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SUBMISSION RELATING TO

CONSULTATION PAPER ON CODES AND GUIDELINES

TO

DR PHILLIP DONATO, CHIROPRACTOR

CHAIR
CHIROPRACTIC BOARD OF AUSTRALIA

FROM

CHIROPRACTORS' ASSOCIATION OF AUSTRALIA

7 April 2010

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This submission is in response to the Consultation paper on codes and guidelines prepared by the Chiropractic Board of Australia.

INTRODUCTION

The Chiropractors Association of Australia (National) Ltd (CAAN) is the peak body representing chiropractors in Australia.

CAAN works at the national level to support chiropractors in practice. We build capacity in chiropractic practice, working at the local level towards a skilled, viable and effective chiropractic sector to improve the health and well-being of Australian communities.

The Chiropractors' Association of Australia, through its state and national branches, provides the organisational interface between government and other stakeholders and chiropractic practice.

CAAN's Code of Professional Conduct for Chiropractors is one of the benchmarks of quality and safety in chiropractic practice and provides future directions for quality improvement.

The CAAN Board is pleased to provide this submission to the Chiropractors Board of Australia (CBA). We hope that the committee will consider the CAAN's feedback provided from across the profession in its ongoing and substantive reviews of the standards.

CAAN would greatly appreciate the opportunity to provide experts and industry representation on the CBA's Guidelines Committee. The submission is presented in key themes and with a focus on those standards and criteria where practice improvement might significantly impact on all groups in our community.

CAAN appreciates the opportunity to provide input on this submission to the CBA to assist in the development of codes and guidelines for the chiropractic profession in Australia.

However, we are concerned that the time allowed for consultation has not facilitated as wide a consultation process as we would have preferred and consequently has not met the CBA's own standard of "wide ranging consultation".

CAAN believes that with the changes recommended in this submission, the CBA guidelines for the practise of chiropractic could be the finest in the world, protecting both the public and the unique nature of the practice of chiropractic.

Please contact our CAAN Chief Executive Officer, Krystina Brown, for any information regarding this submission. Her contact details are on the cover page of the submission.

GUIDELINES ON ADVERTISING

CAAN supports the concept of maintaining high ethical standards in chiropractic advertising. However, we have some concerns with the guidelines for the advertising of regulated health services.

3. Professional Obligations

Substantiation of Claims

Does the Board now intend for chiropractors to warn of "material risks" associated with chiropractic care in all advertising? Considering the relatively benign nature of the vast majority of abreactions to chiropractic care, this seems overly onerous. In particular, CAAN would have concerns about the requirement to warn about the possibility of VAD/stroke given the recent research by Cassidy, Winterstein et al and others which questions the causal relationship between chiropractic cervical adjusting and VAD/stroke.

Many common daily activities have been linked to the onset of stroke. An example of this is drinking from a soft drink can. (*Terrett AGJ. Current concepts in vertebrobasilar complications following cervical manipulation. 2001 NCMIC Group Inc., West Des Moines, Ia.*) By the proposed standard, sellers of Coca Cola should be required to warn the public of this in their advertising too.

Authorising the content of advertising

CAAN is concerned that practitioners are expected to be responsible for the editing and editorialising of journalists. Expecting editorial control is unrealistic. Barring practitioners from being involved in media unless they have editorial control is an unreasonable expectation, especially for CAA media spokespeople.

Suggested wording:
"The chiropractor should take all reasonable steps to ensure accuracy of the reported story."

5. What is unacceptable advertising?

5b. In health care, there are often "windows of opportunity" for being able to impact on the health of individuals. In some cases, time pressures exist. Does the Board always consider it unreasonable to use the phrase "Don't delay" or similar?

eg: Don't delay getting moles checked?
Don't delay having a blood-pressure assessment?
Don't delay getting your child's spine and nervous system checked after a fall?

5f. When compared to rates of medical harm chiropractic is comparatively far safer. The safety record of chiropractic is unequivocally better than that of the medical profession. Medications are more dangerous than chiropractic care by a factor of hundreds. *(Rome, CJA 1999; Dabbs and Lauretti, JMPT 1996*) Surgical intervention is more dangerous than chiropractic care by a factor of tens of thousands. (*Coulter Int J Integ Med, 1999*) For the chiropractic profession to be prevented from telling the public these facts constitutes a public health risk. CAAN is deeply concerned that paragraph **5f** of this section is both anti-competitive and more importantly, potentially dangerous to the health of the public.

Not to state such figures could be construed as false and misleading!

5j. Again, what health risks does the CBA require practitioners to warn against in their advertising?

5m. CAAN is of the opinion that there are circumstances in which it is appropriate to encourage some consumers to undertake a service. We believe that it is unreasonable to suggest that

this should "not ever" happen in advertising. CAAN agrees, however, that all such information needs to be factual and not written in a scare-mongering way.

