ACT Chiropractors & Osteopaths Board
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Dear Chiropractors Board of Australia,

Thank you for the opportunity to comment on the Code of Professional Practice for Chiropractors in Australia (the code). We would like to acknowledge the great amount of work which has been undertaken to create such a detailed document and realise working to the tight time-frames demanded in the implementation of the new scheme makes this process and wide consultation difficult. However the ACT Chiropractors and Osteopaths Board would like to express some strong concerns regarding the guidelines in their current form.

Purpose of the Code

In responding to the draft, we will first outline our perspective on the general purpose of codes and guidelines.

The two primary purposes of a document such as the Code of Professional Practice for Chiropractors in Australia are to:

1. Inform registered chiropractors, and recipients of their care, of what is considered to be reasonable and unreasonable conduct.
2. Act as a referential document when taking disciplinary action against a registered chiropractor.

A secondary but significant other purpose of this code is to communicate our profession's maturity and perspective on health care to other health professionals.
The tone of the code as it stands is too focussed on the small minority of the profession who may engage in misconduct. This is not in the spirit of the guidelines for all health professions, nor in the codes developed by other individual professions, such as the medical profession.
These other documents are aspirational documents outlining the high standards expected of and by a profession. The chiropractic code should provide chiropractors and the recipients of chiropractic care with a description of best practice in chiropractic health care.

Examples taken from the medical code:
http://www.medicalboard.gov.au/documents/Good%20Medical%20Practice%20-%20Australian%20Medical%20Council.pdf

1.1 Purpose of the code
"Good Medical Practice (the code) describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. The code was developed following wide consultation with the medical profession and the community. The code is addressed to doctors and is also intended to let the community know what they can expect from doctors. The application of the code will vary according to individual circumstances, but the principles should not be

compromised."
"This code will be used:
• To support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgment.
• To assist medical boards in their role of protecting the public, by setting and maintaining standards of medical practice. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration."

Inappropriate detail or requirements

Currently the code expands unnecessarily and sometimes provocatively in areas of clinical practice, appearing to express more the disgruntlement of some members of the profession with the practice styles of other practitioners. There is certainly room in our profession for debate over best practice (as there is in other professions) but this code is a leading document for the profession and should show maturity.
It is inappropriate for national guidelines to prescribe details of clinical decision making, micro-manage or make subjective judgements about what practices may or may not be supported by evidence.

Examples of excessive prescription of practice:

2.2.2

> *A practitioner can:*
> *• extend their scope of practice through innovation provided that such development is based on clinical outcome measures, or evidence of efficacy and safety, and is approved by the profession and the relevant health profession board.*

Scope of Practice is not defined and doesn't need to be under the new legislation. However the concept of practising within your area of expertise, competence and scope is already very well covered in several areas in *Code of Conduct for Registered Health Practitioners*.
The statement "and is approved by the profession and the relevant health profession board." is unworkable without properly defined avenues for this process to occur.
It would also prove difficult to be innovative if there is already evidence of efficacy for a specific procedure or mode of practice, as it would to base it on outcome measures. The existence of both of these indicate that the procedure is already in existence and therefore not innovative. It may be more accurate to say that outcome measures should be used in the attempt to extend scope of practice through innovation. However it still remains untenable to approach the 'profession' and registration board with every improvement or individual nuance of practice that is not previously documented.
This is an example of the code's tendency to micro-manage and control rather than regulate and lead.

2.6.2

> *The need for X-rays is supported in cases where "red flags" (suspected pathology) are elicited from the clinical history and examination, for example:*
> *• progressive neurological signs and symptoms;*
> *• suspected tumour/pathology;*
> *• infection;*
> *• age greater than 50 years; and/or*
> *• trauma*
> *• long term corticosteroid use*
> *• intravenous drug users*
> *• possible osteoporosis*
> *• insufficient response to care*

- *adverse response to care*
- *chronic condition etc*

This is not the best place for this sort of information and summarised like this it has little use. Obviously there are reasons outside of this to x-ray as there are also situations in which you would not x-ray someone who met these criteria. There are clinical decision making tools available in more detail elsewhere which could be referenced. Clinical decisions can be complex, difficult and even controversial but this code is not the best place for this. For example, the decision making criteria for prescribing antibiotics is not listed in the Medical Board's code. If the national board feels the profession needs further education in this area, Board newsletters or education modules are more appropriate vehicles.

2.9.4

"hand washing, using and disposing of gloves and aprons, using and disposing of 'sharps' safely and educating patients and their carers about infection."

These are valid points but again better handled in other forums.

