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Submission to Senate Community Affairs Committee

Inquiry into the National Registration and Accreditation Scheme for Doctors and other Health Workers

Dr Geoffrey Harding,
President, AAMM.
1st Floor, 67 Brighton Rd,
Sandgate, Qld, 4017.
Phone: 07 3269 5522 Fax 07 3869 6407
Email drgeoffw@bigpond.net.au

Who we are: AAMM, ACPM, AFMM.

The Australian Association of Musculoskeletal Medicine (AAMM), the Australian College of Physical Medicine (ACPM) and the Australasian Faculty of Musculoskeletal Medicine (AFMM) are making this submission to the Inquiry primarily in response to the submission tendered by the CAA (Chiropractors Association of Australia). The issue is that concerning the practice of spinal manipulation.

We thank the Committee for the opportunity to present this response at this time. The three organizations represent a varied population of medical practitioners in the following ways:

The AAMM is a non-profit organisation that was formed by a group of medical practitioners in 1971 with the aim of promoting the education of doctors in the area of spinal pain disorders. It has as Members, medical practitioners (both GPs and Specialists) who have an interest in the treatment of painful musculoskeletal conditions. Some of these members practice full-time in the area of musculoskeletal medicine but most practice as GPs but have an interest in musculosketal medicine. The membership is currently 220. (There are Associate Members as well – some of these are Physiotherapists and some are even Chiropractors). The AAMM has as one of its main aims the teaching to GPs of skills in the assessment and treatment of painful musculoskeletal conditions in the Australian community. It pursues this goal using the best-available evidence from the world literature as its guide. This organization was instrumental in the setting-up of the first Australian Post-Graduate Diploma in Musculoskeletal Medicine at Flinders University in 1991. The AAMM is a member organization of the International Federation of Manual Medicine (FIMM).

The ACPM is a separate organization which has as its Fellows, GPs who have completed a Post-Graduate Diploma in Physical Medicine (Sydney University) and a prescribed curriculum of post-graduate courses. Again some of these practice full-time in musculoskeletal medicine whist others continue to practice as GPs with an interest in musculoskeletal medicine. This organization was initially formed to provide a forum for GPs who wanted to increase their skills and to standardize their treatment methods.

The Australasian Faculty of Musculoskeletal Medicine was constituted in 1993, and formally incorporated in 1995, as a result of negotiations between the Australian Association of Musculoskeletal Medicine and the New Zealand Association of Musculoskeletal Medicine. The inception of formal postgraduate courses in musculoskeletal pain medicine in three Australasian universities (Otago, Flinders and Newcastle) and one in Physical Medicine (Sydney) led the two national associations to believe that a separate and independent body was required to develop and promulgate standards of practice in the discipline based on a responsible, academic analysis of the scientific literature. Its membership is open to either specialist medical practitioners (Anaesthetists, Rheumatologists, Radiologists, Occupational Physicians etc) or to those GPs who have completed a recognized post-graduate Diploma in Musculoskeletal Medicine from an approved University. To become a Fellow of the Faculty, one has had to sit a comprehensive Fellowship Exam which has a standard equivalent to that undertaken by candidates of most of the Specialist Medical Colleges.

There are many members of the above organizations who are also members of the AMA (Australian Medical Association) and/or the RACGP (Royal Australian College of General

Practitioners) or the RDAA (Rural Doctors Association of Australia) or their specialist colleges. Consequently, the initial submissions by those organizations would have generally been agreeable to most of us, however, the submission by the CAA needs some response from those medical practitioners who have expertise in the area of musculoskeletal medicine.

SPINAL MANIPULATION BACKGROUND

It should be pointed out that spinal manipulation is one of the myriad of non-validated treatment methods that are applied to the management of so-called musculoskeletal pain. Whilst many practitioners attest to its usefulness in the treatment of certain types of spinal and musculoskeletal pain, there is little high-quality scientific evidence that it is in and of itself an effective treatment tool. There is evidence that a combined, multifaceted management approach does improve the treatment of acute and chronic musculoskeletal pain. The types of therapies used by musculoskeletal medical practitioners in the National Musculoskeletal Initiative included manipulation, mobilisation, muscle energy therapy, dry needling soft tissues, injections into tender points (trigger points), injections into joints (spinal and peripheral), use of diagnostic blocks and radiofrequency neurotomy, pharmacotherapy, exercise therapy, explanation as to the cause of pain, reassurance with respect to the generally positive outcome of acute pain conditions, and counselling in the encouragement of normal activity.

To focus on spinal manipulation as a special, even integral tool in the treatment of musculoskeletal pain is to anoint it with a status which is not supported by the evidence. It should be used as a tool – not a paradigm in itself.

It is instructive that the Australasian and international medical organisations who manage these problems world wide changed their names from "manipulative" .., to … "manual" …because it was perceived that manipulation was unproven and that cervical manipulation in any hands, including chiropractors, can cause mortality and morbidity.

Briefly, the three organizations would like the Committee to be aware of the following points, (though we are happy to present more information or answer any questions the Committee might have as a result of our submission).

Main Points

1. In its submission, the CAA has argued that

the proposed legislation has seriously compromised patient safety and quality of care and as a result will permit unnecessarily increased risks to Australians.

These organizations would agree with this statement in that the complete removal of restrictions on manipulation of the spine (apart from the cervical spine) – to allow anyone to perform manipulation, puts the Australian public at unnecessary risk. We would urge that the same restrictions apply to the whole spine as is proposed to the restrictions placed on manipulation of the cervical spine.