6. Specific requirements

6.5 Advertising of price information

After reviewing the ACCC website and the National Law, CAAN fails to understand why practitioners may not advertise time-limited or special offers. We consider that this requires a legal opinion to determine whether this clause constitutes an unlawful restraint of trade.

7. Advertising of Therapeutic Goods

CAAN welcomes this guideline, particularly as it pertains to the use of supplements by chiropractors.

GUIDELINES FOR MANDATORY NOTIFICATION

CAAN sees the potential for serious issues with the current structure of the mandatory reporting process. We are absolutely committed to the safety of the public, however there are too many loopholes in this section that may encourage vexatious complaints.

CAAN believes that registered health practitioners have a responsibility to approach practitioners who they believe may be breaching guidelines. If that approach fails, then perhaps reporting to a regulatory authority would be the next step?

Decision guide: notifying sexual misconduct

This flow-chart reads as if a voluntary notification could be made to the board about an allegation of sexual misconduct even though the first practitioner has no evidence or even belief that the second practitioner has engaged in inappropriate sexual activity with a current or former patient.

Similar confusion exists with regards to the flow-chart on “departure from accepted professional standards” and “student impairment”.

CAAN has reservations about the inflexibility of this section.

BOARD CODE OF CONDUCT

CAAN strongly supports the goal of effective health care delivered in an ethical framework. A code of conduct that allows for the values and beliefs of practitioners and their clients and still achieves that goal would be a wonderful addition to the chiropractic profession.

In particular, CAAN believes that clear, honest and effective communication between practitioners and their clients is an effective prophylaxis for health consumer complaints.

1.2 Professional values and qualities

Practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice.

CAAN believes that manual spinal care such as the chiropractic adjustment or similar procedures should only be performed by chiropractors or other practitioners of similar training.

1.3 Australia and Australian health care

As an association with members from a diversity of cultural backgrounds, CAAN supports and encourages awareness and appreciation of the many cultures that exist in Australia.

2. Providing good care

CAAN believes that the best interests of the health consumer are of paramount importance in their relationship with their health care practitioner.

CAAN believes that there are, however, times when the "alleviation of symptoms" may not be in the long-term best interests of a client. For instance, it may be necessary to work on painful areas of the body to help in the rehabilitation and repair of injured tissues.

3. Working with patients or clients

CAAN completely concurs with the statement "Relationships based on openness, trust and good communication will enable practitioners to work in partnership with patients or clients.

3.14 Personal relationships

CAAN suggests that most chiropractors would be the primary provider of chiropractic services to their team and family. Does this breach the code? As long as there is good case management, is this a real issue? CAAN recommends the use of section 6.9.2.1 of the CAAN Code of Professional Conduct and Practice for Chiropractors (2005):

> *"As chiropractic does not involve critical care (such as surgery) and does not involve in-depth exploration of the patient's psyche (such as occurs in psychology) and as chiropractic has a philosophy that health care is more than the treatment of symptoms and disease and often involves asymptomatic care, it is the policy of the CAA that chiropractors maintain the privilege of providing chiropractic care to their immediate family members and partners, providing that:*
> - *adequate records are kept;*
> - *confidentiality is maintained;*
> - *at all times an option to discontinue care is maintained."*

4. Working with other practitioners

CAAN agrees that a good relationship with colleagues and other health practitioners enhances patient care.

5. Working within the health care system

CAAN concurs that practitioners have a responsibility to contribute to the effectiveness and efficiency of the health care system. We believe chiropractic has a great deal to offer the health care system in this regard. In particular, chiropractors have great potential as primary contact practitioners able to conduct health education, promotion and screening.

6. Minimising risk

CAAN believes that risk minimisation is an important part of the responsibility of all health practitioners. We play an active part in assisting our members to develop and implement appropriate risk management strategies.

CAAN has some concerns about the intention of section 6.3. Is a "professional organisation" exempt from mandatory reporting? Or do we need to institute a risk management process whereby only non-chiropractors (not bound by the Act or these guidelines) talk to members who are at risk of breaching guidelines. However, does this raise the issue of company directors who ARE chiropractors being prosecuted for failure to notify because we devolved responsibility in these areas to non-chiropractors?

7. Maintaining professional performance

CAAN fully supports the concept of ongoing professional development to improve chiropractors' skills in assisting their patients and to keep chiropractors at the forefront of health care delivery. In particular, we are committed to the provision of continuing professional development programs of the highest quality.

8. Professional behaviour

CAAN's commitment to the highest standards of professional behaviour is reflected in its own Code of Professional Conduct and Practice for Chiropractors.

9. Practitioner Health

CAAN agrees that practitioner health and wellbeing is an important ingredient in the provision of quality health care.

9.2 c) Good practice involves understanding the principles of immunisation against communicable diseases and being immunised against relevant communicable diseases.

CAAN is concerned that this may threaten the individual rights of practitioners to manage their own health care in the way they see fit. All Australians have these rights under the Australian Charter of Health Care Rights. In particular, the ACHCR states:

> *"I have the right to be included in decisions and choices about my care. I may join in making decisions about my care and about health service planning."*

10. Teaching, assessing and supervising

CAAN supports and encourages the mentorship, teaching and supervision of practitioners and students as an important part of personal and professional development.

