Chiropractic Board of Australia – Review of Consultation paper on codes and guidelines

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After review please find below the concerns that I have to bring to the boards attention.

Guidelines for advertising of regulated health services

3. Professional Qualifications

This indicates that the use of terms such as 'special interest', 'family chiropractor' or 'wellness chiropractor' are now non-useable as they may be deemed as implicitly implying specialization. Currently, we are able to identify to the public if we have a special interest in working with families and children, that our practice is set up to accommodate these patient groups, and that our staff are able to work with them effectively. As chiropractors will be entering the new legislation with no defined specialty recognition, this serves to act against practitioners identifying their skill-set that enables them to work with certain areas of the public with greater care for the patient.

This guideline could possibly be deemed as interfering with the ability of the public to ascertain easily which practice and specifically which practitioner may suit their needs better.

3. Substantiation of Claims

This indicates that chiropractic advertising in the future will need to have a disclaimer similar to that as required for pharmaceutical medicines, as indicated further on in the guidelines in section 7 (Advertising of Therapeutic Goods). This clause may inhibit the ability of the chiropractor to advertise at all due to space and cost limitations. In Section 7, there is also provision that in regards to therapeutic goods, the warnings must be written in the same size font as the rest of

the text, this provision hasn't been outlined here. This also appears to not account for the informed consent that must be gained from each individual prior to beginning chiropractic care. As outlined in the study published in SPINE 2008 (Cassidy et al., 2008), the risk of Vertebrobasilar (VBA) stroke is very rare, and due to this rarity, surely we should be exempt from printing disclaimers in our advertising material.

6.1 If photographs of people are used in advertising…. Must have been patients of that treatment.

This clause as it is currently written will prohibit chiropractic offices from the use of usual print media and advertising as this indicates that stock photos (readily available online at a very reasonable cost) would not be usable. A normal chiropractic office would most likely be unable to afford a photo shoot of advertising quality. In reference to the use of Before and After photographs, as outlined in the same section, this should remain as indicated with only real patients used. However the initial indication here that only real life patient's are to be used in all forms of advertising is very limiting to the profession. This section will pose a barrier that prevents chiropractors from advertising in a cost-effective and professional manner. As many chiropractors have wall posters that are sourced from external chiropractic media organizations, the people depicted on these posters are not patients of that practice. This guideline would require each individual practice to alter all of their current brochures, posters, patient handouts, and other in-house media that is sourced from professional companies that provide this service for chiropractors.

The cost of re-photographing, re-printing and re-branding in this manner would be extraordinary, and would no-doubt affect severely some abilities of chiropractors to remain open and functional in a profitably business environment.

Code of conduct for registered health practitioners

2.2.n. practicing in accordance with the current and accepted evidence base of the health profession, including clinical outcomes.

This guideline is very vague and doesn't appear to make provisions for current best practice as employed at individual chiropractic offices. There are many reasons that members of the public seek chiropractic care, and they get results in our offices. However, as a profession we are very aware that our evidence base is still continuing to catch up on these cases that as practitioners we see on a daily basis. This provision may exclude us from continuing to see these patients as we continue to gather the data that is required to create an evidence base.

9.2.c. understanding the principles of immunization against communicable diseases and being immunized against relevant communicable diseases.

I see it as unethical for the Chiropractic Board of Australia to instruct practitioners to be fully immunized. This is far outside of the scope of the board to indicate this requirement. It should be removed from these guidelines immediately.

Code of Professional Practice for Chiropractors in Australia

1.6.7 Financial and Management plans should not extend beyond 3 months at any time

This guideline, whilst no doubt aiming at some members of our profession, could limit others of us who are working with current patients with chronic pain syndromes. This may be construed to limit the ability of the chiropractor to make an informed treatment plan for a patient, which, as an example, may be fortnightly visits for a period of time as part of a managed care plan for a chronic pain patient. In this instance management of patients will often extend beyond 3 months duration, and whilst re-assessment will occur to monitor progress, it would be unethical at the outset to not discuss this with the patient and inform them of the likelihood of the need for ongoing care.

2.4 Health care records must be able to provide data for peer review, public health purposes or teaching and research.

This guideline would need to be more specific or removed entirely due to the nature of it's requirements. In order for a professional to need to provide this

information for peer review, what are the exact requirements that need to be met. There is no indication of level of data required on each patient visit. This appears to be separate to the keeping of accurate health records as outlined in section 2.4.1 and 2.4.2 (Health Records), and provides an avenue for the information from all patient visits to be mandated to include specific aspects that may be outside of the scope of daily chiropractic practice.

2.6.4 Routine X-ray screening of consumers including the routine re-evaluation of biomechanical/postural disorders, other than for progressive scoliosis or other exceptional circumstance, may be inappropriate. Follow-up x-rays are not indicated if the health consumer is making adequate clinical recovery except in cases of progressive pathology, fracture repair and progressive scoliosis.

