- accompanied by the fee fixed for that profession, and
- accompanied by any information reasonably required by the responsible board.

CAA is aware that registration fees around the country vary greatly and it trusts that this will be taken into consideration when fee setting is undertaken by the responsible board to ensure that the fee that is set is sufficient to cover **all** operations of the responsible board including the profession specific accrediting agency.

There are strong concerns regarding on-line registration in terms of the authentication of documentation and identification of applicants. Failproof procedures would need to be in place.

It is not intended that the forms for registration be prescribed by regulation. It is expected that the national scheme will include a facility for registrants to make applications on line, as well as paper based applications.

In accordance with Clause 12.4 of the IGA, it is intended that the legislation empower the National Agency to publish a schedule of fees for each profession, for registration and other purposes, following agreement with the respective national boards.

The CAA suggests that the schedule of fees for each profession include all fees associated with being a registered professional including but not limited to: application fees, short-term registration fees, locum fees, late fees, restoration fees and services provided to the professional by the board – eg copies of registration documents, certificates of good standing, etc.

Proposal 4.2.1: It is proposed that the national boards have the power to require the following information to accompany an initial application for registration:

- a. evidence of the applicant's qualifications and supervised practice experience that they believe qualifies them for registration

- b. evidence of successful completion of an examination (if required) set by or on behalf of the responsible board.
- c. evidence of previous registrations and registration status, ie disciplinary history (where the applicant has been registered under another law)
- d. information on any complaints made against the applicant to bodies such as health complaints commissioners, Commonwealth, State or Territory bodies
- e. evidence of recency of practice (except for new graduates, see section 9 of this paper)
- f. workforce data required for national workforce analysis (further discussion of this will be provided in the information-sharing paper), and
- g. any other information reasonably required by the responsible board.

The CAA recommends that initial registrants supply:

- h. a certificate of currency for Professional Indemnity Insurance.

CAA suggests that in Clause 4.2 b. the Chiropractic Boards recommend the addition of the following:

“If an overseas applicant they must pass CCEA eam and have evidence of English language – eg IELTS certificate or similar if from non-English speaking country.

Proposal 4.3.1: There are a number of options available on or relating to requirements for criminal history checking of applicants for registration and renewal of registration:

- Option 1:** That the legislation require criminal history checks be applied to all new applicants for registration from 1 July 2010, but not to existing registrants renewing their registration.
- Option 2:** That the legislation require criminal history checks on all new applicants and at renewal of registration, but these requirements be phased in over time from 1 July 2010.
- Option 3:** The legislation require criminal history checks on all new applicants for registration, with a discretionary power for boards to require checks at annual renewal, and self-declaration obligations imposed on registrants both at annual renewal and during the registration period.
- Option 4:** That the legislation provide the power to require criminal history checks on applicants at the discretion of the relevant board, while not making checks mandatory for all applicants.

The CAA’s preferred position is Option 3. It is suggested that a criminal check be the responsibility of the registrant as it is for chiropractic registrants in WA. It is also recommend that the National profession specific boards have discretionary powers to require a criminal history check at any other time during a registration period if they determine there is sufficient reason.

The IGA at clause 1.25(c) provides that the role of the national boards will include approval of a list of accredited courses of study that meet the qualifications required for general registration.

Proposal 5.1: It is proposed that the legislation define the qualifications for general registration to mean one or a combination of the following:

- an approved course of study
- an approved period of supervised practice (if any) (ie an internship), and
- an examination (if any) set by or on behalf of the responsible board.

CAA recommends that at the end of the first bullet point the following words be added: “accredited by the relevant profession-specific accreditation agency.”

CAA strongly recommends that the wording of this proposal be amended to reflect what we believe the writer meant it to reflect: ie- the registrant should hold either an approved course of study **together with** an approved period of supervised practice (if any) (ie an internship) **and/or** an examination (if any) set by or on behalf of the responsible board.

CAA is of the opinion that professional specific boards should be given the responsibility of determining the combination of qualifications, experience and examination required for registration after consultation with the profession's accrediting body.

Proposal 5.2: It is proposed that, in addition to the powers above relating to the IGA clause 1.25(c) to register those with approved qualifications, boards have the power to register persons who have training and experience the responsible board considers to be substantially equivalent to an approved course of study and supervised practice. This will allow a national board to recognise substantially equivalent qualifications recognised by registration authorities in another country.

The CAA refers the reader to submissions from The Council on Chiropractic Education Australasia and the combined Chiropractic Registration Boards.

Proposal 5.3: It is proposed that qualifications that are ‘approved’ by a responsible board for the purposes of registration are not ‘prescribed in regulation’, but rather that the legislation enables boards to publish a list of approved qualifications on a website.

CAA supports this proposal.

Proposal 6.1.1: It is proposed that the legislation provide for a responsible board at its discretion to exercise the following powers before deciding an application for registration:

- a. investigate the applicant
- b. require the applicant to attend before the board to answer questions about their application
- c. require the applicant to provide further information or any documents considered necessary by the board to decide the application

- d. require the applicant to undergo a written, oral or practical examination to assess the applicant's competence to practise, and
- e. require the applicant to undergo a health assessment (eg a medical examination or psychological assessment) to assess the applicant's capacity to practise.

The CAA supports this proposal as it provides greater assurances for the public.

Proposal 6.1.2: With respect to terminology, it is proposed that the term 'health assessment' be used in the legislation rather than 'medical examination' because it allows a broader range of assessments to be conducted.

The CAA supports this proposal.

6.2 Who makes registration decisions?

The statutory power to make registration decisions will reside with the respective national boards. However, because of the workload associated with the registration function for most of the professions, the legislation will need to make provision to allow decision-making on registration applications (both routine and non-routine applications) to occur at the State and Territory level.

It is anticipated that, in light of the workload, each national board will determine what functions should best be carried out nationally versus at the local level. Each board will determine the combination of committees it requires and that if the workload is relatively small, a single committee may carry out multiple statutory functions spanning the registration, investigation and disciplinary functions, either at the national or local levels. What is required in the legislation is the capacity for some committees of the board to act as the national board for the purposes of some decisions such as registration.

Proposal 6.2.1: It is proposed that when a committee makes registration decisions the responsible board would otherwise be empowered to make, it is constituted appropriately. In order to achieve this, the legislation would require provisions that:

- a. require a committee, when exercising registration functions, to comprise at least the following:
 - i. a chair appointed by the responsible board who may be a registrant (from the profession regulated by the responsible board), or a non-registrant
 - ii. at least two members who are registrants from the profession concerned
 - iii. at least one lawyer
 - iv. at least one community member who is not and has never been a registered practitioner in that profession, and
 - v. no more than two thirds of members being registrants from the profession concerned
- b. allow a committee to regulate its own proceedings, while requiring it to observe the principles of natural justice and procedural fairness, and
- c. allow members appointed to committees to be paid the sitting fees and allowances

approved by the Ministerial Council .

CAA recommends that the Chairman be a current or former registrant in good standing.

CAA suggests that in clause b. after the words “requiring it” the following words be inserted: “for registrants”.

CAA suggests that clause c. the following words be added at the end: “upon the recommendation from the board and agency.”

In addition to this power to establish committees, there is a need for a mechanism in legislation that allows routine registration decisions to be made by staff of the State and Territory offices, on delegation from a national board.

Proposal 6.2.2: It is proposed that the legislation include powers for a responsible board to delegate, in writing, to a member of the responsible board or a member of a committee, a person employed by the National Agency, or a person engaged by the National Agency to provide services to the board, its registration powers and functions under the legislation, other than its powers to:

- a. refuse to grant, or refuse to renew a registration or an endorsement of registration
- b. impose conditions on a registration or endorsement of registration
- c. impose conditions on a registration renewal or endorsement renewal
- d. amend, vary or revoke conditions on a registration or endorsement, and
- e. remove a person’s name from the register where the person no longer meets the requirements for registration (see section ‘12.5 Removal from the register’ of this paper).

CAA agrees with this proposal. The board should also have the ability to delegate those powers as outlined in 6.2.2. This is important to allow timely processing of applications.

Most States and Territories require registered health practitioners to hold or be covered by professional indemnity insurance (PII) arrangements in order to practise. However, the mechanism through which this is achieved varies. [Attachment 1](#) sets out the current arrangements across jurisdictions with respect to PII.

Proposal 6.3.1: It is proposed that the legislation require registrants (except for non-practising registrants if any) to be covered by PII arrangements at all times during the registration period, as a condition of registration, and to require registrants demonstrate coverage to the satisfaction of the responsible board, at the time registration is granted for the first time, and annually on renewal of registration.

The legislation concerning PII must allow registrants to meet the requirements if they are covered by an employer’s PII, their university’s PII, or the PII of a health facility where they are a student, as well as when a registrant purchases their own PII cover.

CAA supports the proposal for compulsory PII arrangements for all practising registrants from time of first registration and then annually on renewal of registration.

A word of caution regarding non-practising registrants. Some practitioners may treat family members and if so, they require PII arrangements.

Currently PI insurance is generally mandatory across the various jurisdictions for the health care professions covered in the paper. The CAA mandates a level of cover for members to join the association.

One area that doesn't appear to have been addressed in the paper is "run-off cover". This is one issue that should be given serious consideration when determining whether "appropriate cover" is in place. Cover is required for those practitioners that cease to practice and/or retire.

By the very nature "claims made" policy coverage (which is the typical style of cover available in the PI market) can leave a gap in protection if cover is not maintained to accommodate a situation where a practitioner has ceased to practice. Having "run -off" and/or "retirees cover" is important to ensure that there are not gaps in the protection of health professionals even though they have ceased to practice.

As an example of this point, a practitioner could treat an infant in the last year as a chiropractor before retiring - effectively the chiropractor requires 18 years plus statutory limitation periods, for "run-off" cover to ensure adequate protection is available in the event of a claim to compensate an aggrieved third party where liability is proven.

Proposal 6.3.2: It is proposed that each national board have the power to issue a guideline about what constitutes acceptable arrangements for PII for registrants.

CAA suggests that each national board consult with their relevant profession regarding acceptable arrangements for PII registrants. Advice sought from independent underwriters and professional associations with industry knowledge of claims histories and trends would be imperative in setting the appropriate dollar amount of PII which may vary from profession to profession.