11. Undertaking research

CAAN supports expansion of the knowledge base through quality research conducted in accordance with NH&MRC guidelines.

CODE OF PROFESSIONAL PRACTICE FOR CHIROPRACTORS IN AUSTRALIA

CAAN agrees with the CBA's sentiments that chiropractors have responsibilities and obligations to consumers of their health services, to the chiropractic profession and to the broader community to provide safe, beneficial, responsible and competent health care which meets best practice standards and is responsive to individual, group and community needs, within a context of justice and respect for peoples' rights.

However, CAAN is of the opinion that many sections of this document unnecessarily duplicate the Board Code of Conduct for registered health practitioners. This opinion is supported by the presence of repeated references to the Code of Conduct for Health Practitioners made throughout sections 1, 2, 4 and 5 of the Code of Professional Practice for Chiropractors in Australia.

CAAN respectfully suggests that Section 3 - Working within the practice environment - is unnecessary because it simply replicates requirements made in other legislation and therefore adds nothing in the way of guidance to Australian chiropractors over already existing guidelines.

The CBA is the only registration board of the ten AHPRA boards that has decided to create its own code of professional conduct. All other boards have chosen to use the Code of Conduct for Health Practitioners or supported an existing code of conduct from another body within the health profession they represent.

Unless the CBA has evidence that the chiropractic profession needs more guidance in this area than other professions, CAAN recommends that the CBA take the same approach as the Dental, Optometry, Osteopathy, Pharmacy, Physiotherapy and Podiatry Boards of Australia and use the general Code of Conduct for Health Practitioners to protect the public from unprofessional conduct/professional misconduct by registrants.

Please see Appendix I for details of CAAN concerns with sections 1 - 5 of the draft Code of Professional Practice for Chiropractors in Australia.

CAAN recommends deletion of the profession-specific code of practice for chiropractors, with the exception of specific Guidelines on Radiology and Continuing Professional Development and the retention of sections 2.12 and 2.13. Our recommendations on those areas are as follows:

RADIOLOGY

CAAN supports the development of Radiology/Radiography guidelines for the chiropractic profession.

The CAAN Radiology Committee has reviewed this section of the CBA draft guidelines in detail. The CAAN Radiology Committee consists of the heads of the radiology departments of all three Australian chiropractic teaching institutions as well as a number of field practitioners with a strong interest in the area of chiropractic radiography.

CAAN recommendations for amendments to the CBA draft Radiography/Radiology guidelines are those of the CAAN Radiology Committee.

Amendment One

That chiropractic not be limited to the proposed "red flag" list of parameters currently provided in sections 2.6.2 and 2.6.3 of the draft.

CAAN recommends that 2.6.1 reads:

"Before a procedure involving exposure of an individual to ionizing radiation is approved or commenced, it must be justified by the chiropractor. Exposure to radiation should not be adopted unless it produces sufficient benefit to the exposed individuals or to society to offset the radiation detriment it may cause."

We further recommend that section 2.6.1 be rewritten in accordance with "Justification of a medical radiation procedure", page 11, from ARPANSA
http://www.arpansa.gov.au/pubs/rps/rps14_draft1.pdf

– as follows:

2.6.1 When determining the net benefit of a chiropractic radiation procedure, the chiropractor must take into account:

(a) the specific objectives of the procedure;

(b) the characteristics of the individual involved;

(c) the total potential diagnostic or therapeutic benefits, including the direct health benefits to the patient and the benefits to society in general;

(d) the individual detriment to the patient that may result from the procedure;

(e) the pregnancy status of a female patient if there is the potential for a radiation dose to the embryo or fetus of more than 0.3 mSv;

(f) the breast-feeding status of the female patient to be administered a radiopharmaceutical if there is the potential for a:
   (i) radiation dose of more than 1 mSv to a breast-fed child; or
   (ii) significant radiation dose to the breast glandular tissue of the patient,

(g) the efficacy, benefits and risk of available alternative techniques having the same objectives, either with less exposure to ionizing radiation or in combination with the medical radiation procedure; and

(h) any medical data (such as previous diagnostic information or medical records) relevant to the medical exposure.

Background:
CAAN feels that the existing clause lacks clarity as to exactly how a practitioner can "justify any decision" and "demonstrate that any benefit will outweigh the risks associated with ionising radiation."

Since section 2.6 requests practitioners specifically comply with the provisions of the Code of Practice for Radiation Protection in the Applications of Ionizing Radiation, (ARPANSA), CAAN recommends that the ARPANSA guideline be directly referenced (as above) to give the practitioner greater guidance.

