HUMEPHILLIPS

Attn: Chair, Chiropractic Board of Australia

Christopher Hume-Phillips to: natboards

To whom it may concern.

Please find below my comments on the Consultation Paper.

Overall, my impression is that this document has been written with a subversive agenda in mind, particularly in relation to the practice of Chiropractic, giving the impression that the Board sees the members of this profession as no more than a bunch of uncontrollable misfits, and I resent being treated as such. I am of the impression that the brevity of the time left available to make submissions on this document was engineered as such.
The overall composition of the document is flawed, and conveys the impression of a work that was rushed together, and clearly lacks evidence of consultative processes.

In my opinion, the Board should feel embarrassed for releasing such a document for comment, as its poor construct, and evidence of a lack of transparency in its formulation, undermines any attempt at credibility that might otherwise have been implied.

Yours in Chiropractic
Dr. Christopher Hume-Phillips

Guidelines on advertising
Describes that advertising can "provide a means of conveying general information on the availablility of services and procedures to consumers" to obtain " a better understanding of services and options" in order to make "informed health care choices".

These guidelines establish such an extremely heavily regulated process, spanning no less than 3 separate Acts (Trade Practices Act, Fair Trading Act, Health Practitioner Regulation National Law Act), resulting in such extensive filtering of the information that can be provided to consumers, ultimately defeating the above-stated intent of providing consumers with a "better understanding of services and options", and will in no way contribute to informed health care choices being made.

3. Professional Obligations
The statement "some consumers may have particular vulnerabilities in relation to the advertising and the provision of services" is extremely unclear and ambiguous, providing the Practitioner with no guidance whatsoever on this concept (a mandate of this document); other than to be "mindful" of the possibility.

Does this mean all business cards must be printed in at least a 36pt font so as to be mindful of those with poor vision? Is the "vulnerability" in relation to a diminished

physical capacity (i.e. visual acuity, colour blindness), or perhaps poor command of the English language (i.e. does printed material have to be made available in multiple languages?).

Substantiation of claims
"Unless there is accepted scientific evidence that there are no material risks associated with the type of treatment.....alert the public to the fact that there are associated health risks".

This statement implies that wherever one would advertise Chiropractic services, a Practitioner must also advertise material risks. As a result, and according to this documents' definition of advertising, implies that all Chiropractors' business cards, practice frontages, letterheads, telephone directory listings, professional directory listings and so on, must contain additional wording documenting all material risks associated with Chiropractic care.

This is nothing short of ridiculous.

Authorising the content of advertising
This section would appear to have been written by individuals who do not have personal experience with the media.

In June 2009, this author had a short, 5 minute t.v. story aired on his particular area of expertise. A total of 4 hours of footage was recorded for this segment. The final edited story was finished 25minutes prior to airing (which the author was advised, is not an unusual time frame). In order to protect their copyright on the material, the t.v. station would not release the final edited story prior to airing. Nor are they in the practice of guaranteeing that the interviewee will have final say over the content.

In such a typical situation, there was absolutely no opportunity to review the final content of the segment prior to airing. Thus it would have been impossible to "ensure that the published version of the advertorial or article adheres to these guidelines".

So in an attempt to convey information on the "availability of services and procedures to consumers.....enabling them to make informed health care choices", a key objective of advertising as stated earlier, which was done with the utmost of professionalism, it would have been impossible to have been undertaken without breeching these proposed guidelines. Nothing short of a ridiculous scenario.

These guidelines would also make it almost impossible for a practitioner to appear on a live-aired program on TV or radio without risk of reprimand.

How on earth is a Practitioner able to help convey " a better understanding of services and options" in order to make "informed health care choices", when these guidelines appear to negate the possibility.

5. What is unacceptable advertising?
j) - Here we see duplication of the earlier farce of disclosing treatment risks, which by definition, would include business cards, letter heads, practice frontages, yellow

pages listings etc.

m) "contain any information.....may suffer from not taking/undertaking the service". And yet, Practitioners are advised to include statements on consent forms that advises patients they may get worse if they do not get treated. This point again illustrates the hypocrisy of these guidelines.

r) "promote.....products that are known to affect health adversely". If a Practitioner is to lead by example, then why are they being asked to be immunised against "relevant communicable diseases", well-documented to affect health adversely?

6. Specific requirements
6.1 Use of graphic or visual representations
In relation to "before and after photographs", unless expensive professional photographic/printing equipment is used, it simply is not possible to have control over factors such as contrast, exposure, due to the inherent nature of office-grade printing equipment including printer brands, ink types, toner types, colour types, paper types, camera types, and even time of day (due to changes in ambient lighting).