Proposal 6.4.1: It is proposed that the legislation provide powers for a responsible board to refuse to grant registration on a number of grounds, including but not limited to the following:

- a. the applicant has not satisfied the board of their **competence to practise** in the regulated profession and this cannot be satisfactorily addressed by the imposition of conditions
- b. the applicant's **character** is such that it would not be in the public interest to allow the applicant to practise in the regulated profession
- c. the applicant is considered by the board to be unfit to practise because of **drug or alcohol dependency** or **physical or mental impairment**
- d. the applicant has been **convicted** of or made the subject of a criminal finding for an offence in any participating jurisdiction or an offence under a foreign law, and the circumstances of the offence are such as to render the applicant unfit in the public interest to practise in the regulated profession
- e. the applicant has previously been registered under this Act or a corresponding previous enactment of a participating jurisdiction, and that registration has been suspended or cancelled, or during the course of that registration, the practitioner has had proceedings brought against him or her and those **proceedings have never been finalised**
- f. the applicant has been **deregistered or suspended** under a foreign law, for any reason relating to conduct that would constitute professional misconduct under this Act, or during the course of that registration, the practitioner has had proceedings brought against him or her and those **proceedings have never been finalised**
- g. the applicant has had **insufficient recent practice** experience in the relevant profession (with the time period within which an applicant must demonstrate they have practised to be determined by the responsible board, eg two years is preferred in some professions, five years in others)
- h. the applicant's **English language proficiency** is not considered sufficient by the board for the applicant to practise in the relevant profession
- i. the applicant does not have arrangements for **professional indemnity insurance** that the responsible board considers sufficient, or
- j. the applicant is **disqualified from applying** for registration under this Act or a previous enactment of a participating jurisdiction.

CAA agrees with this proposal. Suggests the term "drug or alcohol dependency" in clause c) be amended to "substance abuse".

CAA suggests the addition of two more items, namely:

- k. absence of qualifications
- l. reasonable suspicion of fraudulent application

It is expected that the application form for registration would require applicants to make a declaration with respect to each of the above matters, and provide supporting documentary evidence if required.

Proposal 6.4.2: It is proposed that the legislation provide for boards to deal with possible fraudulent registration applications. Failure to disclose relevant matters to a board (such as those listed above) might constitute a fraudulent application under the legislation. In such circumstances, the responsible board might refer the matter to the relevant State or Territory police force. In addition, it is proposed that the legislation set out a process for a responsible board to deal with a registrant whom it has reasonable grounds to believe has obtained, or is attempting to obtain registration by fraud. In such circumstances, the responsible board should be empowered to immediately suspend registration (if already granted), investigate the matter, and refer it, if necessary, for hearing by the relevant State or Territory tribunal. The tribunal would be empowered under the legislation to find that the practitioner's registration has or has not been obtained by fraud, and, if appropriate, order that the practitioner's registration be cancelled. The standard of proof that would apply in such proceedings would be on the balance of probabilities.

CAA agrees with this Proposal however would strongly suggest that a timeframe be included by which the Tribunal must hear the matter to ensure a practitioner natural justice. CAAQ has witnessed in Queensland delays of unacceptable length, e.g. over 12 months, for a Tribunal to hear a case.

Proposal 6.5.1: It is proposed that the legislation provide that in the event that a board is proposing to refuse an application for registration, or to attach conditions to a practitioner's registration, the board would be required to give the applicant notice of its proposal and provide the applicant with an opportunity to make a submission to the board. It is proposed that the legislation include timeframes for this process before a board makes such a decision.

CAA supports the proposal.

Proposal 6.5.2: It is proposed that the legislation require a board to notify an applicant of its decision, within a specified period, eg 28 days after determining an application for registration or renewal of registration, and if the application has been refused, or conditions have been imposed, to provide reasons for the decision. The legislation should also require a board to inform the applicant of their right to seek a review of the board's decision and advise of the appropriate review body (the relevant State or Territory tribunal). It is proposed that the same entitlements and obligations would apply with respect to an endorsement of registration (see section 10 of this paper).

CAA agrees with this proposal.

6.6 Rights of review of registration decisions

There is considerable variability across States and Territories as to the rights of review afforded persons who are refused registration or who have conditions placed on their registration. Attachment 2 sets out a sample of these arrangements.

Proposal 6.6.1: It is proposed that the legislation include provision for registrants or persons refused registration to have a right of review to the relevant State or Territory

tribunal. It is proposed that this would be a merits review (rather than a review on points of law). The legislation would specify the following decisions as reviewable:

- a. A decision to refuse a person’s application for registration or renewal of registration.
- b. A decision to refuse a person’s application for endorsement of registration or renewal of endorsement (see sections 10 and 11 of this paper).
- c. A decision to impose a condition on a person’s registration or endorsement of registration otherwise than by agreement.
- d. A decision to withdraw registration on the basis that a requirement for registration is no longer met.

CAA suggests there be a clause e. A decision to revoke conditions. As in 6.4.2 above CAA suggests a timeframe be included by which the Tribunal must hear the matter to ensure practitioner natural justice.

Proposal 7.1: It is proposed that the legislation enable a national board to grant any one of a number of different types of registration, depending on the circumstances of the applicant, and to impose conditions on a grant of registration. The proposed types and sub-types of registration are set out in Table 2 below.

While the labels vary, most jurisdictions provide in some legislative form for the sub-types of registration listed under specific registration.

CAA supports this Proposal however these categories should not be mandatory for all professions.

TABLE 2: PROPOSED TYPES AND SUB-TYPES OF REGISTRATION

Type of registration	Eligibility
General	Applicants who hold approved qualifications (and have met any other requirements set by the responsible board). This category would include practitioners who hold approved specialist qualifications in addition to their approved general qualifications, and therefore hold a specialist endorsement on their general registration.
Specific	Applicants who do not qualify for general registration. This type of registration would entitle a registrant to practice, subject to a specified form of restriction. The following sub-types of specific registration would apply: <ol style="list-style-type: none"> a. Provisional – to allow an applicant to undertake an internship or other period of supervised clinical practice, following graduation from an approved course of study. b. Area of need – to allow an applicant to work in an area of unmet need. c. Post-graduate supervised practice or training – to allow an applicant to

	<p>be registered on a temporary basis to undertake a period of post-graduate training approved by the responsible board.</p> <p>d. Examination candidates – to allow an applicant to undertake training in preparation for an examination approved by the responsible board.</p> <p>e. Teaching or research – to allow an applicant to fill a teaching or research position approved by the responsible board.</p> <p>f. Recognised specialist qualifications and experience – to allow an applicant with approved specialist qualifications to practise in the specialty.</p> <p>g. Internationally trained specialists – to allow an applicant with “specialist” qualifications that are not approved to undergo further training in that specialty.</p> <p>h. Temporary registration in the public interest – to allow an applicant without approved qualifications to be registered for a limited period if the responsible board considers it is in the public interest. - disagree</p>
Non-practising	Applicants who would otherwise be eligible for registration but who do not intend to practise during the registration period.
Student	Applicants who are enrolled in an approved course of study or undertaking approved supervised clinical training in preparation for an examination for registration.

7.1 General registration

CAA supports “general registration”

7.2 Specific registration

CAA supports the term “specific”

7.3 Non-practising registration

Proposal 7.3.1: It is proposed to include in legislation the capacity for boards to adopt a non-practising category of registration if they wish, in order to:

- make more transparent the distinction between those registrants who are and are not in active practice
- better target competency requirements, and
- provide more accurate data for workforce planning purposes.

It may also mean some non-practising registrants maintain a connection with their profession that may facilitate their return to active practice.

ALTERNATIVE OPTION: Boards be required to have a non-practising category of registration

CAA agrees with this Proposal as it is aware that elderly practitioners hold their professional title in high esteem and introducing a non-practising category would allow them to retain their professional “kudos”.

CAA does not agree with this alternative option as there may be other professions where the inclusion of a non-practising category may cause difficulty.

Proposal 7.3.2: If a non-practising registration is to be provided under the legislation, then it is proposed that those granted this type of registration registrants would be required, as a condition of their registration, not to practise at all. This means that such registrants would be acting unprofessionally (and possibly also committing an offence), if they were to breach the conditions attached to their registration. For example, if a non-practising medical practitioner were to write a prescription this would constitute active practise in breach of their non-practising registration.

CAA agrees with this proposal.

Proposal 7.4.1: It is proposed that the legislative provisions with respect to student registration would be framed to:

- require only those students who are undertaking clinical training that involves contact with patients/clients to be registered
- empower boards to deal with students whose ability to undertake clinical training is affected by physical or mental impairment, drug or alcohol dependency, and
- give boards the discretion to include or not include a student category of registration.

Alternative options are as follows:

Option 1: The legislation include powers to register and regulate students, but only for specified professions and boards, for example, the medical and dental professions.

Option 2: The legislation include powers for all boards to register and regulate students, and student registration be mandatory, but only for those students who are undertaking clinical training, that is, those who are at the point in their course where they are in direct contact with patients.

Option 3: The legislation include powers for all boards to register and regulate students, and student registration be mandatory for students in all regulated professions, at the point of enrolment and for the duration of their course.

CAA’s preferred position is Option 3. CAA (Queensland) is aware of instances where students have been accepted into programs with no hope of being registered once they have completed their training due to physical disabilities.

Proposal 7.5: It is not proposed that the legislation make provision for registration of corporations.

8.1 Title protection

Clause 1.28 of Attachment A of the IGA states that the primary basis for regulation is to be 'protection of professional title', with statutory offences to prevent unregistered or unauthorised persons using professional titles. Table 2 in Attachment A of the IGA sets out the professional titles that are proposed to be restricted under the legislation, with a role for the Ministerial Council in determining any further titles to be restricted.

TABLE 2. PROFESSIONAL TITLES PROPOSED TO BE RESTRICTED UNDER THE NATIONAL SCHEME

Profession	Titles to be protected
Chiropractic	<ul style="list-style-type: none"> • 'chiropractor' • catchall provision along the lines of 'any other title, name, symbol, description, etc, which given the circumstances could be reasonably understood to indicate the person is a chiropractor'
Dental	Titles restricted to those registered in the relevant division of the register: <ul style="list-style-type: none"> • 'dentist' • 'dental therapist' • 'dental hygienist' • 'dental prosthetist' • 'oral health therapist' • catchall provision as above
Medical	<ul style="list-style-type: none"> • 'medical practitioner' • catchall provision as above
Nursing and Midwifery	Titles restricted to those registered in the relevant division of the register: <ul style="list-style-type: none"> • 'nurse' • 'nurse practitioner' • 'enrolled nurse' • 'midwife' • catchall provision as above
Optometry	<ul style="list-style-type: none"> • 'optometrist' • 'optician' • catchall provision as above
Osteopathy	<ul style="list-style-type: none"> • 'osteopath'

	<ul style="list-style-type: none"> • catchall provision as above
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Profession	Titles to be protected
Pharmacy	<ul style="list-style-type: none"> • 'pharmacist' • 'pharmaceutical chemist' • catchall provision as above
Physiotherapy	<ul style="list-style-type: none"> • 'physiotherapist' • 'physical therapist' • catchall provision as above
Psychology	<ul style="list-style-type: none"> • 'psychologist' • catchall provision as above

The CAA supports the list of titles to be protected in the above table. However, it has concerns with the title 'physical therapist' listed under Physiotherapy. In Australia physical therapy is a widely used term and commonly used by a number of health professionals (both registered and unregistered) in describing the care they provide patients.

