就修訂《輔助醫療業條例》立法建議的最新進展

意見書

我們是「物理治療師管理委員會轄下修訂物理治療轉介制度工作小組」(「工作小組」)內的三名病人代表。就醫務衞生局(「醫衞局」)建議修訂《輔助醫療業條例》,以達致「容許物理治療師和職業治療師可在指定情況下無須醫生轉介而直接為病人提供服務」,我們立場如下。

「工作小組」成員已包括物理治療業界、醫學界、法律界及病人界別的代表,各界別基於「循證」(evidence based)原則,就制訂香港的物理治療免轉介制度作深入探討。經長時間討論,最終提出直接尋求物理治療服務的方案(「方案」)(見附件一第 16-25 頁)。

「方案」中直接關於病人求診的建議措施為:

1. 未經醫生診斷的求診者,可接受為期 30 天或 10 次療程,過後如仍未康復,必須取得醫生轉介信,才可繼續物理治療療程;
2. 已經醫生診斷為長期神經肌肉或發展狀況的求診者(chronic neuromascular and developmental condition),其免轉介的物理治療期限和次數則不受限制。

醫衞局現時建議明顯更改了「方案」的建議,即:限制未經醫生診斷的求診者必須已登記有家庭醫生及物理治療師需向該家庭醫生通報,而非方案建議可直接尋求物理治療接受為期 30 天或 10 次療程;及,病人需出示在 12 個月內獲醫生診斷的證明文件,而非在確診為長期病症後可持續接受物理治療。我們認為醫衞局的建議是為病人直接尋求物理治療時,增加了不必要的障礙。

醫衞局聲稱「免轉介不等於免診斷,有關安排必須以保障病人安全為依歸」。我們認同免轉介——直接尋求物理治療,並非免診斷——免卻醫生的醫學診斷(medical diagnosis),但當求診者尋求物理治療時,治療師會就求診者的情況進行評估(physical assessment),如判斷求診者身體狀況有異或有隱患,會建議求診者尋求醫生診斷。因此我們認為,免轉介不會取代免診斷,直接尋求物理治療亦不會影響病人的診斷治療。另外,我們認同需保障病人安全,但從循證角度,外國已實行物理治療免轉介制度多年,從沒有證據證明免轉介會增加對病人的風險。因此我們認為醫衞局現時的建議是過份保護。

我們認為醫衞局的建議,扭曲了藉物理治療免轉介推動基層醫療健康發展的原意,將醫生設定為基層醫療的重心,而非藉著各種醫療專業人員成為首個接觸點,共同建立及擴闊基層醫療服務網絡,擴大市民進入基層醫療健康的接觸點,進而獲取所需服務。

根據一項調查顯示(見附件二),長期病患者、照顧者及一般市民非常支持「方案」建議,我們希望醫衞局及醫療業界聽取病人及市民意見,採納「方案」建議,為香港設立一套更便利病人及市民直接尋求物理治療的免轉介制度。

最後,我們身為「工作小組」成員,為醫衞局沒有採納工作小組努力而得出的「方案」、甚至沒有將「方案」作公開討論,感到不被尊重。同樣,是次修訂將原有的「輔助醫療業」正名為「專職醫療業」,但從現時建議所見,物理治療仍然是一種輔助醫生的專業,正名只是有名無實,著實諷刺,也是對物理治療業界的不尊重。

「物理治療師管理委員會轄下修訂物理治療轉介制度工作小組」成員:陳永佳、林韋雄、彭鴻昌

二零二三年十二月六日

Direct Access Model for Physiotherapy Services in Hong Kong

Working Group on
Implementation of Modified Referral System for
Physiotherapy Services of
Physiotherapists Board

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1. Introduction

In the Chief Executive's Policy Address 2021, it is stated that "***The FHB will follow up with the statutory Boards and Councils of various healthcare professions on the recommendations in the Report of the Strategic Review on Healthcare Manpower Planning and Professional Development promulgated in 2017, including proposing legislative amendments to allow patients to have direct access to healthcare professional services (e.g. physiotherapy and occupational therapy) without a doctor's referral so as to avoid delay in treatment." [1].*** The terms 'direct access' and 'service users' self-referral' are commonly used to refer to the "circumstances where physiotherapy services are available to service users without the need for a third-party referral" [2].

To follow up this recommendation set out in the Policy Address 2021, a direct access model is therefore proposed to enhance access to quality physiotherapy service with patient safety well protected.

This document aims at providing information on the historical perspective, the global trend, the benefits and the justifications for allowing direct access to physiotherapy services in Hong Kong.

This document is prepared by the Working Group on Implementation of Modified Referral System for Physiotherapy Services set up by the Physiotherapists Board (Membership list at **Appendix 1**) after extensive consultations with the professional physiotherapist community, and various stakeholders including patients' associations and medical practitioners.

2. Healthcare Needs of the Public in Hong Kong: Physiotherapy Services in Primary Healthcare

2.1 The need to strengthen primary healthcare

With the rapidly ageing population, prevention and management of chronic conditions will continue to be a major issue in public health. It is thus very important to (i) enhance the public's capability in self-management of health, (ii) provide timely assessment and treatment so that the patients' conditions would not deteriorate to such an extent that may require hospitalizations or more invasive treatments, and (iii) provide rehabilitation support to people with chronic conditions [3]. These are indeed the essence of primary healthcare, which is defined as "*the first point of contact for individuals and families in a continuing healthcare process which entails the provision of accessible, comprehensive, continuing, coordinated and person-centred care in the context of family and community. It contributes to the health of the population through health promotion, disease prevention, disease management and supportive care."* [4]. ***Physiotherapists are one of the key members of the multidisciplinary team to provide the first point of contact for individuals who may benefit from timely physiotherapy assessment and intervention.***

2.2 Physiotherapy services in District Health Centres

The District Health Centres (DHCs) have been set up by the Government to strengthen district-based primary healthcare services across Hong Kong. The three pillars of primary healthcare services are (i) primary prevention (health promotion and education), (ii) secondary prevention (health risk assessment and screening for early identification of chronic diseases), and (iii) tertiary prevention (management of chronic diseases, community rehabilitation service to slow down the progression of chronic disease and prevention of recurrence and debilitating complications) [4]. Physiotherapists are fully capable of providing these services in DHCs to meet the healthcare needs of the public. ***Direct access for physiotherapy services in DHCs would improve system efficiency and allow the public to have easier access to the above preventive care services provided by physiotherapists.***

2.3 Physiotherapy services in welfare and education sectors

According to the 2017 Health Manpower Survey (HMS) conducted by the Department of Health (DH), around 20% of registered physiotherapists were serving in the Non-governmental organisation (NGO) sector [5]. With the recent rapid growth of community care, the percentage of physiotherapists working in NGO sector has been increasing. At present, majority of the physiotherapy services in NGOs is funded by the Elderly Branch and the Rehabilitation & Medical Social Services Branch of the Social Welfare Department (SWD).

