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SUBMISSION TO

CHIROPRACTIC BOARD OF AUSTRALIA

RE

PUBLIC CONSULTATION PAPER ON THE

CODE OF CONDUCT FOR OR CHIROPRACTORS DATED 28 AUGUST, 2012

FROM

CHIROPRACTORS' ASSOCIATION OF AUSTRALIA (NATIONAL) LIMITED

26 October 2012

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

CAA 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 wellbeing of Australian communities.

The CAA, through its state and national branches, provides the organisational interface between government and other stakeholders and chiropractic practice.

CAA is pleased to contribute to the development of professional standards and thanks the Chiropractic Board of Australia for the opportunity to provide input into the public consultation document on the Code of Conduct for Chiropractors.

The following are the CAA's comments on the individual components of the Paper:

There are no changes required for the following sections:

Page 2 Overview – CAA recommends no change
Page 4 Definitions – CAA recommends no change
Page 5 Acknowledgements – CAA recommends no change

1 Introduction Page 6

1.1 Use Of The Code

Bullet point 2: *"… chiropractors should be prepared to explain and justify their decisions and actions, and ~~serious or repeated~~ failure to meet this Code may have consequences for registration."*

CAA comments that the removal of "serious or repeated" suggests a significant shift in stance by the Board. If this is not the case, CAA would suggest returning to the original wording.

1.2 Professional values and qualities
CAA recommends no change.

1.3 Australia and Australian healthcare
CAA recommends no change**.**

1.4 Substitute decision makers
CAA recommends no change.

2 Providing good care Page 8

2.1 Introduction
CAA recommends no change.

2.2 Good practice

CAAN believes that there are times when the "alleviation of symptoms" alone 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, or for patients to experience pain that reminds them to take extra care of an injured area.

There are over-the-counter medications available that will sometimes reduce symptoms faster than many things a chiropractor can do. CAAN would not like to see the CBA suggesting to chiropractors that they should be recommending OTC medications as part of an attempt to "alleviate symptoms".

The practice of chiropractic is not always primarily associated with the "alleviation of symptoms".

The World Federation of Chiropractic defines chiropractic as "…a health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the function of the nervous system and general health."

Further, the WFC's Identity Statement states that the foundation ("the ground") of chiropractic is an "… ability to improve function in the neuromusculoskeletal system and overall health, wellbeing and quality of life" and "… without use of drugs and surgery, enabling patients to avoid these where possible."

The International Chiropractors Association defines chiropractic as "…a non-therapeutic, drugless and surgical-free health science, based on its fundamental principles and philosophy."

According to the CAA definition of chiropractic:

> "The practice of chiropractic focuses on the relationship between structure (primarily the spine, and pelvis) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health."

The purpose of chiropractic defined by the Association of Chiropractic Colleges is "… to optimize health."

All of these definitions are based on function, not symptoms.

Conversely, the Collins English dictionary defines medicine as "… the science of preventing, diagnosing, alleviating, or curing disease."

2.2 i) reads: "*taking steps to alleviate the symptoms and distress of patients*"

CAA believes this is not appropriate for the chiropractic profession, which encompasses a proactive approach to patient care which is cognisant of, but not totally driven by, the treatment of symptoms.

2.3 **Shared decision making**

CAA recommends no change.

2.4 **Decisions about access to care**

2.4(e) currently reads:

"keeping chiropractors and their staff safe when caring for patients; appropriate action should be taken to protect chiropractors and their staff if a patient poses any risk to health or safety and the patient should not be denied care if reasonable steps can be taken to keep chiropractors and their staff safe"

CAA recommends it be amended to read as follows:

"keeping chiropractors and their staff safe when caring for patients. Appropriate action should be taken to protect chiropractors and their staff if a patient poses any risk to health or safety. The patient should not be denied care if reasonable steps can be taken to keep chiropractors and their staff safe"

2.5 Treatment/care in emergencies

CAA recommends no change.

3 Working with Patients Page 10

3.1 Introduction

CAA recommends no change.

