C O C A

21st May 2010

Dr. Phillip Donato
Chair
Chiropractic Board of Australia
PO Box 16085
Collins Street West
MELBOURNE VIC 8007

Chair, Chiropractic Board of Australia, natboards@dhs.vic.gov.au

Dear Dr. Donato,

Re: Consultation Draft Code of Conduct for Chiropractors

The Chiropractic & Osteopathic College of Australasia (COCA) has read and appraised the most recent Draft **C**ode of Conduct for Chiropractors, issued by the Chiropractors Board of Australia (CBA). COCA agrees that in order to prevent confusion by chiropractors that both the Board's Code of Conduct for Chiropractors and the Code of Conduct for Registered Health Practitioners should be combined into one over arching code. However, COCA is concerned that the current draft code of conduct does not provide adequate guidance for Australian chiropractors and the code should more clearly delineate chiropractors' roles and responsibilities, as suggested in COCA's previous submission.

The College recognises that the issuance of any code of conduct or practice guideline, by the CBA, will be met with strong opposition from certain sections of the chiropractic profession. In particular, where codes or guidelines conflict with a chiropractor's core belief system or where they may impinge their style of practice, greater opposition and reluctance to accept those codes or guidelines will ensue. However, the Board's primary role is not to support or formulate any code or guideline to meet with expectation of the profession but rather to set appropriate standards of care, in order to protect the public.

The College recognises that the vast majority of Australian chiropractors, practice in an ethical manner and adhere to good practice principles and follow an evidence based approach to their practice. However, others within the profession do not uphold or practise with such worthwhile ideals. Clearly, it is this minority group within the profession that needs clear and unambiguous guidance with respect to their practice as chiropractors and not the majority whose practice and ethical standards are of acceptable levels. The CBA cannot abrogate or minimise its responsibility of protecting the public by not providing Australian chiropractors with appropriate guidance in these matters.

Furthermore, chiropractic, unlike most other health professions possesses a wide and varied diversity of practice styles, with numerous and diverse treatment regimes, diagnostic paradigms and underlying philosophical tenets. Simply put, such terms as treatment, diagnosis, wellness, health etc. are interpreted quite differently by the many groups within the chiropractic profession.

Chiropractic & Osteopathic College of Australasia
ACN 004 489 909 ABN 58 004 489 909
ph. 1300 13 99 50 fax. 1300 88 66 90
Suite 2, 1 Rooks Road, NUNAWADING, VICTORIA 3131
w w w . c o c a . c o m . a u

On this basis, any generic references or motherhood statements contained in the draft code may suffer from a wide range of interpretation and ultimately not provide the necessary guidance for the profession, as what is and what is not an appropriate standard of practice and or conduct.

In order to highlight this point I draw the Board's attention to Appendix 2: of the code, "Guideline in relation to Radiology/Radiography". The consultation paper refers practitioners to the American College of Radiology (ACR), for the Performance of Spine Radiography in Children and Adults. The consultation paper refers practitioners, via a hyper- link, to an ACR document and suggests that in any decision to obtain clinically-indicated radiographs the practitioner should consider the ACR guidelines. The 2007 revision of the "ACR practice guideline for the performance of spine radiography in children and adults" lists a number of general indicators for spine radiography, including "pain or limitation of motion". This indicator alone would go toward a clinical justification, for some chiropractors, to perform spinal radiography in the absence of any other "red flags" or other clinical indicators. However, the latest 2008 revision of ACR "Appropriateness Criteria" for low back pain removes the "pain or limitation of motion " from its list of indicators and adopts the more traditional "red flag" criteria put forward by most radiography/radiology authorities. The point here is that, in this instance, without clear and prescriptive guidance from the Board some Australian chiropractors would be exposing their patients to unnecessary and harmful radiation by virtue of an ambiguous and outdated guideline.

It must also be recognised that many chiropractic organisations and special interest groups establish and publish their own unique guidelines, which are formulated to suit particular styles of practice or philosophical tenets. While some of these guidelines may adhere to evidence based practice principles and are formulated using well established and appropriate criteria, many guidelines do not. Practising chiropractors may not possess the necessary training or expertise in order to effectively critically appraise all the published guidelines and therefore it is incumbent on the Board to provide those practitioners with the necessary guidance in such circumstances.

