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SUBMISSION RELATING TO

CONSULTATION PAPER ON DRAFT CODE OF CONDUCT

AND COMMENTS IN CAA's PREVIOUS SUBMISSION RELATING TO GUIDELINES DOCUMENTS

TO

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CHAIR
CHIROPRACTIC BOARD OF AUSTRALIA

FROM

CHIROPRACTORS' ASSOCIATION OF AUSTRALIA

29 May 2010

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The CAAN Board is grateful for the opportunity to provide further feedback about the proposed codes and guidelines of the Chiropractic Board of Australia.

We are heartened to see the removal of some of the more inappropriate or irrelevant sections of the initial draft code of practice. However, we see several areas of the current draft of the code of conduct that still require revision.

We hope that the CBA will consider CAAN's feedback provided from across the profession in our ongoing and substantive reviews of these standards.

Whilst CAAN appreciates the opportunity to provide input on this submission to the CBA to assist in the development of codes and guidelines for the chiropractic profession in Australia, we are concerned about the haste with which these documents are being constructed, considering their importance to the chiropractic profession and to the people of Australia. CAA National would greatly appreciate clarification of the evolving nature of this document and the CBA's intention with respect to its review process once the pressing timeframes of national registration have passed.

This submission is presented in two parts:

(1) A response to the document "Revised Consultation Draft Code of Conduct" published on the CBA website on 7 May 2010.

(2) A comment on proposed guidelines in the document "Consultation paper on codes and guidelines", published on the CBA website on 10 March 2010.

Code of Conduct for Chiropractors

CAAN notes the strong influence of the Australian Medical Council Code of Conduct on these guidelines.

Overview:

In the first paragraph, second line: "… within an ethical framework" is pejorative and unnecessary. It suggests that chiropractors do not already work "within an ethical framework". The same phrase could be removed from the first paragraph of section 1.1.

CAAN recommends the removal of the phrase "… within an ethical framework" from the Overview and from section 1.1.

CAAN further recommends the following, paraphrased from the AMC Code of Conduct:

"The practice of chiropractic is challenging and rewarding. No code or guidelines can ever encompass every situation or replace the insight and professional judgment of skilled chiropractors. Good chiropractic practice means using this judgment to try to practise in a way that would meet the standards expected of chiropractors by their peers and the community."

Definitions:

CAAN recommends the following alterations:

"Providing care": change "… whether remunerated or pro bono" to "… whether remunerated or not." This is more consistent with common Australian usage, as well as being more consistent with the definition of "practice" below.

"Practice": "… using professional knowledge in a direct nonclinical (sic) relationship with patients". CAAN does not understand how the use of professional knowledge in a direct relationship with patients could occur in a non-clinical way? This section requires clarification or removal.

A suggested alternate definition is:

"…any role, whether remunerated or not, in which the individual uses their skills and knowledge as a chiropractor in their regulated health profession. For the purposes of this Code, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the chiropractic profession."

1. INTRODUCTION

1.1 Use of the Code

Please see the comments above regarding the use of the phrase "… within an ethical framework".

CAAN recommends the removal of the phrase "… within an ethical framework" from the first paragraph of section 1.1.

1.2 Professional values and qualities

Minimum standard of training for practice of spinal manipulation

This section contains no reference to a minimal standard of training for the practice of spinal manipulation.

CAAN notes the restriction on cervical spinal manipulation as defined under s. 123 of the Act, which limits the performance of cervical spinal manipulation to registered members or students of the chiropractic, osteopathic, physiotherapy or medical professions.

Considering the fact that medical practitioners and physiotherapists receive little or no undergraduate training in the performance of spinal manipulative techniques, let alone in the delivery of a specific chiropractic adjustment, CAAN believes that this may constitute a significant health risk.

CAAN suggests that a higher educational standard should be set. As it stands, a medical practitioner with no training in spinal manipulation can perform that specialised procedure.

CAAN feels confident that the Medical Board of Australia would feel some concern about chiropractors performing any medical procedure with an equivalent lack of training in that procedure.

CAAN asks the CBA to consider the fact that the AMA President has written to the CBA claiming that chiropractors should be required to complete more continuing professional development because of the "high risk" of "spinal manipulation. CAAN is of the firm opinion that adjustment of the spine by qualified chiropractors with 5 years of relevant university-based training is extremely safe. We do not have the same level of confidence about spinal manipulation performed by AMA members with far less training.

CAAN recommends that practitioners who use spinal manipulative procedures should be students of, or registered practitioners with, undergraduate qualifications approved by CCEA, physiotherapists with post-graduate qualifications or medical practitioners with post-graduate qualifications of an equivalent standard to the CCEA-approved chiropractic university degrees available in Australasia.