It is important that the public is protected from individuals who use terminology which implies that they have the skills of a registered health professional.

Proposal 8.1.1: With respect to the use of courtesy titles, such as the title 'doctor' or 'professor', it is proposed that these not be legislated as protected titles, nor reserved for use only by members of one or a number of regulated health professions.

Therefore, unregistered persons using such titles would risk prosecution only where use of a courtesy title could, in the circumstances, lead others into believing the person is qualified and registered under the Act in a regulated health profession when they are not.

It has been standard practice for many years for health professionals with a five year pre-professional tertiary training such as chiropractors, osteopaths, medical practitioners dentists and veterinarians to use the courtesy title "Dr".

The CAA supports this proposal for registered health practitioners who have a minimum qualification or equivalent of five years tertiary education in their specific health specialty. As the scheme is broadened to include other health professions this requirement will become even more relevant.

The CAA supports the use of the courtesy title "Dr" provided its use does not lead others to believe the person is qualified and registered under a regulated health profession when they are not. For example that a clarifier is used in combination with the courtesy title - Dr J Smith, Chiropractor, Dr J Brown, Dentist.

Proposal 8.3.1: With respect to protection of the practice of dentistry, it is proposed that there be defined in legislation a number of restricted acts relating to dentistry and that there be an offence for a person who carries out a restricted act and is not a registered dental care practitioner or a person who falls into a class of exempted persons (for example a registered medical practitioner). It is proposed that the restricted acts with respect to the practice of dentistry be along the following lines:

- a. the performance of any operation on the human teeth or jaws or associated structures
- b. the correction of malpositions of the human teeth or jaws or associated structures
- c. fitting or intra-oral adjustment for a person of artificial teeth or corrective or restorative dental appliances, and
- d. the performance of any operation on, or the giving of any treatment or advice to, any person that is preparatory to or for the purpose of the fitting, insertion, adjusting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances.

The CAA has no objection to this proposal.

Proposal 8.4.1 With respect to protection of the practice of optometry, it is proposed that the legislation prohibit unregistered or unauthorised persons from prescribing optical appliances. It is proposed that an optical appliance would be defined as: 'contact lenses, spectacle lenses, or any other appliance designed to correct, remedy or relieve any refractive abnormality or defect of sight'.

Stakeholders are invited to address in their submissions whether the definition of optical appliance should be framed broadly to include all contact lenses (whether for therapeutic or cosmetic purposes), or narrowly, to exclude 'plano' or cosmetic contact lenses.

If cosmetic contact lenses are included in the definition of a restricted optometry act, the effect would be to make it illegal to supply cosmetic contact lenses to a person, except in accordance with a prescription issued by a registered optometrist or other authorised person.

The CAA has no objection to this proposal.

Proposal 8.4.2: If the prescribing of optical appliances is to be a restricted act under the legislation, then it is proposed that an orthoptist who is listed with the Australian Orthoptic Board (not a statutory board in this scheme) be exempted from committing an offence for prescribing spectacle lenses in the normal course of their practice.

The CAA has no objection to this proposal.

8.5 Restrictions on spinal manipulation

Current arrangements with respect to regulation of spinal manipulation vary across States and Territories, with some jurisdictions restricting its practice to registered practitioners (such as chiropractors, osteopaths, physiotherapists and medical practitioners), and in others, there is no legislative restriction on its practice.

The key question is whether there is any evidence to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions apply. It may be that the more serious risks associated with spinal manipulation relate mainly to manipulation of the cervical spine, and that if a restricted act is to be included in the legislation, it should be narrowly framed.

Clause 1.28(c)(ii) of the IGA (Attachment A) states that 'elements of the practice of spinal manipulation may also require legislative protection, and further work will be undertaken to define these for this purpose'.

Proposal 8.5.1: With respect to protection of the practice of spinal manipulation, it is proposed that further consideration be given to practice restrictions as detailed in the IGA at 1.28(c)(ii).

Stakeholders from the registered and unregistered professions, as well as consumers are invited to include in their submissions on this paper comments on the need, if any, for inclusion in the national legislation of a restricted act with respect to spinal manipulation, and if so, how broadly or narrowly this restricted act should be framed and what definition should be adopted.

The CAA has prepared a separate document on this proposal. Attached to this submission are two Appendices:

Appendix I: CAA submission proposing restricted practice of spinal manipulation

Appendix II: Key points of the CAA submission proposing restricted practice of spinal manipulation

Proposal 9.2.1: With respect to ensuring continuing practitioner competence, it is proposed that the legislation require the boards to establish requirements within each profession for registrants to demonstrate continuing competence at the time of annual renewal, with the scheme to be implemented for each profession on 1 July 2010. Since continuing competence would be a condition of registration renewal, requirements would apply to all registered health professionals, regardless of whether they work in public or private settings, and are employees or self-employed.

CAA supports this proposal and suggests that it would be appropriate for the boards to have the right to establish a practitioner's competence at any time within the duration of the practitioner being registered.

We are assuming that continuing competence would also encompass ongoing continuing profession development and would be mandatory. The CAA supports the terminology competence and continuing professional development. A practitioner could undertake CPD and still not be competent to practice.

The CAA has a national guidelines for continuing professional development and chiropractors must complete 24 hours over a two year period. These 24 hours are divided into three categories and CPD must be undertaken in each of the three categories over the 2 year period. The CAA is very strict in terms of categorizing seminars, on-line CPD and distance education modules to ensure that chiropractors undertake CPD in clinical and diagnostic sciences, risk management and mainstream practice techniques across a two year period. If this were not the case practitioners would not necessarily undertake well-rounded CPD. The CAA believes it is important that the scope of CPD is established to support maximum on-going professional development in the interests of public safety and patient outcomes.

- Proposal 9.2.2:** It is proposed that the legislation enable the national boards to:
- a. develop and publish minimum standards (approved by the Ministerial Council) for:
 - i. the continuing competence requirements that registrants must meet in order to renew their registration in a regulated profession, and
 - ii. the requirements that any accreditation/certification/performance appraisal scheme must meet in order for registrants who participate to be able to satisfy the board's continuing competence requirements
 - b. oversee a system of approval of various accreditation/certification/performance appraisal providers or schemes, or approve an external body or bodies to ensure these schemes meet the board's standards
 - c. refuse to renew the registration of a practitioner on any ground on which the board might refuse to grant registration (see section 6.4 of this paper), and on grounds that the registrant has not met the responsible board's continuing competence requirements and therefore has not demonstrated, to the satisfaction of the board, that they are competent to practise in the regulated profession, and
 - d. impose conditions on registration at renewal in the same way conditions may be imposed at first registration, including with respect to those registrants who have not met the continuing competence requirements of the board.

CAA supports this proposal.

- Proposal 9.3.1:** It is proposed that the legislation require registrants to submit to their respective boards at the time of annual renewal various items of information required by the board in order to determine whether the practitioner is fit to practise. As part of such an annual return, the legislation might require reporting on a range of matters including:
- a. how the board's continuing competence requirements have been met
 - b. if charged with or convicted/subject of a finding of guilt for an offence punishable by 12 months imprisonment or more
 - c. any medical negligence claims
 - d. if any clinical privileges or credentials have been withdrawn or restricted by a health

service body or third party payer, and
e. any data required to be provided to the Ministerial Council for workforce planning purposes.

CAA supports this proposal. Would recommend however, that the words in c. “medical negligence claims” be changed to “any professional negligence or malpractice claims”

Proposal 9.4.1: In addition to the proposed continuing competence arrangements outlined above, it is proposed that the legislation include a range of provisions which empower boards to effectively monitor practitioners whose competence or fitness to practice may be in question. Some of these powers will be addressed in more detail in the consultation paper on complaints and discipline. However, in general terms, it is proposed that the legislation confer on boards the following powers.

CAA supports this proposal.

Proposal 9.4.2: It is proposed that the national boards have a general power to issue guidelines for registrants about standards recommended by the responsible board with respect to professional practice.

The CAA supports this proposal but believes the language is very forceful (“general power”) and given that we would like professions to embrace the scheme, it should be revised. The CAA believes that the national boards should consult with and seek input from the relevant professional association and that this requirement be written into legislation.

While the legislation would not make compliance with board issued guidelines mandatory, a registrant’s compliance or otherwise with any guidelines issued may be taken into account by internal or external disciplinary or performance panels when making findings and determinations with respect to unprofessional conduct or professional misconduct.

Proposal 9.4.3: It is proposed that the legislation require registrants to report to boards, at any time during the registration period, and within 30 days, on the following matters:

- a. if charged with or convicted/subject of a finding of guilt for an offence punishable by 12 months imprisonment or more
- b. any medical negligence claims
- c. any withdrawal or limitation of clinical privileges or credentials by a health service body, and
- d. any other matter set down from time to time by the Ministerial Council.

CAA supports this proposal.

Proposal 10.1.1: Given the framework set out in the IGA, it is proposed that the legislation include the following provisions:

- a. A general power (in the part of the legislation which sets out the broad powers and functions of the national boards) for the national boards to recommend to the Ministerial Council specialties that should be recognised for their profession, and the qualifications that the responsible board considers should apply for the purposes of endorsement of registration in each recognised specialty. This would be in addition to the role of the national boards in recommending to the Ministerial Council approved qualifications for registration purposes.
- b. Powers for the Ministerial Council, following recommendation from a national board to:

- i. approve those professions for which specialist recognition will operate under the national scheme
- ii. approve the list of specialties against which those boards referred to above will approve suitably qualified registrants for endorsement of their registration
- iii. approve the qualifications required for endorsement in each approved specialty, and
- iv. approve changes, from time to time, to the list of recognised specialties for a regulated profession and the qualification requirements for specialist endorsement within an approved specialty.

- c. For those boards with a specialist endorsement function, the same powers as when dealing with an application for registration or renewal of registration, that is, powers to receive an application for endorsement of registration, require further information, require attendance at the board, refuse an endorsement or attach conditions to an endorsement, etc. Review rights would also apply.

- d. Offences for registered or unregistered persons who:

- i. Use restricted titles listed in the legislation (for example, the titles of 'medical specialist', 'surgeon' or 'dental specialist') when they are not entitled to; or
- ii. Hold themselves out as being registered and endorsed as a specialist under the legislation when they are not.

CAA agrees with this proposal. It does however question b iii. "approve qualifications required for endorsement in each approved specialty". We feel that this is oddly located – do qualifications fit in with the Ministerial Council's jurisdiction which is approving "standards".