In general, the College believes that the Consultation Draft Code of Conduct for Chiropractors needs to be more prescriptive, in order to avoid confusion by chiropractors as to its intent and to provide clear unambiguous guidance for chiropractors as to what is acceptable and unacceptable conduct.

It is also worthy to note that under the proposed legislation an approved registration standard or a code or guideline approved by a National Board, is admissible in proceedings as evidence of what constitutes appropriate professional conduct or practice for the health profession. The College suggests that codes of conduct and guidelines on practice standards, which lack specificity or are ambiguous and generic in nature, could not be used as evidence in any disciplinary actions taken by the Board, as they open themselves to criticism and become vulnerable to different interpretations.

The "Code of Conduct" should be designed in such a way as to provide practitioners with a framework to guide professional judgement and to assist the Board in their fundamental role of protecting the public by setting and maintaining standards of good practice. The code should also provide the CBA with a framework upon which it can make decisions regarding registration applications and notifications of misconduct. The proposed code fails to fully address these aims, particularly in relation to guidance in matters of misconduct and more importantly protection the public.

Specifically the College urges the CBA to address the following areas of conduct:

Professional Values and Qualities/Providing Good Care

Chiropractic Care of Children

The Board suggests that practitioners should have qualifications and experience when providing advice on over the counter scheduled medicines, herbal remedies and vitamin supplements.

The treatment of children by chiropractors a for wide range of health conditions appears to be expanding, yet the Board has not seen fit to alert practitioners that they should consider whether they have appropriate training and qualifications to undertake such treatment.

Certain treatments, assessments and examination procedures for children require far more extensive training and experience than provided in some undergraduate chiropractic teaching institutions. It is incumbent on chiropractors who engage in the treatment of children to possess the necessary training, skills and experience to competently provide care for children.

Recommendation: That the code of conduct is amended to include a statement that practitioners should be aware that assessment, examination and treatment of children may require skills, training and or experience beyond that provided in undergraduate training.

Health Screening
Practitioners should be aware that "screening" for health problems may be associated with harms such as false positives which may generate patient anxiety and unnecessary treatment.

Recommendation: That the code of conduct is amended to include a statement that when practitioners engage in health screening they should be aware of the reliability of the screening method and inform participants involved in the screening of the potential for false positive results.

Informed Financial Consent – Fees
Where patients elect to undergo pre-paid financial agreements, relating to their care, it is incumbent on practitioners to justify ongoing treatment beyond 3 months or 12 visits via the use of validated patient outcome measures. Evidence based practice guidelines for all health professionals require clinical justification via the use of validated outcome measures in any long term treatment program and this form of justification should be mandatory for chiropractors who engage their patients in protracted treatment plans.

Recommendation: That the code of conduct is amended to include a statement that where treatment extends beyond 3 months or 12 visits, whichever is the greatest, that clinical justification for continued care includes the use of validated patient outcome measures.

Use of Diagnostic Tools, Tests and Procedures
The College agrees with the general thrust and intent of the code with respect to the use of diagnostic tools, tests and procedures. However, the College suggests that specific reference is required for practitioners using surface electromyography (sEMG) and thermography. These diagnostics aids are widely used by many chiropractors in advertising their practices and in the diagnostic evaluation of patients. Many chiropractors are potentially mislead as to the clinical reliability or validity of these instruments, either by the promotional advertising put forward by the manufacturers of these instruments or by research that does not withstand critical appraisal. The Chiropractors Registration Board of Victoria recently undertook an extensive literature review on the reliability and validity of sEMG, as typically used by chiropractors. (1) After reviewing this study and others,(2-9) the Board concluded that there is a lack of good quality evidence to support the clinical use of sEMG by chiropractors as a diagnostic tool in the assessment of functional biomechanical disorders of the spine, including the detection of vertebral subluxations.

The Board was of the opinion, that the use of sEMG in clinical practice by some practitioners may expose the public to the risk of receiving a misdiagnosis, inappropriate treatment or treatment not necessarily required for their health and well-being. Similar criticisms and potential harms also arise from the use of thermography in chiropractic practice(5,8). Many chiropractors may not possess the skills necessary to critically appraise the literature and scientific merit of theses diagnostic tools and may therefore be mislead by misinformation or inaccurate information as to the diagnostic reliability and validity of these instruments.

Therefore, in such circumstances chiropractors should be guided by the CBA on the appropriate clinical use of these instruments.