Scope of practice

CAAN notes the newly added warning to chiropractors "… to consider whether they have the appropriate qualifications and experience to provide advice on over the counter scheduled medicines, herbal remedies, vitamin supplements (sic)."

Section 3.3.2 of the AMC Code of Conduct for medical practitioners states that good communication involves asking about forms of treatment patient is receiving or has tried, including CAM. The AMC document does not query the medical practitioner's capacity to pass comment on chiropractic or CAM approaches. CAAN objects to chiropractors being asked to meet a more stringent standard than their medical colleagues. With recent government press releases underlining the integral role of the allied health professions as an essential pillar in the health care system, CAAN suggests that the CBA and the AHPRA might want to affirm the professionalism and capacity of chiropractors.

CAAN recommends the removal of the first paragraph on page 3 of the draft code of conduct.

2. PROVIDING GOOD CARE

2.1 Introduction

This section is primarily drawn from section 2.1 of the AMC Code of Conduct. Additions to the AMC Code are:

2.1 b): CAAN believes that in light of 2.1 a) and c), 2.1 b) is unnecessary. Assessment and examination (a), coupled with formulating and implementing a management plan (c), clearly imply the need for a clinical assessment/analysis/diagnosis. 2.1 b) is therefore superfluous.

2.1 e): Considering the presence of 2.2 a), 2.1 e) is unnecessary.

CAAN recommends the removal of section 2.1 b) and e).

Alternatively, revert to wording of AMC document for 2.1 e):

"2.1.4 Referring a patient to another practitioner when this is in the patient's best interests."

2.2 Good care

This section is primarily drawn from section 2.2 of the AMC Code of Conduct.

2.2 a) comes from the AMC Code section 2.2.1, but with added wording.

CAAN recommends restoring the original wording of 2.2.1 to the CBA document:

2.2.1 Recognising and working within the limits of your competence and scope of practice.

2.2 c) does not have a correlate in the AMC document. It adds nothing to 2.2 b) and should therefore be removed. Should the CBA choose to retain 2.2 c), CAAN recommends that limits

of competence and scope of practice be defined objectively as a part of the development of these guidelines.

CAAN suggests the removal of clause 2.2 c).

Section 2.2 i) is also a new addition to the points in the AMC document. It adds nothing to points previously raised elsewhere in this draft code of conduct relating to safety and quality.

CAAN suggests the removal of clause 2.2 i).

Whilst it is usually appropriate for medical practitioners to focus primarily on the "alleviation of symptoms", such an expectation is inappropriate for chiropractors, whose focus includes the restoration of health and function. This is congruent with the Australian Federal Government's stated focus on health literacy and disease prevention.

It suggests that the treatment of symptoms should be an over-riding focus for chiropractors. CAAN is concerned that this does not reflect the philosophy or practice of chiropractic, nor the best interests of patients.

CAAN believes that 2.2 j) does not belong in a chiropractic code or guideline.

CAAN believes that there are times when the "alleviation of symptoms" alone may not be in the long-term best interests of a client. For instance, it may be necessary to work on painful areas of the body to help in the rehabilitation and repair of injured tissues, or for patients to experience pain that reminds them to take extra care of an injured area.

Further, there are over-the-counter medications available that will usually reduce symptoms faster than many things a chiropractor can do. CAAN would not like to see the CBA suggesting to chiropractors that they should be recommending OTC medications as part of an attempt to "alleviate symptoms".

The practice of chiropractic is not always primarily associated with the "alleviation of symptoms".

The World Federation of Chiropractic defines chiropractic as "...a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the function of the nervous system and general health."

Further, the WFC's Identity Statement states that the foundation ("the ground") of chiropractic is an "... ability to improve function in the neuromusculoskeletal system and overall health, wellbeing and quality of life" and "... without use of drugs and surgery, enabling patients to avoid these where possible."

The International Chiropractors Association defines chiropractic as "...a non-therapeutic, drugless and surgical-free health science, based on its fundamental principles and philosophy."

According to the CAA definition of chiropractic:

"The practice of chiropractic focuses on the relationship between structure (primarily the spine, and pelvis) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health."

The purpose of chiropractic defined by the Association of Chiropractic Colleges is "… to optimize health."

All of these definitions are based on function, not symptoms.

Conversely, the Collins English dictionary defines medicine as "… the science of preventing, diagnosing, alleviating, or curing disease." Section 2.2 j) is appropriate for a profession based on philosophical constructs of the treatment of disease, but not appropriate for the chiropractic profession, which encompasses a proactive approach to patient care independent of the treatment of symptoms along a continuum of care from palliative through to preventive approaches to the prediction and proactive intervention to assist patients in the creation of optimal health outcomes.

CAAN recommends removal of clause 2.2 j).