2. However, the CAA submission states further that

The CAA is of the view that spinal manipulation should be a restricted practice and that any person performing the manipulation of any part of the spine must be either a registered chiropractor or osteopath or a registered health practitioner who can <u>demonstrate equivalency of competence by appropriate, accredited, prescribed and clearly identified postgraduate training.</u> The CAA asserts that citizens face significant risks which could result in serious injury to them if they were in the hands of unskilled, unregulated persons performing spinal manipulation.

We believe this proposal is totally unwarranted and self-serving. Their proposed changes will not adversely affect the safety of the Australian public. Such changes (if adopted) will lead to considerable economic hardship for patients. It would reassign the problem of musculoskeltal pain problems to a chiropractic paradigm which is largely mechanically based and is narrowly focused on spinal manipulation as the prime tool to treat pain in the musculoskeletal system. This is totally out of step with the scientific literature. Further, medical practitioners are not "unskilled", and they are not "unregulated".

3. The CAA is arguing for "*equivalency of competence by appropriate, accredited, prescribed and clearly identified postgraduate training*"
Demanding equivalence of competency to a chiropractic model is totally unwarranted since we would argue that model is flawed and unscientific.

4. As pointed out above, the CAA is calling for even more restrictions, notably that
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.
This proposal would mean that no medical practitioner (unless those who had completed a post-graduate diploma in (presumably) chiropractic manipulation techniques) would be able to
- reduce a dislocated finger joint
- reduce a dislocated shoulder joint
- reduce a disclocated elbow joint ("pulled elbow" is a relatively common mishap affecting young children and is treated most often by the GP).

5. Discussion on the public hearings regarding an article in the MJA needs to be addressed.
A Senator has stated that he read that the article claimed that "GPs who specialised in back problems had worse outcomes than GPs who did not claim to specialise in back problems". The article does not make any finding on outcomes – just on adherence to guidelines.
The author of the article made reference to a study she undertook in which "we have recently observed that a self-reported special interest in back pain among Australian general practitioners is strongly associated with back pain management beliefs and practices that are contrary to the best available evidence".25
The article referred to contains a number of major flaws and cannot be relied on:
- the doctors surveyed simply said they had an interest in back pain. They were not specializing in back pain. The questions in the survey were poorly framed and ambiguous – the more you know about a subject, the less black and white are the answers. Although the original article found that doctors who had expertise in musculoskeletal medicine or occupational medicine did follow the guidelines, this was not contained in the headline (and so misrepresents the truth).

6. Discussion between the Senator and the CAA representative regarding a paper analyzing the examination skills and knowledge of medical graduates
"I have a paper here from the journal Australasian Musculoskeletal Medicine from 2002 from the School of Medicine of Flinders University, Adelaide. I will read a couple of paragraphs. They read: Deficiencies in musculoskeletal competence among general

medical practitioners is commonly acknowledged. The degree of this deficiency is thought to be widespread. … … …
Musculoskeletal knowledge among recent medical graduates has again been found wanting. The need for further musculoskeletal education has been established."
The Journal referred to is the AAMM Journal. It is our role to investigate and promote the better education of all medical graduates. The deficiencies referred to are relative – we would like better training in the undergraduate years – but that does not mean that doctors have no skills in this area – we would like them to have more. Cardiologists would like GPs to be better at Cardiology, Psychiatrists would like GPs to be better at psychiatry, etc. A recent report in the Internal Medicine Journal by Hilmer and colleagues Do medical courses adequately prepare interns for safe and effective prescribing in New South Wales public hospitals? Volume 39 Issue 7, Pages 428 – 434 suggests that interns have deficiencies here. That does not mean they have no skills – in a perfect world they need better skills. The article states that "Most interns recognized these deficits and would have liked more clinical pharmacology training at medical school". Medical Schools would argue that they can't teach all of the required material to everyone's satisfaction, however the system works – but not perfectly. This is a problem in all medical schools worldwide (and one would suggest all chiropractic schools, and schools teaching political science).

7. To date there has not been one scientific study comparing chiropractic manipulation with manipulation by other professionals. To date the evidence for manipulation in general is mixed and it is becoming increasingly apparent that there is an overreliance on manipulation by allied health professionals – and in particular chiropractors. To have the legislation controlled by chiropractors views may be quite dangerous. A multidisciplinary approach incorporating active exercises is more appropriate. Doctors with post graduate training in this area have a proven track record of superior outcomes as demonstrated by the National Musculoskeletal Initiative. (ref 1)

Additionally, musculoskeletal medicine practitioners have been shown to reduce waiting lists substantially in public hospital orthopaedic and rheumatology outpatient departments. At Newcastle Hospital in NSW a musculoskeletal physician dramatically reduced the waiting list times to see orthopaedic surgeons.(ref 2)

SUMMARY:
Over the past 20 years there has been encouraging signs of cooperation between individual chiropractors and medical practitioners with many attending the Annual Scientific Conferences of the AAMM. Medical practitioner organizations have not been calling for restrictions on Chiropractic practice. This perplexing push to restrict practice as part of its submission to this Inquiry places us in a position where we must call on the Inquiry to ignore it as it will not materially affect the safety of the public but will cause it significant hardship and expense.

We thank the Committee for its indulgence in allowing this submission for consideration and would be happy to provide further background material and answer any questions arising from this or any other submission.

Dr Geoff Harding.

(ref 1) McGuirk B, King W, Govind J, Lowry J, Bogduk N. The safety, efficacy, and cost-effectiveness of evidence-based guidelines for the management of acute low back pain in primary care. Spine 2001; 26:2615-2622.
(ref 2) McGuirk B, Ghabrial YAE, Bogduk N. Evidence-Based Guidelines Improve Performance Measures in Orthopaedic Outpatients for Low Back Pain. Presentation Australian Spine Society 2007