Proposal 10.1.3: With respect to protection of specialist titles, it is proposed that:

- for registered medical practitioners:
 - those with specialist endorsement from the Medical Board of Australia be authorised to use the title 'medical specialist', and

- there be an offence for a person who is not a registered medical practitioner with endorsement as a specialist to hold themselves out as a medical specialist
- for registered dentists:
 - those endorsed as dental specialists by the Dental Care Practitioners Board of Australia be authorised to use the title 'dental specialist', and
 - there be an offence for a person who is not a registered dentist with endorsement as a specialist to hold themselves out as a dental specialist
- for registered podiatrists:
 - there be an offence for a person who is not a registered podiatrist with endorsement as a podiatric surgeon to hold themselves out as a podiatric specialist.

Further work will be necessary to determine whether specialist recognition is required under the scheme for any other professions, and if so, which specialties will be recognised and what qualifications requirements will apply for each. Any decision by the Ministerial Council to recognise additional specialties within a profession should weigh the costs and benefits of recognizing particular specialties within the registration scheme, and the risk of further stratifying the workforce and entrenching unnecessary rigidities.

The CAA has no objection to the proposals above however it is of the view that this should not be closed in legislation to medicine, dentistry and podiatry, although it is noted that being listed in the legislation specific practitioners are open to prosecution for misuse of the title. There should be provision made for future development of specialisation within other professions.

Clause 1.32 of the IGA (Attachment A), states:

State and Territory drugs and poisons legislation will, at the discretion of States and Territories, provide a mechanism through which suitably qualified registrants of the nursing and allied health professions may be authorised to possess, administer and prescribe scheduled medicines, with :

- a) responsibility for determining the qualification requirements and endorsing qualified individuals residing with the relevant board, and*
- b) authorisation for particular professions (or sub-groups within professions) to obtain, possess, use, sell or supply (administer or prescribe) medicines to be granted under State and Territory drugs and poisons legislation.*

Therefore, the intention is that the registration legislation work in combination with State and Territory drugs and poisons legislation to identify and authorise suitably qualified practitioners to prescribe scheduled medicines.

Proposal 10.2.1: To give effect to this, it is proposed that the national legislation make provision for a prescribing endorsement for those boards that regulate the nursing and allied health professions. This will link to various authorities conferred on identified practitioners under State and Territory drugs and poisons legislation.

CAA has no objection to this proposal.

Proposal 10.3.1: It is proposed that the national legislation make provision for a mechanism through which a board may identify a sub-group of practitioners within the profession who have specific training and are considered qualified to deliver a particular type of service that they would otherwise be prevented by law from delivering.

In order to give effect to this, it is proposed that the legislation include provisions that:

- a. empower a responsible board to endorse a registrant whom it considers qualified to practice in an 'approved area of practice', and to impose any conditions on an endorsement
- b. empower the Ministerial Council, on application from a responsible board, to approve an 'area of practice' for the purposes of endorsement of registration and, at any time, to amend, vary or revoke a notice approving an area of practice
- c. require the responsible board to publish a list of 'approved areas of practice' on its website and in a publication circulated to registrants regulated by the board, and
- d. set out the powers of boards with respect to applications for endorsement qualifications required for endorsement and powers to refuse an endorsement (in a similar manner to those provisions relating to applications, qualifications for and refusal of registration).

The distinction between an endorsement with respect to an 'approved area of practice' and an endorsement as a 'specialist' would be the level and complexity of the training required, and whether this is or may in the future be part of an undergraduate qualification (an approved area of practice), or is only available to post-graduates (specialties).

The endorsement function would serve as a means of identifying practitioners with particular qualifications who are then authorised to undertake practices or provide certain kinds of services that are otherwise restricted under the Act or under other legislative or administrative schemes, such as Medicare, PBS.

The CAA supports this proposal. This would ensure the regulation of any highly specialized procedures and techniques and that they are undertaken only by those practitioners who are suitably qualified to carry them out.

Proposal 11.1.1: It is proposed that the legislation provide for the national boards to grant registration for a period of up to 12 months and that a grant of registration be subject to annual renewal.

It is not proposed that there be a standard registration period in legislation that applies to all practitioners, for example a calendar year or a financial year. Rather, it is proposed that the legislation enable, for example, renewals to be staggered throughout the year, with the renewal date for each practitioner falling due 12 months after they first registered or renewed their registration.

The CAA does not support the proposal of introducing staggered renewal dates. It may initially cause some confusion with registrants who have their registration renewal period ingrained and who are therefore more likely to pay their registration on time. It may also

cause some degree of administrative concern for professional associations which rely upon members holding current registration at all times they are members.

At present CAA is aware that each member's registration expires on 30 June and it is therefore able to undertake a membership search of the Registration Board's database on 1 July each year. If each member's registration moves to an "anniversary" date, this will cause more administrative strain and expense on the professional association.

With staggered renewal dates it would be a nightmare for practitioners to work out their compliance with CPD which often runs over a two year calendar period, and professional indemnity insurance and any other reporting requirements.

Proposal 11.2.1: It is proposed that the legislation provide powers for the national boards to issue certificates of registration or renewal of registration to those persons who have met the registration or renewal requirements specified by the responsible board.

CAA supports this proposal.

Proposal 11.2.2: It is proposed that the legislation provide for these certificates/renewals to be in a form approved by the responsible board (subject to the operational framework established by the National Agency in consultation with the national boards). It is not proposed that there be a separate 'practising certificate' in addition to the certificate of registration or renewal of registration. It is proposed that if practitioners are required, by their employers or agents for example, to demonstrate their right to practise, then they should show their current registration or renewal certificate. There should be flexibility under these arrangements to allow a responsible board to issue either electronically or otherwise, on first registration, an attractive certificate suitable for display, and to issue a renewal in different form (for example a wallet sized card).

CAA supports this proposal.

Proposal 11.2.3: It is proposed that the legislation require a practitioner whose registration has been suspended or cancelled to return their certificate of registration to the responsible board. It is proposed that the legislation also provide that, for the purposes of legal certainty, in the absence of evidence to the contrary, a certificate of registration is evidence that the person to whom the certificate is issued is registered.

CAA supports this proposal.

Proposal 11.2.4: It is proposed that the legislation impose an obligation on registered practitioners to notify the responsible board of a change of contact address details within 28 days and that a penalty apply for failure to comply.

ALTERNATIVE OPTION: There be no penalty for failure to notify of change of address.

A view has been expressed that, in order to protect the public, the new system needs to provide for the tracking of movement of practitioners across the country, so that a responsible board is able to determine in which jurisdictions and/or practice locations a practitioner is working.

The CAA supports proposal 11.2.4 but does not support the alternative option.

Proposal 11.2.5: It is proposed that the legislation provide a power for boards to require registrants provide details of each practice address from which they offer regulated health services. Special arrangements would be required so that the reporting obligations are manageable for locum practitioners whose practice address changes regularly.

CAA suggests that this proposal, especially for locum practitioners, would cause insurmountable work. It is suggested that registrants be required to indicate the practice where they principally provide health services, and then list other practices where limited health services are supplied. It could provide a problem with a practitioner offering a mobile service where their place of practice might vary week to week eg hospitals, nursing homes, house calls.

Proposal 11.3.1: It is proposed that the legislation include provision for a 'grace' period of three months following expiry of registration, during which a practitioner is 'deemed' to be registered, but that if they fail to renew by the end of this period, then the board removes their name from the relevant register

ALTERNATIVE OPTION: That there is no 'grace' period and that if a practitioner fails to renew their registration on time, their name is removed immediately from the register and they may be committing an offence if they continue to practise.

CAA does not support proposal 11.3.1 as it allows a practitioner to continue working for a period of up to 3 months without paying their associated renewal fee and then finishing practice. It could also be a problem with Professional Indemnity Insurance as for chiropractors they must be registered in order to be covered. Three months is too long - if a claim is made against them in the three month grace period how would this sit with PII providers, especially if they did not renew their registration?

If Proposal 11.3.1 is to exist at all in legislation the CAA would support a period of one month's grace, with a financial penalty, for a practitioner who fails to renew their registration on time, before their name is removed immediately from the register.

CAA's preferred position, in the interests of public safety, is that there be no grace period.

Proposal 11.4.1: It is proposed that the legislation include provisions that allow a

practitioner's name to be restored to the register, if they re-apply within a period of two years following a lapse of registration (under this Act, or a previous enactment of a participating jurisdiction), and they meet any continuing competence requirements set by the responsible board.

ALTERNATIVE OPTION: There be no provision for restoration to the register, and practitioners who hold outdated qualifications and let their registration lapse be required to meet current registration requirements in the event that they reapply for registration, that is, they complete either an approved course of study and supervised practice, or an approved re-entry or refresher course.

CAA supports proposal 11.4.1. It does not support the alternative option.

Proposal 11.5.1: It is proposed that the legislation include provision for a responsible board to remove a person's name from the register for a range of specified reasons, including where they no longer meet the mandatory requirements for registration, removal in cases of death, failure to renew, cancellation by agreement or via a tribunal decision.

CAA agrees with this proposal.

Proposal 12.1: With respect to transition arrangements, it is proposed that transitional provisions provide for:

- a. all persons who are registered on 30 June 2010 in one or more of the ten regulated health professions be automatically deemed to be registered under the new national scheme on 1 July 2010, on the register or division of the register specified in the transition provisions, and for the term specified in their registration renewal
- b. all persons who have endorsements on their registration of a type available under the national scheme on 30 June 2010 be deemed to have endorsement of that type under the national scheme from 1 July 2010
- c. all persons who have conditions imposed on their registration or endorsement of registration on 30 June 2010 in one jurisdiction be automatically deemed to have the same conditions imposed on their registration or endorsement of registration from 1 July 2010
- d. where there are disparities between the types of registration or endorsements available under the national scheme and those conferred by existing State and Territory legislation, wherever possible registrants be migrated across to the national scheme with the widest possible scope of practice that is consistent with public safety. They would then be expected to practice within their competence, with conditions imposed only if it is considered necessary to limit their practice in order to protect the public
- e. where a practitioner is registered in more than one jurisdiction and these registrations expire at different dates, then they be automatically deemed to be registered through until the latest date of registration that applies, unless they have conditions placed on their registration, in which case, they will be deemed to be registered through until the

first expiration date that applies, and

- f. if a practitioner holds or has held multiple registrations and has been either deregistered in one jurisdiction, or has not renewed in a jurisdiction where an investigation or disciplinary process was not finalised, then they not be automatically 'deemed' to be registered from 1 July 2010 and will be required to make a fresh application for registration with an expeditious process required.

It should be noted that the provision at (a) caters for the circumstances of those whose qualifications have been gained through programs of study which are no longer accredited. As long as the practitioner is registered on 30 June 2010, they will continue to be registered under the national scheme on 1 July 2010.

CAA supports this proposal.