Section 2.2 o.) also has no correlate in the AMC document. It requires chiropractors to practise "…in accordance with the current and accepted evidence base of the chiropractic profession, including clinical outcomes." This recommendation goes against the recommendations of Sackett et al that evidence-based practice should include consideration of patient values and doctor experience.

Considering the lack definition of the phrase "… including clinical outcomes" and the lack of peer-reviewed evidence to suggest that working in an evidence-based (rather than evidence-informed) model has any superiority in terms of clinical outcomes, CAAN believes that section 2.2 o) should be deleted.

For further reading, see "Deconstructing the evidence-based discourse in health sciences: truth, power and fascism" Holmes et al, Int J Evid Based Healthc 2006; 4: 180–186; Sackett D. Evidence based medicine: what it is and what it isn't. BMJ 1996;312:71-72.

2.5 Shared decision making

This section also comes from the AMC document.

Throughout these guidelines, CBA uses the terms "treat", "treating" and "treatment". Again in this section, the term "treating chiropractor" is used.

The concept of "treatment" suggests condition- or symptom-based management. This is not reflective of chiropractic practice. An understanding of medicine and of chiropractic indicates that such activity is the basic act of medicine, not of chiropractic.

CAAN would prefer to see the CBA use the term "care", as in "chiropractic care/intervention" vs "chiropractic treatment" throughout the guidelines documents.

CAAN recommends the deletion of the word "treating" from section 2.5 and the re-evaluation of the word "treatment" and its variants from throughout all chiropractic guidelines documents.

2.6 Decisions about access to care

This section comes primarily from section 2.4 of the AMC document. Section 2.6 d) has no correlate in the AMC document. It is unnecessary and pejorative.

Considering the presence of 2.6 f), 2.6 g) appears redundant and should be removed.

CAAN suggests the deletion of section 2.6 d) and g).

2.7 Treatment in emergencies

This section again draws directly from the AMC Code. Emergencies are a frequent occurrence in the standard practice of medical practitioners. To include this section here, however, requires clarification by the CBA as to its relevance in chiropractic practice.

CAAN recommends that this section is removed or re-written with specific detail to more clearly explain the CBA's purpose for including this section in a Code of Conduct for chiropractors.

3. WORKING WITH PATIENTS

3.2 Partnership

Section 3.2 draws from section 3.2 of the AMC document.

Section 3.2 e) correlates to the more clearly written and succinct 3.2.5 of the AMC document. In particular, the CAA is concerned about allowing "... the stated needs of patients" dictate the information and advice that a chiropractor might share with their clients.

Section 3.2 f) is another addition by the CBA to the AMC wording.

With regard to 3.2 e), CAAN recommends reverting to the wording of 3.2.5 of the AMC document:

"Encouraging and supporting patients to be well informed about their health and to use this information wisely when they are making decisions."

In the left column on p.5 of the draft Code of Conduct is a paragraph that begins "A good partnership between a chiropractor ...". This is followed by points a) – d) which outline contributions patients should make to the "therapeutic partnership" (CAAN prefers "clinical interaction").

Whilst these qualities may be valuable, it is inappropriate and pointless to outline them in this document. CBA has no jurisdiction over the activities of patients.

CAAN recommends the deletion of the above-mentioned paragraph and subsequent points a) – d).

3.3 Effective Communication

This section is drawn from the AMC Code, section 3.3.

Section 3.3 d) correlates to 3.3.4 of the AMC Code. CAAN is concerned that chiropractors are being asked to be experts not only in chiropractic, but also in all "available health care options". This is an unreasonable expectation.

CAAN recommends returning to a version of the original, clearer and more succinct wording:

Discussing with patients their condition and the available management options, including their potential benefit and harm.

Section 3.3 f) addresses informed consent, which is covered thoroughly in section 3.5.

CAAN recommends deleting 3.3 f).

Section 3.3 j) has no correlate in the AMC Code. CAAN is concerned that the admonition to provide "… relevant information to other stakeholders including members of the treating team" may be seen to contradict section 3.4.

CAAN recommends the deletion of section 3.3 j).

3.4 Confidentiality and Privacy:

Section 3.4 is based on section 3.4 of the AMC Code of Conduct. Section 3.4 of the CBA Code has ten sub-sections. In contrast, section 3.4 of the AMC Code has three. Those three sub-sections correlate to 3.4 a), d) and e).

CAAN believes that 3.4 e) regarding "genetic information" is irrelevant to the practice of chiropractic.

Any potential issues in chiropractic practice with regard to genetic information and patient confidentiality as it relates to patient records or practice environment are addressed by 3.4 a) and d).

CAAN recommends the removal of section 3.4 b), c), e) – j).

