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DISCUSSION PAPER

CONSULTATION SESSION

CODE OF CONDUCT FOR CHIROPRACTORS

TO

DR PHILLIP DONATO, CHIROPRACTOR

CHAIR
CHIROPRACTIC BOARD OF AUSTRALIA

FROM

CHIROPRACTORS' ASSOCIATION OF AUSTRALIA

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2.1 Providing Good Care – addition of b) from draft Code of Practice

2.1 Introduction

Care of the patient is the primary concern for chiropractors in clinical practice. Providing good care includes:

a). assessing the patient, taking into account his or her history, views and an appropriate physical examination where relevant; the history includes relevant psychological, social and cultural aspects

b). ensuring that the diagnosis is relevant, justifiable and based on sound clinical reasoning

c). formulating and implementing a suitable management plan (including providing treatment and advice and, where relevant, arranging investigations and liaising with other treating practitioners)

d). facilitating coordination and continuity of care

e). recognising the limits to a chiropractor's own skill and competence and referring a patient to another practitioner when this is in the best interests of the patients

f). recognising and respecting the rights of patients to make their own decisions.

This section is primarily drawn from section 2.1 of the AMC Code of Conduct.

2.1 b): CAAN believes that in light of 2.1 a) and c), 2.1 b) is unnecessary. There is no correlating clause in the AMC document. 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.

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

CAAN recommends the removal of section 2.1 b

2.2 Good Care – addition of part a) and i) in relation to skill and competence

Maintaining a high level of professional competence and conduct is essential for good care. Good practice involves:

a). recognising and working within the limits of a chiropractor's competence and scope of practice and seeking advice from or referring patients to a more suitably qualified practitioner when it is considered in the patient 's best interests

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 [the individual chiropractor's] competence and scope of practice."

Section 2.2 i):

i). ensuring that services offered are provided with the best possible skill, care and competence

is also a new addition to the points in the AMC document. It adds nothing to points relating to safety and quality previously addressed in section 2.1 and elsewhere in section 2.2.

CAAN suggests the removal of clause 2.2 i).

3.4 Confidentiality and Privacy – addition of parts g) and h)

Chiropractors have ethical and legal obligations to protect the privacy of people requiring and receiving care. Patients have a right to expect that chiropractors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations. Good practice involves:

a). treating information about patients as confidential

b). seeking consent from patients before disclosing information where practicable

c). being aware of the requirements of the privacy and/ or health records legislation that operates in relevant States and Territories and applying these requirements to information held in all formats, including electronic information

d). sharing information appropriately about patients for their health care while remaining consistent with privacy legislation and professional guidelines about confidentiality

e). where relevant, being aware that there are complex issues relating to genetic information and seeking appropriate advice about disclosure of such information

f). providing appropriate surroundings to enable private and confidential consultations and discussions to take place

g). ensuring that a patient's confidentiality, privacy and standards of care are maintained even in a practice setting where there is limited auditory and visual privacy

h). the ability to offer at least one private consulting room for confidential consultations and discussions to take place

i). ensuring that all staff are aware of the need to respect the confidentiality and privacy of patients and refrain from discussing patients in a non-professional context

j). using appropriate consent forms for release of information which limits disclosure to relevant health and medical information.

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); i.e., revert to the same guidelines as exist for medical practitioners rather than having a more prescriptive standard. See summary statement, next page.

Summary: remove all but a) and d). Sections a), d) and e) are drawn from the AMC Code. Section e) is not relevant to chiropractic practice.

Therefore delete all but a) and d).

3.5 Informed Consent - Addition of b) and d) from draft Code of Practice

Informed consent is a person's voluntary decision about health care that is made with knowledge and understanding of the benefits and risks involved.

A useful guide to the information that chiropractors need to give to patients is available in the National Health and Medical Research Council (NHMRC) publication General Guidelines for Medical Practitioners in Providing Information to Patients (www.nhmrc.gov.au).

The NHMRC Guidelines cover the information that chiropractors should provide about their proposed management or approach, including the need to provide more information where the risk of harm is greater and likely to be more serious and advice about how to present information.
Good practice involves:
a). providing information to patients in a way they can understand before asking for their consent
b). an explanation of the treatment recommended, it's (sic) likely duration, expected benefits and cost, any alternative(s) to the proposed care and their relative risks/benefits as well as the likely consequences of no care
c). obtaining informed consent or other valid authority before undertaking any examination or investigation, providing treatment (except in an emergency) or involving patients in teaching or research, including providing information on material risks
d). that consent is freely given, there should be no coercion or pressure exerted in an attempt to gain consent
e). when referring a patient for investigation or treatment, advising the patient that there may be additional costs, which he or she may wish to clarify before proceeding
f). when working with a patient whose capacity to give consent is or may be impaired or limited, obtaining the consent of people with legal authority to act on behalf of the patient and attempting to obtain the consent of the patient as far as practically possible
g). documenting consent appropriately, including considering the need for written consent for procedures which may result in serious injury or death.

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. It has no correlate in the AMC Code.

CAAN recommends the removal of section 3.5 d).

3.6 Informed financial consent – fees - Modification of consent from draft Code of Conduct and add 1.6 Fees from draft Code of Practice

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.

CAAN is concerned that section 3.6 may limit access to care and freedom of health care choice for Australians. CAAN suggests that chiropractors and their patients be free to make reasonable financial arrangements, 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.

4 Working Within Practice – additional section, some reference take from draft CoP (NB see 4.2 in draft Code of Conduct and 2.7, 2.9 in draft Code of 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."

5.5 Delegation to unregistered staff and assistants – additional section, some references taken from draft Code of Practice

CAAN supports the CBA's modifications to section 5.5

9.4 Health Records – addition of f) and i) and modifications to d) and e)

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".

CAAN supports the additions of f) and i). However, we recommend other changes to 9.4 as noted in our submission dated 21 May 2010.

9.12 Financial and Commercial Dealings – addition of f): modified from 4.5 of draft Code of Practice.

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.

9.12 f) not directly or indirectly sharing or agreeing to share fees paid by a patient with any other person who is not an employer, employee, principle or associate of the chiropractor, or receive other forms of remuneration, without the informed financial consent of the patient

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 deletion of 9.12 f). However, we recommend changes to other parts of 9.12 as noted in our submission dated 21 May 2010.

Appendix I – Spinal screenings – from 5.1 of draft Code of Practice

CAAN has some significant concerns with Appendix I: Guidelines in relation to public spinal screening.

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 II – Radiology/Radiography – from modified 2.6 draft Code of Practice

Comments on Appendix II come from the CAAN radiology committee, comprised of senior lecturers in chiropractic radiology at all three Australian chiropractic university undergraduate programs, four experienced field practitioners and a provider of diagnostic services with a masters degree in radiology from Wales University.

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" (as opposed to any suggestion of dose limits relative to patients) 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. (Modification underlined)

Justification:

CAAN suggests that the spelling, grammar and phrasing of this wording require 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 III – Frequency and Duration of Care – from modified 2.11 draft Code of Practice

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. Delete.

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 implementing 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. Delete.

CAAN recommends the deletion of Appendix 3