3.2 Partnership

3.2(g) currently reads

"*recognising that there is a power imbalance in the chiropractor–patient relationship, and consequently the need exists to ensure that all decisions are directly relevant to clinical experience; unaffected by non-clinical motivations; and capable of being regarded so by reasonable observers in the circumstances (also see Section 9.2: Professional boundaries and Section 9.12: Financial and commercial dealings)."*

CAA recommends it be amended to read as follows:

"recognising that there is a power imbalance in the chiropractor-patient relationship. Therefore it is important that all clinical decisions are directly relevant to clinical experience, unaffected by non-clinical motivations and capable of being regarded as so by reasonable observers in the circumstances (also see Section 9.2: Professional boundaries and …)"

3.3 Effective communication

CAA recommends no change.

3.4 Confidentiality and privacy

CAA recommends no change.

3.5 Informed consent

CAA recommends no change.

3.6 Informed financial consent

CAA is of the view that Section d) is unnecessary in light of f). It is considered that, in any event, a person who pre-pays for visits can have a refund of unused fees with no financial disadvantage.

CAA's recommendation is that d) should be removed.

3.7 Children and young people
CAA recommends no change.

3.8 Culturally safe and sensitive practice
CAA recommends no change.

3.9 Patients with additional needs
CAA recommends no change.

3.10 Relatives, carers and partners
CAA recommends no change.

3.11 Adverse events and open disclosure
CAA recommends no change.

3.12 When a complaint is made by a patient
CAA recommends no change.

3.13 Ending a professional relationship
CAA recommends no change.

3.14 Personal relationships
CAA recommends no change.

3.15 Working with multiple patients
CAA recommends no change.

3.16 Closing a practice
CAA recommends no change.

4 Modalities (previously WORKING WITHIN PRACTICE) Page 16

4.17 Use of diagnostic and therapeutic modalities in chiropractic practice
CAA recommends no change.

5 Working with other practitioners Page 17

5.1 Respect for colleagues and other practitioners
CAA recommends no change.

5.2 Delegation, referral and handover
CAA recommends no change.

5.3 Working with other practitioners (Previously "Teamwork")
CAA recommends no change.

5.4 Delegation to unregistered staff, chiropractic students and assistants

Section 5.4 d) requires "… *specific consent from the patient for a delegate to perform (a delegated clinical) activity*".

CAA would be comfortable with verbal consent being gained for such activities, but believes that written, signed consent is overly onerous in the context of having an assistant measure height, weight or make other basic assessments.

CAA recommends 5.4 d) requires "verbal consent".

6 Working within the healthcare system Page 19

6.1 Introduction

CAA recommends no change.

6.2 Wise use of healthcare resources

6.2(a) reads: *"ensuring that the services provided are appropriate for the assessed needs of the patient and are not excessive, unnecessary or not reasonably required "*

CAA comments that just as there may be potential for patient harm from over-servicing, there may also be potential harm from under-servicing patients. Particularly in the case of long-term health issues, ongoing case management is an important step in attaining optimal outcomes.

CAA recommends that 6.2(a) is amended to read:

"ensuring that the services provided are appropriate for the assessed needs of the patient and are neither excessive, unnecessary or not reasonably required nor inadequate, incomplete or otherwise inappropriate.

6.3 Health advocacy

CAA recommends no change.

6.4 Public health matters

Second paragraph of Section 6.4 reads: *"On any public health matter, practitioners are obliged to provide balanced, non-biased and evidence informed information in order to enable members of the public to make informed health decisions."*

CAA would appreciate the removal of "balanced" or "non-biased (sic)". Information that is unbiased is also balanced. We suggest either "… provide balanced and evidence-informed information …" or "… provide unbiased and evidence-informed information …".

7 Minimising risk Page 20

7.1 Introduction

CAA recommends no change.

7.2 Risk management

CAA recommends no change.

7.3 Chiropractor performance

CAA recommends no change.

8.1 Introduction

CAA recommends no change.

8.2 Continuing professional development

CAA recommends no change.

9.1 Introduction

CAA recommends no change.

9.2 Professional boundaries

CAA recommends no change.

9.3 Reporting requirements

CAA recommends no change.

9.4 Health records

CAA recommends no change.

9.5 Insurance

CAA recommends no change.

9.6 Advertising

CAA recommends no change.

9.7 Legal, insurance and other assessments

CAA recommends no change.

9.8 Reports, certificates and giving evidence

CAA recommends no change.

9.9 Curriculum vitae

CAA recommends no change.

9.10 Investigations

CAA recommends no change.

9.11 Conflicts of interest

CAA recommends no change.

