CAM therapy is one of the fastest growing areas in health care, and while there is common ground with traditional areas of developed scholarship such as medicine and nursing law, ethics and business, unique issues do arise in CAM due to a number of factors. Prime among these is the wide-ranging differences between the CAM therapies themselves — their philosophies, goals and practice. Secondly, they operate at the boundary between highly controlled professions and emerging, unregulated practitioner groups. The controversial status relating to evidence for CAM therapy is an example of one of those issues. Similarly, business concerns are prominent for the CAM therapist (more so than for many other health professionals), as many CAM therapists offer their services in a private practice setting.

Essentials of Law, Ethics and Professional Issues for CAM is in two parts. Part one sets out foundation principles in law, business and ethics. Part two focuses on the major individual CAM therapies and approaches issuing from those unique perspectives.

Features
• presents a combined solution for professional practice courses
• covers legal responsibilities which affect everyday practice
• discusses ethical approaches to problems arising in the workplace
• includes case studies, alert boxes, tips and explanations

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Essentials of law, ethics and professional issues for CAM

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We decided to write this book because CAM therapy is one of the fastest growing areas in health care yet very little exists for those people interested in CAM ethics and law. Naturally there is some overlap with traditional areas of developed scholarship such as medicine and nursing law, ethics and business; however unique issues arise in CAM due to a number of factors. First of all there are wide ranging differences between the CAM therapies themselves – their philosophies, goals and practice. Secondly, they operate at the nebulous boundary between highly controlled professions and emerging unregulated practitioner groups. The issues are complicated by gate keeping factors causing friction between medical practitioners and CAM therapists. The controversial status relating to evidence for CAM therapy is an example of one of those issues. Similarly, business concerns are prominent for CAM therapist (as they are for other professionals). Unlike traditional public sector workers, most CAM therapists offer their services in a private practice setting.

There are so many issues that arise for CAM therapists in today’s changing society that no book could do justice to every aspect of practice and future challenges. However, we see this book as a beginning, laying down some of the more important considerations of practice in this area.

This book seeks to provide a legal, ethical and business framework for students, educators and practitioners. We have divided the book into two parts. Part one deals with law, business and ethics in a more generic fashion, laying out foundational principles. Part two focuses on the major individual CAM therapies and approaches issues from those unique perspectives. By adopting this structure we have attempted to cover all key issues yet maintain a focus on each of the major CAM therapies.
Chiropractic and osteopathy are two manual therapy complementary and alternative medicine (CAM) professions which are more recognised by their similarities than distinguished by their differences. Both arose in the USA in the mid to late 19th century out of dissatisfaction with the medical approach to dealing with illness. Both have evolved from simplistic beginnings to occupy the position of most conservative of the CAM therapies. They make use of medical terminology, medical diagnostics and the support of the healthcare system in general. Their fundamental treatment strategies revolve around manipulation of the spine, extremity joints and soft tissues of the body. Whilst having distinct historical differences they have come together to a large extent, in a similar fashion to how medical manipulators and physiotherapists who use joint manipulation have come together. The driving force for these four professions to be drawn as one has been the sharing of research and the adoption of an evidence-based approach. In this chapter, although more detail will be expended explaining chiropractic principles, more often than not the same will hold true for osteopathy. Repetition has been avoided by highlighting the fewer differences rather than reiterating the many similarities.

**WHAT IS CHIROPRACTIC?**

Chiropractic occupies a unique position in the spectrum of healthcare professions. Being arguably the most researched and firmly established of the alternatives to medical care, it is regarded by many to be almost mainstream. Indeed, this professional group commonly is omitted from lists of complementary health professions because, in many ways, it emulates the medical profession. The World Health Organization defines chiropractic as:

- a health care profession concerned with the diagnosis, treatment and prevention of disorders of the neuromusculoskeletal system and the effects of these disorders on general health. There is an emphasis on manual techniques, including joint adjustment and/or manipulation with a particular focus on subluxations.¹

The definition of chiropractic proffered by the Association of Chiropractic Colleges takes a more historical and political view in that it brings into focus issues such as the body’s ability to heal itself, and the fact that chiropractors differentiate
themselves from medical practitioners in that they do not prescribe drugs, nor perform surgery. The Association of Chiropractic Colleges also finds it important to stake a claim on chiropractors being partners in a healthcare team, rather than members of an isolated profession. Although this is generally true, it is unusual to include such sentiments within a definition of a profession. Indeed, what this brings to light is that the profession seeks to reposition itself as more willing to operate within mainstream healthcare.

Chiropractic is a healthcare discipline that emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, doctors of chiropractic recognize the value and responsibility of working in cooperation with other healthcare practitioners when in the best interest of the patient.2

Although best known for their management of low-back pain, chiropractors claim a far wider ambit. Recognising the role of the nervous system as a functional mediator in virtually all tissues of the body, chiropractors treat a wide range of body systems which have been compromised by nervous system dysfunction. As the spine is the anatomical structure housing the nervous system extension from the brain, it is clearly the focus of most chiropractic techniques.

More recently, a differentiation between ‘classical chiropractic’ and ‘modern multimodal chiropractic’ has been made.3 In classical chiropractic traditional beliefs and behaviours are maintained. These include the notion that chiropractors do not perform diagnosis per se; that is, they do not seek to identify named diseases but rather analyse spinal mechanical faults and eliminate them using a spinal ‘adjustment’. Adjustments are a specialised form of joint manipulation which place great emphasis on the correction of bone and joint position and specific mobility. These mechanical faults are named ‘subluxations’. When used medically, the term ‘subluxation’ refers to a malposition of a joint approaching the severity of a dislocation but with the joint surfaces remaining in contact. When used by classical chiropractors, ‘subluxation’ refers to a more subtle form of joint dysfunction wherein the joint is still able to move and otherwise function relatively normally, but only at the expense of some form of neurological compromise and/or pain. Accordingly, classical chiropractors typically identify these small bony displacements measured from X-ray films or by physical testing, such as palpation. Adjustments are delivered so that they affect only the subluxated joints.