Service units with physiotherapy provision under the Elderly Branch are residential home, day care, and home care services for the elderly as well as multidisciplinary outreach teams for private elderly homes, while those under the Rehabilitation & Medical Social Services Branch include special preschool, sheltered vocational, adult day activity, and adult residential services for persons with childhood-onset disorders across their lifespan; together with residential, out-patient and domiciliary rehabilitation as well as district support services for persons with long-term disabilities due to adult-onset disorders. Apart from SWD, there is also provision of physiotherapy services in special schools funded by the Education Bureau.

Overall, the clients in the above settings are those who have a pre-existing diagnosis of a developmental or chronic condition and experienced long-term or lifelong disabilities. ***Implementation of direct access would facilitate easier access to physiotherapy service for those with chronic disabilities in the community and residential care settings who need long-term physiotherapy intervention for health promotion, for fitness and maintenance purposes and for supporting self-management.***

2.4 Physiotherapy services in private sector

The 2017 HMS conducted by DH also revealed that around 40% of registered physiotherapists were working in the private sector [5]. In private clinics, majority of patient cases are musculoskeletal in nature. The most common conditions are neck pain, back pain, frozen shoulder, tennis elbow, knee pain, sprained ankle, repetitive strain injuries and etc. Many of these cases can be

effectively prevented or managed in the early stage with conservative treatments such as exercise training, postural education, and pain and inflammation management. In school-based or field settings (e.g., soccer pitches, sports grounds, etc.), physiotherapists work closely with athletes/student athletes in preparation for the games as well as timely handling of acute sports injuries during the games. In workplaces, physiotherapy services include assessment and education of workers to promote occupational health and reduce risk for work injuries. ***Adoption of direct access in these settings would enable the patients to receive timely physiotherapy service for better health outcomes by minimizing the risk of the patients' conditions becoming chronic. Health complications arising from delayed physiotherapy interventions that may require hospitalizations or more invasive treatments can also be minimized.***

After all, in various community and primary healthcare settings, there is significant demand in direct access for physiotherapy services. The roles of physiotherapists in primary healthcare include but not limited to: screening and early detection, management of acute and chronic conditions, supporting patients in self-management, health promotion and prevention of illness and injury.

3. Direct access: Historical Perspective and Global Trend

3.1 History of direct access

The history of direct access to physiotherapy service goes back to more than four decades ago in Australia [6,7]. It became increasingly clear that physiotherapists have much to offer to the general public, including those that did not require a referral from medical practitioners. Physiotherapy education in Australia had also evolved sufficiently to prepare physiotherapists to manage direct access [6]. In 1976, the Australian Physiotherapy Association took an important step of allowing its members to provide physiotherapy services to self-referred cases, in addition to those who are referred to physiotherapy by a medical practitioner [6,7]. In 1995, the World Confederation for Physical Therapy (WCPT) issued the Declaration of Principle on Autonomy which states '*Patients/clients should have direct access to physical therapist services*'.

3.2 Current global data on direct access

Since the first adoption of direct access by Australia in 1976, an increasing number of countries have followed a similar practice [8,9]. According to the data provided by World Physiotherapy (formerly WCPT) in 2020 [10], among its 111 Member Organizations, 73% have adopted various forms of direct access (full direct access: 28%, direct access in private sector only: 42%, direct access in public sector only: 3%) (Appendix 2), including Australia, Canada and United Kingdom, where physiotherapists are first contact practitioners to provide clients with timely assessment, treatment and advice on self-management [11-13]. When needed, physiotherapists refer clients for further investigations, or to secondary and tertiary services such as specialist and hospital services.

3.3 Overseas experience: Thailand and Indonesia

Direct access has been adopted in the above developed countries since decades ago and it is not an easy task to trace back to their history of implementation. Alternatively, the Working Group has studied two developing countries in Southeast Asia, namely Thailand and Indonesia, where direct access has been adopted in recent years. The Working Group held a sharing session on 19 July

2022 with guest representatives from academic and professional associations[1] in Thailand and Indonesia to understand and exchange experience in the implementation of direct access.

Direct access has been implemented in Thailand and Indonesia since 2004 and 2013 respectively. In both countries, physiotherapists have already been granted full access rights to serve as the first contact practitioners right from the start of the implementation of direct access, without any pilot schemes launched or any changes made to the direct access arrangement since its implementation. No restriction is imposed on duration of physiotherapist treatments. In addition, physiotherapists in both countries are eligible for direct access upon completing undergraduate education and obtaining physiotherapist licenses, without requirement of additional training specifically for direct access. Both countries do not require physiotherapists who participate in direct access to purchase professional indemnity insurance.

In both countries, there has been no major concern over patient safety arising from direct access. The situation of reporting of adverse effects or malpractice of physiotherapists is not significant. In general, patients in the two countries are confident in the capabilities of physiotherapists. It is recognised that the implementation of direct access has greatly shortened patients' waiting time for physiotherapy services.

Overall speaking, the above data and facts clearly show that **direct access to physiotherapy services is a global trend. In Hong Kong, as a metropolitan city with a well-developed healthcare system, it is important that we are benchmarked with the international practice.**

[1] The representatives included the Dean of the Faculty of Physical Therapy, Srinakharinwirot University in Thailand, the former President of the Physical Therapy Association of Thailand and the President and his colleagues of the Indonesian Physiotherapy Association

4. Benefits of Direct Access

An increasing number of countries have adopted direct access for physiotherapy, which confers a multitude of benefits.

4.1 Direct access allows patients to become more autonomous in making health decisions

The adoption of direct access allows patients to be more proactive, more autonomous in making health decisions, and more interested in self-management. The implementation of direct access thus puts patients in better control of their health care [14]. ***Ultimately, it is the right of a patient to seek physiotherapy assessment, evaluation and interventions directly from a qualified physiotherapist without a medical referral***. Citizens of Hong Kong have the right to choose a medical doctor, Chinese medicine practitioner or chiropractor for their health complaints. Simultaneously, they should also have the right to choose physiotherapy.

4.2 Direct access allows patients to receive timely physiotherapy and improve system efficiency

Research has demonstrated that the implementation of direct access allows the general public to have easy access for timely physiotherapy, with better health outcomes and greater level of satisfaction [14-17]. ***It also enhances system efficiency by eliminating the need of doctor's referrals for conditions that physiotherapists are well equipped to provide intervention.***

4.3 Direct access can reduce healthcare cost

Direct access helps to reduce the financial burden on the healthcare system. Research has revealed that the cost of total healthcare in direct access model for physiotherapy was lower than the referred access by physician model. This was due to reduced physiotherapy treatment sessions, and less utilisation of other medical services (e.g., imaging, hospitalisation, specialist care) [16-22]. For example, the average cost benefit of direct access to National Health Service (NHS) Scotland was identified as being approximately £2 million per annum [18].