Recommendation: That the code of conduct be amended to reflect that the current scientific evidence does not support the use of static sEMG or thermography in the diagnosis or prognosis of vertebral subluxations or other neuro-pathomechanical syndromes.

1. Brian Budgell D.C., Ph.D.The Use of Surface Electromyography in the Assessment of Functional Biomechanical Disorders of the Spine A Report to the Chiropractors Registration Board of Victoria Submitted July 12, 2007
2. Clinical utility of surface EMG: report of the Therapeutics and Technology Pullman SL, Goodin DS, Marquinez AI, Tabbal S, Rubin M. Clinical utility of surface EMG: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Neurology 2000 Jul 25;55(2):171-7.
3. Technology review: the use of surface EMG in the diagnosis and treatment of nerve and muscle disorders American Association of Electrodiagnostic Medicine American Academy of Physical Medicine and Rehabilitation *Muscle Nerve* 22: Supplement 8: S239-S242, 1999
4. Kamei K, Kumar DK, Polus BI. Reliability and validity of surface electromyography (SEMG) to study the functional status of lumbar paraspinal muscles during execution of the unsupported sitting posture Chiropractic Journal of Australia (1)37;2007
5. Chiropractic Best Practices. A Systematic Review by the Research Commission of the Council on Chiropractic Guidelines & Practice Parameters
6. Austin D McMillin The role of diagnostic instrumentation in the evaluation of spine trauma. Publication title:Topics in Clinical Chiropractic. Frederick: Sep 1998. Vol. 5, Iss. 3;
7. Meyer JJ. The validity of thoracolumbar paraspinal scanning EMG as a diagnostic test: an examination of the current literature. J Manip Ther Physiol 1995:18(7);482-4
8. Boline PD et al Interexaminaer reliability of eight evaluative dimensions of lumbar segmental abnormality: Part II J Manip Physiol Ther 1993:16(6); 363-74
9. Lehman GJ, McGill SM. The importance of normalisation in the interpretation of surface electromyography: A proof of principle. J Manip Physiol Ther 1999:22(7)

Public health – Vaccination

The College refers the Board to its previous submission in this regard. It is assumed that the Code of Conduct for Registered Health Practitioners was intended to apply to all health practitioners, including chiropractors. As previously stated this code of conduct emphasises that as part of good practice, practitioners have a responsibility to promote the health of the community, through disease prevention and control and education. The code also suggests that practitioners put aside their own personal beliefs and values, when they conflict with professional values, such as health promotion and disease prevention and that they understand the principles of immunisation against communicable diseases and ***be immunised against relevant communicable diseases.*** The current draft code of conduct does not contain the recommendation for chiropractors to be immunised against relevant communicable diseases. However, a review of the codes and guidelines of the various health practitioner boards indicates that, with the exception of the Psychology Board of Australia, the six other Boards, who have issued codes of conduct for their professions, suggest that good practice involves not only understanding the principles of immunisation against communicable diseases but also for practitioners to be immunised against relevant communicable diseases**.**

Given that most other boards have adopted this sensible and accountable approach to immunisation, the College would be grateful if the Board would provide the rationale it employed to justify its position in this regard.

There is clear scientific consensus in favour of mass vaccination as a safe and cost effective public health intervention. Most State and Territory Governments, in line with recommendations form the National Health and Medical Council of Australia, (1) either require or recommend that health care workers who are in contact with their patients be immunised against relevant communicable diseases.

This consensus is reflected in the strong pro-vaccination policies adopted by the United Nations, the Victorian and Australian Governments and governments of most other developed countries.

Substantial evidence exists that many chiropractors adopt an anti-vaccination policy and that often those personal beliefs are discussed with their patients and in so doing they may discourage those patients, and their children, from undergoing vaccination. (2,3)

The College can only restate its view, that the Board include in its code of conduct, reference to the need for chiropractors to set aside any anti-vaccination beliefs they have, in favour of the promotion of health and disease prevention through vaccination and to be immunised against relevant communicable diseases.

Recommendation: That the code of conduct is amended to include statements:

a) That chiropractors should ensure that any information they provide to patients accurately reflects the contemporary scientific evidence in favour of vaccination and that the Victorian and Australian governments have in place pro-vaccination policies.
b) That when any information is provided to patients regarding any side-effects or negative impacts of vaccination that the information is balanced in content, reflects the current scientific research in this area and is not provided outside its appropriate context.
c) That the display of posters, pamphlets or other written material is balanced in content and reflects the current scientific research in this area.
d) That, unless the practitioner has appropriate training in this field, when asked by a patient or the public to comment on or provide information on vaccination or immunisation, that the patient or public be referred to other health professionals with more extensive knowledge and training in this field.
e) That practitioners should be immunised against all relevant communicable diseases.