PLEASE REFER TO TWO APPENDICES ATTACHED TO THIS SUBMISSION

Appendix I: CAA submission proposing restricted practice of spinal manipulation

Appended II: Key points of the CAA submission proposing restricted practice of spinal manipulation

29 October 2008

APPENDIX 1

TO CHIROPRACTORS' ASSOCIATION OF AUSTRALIA (NATIONAL) LIMITED'S SUBMISSION ON CONSULTATION PAPER ON PROPOSED REGISTRATION ARRANGEMENTS FOR THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME

8.5 Restrictions on spinal manipulation

The CAA agrees that the legislation supporting the new national registration and accreditation scheme should be based on the safety of the public being paramount and that high quality care be encouraged.

The CAA believes that legislated restrictions on practice should only be included where the benefits to the community as a whole outweigh the costs, or potential costs to the consumer. These comments relate to potential risks to patients' health and wellbeing.

This document addresses the four points raised in the Consultation Paper "Proposed Registration Arrangements, Section 8.5 – namely:

1. Is there any evidence to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions apply?
2. Should the restricted act if included be narrowly framed eg manipulation to the cervical spine?
3. The need, if any, for inclusion in the national legislation of a restricted act with respect to spinal manipulation? If so, how broad or narrow framed?
4. What definition should be adopted?

Spinal Manipulation

The foundation of chiropractic care is built on the premise that the patient's safety and their health and well-being is paramount.

Irregardless of the availability or not of evidence to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions do apply, the CAA is of the view that consumers should not only expect, but be afforded the highest quality health care available to them which is delivered by well-informed, suitably trained and qualified, competent, skilled health professionals.

The CAA believes that the public should be legally protected from health workers who are unskilled, unqualified, insufficiently trained and incompetent and whose health service delivery could potentially cause harm to their patients.

It is the CAA's opinion that spinal manipulation be extended to incorporate extremity joint manipulation.

The CAA strongly advocates that manipulation of the spine and extremities be a restricted act within the national legislation.

Secondly, the CAA strongly advocates that manipulation of the spine and extremities be restricted to registered chiropractors and osteopaths, or those other registered health practitioners who can demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified post-graduate training – eg Musculoskeletal/Manipulative Physiotherapists.

A restricted act within the national legislation would prevent health workers (both registered and unregistered) from undertaking manipulation of the spine and extremities if they are not adequately trained nor competent to do so, resulting in their prosecution if they breach the provision of the legislation.

There is considerable information in the literature relating to injuries or other adverse events that have occurred in jurisdictions where spinal manipulation is not restricted. Below is a list of some examples:

Mendez Gonzalez M, Garcia C, Suarez E, Fernandez Diaz D, Blazquez Menes B. Wallenberg's syndrome secondary to dissection of the vertebral artery caused by chiropractic manipulation. Rev Neurol. 2003;37(9): 837-9.
The patient suffered serious injury in Spain, a jurisdiction without restriction. The professional who performed the manipulation was not a chiropractor and the term chiropractic manipulation was used inappropriately.

Markovitch H. Chiropractic causes leak of CSF. BMJ 2003; 326:1353
Serious injury caused to patient in Germany. Blamed on chiropractor, practitioner was not a chiropractor. Jurisdiction with no restriction.

Neetu R, Chandra MS, Rashmi M. Cervical Spinal epidural hematoma with acute Brown-Sequard presentation [Letter to editor]. Neurology India 2006;54;107-108

The authors attribute an injury to a patient to "chiropractic manipulation". It was subsequently confirmed that the "chiropractic manouvre" was not carried out by a qualified person. India is a jurisdiction with no restriction.

Wenban, Adrian B. Inappropriate use of the title chiropractor: Reasons for concern? [Letter to editor] Clinical Neurology and Neurosurgery 2008 (formally accepted for publication October 2008 – date published not available)

This letter was in response to Gouveia Lo, Castanho P, Ferreira JJ, Guedes MM, Falcao F, Melo TP. Chiropractic manipulation: Reasons for concern? Clin Neurol Neurosurg 2007[Epub ahead of print].

In his letter to the editor Dr Wenban states that the principal author of the case series confirmed that “she and her co-authors had no knowledge of the qualifications of those referred to as chiropractors in their case series and that their basis for using the title chiropractor was the patient’s report of the techniques used.”

Through researchers outside the chiropractic community using the term “chiropractic manipulation” in a generic sense, it has been revealed that there have been very serious injuries to patients in countries in which chiropractic is not regulated by law and “chiropractic manipulation” has not been carried out by a chiropractor.

Terrett AGJ. Misuse of the literature by medical authors in discussing spinal manipulative therapy injury. J Manip Physiol Ther 1995; 18(4):203-10.

Terrett concluded, “the words chiropractic and chiropractor have been incorrectly used in numerous publications dealing with SMT injury by medical authors, respected medical journals and medical organizations” Most of the injuries were blamed on chiropractic (spinal manipulation) but the practitioners involved were not chiropractors

In 2004 a prominent chiropractor researcher, Dr Adrian Wenban, B.Sc., B.App.Sc., M.Med.Sc., reviewed a total of 24 European peer-reviewed biomedical papers relating to chiropractic and manipulation. The results of this review revealed that the terms chiropractor and chiropractic manipulation had been inappropriately used. In 20 cases involving injury attributed to chiropractors, the principal researcher was unable to confirm that the providers were qualified chiropractors but subsequently conceded that they were not.

The World Federation of Chiropractic (WFC) www.wfc.org.au in its policy statement “Use of the Title Chiropractor” addresses situations where persons without a formal and acceptable chiropractic education practice as chiropractors in countries where the practice of chiropractic is not regulated by law. It also addresses persons who have frequently taken brief instruction in treatment techniques at unofficial schools or courses claiming to offer chiropractic education. The WFC policy states:

“The title chiropractor, doctor of chiropractic and titles derived from them should only be used by duly licensed or registered chiropractors or graduates of chiropractic educational programmes that are formally accredited by a chiropractic accreditation agency or an alternative government-recognised accreditation process in the country in question.”

It goes on further to state that the term chiropractic and terms derived from it, in so far as they are used in an **educational** context or a **professional** context to describe a job, service, or treatment purporting to be chiropractic practice, *“should only be used by chiropractors or doctors of chiropractic who have graduated from chiropractic educational institutions formally accredited by a recognized process in the country in question.”*

Bateman W, Pollard H, Vemulpad S. Spinal Manipulation in Australia: To What Extent Does Australian Legislation Protect the Public and the Professions? Chiropr J Aust 2004;34:129-135

ABSTRACT: *Objectives:* To examine the extent the Australian legislation protects (a) the professions that have spinal manipulation as a core practice, (b) the public from untrained manipulators. To consider the strengths, weaknesses and effectiveness of current Australian legislative approaches. *Data Sources:* The Library of the Supreme Court of New South Wales, Macquarie University Library, American and Australian state parliamentary and legislative web sites, relevant professional association web sites, World Federation of Chiropractic web site, Federation of Chiropractic Licensing Boards and MEDLINE databases were used. **Conclusion:** **Many authorities agree that there is a need to protect the public from untrained manipulators. In recent years the NSW Department of Health, after public submissions and research, determined that the risk to the public of untrained manipulators was such that it overrode the anticompetitive aspects of federal legislation. There are several possible approaches to protecting the public from untrained spinal manipulators, and to protect the professions by restricting the use of certain professional titles to practitioners who meet certain regulatory requirements in Australian jurisdictions at an appropriate level of training and education.**

The most in-depth and authoritative review into the chiropractic profession and the practice spinal manipulation in Australasia remains the report of the New Zealand Commission of Inquiry into Chiropractic which was published in 1979. (1) Though this review is now nearly 30 years old, it was undertaken by the New Zealand government and as such remains an independent examination of the Chiropractic profession and spinal manipulation carried out by other professions.

The commission's opportunity to gather and examine evidence was extremely wide, since there were no restraints on time, and both medicine and chiropractic worldwide saw this as the test case for chiropractic. Consumer, chiropractic, medical and physiotherapy witnesses from the United States, Europe, Canada and Australia gave evidence at the New Zealand hearings. The inquiry extended over 18 months.

One of several government commissions to investigate the chiropractic profession, the New Zealand Commission of Inquiry is regarded as having delivered the most detailed and exhaustive report.

Many of the findings of this Commission of Inquiry remain as valid today as they did when they were published in 1979 perhaps with the exception of recommendations No 3 and 4 which states that chiropractors are the only health practitioners who are necessarily equipped by their training to carry out spinal manipulative therapy and that GPs and physiotherapists have no adequate training in spinal manual therapy. It would be true to say that in 2008, physiotherapists with post-graduate spinal manipulative training are now duly qualified practitioners of the art. As far as we are aware, there remains no training in manual spinal therapy or spinal manipulation within the undergraduate training of a GP.

The Commission determined that "spinal manual therapy (SMT) in the hands of a registered chiropractor is safe".

The Commission commented on the provision of spinal manual therapy by medical practitioners as follows:

"It is wrong that the present law, or any medical ethical rules, should have the effect that a patient can receive spinal manual therapy which is subsidized by a health benefit, only from those health professionals least well qualified to deliver it." (1)

The Inquiry further states:

"The responsibility for spinal manual therapy training, because of its specialized nature, should lie with the chiropractic profession. Part time or vacation courses in spinal manual therapy for other health professionals should not be encouraged." (1)

The Commission found that "...to acquire a degree of diagnostic and manual skill sufficient to match chiropractic standards, a medical graduate would require up to 12 months full-time training ..."

Serious risks to public safety occurring as a consequence to such limited training are a concern to the chiropractic profession and certainly should be of major

concern to Commonwealth, State and Territory Health Ministers, as well as consumers.

In Australia a correspondence course on spinal manipulation for doctors carried the accreditation of The Royal Australian College of General Practitioners. There was one optional practical weekend workshop and the mail-order course was followed by a “formal assessment by correspondence”. Given the known risks of spinal manipulation, practice based on such a low standard of training should not be permitted. According to Henderson et al (14), as quoted in the WHO Guidelines on basic training and safety in Chiropractic” causes of complications and adverse reactions are:-

- Lack of knowledge
- Lack of skill
- Lack of rational attitude and technique

It is hard to imagine the medical practitioners could acquire the knowledge, skill, attitude and technique for safe performance of spinal manipulation via correspondence, weekend or other short and inadequate training.