Instead of the list of indications for radiography listed in 2.6.2 and 2.6.3, we propose that the CBA adopt the American College of Radiology (ACR) Guidelines for the Performance of Spine Radiography in Children and Adults (Revised 2007, 2008).
http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/pediatric/spine_radiography.aspx

Background
Indications for radiography from a chiropractic registration board must acknowledge the particular health issues that chiropractors deal with and the particular interventions used by chiropractors. The proposed “red flags” list in sections 2.6.2 and 2.6.3 has been shortened by the standards set by nearly all international guidelines for musculoskeletal radiography. While there is some debate between international guidelines proposed for chiropractic, the ACR Guidelines are from the largest radiology body in the world. The American College of Radiology is an organization of more than 30,000 members.

ACR Indications for radiography:

A. General indications include, but are not limited to, the evaluation of:
1. Pain or limitation of motion.
2. Spinal trauma (symptomatic or at risk patients).
3. Surgical planning.
4. Previous surgery.
5. Suspected malignancy.
6. Congenital anomalies.
7. Previously detected spinal abnormality.
8. Alignment abnormalities, including scoliosis and kyphosis.

B. Specific indications include, but are not limited to, the evaluation of:
1. Shoulder or arm pain from suspected cervical radiculopathy.
2. Occipital headache.
3. Pain radiating around the chest wall.
4. Pain radiating into the buttock, hip, or groin.
5. Compression fractures.

Please note the 117 studies provided in Attachment 2 supportive of radiographic assessment of mechanical pain or where positive mechanical-based orthopedic findings are found on the initial examination and the 238 studies supportive of radiographic assessment of biomechanical health issues.

Chiropractic radiography guidelines must provide recognition of the needs of a profession that is based on physical interventions, including spinal adjustments, not medical interventions. These guidelines must provide recognition of the needs of a profession primarily assessing and managing mechanical pain and biomechanical health issues. Chiropractic radiographic indications are not specifically limited to the identification of "red-flag" pathologies.

Chiropractors manage biomechanical health factors that cause a multi-million dollar drain on the Australian health-care purse. This list of conditions includes thoracic kyphosis, degenerative disc disease and spinal osteoarthritis, scoliosis, spinal canal stenosis, mechanical neck and back pain, radicular pain and headache. We would further argue that chiropractic may offer the public comparatively safer and less expensive protocols of care compared to medical treatment in these health areas.

CAAN recommends that section 2.6.3 be removed, as the chiropractic radiographic examination of children is amply covered by the ACR guidelines.

Background**:**
Radiology for children deserves very careful consideration. CAAN acknowledges that chiropractors are primary health care professionals trained in diagnosis. We believe that this entitles chiropractors to the same recognition and scope to investigate a presenting complaint and conduct radiographic examination for further investigation when appropriate afforded to other primary health care professionals.

There are three important sections to the ACR guidelines regarding children. These guidelines recognise the role radiography may have when an adult or child presents with (a) unexplained pain, (b) pain after trauma and (c) suspicion of congenital anomalies. The ACR guidelines provide specific reference to limiting the number of views for children.

The ACR guidelines do not give *carte blanche* approval for routine radiography of asymptomatic children.

Amendment 2

CAAN recommends that section 2.6 formally states and enshrines the importance of the individual clinician's decision-making. We propose the following paraphrased statement be adopted from the American College of Radiology Guidelines.

"The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the chiropractor in light of all the circumstances presented."

The CAAN Radiology Committee also recommends the inclusion of the following statement:

"A practitioner must also be able to justify any decision to obtain any diagnostic imaging of a patient. Imaging guidelines are available to assist in this decision making process, but should not be implied to establish the legal standard of care."

Background
All radiographic guidelines acknowledge the importance of the individual clinician's decision-making. (See below.) No clinical guidelines assume that one type of assessment and one type of care must fit all clinicians for all patients all of the time. Chiropractic is a diverse profession with a growing and diverse range of relevant interventions.

CAAN notes other radiology guideline examples where the individual clinician's responsibility to, and

capacity for, making a clinical decision about the cost/benefit ratio of radiography is acknowledged.

1. The American College of Chiropractic Radiologists (ACCR) Radiography Guidelines

"Guidelines address issues common to clinical practice. They are not rules, but guidelines which attempt to define the principles of practice that should generally produce a high quality radiologic procedure. Adherence to radiography guidelines will not assure a successful outcome in every clinical situation. These guidelines are not intended to establish a legal standard of care or conduct, and deviation from a guideline does not, in and of itself, indicate or imply that such practice is below acceptable level of care. *The ultimate judgment regarding any specific procedure or course of conduct must be made by the physician/Doctor of Chiropractic in light of all circumstances presented by the individual clinical setting".*

2. The Quebec guidelines - http://www.jmptonline.org/article/PIIS0161475407003041/fulltext

"These evidence-based diagnostic imaging practice guidelines are intended to assist chiropractors and other primary care providers in decision making on the appropriate use of diagnostic imaging for specific clinical presentations. *In all cases, the guidelines are intended to be used in conjunction with sound clinical judgment and experience*. Application of these guidelines should help avoid unnecessary radiographs, increase examination precision, and decrease health care costs without compromising the quality of care. All guidelines are documents to be refined and modified regularly with new information and experience."