1. NH&MRC. Infection Control in a Health Care Setting. Guidelines for the prevention of transmission of infectious diseases. 1996. http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/withdrawn/ic6.pdf
2. Page SA et al Immunization and the chiropractor-patient interaction: a Western Canadian study. J Manip Physiol Ther 2006;29(2):156-61
3. Smith PJ et al. Association between health care providers' influence on parents who have concerns about vaccine safety and vaccination coverage. Paediatrics 2006;118(5):e1287-92

Professional boundaries

The draft code of conduct in this area of practice predominately deals with exploiting the vulnerability of patients and the abuse of the practitioners' position of power in relation to practitioner patient sexual relationships. The previous draft code of professional practice covered this important area of practitioner/patient inter-relationships in far more detail than the current draft code of conduct. While the College does not recommend that all the matters raised in the previous code of practice be included in this code, it does suggest that examples of some forms of unacceptable behaviour be included in this section of the code, in order for practitioners to fully understand what the Board and society consider to be transgressions of professional boundaries.

Recommendation: That the code of conduct is amended to more clearly delineate the type and nature of professional boundary transgressions.

Health records

The College suggests that the proposed code of conduct does not adequately address a practitioner's responsibility with respect to the maintenance and handling of health records. Practitioners should be alerted to their responsibilities as mandated under the Australian Government, Office of the Privacy Commissioner and individual State and Territory legislation, relating to the maintenance and handling of health records.

Recommendation: That the code of conduct is amended include reference to Australian, State and Territory government legislation in respect of the maintenance and handling of health records.

Teaching, supervising and assessing

The current draft code of conduct fails to adequately address and give guidance to field practitioners engaged in clinical supervision, mentoring or assessment of students. While the College understands that many aspects of this form of student training will be addressed as part of teaching institution accreditation, the Board also has a direct responsibly to the profession, students and the public in ensuring that registered chiropractors, who become involved in this form of education, have the necessary training and experience. While it is beyond the scope of this submission to provide the Board with a detailed proposal relating to student supervision and assessment the College strongly recommends that the Board issue specific guidelines on this aspect of student training. Failure to do so may result in students receiving inadequate or inappropriate supervision and training and therefore place the public at increased risk.

Recommendation: That the code of conduct be amended to include appropriate guidelines on student supervision and intern placement in private chiropractic practices.

The current code of conduct, point 11.4, c), relating to Students, states that patients be informed about the involvement of students and encouraged to provide their consent for student participation. The College suggests that before a student actively participates in the clinical encounter, that formal informed consent be obtained from the patient. In cases where a student is passively involved in the clinical encounter, such as during observation, that consent also be obtained. Consent in these circumstances may be verbal and if provide by the patient it should be recorded in the patient's clinical file. The patient should also be advised, as part of the consent process, that any refusal to allow student involvement will not adversely affect the provision of care by the supervising chiropractor.

Recommendation: That the code of conduct is amended to include a provision:

That where a student is actively involved in a clinical encounter that formal informed consent be obtained from the patient prior to the student involvement.

That where a student is passively involved a clinical encounter, such as observation, that as a minimum verbal informed consent be obtained from the patient prior to the student involvement

That in any circumstance where a student is involved in a clinical encounter that the patient is informed that they may refuse to allow student participation and that such refusal will not adversely affect the provision of care by the supervising chiropractor.

Reporting Child Abuse

The College notes that the previous Code of professional practice for chiropractors in Australia, included reference to the legal responsibility of chiropractors to report suspected child abuse to the relevant authorities.

As chiropractors concern themselves mainly with the treatment of musculoskeletal conditions it is possible that they may be asked to treat children with injuries that result from child abuse. The College therefore recommends that the code of conduct be amended to include appropriate guidance for practitioners should they encounter suspected child abuse.

Recommendation: That the code of conduct be amended to include the following clauses relating to the reporting of suspected child abuse:

In each State, the law relating to child protection is set out in relevant legislation.

Most State Acts make it compulsory for certain groups of people to report suspected child abuse to their local child protection service or agency when they have formed a reasonable suspicion, in the course of their work, that a child or young person has suffered or is suffering sexual abuse or non-accidental physical injury.