3.5 Informed Consent

Section 3.5 is sourced from the AMC Code of Conduct. Additional points have been added to the AMC Code's section on Informed Consent for the CBA document. Most of these additions are problematic.

NHMRC guidelines on Informed Consent, if quoted, should be tabled as part of this document or the reference removed.

In relation to the CBA Code:

3.5 b) comes from the original Code of Practice, section 1.3. CAAN has already recommended removing section 1.3 as it confuses and complicates the issues of informed consent.

Further, the NHMRC guidelines state that: "The community recognises that patients are entitled to make their own decisions. In order to do so, they must have enough information about their condition, investigation options, treatment options, benefits, possible adverse effects of investigations or treatment, and the likely result if treatment is not undertaken. It is not possible however, to provide complete information or to predict outcomes or assess risks with certainty, and patients need to be aware of this uncertainty." (Emphasis added.)

This is not consistent with the expectations placed on practitioners by 3.5 b).

For greater clarity, CAAN recommends the replacement of 3.5 b) with 3.5.3 from the AMC Code of Conduct:

"Ensuring that your patients are informed about your fees and charges."

3.5 d) is pejorative and unnecessary.

CAAN recommends the removal of section 3.5 d).

3.6 Informed Financial Consent

The pertinent issues in this section are covered in:
- the guidelines for advertising, sub-section 4 i) and section 6.5
- the Code of Conduct, sections 1.2, 2.1: particularly sections c) and f), 2.2: particularly sections d), f), g), h), i), k) and m), 2.6: particularly sections a) and d), 3.2: particularly sections e), f) and g), 3.3, particularly section c), section 3.5, section 6.2, section 9.11:particularly sub-section b) and section 9.12.

CAAN is unaware of ANY peer-reviewed evidence to suggest that care plans and financial arrangements between practitioners and their clients should not exceed 3 months. Particularly in chronic cases, care plans could often be laid out for some months ahead using an understanding of the time frames involved in rehabilitation of chronic injuries.

Without a compelling, evidence-informed reason to limit the time frames for financial arrangements as suggested in section 3.6 g), CAAN is concerned that CBA may limit access to , as long as those arrangements are conducted in line with the above sections of the draft Code of Conduct.

CAAN recommends the removal of section 3.6 from the Code of Conduct.

3.7 Children and Young People

Section 3.7 also draws heavily on the AMC Code of Conduct's section 3.6.

Once more, there have been additions and alterations made to the AMC document for inclusion in the CBA draft document. It is these additions that are problematic.

Section 3.7 b) covers the issue of informed consent, which has been addressed fully in the previous section, 3.5. Also, its obscure wording about "… chiropractic management of certain conditions …" fails to provide clear guidance for practitioners. Not only does it have no correlate within the AMC Code but there is no other registered health profession that has such a clause within its draft guidelines.

As previously stated, chiropractic is NOT necessarily the treatment of conditions.

Section 3.7 c) again addresses informed consent. CAAN believes 3.7 c) is redundant.

Section 3.7 d) contains more detailed and helpful information about informed consent than the corresponding section of the AMC Code. CAAN suggests that it would be more useful if it were included in section 3.5.

Section 3.7 f) has been addressed in the CBA's Appendix 2 "Guideline in relation to radiography/radiology". The initial CAAN submission to the CBA gave extensive recommendations on the radiology/radiography issue after wide-ranging consultation with the senior chiropractic radiologists in Australia. This submission contains further recommendations in response to Appendix 2. CAAN believes 3.7 f) is redundant.

Section 3.7 g) pertains to record keeping. Section 9.4 of the CBA draft Code of Conduct addresses record-keeping in detail. Section 3.7 g) is redundant.

CAAN recommends moving section 3.7 d) to section 3.5 and removing sub-sections 3.7 b), c), f) and g).

3.14 Personal relationships

CAAN notes the incorporation of some of its suggestions with regard to personal relationships in practice.

CAAN recommends further re-wording of this section:

"Good practice recognises that providing care to close friends, work colleagues and family members requires careful attention to potential issues of objectivity, continuity of care and potential risks to the chiropractor or patient.

"Providing care to those in a close relationship as described above is acceptable as long as the chiropractor ensures that:

- adequate records are kept;
- confidentiality is maintained;
- at all times an option to discontinue care is maintained."

3.15 Working with multiple patients

The issues of confidentiality and privacy in section 3.15 are addressed in section 3.4: Confidentiality and Privacy.

CAAN recommends the removal of section 3.15.

3.16 Closing a practice

There is a slight inconsistency between 3.16 a) and b) and some awkwardness of the language of 3.16 b).

CAAN suggests rewording 3.16 b) to state (changes underlined):

"Where possible, facilitating arrangements for the continuing care of all current patients, including the transfer or appropriate management of all patient records while acting in accordance with the legislation governing health records in the jurisdiction."

