



Issue 16 July 2007

## Dear Registrant

By now most of you will have received your 2007/08 Practising Certificate, confirming your registration for this year. As anticipated, many practitioners had difficulty in completing the new and rather lengthy application form for registration and in fact about 25% of all applications had to be returned to the applicant, as they were incorrect or incomplete.

One particular point of concern, which has been identified via the new application form, is the number of practitioners who did not have Professional Indemnity Insurance cover. Here, I am not referring to inadequate cover but no cover at all. I find it astonishing that any healthcare practitioner could place himself or herself in such a vulnerable position, given the litigious nature of our society today. And while some practitioners have pleaded their case that they do not require Professional Indemnity Insurance because they only practice for limited hours, there is still a risk of a malpractice claim and to ignore that risk is unacceptable. Also, many chiropractors that only work as locum tenens have erroneously argued that they do not require cover, as they will be covered under the insurance held by the principle of the practice that employs them.

**The new legislation is quite clear, if you wish to be registered as a chiropractor in the State of Victoria there is a mandatory requirement that you must provide the Board with current evidence of Professional Indemnity Insurance with a minimum cover of \$10 million.** Further, this requirement is unlikely to change in the foreseeable future, even with the anticipated introduction of National Health Professionals Registration and Accreditation Act in 2008.

Another new and extremely important Guideline that has been recently posted on the Board's website relates to notifying the Board of any amount of damages awarded in cases of malpractice. The new Act, pursuant to s34-1 and s34-6 states, in part "If a person has claimed damages or other compensation from a registered health practitioner for alleged negligence in the course of providing regulated health services, the health practitioner must provide the responsible board with information about the amount of damages or other compensation the health practitioner is ordered by a court to pay within 30 days after the order is made."

As highlighted in previous Newsletters the new Act also requires any practice guidelines, issued by the Board, to be approved by the Minister. As well as formulating new guidelines, the Board is currently reviewing all its existing guidelines and has recently completed and issued revised guidelines on Frequency and Duration of Care. The Board felt that this revision was necessary, as apart from breaches of Advertising Guidelines, complaints about frequency and duration of care receive the highest number of complaints from the public.

The new Frequency and Duration of Care Guidelines, like all guidelines issued by the Board, are provided to assist chiropractors in the way that they conduct their practice of chiropractic. Practitioners should note that the guidelines state maximum therapeutic benefit is the prime objective of all care provision and must be expressly considered in cases of elective or supportive care. The guidelines also highlight the potential for adverse effects in the provision of prolonged passive care. Where treatment continues in excess of

### Information and Contacts

If you are unsure or require further information on any topic, please contact the Registrar on:

**Telephone (03) 9639 8652**

**Facsimile (03) 9639 8653**

The Board has a home page on the Internet, the address is:

**[chiroreg.vic.gov.au](http://chiroreg.vic.gov.au)**

### Board Members

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three months in duration, the use of periodic validated objective and subjective outcome measures is necessary in order to justify ongoing therapy.

In a number of recent Informal Hearings the chiropractor has been found guilty of “providing a person with health services of a kind that are excessive, unnecessary or excessive care not reasonably required for that person’s wellbeing”. In many instances the practitioner attempted to defend long and frequent treatment plans with evidence that was considered by the Board not to be of an acceptable quality and or they failed to employ periodic subjective or objective outcome measures to justify prolonged periods of care. In general, in order to justify frequent and long periods of care the supporting evidence should be of good quality and published in a quality peer reviewed journal. Single case reports and research published in trade journals are, in the main, not considered an acceptable level of evidence. Furthermore, even if there is an acceptable body of literature to support frequent and long periods of care for a particular condition, appropriate periodic outcome measures are still required in order to justify ongoing care, once maximum therapeutic benefit has been achieved.

I urge all practitioners to familiarise themselves with, and follow these and other guidelines issued by the Board, in order to provide the best possible care for their patients, and avoid the potential for complaints. For your information detailed below are the revised Frequency and Duration of Care Guidelines:

## **FREQUENCY AND DURATION OF CARE GUIDELINES**

### **Preamble**

Frequency and duration of care guidelines are provided to *assist chiropractors* in clinical decision-making.

It is understood that chiropractors treat conditions other than those of a somatic origin and it is not within the scope of these guidelines to provide chiropractors with prescriptive treatment protocols for each separate condition. It is also recognised that chiropractic therapy is not restricted to spinal manipulation and many chiropractors employ a variety of treatment modalities. However, regardless of the condition being treated and the type of treatment provided, the basic principles relating to the frequency and duration of treatment outlined in these guidelines apply.

### **Guidelines**

- The primary goal of chiropractic care is to provide sufficient care to restore health, maintain it and prevent the recurrence of injury or illness.
- Maximum therapeutic benefit should be the prime objective of all care provision and in particular the concept of maximum therapeutic benefit must be considered in cases of elective care or supportive care.
- Care should be based on both subjective and objective information derived from the patient’s case history, examinations and diagnosis and where possible in conjunction with the best available scientific evidence.
- The natural history of the condition being treated is a reference point to treatment expectations and the basis from which a measurable therapeutic plan can be established.
- The initial and subsequent treatment plan(s) should take into consideration “red flags” and determine whether chiropractic treatment and or referral for a second opinion or emergency treatment are warranted.