3. The PCCRP guidelines - http://www.pccrp.org/preface.htm

"The PCCRP Guidelines contained herein are evidence-based suggestions for appropriate radiographic evaluations of patients seeking chiropractic care. *No guideline can replace the clinical decisions made by a chiropractic practitioner in the course of treating an individual patient's health problem*. Any approach, by a practitioner, that is different from the PCCRP Guidelines, does not necessarily mean that the approach in question was below the standard of care. However, any chiropractic practitioner, who adopts a course of action different from the PCCRP Guidelines, is advised to keep sufficient patient records to explain why such an action was undertaken".

4. The father of evidence-based medicine, Sackett, points out that "… all levels of evidence and clinical experience should be considered in patient assessment". *[i] [ii] [iii] [iv] [v]*

"EBM is NOT restricted to randomized control trials and meta-analysis. It involves tracking down the best external evidence with which to answer our clinical questions". *[v]*

"[Evidence-based medicine] means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise, we mean the proficiency and judgment that we individual clinicians acquire through clinical experience and clinical practice".

Sackett goes further: "By best available external clinical evidence, we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. Good doctors use both ***individual clinical expertise*** and the best available external evidence, and ***neither alone is enough*** [emphasis added]. ***Without clinical expertise, practice risks becoming tyrannized by external evidence,*** for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients."

[i] Sacket DL. Evidence based medicene. Editorial. Spine1998;23(10):1085-86
[ii] Sackett DL, Richardson WS, Rosenburg WHaynes RB. Evidence based medicine:How to practice and teach EBM. New York. Churchill Livingstone 1997
[iii] Sackett DL, Rosenburg WMC, Gray JAM, et al. "Evidence based medicine:what it is and what it isn"t" BMJ 1996;312:71-72
[iv] Sackett DL, Haynes RB, Guyatt GH, Tugwell P. In: Clinical epidemiology: a basic science for

clinical medicine. 2nd ed.. Boston: Little Brown and Company; 1991;p. 441
[v] Sackett DL, Haynes RB, Tugell PX, Trout KS, Stoddard GL. How to read clinical journals: To learn about diagnostic test. Can Med Assoc J. 1981; 124:703–709

Amendment 3

That section 2.6.4 be re-written as follows:

"The use of radiography as a routine clinical procedure for initial assessment or re-evaluation or general screening tool may or may not be inappropriate. X ray may best be considered after the findings of a history, and chiropractic, orthopaedic and biomechanical examination and when clinical decision making is applied to diagnostic considerations, intended interventions or possible contraindications to the type of care considered.

Follow-up radiography is only applicable when recognised interventions are recommended for that condition over an appropriate period of time.

A radiographic procedure can give a better clinical reliability for certain types of spinal assessment measurements recognised both within orthopaedic medicine and chiropractic and we recognise the poor reliability of alternative measurement methods for specific biomechanical spinal-health presentations. The application of radiographic measurements may include conditions such as segmental instability, scoliosis, thoracic kyphosis, hyper- and hypolordosis of lumbar spine, cervical spine kyphosis and short-leg syndrome.

Radiography may provide better clinical utility, reliability and validity for both initial care assessment and the long-term treatment efficacy".

Background
Radiographic procedures must have clinical relevance. However, the statement in section 2.6.4 falls fundamentally short on clinical provision for a range of biomechanical/postural disorders other than scoliosis. It further fails to provide for the possible need for the measurement of treatment efficacy.

Section 2.6 requests practitioners specifically comply with the provisions of Code of Practice for Radiation Protection in the Applications of Ionizing
Radiation ARPANSA http://www.arpansa.gov.au/pubs/rps/rps19.pdf

Therefore CAAN draws the attention of the CBA to section 3.2.2 of ARPANSA in support the above:

"In determining the net benefit from a radiation procedure, the chiropractor must take into account:
(a) the specific objectives of the procedure;
(b) the characteristics of the individual involved;
(c) the total potential benefits, including the direct health benefits to the person and, where relevant, the benefits to society in general;
(d) the individual detriment to the client that may result from the procedure;
(e) the pregnancy status of a female client of child bearing capacity;
(f) the efficacy, benefits and risk of available alternate techniques having the same objectives with less or no exposure to ionizing radiation"

With regard to the above extract from ARPANSA:
1. *"In determining the net benefit from a radiation procedure, the chiropractor must take into account: (a) the specific objectives of the procedure;*

A radiographic procedure may at times be required to provide the patient with the correct diagnosis and optimal care. Radiographic investigation may be needed after the findings of an individual patient's history, chiropractic, orthopaedic and physical examination are considered. The chiropractor has a clinical responsibility to provide every patient with an accurate differential diagnosis for his or her underlying condition and before a sound clinical rationale for physical management can be made. Radiographic procedures are often a required part of this process.