4.4 Direct access poses no excessive health risk to patients

Research has also examined the issue of patient safety after implementation of direct access. In a retrospective study involving 12,976 patients, Mintken et al. [23] showed that after adoption of direct access, there were no reported unidentified cases of serious medical pathology or adverse events. In another study by Moore et al. [24] involving 472,013 patient visits with different pathologies, no disciplinary or legal actions ensue from adoption of direct access. Research evidence also showed no significant difference in incidence of adverse events between the direct access group and referred access group [16,17,24]. ***Overall, research evidence showed that adoption of direct access does not increase the risk of adverse events or malpractice cases.***

One potential concern raised is whether serious pathologies would be missed among patients seen by physiotherapists if direct access is implemented. In direct access settings, a physiotherapist's ability to recognize clinical danger signs (i.e. screening for red flags) and understand when patients should be referred to a physician is vital to patient safety [25]. Screening for serious medical condition using red flags is a routine procedure of physiotherapy assessment during the first consultation. According to a nationwide survey in Denmark done by [26] quoted, it is stated that "*All the included patients in the present study had been referred by the GP, meaning the GP had screened for serious pathology as a natural part of their consultation. Despite that, 2.30% of the patients were diagnosed with serious pathology within 180 days from their first contact. Although the authors cannot assume that all of these patients would have had symptoms of serious pathology, it remains certain that the physiotherapists cannot solely rely on the initial screening from the GP, because these serious conditions may cause symptoms that develop over time*." Despite this, 2.3% of these patients seen by the physiotherapists were found to have serious pathology**.** ***The appropriate screening for serious pathology, regardless of whether the patients are referred by a doctor to see a physiotherapist or self-refer to a physiotherapist, is essential.*** Various studies reported that Physiotherapists are capable to diagnose as accurately as orthopedic surgeons, sports medicine physicians [27], and

emergency department physicians in Canada [28] and as accurately as general practitioners in the UK [29]. However, one study found that physical therapists regularly (85% of cases) documented the presence or absence of only 9 of 17 "red-flag" items in patients with lumbosacral spine conditions [30], while another [31] found that approximately 25% of physical therapists would not contact physicians when the probability of deep vein thrombosis in patients with musculoskeletal conditions. There are studies using paper case scenarios with description of patient's signs and symptoms and initial histories for accessing the ability of physical therapists in clinical decision. Jette's study [32] is a survey questionnaire based on 11 paper case scenarios which consist of short initial patient histories and patient's signs and symptoms. The average percentages of correct decisions were 87%, 88%, and 79% for musculoskeletal, noncritical medical, and critical medical conditions, respectively. The authors commented that the limited information likely contributed to the difficulty in identifying the correct management decision. Arecent Swiss study [33] similarly used paper case scenarios to examine the physiotherapists' ability to diagnose and triage patients in a simulated direct access setting, and to make correct management decisions. Each scenario briefly described a patient history along with their associated signs and symptoms. It showed substantial heterogeneity, with only 55.0% correct diagnoses (62.7% for non-Critical Medical, 61.7% for MSK, and 40.5% for Critical Medical scenarios) and 71.2% correct management decisions (78.1% for non-Critical Medical, 73.0% for MSK, and 62.3% for Critical Medical scenarios). Both mentioned studies did not include any additional tests and investigation to confirm the actual physical problems of the scenarios. This limited information could contribute to the difficulties in making correct medical diagnosis (i.e. ligamentous Injury, costochondritis, intermittent claudication, fracture, septic joint, angina). In real clinical practice, ***physiotherapists make their clinical decision according to past medial history, present medical history, the described signs and symptoms as well as physical assessment, aggravating and easing factors of patients' sign and symptoms. When we suspect a patient having serious pathology (i.e. positive warning signs or "Red flags"), we refer the patient to***

medical practitioners to have investigations/imaging/laboratory tests to confirm the diagnosis for further medical and/or surgical management.

In Hong Kong***, Physiotherapists have adequate knowledge and training to safely determine whether a patient is a suitable candidate for physiotherapy intervention or require further medical consultation and management.*** As such, physiotherapists have participated in clinical triage of patients in the Accident & Emergency Departments under Hospital Authority for years. Physiotherapists are fully capable of determining whether a patient has gained maximum benefit from physiotherapy intervention for discharge or should be adequately referred to appropriate health care professionals.

It is already clearly stated in Part I of the existing Code of Practice of the Physiotherapists Board of Hong Kong (Code of Practice) that a registered physiotherapist shall "*recognize the extent and limitation of his professional expertise and provide services that are within his competence*" and "*refer any persons under his care to the appropriate health team members whenever necessary*." [34]

Whereas alleged malpractice cases, formal complaints can be lodged to the Physiotherapists Board (PT Board). As described in the Part III and IV Code of Practice) [34], PT Board has well-established standard procedures for handling relevant complaints.

In summary, research evidence demonstrates that direct access can lead to more timely physiotherapy intervention, better patient health outcomes, greater patient satisfaction level, and reduced healthcare cost. ***The potential benefits far outweigh the potential risks. Hence, the adoption of direct access to physiotherapy is a sensible and realistic way ahead. Moreover, implementation of direct access does not preclude any patients from seeking a physician's referral for physiotherapy.***

5. Readiness for Direct Access: Entry-level Physiotherapy Education in Hong Kong

Physiotherapy education in Hong Kong have developed sufficiently to underpin the move towards direct access.

5.1 History of entry-level physiotherapy education in Hong Kong

Physiotherapy education in Hong Kong has ***more than 60 years*** of history**.** In 1991, entry-level physiotherapy education at the Hong Kong Polytechnic was converted from a Professional Diploma programme to a Bachelor of Science degree programme. In 1998, the physiotherapy education programme at the Hong Kong Polytechnic University was validated into a Bachelor of Science (Honours) programme. Another important development in physiotherapy education occurred in 2011, when a Master in Physiotherapy entry-level programme was established by the Hong Kong Polytechnic University to enable Bachelor degree holders to gain professional qualifications to become registered physiotherapists in Hong Kong upon graduation. This development is in line with the advancement of physiotherapy education made by a number of developed countries (e.g., Canada, Australia), where the entry-level physiotherapy education has been upgraded to a post-graduate programme. With the surging demand for physiotherapists, three additional self-financed compatible physiotherapy BSc (Honours) programmes have been launched in Tung Wah College (2018), Caritas Institute of Higher Education (2019) and Hong Kong Metropolitan University (2019).

In order to ensure quality education provided by all local physiotherapy education providers, the structural governance and frameworks are available for quality assurance in all individual Hong Kong physiotherapy education institutions (Part D at **Appendix 3**).

5.2 Physiotherapy education curriculum adequately prepares graduates for independent practice in all settings

The curriculum of physiotherapy programme includes but not limited to the study of biological sciences (e.g. human and functional anatomy, human

physiology, pathology), applied sciences (e.g. human development, movement science and exercise physiology), clinical sciences, scientific inquiry (e.g. research, statistics, literature reviews), professionalism and ethics, and psychosocial sciences. The curriculum is specifically designed for intensive training in physiotherapy evaluation, clinical reasoning, critical thinking and decision making together with evidence-based practice. The training also includes a minimum of 1,000 hours of mandatory clinical placement in various clinical settings such as public /private hospitals, community /day/ambulatory centers, private clinics, NGOs and etc. with different care levels including primary, secondary, tertiary and quaternary. All in all, ***the Physiotherapy training programmes in Hong Kong meet the international standard as stated in the "Physiotherapist Education Framework; Section 2 Physiotherapists entry level education programme" by World Physiotherapy*** [35].