Modern multimodal chiropractic fashions itself on the principles of evidence-based practice. While spinal faults are identified and managed this may be done so within an entirely different paradigm. The modern multimodal chiropractor does not recognise that spinal joints suffer subluxation in the sense of possessing positional disrelationship or mobility deficit requiring a specific corrective approach. Rather than use specific adjustments modern multimodal chiropractors tend to use manipulation directed to individual joints or groups of joints. They identify joint sprains and strains which are amenable to manipulation more generally.

Classical chiropractors do not perform diagnosis per se whereas modern multimodal chiropractors do. In the same vein, classical chiropractors do not render
treatment whereas modern multimodal chiropractors do. Classical chiropractors deliver spinal adjustments and render chiropractic care instead.

While such distinctions appear to be based in semantics they do lead to real behavioural differences between various chiropractors. For instance, classical chiropractors are much more likely to hold fundamental views on healthcare behaviour, be antidrug and antisurgery, be anti-immunisation, and be less likely to work well with other health professionals, especially medical doctors. Further, they are more likely to involve their clients in ongoing programs of care directed toward ‘wellness’. Modern multimodal chiropractors typically take an opposing view to each of the above.

This schism has set up an interesting dynamic within the profession. Both groups, as well as adhering to their preferred position, are critical of the other. To be fair to both groups (that is, to criticise them both) it could be pointed out that while modern multimodal chiropractors claim an evidence basis for their behaviours, they have yet to provide substantial evidence that their approach is clinically more effective than the classical approach. Similarly, the behaviour of classical chiropractors can also be admonished for its continued eccentricity within the healthcare system.

For the healthcare consumer this provides some options. Essentially, healthcare consumers can choose classical chiropractic as an ‘alternative medicine’ path, or can opt for multimodal chiropractic as a form of evidence-based complementary medicine.

WHAT IS OSTEOPATHY?
It is important to note geographic differences in the practice of osteopathy. In virtually all countries outside the USA osteopathy is practised in much the same manner as chiropractic. In the USA osteopathy is a branch of medicine, with professionals graduating from schools of osteopathic medicine, licensed to prescribe medications and providing minor surgery services to outpatients. This fundamental scope of practice difference derives from a political event rather than a primary philosophical difference, discussed in the next section. Osteopaths around the world are concerned with whole-body health using musculoskeletal therapy such as spinal manipulation for its vector of intervention.

Chiropractors and osteopaths share so many similarities most patients cannot ascertain substantial differences between the two groups. For the two professions to remain distinct they will need to continue to evolve along their separate paths. This is becoming increasingly difficult in an era when all health professionals share and use researched evidence as a guide to practice.

Throughout its history osteopathy has adhered to a few basic philosophical tenets. The first is an appreciation of holism in the recognition of the interaction of body, mind and spirit. The founder of osteopathy, Andrew Taylor Still termed this the ‘triune of man’.4 Secondly, the maxim ‘structure governs function’ described a form of physical determinism or mechanical appreciation of the body. Such philosophy was popular throughout the Western world in the first century following the industrial revolution. Finally, the body inherently possesses the ability to regulate, heal and develop itself – usually without the need for any
external aid. These concepts were promulgated by Still in the mid-1870s and then readily adopted by Daniel David Palmer (see below) and incorporated with little alteration into his chiropractic paradigm some two decades later.

Today osteopaths remain adherent to their basic philosophical premise. Technical skills have been expanded to include attention to almost all human ailments via manual therapy. Manipulation of the cranial vault is a fascinating and controversial area of specialisation.

**HISTORY OF CHIROPRACTIC AND OSTEOPATHY**

The practice of spinal manipulation is based in antiquity with the earliest references to this treatment arising 6000 years ago in India and 5000 years ago in Egypt. Statues, texts and carvings from several ancient cultures depict the application of spinal manipulation. Reference to spinal manipulation can be found in the classic Greek era and also in Babylonian, Egyptian, Chinese, Assyrian, Hindu and Tibetan works.

While the practice of spinal manipulation is ancient and can be traced to many cultures, the organised professions of chiropractic and osteopathy are children of 19th-century America. Chiropractic was discovered by DD Palmer in Davenport, Iowa, USA. Palmer acknowledged that manipulation was ancient folk medicine but brought a unique interpretation to light, creating a new paradigm in modern CAM. What Palmer determined was that spinal faults interrupted the normal operation of the nervous system, by creating impediments to free nerve flow. Unlike other manipulators before him, and his contemporaries, the osteopaths, Palmer used the bony protuberances of the vertebrae as levers in their correction. In doing so Palmer emphasised specificity as a major goal and integral feature of this manipulation. Thus the term ‘adjustment’ was applied to distinguish this new approach from other forms of manipulation.

DD Palmer had a varied background, having tried his hand at a range of professional and business pursuits. In 1895 Palmer was consulting as a magnetic healer. Although reports of the discovery of chiropractic differ in detail, the following history is usually put forward. Harvey Lillard, Palmer’s janitor, related to him that 17 years previously when working in a cramped posture in a confined space he felt a ‘pop’ in his back. At that time he became partially deaf. Palmer examined Lillard and found a prominent and sore lump on his back. Reasoning that a bone had moved out of place he used his hand to ‘rack’ the bone back into place. Lillard reported that immediately he could hear the sounds of the wheels on the carts being driven on the street below. His hearing had been restored.

Initially Palmer thought that he had discovered a cure for deafness. Alas, after advertising for deaf clients and unsuccessfully treating them he rethought his discovery and expanded his scope of practice. He did attain a number of dramatic results with some diverse conditions and this helped shape his understanding of the profession he was creating. In 1896 he began teaching others his techniques in a school attached to his clinical practice – the Palmer School of Chiropractic.

The successes of early chiropractors led to their prosecution for practising medicine and/or osteopathy without a licence. Several chiropractors were each jailed multiple times, including DD Palmer. Palmer’s son, Bartlett Joshua Palmer,
took over the running of the Palmer School and, in an attempt to protect new graduates from prosecution, helped to set up a professional association which covered legal costs of its members. Its first test came in 1907 when an early graduate named Shegataro Morikubo was arrested for practising osteopathy without a licence. A successful defence was mounted on the basis that chiropractic was philosophically different to osteopathy (and medicine). Fundamental to this philosophy were the following distinctions.