2. *"In determining the net benefit from a radiation procedure, the chiropractor must take into*

account: (b) the characteristics of the individual involved;

If the management plan for the patient can be determined and will not be affected by the outcome of the radiographs, then radiographs should not be performed.

3. "In determining the net benefit from a radiation procedure, the chiropractor must take into account: (c) the total potential benefits, including the direct health benefits to the person and, where relevant, the benefits to society in general;

As previously stated, chiropractic recognises and addresses biomechanical health factors that cause a multi-million dollar drain on the health-care purse. Radiographic examination can be an important part of the clinical examination required to appropriately manage many of these conditions.

Sub-section 2.6.4 and the red-flag list in section 2.6.2 ignore these clinical facts. Radiographic examination must be considered if it may provide greater patient and public safety. Radiography may identify a range of clinical contraindications to certain physical interventions or manual spinal adjustments. Chiropractors have a responsibility to provide safe care to patients and the right to take reasonable steps to provide protection from litigation. Please note the 11 studies regarding contraindications in Atachment 2.

4. "In determining the net benefit from a radiation procedure, the chiropractor must take into account: (d) the individual detriment to the client that may result from the procedure;

Full-spine radiography should not be routine. Initial x-ray evaluation and re-evaluation of patients is inappropriate unless the initial examination reveals a recognised spinal biomechanical condition or positive mechanically-based orthopaedic findings.

A radiographic procedure can give better clinical reliability for certain types of spinal assessment measurements (see the 37 studies in attachment two). Most of these radiographic measurements are recognised both within orthopaedic medicine and chiropractic.

There can be poor reliability of alternative examination or re-examination methods for specific spinal measurements important to spine biomechanical health.

Spine-based radiographic measurements are acknowledged within wider orthopaedic health sciences and including the measurement of segmental alignment and instability, scoliosis, thoracic kyphosis, hyper- and hypo-lordosis of lumbar spine, cervical spine kyphosis and short leg syndrome. Radiography may sometimes provide better clinical utility, reliability and validity for both initial care assessment and the long-term treatment efficacy.

- **Please see ATTACHMENT 1: NORMAL SPINE MODEL**

- **Please see ATTACHMENT 2: RADIOLOGY OF ABNORMAL BIOMECHANICS**

  SECTION ONE: Provides a list of biomechanical-based spinal health condition/s. These conditions are routinely identified from radiographic investigation after the initial history, initial orthopaedic, neurological and physical examination findings (238 studies)

  SECTION TWO: The evidence supportive of how changes in intervention approaches may result (including the management, stabilization or correction) when the above conditions are identified on initial chiropractic radiographs (80 studies).

  SECTION THREE: The role of follow-up radiographic evaluation after recognised periods of conservative physical management for specific radiographic findings and conditions thereby establishing and documenting the efficacy of care. (25 studies).

SECTION FOUR: The role of radiographic evaluation for patients presenting with mechanical pain or a changing symptomatic picture or where positive mechanical-based orthopedic findings are found on the initial examination. (117 studies).

SECTION FIVE: The importance of radiographic evaluation following the initial history and examination of a patient presenting with a history of physical trauma or falling (28 studies).

SECTION SIX: The reliability and repeatability of radiographic positioning and radiographic alignment assessment methods used in medicine and chiropractic. Includes studies confirming the poor reliability of alternative measuring methods. (37 references).

SECTION SEVEN: A radiographic evaluation may commonly reveal clinical information that may contraindicate the safety of certain physical interventions including spinal manipulation (11 studies)

- **Please see ATTACHMENT 3: THE COMPARATIVE PUBLIC BENEFIT OF RADIOLOGY IN A CHIROPRACTIC PRACTICE**

SECTION ONE: Financial cost comparisons of Chiropractic and Medicine (18 studies)

SECTION TWO: Chiropractic clinical relevance/therapeutic comparisons (21 studies)

SECTION THREE: Chiropractic health promotion/patient satisfaction outcomes (6 studies)

SECTION FOUR: Medical harm within musculoskeletal care (38 studies)

GUIDELINES ON CONTINUING PROFESSIONAL DEVELOPMENT

CAAN is deeply committed to the process of ongoing improvement through continuing professional development. We support an increased expectation for continuing professional development for chiropractors. We agree with the concept of a mixture of formal and informal learning to achieve professional development outcomes.

CAAN stands ready to assist the CBA in the provision of quality CPD to chiropractors and in the administration associated with monitoring practitioner compliance for CPD.

CAAN suggests some changes to the CPD guidelines:

1. CAAN assumes that “accreditation activities” involve the CCEA accreditation of chiropractic programs in Australasia. We agree that this difficult and important work deserves formal CPD credit for those involved.

2. The current draft CBA guidelines for continuing professional development lists a number of activities as appropriate formal learning activities, including:
    - Undertaking research and presentation of work
    - Making presentations of new material
        - How does the CBA differentiate between presentation of research findings and presentation of “new material”?
        - How would the CBA define “new material”?