5.3 Primary healthcare is well covered in physiotherapy education curriculum

The contemporary physiotherapy education curriculum (Part A at **Appendix 3)** has incorporated the content related to the paradigm shift in healthcare service delivery with increasing emphasis on community-based rehabilitation and primary healthcare. ***Emphasis on the vital role for disease prevention and health promotion together with patient screening are well covered in the entry level physiotherapy training programmes*** (Part B at **Appendix 3**).

5.4 Professional ethics is integral to physiotherapy education

All physiotherapy students are well aware of the professional ethics which is also an integral part of the entry level physiotherapy curriculum (Pact C at **Appendix 3**). Whosoever graduated as a registered physiotherapist shall: "***Recognize the extent and limitation of his professional expertise and provide services that are within his competence*****";** and "***Refer any persons under his care to the appropriate health team members whenever necessary*****"** (re: Part I in Basic Ethical Principles of the Code of Practice of Physiotherapist)

In summary, the entry level physiotherapy education programmes in Hong Kong are well developed and should adequately prepare the graduates for managing clients with direct access.

6. Readiness for Direct Access: Continuing Professional Development

Continuing professional development (CPD) is very important as it enables physiotherapists to advance their professional knowledge and skills to deliver effective physiotherapy intervention to meet clients' healthcare needs.

6.1 Physiotherapists in Hong Kong show high commitment to CPD

All along, registered physiotherapists in Hong Kong have been committing themselves to CPD. According to the 2017 Health Manpower Survey conducted by the Department of Health, ***approximately 90% of registered physiotherapists who participated in the survey had received additional training in different specialties*** (e.g., manipulative physiotherapy, sports physiotherapy etc.) [5], and 65% had already obtained a post-graduate Master's degree. Thus, registered physiotherapists in Hong Kong have demonstrated professional commitment to CPD for the effectiveness of their professional service.

6.2 Implementation of mandatory CPD Scheme for physiotherapists

The Chief Executive's Policy Address 2021 has highlighted the need "***to make continuing professional education and/or continuing professional development a mandatory requirement for supplementary medical professionals under the relevant ordinance…***" [2]. A Working Group has been formed by the PT Board to undertake the preparation work related to implementation of the mandatory CPD Scheme. ***It is anticipated that the mandatory CPD Scheme would be implemented to link with the renewal of the practicing certificate ultimately. This will definitely be conducive to the public interest and will assure the standard of physiotherapy practice.***

CPD courses related to direct access will be offered to increase the awareness of the roles, liabilities, and responsibilities of physiotherapists associated with working as a first contact practitioner under the direct access model.

7. Professional Indemnity Coverage

7.1 Professional indemnity insurance for registered physiotherapists in Hong Kong

All along, several insurance brokers have been offering professional indemnity insurance packages for registered physiotherapists practicing in Hong Kong (**Appendix 4**). ***The annual premium ranges from HKD 2,002 to HKD 5,260.***

7.2 Professional indemnity insurance for registered physiotherapists in Australia and Canada

In developed countries like Australia and Canada, where direct access is well established, the amount of insurance premium is comparable to Hong Kong. In Australia, members of the Australia Physiotherapy Association can opt to join membership with insurance coverage (AUD 20,000,000 limit of indemnity), and the fee is AUD 1,055 for full time physiotherapist in private sector (equivalent to HKD 5,905) and AUD 775 for part time physiotherapist in private sector (equivalent to HKD 4,338). However, when comparing with the membership fee without insurance coverage, ***the actual additional cost related to insurance coverage is only HKD 980 (part time) and HKD 1,427 (full time) per year*** (**Appendix 5**).

In Canada, many different insurance companies offer malpractice insurance, and PhysioSure (**Appendix 6**) is one of the popular ones. ***The insurance package, with a CAD 5,000,000 limit of indemnity, involves an annual premium of (CAD 235-263; equivalent to HKD 1,440-1,612).***

7.3 Professional indemnity insurance of other profession as reference

Chiropractor is one of the healthcare professions in Hong Kong having direct access. Hong Kong Chiropractic Association Limited provides professional indemnity insurance to their members in a group. The insurer is Liberty Specialty Markets Hong Kong Limited. ***The premium per insured member is around HKD 2,100.***

7.4 Enquiry to Insurance Companies on the Expected Insurance premium after direct access

The three most popular insurance companies that are providing professional indemnity insurance in Hong Kong were consulted about the premium change if direct access is implemented in Hong Kong. *QBE Hong Kong and Shanghai Insurance Limited is unable to reply any additional premium will be applied due to lack of underwriting information.* ***Liberty Specialty Markets Hong Kong Limited and Chubb Insurance Hong Kong Limited replied that NO additional premium will be charged.*** **(Appendix 7).** ***Insurance premium is not expected to substantially increase with adoption of direct access.***

Overall, the annual premium currently paid by physiotherapists in Hong Kong is quite comparable to their counterparts in Australia and Canada, despite the difference in physiotherapy referral system. Major insurance brokers which offer physiotherapy malpractice insurance in Hong Kong opined that because of the non-invasive nature of physiotherapy intervention, the amount of insurance premium would not be substantially increased when direct access is implemented. It is envisaged that individual physiotherapist can have the freedom to opt for providing intervention to cases with or without doctor's referral.

8. Proposed Direct Access Model

8.1 Development process of the current proposal

The current proposal is developed after extensive consultations with the physiotherapy community (refer to **Appendix 8**) and other stakeholders including patients' organisations (refer to **Appendix 9** for letter and position statement of support from patients' organisations) and doctors (refer to **Appendix 10** for position statement).

Before that, two surveys were conducted by the Hong Kong Physiotherapy Association (HKPA) in 2017 and 2018 respectively to gather opinion from general public as to whether direct access should be implemented. In the 2017 survey involving 1,004 participants, majority (89%) agreed that citizens of Hong Kong deserve the right to choose "doctor's referral" or "self-referral" to access physiotherapy service. This percentage was even increased to 94% when the same question was asked in the 2018 survey involving 1,749 study participants.

After the Policy Address was announced in October 2021, a series of forums and meetings were also conducted to gather the opinion extensively from physiotherapists and concerned stakeholders on the implementation of direct access. The Working Group on Implementation of Modified Referral System for Physiotherapy Services (Working Group), which consists of stakeholders from various sectors (physiotherapists, patient organisations, medical practitioners, legal personnel) also held meetings on 4 May 2022 and 12 July 2022 to gather feedback on the preliminary draft of the proposal. Written feedbacks and position statements from different stakeholders have been collected since May 2022.

The contents of the current proposal are based on either consensus or majority view from the Working Group members. Different opinions from all members in written or verbal format were received during the process of proposal drafting. The diverse opinions were also addressed through extensive discussions among the Working Group members. In order to take a step forward, views and suggestions which gained the majority support are adopted in the proposal. In particular for the important issue of patient safety as raised by certain stakeholders,

some additional measures have been proposed to address the safety concern for direct access physiotherapy service without pre-existing diagnosis and pre-requisite requirement for physiotherapist conducting direct access. Summary of opinions collected before and after the aforementioned meeting held on 12 July 2022 are at **Appendix 11**.