- Chiropractors do not perform a diagnosis; instead they analyse the spine for physical imbalances and especially identify subluxation.
- Chiropractors do not treat any conditions or diseases; instead they remove subluxation by administering spinal adjustments.
- Chiropractors do not effect a cure; they merely remove subluxations which are an impediment to the body’s innate intelligence which sustains and heals the body.

Although initially developed as the successful strategy to exonerate arrested chiropractors, this philosophy has been retained by a large sector of the profession, thereby cementing their uniqueness among healthcare professionals. The retention of this philosophy is the genesis of the schism in chiropractic today.

In 2010 there were over 40 chiropractic courses of training. Chiropractic has evolved to being one of the most recognised and utilised healthcare strategies today.

Osteopathy developed out of continued frustration with the medical profession of the mid 19th century. Andrew Taylor Still, a medical practitioner and army surgeon, lost four of his children to infectious disease. Medical treatment at that time was primitive and clearly not related to beneficial outcomes. Still’s personal losses, and the realisation that much of what he was trained to do as a medical doctor was in fact harmful, led him to eschew his training and develop his own vitalistic methods to care for the sick. Although derided for most of the latter part of his life as a ‘crank’, Still’s pioneering work created the osteopathic profession and informed the early development of chiropractic.

In 1874 Still proclaimed his new approach as a reformation in medical science rather than as some alternative option. In the ensuing years he developed a powerful following; patients travelled across the country to receive his ministrations. Despite long-lasting illnesses that left him frail and earned him the epitaph ‘the old doctor’, his practice continued to grow, being maintained by his wife and children while he was infirm. In 1892, 3 years before Palmer discovered chiropractic, Still established the American School of Osteopathy. His first small class comprised family members and others close to him. Still’s autobiography, published in 1897, relates how he had cured his headaches at the age of 10 by intuitively using a rope swing applied to his upper neck as a form of traction.

Today there are almost 50 recognised courses of training in osteopathy.

**RECOGNITION AND STATUS OF THE PROFESSION IN LAW**

Chiropractic and osteopathy are recognised at law as health professions in over 40 countries. In all cases practitioners are primary contact professionals; patients do not need to be referred by a doctor or another practitioner. While there is
considerable debate on prescription rights, at this time Australian chiropractors and osteopaths are not licensed to prescribe schedule-restricted pharmacological agents, nor to perform surgery. As noted above, American osteopaths are licensed to provide those services. In unique contrast to this is the state of Oregon, USA, where chiropractors are trained and licensed to perform a range of traditional medical procedures, such as minor surgery and obstetric procedures, and are authorised to sign birth and death certificates.

**Professional registration**

All Australian states and territories limit the practice of spinal manipulation and/or the use of the titles ‘chiropractor’ and ‘osteopath’ to registered (i.e. licensed) individuals. From mid-2010 the administration of registration of both professions passed on to national registration boards in line with the centralisation of registration of all health professions managed under the Council of Australian Governments. This process is managed by the Australian Health Practitioner Regulation Agency (AHPRA). It is responsible for the registration and accreditation of 10 health professions across Australia. The umbrella organisation AHPRA ensures that consistency is maintained across the 10 national boards. The reader is directed to the websites of the Chiropractic Board of Australia (http://www.chiropracticboard.gov.au/) and the Osteopathic Board of Australia (http://www.osteopathyboard.gov.au/) for current information on this new development.

Osteopathy and chiropractic are the most recognised and regulated of the CAM therapies. The practice of osteopathy and chiropractic is closely controlled by their national registration boards and they are subject to a wide range of legislative arrangements which act on most other health professions.

To qualify for a licence a person must have successfully completed an accredited course of training or passed examinations established for licensing as a chiropractor or osteopath. In New South Wales the practice of spinal manipulation is restricted to four professional groups – chiropractors, osteopaths, physiotherapists and medical practitioners; this proscription is legislated in the Public Health Act 2001. On the other hand, at the time of writing, the practice of spinal manipulation is not proscribed in the state of Victoria.

Registration as a chiropractor or osteopath entails a number of responsibilities mandated by statute or regulation. These include the following:

- a standard of professional conduct
- maintenance of competency and currency in knowledge and skill
- maintenance of not less than $10 million in professional indemnity insurance
- upholding patient confidentiality and maintaining a professional distance
- maintenance of clinical records
- gaining proper informed consent prior to the delivery of treatment
- advising the board of any pending legal challenge, formal complaint or conviction against the practitioner.\(^6\, ^7\)
Health funds
Neither chiropractic nor osteopathic treatments are subsidised under Medicare, the national public health scheme. However, under Medicare’s enhanced primary care arrangements, Australians can receive five reimbursed treatments when referred by a general practitioner. All Australian private health funds do reimburse chiropractic and osteopathic treatment expenses for those who purchase extras insurance cover. Reimbursements vary across the funds but approximate to $500 per insured person per annum.

Other third-party payers
The Department of Veterans’ Affairs pays for chiropractic and osteopathic treatment for returned servicemen and service women. Chiropractors and osteopaths must apply to become an approved Department of Veterans’ Affairs health provider. Approved providers are permitted to determine the type and frequency of treatment. Interestingly, a veteran is not permitted concurrently to undergo any two or more of chiropractic, osteopathy and/or physiotherapy treatment. For the department’s purposes, those three treatments are duplicative. The treatments rendered must be deemed to be reasonably necessary. Treatments considered to be of an optional nature, such as health promotional or ‘wellness’ interventions, are not supported by the department.

PROFESSIONAL ASSOCIATIONS
The Chiropractors’ Association of Australia (CAA)
In Australia the chiropractic profession is served by a national professional association – the CAA. Although it celebrated its 20th anniversary in 2010, the origins of the CAA trace back to 1938 in the formation of the Australian Chiropractors’ Association, a body supporting its mostly American-trained membership. The CAA formed when the Australian Chiropractors’ Association merged with the United Chiropractors’ Association, the latter being a coalition of splinter groups and regional professional bodies, mostly made up of Australian trained practitioners. Long-standing tensions between Australian and North American-trained chiropractors are now a thing of the past. The CAA website is located at http://chiropractors.asn.au/. Its code of conduct is published on the web.