A practitioner who has formed a reasonable suspicion that a child or young person has suffered or is suffering sexual abuse or non-accidental physical injury should report the matter to their local child protection service or agency.

If not otherwise required to by relevant legislation, a practitioner who believes or suspects that a child or young person is in need of care and protection should report the matter to their local child protection service or agency.

Spinal Screenings

Given the aims and nature of public spinal screenings it is not possible to provide screening participants with any diagnosis and therefore any suggestions on proposed treatment. Further, during spinal screenings some chiropractors utilise tools and equipment which lack the necessary clinical reliability and validity for such a purpose, such as sEMG and thermography.

Recommendation: That the code of conduct is amended to include statements:

Due the aims and nature of public spinal screenings it is inappropriate to offer screening participants with any diagnosis or treatment options.

Only tools and instruments which have been shown to have acceptable levels of reliability and validity should be used in spinal screenings.

Radiology/Radiography

The scientific literature now strongly warns all health practitioners about the harms caused by excessive and unnecessary radiation and the need to carefully examine the risk/ benefit ratio before performing any diagnostic radiation procedure. Evidence based practice suggests that diagnostic X-ray examinations should only be performed when there is adequate clinical justification.

As previously mentioned, the Board's reference to the American College of Radiology's, "Practice guideline for the performance of spine radiography in children and adults, Revised 2007," is misleading. This guideline lists as one criteria, as a general indicator for spinal X-rays, "pain or limitation of motion". The ACR's 2008 Appropriateness criteria for the use of X-ray in cases of low back pain do not include "pain or limitation of motion "as an indicator for X-ray investigation. (1) In fact the revised paper states "It is now clear from the above studies and others that uncomplicated acute low back pain or radiculopathy is a benign self-limiting condition that does not warrant any imaging studies."

This recommendation is in keeping with other published recommendations on the use of radiography for spinal pain. In particular, this recommendation is supported by the NH&MRC's 2008 publication, "Lumbar spine imaging in acute non-specific low back pain – A summary of the best available and information on current clinical practice." (2) Furthermore, a literature search, of the international scientific literature for clinical practice guidelines for acute non-specific low back pain resulted in 13 guidelines, all of which recommended against the use of X-rays in the absence of "red flags".(3-15) Similar guidelines were also published by the Department of Health in Western Australia in relation to non-traumatic neck pain. These guidelines also recommended that plain film X-ray examination should only be performed in the presence of "red flags".(16)

With respect to chiropractic radiography, in 2008 Bussières et al (15) published an expert consensus on "Diagnostic imaging practice guidelines for musculoskeletal complaints in adults -An evidence-based approach-Part 3: spinal disorders."

The consensus was arrived at after 45 Delphi panellists undertook to formulate radiography guidelines for the chiropractic profession. These guidelines are in agreement with other recognised guidelines on the use of spinal radiography and do not support the use of radiography except in the presence of recognised "red flags". The author's also stated that routine lumbar spine radiography is not indicated because of the low incidence of unexpected findings and that X-rays taken to identify spinal anomalies such as blocked vertebrae, spina bifida occulta, facet tropism etc. prior to spinal manipulation are not recommended.

The study also recommends that radiography should not be performed for the purpose of biomechanical and postural analysis. This is an important recommendation, as some chiropractors routinely use X-rays to perform such tasks and to detect vertebral subluxations or perform periodic spinal X-rays, in order to quantify changes in spinal posture, as a consequence of treatment provided.

The College suggests that in order to provide clear guidance on the appropriate use of spinal radiography in chiropractic practice, that the Board publish the specific indicators for plain film radiography as previously presented as "red flags" in the Code of Professional Practice for Chiropractors in Australia.

The College suggests that practitioners be informed that routine or repeat radiography in chiropractic practice, to assess postural and biomechanical disorders, is not supported by the literature and may be inappropriate.

The College also suggests that in the absence of other clinical signs and symptoms, the use of spinal radiography to detect congenital anomalies of the spine, without justifiable clinical signs and symptoms is not supported by the literature and may be inappropriate.

Recommendation: That the code of conduct be amended to give clear guidance for practitioners in the use of spinal radiography:

A practitioner must be able to justify any decision to obtain any diagnostic imaging of a patient and demonstrate that any benefits outweigh the risks associated with ionizing radiation.