8.2 Features of the proposed direct access model

The direct access model is proposed after considering the alignment with the recommendations made in the Policy Address 2021 [1], and also taking reference from overseas experience [36], considering the comments raised by different stakeholders in the Working Group and additional measures for addressing diversified views. The key features of the proposed direct access model and related rationale are described below:

8.2.1 The model allows the citizens of Hong Kong to have direct access to physiotherapy service without referral in primary healthcare settings, and residential care facilities

Direct access to physiotherapy in the primary healthcare settings would allow the public to receive timely physiotherapy services in the community without delay. Direct access in community settings helps to resolve the clients' health problems at an early stage (e.g., musculoskeletal pain/injuries, etc.) through conservative treatments such as exercise training, postural education, and pain and inflammation management, thereby reducing the need for emergency attendance and hospital admissions. The notion of early detection and management of health problems at an early stage is also the key principle underpinning the work of DHCs and DHC Express, which serve as the main hubs for primary healthcare services. Community-dwelling individuals living with a chronic condition can greatly benefit from direct access to physiotherapy service (e.g., DHCs, private physiotherapy clinics, service units operated by NGOs, etc.) for maintenance/promotion of fitness and function, and education on chronic disease self-management. In school-based settings, recreational and sports facilities (e.g., soccer pitches, sports grounds, gymnasiums, etc.), physiotherapists have an important role in preparing athletes/student athletes for the games as well as timely handling of acute sports injuries during the games. Direct access is also

highly relevant in workplaces, where physiotherapy services include application of workplace ergonomics, assessment and education of workers to promote occupational health and reduce risk for work injuries.

Implementation of direct access also benefits the service users in the welfare sectors. The physiotherapy services offered by NGOs include, but not limited to, special child care, special education, sheltered employment, as well as residential, on-site outreaching, day-care/-activity, ambulatory day, and home-based services.

Direct access to physiotherapy service in residential care facilities is also important because elderly persons and persons with disabilities in residential care facilities require long-term physiotherapy interventions for maintenance of function and prevention of secondary complications.

The individual primary health care physiotherapy service provider or institution has autonomy to opt for providing its physiotherapy service under direct access.

Overall, direct access can benefit many citizens of Hong Kong and is a viable way to improve patient health outcomes, ease the health manpower strain, and reduce the healthcare cost. As noted in section 4, strong empirical evidence from overseas countries where direct access is implemented shows that direct access confers many benefits to the public and healthcare system without compromising patient safety.

Thus, the proposed amendment to Code of Practice includes a clause specifying that one can have direct access to physiotherapy service without a referral from a registered medical practitioner in community settings and residential care facilities (**see point 13.1 in section 8.3.2 below**)

8.2.2 The pre-requisite requirement of a physiotherapist conducting direct access

In order to enhance patient safety and smooth running of direct access in different primary care setting, ***an 8-hour training program is a pre-requisite requirement*** of a physiotherapist conducting direct access in his /her practice. The training

contents includes understanding of the revised Code of Practice for direct access system, requirement of documentation, operation of the Electronic Health Record Sharing System (eHRSS) (**Appendix 12**). ***Only registered physiotherapists, who have at least 2000 hours of clinical practice, are accepted to enroll in this training program.*** This training program must be provided by organisations recognised by the PT Board. All physiotherapists are required to sit for an examination after the training program. ***Only physiotherapists who have completed the program and passed the examination would be accredited to deliver physiotherapy service under direct access.***

8.2.3 The model specifies the circumstances where referring the patient to a registered medical practitioner is necessary

To further protect patient safety, the proposed model specifies the circumstances where referring the patient to a registered medical practitioner is necessary**.**

First, direct access in secondary and tertiary healthcare settings would not be considered. Patients in secondary (i.e., *specialized ambulatory medical services and general hospital care*) and tertiary (i.e., *highly complex and costly hospital care, usually with the application of advanced technology and multi-disciplinary specialized expertise*) healthcare settings often have more serious and complex health conditions that require specialized and multidisciplinary medical care services. A referral from a medical practitioner is required before patients in secondary and tertiary healthcare settings receive physiotherapy intervention. This is specified in the proposed amendment to **Code of Practice Point 13.2 (a) in section 8.3.2 below**.

Second, the physiotherapist must refer the patient/client to a medical practitioner if the patient/client exhibits signs or symptoms beyond the scope of practice of a physiotherapist. Physiotherapists have adequate knowledge and training to safely determine whether an individual is a suitable candidate for physiotherapy intervention or require further medical consultation and management. An example is screening for signs and symptoms found in the patient's history and clinical examination that may indicate serious diseases (e.g. red flags, with examples shown in **Appendix 13*)*** [37-58].
Thus, to further protect patient safety, the proposed amendment to the Code of

Practice includes a clause stipulating that if the physiotherapy assessment reveals findings outside the scope of knowledge, experience, and/or expertise of the physiotherapist, the patient shall be referred to a medical practitioner [59,60] (**see point 13.6 in section 8.3.2 below**). This clause is formulated after taking reference from the World Physiotherapy Guideline for Standards of Physical Therapy Practice [59], European Core Standards of Physiotherapy Practice [60] and provisional direct access models used in some US states [36]. This proposed amendment is also consistent with point 5 and 6 in part I (Basic Ethical Principles) of the existing Code of Practice which reads:

- *Recognise the extent and limitation of his professional expertise and provide services that are within his competence.*
- *Refer any persons under his care to the appropriate health team members whenever necessary.*

Third, after 30 calendar days or 10 visits from the initiation of a physiotherapy plan of intervention, whichever occurs first, the physiotherapist must provide a progress report to the patient for their consideration medical consultation. Any physiotherapy treatment beyond 30 days or 10 visits, whichever occurs first, the physiotherapist must provide an updated progress report to this patient for his/her consideration of medical consultation. The progress report should contain the information of the physiotherapy consultation history that includes the treatment starting date and total number of attended session, the primary complaint of the patient, the initial and updated subjective complaints and key objective assessment, the progression of his /her primary complaint, the response to the treatment and recommendation of further management, for example: discharge planning, medical consultation from a medical practitioner. A referral from medical practitioner is required for extension of treatment beyond 30 calendar days or 10 visits from initiation of a physiotherapy intervention. This is reflected in the proposed amendment to the Code of Practice (**point 13.2 (b) in section 8.3.2 below***).* It is unethical to continue physiotherapy services beyond the point of possible benefit. Imposing a time restriction on providing a progress report for elaboration of treatment progress for medical consultation and getting a referral from medical practitioner for any extension of physiotherapy treatment can further safeguard patient interest. Moreover, the physiotherapist is required to provide

the patient with a written discharge summary upon the planned patient's discharge, documenting the patient's primary complaint, key initial assessment findings, physiotherapy treatment provided, patient's health status in relation to the primary complaint at the time of discharge, start and end dates of physiotherapy treatment, and total number of physiotherapy treatment sessions provided **(point 13.4 in section 8.3.2 below)**. If the patient defaults in attending his/her physiotherapy appointment and the discharge summary cannot be delivered to him/her, the physiotherapist is required to update the patient's record.