- The initial and subsequent treatment plan(s) should consider psychosocial “yellow flags”.
- The treatment plan should be based on best practices as reflected in current literature and accepted standards of chiropractic care.
- Care should relate to patients’ needs and expectations and must be reassessed periodically.
- The treatment plan should consider the need for coordinated interdisciplinary care and co-management where clinically required.
- It is the practitioner’s responsibility to ensure that the patient understands and accepts the treatment goals and treatment plan.
- An estimated time frame for achieving reduced pain and or improved function should be made and discussed with the patient. Any time frame for improvement should not be based on anecdotal evidence or the practitioner’s personal opinion alone but must be based on other factors such as patient’s presentation, clinical findings, natural history of condition being treated, accepted standards of present day chiropractic care and the best scientific literature available.
- During the course of treatment the practitioner should ensure that treatment outcomes are measured using objective as well as subjective measures via the use of general or condition specific assessment tools.
- Failure of a patient to achieve therapeutic benefit within the proposed time frame requires the practitioner to either change the mode of treatment, consider a different diagnosis or refer the patient to another health professional
- Practitioners should be aware of the potential for adverse effects of the provision of prolonged passive care, such as therapy dependence, somatization, illness behaviour or secondary gain. Active care including such interventions as rehabilitation, home based self care and lifestyle modifications are required in such cases.
- In cases where treatment continues in excess of 3 months in duration, such as in cases where supportive or elective care is undertaken, the use of periodic validated objective and subjective outcome measures is necessary in order to justify ongoing therapy.
- Based on the administration of periodic outcome measures, and where maximum therapeutic benefit has been achieved, a controlled period of therapy withdrawal may also be required in order to justify ongoing care
- It is essential that patient progress and findings from outcome measures are recorded (see Management of Patient Records Guidelines CRBV) throughout the treatment program in order to determine whether treatment goals are being met.

#### **GLOSSARY OF TERMS**

**Active Care:** Modes of treatment/care requiring “active” involvement, participation, and responsibility on the part of the patient in recovery and rehabilitation.

**Best Treatment Practices:** Treatment which is associated with the lowest risk and highest efficacy.

**Duration** - Based on the patient’s diagnosis, the length of the treatment schedule (in days, weeks, or months) required to either correct the patient’s condition or to achieve a level of maximum therapeutic benefit.

**Elective Care:** Treatment/care that is discretionary and at the option of the patient who wishes to promote or maintain optimum function with preventative/maintenance care. Elective care follows appropriate application of active and passive care, including rehabilitation and lifestyle modifications. It is appropriate when alternative care options, including home-based self-care, have been considered and attempted and failed to provide sustained benefit. Elective care may be inappropriate when it interferes with other appropriate primary care, or when the risk of elective care outweighs its benefits, i.e., intervention dependence, somatization, illness behavior or secondary gain.

**Frequency of Care:** The number of times a patient is treated over a given period and the interval between those treatments.

**Maximum Therapeutic Benefit:** The return to pre-injury/illness status or the minimum level of symptomatology or disability attainable on a given treatment/care approach.

**Natural history:** The expected clinical course of recovery for uncomplicated cases without treatment.

**Objective outcome measures:** Assessments that are measured by the examiner Outcome measures: Tools that assess change in patient characteristics as a result of therapeutic intervention over time. Outcome measures provide a method to assess whether treatment has been effective or not. Include objective and subjective assessments, general or condition specific.

**Passive Care:** The application of treatment/care procedures by the caregiver to a patient who has little or no involvement in bringing about recovery and rehabilitation.

**Physician/Patient Dependence:** A dysfunctional relationship where the patient's needs exceed the limits of a professional relationship. There is a loss of balance within the relationship, and the patient becomes overly reliant/dependent on the doctor for a number of needs and/or voids in his/her life.

**Red flags:** History and physical examination findings which alert the clinician to the likelihood that serious pathology may be contributing to the clinical presentation and referral for a second opinion or other treatment is warranted.

**Referral:** The direction of a patient to another health care professional or institution for evaluation, consultation or care.

**Subjective outcome measures:** Assessments that are patient perceptions.

**Supportive Care** - Care for patients who have reached maximum *therapeutic* benefit, but who fail to sustain this benefit and progressively deteriorate when there are periodic trials of withdrawal of care. Supportive care follows appropriate application of active and passive care, including rehabilitation and lifestyle modifications. It is appropriate when alternative care options, including home-based self-care, have been considered and attempted and failed to provide sustained benefit. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when the risk of supportive care outweighs its benefits, i.e., intervention dependence, somatization, illness behavior or secondary gain.

**Treatment Plan:** The treatment modalities and frequency and duration of care that the practitioner believes are needed to achieve the treatment outcomes. This should include treatment goals which the practitioner and patient agree to aim for prior to care commencing.

**Yellow Flags:** Beliefs and behaviours of a patient which identify them at increased risk of developing, or perpetuating long term disability and work loss associated their condition.

I hope you find the information in this Newsletter informative and useful and remember all the Board's Guidelines as well as a wealth of other information is available on the website [www.chiroreg.vic.gov.au](http://www.chiroreg.vic.gov.au)

Regards,

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President

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