A judgement handed down by a NSW Medical Tribunal in 1986 expressed concern over the dangers of spinal manipulations carried out by practitioners without recognised expertise or under conditions where expert assistance was not available. The case related to a medical doctor who had performed spinal manipulation on a patient who subsequently died. In its conclusions the Medical Tribunal stated “To the extent to which cervical manipulation is carried out by unregistered and unsupervised persons, we can only say the prospect is frightening and the public should be warned.” (45-46)

Deficiencies in musculoskeletal competence amongst general medical practitioners have been highlighted in published literature. In 2002 Vlahos, et al concluded that “Musculoskeletal knowledge among recent medical graduates has again been found wanting. The need for further musculoskeletal education has been established.” (2) This was an Australian study and it seems unlikely that practitioners with such training would be able to identify the contraindications to spinal manipulation and, as spinal manipulation is not taught at the undergraduate level in medical schools, they would not be able to perform it on the basis of their undergraduate education. Yet current laws permit them to do so.

These deficiencies in Australia followed an American study which found that 82% of new medical residents at the University of Pennsylvania School of medicine failed a musculoskeletal medicine knowledge exam. (3)

In the United States a study was conducted in 2000 to "determine whether training primary care physicians in techniques of limited manual therapy would

result in improved outcomes for their patients with acute low back pain." (4) The authors trained 31 primary-care-MDs in "a sequence of eight standard manual therapy techniques." Two hundred and ninety-five patients were randomized into two treatment groups. One group received what was termed "enhanced care;" the other received "enhanced care with manual therapy." The main outcome measures included the "Roland-Morris functional disability scale measured over time and patient-reported time to functional recovery, time to complete recovery, and satisfaction with care."

The conclusion was: "Limited training in manual therapy techniques offers very modest benefits, compared with high-quality (enhanced) care for acute low back pain. (4)

Currently the NSW Public Health Act 1991 No. 10, Part 2A, Division 2, Section 10AC restricts persons engaging in spinal manipulation, classifies spinal manipulation as a "restricted health service", and defines spinal manipulation. See wording below:

.....

Public Health Act 1991 No 10

Current version for 8 August 2008 to date (accessed 29 October 2008 at 18:26)

[Part 2A](#) [Division 2](#) [Section 10AC](#)

<< page >>

10AC Spinal manipulation

- 1) *A person must not engage in spinal manipulation in the course of providing a health service unless the person:*
 - (a) *is a registered chiropractor, or a chiropractic student acting under the appropriate supervision of a registered chiropractor, or*
 - (b) *is a registered medical practitioner, or a medical student acting under the appropriate supervision of a registered medical practitioner, or*
 - (c) *is a registered osteopath, or an osteopathy student acting under the appropriate supervision of a registered osteopath, or*
 - (d) *is a registered physiotherapist, or a physiotherapy student acting under the appropriate supervision of a registered physiotherapist.*

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

- (2) *For the purposes of this Division, spinal manipulation is a restricted health service.*
- (3) *An authorised person or inspector appointed under any of the following Acts is authorised to ascertain whether this section is being complied with:*
 - (a) [Chiropractors Act 2001](#),
 - (b) [Medical Practice Act 1992](#),
 - (c) [Osteopaths Act 2001](#),
 - (d) [Physiotherapists Act 2001](#).

(4) In this section:

spinal manipulation means the rapid application of a force (whether by manual or mechanical means) to any part of a person's body that affects a joint or segment of the vertebral column.

.....

By way of background, manipulation differs considerably from mobilisation. Mobilisation is a movement with very little force carried out within the available range of joint motion to the limits of potential joint motion.

A joint manipulation is a manual procedure involving directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit. (5) It is therefore imperative that health professionals delivering manipulation of the spine and extremities are suitably trained and qualified to do so.

Manipulations and chiropractic adjustments both involve thrusting techniques directed at improving the joint and neurophysiological function.

There are numerous methods or techniques employed by clinicians who practice spinal manipulation. Factors to consider in the application of manipulation/adjustment of the spine and extremities relate to velocity - whether the thrust is high or low velocity in terms of its activating force; whether the range is small or great; the specificity – whether a single joint or multiple joints are the target of or affected by the thrust; the direction of the thrust; and whether it is a long lever (a long bone is used as a lever to exert force into the spine) or short lever (the practitioner's hand or instrument contact is on part of the target joint). These dynamic and complex methods require careful and skilful use. To ensure patient safety and high quality care they should only be undertaken by suitably qualified health professionals.

The World Health Organization "Guidelines on basic training and safety in Chiropractic" (5) encourages and supports the proper use of the practice of SMT (Spinal Manipulation) including the understanding of the significance and detection of contraindications for such care. WHO discusses the need to facilitate safe and qualified practice as well as protect the public and patients by:

- Providing minimum requirements for education
- Reviewing contraindications; minimizing the risk of accidents; advise on the management of complications arising during treatment; and to promote safe practice.

Spinal manipulation (SMT) involves the forceful passive movement of the joint beyond its active limit of motion and as such practitioners providing this care must identify the risk factors that contraindicate this modality.

Contraindications

Contraindications to SMT range from a non-indication for such an intervention, where SMT may do no good, but should not cause any harm, to an absolute contra-indication, where SMT is life-threatening and/or catastrophic. The haphazard application of SMT by non-regulated individuals and untrained is dangerous.

There are a number of contraindications to joint manipulation (especially spinal), which have been reviewed in practice guidelines developed by the chiropractic profession and in the general chiropractic literature (6-12).

An extensive list of absolute and relative contraindications can be found in the WHO document "Guidelines on basic training and safety in Chiropractic" (13).

Complications

A discussion of contraindications, accidents and adverse reactions is found in the WHO document as detailed above. (13) According to Henderson et al (14) causes of complications and adverse reactions are:-

- Lack of knowledge
- Lack of skill
- Lack of rational attitude and technique

Henderson gives examples of inappropriate practices and a description of serious adverse outcomes to all spinal regions (15-27). SMT is generally regarded as safe, effective and conservative, however although rare, accidents have been reported. As with all therapeutic interventions, complications can arise. Serious neurological and vascular complications have been reported and in some instances catastrophic. Examples of reported incidences are as follows:-

Cervical Region

- Vertebrobasilar accidents (6-9, 11-12, 15, 19, 27-30)
- Horner's syndrome (16)
- Diaphragmatic paralysis (17)
- Myelopathy (18)
- Cervical disc lesions (24)
- Pathological fractures (19,20)

Thoracic Region

- Rib fracture and costochondral separation (21)

Lumbar Region

- Lumbar disc rupture (25)
- Lumbar artery aneurysm (26)
- Cauda equine syndrome (25)

Miscellaneous Neuro Conditions Reported to have occurred following SMT. (31)

- Upper brachial plexus paralysis
- Axillary nerve lesion
- Long thoracic nerve lesion
- Spinal accessory neuropathy
- Diaphragmatic paralysis – phrenic N.
- Femoral neuropathy
- Spinal Haemotoma (31)

Reports of neurological complications following SMT fall into four major categories:-

1. Cerebrovascular accidents or incidents as a consequence of arterial dissections resulting in specific stroke syndromes.
2. Lumbar disc syndromes including radiculopathy and cauda equine syndrome.
3. Cervical disc syndromes including radiculopathy and myelopathy
4. Miscellaneous and often unexplained post-manipulation symptoms. (31)

Cerebrovascular Accidents (CVA)

Estimates of the incidence of serious cerebrovascular syndromes following cervical SMT based on clinical surveys range from 1 in 400,000 to 1 in 2 million dependent upon various authorities.

In the example of arterial dissection, there are no highly reliable clinical tests to determine this possibility, however, practitioners are on the “look-out” for various initial symptoms which may or may not be present; eg “thunder-clap” headaches and any brain-stem related signs and symptoms – dizziness, drop attacks, visual problems, speech difficulties, coordination difficulties, one-sided numbness, etc. The lay-person does not have the knowledge and clinical skills to assess the patient properly. In such instances, if SMT was utilized the underlying arterial dissection could be further aggravated leading to a significant condition.

Disc Syndromes

In the case of a presenting cervical or lumbar disc injury, the trained professional understands the underlying disc and nerve anatomy, understands the pathology, can clinically assess the patient for signs and symptoms of a nerve root lesion (muscle strength, sensory loss, reflexes and nerve tension tests) and therefore in appropriate cases would desist from treatment and refer for appropriate imaging versus aggravating the pathology with the possible need of urgent surgery.

Prevention of Complications from manipulation

Complications that can arise from SMT can often-times be prevented by careful appraisal of the patient’s history and examination findings. Information must be sought about coexisting diseases and the use of medications, including long term steroid and anticoagulant therapy. A detailed and meticulous examination must

be carried out. The use of appropriate technique is essential and the practitioner must avoid techniques known to be potentially hazardous. (32)

Trained professionals are required to obtain Informed Consent which includes a discussion and explanation of both positive and negative outcomes, a list of options, and the knowledgeable ability to answer and explain any questions the patient might have. How can the layperson be able to provide this requirement without sufficient formal training and expertise?

Regulated trained professionals are required to have adequate public indemnity insurance when performing SMT. This allows patients access to funds in the event of a proven injury. How could laypersons using SMT receive this form of insurance from insurers without adequate tertiary training?

It would be unsatisfactory to allow uninsured laypersons to perform a therapeutic method which can have serious/lethal consequences, without the injured person having access to financial aid which may be required for daily living.

Furthermore regulated practitioners expertly educated and trained in these procedures are taught courses in first aid as well as instructions for those occasions where adverse incidents occur. There are further professional expectations and requirements for Continuing Professional Development program which include regular risk management re-education including the need for continual first aid updates.

Chiropractors are required to complete 5 years of university education to receive double degrees at the Bachelor and Masters levels in order to be deemed competent to undertake manipulation of the spine and extremities and to be registered as a chiropractor. In contrast Physiotherapists complete a four year undergraduate degree.

Chiropractic practice involves a general and specific range of diagnostic methods, including skeletal imaging, laboratory tests, orthopaedic and neurological evaluations, as well as observational and tactile assessments. Patient management involves spinal adjustment and other manual therapies, rehabilitative exercises, supportive and adjunctive measures, patient education and counselling. (5)

The outcomes of an accredited Chiropractic program include being a primary health care practitioner with specific, comprehensive and specialised skills in manipulation of the spine and extremities, including the identification of indications and contraindications as well as the highly competent delivery of therapeutic intervention to and about the spine taking account of the patient's age and clinical presentation.

By way of a guide the Australian chiropractic programs require over 4,200 hours of face-to-face instruction training to produce an entry-level chiropractor eligible for registration. Typically around some 60% of that training is discipline specific to chiropractic and spinal manipulation. Within this students will learn clinical decision making including diagnosis and management that supports the safe and competent delivery of manipulation of the spine and extremities.

The student chiropractor's education does not relate solely to the psychomotor skill of manipulation. In addition to attaining competence in the safety and effective performance of manipulation the training includes the development of capabilities in diagnosis to determine not only the clinical indicators for manipulation or referral, but also the capabilities to determine and deliver the most effective manipulation in any given patient.