Fourth, the progress report upon 30 calendar days or 10 visits from the initiation of a physiotherapy plan of intervention and discharge summary should be uploaded in eHRSS. eHRSS is an electronic health record platform across private and public health care providers. It provides health care providers a quick access to patient treatment record for reference. The uploaded physiotherapy progress report and discharge summary of the patient, who underwent direct access, would be accessed by his /her other health care providers and medical practitioners. This can enhance the continuity of patient care across different health care providers. In the current eHRSS, physiotherapist has ten ordinary control domains and three restricted control domains (**Appendix 14**) [61]. The progress report and discharge summary can be uploaded through one of ordinary control domain, namely clinical note/ summary.

Finally, a physiotherapist shall not initiate physiotherapy treatment and shall advise the patient to consult a registered medical practitioner, if patient seeks physiotherapy services for the same or similar condition within 6 months of being discharged by the physiotherapist. This measure, adapted from similar practice in certain US states [36], is intended to prevent abusive use of direct access to physiotherapy service (**point 13.2 (c) in section 8.3.2 below**). The patient is required to sign on a written consent provided upon the initial physiotherapy visit to declare that he/she has not received physiotherapy service in the last 6 months for the same or similar condition (**point 13.3 (a) in section 8.3.2 below**).

8.2.3 Exemptions to the time restriction on duration of physiotherapy intervention are provided to cater for the healthcare needs of certain patient/client groups.

For the following patient/client groups, there are exemptions to the 10-visit/ 30-day proviso noted in section 8.2.2. These groups include:

- Cases for health promotion, wellness, fitness, and maintenance purposes.
- Cases for workplace ergonomics.
- Cases for prevention of injuries, impairments, disabilities, and functional limitations.
- Residents in residential care facilities.
- Students with chronic disabilities or special needs in school-based settings when the service is being provided for problems or symptoms associated with the chronic disabilities or special needs.
- Patients previously diagnosed with a chronic neuromuscular or developmental condition when the service is being provided for problems or symptoms associated with that previously diagnosed condition.

The above exemptions are proposed after taking reference from the direct access models used in some US states [36].

The visit and day restrictions do not apply to health and wellness promotion, workplace ergonomics, and preventive care because the service required is more long-term. Residents in residential care facilities need long-term physiotherapy intervention to maintain their functional level. Similarly, students with disabilities or special needs also require continuous physiotherapy service as part of the overall care plan for enhancing their development and function, and should thus be exempted from the visit and day limitations.

Under the proposed model, patients with a pre-existing diagnosis of a chronic neuromuscular (e.g. stroke) or developmental condition (e.g. cerebral palsy) can have direct access to physiotherapy service without the visit and day limitations if the physiotherapy service being sought is for problems or symptoms associated with that previously diagnosed condition. As the conditions of these patients are chronic in nature, the physiotherapy intervention is for maintenance purposes and

prevention of secondary complications (e.g. fall prevention). This system will help community-dwelling individuals who are living with a chronic condition to have timely physiotherapy service for management of their chronic diseases. It would also free up more physician consultation time for those patients who truly need it.

Overall, to better cater for the healthcare needs of the above patient/client groups, amendment to the Code of Practice is proposed to allow for exemptions to the 10-visit or 30-day limit (**see point 13.5 in section 8.3.2 below**).

8.2.4 The proposed direct access model includes measures to ensure patients are well informed of their rights when they self-refer to a physiotherapist

When a patient self-refers to a physiotherapist, the physiotherapist shall get a written consent (**Appendix 15A)** from the patient prior to the commencement of treatment to highlight the following:

(1) The patient has not received physiotherapy treatment for the same or similar condition within the last 6 months.
(2) The patient is receiving direct physiotherapy service without a referral from a doctor.
(3) A physiotherapy assessment is not a medical diagnosis by a doctor.
(4) If the patient's condition requires healthcare services beyond the scope of physiotherapy practice, or any change of conditions which deem other healthcare intervention necessary, the physiotherapist is obligated to discontinue physiotherapy service and refer the patient to a registered medical practitioner.
(5) The patient has the right to discontinue physiotherapy service at his/her own discretion and opts to consult a registered medical practitioner any time during the course of physiotherapy service.
(6) The patient may continue to receive direct physiotherapy treatment services for a period of up to 10 visits or 30 calendar days, whichever occurs first, after which time a physiotherapist may continue providing him/her with physiotherapy treatment services only after receiving a referral from a registered medical practitioner.
(7) The physiotherapy services without a referral might not be covered by the patient's health plan or insurer.

For the patients fall under the exemptions to the 10-visit/ 30-day stated in section 8.2.3, physiotherapist get a written consent (**Appendix 15B**) from the patient with the following highlights:

(1) The patient is receiving direct physiotherapy service without a referral from a doctor.
(2) A physiotherapy assessment is not a medical diagnosis by a doctor.
(3) If the patient's condition requires healthcare services beyond the scope of physiotherapy practice, or any change of conditions which deem other healthcare intervention necessary, the physiotherapist is obligated to discontinue physiotherapy service and refer the patient to a registered medical practitioner.
(4) The patient has the right to discontinue physiotherapy service at his/her own discretion and opts to consult a registered medical practitioner any time during the course of physiotherapy service.
(5) The physiotherapy services without a referral might not be covered by the patient's health plan or insurer.

The physiotherapist should verbally explain the content of the written consent. The form must be signed by the patient before initiation of physiotherapy treatment. A copy of the signed written notice in the patient's file.

8.2.5 Additional amendments to the Code of Practice are incorporated to govern the dissemination of information to deter canvassing

With the implementation of direct access, there may be a need to strengthen the regulations in relation to dissemination of information and canvassing. In Part III of the current Code of Practice, there are existing guidance for the following areas:

Point 6. Professional Communication and information dissemination
Point 7. Depreciation of other physiotherapists
Point 8. Canvassing

A comparison was made with the Chiropractors Council Code of Practice [62], and the Code of Professional Conduct for the Guidance of Registered Medical Practitioners [63], because both chiropractors and registered medical practitioners are primary healthcare professionals who have direct access. Proposed amendments to Point 6-8 of Part III of Code of Practice are intended to make it

more in line with the Code of Practice of other primary healthcare professionals, thereby further safeguarding patient interest (**see section 8.3.3 below**).

8.3 Amendment of relevant clauses in Code of Practice

8.3.1 Current Code of Practice governing physiotherapy referral system

Currently, the physiotherapy referral system is guided by the following clauses in the Code of Practice [25]:

13.1 In broad terms a patient's illness should be assessed or treated on referral from, or while having direct access to, a registered medical practitioner, or a person registered in respect of a medical clinic exempted under section 8(1) of the Medical Clinics Ordinance, Cap. 343.

13.2 In emergencies and under certain other circumstances, a physiotherapist may be obliged to undertake some treatment without such previous referral. In such an eventuality the physiotherapist should ensure that such assessment and treatment as is undertaken be strictly limited to what the practitioner of physiotherapy has been trained to do.