5.2.1

"In situations where practitioners are likely to interact with suicidal health consumers, or other consumers who are at risk, it is important that:

- *practitioners ensure that all staff have undertaken a basic training course in suicide intervention skills or appropriate interventions for the particular type of risk;"*

An admirable goal, but assuming almost all health practitioners and their staff at some point "*are likely to interact with suicidal health consumers, or other consumers who are at risk"* this is a requirement which requires some significant provisioning and preparation.

2.10

Practitioners should tailor each health consumer's care with consideration of the

- *age of the consumer*
- *tolerance of a treatment method;*
- *skeletal maturity & fragility;*
- *neuro-musculoskeletal development;*
- *flexibility;*
- *possible physical, psychological and emotional responses to care;*
- *consumer's current condition e.g. more sensitive or predisposed to injury or damage;*
- *pathology present;*
- *past responses to care for the same condition or presentation;*
- *consideration of any identified potential adverse outcomes and contraindications.*

Are the dot points here really necessary? The inclusion of clinical advice rather than professional guidelines detracts from the purpose and meaning of this document.

2.10.7

In planning chiropractic management of children practitioners should consider:

- *frequent chiropractic checks or treatment of children without symptoms or signs has not been supported by current available evidence and is currently not recommended, except for assessing developmental milestones. Should a parent elect to have their child undergo regular chiropractic examination or treatment in the absence of any clinical justification then it is the*

responsibility of the practitioner to provide the parent with a balanced view of the factual evidence relating to such examination or treatment as part of the informed consent process;

This is unnecessary and the intent of the first sentence is well covered in the preceding points which state:

- *the frequency and duration of care for children is usually less than that required for an adult;*
- *improvement of signs and symptoms in children usually occurs more quickly than for adults;*

Using phrases such as "*has not been supported by current available evidence and is currently not recommended*" again moves outside the scope of this document and would open up the need for encyclopaedic volumes on guidelines across all professions if they were to move into the area of assessing and judging literature and accumulated clinical knowledge. It is untenable for the Board to keep constantly updating the code to reflect the latest incontrovertible evidence assessed on specific points.
The second sentence: "*Should a parent elect.....*" is already well covered in 3.5 and 3.6 of the *Code of conduct for registered Health Practitioners.*

Consultation

The legislation says that

> (1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wideranging consultation about its content.

The Medical Board had its code developed as a project of the Australian Medical Council and consulted:

- all state and territory boards,
- representatives of Federal Australian Medical Association (AMA),
- the AMA,
- Council of Doctors in Training
- the Australian Medical Students Association (AMSA), and
- the Health Consumers Group.

Numerous other people and documents nationally and internationally were also acknowledged in the development of the code.

This consultation process has not been adhered to in the case of the chiropractic code. Three weeks to comment is inadequate.

Duplication of existing guidelines

The national guidelines for all professions should not be duplicated. Relevant codes should be referenced rather than restated or reworded. Rewording, in particular, can lead to confusion. Where there are small differences in wording or meaning which becomes the higher level document?
At a quick scan estimates of up to 75% of the material in the Chiropractic specific code is already in other guidelines and laws.

Examples of duplication:
There are numerous duplications, as the code itself states frequently. For example:

1.1 Rights and responsibilities
(See also Code of Conduct for Health Practitioners

sections 1.0, 2.0, 3.0, 10 and 11)

1.2 Capacity to give Consent
(See also Code of Conduct for Health Practitioners sections 3.5, 3.6.2, 3.8, 3.9.2)
2.4 Health records
(See also Code of Conduct for Health Practitioners sections 3.16 and 8.4)

Within 2.4 there is also some duplication, and an unnecessary and potentially alarming point:
"be able to provide data for peer review, public health purposes or teaching and research"
While we suspect the intention is they should be of a ***quality which could*** "...provide data for peer review....." and are not suggesting confidential patient information could be demanded by the Board, this is not clear. It is also unnecessary, given the existing comprehensive guidelines such as those in 8.4 of the *Code of Conduct for Registered Health Practitioners*.

Recommendation

The ACT Chiropractors and Osteopaths Board recommends that before adopting a Code of Professional Practice for Chiropractors in Australia the CBA:

1. Combine the existing *Code of Conduct for Registered Health Practitioners* with *Code of Professional Practice for Chiropractors* and in doing so remove the significant amount of duplication which currently exists. Where possible, keep the code and wording in the generic document as this keeps our profession's values and codes consistent with other registered health professionals.

2. Keep the tone of any additions to the combined document appropriate for a code which aspires to high standards and addresses the bulk of the profession, not just those who may engage in misconduct.

3. Remove or reword potentially confusing, opinionated or overly prescriptive guidelines.

4. Find alternative methods of addressing areas which are based on different styles of practice or move into the area of clinical decision making, for example, Board newsletters, education modules, appendices or referencing widely consulted or internationally accepted documents.

5. The committee developing the code needs to allow more time and seek wider consultation before adopting the code.

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