The CAA comprises a federation of eight autonomous state and territory branches. The branches are responsible for specific state-based needs, including membership management, disciplinary matters, branch-level benefits and state-based public education, policy and communication.

The CAA publishes the Chiropractic Journal of Australia (CJA). The journal is a peer-reviewed publication whose objective is the advancement of chiropractic science, principles and practice. The journal is published quarterly and includes the gamut of article types, including original articles, case reports, literature reviews, book reviews and editorials. CJA is indexed in Mantis and the Index to Chiropractic Literature databases. As at January 2011, the CJA is not indexed in PubMed, nor does it enjoy an impact factor rating.
The Australian Osteopathic Association (AOA)
The AOA is the professional body established for osteopaths. The core business of the AOA is liaising with political organisations and statutory bodies regarding any legislative, regulatory, professional and educational issues affecting members. Established in 1955 in Victoria, the AOA became a unified national body in 1991, representing its registered members in all states and territories of Australia. The AOA has links with like bodies overseas and is a participant in the Osteopathic International Alliance. As at January 2011 the AOA had approximately 1500 members. The AOA website is located at http://www.osteopathic.com.au/index.php/home. It also publishes a statement of ethical principals.9

The Chiropractic and Osteopathic College of Australasia (COCA)
A third professional group exists which is directed more toward serving the academic and continuing education needs of the chiropractic and osteopathic professions. COCA is a professional society which accepts all health professionals into its membership. Its goal is ‘to foster quality continuing education to its members, and to promote the interchange of information across disciplines’.10 The COCA website is located at http://www.coca.com.au/.

Originally established as a training school under the name of the British and Australia Institute of Naturopathy, Osteopathy and Chiropractic in 1944 by FG Roberts, the institute became COCA in 1959. The college ceased its training programs to transform itself into a learned society but retains its name to this day.

From 1992 to 1996 COCA published the peer-reviewed *Chiropractic and Osteopathic Musculoskeletal Special Interest Group Review*. From 1996 to 2003 it published the paper-based journal *Australasian Chiropractic and Osteopathy* (C&O). In 1996 the journal C&O became an online publication. A joint-venture agreement with the European Academy of Chiropractic (EAC) and the European Chiropractors’ Union (ECU) was signed in June 2010, making the journal the official publication of COCA and EAC. The EAC is a wholly owned subsidiary of the ECU, which is a union of 19 European chiropractic associations, including the British Chiropractors’ Association. Accordingly the journal changed its name again on 1 January 2011 to *Chiropractic and Manual Therapies*. The journal remains a member of the BioMed Central publishing group and continues as an online journal. The journal is indexed in major health databases, including PubMed, Scopus, Mantis and the Index to Chiropractic Literature. An impact factor rating is pending.

EDUCATIONAL REQUIREMENTS IN CHIROPRACTIC AND OSTEOPATHY

Institutions offering training

At the time of writing there were over 40 institutions involved in the primary training of chiropractors, of which three are in Australia. The first school, Palmer College of Chiropractic, was established in 1897 in Iowa, USA, by the founder of chiropractic, Daniel David Palmer. The oldest existing chiropractic school in Australia is the Department of Chiropractic at Macquarie University in Sydney.
It was formed after the absorption of the Sydney College of Chiropractic into the University. The Sydney College was established in 1959.

The Chiropractic Department at Macquarie University was founded in 1990 by Rod Bonello, a Sydney College graduate and the author of this chapter. It became the first chiropractic training program to be offered by a university. This represented a milestone in the legitimisation of the profession and acceptance into mainstream academic circles. Macquarie offers the combined program of Bachelor of Chiropractic Science, Master of Chiropractic to satisfy registration requirements for chiropractors. The Macquarie curriculum is largely evidence-based and its program is fully accredited with all international authorities involved in the accreditation of chiropractic degrees.

Soon after the establishment of chiropractic at Macquarie University, the chiropractic course at Phillip Institute of Technology was merged into the Royal Melbourne Institute of Technology (RMIT). The first Head of School was Andries Kleynhans, an American graduate of the National College in Chicago. RMIT offers the articulated degrees Bachelor of Health Science, Master of Clinical Chiropractic, leading to registration of its graduates as chiropractors. The RMIT program is also fully accredited locally and internationally.

The third Australian program in chiropractic, established in 2002, is offered by Murdoch University in Perth, Western Australia. The first Head of School was Stephan Pallister. Originally championed by the CAA as a new school which would be significantly different from the existing schools, especially in the area of principles and philosophy of chiropractic, the Murdoch program quickly evolved into being a highly evidence-based school, not dissimilar from Macquarie and RMIT. The Murdoch double-degree course is of 5 years’ duration, leading to the degrees Bachelor of Chiropractic and Bachelor of Health Science.

Australian chiropractic schools are involved in developing liaisons with Asian chiropractic associations to assist in the establishment of new schools. This difficult area has been met with mixed success in Japan, Malaysia and Korea.

Currently there are three universities offering osteopathic training in Australia. RMIT delivers a 5-year articulated program leading to the degrees Bachelor of Applied Science (Osteopathy) and Master of Osteopathy. It is currently the longest-running osteopathic course in Australia, having been established by Andries Kleynhans. Although a sister program to the chiropractic degrees in the School of Health Sciences, osteopathy and chiropractic do not share course units, thereby creating differences in the two graduate streams.

The Victoria University School of Biomedical and Health Sciences offers a similarly structured program. Commenced in 1995 under the leadership of Peter Gibbons, the program graduates between 50 and 60 osteopaths annually.

Southern Cross University offers the articulated degrees of Bachelor of Applied Clinical Sciences, Master of Health Science Medicine in Osteopathy. The program under Paul Orrock was established in 2006 and, for its initial graduation in 2012, is expecting to produce 13 osteopaths.

All Australian chiropractic and osteopathic schools require that applicants have completed high school at a strong level of performance, but also allow admission to those with a deemed equivalent level of attainment considering work experience or other achievement. Admission under equity schemes is also possible for
individuals who have suffered a disadvantage, are of Aboriginal or Torres Strait Islander background or are mature-aged applicants.