Diagnosis includes training in the use of discipline specific skills as well as the generic diagnostic skills common to primary contact health care professionals such as the taking of blood pressure, vital signs and auscultation of heart and lung sounds.

Chiropractors are also trained to take radiographic views of the spine and extremities and to interpret these views in a manner that supports the safe and effective provision of manipulation.

In contrast the training provided to Osteopaths does not equip them to possess licensure as a radiographer. For example in NSW chiropractors are licensed for supervision and licensed for use for chiropractic radiography under the NSW Radiation Control Act 1990. If they own x-ray equipment, they are also required to hold a Certificate for Xray Equipment under the NSW Radiation Control Act 1990.

Within Australian chiropractic programs the extensive amount of clinical training includes 1000 hours of supervised clinical practice and this training is currently not funded by the Federal Government.

It is recommended that practice restriction should be based upon:

- public safety
- the need for practitioners with demonstrated practical and cognitive skill in the application of spinal manipulative therapy
- the need for formal education with minimum standards and requirements as detailed within the WHO document (13). (only the chiropractic and osteopathic professions meet this requirement within the entry-level programs in Australia). The WHO document recommends that other health practitioners would need a further 12 months instruction in SMT.

- a professional code of practice to include (a) the need for health professionals to administer and provide interventions of demonstrated competence, and (b) the minimum educational standard necessary for the provision of SMT.
- the need to recognise and understand the significance of contraindications, the ability to minimize risk, the ability to administer first and provide appropriate advice and management in the event of a serious complication.
- the ability to provide genuine Informed Consent
- the availability and regulated requirement of public indemnity and malpractice insurance.
- Ongoing life-long continuing professional education and development.

Definitions of Spinal Manipulation

The CAA considers that a definition of Spinal Manipulation be included in the legislation.

The CAA suggests the following definition of Spinal Manipulation:

spinal manipulation means the rapid application of a force (whether by manual or mechanical means) to any part of a person's body that affects a segment of the vertebral column or other joints.

Manipulation of the cervical spine

The CAA does not support the separation of cervical manipulation from the term spinal manipulation in regard to restriction of practice, as serious injury, such as rib fracture or cauda equina syndrome, may result from manipulation of other areas of the spine.

As serious injury, such as rib fracture or cauda equina syndrome, may result from manipulation of other areas of the spine, the CAA strongly advocates that manipulation of the spine (including the cervical spine) and extremities be restricted to registered chiropractors and osteopaths, or those other registered health practitioners who can demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified post-graduate training. – eg Musculoskeletal/Manipulative Physiotherapists

However if spinal manipulation is not restricted the CAA strongly advocates that cervical manipulation should definitely be restricted to registered chiropractors and osteopaths, or those other registered health practitioners who can demonstrate equivalency of competence to undertake cervical manipulation by appropriate, accredited, prescribed and clearly identified post-graduate training. - eg Musculoskeletal Manipulative Physiotherapists.

Prof Kathryn M Refshauge in a paper published in 2002: "Professional responsibility in relation to cervical spine manipulation", which relates predominantly to physiotherapists and physiotherapy, states: (33)

"Given the wide discrepancy in educational standards, and because of our responsibility to maximise safety and care for our patients, the profession should consider the required level of education for cervical spine manipulation. A minimum requirement could be completion of a university postgraduate program in manipulative physiotherapy, or of a short (eg three months) formal continuing education course accredited by the APA. Alternatively, the teaching of cervical spine manipulation could be included in all undergraduate physiotherapy programs. Such changes would need to be prescribed either in the relevant Registration Acts or in a professional code of practice. or require review of university curricula. The relative merits of each of these approaches should be debated.

The first option is that completion of a Graduate Diploma or Masters degree in Manipulative Physiotherapy be considered the required level of education for the performance of cervical, spine manipulation. The knowledge and skills of graduates from these courses is likely to exceed that of graduates from entry-level programs. The graduate courses include not only teaching of the practical skill of manipulation, but also an exploration of the relevant neuroanatomy and biomechanics in addition to the clinical reasoning required for appropriate selection of patients and manipulative techniques."

This paper implies that cervical spine manipulation is not taught in all undergraduate four year Physiotherapy programs.

The World Health Organisation (WHO) Guidelines on basic training and safety in chiropractic (5) states that "vascular accidents are responsible for the major criticism of spinal manipulative therapy". They point out that "critics of manipulative therapy emphasize the possibility of serious injury, especially at the brain stem, due to arterial trauma after cervical manipulation. It has required only the very rare reporting of these accidents to malign a therapeutic procedure that, in experienced hands, gives beneficial results with few adverse side effects."(34)

The WHO document further states "In very rare instances the manipulative adjustment to the cervical spine of a vulnerable patient becomes the final

intrusive act which, almost by chance, results in a very serious consequence” (35-38)

Further the WHO document states that “While it is understood that the actual incidence of cerebral vascular injury could be higher than the number of reported incidents, estimates from recognized authorities in research in this area have varied from as little as one fatality in several tens of millions of manipulations (39), one in 10 million (40) and one in one million (41) to the slightly more significant ‘one important complication in 400,000 cervical manipulations’”. (42)

Cassidy, et al undertook a study to investigate associations between chiropractic visits and vertebralbasilar artery (VBA) stroke and to contrast this with primary care physicians (PCP) visits and VBA stroke. (43). Cassidy et al concluded that “VBA stroke is a very rare event in the population. The increased risks of VBA stroke associated with chiropractic and PCP (primary care physicians) is likely due to patients with headache and neck pain from VBA dissection seeking care before their stroke. They found no evidence of excess risk of VBA stroke associated chiropractic care compared to primary care.”

Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Scott Haldeman S, Carey P, Townsend M, Papadopoulos C. *CMAJ* 2001;165(7):905-6.

A paper published in the October 2 2001 issue of the *Canadian Medical Association Journal (CMAJ)* by Scott Haldeman, DC, MD, PhD, Paul Carey, et al. (“Arterial Dissections following Cervical Manipulation: the Chiropractic Experience”) reports that the chances of arterial dissection after cervical manipulation is approximately 1 in 5.85 million manipulations.

Specifically, the authors state:

“The likelihood that a chiropractor will be made aware of an arterial dissection following cervical manipulation is approximately **1:8.06 million office visits, 1:5.85 million cervical manipulations, 1:1430 chiropractic practice years and 1:48 chiropractic practice careers.**”

Risk Factors and Precipitating Neck Movements Causing Vertebralbasilar Artery Dissection After Cervical Trauma and Spinal Manipulation.

Haldeman and Kohlbeck. *Spine* Vol 24 No 8, 1999 page 785-794.

This paper reviewed 367 case reports of Vertebralbasilar arterial dissection or occlusion.

The following is a summary of his findings:

Vertebralbasilar artery dissections have been classified as:

Spontaneous, 160 or 43% of this group.
Post-manipulative, 115 or 31% of this group.
Associated with Trivial Trauma, 58 or 15.6% of this group.
Associated with Major Trauma, 37 or 10% of this group.

Trivial trauma includes almost any action that occurred just prior to the stroke occurring, such as swimming, walking, wall papering, sneezing, archery, yoga, turning head whilst driving, etc.

There is not a great deal of literature pertaining to the complications associated with manipulation of the lower back. One study quoted by S Haldeman in his text book *Principles and Practice of Chiropractic*, 2nd Edition, 1992, reviewed the results of over half a million lumbar spine manipulations performed by 406 medical practitioners. Increased frequency of low back pain was reported in 1 in 4000 manipulations, radicular pain reported 1 in 62,000, and radicular syndromes 1 in 188,000.

Terrett AG ; Kleynhans AM Complications from manipulation of the low back. *Chiropractic J Aust* 1992 Dec;22(4):129-40

"Practitioners of spinal manipulation should ensure that their therapy is as safe as possible for patients. Past attention to complications from manipulation centred mainly on the more serious vascular accidents of the cervical spine. The less life-threatening complications from manipulation of the lumbar spine have been largely overlooked. This descriptive analysis of such cases reported in the literature provides a basis for the development of diagnostic and therapeutic approaches designed to minimise complications."

This review of the literature between 1911 and 1991 for disc related complications from low back spinal manipulative therapy revealed 65 cases, 44% of which were associated with medical manipulation under anaesthetic. The balance was made up of a variety of practitioner groups including Osteopaths, Chiropractors, Naturopaths, Physiotherapists and a collection of unknowns (25%).

When one considers the statistical incidents of serious complications associated with spinal manipulation, an immediate comparison should be made between the incidence of lumbar spine disc lesions with or without Cauda Equina syndrome following lumbar spine manipulation and alleged cervical vessel dissection following cervical spine manipulation.

Most estimates of these complications are made on retrospective analyses of case literature, insurance statistics and extrapolations from various sample sizes. Accepting the limitations of all these methodologies, the likelihood of a vascular accident occurring following cervical spine manipulation would appear to be approximately 1 in one million neck manipulations, (with estimates ranging from

one in 400,000 to less than 1 in over 5 million). The likelihood of a serious complication resulting from lumbar spine manipulation would appear to be approximately 1 in 200,000 with some estimates ranging as low as 1 and 3.7 million lumbar spine manipulations.

Clearly the rates of complications in either the cervical or lumbar spine in association with spinal manipulation are not known but are merely best estimates.

These statistics must be viewed within the context of the frequency of the performance of lumbar spine manipulation as compared to cervical spine manipulation. Approximately 65% of all patients presenting to chiropractors do so for lumbar spine complaints and approximately 15% percent for cervical spine related disorders. This suggests that the application of lumbar spine manipulation is potentially four times higher than that of cervical spine manipulation.

Whilst death following cervical spine manipulation has been recorded the extreme rarity of this occurring renders any attempt to calculate a statistical instance of its likelihood as meaningless. (figures published by Alan Terrett in 2001 (44) (indicate 37 deaths internationally over a 65 year period between 1934 and 1999, which involved all professionals manipulating the cervical spine including chiropractors, medical practitioners, osteopaths, naturopaths and others.)

It must therefore be questioned as to whether or not lumbar spine manipulation presents more of a risk in relation to potential complications than cervical spine manipulation. The litigation experience in Australia confirms a bias in relation to claims related to alleged lumbar spine injury and/or aggravation of existing conditions. Therefore, there would be little objective reason to single out cervical spine manipulation for special restrictive regulation.

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APPENDIX 11

TO CHIROPRACTORS' ASSOCIATION OF AUSTRALIA (NATIONAL) LIMITED'S SUBMISSION ON CONSULTATION PAPER ON PROPOSED REGISTRATION ARRANGEMENTS FOR THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME

8.5 Restrictions on spinal manipulation

KEY POINTS

The CAA agrees that the legislation supporting the new national registration and accreditation scheme should be based on the safety of the public being paramount and that high quality care be encouraged.