As the Chiropractic Board of Australia well knows, chiropractors have a rigorous and extensive university qualified degree that allows them to make clinical decisions based upon the patient in their care. This recommendation appears to remove the ability of the chiropractor to utilize there judgement in each individual case as it presents to their office. It is my understanding, as a member of the Chiropractors Registration Board of Western Australia, that our registration boards are in existence to protect the public. This guideline appears to be superfluous in it's context , and limiting to the scope of chiropractic practice.

2.10.7 Paragraph 6 – Frequent chiropractic checks or treatment of children without symptoms or signs has not been supported by current available evidence and is currently not recommended, except for assessing developmental milestones Should a parent elect to have their child undergo regular chiropractic examination or treatment in the absence of any clinical justification then it is the responsibility of the practitioner to provide the parent with a balanced view of the factual evidence relating to such examination or treatment as part of the informed consent process.

The use of chiropractic with members of the population who are not experiencing signs or symptoms has been a component of best practice for many generations of chiropractors. A study completed by Blanks et al (Blanks & Schuster, 1997) identified that patients under chiropractic care experienced

benefits in all four domains of health (physical state, mental/emotional state, stress evaluation, life enjoyment). In 2004, a review conducted by Hannon (Hannon, SM 2004) identified the measurable health benefits to people who were getting chiropractic adjustments, regardless of the presence of absence of symptoms. It concluded that chiropractic care has the potential for long-term, overall health benefit to patients. Research in 2002 (Bronfort G et al, 2002) that examined the affect that chiropractic treatment had on chronic asthmatic children. Amongst other findings, the most pertinent was that it highlighted that the children 'rated their quality of life substantially higher and their asthma severity substantially lower. These improvements were maintained at the 1-year follow-up assessment'. Whilst these children weren't asymptomatic, this highlights the role that Chiropractic may play in improving quality of life in children. Whilst these studies are not all specifically pertaining to children, it does provide some definitive indications as the effectiveness of ongoing chiropractic care in helping our patients maintain health.

In light of this research, it is pertinent to view the most recent information from the Australian Bureau of Statistics (Australian Bureau of Statistics (ABS) 2004), that identifies amongst other things, that 6% of children have attention problems and 5% have aggressive behaviour. The Australian Institute of Health and Welfare (AIHW 2008), identified that in the 5-12 year age group, there are 178 admissions to hospitals for mental health and behavioural disorders per 100,000 children. This highlights the ever increasing need for children to be involved in quality health-care that can not only assess developmental milestones, but can also allow for determination of early warning signs of these behavioural changes, and can be a meaningful and effective component of a non-hospital based treatment program for the child. If there isn't a 'frequent' assessment being undertaken of children by a primary health care practitioner, such as a qualified and registered chiropractor, this may be missed.

There have been numerous case-studies published that relate to the effectiveness of chiropractic care for behavioural disorders in children. A recent review of the literature pertaining to this was conducted in 2007 by Yannick Pauli (Pauli Y,

2007) identified, that whilst the research was of the lowest level of evidence primarily, there is scope that chiropractors and the 'model of the vertebral subluxation and its effects on cognitive function may serve as a link between the field of chiropractic care and the neuroscience of those disorders'. A case study published by Behrendt and Olsen (2004) highlighted the importance of chiropractic care in the reduction of anxiety in a patient, including medication reduction etc. There are promising signs that children also benefit in similar ways from regular chiropractic care. Even though there is no level 1 evidence base to support this, the supposition contained within the guidelines that there is no evidence at all to support regular visits to a chiropractor is absurd.

With the future of healthcare generationally shifting towards prevention, not merely early detection or disease care, we may be able to place ourselves at the forefront of these health care strategies. As outlined above, there are adult based population studies that evidence the role that chiropractic plays in preventative health outcomes. It is pertinent at this time to not place a block through poorly worded legislation to allow children the same rights as adults to access the possibility of chiropractic affecting their positive health outcomes in the future.

Paragraph 7 – Practitioners should be aware that 'screening' for health problems may be associated with harms such as false positives which may generate anxiety and unnecessary treatment.

The nature of a screening is to determine if further assessment needs to be undertaken. Screening procedures are utilized in many aspects of health care throughout Australia, from pap smears, PSA testings, Coeliac blood tests, bowel function screening through stool examination, self-examination of breasts and testes, the list is long and large. In all of these screening procedures, there is a component of mental anxiety that pertains to the finding of a problem on a screening, which is then relieved or quantified through further examination.

The screening of the pediatric patient by the chiropractor serves in much the same way to identify if that child requires further more thorough assessment. To remove the ability of the chiropractor to undertake screening assessments on children removes the choice for a parent consumer to determine if they would like a more thorough examination to occur. It also flies in the face of the current preventative health measures that are being brought in to the Australian health Care system. Not just early detection measures, which a screening assessment can be a significant part of, but also prevention of future problems through the effective screening of the child's spine.

As many other health professions are looking to develop useful tools to aide in this prevention and early detection, Chiropractors in the field have already got in place an ability to apply this at the ground level. This guideline may prevent the utilization of a procedure that is at the forefront of where health in society is heading.

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