COMMENTS FOR THE DRAFT CODE OF PROFESSIONAL PRACTICE FOR CHIROPRACTORS IN AUSTRALIA.

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CONSULTATION

My first question however is why out of all the professions are we having a separate code?

Attachment A, part 5 (1) if a National Board develops a registration standard or a code or a guideline, it must ensure there is wide ranging consultation about its content.

- The National Board released the draft guidelines for consultation with a three-week opportunity for submissions. It was only our President and Vice-President of the CAA in QLD that received notice of this and so was then up to them to inform the CAA members. I am not even sure how any other Chiropractor would have known

This is certainly not an acceptable time frame to read and comment on these documents.

My first comments are on the specific Chiropractic code of professional practice.

1. Working with the Patient, client, and consumer.

1.1.1 Point 8. –Receive a fair settlement of just claims. What does this mean?

1.1.1 Point 18. Refuse to give access to some or all of their health information - A Client must always disclose ALL information. If they do not how can an accurate diagnosis and treatment of care be given. I think that in the informed consent the client is aware that all

relevant information must be given by the client otherwise the practitioner can refuse to give care.

1.6.7 Fees. Point 12. Financial and management plans should not extend beyond 3 months at any time. - A management time frame is up to and only decided by the practicing Chiropractor in the best interest of the client. They have assessed, given examination, taken history, x-rayed and if in their clinical experience a outcome is expected to take longer than 3 months then that is what is appropriate. As long as an extended time is clearly related, understood and signed off by the client.

1.7.4. Professional boundaries who decides the nature and the duration of the practitioner /health consumer relationship?

1.7.7 The introduction is very unspecific. Point 2. Inappropriate touching can be subjective, there is nothing stated that as long as the Chiropractor has stated what they are going to do and there is a second person in the room (CA).

2.2.2. What relevant health profession boards do we have to satisfy with our research? Which part of our profession do we have to satisfy? Who decided what clinical outcome measures or evidence of efficiency of safety? Is it not just as important to get Chiropractors to develop skills in research to present new ideas and proposals to <u>our</u> profession.

2.3 Advertising. I am always amazed and saddened that we as a profession do what ever we can so that we do not advertise/promote ourselves. We have clauses so that we are stopped!!!!!!!!!!! No wonder the public have such a dim view as they have no idea what we are about.

2.6 Radiology/Radiography.

2.6.3. Why are we restricting ourselves with x-raying children. This assumes that the Chiropractic colleges are of a sub standard and therefore the Chiropractors that are graduated are not able to make an appropriate and safe diagnosis for their clients. (Please note 2.10.7.)

2.6.4. Again restrictive and undermining of the Diagnosing Chiropractor.

2.7 Diagnostic tools. Once again this is becoming restrictive to the diagnosing that a specific Chiropractor chooses.

2.9. Acupuncture. What is this doing in the Chiropractic code? This has no place.

2.10. Working with adults and children. This is again restricting what a trained Chiropractor has learnt and gone on to learn.

2.10.7 point 4. Due to this it then relates back to 2.6.3. And the importance of x-raying children to dismiss any "increased incidence of serious pathology causing neck and back pain in children as compared to adults"

Point 5. The frequency of checks for a child should be up to the Chiropractic in hand. Waiting for a milestone before checking is absolutely ludicrous.

2.11.9. Why are restricting to 3 months care only. Who has decided that this is enough? Why do we have to validate objective and subjective findings to justify what we feel is necessary in our clinical judgement to our clients?

3.1.2. I don't believe that we should have to have after hour's number on display. If someone is that bad that they need after hours service it may be better for them to go to hospital.

4.1. **Working with other practitioners.**

Chiropractic is an amazing profession that allows a great deal of different techniques to support the public with their health. If one Chiro doesn't like what another is doing then this gives them free chance to get them into trouble. This is destructive for a profession. It is separating and not encompassing.

CPD

3.3 requirements The board should not have the ability to just vary the requirements as a when they see fit. If they wish to change them it should be at a given time frame of notice.

3.8. It should be stated here all the ways in which action will be taken and not be able to use the "not limited to" line to be able to change what they want and do what they want.