The need for X-rays must be supported from the clinical history and examination in which "red flags" (suspected pathology) are identified and in accordance with the appropriateness criteria suggested by, Bussières E et al. Diagnostic imaging practice guidelines for musculoskeletal complaints in adults - An evidence-based approach-Part3: Spinal Disorders (15)

The clinical indications for requiring X-rays of children is limited to conditions such as fracture, dislocation, bone pathology, unresolved skeletal/spinal pain, scoliosis and to exclude or confirm a clinical suspicion of conditions which may be a contra-indication to proposed care.

Routine X-ray screening of consumers including the routine evaluation or re-evaluation of biomechanical/postural disorders, other than for progressive scoliosis or other exceptional circumstances, is not supported by the scientific literature and may be inappropriate.

X-ray examination for the detection of congenital anomalies of the spine, without justifiable clinical signs and symptoms, is not supported by the scientific literature and may be inappropriate.

1. ACR Appropriateness criteria. Low back pain. Uncomplicated acute low back pain and or radiculopathy, non- surgical presentation. No red flags. American College of Radiology 2008.
2. Lumbar spine imaging in acute non-specific low back pain – A summary of the best available and information on current clinical practice. National Health and Medical Research Council. 2008 http://www.nhmrc.gov.au/_files_nhmrc/file/nics/news_events/Lumbar%20imaging%20in%20acute%20non-specific%20low%20back%20pain%20%5BPDF%20130%20KB%5D.pdf
3. Institute for Clinical Systems Improvement (ICSI) 2008
4. New Zealand Guidelines Group (NZGG) 2004

5. American College of Physicians and American Pain Society 2007
6. Work Loss Data Institute 2007
7. Michigan Quality Improvement Consortium 2008
8. American College of Occupational and Environmental Medicine 2007
9. University of Michigan Health System 2005
10. European Guidelines for the Management of Acute Non-specific LBP in Primary Care 2004
11. American College of Radiology 2008
12. Council on Chiropractic Guidelines and Practice Parameters (CCGPP) 2008
13. National Institute of Clinical Excellence (NICE) 2009
14. Towards Optimising Practice 2009
15. Bussières E et al. Diagnostic imaging practice guidelines for musculoskeletal complaints in adults -An evidence-based approach-Part 3: Spinal Disorders J Manip Physiol Ther 2008;31(3):33-88
16. Diagnostic Imaging Pathways – Non-traumatic neck pain. Dept of Health Western Australia 2007. http://www.imagingpathways.health.wa.gov.au/includes/dipmenu/neckpain/summary.html

Duration and Frequency of Care

The CBA is and should be committed to encouraging chiropractors to practise evidence based health care. The College believes that the Board has a responsibility to the public to prohibit or limit treatments, provided by chiropractors that are ineffective or lack evidence of efficacy and in this regard this responsibility to the public is even more compelling, when other treatment options have been demonstrated to be beneficial. (1). A recent systematic review of the effectiveness of manual therapy, indicates that many non-musculoskeletal conditions, for which chiropractors treat with spinal manipulation, are either ineffective or lack sufficient evidence of efficacy. Simply claiming a therapy to be effective when there is no evidence to support this claim is unacceptable in the modern day culture of evidence based practice. (2)

Recommendation: That the code of conduct be amended to include statements:

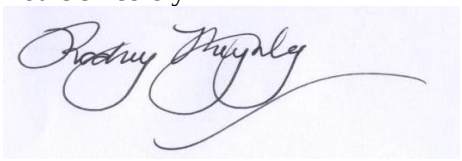
That it is inappropriate to provide chiropractic therapy for conditions, where the scientific evidence has shown it to be ineffective.

That it is inappropriate to provide chiropractic therapy for conditions where there is insufficient evidence to support its use and where other treatment options have been shown to be effective.

1. Bronfort G, Haas M, Evans R, Leiniger B, Triano J. Effectiveness of manual therapies: the UK evidence report. *Chiropractic & Osteopathy* 2010, 18:3 doi:10.1186/1746-1340-18-3
2. Haldeman S. Commentary on the United Kingdom evidence report about the effectiveness of manual therapies. *Chiropractic & Osteopathy* 2010, 18:4 doi:10.1186/1746-1340-18-4

We thank the Board for the opportunity to provide this submission and hope that our comments and suggested amendments assist the Board in the development of its code of conduct.

Yours sincerely



Mr. Rodney Kreymborg
General Manager