Research literacy and training are features of the Australian schools where students are required to complete a research activity as part of their training. This training in providing a foundation in critical thinking skills is recognised as an essential attribute for new graduates in these still-emerging professions.

Australian schools of chiropractic and osteopathy operate some of the most sophisticated educational programs in these disciplines in the world. Demand for places in the schools continues to rise and far outstrips the number which can be accepted.

**Accreditation**

In the Australian higher-education sector universities are self-regulating with respect to academic standards. The Acts of parliament under which universities are established make this function fundamental to the operation of these institutions. Where universities interface with professions in providing professional training, the professions play a monitoring role to ensure that the product of the university meets with the needs and expectations of the profession and the clients served by that profession.

The accreditation process uses the method of self-evaluation, where institutions identify and report on their areas of both strength and weakness. On-site inspections and periodic monitoring strategies are put in place between inspections. Institutions are granted accreditation in periods; that is, a school may be accredited for 1–5 years depending on how closely standards are met. Additionally, the accreditation period may be affected if the school is in a state of rapid evolution. Loss of accreditation status would be a serious message to all stakeholders that a program is in trouble.

Standards of education and training in chiropractic are monitored by the Council for Chiropractic Education Australasia (CCEA). The CCEA is an independent body, established by the chiropractic profession to serve the needs of the profession, the educational institutions, the registration authorities and the public, with respect to educational quality.

Osteopathic accreditation services are provided by the Australian and New Zealand Osteopathic Council (ANZOC), which replaced its predecessor, the Australian Osteopathic Council in February 2010. The ANZOC is an independent body responsible for accreditation of institutions teaching osteopathic programs in both Australia and New Zealand and for the assessment of overseas-qualified osteopaths.

**Continuing education**

A basic responsibility of any profession is the maintenance of currency in knowledge and skill of its practitioners. Systems which monitor and safeguard the lifelong learning of members of the profession are a major factor in quality assurance for the services provided to the public. Both the Chiropractic Board of Australia and the Osteopathy Board of Australia became operational in 2010 and mandate a minimum of 25 hours of continuing education for all registrants.
Registrants who cannot show that they have engaged in 25 hours of approved educational activity risk losing their licence to practise.

**THERAPEUTIC RATIONALE**

Chiropractors and osteopaths hold that spinal mechanical faults, called subluxations or somatic dysfunction, are very common. Usually these have little consequence other than causing joint stiffness and discomfort. At times, however, they may lead to more profound symptoms, including not only pain syndromes but dysfunctions of various systems of the body. These lesions have been linked to cardiovascular disturbance such as raised blood pressure, respiratory disturbances such as asthma, dysmenorrhoea, migraine and other headaches, and paediatric conditions such as enuresis, infantile colic and many other conditions.

The claim of the two professions to be an effective therapeutic option in such wide-ranging conditions has been controversial. This is especially so in a conservative field dominated by a powerful medical lobby. The recent acceptance of complementary and alternative approaches in healthcare has now placed chiropractic as arguably the most accepted, or at least popular, of these alternatives. Osteopathy, although less popular, is more aligned with medical philosophy and practice.

**How chiropractic and osteopathy work**

A number of theories have been put forward to support the claims of chiropractors and osteopaths. The absence of a single unified theory for the validation is not surprising considering that health and illness are governed by multifactorial processes. In conjunction with this, these two professions, like most professions, enjoy a diversity of special-interest groups with differing philosophies and perspectives, each postulating differing models to explain observed findings. Leach has summarised the major theories proposed in reference to chiropractic.11

- **Axoplasmic flow interruption**: aberrations in the flow along axons may be adversely affected directly or indirectly by vertebral subluxation. Irritation or compression of spinal nerves or their roots may cause facilitation or inhibition of nerve impulses.
- **Immobilisation degeneration**: trauma or repetitive microtrauma may lead to a proinflammatory state in spinal joints which fosters a chronic degenerative joint disease. Chiropractic care maintains joint mobility and may be preventive to this process.
- **Inflammatory processes**: vertebral subluxation may be created as an aftermath of spinal joint inflammatory episodes after trauma.
- **Joint instability**: repetitive traumas may cause spinal joint change in ligament quality so that the joint no longer can adopt its normal positioning nor participate in symmetrical movement. This is a precursor to pathological joint stabilisation according to the Kirkaldy–Willis model of spinal degeneration.
- **Somatic dysfunction mimicry**: connective tissue dysfunctions, such as spinal somatic problems including vertebral subluxation, very commonly create
symptom patterns reminiscent of organic disease. The removal of the somatic dysfunction may be wrongly credited with the ‘cure’ of the organic disease.

- Myelopathy: in certain circumstances vertebral subluxation may contribute to spinal cord pressure. This is most likely to occur in the cervical spine where the relative dimension of the spinal canal is very small considering the presence of the cervical cord enlargement. Motor and sensory dysfunction affecting the whole body may result.

- Neuroimmune dysfunction: by affecting sympathetic system impulses vertebral subluxation may influence immune responses which can create trophic change in body systems.

- Neuropathologies: subluxation may affect neural blood supply, having consequences for the nerves themselves as well as the muscles and organs supplied by those nerves.

- Segmental dysfunction: very commonly spinal joints may develop mobility deficit leading to pain and joint stiffness. These subluxations are usually short-lived and innocuous, although they may become self-perpetuating and lead to other states, listed above.

- Somatoautonomic reflexes: (also known as somatovisceral reflexes): the local irritation caused by subluxation may produce neural facilitation which adversely affects organs supplied by those nerves, leading to visceral dysfunction.

- Vertebral subluxation complex: a model which describes five component features of subluxation from cellular level to gross anatomical change. These changes are mediated by processes including histochemical change and kinesiopathology.

- Vertebrobasilar insufficiency: cervical spine subluxation may contribute to insufficiency in blood supplied to the brain by the vertebral arteries. Usually mediated by vasospasm, the insufficiency may be related to wide-ranging effects such as balance problems, dizziness and loss of visual acuity.

- Wellness models: these postulate that the removal of vertebral subluxation is associated with a health promotional state, forestalling spinal degeneration and some neural-based dysfunctions. It is a model for preventive maintenance healthcare.