8.3.2 Proposed amendments to Code of Practice concerning physiotherapy referral system

The following amendments are proposed to reflect the adoption of a direct access model:

13.1 Physiotherapists may assess and/or treat patients without a referral from a registered medical practitioner, or a person registered in respect of a medical clinic exempted under section 8(1) of the Medical Clinics Ordinance, Cap. 343, provided that:-

(a) the context in which the patient is requesting the services of a

physiotherapist is provided exclusively in a primary healthcare setting, whether in the public or private sector, and the physiotherapist, who after having carried out an assessment on the patient, is of the reasonable belief of that the condition for which the patient is seeking treatment does not indicate any need for medical intervention in the sphere of secondary and/or tertiary healthcare;

(b) he or she has at least 2000 hours of postgraduate clinical experience in physiotherapy; and

(c) he or she has completed and passed all assessments and examinations in relation to a direct access training course whereby the contents of such course and its provider has been recognized by the Board.

13.2 The primary healthcare settings referred to in section 13.1 shall include but not be limited to services provided by physiotherapists acting in that capacity, as part of the services provided at (or where the physiotherapists' services are contracted to be provided off-site or in the manner of outreach services, by) the following:

(a) District Health Centres and their satellite centres set up by the Food and Health Bureau;

(b) Service units operated by non-governmental organisations;

(c) Private healthcare facilities licenced to operate under the Medical Clinics Ordinance (Cap. 343);

(d) Clinics and health services establishments registered under the Private Healthcare Facilities Ordinance (Cap. 633);

(e) Service providers listed in the Primary Care Directory overseen by the Primary Healthcare Office, Health Bureau;

(f) Elderly Health Centres established by the Department of Health

(g) Residential Care Homes as defined in in the Residential Care Homes (Elderly Persons) Ordinance (Cap. 459);

(h) Residential Care Homes for Persons with Disabilities as defined in the Residential Care Homes (Persons with Disabilities)

Ordinance (Cap. 613);

(i) Halfway Houses covered by the Central Referral System for Rehabilitation Services of the Social Welfare Department;

(j) School-based settings in respect of students suffering from disabilities;

(k) Sporting, fitness and/or dance events, competitions, practices, rehearsals and/or trainings;

(l) Service recipient's own residence and

(m) Gymnasiums, spas, sports, fitness and/or health centres/clubs.

13.3 Referral from a registered medical practitioner or a person registered in respect of a medical clinic exempted under section 8(1) of the Medical Clinics Ordinance, Cap. 343. must be obtained before a patient receives physiotherapy treatment if:

(a) The physiotherapy treatment is required in the sphere of secondary and tertiary healthcare.

(b) Physiotherapy treatment is required beyond 10 visits or 30 calendar days, whichever occurs first, beginning with the date of initiation of treatment.

(c) The patient seeks physiotherapy services for the same-condition within 6 months of being discharged by a physiotherapist.

13.4 A physiotherapist shall not assess or treat a patient unless a signed written consent is given by the patient in respect of and/or confirming the following matters:

(a) The patient has not received treatment from a physiotherapist for the same condition within the last 6 months.

(b) The patient understands that he/she is receiving treatment without a referral and may continue to receive treatment for a period of up to 10 visits or 30 calendar days, whichever occurs first, after which a physiotherapist must discontinue treatment.

(c) If treatment is required beyond 10 visits or 30 calendar days,

whichever occurs first, a referral from a registered medical practitioner needs to be obtained before treatment by a physiotherapist may continue.

(d) *If the patient's condition requires healthcare services beyond the scope of physiotherapy practice, or any change of condition arises which indicate other healthcare intervention necessary, the physiotherapist is obligated to discontinue treatment immediately and advise the patient to consult a registered medical practitioner for a holistic assessment.*

(e) *The patient has the right to discontinue treatment at his/her own discretion and may opt to consult a registered medical practitioner any time during the course of treatment.*

(f) *Treatment without a referral might not be covered by the patient's health plan or insurer;*

(g) *An assessment by a physiotherapist is not a medical diagnosis by a doctor.*

(h) *The physiotherapist shall provide the patient with a written discharge summary upon a planned patient's discharge.*

13.5 *For patients who have received direct treatment without a referral and are discharged from physiotherapy services within the visit and day limitations specified in 13.3 (b), the physiotherapist shall provide a written discharge summary upon a planned patient's discharge that documents the following:*

(a) *Primary complaint(s) of the patient;*

(b) *Key physiotherapy assessment findings on initial visit;*

(c) *Type of treatment provided;*

(d) *Patient's health status in relation to the primary complaint at the time of discharge;*

(e) *Start and end dates of treatment; and*

(f) *Total number of treatment sessions provided.*

13.6 *The visit and day limitations specified in 13.3(b) does not apply to physiotherapy services provided under the following circumstances:*

(a) For health promotion, wellness, fitness, and maintenance purposes.

(b) For workplace ergonomics.

(c) For prevention of injuries, impairments, disabilities, and functional limitations.

(d) To residents in residential care facilities.

(e) To students with chronic disabilities or special needs in school-based settings when the service is being provided for problems or symptoms associated with the chronic disabilities or special needs.

(f) To a patient previously diagnosed with a chronic neuromuscular or developmental condition when the service is being provided for problems or symptoms associated with that previously diagnosed condition; the diagnosis must have been made by a registered medical practitioner or a person registered in respect of a medical clinic exempted under section 8(1) of the Medical Clinics Ordinance, Cap. 343.

A physiotherapist shall not assess or treat a patient unless a signed written consent is given by the patient of the above circumstances (13.5) in respect of and/or confirming the following matters:

(a) If the patient's condition requires healthcare services beyond the scope of physiotherapy practice, or any change of condition arises which indicate other healthcare intervention necessary, the physiotherapist is obligated to discontinue treatment immediately and advise the patient to consult a registered medical practitioner for a holistic assessment.

(b) The patient has the right to discontinue treatment at his/her own discretion and may opt to consult a registered medical practitioner any time during the course of treatment.

(c) Treatment without a referral might not be covered by the patient's health plan or insurer;

(d) An assessment by a physiotherapist is not a medical diagnosis by a doctor.

(e) The physiotherapist shall provide the patient with a written discharge summary upon a planned patient's discharge.

13.7 At any time during the course of treatment, a physiotherapist should discontinue treatment and refer the patient to a registered medical practitioner, or a person registered in respect of a medical clinic exempted under section 8(1) of the Medical Clinics Ordinance, Cap. 343 immediately if the physiotherapy assessment of the patient reveals findings outside the scope of knowledge, experience, and/or expertise of the physiotherapist.

13.8 In all circumstances, a physiotherapist should ensure that all assessments and treatments undertaken be strictly limited to what the practitioner of physiotherapy has been trained to do.