Ensuring this level of accuracy between images simply isn't possible in the normal office environment and creates an unrealistic level of expectation.

- "confirming that the referenced procedure is the only change that has occurred for the person being photographed" – This should be worded thus – "that the procedure/s responsible for the referenced change/s should be identified".

Would it not make more sense to simply state that "where before-and-after photography is used, reasonable effort must be made to ensure the relative consistency of the photographic process and reproducibility, within the limitations of the environment in which it is utilised."

6.5 Advertising of price information
"Practitioners.....must not advertise time-limited and special offers"

Firstly, does this relate to services only, or does this include products also, such as pillows, supplements etc?

Secondly, it is well-accepted that consumers are very much price-driven, and national initiatives by professional associations to draw attention to certain health matters, such as Chiropractic Care Week (a time-limited event!), do well to encourage "fence-sitters" to investigate chiropractic care for their spinal health. Such important initiatives should not be hampered by preventing Practitioners from offering a time-limited, or special, offer to encourage them to investigate further.

Why would the Board see fit to stifle the opportunity of a profession and it's members, to encourage more members of the community to consider Chiropractic care?

Thirdly, preventing Practitioners from providing such opportunities provides for anti-competitive, trade-restraining, restrictions. Has this proposed restriction been approved by the ACCC?

7. Advertising of therapeutic goods.

This section clearly demonstrates that members of the Board do not have a working knowledge of the Chiropractic profession. Unless Chiropractors are going to be permitted to start writing prescriptions, sections 7.2 to 7.7 inclusive are completely irrelevant.

8. Consequences of breach of advertising requirements

Here we have a situation whereby an authority is happy to make the rules, and enforce the rules, yet according to the third paragraph, "National Boards cannot.....", it is anyone's guess as to how the Board will measure an alleged breach.

The document constantly refers to those members of the public with limited understanding, and are "vulnerable" (whatever that means). I suspect that the Board is trying to politely refer to the "idiots" of society – and this I mean by dictionary definition. Does this mean that the Board intends to make it's judgements based on it's perception of what an "idiot" (by definition) would think. Which then leads to the presumption that the Board would have us all treat past/current/prospective clients as idiots?

How does the Board plan to explain it's expertise in considering things from an idiot's point of view. (I am reminded here of an appropriate quote by Forrest Gump: "Stupid is as stupid does".)

Can't wait to share that with my patients! I doubt it will do much to foster any sense of confidence in the Board acting as a patient advocate.

Code of Conduct for Registered Health Practitioners

2.2 Good Care
i) This section does not allow for the inherent risks that can be associated with the alleviation of symptoms where doing so can provide for greater risk of further injury due to the absence of subjective pain suggesting tissue injury/damage.
n) "Accepted" by whom? The Board doesn't clarify this, creating the possibility it may decide to be a self-determined "authority" on what is "accepted", overriding what may be considered as acceptable to the profession as a whole. In addition, there is no reference to the quality of the evidence-base, suggesting a simple published case study would suffice if no other evidence existed. Do the members of the Board in fact have the necessary qualifications and expertise to make decisions on the nature of 'evidence'? I would image that an academic background, a PhD at the least, would be required to do so.

2.4 Decisions about access to care
e) As Chiropractors are not in the habit of having such things as sedatives,

restraining equipment or security staff at hand should a client pose a risk to staff's health or safety, there's no way I am going to NOT deny care for that patient and put my staff at risk.

3.3 Effective Communication
i) This item will effectively lead to forced discrimination against any non-English speaking, or hearing impaired individual who requires an interpreter/communicator to be present due to prohibitive costs and impracticality of scheduling, who would otherwise usually rely on a family member to do so.

It would be reasonable to presume that the attending family member acting as interpreter/communicator is there because they are trusted by the patient at hand. Why go to such prohibitive lengths to make accessing health care so difficult for these patients?

Are the representative consumer groups, such as the Deaf Society, or ethnic groups, aware of your recommendations? There has been no disclosure in this document that such consultation has occurred. This item appears to go out of its way to limit access of these groups to health practitioners by requiring them to 'qualified interpreters' for these patients.

3.5 Informed Consent
b) As this reads, consent needs to be obtained a) prior to examination AND b) before treatment also. Should we also obtain consent before they walk in the door, as there may be risks associated with entering the premises, such as rugs, steps, screaming children, boring music playing in the reception area, or offensive National Geographic pictures in the magazine racks – they could be scarred for life!

Where does this stop?

3.6 Children and Young people
a) Define "young".
b) This goes back to the 'idiot' clause referred to earlier. In other words, if they're not idiots, you can get their consent to proceed.

