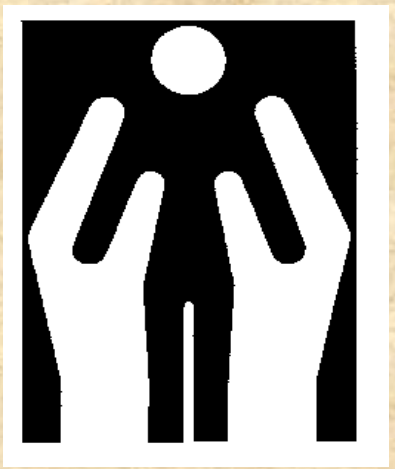
FORMAL SUBMISSION

Chiropractors' Association of Australia (WA) Limited



Review of Medical Act 1894

Health Department of Western Australia

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ACKNOWLEDGEMENTS

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Chiropractors' Association of Australia (WA) Limited

PLEASE NOTE THAT THE FOLLOWING PAGES ARE FROM THE IATROGENESIS COMPONENT OF THIS SUBMISSION.

IATROGENESIS

3.1 THE EXTENT OF THE PROBLEM

It is only very recently that the medical profession has publicly admitted that it has a major problem regarding the control of medical error. As the March 18, 2000 Editorials in the British Medical Journal (BMJ) states, **"***We have a serious problem, and it cries for timely effective solutions ……Effective solutions, however, are proving to be a daunting challenge"***.** [i]

Another Editorials article in the BMJ points out, *"Health care's track record of failure to act on over three decades of accumulating evidence of medical errors offers plenty of ammunition to those who claim that we need to be forced to do what is, at bottom, right"* [ii] *and "They (the public) are asking us to promise something reasonable, but more than we have ever promised before: that they will not be harmed by the care that is supposed to help them".* [iii]

Mackay expands on the problem, *'Death from drug-induced illness is not unusual. Such deaths are rarely reported as being caused by drugs. Harm caused by this mass-prescribed medication is greatly under estimated by those who prescribe it. Because such harm may be completely unrecognised, and when recognised, is usually unreported, measurement of its extent is difficult.'* As he wryly comments, *'Quality assurance, peer review, best practice, drug audits – all lovely words – but doctors responsible for this pharmacological mayhem do not have time to take part in these activities. They are too busy writing prescriptions'***.** [iv]

Runciman et al identify a major area of concern, *'Problems that arise from health-care management, rather than from a disease process, are now recognised as making a substantial contribution to patient morbidity and mortality and to the cost of health care'.* [v]

Rigby et al echo the same sentiments, *'Adverse events arising from health – care management, rather than a disease process, may place a burden on society as great as all other forms of injury put together'* [vi]

Jerry Sikorski agrees, *'The misuse and overuse of powerful remedies is now universal, and a daily occurrence in the lives of most doctors'* [vii]

He is supported by Lucian L Leape, *'Errors in drug use are common, costly and often result in injury'* [viii]

Beatrice Faust points out, [ix] *'Medicine has the aura of being scientific because the discoveries of science are available for doctors to apply but they rarely apply the principles of scepticism and tentativeness that distinguish scientific from technological thinking.***'**

Eddy and Smith[x] make the alarming statement that, *"Only about 15% of all medical interventions are supported by scientific evidence. This is partly because only 1% of the articles written in medical journals are scientifically sound and partly because many treatments have never been assessed at all".*

In similar vein Dr. Vernon Coleman asks in his book, How to Stop Your Doctor Killing You, *"How can doctors possibly regard themselves as*

practicing science when six out of seven treatment regimes are unsupported by scientific evidence and when 99% of the articles upon which clinical decisions are based are scientifically unsound?" [xi]

These two statements make quite clear that 85% of current medical treatments lack a sound scientific foundation for their use and would be disqualified from Medicare rebates if this were the criterion for acceptance.

Cullen et al further highlight the complexities of the problem, *"Of course one of the major problems is that we currently under-report error and near misses by a factor of 10!"*[xii] *"If they were reported accurately and the climate was appropriate for correction of the many causes of error, our patients would be injured less often and health-care costs would go down considerably".* [xiii] [xiv] Classen et al and Bates et al claim in JAMA (1997).

It is strange that while other leading causes of morbidity and mortality, such as the road toll, are collated and published, there is not one medical organisation that officially collates and publishes the total number of deaths and injuries arising from medical error.