9.12 Financial and commercial dealings

9.12(c) reads: "*not becoming involved financially with patients; for example, through loans or investment schemes*"

CAA recommends that c) be removed. It is not workable in some small communities. The problem is not with financial dealings per se. The problem is with poor business ethics. This is addressed in the rest of 9.12.

10 Ensuring chiropractor health Page 27

10.1 Introduction
CAA recommends no change.

10.2 Chiropractors health
CAA recommends no change.

10.3 Other practitioners health
CAA recommends no change.

11 Teaching, supervising and assessing Page 28

11.1 Introduction
CAA recommends no change.

11.2 Teaching and supervising
CAA recommends no change.

11.3 Assessing colleagues
CAA recommends no change.

11.4 Students
CAA recommends no change.

12 Undertaking Research Page 29

12.1 Introduction
CAA recommends no change.

12.2 Research ethics
CAA recommends no change.

12.3 Treating chiropractors and research
CAA recommends no change.

Appendix 1 - Page 31
Guideline in relation to public health activities

CAA questions the usefulness of the artificial delineation between non-identifying "public health activities" and branded "promotional activities".

The rules are the same for both except that for a promotional activity, "*…practitioners must also ensure that the promotional activity is represented as a promotional activity.*" The use of identifying logos, business cards, etc., would make such an activity "promotional" by the board's definition.

Item b) currently reads: "providing the participant with contact details at their request, but should not include obtaining contact information from participants or the making of appointments at the time of the activity"

CAA comments that as time-limited or special offers are banned, there is no inducement for members of the public to make an appointment for a consultation and examination. As such, there is no risk to the public.

CAAN recommends that item b) is rewritten to allow the making of appointments at spinal screenings.

Appendix 2 - Page 33
Guideline in relation to radiology/ radiography

The CAA recognises the role of imaging to a spine-care profession. Arthritis and musculoskeletal conditions alone are the largest cause of disability in modern economies around the world with 6.3 million Australians (31%) suffering within this health domain; one that absorbs 9.2% of total health expenditure ($4.6billion). [1] The CAA recognises the need for chiropractic clinicians to have the diagnostic skills necessary to best assess risk factors that are related to the cause and progression of degenerative joint conditions, especially of the human spine, so clinicians can employ strategies that may maximize evidence-informed management.

"Chiropractors use radiography for several purposes following the identification of various history and examination findings, including: confirmation of diagnosis/pathology; determining appropriateness of care and; identifying contraindications or factors that would affect or modify the type of treatment/care proposed."

Response: The CAA supports this statement as it pertains to the additional role that radiography provides to a physical-care and a spine-care profession. This statement recognises and supports the key imaging considerations that are distinct from studies limited to the role of imaging toward pain relief or pharmaceutical care.

Identifying contra-indications - Guild insurance has tabled the high percentage of all litigation from spinal manipulation to pre-existing disc disease in both the cervical and lumbar spine. In an 18-mth period this litigation amounted to over 60% of litigation cases tabled.[2] Both conventional and advanced imaging is recognized as an important diagnostic tool that can assist in the assessment of pre-existing including pre-existing disc disease. [3]

Further, in studies specifically considering the role of chiropractic interventions, spinal radiographs demonstrate 66%–91% of patients can have significant abnormalities that would alter interventions. Up to 33% of spinal radiographs have relative contraindications and 14% have absolute contraindications to certain types of chiropractic adjustments.[4-6]

Confirmation of diagnosis/pathology – chiropractors have a legal responsibility to provide an accurate diagnosis and evidence-informed follow-up care or appropriate referral. Conventional imaging when appropriate is critical to this responsibility. Studies reveal up to 91% of physicians across a range of specialty lines identify defensive medicine as a factor that is sometimes necessary to protect themselves from lawsuits when examining certain patients under certain circumstances and following certain history and examination findings. [7]

Factors that would affect or modify the type of treatment/care proposed - these factors can include imaging-based assessment of abnormal regional and global spine alignment health (lordosis, kyphosis, scoliosis, sagittal balance, short leg syndrome); findings that can be significant risk factors toward adverse health affects of pain, disability and disc disease. [8-32] These findings also contribute to other mainstream billion-dollar health issues including headache [34-35] and increased risk of fracture and falls within older populations. [11, 36-38]

Orthopedic literature largely recognises that physical examination and surface measurements lack the validity and reliability of diagnostic imaging for diagnosis and measurement of these pelvic and spinal

health alignment factors. [39-49]

The CAA therefore recognizes that optimal management of a range of spine-based conditions may not occur without imaging when appropriate. The CAA recognizes that these findings, when identified and assessed by imaging, can alter management and often has a reasonable probability to improve patient outcomes through subsequent evidence informed care. [50-88]

"Chiropractors must comply with the provisions of the code of practice for radiation protection and the Application of Ionizing Radiation by Chiropractors (2009) or any subsequent version as published by the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA Code), and applicable commonwealth, state or territory laws in relation to best practice (see www.arpansa.gov.au under Publications)."