4. Working with other practitioners
This sections needs to include a point c), indicating that a practitioner must not prejudice a patients' care based on the practitioners own personal belief about another profession. All too often, patients are still getting 'bed rest and analgesics' prescribed by GP's for lower back disorders despite the research showing that Chiropractic care is often the treatment of choice. Many of these GP's refuse to refer their patients to chiropractors due to no more than ignorance, and often berate those patients that do consult chiropractors. There simply is not enough accountability for this type of behaviour.

Personally, this author has had a gut-full of the disrespect displayed by specialists and surgeons in particular, despite genuine attempts at collaboration, purely for the patient's benefit.

4.3 Delegation, referral and handover

These scenarios do not allow for a scenario where a patient who previously saw the principal, returns after an interval as a re-activated patient, and sees an associate. Nor does it account for scenarios where a patient routinely sees more than one practitioner at the practice, and is on 'supportive' care, and not for any particular condition. In addition, the scenario of a patient who routinely consults 2 same practitioners (e.g. 2 chiropractors) at different practices, that are not in any way connected. Both may be managing the same condition for the patient, however, the patient for any of a number of reasons, maintains an active regime with both practitioners (who are both aware).

8.12 Financial and commercial dealings
c) Noting of token gifts.....now this is really getting out of hand. First they were just 'idiots', and now they are 'untrustworthy idiots'.

9.2 Practitioner Health
c) Not a chance. I understand the principles of immunisation, and I also understand the risks associated with this invasive medical procedure, and exercise my option to NOT consent to this medical procedure due to the material risks associated with it, particularly the undisclosed ones. Will the Board bear the liability associated with having practitioners undertaking this invasive medical procedure? (I doubt it – especially if an identified cancer prevalence suddenly increases in health practitioners due to this sort of procedure).

10.2 Teaching and supervising
d) This items would suggest that should my son, or daughters, wish to follow in my footsteps, and emulate their father's successes in practice, they can't do it with me looking over their shoulder?

All too often, sons and daughters have chosen to follow in their parents footsteps, to "carry on their good work", receiving guidance from their parent/s. Now, the Chiropractic Board of Australia deems this noble family tradition as 'bad practice'. Utterly shameful.

Code of Professional Conduct for Chiropractors in Australia

1. Working with the Patient.....

1.1.1 States that a patient has the right to refuse access to some or all of their health information.

What happens if such a refusal, results in an adverse event, that might not have occurred had that information been provided by the patient?

A patient should be bound by a 'duty of disclosure', as the withholding of certain information could in some cases be considered as self-diagnosis, or be an attempt to deliberately induce an adverse event for the purpose of lodging a damages claim against the practitioner, by withholding information that might have led the practitioner to treat otherwise.

1.1.2 This section should identify that a patient has a duty of care to themselves, in regards to their own health, and a duty as a patient, particularly in regards such as compliance with care plans, undertaking exercises, diets or other recommendations by the

practitioner.

There should be identifiable penalties for patients who do not comply with their duty as a patient. This small section of the entire Consultation document, is the ONLY section that identifies ANY responsibilities of the patient in any form. Oh let me guess, we're back to treating them as 'idiots' again aren't we.....silly me....should have figured that out by now!

1.2 Capacity to give Consent

1.2.1 (re considering if a patient is of sufficient age/mental/emotional capacity) Here you are asking the Chiropractor, not a trained lawyer/solicitor, to make a legal determination, which he is not necessarily trained to do. For goodness sake – pick a number!

1.3.4 Informed Consent

As discussed earlier, due to the inherent impracticality of this 'guideline', treating patients who fall into this category will be impractical for both parties, resulting in a discriminatory setting for these prospective patients.

1.4 Refusal to provide a service.....

Other scenarios that should qualify for discontinuation/refusal of care should also include;

1. Non-compliance with care plan attendance.
2. Non-compliance with excercises issued/recommended
3. Greater than 2 consecutive 'so-show' non-attendance appointments
4. Failure to pay for services rendered/products supplied.
5. Non-disclosure of health information that is determined to be relevant to the patients health and chiropractic care.

1.7 Professional boundaries

This section is largely a repeat of earlier information.

2. Working as the practitioner

2.3 Advertising – why bother make any mention here when such copious amounts of space has been devoted to this elsewhere. In fact, why not dump the other section, and just leave it as this.

2.9 Acupuncture and Dry needling

These seems a little irrelevant in a Chiropractic Act. So far the Board has been very good at referring the reader to numerous other Acts and so forth. Why not add one more to the list?

2.10, and 2.11

Both these sections are clearly written by individuals who are unfamiliar with the practice of Chiropractic.

4. Working with other practitioners