Naturally the above models apply equally to osteopathic mechanisms, although terminology differences would largely be eliminated by substituting the words ‘osteopathic lesion’ or ‘somatic dysfunction’ for ‘subluxation’.

**SCOPE OF PRACTICE**

**Diagnostic techniques**

Modern chiropractors and osteopaths employ a range of diagnostic techniques but largely concentrate on clinical history taking and the performance of a physical examination of the neuromusculoskeletal system in carrying out diagnosis. As they are primary contact clinicians – that is, their patients are self-referring – they are responsible for their patients’ diagnosis and are not reliant on external triage,
Osteopaths and chiropractors make use of diagnostic instruments commonly employed by other healthcare professionals, especially those concerned with musculoskeletal medicine. These include the reflex hammer, blood pressure cuff, ophthalmoscope, otoscope, dynamometer, goniometer, tape measure, sensory testing apparatus and so on. Very commonly, however, they may rely on visual observation and manual testing only in assessing the patient. The basic diagnosis made relates to the determination of whether the patient’s complaint is a mechanical one, and therefore amenable to manipulative or other physical intervention, or non-mechanical and therefore more likely to require a different approach such as medical or other referral. Whilst this may appear to be a simplification it would none the less represent the most common diagnostic answer sought by the chiropractor and osteopath.

The fundamental diagnostic decision made by osteopaths and chiropractors is whether or not the patient possesses a problem amenable to physical treatment such as manipulation.

In making the determinations described above, both chiropractors and osteopaths seek to identify functional disturbances in the body. Where these disturbances relate to the musculoskeletal system there are generally two possibilities. Either a body tissue is damaged, such as a sprained ligament, or the tissues are not functioning correctly but are in themselves otherwise normal. This second possibility may be exemplified by imbalances in muscle tone in the neck. In such a case neck mobility will be affected and commonly would be accompanied by neck pain and/or headache.

Today, osteopaths and chiropractors seek to diagnose and manage a wide range of conditions. Whilst some specialise in well-defined areas – such as paediatrics, cranial problems, sports injuries, emotional health or women’s health – the vast majority are generalists. In addition, whereas the focus in the past was more centred on the spine, nowadays the whole body from the extremities to the organs falls under the consideration of osteopaths and chiropractors. In response to the adoption of primary contact diagnostic responsibility and the move away from a more limited orientation, the accredited courses of training in chiropractic and osteopathy now devote hundreds of curriculum hours to diagnostic training.

**Therapeutic techniques**

In concert with the expansion of diagnostic responsibility, therapeutic techniques have continued to expand. The fundamental therapeutic approach of these two professions, however, remains spinal manipulation. In most cases spinal manipulation involves the application of force by hand directly on the patient. The force is usually delivered in a focused manner involving highly specialised contact and delivered with a short, sharp impulse-type manoeuvre designed to cause a rapid but small movement in the patient. Typically applied to the spine, such highly specialised manipulations are called ‘adjustments’ and are described as 'high-velocity, low-amplitude' moves. During the performance of such manipulations
it is most common for cavitation to take place; that is, cracking or popping sounds emanating from the manipulated joints. Such sounds mostly arise from synovial fluid within the joints when the fluid is suddenly moved. The sudden movement momentarily creates a vacuum in the synovial fluid which leads to the formation of gas bubbles within the fluid, in the same way that gas bubbles form in carbonated soft drinks when depressurised. These sounds were thought to be incidental to the procedure but there is some evidence that the sound itself may contribute to the therapeutic effect.

Although spinal manipulation is usually delivered by hand, mechanically assisted manipulation and adjustment techniques are available in addition to the more traditional methods.

It has been estimated that there are over 200 differently identified chiropractic and osteopathic technique systems in use. Most are variations of the basic procedures and often differ in rationale rather than physical procedure per se. Most of the chiropractic technique systems are listed in Table 10.1.12

There are many technique options available to chiropractors and osteopaths. In choosing the appropriate technique for a patient it is more important to base this decision on the individual needs of the patient rather than the personal preference of the therapist.

Generally it is true that the popularity of the chiropractic and osteopathic professions can be attributed to success in managing musculoskeletal conditions. Low-back pain is a case in point. Although a very common disorder, low-back pain is generally very poorly managed by most of the health professions. Both osteopathy and chiropractic, on the other hand, have built their reputations on being particularly effective in the management of spinal complaints, especially low-back pain. This success is most likely due to the direct nature of the intervention. Leaving aside active care strategies such as exercises, medicine generally employs a pharmacological management strategy for low-back pain whilst chiropractors and osteopaths apply physical intervention directly to the low back. This direct and mechanically based approach is more easily appreciated and understood by patients.

## Conditions treated

Because mechanical problems in the body are commonly associated with compromise to nerve tissue, the effects of such mechanical problems often go far beyond basic mechanical symptoms. Compromised neural tissue may lead to overt symptoms such as sciatica and painful ‘pins and needles’, or to more subtle consequences such as organic dysfunction in the end-organs supplied by those nerves. Such effects have been described at length by Cramer et al.13 and by Pollard14 as somatovisceral reflex effects. Because of such effects osteopaths and chiropractors have had some success in the management of wide-ranging conditions. Box 10.1 gives an indication of the types of conditions managed by chiropractors and osteopaths. Not all conditions listed will necessarily be amenable to chiropractic or osteopathic care – only in cases where the symptom pattern is associated with mechanical dysfunction would there be a reasonable expectation that such an approach may be a treatment option (Fig 10.1).
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Box 10.1 Conditions managed by chiropractors

**Physical conditions commonly managed by chiropractors**
- Traumatic sprains and strains of the joints and muscles
- Sports and work-related injuries
- Chronic joint problems such as arthritic conditions
- Acute inflammatory joint conditions
- Scoliosis and other postural conditions
- Spinal stenosis
- Neural compression syndromes such as carpal tunnel syndrome
- Thoracic outlet syndrome
- The physical effects of psychological stress

**Emotional conditions commonly managed by chiropractors**
- Stress
- Low- to moderate-level anxiety
- Mild depression

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Figure 10.1 Osteopathic treatment of spinal dysfunction. OCF, osteopathy in the cranial field; HVLA, high-velocity, low-amplitude. Modified from Fryer et al.¹⁵