4. WORKING WITHIN PRACTICE

CAAN notes that there is no correlate for section 4 within the AMC Code.

CAAN recommends the deletion of this section on the basis that it is an unreasonable impost when other professions are not similarly limited.

4.1 Use of Modalities in Chiropractic Practice

This is a National code and any specific Victorian idiosyncrasies should be addressed in an appendix. CAAN understands that this issue will be addressed with the introduction of the Chinese Medicine Board of Australia in July 2011.

The Chiropractors Registration Board of Victoria currently has approximately 42 registrants endorsed for acupuncture.

Considering this small number, CAAN recommends that this could be moved to an appendix that is marked for deletion on 1st July 2011, at which time these practitioners will fall under the jurisdiction of the CMBA.

4.2 Use of diagnostic tools, tests and procedures

Many commonly used chiropractic and orthopaedic tests suffer from a lack of supportive evidence of validity. However, when used in concert with each other, they may still be useful in forming a clinical impression.

CAAN recommends the deletion of this section.

If the CBA considers it necessary to persist with section 4.2, CAAN recommends the following replacement wording:

"The over-reliance by a chiropractor on any one diagnostic tool or process increases the risk of patients receiving a misdiagnosis or inappropriate care.

"Therefore, chiropractors should conduct a full and thorough assessment using the tools most appropriate for the gathering of information necessary to form a clinical impression."

5.3 Teamwork

CAAN notes the similarity to section 4.4 of the AMC Code and suggests that a paraphrase of section 4.5.3 could be included.

CAAN suggests the inclusion of 5.3 c):

"Advocating the benefit of a chiropractor to a patient who does not already have one."

5.4 Coordinating care with other practitioners

Section 5.4 is drawn from section 4.5 of the AMC Code.

The phrase "... ensuring that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient" in section 5.4 b) may be appropriate in a hospital setting where care is being shared between several registered professionals.

However, in a chiropractic setting where patient-centred care is practiced, CAAN suggests that it is almost always patients themselves who have "... ultimate responsibility ..." for coordinating their care.

CAAN suggests the deletion of 5.4 b).

CAAN suggests that 5.3 c) should actually be 5.3 c) and d):

5.3 c) communicating effectively with other team members.
5.3 d) informing patients about the roles of team members.

6 Working within the health care system

6.2 Wise use of health care resources

Section 6.2 a) correlates the AMC Code section 5.2.1. Again, the CBA has added to 5.2.1 with clearly pejorative and demeaning language.

CAAN suggests reverting to the wording of 5.2.1:

"Ensuring that the services you provide are necessary and likely to benefit the patient."

7.3 Chiropractor performance

Section 7.3 f) raises significant risk management questions for the CAA.

CAAN requests URGENT CLARIFICATION from the CBA regarding the CBA's perceptions of CAAN's obligations and liabilities in relation to mandatory reporting. Is a "professional organisation" exempt from mandatory reporting? Or do we need to institute a risk management process whereby only non-chiropractors (not bound by the Act or these guidelines) talk to members who are at risk of breaching guidelines. However, does this raise the issue of company directors who ARE chiropractors being prosecuted for failure to notify because we devolved responsibility in these areas to non-chiropractors?

9. PROFESSIONAL BEHAVIOUR

9.2 Professional boundaries

CAAN agrees that maintenance of clear personal and professional boundaries is an integral part of a good chiropractor-patient relationship.

With an appropriate cooling-off period after ceasing care, or with minimal professional interaction, sexual relationships clients or related people may be reasonable and appropriate.

CAAN recommends an alteration to section 9.2 c): (alteration underlined)

"recognising that sexual relationships with people who have previously been a patient may be inappropriate, depending on the extent of the professional relationship and the vulnerability of a previous client.

9.4 Health records

Section 9.4 a) tells chiropractors that they are required to keep "... up-to-date and legible records that report relevant details of clinical history, clinical findings and determinations, investigations, information given to patients, medication and other management."

It is impractical for a chiropractor to constantly record (up-to-date) details of all information and medication given to a person from any source.

CAAN recommends that section 9.4 a) reads:

"... up-to-date and legible records that report relevant details."

Section 9.4 d) should read "... another chiropractor ...", not "... another practitioner ...". Chiropractic training is required to interpret chiropractic records.

CAAN recommends that 9.4 d) reads:

"Ensuring that records contain sufficient information to allow another chiropractor to continue the management of the patient and to facilitate continuity of care".

9.6 Advertising

Section 9.6 adds nothing to the Advertising guidelines already proposed by the Chiropractic Board.

CAAN recommends the deletion of section 9.6.