    CAAN suggests definitions of these terms be included in the guidelines.

3. In regard to Requirement 3.3, CAAN would respectfully request that any changes in CPD requirements be made with enough notice to enable CPD providers and the organisations recording CPD on behalf of chiropractors sufficient time to alter their systems and procedures to fit those changes made by the CBA.

APPENDIX 1

FURTHER COMMENTS ON DRAFT CODE OF PROFESSIONAL PRACTICE FOR CHIROPRACTORS IN AUSTRALIA

Within the section on Draft Code of Professional Practice for Chiropractors in the main part of the submission, the following comments are made:

The CBA is the only registration board of the ten AHPRA boards that has decided to create its own code of professional conduct. All other boards have chosen to use the Code of Conduct for Health Practitioners or supported an existing code of conduct from another body within the health profession they represent.

Unless the CBA has evidence that the chiropractic profession needs more guidance in this area than other professions, CAAN recommends that the CBA take the same approach as the Dental, Optometry, Osteopathy, Pharmacy, Physiotherapy and Podiatry Boards of Australia and use the general Code of Conduct for Health Practitioners to protect the public from unprofessional conduct / professional misconduct by registrants.

The following concerns are raised by CAAN in regard to sections 1 – 5 of the draft Code of Professional Practice for Chiropractors in Australia.

SECTION 1 Working with the patient, client and consumer

CAAN respectfully suggests that the Code of Conduct for Health Practitioners (the Code of Conduct) is sufficient to cover all pertinent points in Section 1 of the draft Code of Professional Practice for Chiropractors in Australia (the Code of Practice). As the Board itself notes, sections 1, 2, 3, 10 and 11 of the Code of Conduct relate to the areas of practice discussed in section 1 of the Code of Practice.

Where the Code of Conduct and the Code of Practice deal with the same issues, confusion may arise as to which part of the guidelines are to be followed. For example, section 2.10.7 of the Code of Practice suggests that screenings "… may be associated with harms …". This may lead practitioners to avoid doing public health screenings. However, section 5.4b of the Code of Conduct states that "Practitioners have a responsibility to promote the health of the community through … education, and where relevant, screening."

We suggest that guidelines should give guidance to the profession rather than become a source of confusion. Feedback from our members suggests that the duplications and contradictions between the Code of Conduct and the Code of Practice is a great source of confusion and concern.

Further:

1.1 Rights and responsibilities

- CAAN queries the use of the phrase "… waives the right" in a bullet point in section 1.1.1 on the left side of p.2 of the Code of Practice. An individual may waive their rights, legislation cannot waive an individual's rights, although it may over-rule those rights.

- We would suggest that the first bullet point in section 1.1.2 is actually part of the bold text above that bullet point.

1.2 Capacity to give Consent

Consent issues have been covered in detail in sections 3.5, 3.6b (noted as 3.6.2 in the preamble to section 1.2), 3.8 and 3.9b (noted as 3.9.2 in the preamble to section 1.2) of the Code of Conduct.

1.3 Informed Consent

See comments on section 1.2.

1.4 Refusal to provide a service and discontinuation of treatment prior to completion of course of care

CAAN believes that sections 1-6 of the Code of Conduct more than adequately cover this area of practice.

1.5 Confidentiality and privacy

Section 3.4 of the Code of Conduct covers these issues in full.

1.6 Fees

CAAN believes that the pertinent issues in this section are covered in the guidelines for advertising (sections 4i and 6.5) and the Code of Conduct (sections 1.2, 2.1b, 2.2d, 2.2f, 2.2j, 2.2n, 2.4, 3.2, 3.3, 3.5, 3.6, 5.2, 8.11 and particularly 8.12.).

CAAN believes that there is no peer-reviewed evidence to suggest that care plans and financial arrangements between practitioners and their clients should not exceed 3 months, as stated in section 1.6.7. 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.

We see no reason to limit the time-frames for financial arrangements as long as dealings are conducted in line with the above sections of the Code of Conduct.

1.7 Professional Boundaries

Section 3.4 of the Code of Conduct covers these issues in full. Please note previous comments with regard to section 3.14 of the Code of Conduct.

1.8 Provision of Certificates

Covered fully by section 8.8 of the Code of Conduct.

SECTION 2: Working as the practitioner

2.1 Continuing professional development

Covered fully in the detailed Guidelines for Continuing Professional Development.

2.2 Responsibilities of the practitioner

Covered in detail by several areas of the Code of Conduct, particularly section 4.

CAAN has particular concern with the proposed requirement under section 2.2.2 for "… approval by the profession and the relevant health profession board" before a practitioner may "extend their scope of practice through innovation …" Does this mean that every new

technique and every departure from standard chiropractic technique protocols would require such approval?

2.3 Advertising

Covered fully in the detailed Guidelines on Advertising for Health Practitioners.