**Preventive care and maintenance**

The term ‘wellness care’ has been adopted by the chiropractic profession and is essentially the rendering of preventive maintenance treatment to promote well-being and to stave off illness or other malady. The osteopathic profession has been more reluctant to embrace this approach. In the most general sense, all healthcare practitioners should involve themselves in counselling their patients against unhealthy habituations and risk-taking behaviours. When used by chiropractors, the term ‘wellness care’ more specifically relates to the rendering of periodic chiropractic adjustments in the same vein as the dental recommendation of 6-monthly visits irrespective of the presence of toothache. Such preventive...
treatment is designed to maintain spinal flexibility and good alignment which is postulated to prevent the development of subluxation and other mechanical functional problems. The evidence basis for this postulation is not strong, although the work of Moller et al\textsuperscript{16} has recently investigated this matter in large cross-sectional studies in Denmark.

**Practice guidelines**

The chiropractic and osteopathic professions have involved themselves in consensus review processes designed to bring to light the best evidence available on daily practice matters. Such consensus meetings have been both multidisciplinary as well as consensus gatherings focused on solely mechanical diagnosis and management issues, such as the Glenerin Mercy Guideline\textsuperscript{17,18} and abortive Australian chiropractic guideline processes.

**Practice accreditation**

Chiropractors and osteopaths may choose to have their practices reviewed by external assessors against quality criteria established by COCA. This relatively new service is being taken up by an increasing number of practitioners who wish to attain accreditation as part of a quality management strategy, or are looking to promote their clinic facility as an independently assessed example of best practice.

**Safety issues – risks of neck manipulation**

Much has been written and even more speculated about the risks associated with manipulative treatment – especially the risks associated with neck manipulation. While it is certainly true that spinal manipulation carries risk, and that neck manipulation carries a specific risk of association with stroke, the debate has been too often associated with political posturing and reaction. Naturally, virtually all therapeutic interventions carry a degree of risk. Our healthcare and legislative systems recognise this and seek to ensure that such risks are reasonable. The risks associated with a therapeutic procedure are acceptable on the following grounds:

- the risk is not statistically high
- the therapeutic procedure is applied in cases of genuine need
- the relationship between need and risk is reasonable
- there is a lack of alternative therapeutic procedures which have similar efficacy but less attendant risk
- patients are appraised of the risks and they give informed consent accordingly.

In respect of the above, albeit with some dissension, it is common consensus amongst most health professionals that manipulative interventions are relatively safe. Further, when applied appropriately, chiropractic and osteopathic interventions are some of the safest options in the management of a wide range of musculoskeletal conditions.

It has been commonly accepted that the risk of stroke following neck manipulation is somewhere in the order of one chance in between 4000000 to one chance in 40,000. In cases where stroke has followed manipulation, most patients
have had a substantial recovery, and often a full recovery. At the other extreme, stroke may lead to permanent disability or death. For this reason, spinal manipulation and especially manipulation of the neck must be carried out not only by persons licensed to do so, but by those who are sufficiently expert to undertake this therapy. More recent research has questioned the causal link between neck manipulation and stroke, finding that patients who were already undergoing the beginnings of vertebral artery stroke were more likely to see a chiropractor for the associated neck pain and headache. The ensuing neck manipulation was an incidental rather than causal effect of the eventual stroke.19

Other risks associated with joint manipulation range from posttreatment soreness through to injury of muscle or ligament. Such adverse incidents are relatively minor and quickly resolved. The vast majority of treatments involving spinal manipulation are comfortable, safe and effective.

RESEARCH EVIDENCE
Evidence supporting the use of manipulative procedures is well evolved in some areas (such as management of low-back pain) but poorly developed in others (such as management of systemic disorders). The research base for this area is rapidly expanding. This is because for most of its history chiropractic and osteopathic education and research occurred away from the major institutes of learning, thereby greatly limiting their capacity for real progress. The last 20 years in Australia have seen chiropractic and, more recently, osteopathy move into multidisciplinary educational institutions so that the incorporation of research into the academic programs has become natural.

Nature of the evidence
Like most CAM therapies, the evidence for the efficacy of manipulative care at present outstrips the understanding of the physiological mechanisms for those treatment effects. The types of evidence which have been presented in the past centred on anecdotal reports, case reports and case studies through to case series. The provision of experimental evidence for efficacy was then underpinned by case-control studies and cohort studies. More recently the use of randomised controlled trials (RCTs) has exploded in the professions’ attempts to attribute benefits observed to the treatments rendered. Whilst RCTs on low-back pain management are most numerous, there now exist RCTs reported on conditions as diverse as headache, migraine, sports injury management, infantile colic, chest pain, hip and shoulder problems, tennis elbow and hundreds of others. Not all of the evidence is of very high quality and indeed some is in conflict, as is the nature of such things.

Ethics matters related to chiropractic and osteopathy
Ethics issues surrounding the provision of treatment and the behaviour of chiropractors and osteopaths are identical to those attending other healthcare professionals. The following paragraphs outline some of these issues in a context more specific to osteopathy and chiropractic.
Essentials of law, ethics and professional issues for CAM

Overservicing
Because manipulative care frequently involves treatment for specific complaints as well as ongoing rehabilitation for chronic problems, reasonable treatment may become protracted. The addition of preventive care and health promotion services which are unrelated to treatment per se has created confusion in terms of proper length of treatment. It is expected that practitioners discuss treatment aims and scheduling with patients so that clearly informed decisions about length of treatment can be made. Typically this involves the outlining of three stages of care. The first stage is corrective care or ‘treatment’, which is focused at correcting the presenting problem; for example, treatment for low-back pain. Secondly, after successfully addressing symptoms, a program of rehabilitation is usually recommended to assist the full return of the injured or dysfunctional part to health. This is important in preventing recurrence of the original problem. Thirdly, practitioners often offer ‘maintenance’ care. This form of intervention is not directed to the treatment of any specific problem but seeks to ensure that the body, and especially the spine, is functioning efficiently as a whole. This type of service is offered at varying levels of frequency.