9.7 Legal, insurance and other assessments

When a legal, insurance or other assessment uncovers a previously undiscovered, serious problem, it is not enough to tell the patient or the practitioner. Both should be informed.

CAAN suggests an alteration (as underlined) to section 9.7 e)

"… there is a duty of care to inform the patient and their health practitioner."

9.8 Reports, certificates and giving evidence

Section 9.8 comes directly from section 8.8 of the AMC document. Clauses a) and b) are both quite demeaning in tone. Alteration of these sub-sections by removing "… and not misleading …" and "… and not omitting relevant information deliberately" removes the demeaning direction and does not alter the tone or spirit of the clauses.

CAAN recommends the alteration of sections 9.8 a) and b):

a) being honest ~~and not misleading~~ when writing reports and certificates and only signing documents believed to be accurate and current

b) taking reasonable steps to verify the content before signing a report or certificate ~~and not omitting relevant information deliberately~~

9.10 Investigations

In sub-section c), CAAN would appreciate a definition of "anyone entitled to ask". The lack of clarity of this sub-section seems unhelpful given the stressful situations in which practitioners will probably be if they are accessing this section of the code.

CAAN recommends defining "anyone entitled to ask" with regard to relevant legislation.

9.11 Conflicts of interest

Section 9.11 comes directly from the AMC document. It is written for the medical profession and therefore has sections in it that don't relate to chiropractors. These require some rewording.

CAAN recommends the following changes to section 9.11:

d) Delete "… pharmaceutical and other …"
e) Delete "… drugs or other …"

9.12 Financial and commercial dealings

Section 9.12 is based on the AMC Code's section 8.12. The challenges in section 9.12 arise from additions made by the CBA to the original source document.

Section 9.12 c) places an unnecessary limitation and record-keeping burden on chiropractors. The receipt of unsolicited gifts from patients is not unethical. Making a file note or telling a colleague about, for example, every box of chocolates or bottle of wine one gets from patients at Christmas is both onerous and unnecessary.

Section 9.12 d) is an overly onerous requirement and should be deleted.

Section 9.12 f) has been added to the wording from the AMC Code, but covers the same ground as 9.12 g).

CAAN recommends the deletion of sections 9.12 c), d) and f)

10. ENSURING CHIROPRACTOR HEALTH

10.2 Chiropractor health

Section 10.2 a) has been improved in comparison to the original consultation document from CBA. However, CAAN suggests using the same wording as the Optometry Board of Australia with respect to this section. CAAN considers this a more inclusive clause.

CAAN recommends that 10.2 a) read:

"attending to personal health needs"

Section 10.2 c) picks out a seemingly random aspect of public health policy. Immunisation is not a central aspect of chiropractic practice. Vaccination does not guarantee immunisation. Mandating an "understanding" of the "principles of immunisation against communicable diseases" is a simplistic requirement that will be considered by most of the chiropractic profession as a direct insult towards the right of free will and informed choice.

In light of recent safety concerns, hospitalisations and deaths from influenza vaccination a government regulatory body may wish to consider the wisdom of this subsection.

The issue of vaccination requires consideration of complicated variables, including the virulence of the disease in question, the evidence (or lack thereof) of safety and efficacy of the vaccine in question, the individual health status of the patient and the environmental/geo-medical context in which the vaccine is being considered.

Section 10.2 d) addresses the issue of self-prescribing for chiropractors who are able to prescribe medicines. CAAN suggests that those chiropractors who are qualified to prescribe medication do so under another qualification, such as a medical degree.

If such individuals wish to practice medicine, including the prescription of medications, from July 1st, 2010, they will do so under the purview of the Medical Board of Australia, thus negating the necessity of section 10.2 d).

CAAN recommends the removal of sections 10.2 c) and d).

10.3 Other practitioners' health

CAAN supports the concept of supporting colleagues to maintain good health.

Section 10.3 b) is a variant of section 9.3.2 of the AMC Code. CAAN recommends a slight rewording of this section.

CAAN recommends 10.3 b) reads:

"notifying the boards if taking care of a practitioner whose ability to practise may be impaired and may thereby be placing patients at risk of harm. This is always a professional, and in some jurisdictions, a statutory, responsibility.

APPENDIX 1: Guidelines in relation to Public Spinal Screening

CAAN has some significant concerns with Appendix I: Guidelines in relation to public spinal screening. Time constraints prevent detailed explanation.

However, CAAN recommends the following re-write of this section:

The aim of this guideline is to assist chiropractors in performing public spinal screening in a safe and responsible manner.

It is the responsibility of the individuals involved to ensure that all necessary permits are in place prior to the commencement of the public place marketing. No notification to the Chiropractic Board of Australia (the Board) is necessary.