One person who claims to have collated these statistics is John Archer. He estimates these figures would be approximately 50,000 (deaths) and 750,000 (injuries) in Australia on an annual basis. [xv]

Last year Dr David Lawrence, chief executive of Kaiser Permante, said in a speech to the National Press Club, **"***Medical accidents and mistakes kill 400,000 people a year in the USA, ranking behind only heart disease and cancer as the leading causes of death"*. He starkly points out that, *"Mistakes alone kill more people each year than tobacco, alcohol, fire arms or automobiles".* [xvi]

Edgar Suter, the author of "What Doctors Don't Tell You" comments, when comparing the rates of iatrogenesis to the misuse of firearms, *"If you live in the USA where about 40,000 people are shot dead each year, you are never-the-less three times more likely to be killed by a doctor than by a gun"***.** [xvii]

John Archer also makes a comparison – with the Australian road toll. *'It seems that each year physician-induced injury and death contributes to an epidemic of death and injury that makes Australia's road toll pale into insignificance.***"** [xviii]

Australian writer Darren Gray reveals, *"More than 80,000 people are taken to hospital each year because of adverse drug re-actions, many of them avoidable."* [xix]

An Australian study by Dr. Ross Wilson, Director of Quality Assurance at Sydney's Royal North Shore Hospital, seems to confirm John Archer's evaluation. He found that 18,000 hospitalised Australians die each year as a result of medical mistakes and up to 50,000 are left permanently disabled by hospital bungles which cost the country $1 billion annually**.** [xx]

These figures of course say nothing about the huge number of unhospitalised patients who suffer from medical mistakes, of greater or less severity, including death and permanent disability. The total cost of medical error, including the two major contributors, surgery and adverse drug reactions,

must be enormous. As the full extent of medical error has not been determined costs can only be approximations. Pharmaceutical companies spend more than $1 million a day on sales and marketing of their products to Australian medical practitioners. This includes inducements to prescribe their particular products.[xxi] With $4 billion being spent on drugs (in 1997)) which was 11% of the total health budget[xxii] any improvement in error management, including virtually unrestricted prescribing rights, must be the major goal of government agencies involved in controlling health expenditure. The enormity of the price Australians pay for having only the medical approach to health available "free" (under Medicare) is only now beginning to be revealed.

3.2 COMMENT

In the face of such facts being quoted from within the medical profession it is not at all surprising that the rate of iatrogenesis in Australia has reached epidemic proportions.

These admissions, from leading members of the medical profession, are almost mind-bending in their implications. The medical profession can no longer claim to be the protector of public health. It can claim, with justification, to be one of the prime causes of unnecessary death and disability in Australia. It can no longer justify its attempts to retard the development of other health professions on the pretext of safeguarding public health. It is past time for it to concentrate its energies on rectifying its own tragic mistakes. It appears that the stature and influence of the medical profession are the reasons why this tragic situation has not been widely disseminated by the news media.

Unless the new Medical Act specifically addresses this issue it will be swept under the carpet and treated as if it didn't exist. Action, even if unpleasant and unpopular, must be taken to correct the horrifying problem of medical iatrogenesis.

3.3 MEDICAL ERROR IN WESTERN AUSTRALIA

It is unfortunate that in Recommendation 1 – Objectives of the Medical Act, there appears to be little recognition of the widespread medical error that must exist in Western Australia.

The recommended principal stated objective diverts attention from the appalling existing iatrogenic situation and directs attention to those, "who do not possess the necessary qualifications, skill, or experience to practise medicine safely or competently." Who are these unidentified persons who would utilise medical services to produce harmful consequences?

One group that the recommended principal objective apparently does not consider utilises medical services to produce harmful consequences, is the vast majority of registered medical practitioners. But in fact does this group possess the necessary qualifications, skill or experience to practise medicine safely and competently?

A perusal of the aforementioned facts, derived from medical sources, indicates that this group would be fortunate to have the necessary qualifications, skill or experience to practise medicine safely and competently. In the absence of statistics to demonstrate that Western Australian medical practitioners are superior to their medical brethren in other states, it must be presumed that they contribute their share to the 18,000 deaths and 50,000 permanently disabled in Australian hospitals as a result of medical error each year. Using the 1995 figures from QAHCS as an indicator – although these figures are more than five years old and are probably conservative - almost 30,000 hospitalised Western Australians suffer adverse events each year. Of these approximately 1000 die and 4000 are permanently disabled. These figures say nothing about the enormous additional suffering and costs involved in those who re-act adversely to medical intervention but are not hospitalised. In the whole of Australia, according to Archer's estimation, approximately 50,000 die and even more are left permanently disabled. Others recover many only to the extent that they can't be classified as permanently disabled.

The recommended principal objective therefore needs to be amended as suggested in the consideration of Recommendation 1 on Page 1 of this brief. This would then focus the attention of the new Medical Act on the deficiencies in qualifications, skill or experience of medical registrants in Western Australia and their difficulties in attempting to practise medicine safely and competently.