An analogy which may illustrate the phases of care is made with dentistry. A patient may present with a toothache. A diagnosis is made and treatment is given. This may involve a dental filling or removal of a tooth or abscess. Such treatment may take anything from one visit to several. Following this, other associated problems may require attention. Next follows a set of recommendations for ongoing maintenance, including periodic visits irrespective of the presence of symptoms.

Professional boundaries
Because chiropractic and osteopathic treatment involves a high level of physical contact between the doctor and the patient, and as the patient is commonly in some state of undress, the temptation exists for some practitioners to breach the professional boundary, making inappropriate advances to the patient. At no time can a chiropractor or osteopath commence such a close liaison with a patient and continue to maintain that person under therapeutic care. The commencement of a close relationship with a patient could be commenced after the cessation of the therapeutic relationship, but should only be done so after sufficient time has passed so that the effects of patient dependency have dissipated.

Informed consent
All healthcare providers must gain properly informed consent from patients prior to the commencement of therapy. For chiropractors and osteopaths this issue is particularly important in cases where the treatment carries the potential for serious injury to the patient, such as stroke following manipulation of the neck. Albeit very rare, the consequences of postmanipulation stroke may be catastrophic so this issue must be discussed with patients prior to the commencement of care.

Prepaid contracts for service
In recent years the creation of prepaid treatment plans has been adopted by some manipulative therapists. The potentially coercive nature of such plans, especially the punitive consequences of extricating oneself from some such plans, makes
this area ripe for the exercise of poor ethics. Prepaid arrangements to have treat-
ment must in no way influence a patient’s decision on whether to have treatment, 
how much treatment to have, when to cease treatment and changing 
a practitioner.

Record keeping
The maintenance of quality patient records is vital to ensure that patients can 
receive ongoing care which builds from previous sessions and maximises diag-
nostic and therapeutic effectiveness and efficiency. If things go wrong as a result 
of treatment, it is the clinical records that are probably the most helpful in deter-
ming what went wrong and the next best course of action. This is especially 
so when such consideration needs to be made some time after the incident in 
question, such as when the matter escalates into a medicolegal dispute.

CASE STUDY
James, who is dual-registered as both an osteopath and chiropractor, practises in 
New South Wales. He graduated in 1978 and has maintained a successful practice 
throughout that time. He employs a range of spinal manipulative techniques and 
soft-tissue procedures almost exclusively drawn from those he was taught at 
college.

Complaining of neck and arm pain, 58-year-old Brian consults James for 
treatment. After a brief history James examines Brian’s neck by palpating the 
joints and muscles of the neck and checking its range of motion. After doing so 
James says: ‘OK, Brian, I’ve found your problem. You have lesions in your joints 
at the base of the neck and I can fix those. Please lie down.’ James proceeds to 
place Brian’s neck into a position of rotation and side-bending and asks Brian to 
relax and allow the neck to become limp. Brian finds it difficult to relax as he’s 
never had someone else hold his neck in this way. James delivers a sharp push 
to the neck, creating a number of cracking sounds which surprise Brian. Although 
Brian suspected that the treatment might involve some kind of joint cracking, he 
ever imagined that it would be so dramatic.

Immediately after the manipulation Brian felt differently. The manipulation 
had been somewhat painful but had only lasted a moment. On sitting up Brian 
moved his head to the left and the right as instructed by James and reported that 
it appeared to move more easily. Brian also noted that there was a fine grinding 
oise now associated with neck movement that was not present beforehand. Also, 
the pain in Brian’s arm had not diminished. Brian was unsure whether it had in 
fact become a little worse.

James then advised Brian that he would need to continue treatment for 
8 weeks at three visits per week. This surprised Brian as he was under the impres-
sion that two or three visits were all that would be needed. As Brian was not 
financially comfortable he would need to reconsider if this was acceptable.

Questions
1. What are the possible departures from professional best practice in this 
   case?
2. What should have been done differently?
James graduated over 30 years ago and seems to practise in the manner he was taught. It is imperative that all practitioners keep up with advances in the understanding of health, disease and evidence-based treatments. Taking an inadequate history and omitting a number of basic orthopaedic and neurological tests represent a departure from reasonable professional expectations. For instance, Brian has arm symptoms and this would have necessitated the performance of tests to determine the patency of the cervical spine nerve roots. Additionally, there is a clear need to perform some tests to determine that Brian’s symptoms are not related to some underlying pathology which may represent a red flag against osteopathic or chiropractic treatment.

James states: ‘You have lesions in your joints at the base of the neck and I can fix those.’ This is insufficient as a diagnosis for James to base his work on, and is insufficient communication of a diagnosis to Brian. Further, by claiming that he can fix the problem, James is making an undertaking that he may not be able to fulfil. Even cases which appear to be clear-cut cannot be predicted with certainty. If James is unable to fulfil his undertaking this may be grounds for a breach of contract. Instead he should have said something like: ‘This is the kind of problem we usually have excellent results for and, although we cannot be certain, I am expecting a good result in your case’.

A major problem is that James did not gain informed consent. James should have outlined the diagnosis, outlined the treatment options, including his treatment, outlined the risks and benefits of treatment, and asked Brian if he had any questions on the matter. After Brian’s questions had been answered (and recorded), James should have asked Brian if he was prepared to start treatment.

Prior to rendering treatment, James should have performed some safety screen tests to minimise the possibility of Brian being a poor candidate for the treatment. Although such tests are far from completely reliable, in concert with other information they form an essential component in fulfilling the duty of care to practise in a safe manner.

Brian’s reactions after treatment are not unusual. The removal of arm symptoms arising from the neck, as occurs in radiculopathy, for instance, can take several weeks. The timeframe of management and the number of treatments likely to be required should have been discussed before starting the treatment program.

The poor communication in this case is typical of the type of cases which become the subject of complaints hearings. Practitioners, and perhaps older practitioners in particular, are reluctant to enter into such discussions with patients. They do not wish to convey any messages of uncertainty or to reinforce any concerns about dangers or adverse reactions to treatment. Today, patients are little concerned with such disclosures and, indeed, are coming to expect a more forthright and honest approach from their doctors.

References