Chiropractors undertaking public spinal screening should also be aware and comply with the provisions of the Health Practitioner Regulation National Law Act 2009 that relate to advertising and the Board's guidelines on advertising found at: www.chiropracticboard.gov.au.

Good practice in relation to public spinal screening involves:

a) ensuring that members of the public are aware that any evaluation at a spinal screening is not the equivalent of a comprehensive spinal examination

b) obtaining contact information from participants for the purpose of risk management

(Chiropractors need to be able to defend themselves in the case of a PI issue. Recording who was screened is sensible risk management practice.)

c) providing identifying information (such as a business card or other information) to all participants to establish the chiropractor's qualifications and identity and to prevent non-chiropractors impersonating registered practitioners.

(Reasoning is self-evident.)

d) that contact is not made with participants after a screening without first seeking and receiving permission

(Allows the public to follow up on findings of screening without impediment.)

e) that they are only performed by a registered chiropractor or a registered student participating in an approved supervised practice program (students should be in their final year of study in course approved by the Board to become a chiropractor)

NB Whilst it is common practice for chiropractors to provide spinal screenings as a free community service, CAAN believes that chiropractors have a right to charge a reasonable fee for conducting a public health screening service, should they so choose.

APPENDIX 2: Radiology

Introduction

The implied meaning and tone of the first sentence in this paragraph appears to describe and present chiropractic radiography within a somewhat non-clinical and casual language. We would find it unlikely that a medical doctor would describe his clinical skills as part of his "suite of diagnostic procedures".

This phrasing might appear demeaning and casual to a profession which recognises the critical role radiology plays in the analysis of complicated spinal pathomechanics. CAAN further suggests that the notion that chiropractic radiography is somehow "offered" to patients may also seem insincere and degrading and falls short of the clinical tone that this important diagnostic procedure deserves.

CAAN suggests the following re-wording of the introduction:

"Radiographic imaging is an established diagnostic procedure utilized by chiropractors, performed either in a chiropractic office or through referral.

"Chiropractors use radiography for several purposes following the identification of various history and examination findings, including but not limited to:

- confirmation of diagnosis/pathology;
- determining appropriateness of care;
- identifying contraindications or factors that would affect or modify the type of care proposed".

ARPANSA Code of Practice for Radiation Protection in the Application of Ionizing Radiation by Chiropractors

1. The key purposes of the ARPANSA Code are ...

CAAN recommends no change to this section.

2. The key radiation protection principles of the ARPANSA Code are ...

Dose Limits:

This sentence in isolation from the relevant section within the ARPANSA code may be confusing to practitioners in regards to whom RPS1 relates.

CAAN suggests clarification that RPS1 actually relates to occupational and public "dose limits" with the following rewording:

• Dose limits – applications of ionizing radiation must be managed in a way to not exceed dose limits specified in RPS1 for occupational and public dose limits.

Justification:

CAAN suggests that the spelling, grammar and phrasing of this wording requires amendment.

Suggested amended wording:

• Justification – No practice involving exposure to ionizing radiation for diagnostic purposes should be adopted unless it produces sufficient benefit to the exposed individuals or society to offset the radiation detriment it may cause.

3. The Responsible Person …

No change.

4. The chiropractor …

No change.

Additional key points in relation to Radiology/Radiography

With regard to the four points of clarification:

Point 1 appears to be unnecessary as it only repeats what has already been written elsewhere in Appendix Two. It does not add any further information to what has already been stated from the ARPANSA code quoted above it.

CAAN recommends the removal of point 1.

APPENDIX 3: Guideline in relation to Duration and Frequency of Care

CAAN believes that Appendix 3 is unnecessary. Each of the points raised has been addressed elsewhere in the draft Code of Conduct.

Point 1: Addressed in sections 1.2, 2.1, 2.6 and 6.2.

Point 2: The first sentence is addressed in section 3.2 c). The second sentence again raises the spectre of patients' perception of their "needs" being given more importance in the clinical encounter than the chiropractor's clinical assessment. This is a dangerous and unreasonable suggestion. Delete.

Points 3 and 4: The process of developing and implement care plans is addressed in section 2.1, 2.2, 3.3 and 3.5. Delete.

Points 5 and 6: Informed consent is addressed in the Introduction to the Board's draft Code of Conduct, as well as in detail in section 3.5.

CAAN recommends the deletion of Appendix 3

QUERIES ABOUT CONSULTATION WITH REGARD TO GUIDELINES ON CONTINUING PROFESSIONAL DEVELOPMENT

CAAN is concerned about the apparent circumvention of the consultation process with regard to CPD guidelines.

According to a letter from the AHWMC posted on the CBA website, on 24 February 2010, CBA sent a final draft of CPD guidelines to AHWMC.