RECCOMENDATIONS

THE NATIONAL CHIROPRACTORS BOARD REMOVES THE CODE OF PROFESSIONAL PRACTICE FOR CHIROPRACTORS IN AUSTRALIA FROM CONSIDERATION.

Part 5; Division 3 shows it is not mandatory to have a separate code of guidelines. Nor has the National board ensured wide-ranging consultation about its contents, as this is required under section 40.

Second comments for the general guidelines:

CODE OF CONDUT FOR REGISTERED HEALTH PRACTITIONERS

3. WORKING WITH CLIENTS

3.2. Partnership – h) I think we should have a right to be able to refuse care if we believe it is not in the best interests of the client.

3.12. End of life Care – l) That a practitioner can refuse care if it deemed inappropriate and not supportive of the client.

9. ENSURING PRACTITIONER HEALTH

9.2. c) this should be removed completely. Why is this in here? If you understand the principle of immunization then you would never do it. To suggest that one is only healthy if they are immunized is wrong and unscientific. This predisposes to me that you can use this against someone who chooses not to be immunized.
Refer to 6.7. Information: Be presented in a manner that is accurate, balanced and not misleading.

Comments for:

INTRODUCTION

SUMMARY OF GUIDELINES

Advertising can provide a means of conveying general information on the availability of services and procedures to consumers – does this mean that the CAA can advertise on behalf of the members?

3rd paragraph – There are risks that advertising which are false and misleading or deceptive? - Who decides this?

PROFESSIONAL OBLIGATIONS

Substantiation of claims – 2nd sentence – Unless there is *accepted scientific evidence*. Who decides this?

Authorizing the content of advertising – the 3rd paragraph should not be there, whom do we get to sign of and who says they are correct?

WHAT IS ACCEPTABLE ADVERTISING?

D) Availability of after hour's services – I don't think this should apply to chiropractors, if they wish to give out their number that is up to them. If

someone is in that much pain that they can not wait until the next day then maybe they should go to hospital!

SPECIFIC REQUIREMENTS

6.4 use of titles in advertising

If practitioners choose to adopt the title 'Dr' in their advertising, and they are not a registered medical practitioner then they should make clear that they do not hold registration of medical practitioner. *When did a Medical Practitioner obtain sole right to use this title? It is an honoree title to all professions up standing in the community. Therefore if a medical doctor uses this title they should state at the end Dr Joe Bloggs M.D.*

O**ther qualifications or memberships**

Bottom paragraph – is there any risk of people misunderstanding or misinterpreting the words, letter or titles I use – the only confusion now is the MD has taken over a title that is honoree – therefore my above suggestion that anyone who uses the title say why? *Dr Joe Bloggs M.D.*

6.7 Use of scientific information in advertising.

Point 4. Be from a reputable and verifiable source. What does this mean? Only independent research can be used if this is the case. Therefore anything funded by the pharmaceutical companies in not reputable ???

ATTACHMENT 1.

133. ADVERTISING

1. Maximum penalty – how does a) and b) differ?

PAGE 11. PART 11. – At what point is this done and what warnings are given before this happens?

Comments for:

GUIDELINES FOR MANDATORY NOTIFICATIONS

S.140(b) It is not noted (that I can find) any mention that if a patient needs to be touched in a presumed sexual way. It is Important to note that at sometimes there may be reasons to touch a patient in an appropriate place. Therefore, note should be made to explain everything to the patient and ideally have another member of staff in the room.

CONSEQUENCES OF FAILURE TO NOTIFY

REGISTERED HEALTH PRACTITIONERS

1ST Paragraph. – Last sentence - …may be subject to health, conduct, or performance action by the board that registers the practitioner? What does this mean???

RECCOMENDATIONS

Making note somewhere that a practitioner can refuse care where either they or the client is in anyway unsafe. A practitioner should always have the right to refuse to treat/check/care for someone.

After hours service. This should be at a practitioner's discretion. If someone is bad enough to need to be seen then they must need to go to hospital?

Immunization, remove this. This is choice by a practitioner and **should not** be commented on in a document of this nature. This is still a choice.

Every profession who uses the title Dr. is to do so with their profession stated at the end of their name, regardless of their profession.