Response: The CAA supports this statement in providing recognition of the code of practice for radiation protection within Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) for chiropractors as providing an appropriate framework for clinical decision making in this regard. [89]

The CAA specifically acknowledges the unique role of imaging outlined in section 3.2.2 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; and (g) any data and records relevant to the radiation exposure.

"The ultimate judgment regarding the application of any radiation-based procedure must be made by the chiropractor in light of all the circumstances presented and in an 'evidence informed context'."

Response: The CAA supports this statement and the respect for clinical judgment. Chiropractors are often faced with a range of history and examination findings and patient expectations that must be balanced against the more narrow outcomes from the clinical trials which focus on single criteria (such as pain relief) alone. One example is studies which narrow and isolate the role of imaging to a single outcome such as the failure of imaging to improve the relief of acute back pain. [90-92] Pain relief has been identified as only one factor that is relevant to clinical decision-making in regard to the role of imaging in the context of a range of evidence that sits before our clinicians in everyday practice. [93] The clinician ultimately remains the best judge in balancing external evidence, patient values and history and examination findings and potential indications and contraindications to care.

To date different international chiropractic x-ray guidelines have endeavored to grapple with different inclusion criteria on the topic of imaging in chiropractic practice. [94-95] The latter guideline however does acknowledge how " guidelines do not address all possible conditions associated with musculoskeletal disorders, only those that account for the majority of initial visits to a practitioner. Like other diagnostic tests, imaging studies should only be considered if (a) they yield clinically important information beyond that obtained from the history and physical examination; (b) this information can potentially alter patient management and; (c) this altered management has a reasonable probability to improve patient

outcomes". Individual guidelines do not assume to understand all of the possible findings that sit before clinicians.

In conclusion, the CAA recognises the role of imaging in the identification of medical red flags, we equally recognise the additional role of imaging toward the diagnosis, treatment and progression of a range of mechanical disorders of the musculoskeletal system and toward optimal spine-care specifically. We provide our support toward the current Radiography/Radiology Appendix 2 draft in this regard.

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Appendix 3 - Page 35
Guideline in relation to duration and frequency of care

CAA recommends no changes for Paragraphs 1. and 2.

CAA's recommended change:

The phrase "in an evidence informed context" is used repeatedly in this document. Doing so does not add anything to its meaning. According to point 1, a program of care should be developed in an evidence informed context. It follows that review and reassessment should also be evidence informed.

In Paragraph 3 CAA recommends the removal of:

- **3(a) as it is already covered in Paragraph 1;**
- **3(b) as it is already covered in Paragraph 1; as a 'program of care' will, by definition, lay out the proposed management; and**
- **3(f) as it is already covered in 2.1 (c)**

CAA also suggests that 3(c) – 3 (e) could be included below 1(f)

In Paragraph 4 - CAA notes that there are two "ands" in the first sentence.
No other change.

The current wording of paragraph 4 (e) is: *the number of visits proposed (which should have a rationale and not be arbitrary or excessive) and;*

Paragraph 4(e) doesn't take into account the common problem of under-servicing. Optimal patient outcomes require a common-sense approach to care. Long-term health problems (neuromusculoskeletal or otherwise) don't tend to change with inadequate care. This is a disservice to all involved.

CAA's recommended change to 4 (e) : the number of visits proposed (which should have a reasonable rationale and not be arbitrary).

The current wording of paragraph 4(f) is "*an understanding and agreement by the patient of the aims surrounding the proposed program of care*. "

An agreement by a client to begin a program of care that is "based on clinical need", "tailored to the specific needs of each patient" and has "a plan for review/reassessment" will implicitly or explicitly mean that the client understands the aims of the proposed care.

It is CAA's recommendation that paragraph 4(f) is removed.

CAA has no recommended change for Paragraphs 5 and 6.