On 31 March 2010, AHWMC advised CBA that it had approved a number of registration standards INCLUDING GUIDELINES ON CPD.

Considering that the profession received a consultation document on 10 March 2010 with a deadline for submissions of 7 April, CAAN would like urgent clarification of the CBA's actions with regard to an apparent circumvention of the consultation process.

RE-STATEMENT OF OBJECTIONS AND RECOMMENDATIONS REGARDING PREVIOUSLY RELEASED SECTIONS:

GUIDELINES ON ADVERTISING

CAAN supports the concept of maintaining high ethical standards in chiropractic advertising. However, we have some concerns with the guidelines for the advertising of regulated health services.

3. Professional Obligations

Substantiation of Claims

Does the Board now intend for chiropractors to warn of "material risks" associated with chiropractic care in all advertising? Considering the relatively benign nature of the vast majority of abreactions to chiropractic care, this seems overly onerous. In particular, CAAN would have concerns about the requirement to warn about the possibility of VAD/stroke given the recent research by Cassidy, Winterstein et al and others which questions the causal relationship between chiropractic cervical adjusting and VAD/stroke.

Many common daily activities have been linked to the onset of stroke. An example of this is drinking from a soft drink can. (*Terrett AGJ. Current concepts in vertebrobasilar complications following cervical manipulation. 2001 NCMIC Group Inc., West Des Moines, Ia.*) By the proposed standard, sellers of Coca Cola should be required to warn the public of this in their advertising too.

Authorising the content of advertising

CAAN is concerned that practitioners are expected to be responsible for the editing and editorialising of journalists. Expecting editorial control is unrealistic. Barring practitioners from being involved in media unless they have editorial control is an unreasonable expectation, especially for CAA media spokespeople.

Suggested wording:
"The chiropractor should take all reasonable steps to ensure accuracy of the reported story."

5. What is unacceptable advertising?

This list is confusing and in some cases just plain wrong. They're trying to give examples to clarify what is and is not OK. They just end up becoming more prescriptive and proscriptive. For examples, see following comments.

Better solution is to quote sections 133 a. – e. of the Act. (See below.)

5b. In health care, there are often "windows of opportunity" for being able to impact on the health of individuals. In some cases, time pressures exist. Does the Board always consider it unreasonable to use the phrase "Don't delay" or similar?

eg: Don't delay getting moles checked?

Don't delay having a blood-pressure assessment?
Don't delay getting your child's spine and nervous system checked after a fall?

5f. When compared to rates of iatrogenesis with commonly-performed medical, procedures, chiropractic is comparatively far safer. The safety record of chiropractic is unequivocally better than that of the medical profession. Medications are more dangerous than chiropractic care by a factor of hundreds. (Rome, CJA 1999; Dabbs and Lauretti, JMPT 1996) Surgical intervention is more dangerous than chiropractic care by a factor of tens of thousands. (Coulter Int J Integ Med, 1999) For the chiropractic profession to be prevented from telling the public these facts constitutes a public health risk. CAAN is deeply concerned that paragraph 5f of this section is both anti-competitive and more importantly, potentially dangerous to the health of the public.

Not to state such figures could be construed as false and misleading!

5j. Again, what health risks does the CBA require practitioners to warn against in their advertising?

5m. CAAN is of the opinion that there are circumstances in which it is appropriate to encourage some consumers to undertake a service. We believe that it is unreasonable to suggest that this should "not ever" happen in advertising. CAAN agrees, however, that all such information needs to be factual and not written in a scare-mongering way.

6. Specific requirements

6.5 Advertising of price information

After reviewing the ACCC website and the National Law, CAAN fails to understand why practitioners may not advertise time-limited or special offers. We consider that this requires a legal opinion to determine whether this clause constitutes an unlawful restraint of trade.

7. Advertising of Therapeutic Goods

CAAN welcomes this guideline, particularly as it pertains to the use of supplements by chiropractors.

GUIDELINES FOR MANDATORY NOTIFICATION

CAAN sees the potential for serious issues with the current structure of the mandatory reporting process. We are absolutely committed to the safety of the public, however there are too many loopholes in this section that may encourage vexatious complaints.

CAAN believes that registered health practitioners have a responsibility to approach practitioners who they believe may be breaching guidelines. If that approach fails, then perhaps reporting to a regulatory authority would be the next step?

Decision guide: notifying sexual misconduct

This flow-chart reads as if a voluntary notification could be made to the board about an allegation of sexual misconduct even though the first practitioner has no evidence or even belief

that the second practitioner has engaged in inappropriate sexual activity with a current or former patient.

Similar confusion exists with regards to the flow-chart on “departure from accepted professional standards” and “student impairment”.

CAAN has reservations about the inflexibility of this section.