2.4 Health Records

Covered fully in the Code of Conduct in sections 2.2e, 3.4c, 3.16b and especially 8.4

CAAN would support the use of a practitioner-provided glossary to ensure that records are easily understood by fellow practitioners as per section 2.4.2.

With regards to 2.4.3, we suggest that a detailed notation of subjective and objective responses to care may not always be relevant or necessary on each occasion. This is particularly true in the management of chronic cases.

2.5 Names and titles

Considering the coverage of this issue in the guidelines for advertising for health practitioners and the specificity of the National Law regarding the use of titles, there seems no need for this section.

2.6 Radiology / Radiography – see detailed response above.

2.7 Diagnostic tools, tests and processes

CAAN suggests the deletion of this section because of its lack of clarity and questionable scientific basis. Considering the state of the peer-reviewed literature with regard to inter- and intra-examiner reliability and accuracy of motion palpation and many orthopaedic testing procedures, CAAN suggests that the singling out of "… sEMG, X-ray analysis, thermography, etc" is at best arbitrary.

As such, we recommend the following re-wording of this section:

> "The over-reliance on any one diagnostic tool or process increases the risk of health consumers receiving a misdiagnosis, inappropriate treatment or treatment not necessarily required for their health and well-being.
>
> "Therefore, practitioners should conduct a full and thorough assessment using the tools most appropriate for the gathering of information necessary to form a diagnosis."

2.8 Delegation of practice

Covered by the overview of the Code of Conduct, in particular, sections 1.1, 4.3, 6.2, and 10.

2.9 Acupuncture and Dry Needling

CAAN suggests that these procedures do not form part of the core practice of chiropractic. Practitioners using these procedures should be guided by the relevant sections of the guidelines of relevant professional bodies, such as the Chinese Medicine Registration Board of Victoria, the Australian Natural Therapists Association, etc.

2.10 Working with adults and children

Considering the paucity of scientific evidence to support many of the Board's assertions in this section, CAAN would suggest using section 3.6 of the Code of Conduct to address any issues regarding the chiropractic care of children.

2.11 Duration and frequency of care

CAAN has serious concerns with many parts of this section.

In particular, we note that health promotion in the chiropractic context is overwhelmingly applied in a one-on-one consultation. To limit one-on-one consultations for this purpose would be to limit chiropractic health promotion "on a population level".

Considering the research by Sarnat et al (JMPT 2007) showing the very significant reductions in health care costs when chiropractors act as portals of entry into the health care system, we believe that section 2.11 may constitute a health risk to the Australian people.

We suggest using components of sections 2, 3, 5, 6 and 8 of the Code of Conduct to address frequency and duration of care issues.

In 2.11.1 where reference is made to the "primary goal of chiropractic care….." the following quotes from the New Jersey State Government statutes for the registration of chiropractors may be useful as definitions within the CBA guidelines:

Chiropractic subluxation: a complex of functional, structural or pathological articular lesions or a local or systemic aberration of the nervous system caused by pressure, traction, stretch, torsion, chemical or electrical irritation, stimulation or inhibition of the nerve that compromises neural integrity as determined by chiropractic analytical procedures.

Practice of chiropractic: a philosophy, science and healing art concerned with the restoration and preservation of health and wellness through the promotion of wellbeing, prevention of disease and promotion and support of the inherent or innate recuperative powers of the body.

2.12 Recency of practice

CAAN has made comment on recency of practice standards in previous submissions.

2.13 Professional indemnity and public liability insurance

CAAN supports the CBA fully with regard to PI/PL insurance.

Section 3 Working within the practice environment

As section 3 of the Code of Practice pertains to standards already required under other Occupational Health and Safety legislation, CAAN believes that it is superfluous.

Section 4 Working with other practitioners

Considering the presence of guidelines for mandatory notifications, plus sections 4.3, 6.3, 8.1, 8.3, 8.10, 8.11 and 9.3 of the Code of Conduct, CAAN believes that section 4 of the Code of Practice is unnecessary.

The use of the term "informed financial consent" may be better replaced with "informed consent" to save further confusion.

Section 5 Working with the broader community

5.1 Spinal postural assessment and public place marketing

Concerns about "scientific and clinical relevance" of screening findings and other matters raised in this section can be addressed using the guidelines on Advertising for the health professions.

CAAN believes that the use of phrases such as "… tout for business …" and the overall pejorative tone of section 5.1 of the Code of Practice may discourage practitioners from fulfilling their responsibilities as outlined in section 5.4b of the Code of Conduct.

5.2 Provision of care to health consumers who are at risk

Sections 6.1-6.2 of the Code of Conduct adequately address these issues. Whilst we support the concept of taking extra care and attention with those clients who are at risk, CAAN suggests that it is an overly onerous requirement that all staff undertake suicide prevention training in the chiropractic context of health care delivery.

5.3 Reporting child abuse

CAAN supports the immediate reporting of suspected child abuse. However, this legal requirement is already covered under other legislation. It is, therefore, unnecessary in this document.