There are no statistics to suggest that alternative health professionals, some of whom exist in limbo as a result of medical determination to prevent them gaining registration and the legal stature that would afford them, pose any danger to the health of Western Australians. As the New Zealand Report comments, *'We have no doubt that every effort was made to locate verifiable cases of harm caused by chiropractors'*. (p78) This general comment would apply with equal force to all non-medical groups in Australia whose recognition is opposed by the medical profession. Their methods of practice are such that they are unlikely to create harmful consequences. Registration of these well-patronised independent health professions would allow them and their patients, to enjoy the same advantages available to other registered health professions in Western Australia. They would then be able to compete on more equal terms with other registered health professions. Their apparent safety makes them particularly attractive to those who have suffered adverse medical reactions. At the present time, because the practice of medicine is all-encompassing, these well-defined health professionals are never-the-less proffering medical services and could be considered to be holding themselves out as doctors and are therefore liable to be prosecuted at the decision of the Medical Board. [xxiii] This is an unfair and unreasonable situation created by medical opposition to the registration of all non-medical health disciplines. It also provides a clear example of how the medical profession influences the control of health services in Western Australia.

3.4 AN ADDITIONAL OBJECTIVE

A very important additional objective that needs to be included in Recommendation One is that the Medical Act will provide for the establishment and accurate maintenance of an Iatrogenic Register. The

Medical Board and the Department of Health confirm that there is no such record in WA.

The absence of such a record suggests that the problem of iatrogenesis has been largely ignored as Leape commented[xxiv] Its establishment and accurate maintenance would go a long way to improve the performance of those medical practitioners who prescribe pharmaceutical products routinely. Such a register would have at least a four-fold benefit:

First, it would keep the public informed of the performance of the medical profession each year (and perhaps entice some of their departed patronage to return to the medical fold).

Second, it would provide the Medical Registration Board with accurate information as to whose licenses should be made conditional.

Third, it would indicate those medical practitioners who require more concentrated continuing education.

Fourth, it would provide insurers with information so malpractice insurance premiums could be adjusted to reward those whose names appear on the Register most infrequently.

3.5 PROBLEMS IN THE USE OF PHARMACEUTICAL MEDICINE

Few of the discussions in medical literature appear to recognise or admit that the sombre spectre of medical error is unlikely to be reduced to anything approaching zero proportions. Wilson makes the alarming prediction that medical error is unlikely to be reduced to half its present level. The discussions in medical literature on medical error centre on avoidable medical error and steps that can be taken to lessen the effects of this hazard.

i O'Leary DS (2000)'Accreditation's role in reducing medical errors' BMJ; 320: 727-728

ii Leape LL, Berwick DM (2000) 'Safe health care: are we up to it?' BMJ;320: 725-726

iii Leape LL, Berwick DM (2000) ibid

iv Mackay M. (1998) 'Prescribed drugs: a major cause of ill-health'. Australian Health Review; 21;(4):263

v Runciman, WB, Helps, SC, Sexton, EJ, Malpass A (1998) 'Classification for incidents and accidents in the health care system' J Qual Clin Prac; 3:199-211

vi Rigby K, Clark RB, Runciman WB (1998)'Adverse events in health care: Setting priorities based on economic evaluation' J Qual. Clin. Prac; 1:7-12

vii Sikorski J (1993) 'Medicine Adrift', Pelican Press, Gold Coast, Australia p 18

viii Leape LL et al (1995) 'Systems Analysis of Adverse Drug Events'. JAMA; 274:1 p35

ix Faust B (1993)'Benzo Junkie', Viking, Ringwood, Victoria p 99

x Eddy D, Smith R, (1991) 'Where is the wisdom?'. BMJ; 303:798-9

xi Coleman V, (1996) 'How To Stop Your Doctor Killing You' Barnes Staple England, page 42

xii Cullen D J, Bates D W, Small S D, Cooper JB, Nemeskal A T, Leape L L, (1995) 'The incident reporting system does not detect adverse drug events: a problem for quality improvement'. Jl Comm. J. Qual.Improve; 21:541-548.

xiii Classen DC, Pestotnik SL, Evans RS, Lloyd JF, Burke JP (1997) 'Adverse drug events in hospitalized patients: Excess length of stay, extra costs, and attributable mortality' JAMA; 277:301-306

xiv Bates DW, Spell N, Cullen DJ, Burdick E, Laird N. Petersen LA (1997) JAMA; 277:307-311

xv Archer J (1995) 'Bad Medicine', Simon and Shuster East Roseville Australia p184

xvi Rosenblatt RA (1999) HMO chief: "Patients are at risk" Los Angeles Times July 15

xvii Suter EA (1993) What doctors don't tell you Lancet;342:9-12.

xviii Archer J (1995) ibid p184

xix Gray D (1999) 'Prescriptions put 80,000 in hospital – study', The Age Melbourne March 1

xx Wilson R McL et al (1995) ibid

xxi Riggett E (1999) 'GPs a target for soft sell'. Herald Sun Melbourne July 26.

xxii Hynes T, Goss J (1997) 'Health expenditure' Bulletin No 13. Australian Institute of Health & Welfare, Canberra p14

xxiii Bradbury v Jayawardana (1993) Supreme Court of W.A. Rowlands J SJA 1205 of 1992, April 27

xxiv Leape LL (1995) ibid