The CAA believes that legislated restrictions on practice should only be included where the benefits to the community as a whole outweigh the costs, or potential costs to the consumer. These comments relate to potential risks to patients' health and wellbeing.

This document addresses the four points raised in the Consultation Paper "Proposed Registration Arrangements, Section 8.5 – namely:

5. Is there any evidence to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions apply?
6. Should the restricted act if included be narrowly framed eg manipulation to the cervical spine?
7. The need, if any, for inclusion in the national legislation of a restricted act with respect to spinal manipulation? If so, how broad or narrow framed?
8. What definition should be adopted?

1. We wish to respond to Question 3. first, as the answers to the other questions flow from it.

1.1 We firmly believe that there is a need for the inclusion in the national legislation of a restricted act with respect to spinal manipulation and extremities. Our reasons are as follows:

1.1.1 **There are known contraindication to and risks associated with spinal manipulation.**

These are classified as nonindications, relative contraindications and absolute indications. A list can be found in the World Health Organisation's Guidelines on Basic Training and Safety in Chiropractic. (1)

The WHO Guidelines state:

'When employed skilfully and appropriately, chiropractic care is safe and effective for the prevention and management of a number of health problems. There are, however, known risks and contraindications to manual and other treatment protocols used in chiropractic practice.' (p19)

In the interests of patient safety a person considering performing spinal manipulation must be able to recognise and consider this wide range of conditions, some of which are rare. Such recognition requires appropriate and specialised training. Most health care practitioners do not receive such training.

The known risks, complications and adverse reactions to spinal manipulation are also listed in the Guidelines, as follows:

'5. Accidents and adverse reactions

5.1 Causes of complications and adverse reactions

See Henderson (42):

- lack of knowledge
- lack of skill
- lack of rational attitude and technique.

5.2 Examples of inappropriate practices

See Henderson (42):

- inadequate diagnostic habits
- inadequate diagnostic imaging evaluation
- delay in referral
- delay in re-evaluation
- lack of interprofessional cooperation
- failure to take into account patient tolerances
- poor technique selection or implementation
- excessive or unnecessary use of manipulation.

5.3 Serious adverse consequences

Manipulation is regarded as a relatively safe, effective and conservative means of providing pain relief and structural improvement of biomechanical problems of the spine. As with all therapeutic interventions, however, complications can arise. Serious neurological complications and vascular accidents have been reported, although both are rare (43).

5.3.1 Cervical region

- vertebrobasilar accidents (see part 2, section 3.3 above)
- Horner's syndrome (44)
- diaphragmatic paralysis (45)
- myelopathy (46)
- cervical disc lesions (25:66)
- pathological fractures (47, 48)

5.3.2 Thoracic region

- rib fracture and costochondral separation (49)

5.3.3 Lumbar region

- an increase in neurological symptoms that originally resulted from a disc Injury (50)
- cauda equina syndrome (51, 52)
- lumbar disc herniation (52)
- rupture of abdominal aortic aneurysm (53)

5.4 Vascular accidents

Understandably, vascular accidents are responsible for the major criticism of spinal manipulative therapy. However, it has been pointed out that "critics of manipulative therapy emphasize the possibility of serious injury, especially at the brain stem, due to arterial trauma after cervical manipulation. It has required only the very rare reporting of these accidents to malign a therapeutic procedure that, in experienced hands, gives beneficial results with few adverse side effects" (43).

'In very rare instances, the manipulative adjustment to the cervical spine of a vulnerable patient becomes the final intrusive act which, almost by chance, results in a very serious consequence (54, 55, 56, 57).'

1.2 Given the seriousness of some of these potential injuries, and the listing of

their causes as involving lack of knowledge, lack of skill and lack of rational attitude and technique, it seems obvious that in the interests of the safety of the public require inclusion in the national legislation of a restricted act with respect to spinal manipulation.

- 1.3 It should also be noted that, should such a serious injury occur, the patient involved may need extended and expensive rehabilitative care and other support. This could be very expensive and the major potential source of money to finance this support would be the involved practitioner's professional indemnity insurance. If spinal manipulation was not a restricted act under legislation, a lay person performing such manipulation may not have such insurance.

2. We now respond to Question 2, 'Should the restricted act be included but narrowly framed eg manipulation to the cervical spine?'

- 2.1 Given that the WHO Guidelines, as quoted above, list possible serious adverse consequences from manipulation of not only the cervical spine, but also the thoracic and lumbar spines, it again seems clear that the restricted act should apply to these regions also.
- 2.2 Given that the sacrum and coccyx are anatomically part of the lumbar spine, and that manipulation of these structures is frequently achieved via contact on and leverage via the structures of the pelvis, it is clear that the restricted act should apply to the pelvic structures also.
- 2.3 Further, given that the forces used in spinal manipulation are similar to those used in extremity joints, it is clear that the restricted act should apply to extremity joints also. These would include the joints of the chest, shoulders, arms, hands, hips, knees, ankles and feet.

3. We now respond to question 1. Is there any evidence to suggest that the community is more vulnerable in those jurisdictions where no restrictions apply, compared with those where restrictions apply?

- 3.1 It is not possible to offer any such evidence with regard to Australia, as restrictions apply in this country. We do however note the injuries resulting from spinal manipulations carried out by non-chiropractors in jurisdictions in which no restrictions apply and reported in medical journals in other countries.

- **Mendez Gonzalez M, Garcia C, Suarez E, Fernandez Diaz D, Blazquez Menes B. Wallenberg's syndrome secondary to dissection of the vertebral artery caused by chiropractic manipulation. Rev Neurol. 2003;37(9): 837-9.**

The patient suffered serious injury in Spain, a jurisdiction without restriction. The professional who performed the manipulation was not a chiropractor and the term chiropractic manipulation was used inappropriately.

- **Markovitch H. Chiropractic causes leak of CSF. BMJ 2003; 326:1353**
Serious injury caused to patient in Germany. This was blamed on chiropractor, although the practitioner was not a chiropractor. Jurisdiction with no restriction.

- **Neetu R, Chandra MS, Rashmi M. Cervical Spinal epidural hematoma with acute Brown-Sequard presentation [Letter to editor]. Neurology India 2006;54;107-108**
The authors attribute an injury to a patient to “chiropractic manipulation”. It was subsequently confirmed that the “chiropractic manouvre” was not carried out by a qualified person. India is a jurisdiction with no restriction.

- **Wenban, Adrian B. Inappropriate use of the title chiropractor: Reasons for concern? [Letter to editor] Clinical Neurology and Neurosurgery 2008 (formally accepted for publication October 2008 – date published not available)**
This letter was in response to Gouveia Lo, Castanho P, Ferreira JJ, Guedes MM, Falcao F, Melo TP. Chiropractic manipulation: Reasons for concern? Clin Neurol Neurosurg 2007[Epub ahead of print].

In his letter to the editor Dr Wenban states that the principal author of the case series by Gouveia et al confirmed that “she and her co-authors had no knowledge of the qualifications of those referred to as chiropractors in their case series and that their basis for using the title chiropractor was the patient’s report of the techniques used.”

- Through researchers outside the chiropractic community using the term “chiropractic manipulation” in a generic sense, it has been revealed that there have been very serious injuries to patients in countries in which chiropractic is not restricted by law and so called “chiropractic manipulation” has not been carried out by a chiropractor.

- **Terrett AGJ. Misuse of the literature by medical authors in discussing spinal manipulative therapy injury. J Manip Physiol Ther 1995; 18(4):203-10.**
Terrett concluded, “the words chiropractic and chiropractor have been incorrectly used in numerous publications dealing with SMT

injury by medical authors, respected medical journals and medical organizations". Most of the injuries were blamed on chiropractic (spinal manipulation) when the practitioners involved were not chiropractors.

- In 2004 a prominent chiropractor researcher, Dr Adrian Wenban, B.Sc., B.App.Sc., M.Med.Sc., reviewed a total of 24 European peer-reviewed biomedical papers relating to chiropractic and manipulation. The results of this review revealed that the terms chiropractor and chiropractic manipulation had been inappropriately used. In 20 cases involving injury attributed to chiropractors, the principal researcher was unable to confirm that the providers were qualified chiropractors but subsequently conceded that they were not.

3.2 We are aware of a correspondence course in spinal manipulation that has been offered to medical practitioners in Australia. This course was composed of 10 short lessons, some of which were one page long. This contrasts sharply with the New Zealand Commission of Inquiry finding that *"It is wrong that the present law, or any medical ethical rules, should have the effect that a patient can receive spinal manual therapy which is subsidized by a health benefit, only from those health professionals least well qualified to deliver it."* (2)

3.3 The Commission further found :

"The responsibility for spinal manual therapy training, because of its specialized nature, should lie with the chiropractic profession. Part time or vacation courses in spinal manual therapy for other health professionals should not be encouraged."

The Commission found that *"....to acquire a degree of diagnostic and manual skill sufficient to match chiropractic standards, a medical graduate would require up to 12 months full-time training..."*

3.4 We are also aware of the Cameron case, in which a Sydney man died after receiving neck manipulations from Chatswood medical practitioner Robert Bosenquet, who was struck off. In handing down its judgement, the NSW Medical Disciplinary Tribunal expressed concern over the dangers of spinal manipulation being carried out by practitioners without recognized expertise. It stated, ' To the extent to which cervical manipulation is carried out by unregistered and unsupervised persons we can only say the prospect is frightening and the public should be warned.' (3-4)

4. Serious risks to public safety occurring as a consequence to limited training in spinal manipulation are a concern to the chiropractic profession

and certainly should be of major concern to Commonwealth, State and Territory Ministers.

5. It is unsatisfactory to allow inadequately trained registered and unregistered health professionals to perform spinal manipulation which may lead to serious/lethal consequences for patients.
6. **To minimize the risk of serious injury to patients the CAA strongly recommends that spinal manipulation be restricted to practitioners who have received adequate training in it. This would include 5 year trained chiropractors and osteopaths and physiotherapists and medical practitioners who have completed a minimum of one year post graduate diploma in manual therapy. Medical practitioners and physiotherapists who have not completed such training should not be permitted to perform spinal manipulations.**
7. It is recommended that readers of these key points also read the CAA's full submission "Restrictions on spinal manipulation" which is Appendix I to the Consultation Paper on Proposed Registration Arrangements for the National Registration Scheme.

References:

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1. *World Health Organisation (WHO) Guidelines on Basic Training and Safety in Chiropractic, 2005*
2. *Chiropractic in New Zealand: Report of Commission of Inquiry" Government Printer, Wellington, New Zealand. 1979*
3. *Sydney Morning Herald May 16, 1986. p 3.*
4. *Cervical Manipulation: Anatomy of a Disaster. Medical Practice, July, 1986. p26-27.*