8.3.3 Amendments to Code of Practice concerning information dissemination and canvassing

Amendments to the Code of Practice concerning information dissemination and canvassing are proposed to further safeguard public interest. The proposed amendments are adapted from the Chiropractors Council Code of Practice [64] and the Code of Conduct for the Guidance of Registered Medical Practitioners [64], where applicable. Proposed amendments to the relevant sections of part III of the Code of Practice are shown in **Appendix 16:**

- Section 6.2.1 and 6.2.2 under Rules of Good Communication and Information Dissemination (**Appendix 16A**)
- Section 6.2.3 Practice Promotion (**Appendix 16B**)
- Section 6.3 Dissemination of Service Information to the Public (**Appendix 16C**)
- Section 6.4 Dissemination of Service Information to Patients (**Appendix 16D**)
- Section 6.6 Physiotherapy Health Education Activities (**Appendix 16E**)
- Section 8. Canvassing (**Appendix 16F**)
- Addition of a section on Physiotherapists Directories (**Appendix 16G**)

9. Public Education

Majority of the public should have good knowledge of what physiotherapists can offer and are aware of the requirement to obtain a doctor's referral before receiving physiotherapy service. According to the survey conducted by HKPA in 2017 involving 1,004 participants, 66% of the respondents had received physiotherapy service themselves and 41% reported that their family members or friends had received physiotherapy service. These figures were 64% and 79% respectively in the 2018 HKPA survey involving 1,749 participants. When being asked whether they were aware of the need to obtain a doctor's referral before receiving physiotherapy service, 88% and 82% of the survey participants indicated a positive response. Overall, the survey results indicated that majority of the population have received physiotherapy service and should have a reasonable knowledge of what physiotherapists can offer. Majority of the public also have good knowledge in the existing physiotherapy referral system.

Similar to launching of other new health services (e.g., DHC), public education is an important element both before and after the implementation of direct access. The physiotherapy professional associations (HKPA and Hong Kong Physiotherapists' Union) will work with the government and patient organisations to run public education and mass media campaigns so that the public and physiotherapy service recipients are well aware of the key features of the new physiotherapy direct access model, so that they can acquire the information needed to make appropriate health decisions.

10. Monitoring

The implementation of direct access model should be subject to ***review in 3 years' time by the PT Board.*** Any violation to the regulations described in section 8.4 above should be tackled by the PT Board as per the existing standard protocol for handling professional misconduct. Patient safety may be reflected by the number of malpractice cases. As part of quality assurance, the PT Board could monitor the number of malpractice cases during the review period to determine whether there is a significant increase in such cases upon the implementation of direct access [64]. In addition, a study can be done to obtain data on different stakeholders' experience with direct access (e.g., waiting time for physiotherapy service, number of physiotherapy sessions, level of satisfaction).

Under the proposed mandatory CPD scheme, all registered physiotherapists are required to attain a minimum of 45 CPD points in each 3-year CPD cycle, with a minimum of 5 CPD points each year during the cycle. In addition, 23 out of the required 45 CPD points must be gained from participating in core CPD activities (**Appendix 17**). Adherence to the mandatory CPD requirements is a pre-requisite for renewal of the practicing certificate ultimately. This mechanism will further ensure the competency level of all registered physiotherapists, and thus patient safety when direct access is implemented.

11. Concluding Remarks

The proposed direct access model is designed to empower patients to make their own health decisions and receive timely physiotherapy service in primary healthcare at various community settings. Patient safety is fully considered with restrictions on the scope of service. The circumstances where an individual should be referred to medical practitioners are also explicitly stated. The proposed direct access model aims to optimise quality patient care, improve system efficiency, and save healthcare cost without compromising patient safety.

References

1) The Chief Executive's Policy Address 2021. https://www.policyaddress.gov.hk/2021/eng/p133.html. (accessed April 2, 2022)
2) World Physiotherapy. Direct access and self-referral. https://world.physio/advocacy/direct-access. (accessed April 2, 2022)
3) The Chief Executive's Policy Address 2019. https://www.policyaddress.gov.hk/2019/eng/pdf/PA2019.pdf
4) Food and Health Bureau, The Government of HKSAR. District Health Centre. https://www.dhc.gov.hk/en/what_is_primary_healthcare.html. (accessed April 2, 2022)
5) Department of Health. 2017 Health Manpower Survey. 2017. https://www.dh.gov.hk/english/statistics/statistics_hms/sumpt17.html. (accessed April 2, 2022)
6) Galley P. Patient referral and the physiotherapist. Aus J Physiother. 1976;22:117-120.
7) Kruger J. Patient referral and the physiotherapist: three decades later. Aus J Physother. 2010;56:217-218.
8) Bury TJ, Stokes EK. Direct access and patient/client self-referral to physiotherapy: a review of contemporary practice within the European Union. Physiotherapy. 2013;99:285-291.
9) Bury TJ, Stokes EK. A global view of direct access and patient self-referral to physical therapy: implications for the profession. Phys Ther. 2013;93:449-59.
10) World Physiotherapy. 2020. https://world.physio/our-members. (accessed Feb 10, 2022)
11) Australia Institute of Health and Welfare. 2008. Review and evaluation of Australian information about primary health care a focus on general practice.
12) Ontario Physiotherapy Association. 2013. Physiotherapists in primary health care.
13) Chartered Society of Physiotherapy. 2018. First contact physiotherapy posts in general practice: A guide for implementation in England.
14) Denninger TR, Cook CE, Chapman CG, McHenry T, Thigpen CA. The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry. J Orthop Sports Phys Ther. 2018;48:63-71.

15) Brooks G, Dripchak S, Vanbeveren P, Allaben S. Is a prescriptive or an open referral related to physical therapy outcomes in patients with lumbar spine-related problems? J Orthop Sports Phys Ther. 2008;38:109-115.
16) Taylor NF, Norman E, Roddy L, Tang C, Pagram A, Hearn K. Primary contact physiotherapy in emergency departments can reduce length of stay for patients with peripheral musculoskeletal injuries compared with secondary contact physiotherapy: a prospective non-randomised controlled trial. Physiotherapy. 2011;97:107-114.
17) World Confederation for Physical Therapy. Direct access and self-referral to physical therapy: key facts and references. 2013.
18) Holdsworth LK, Webster VS, McFadyen AK. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. Physiotherapy. 2007;93:3-11.
19) Leemrijse CJ, Swinkels ICS, Veenhof C. Direct access to physical therapy in the Netherlands: results from the first year in community-based physical therapy. Physical Therapy. 2008;88:936-946.
20) Ojha HA, Snyder RS, Davenport TE. Direct access compared with referred physical therapy episodes of care: a systematic review. Phys Ther. 2014;94:14–30.
21) Hon S, Ritter R, Allen DD. Cost-effectiveness and outcomes of direct access to physical therapy for musculoskeletal disorders compared to physician-first access in the United States: systematic review and meta-Analysis. Phys Ther. 2021 Jan 4;101:pzaa201. doi: 10.1093/ptj/pzaa201.
22) Daker-White G, Carr AJ, Harvey I, et al. A randomized controlled trial. Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments. J Epidemiol Community Health. 1999;53:643-650.
23) Mintken PE, Pascoe SC, Barsch AK, Cleland JA. Direct access to physical therapy services is safe in a university student health center setting. J Allied Health. 2015;44:164-168.
24) Moore JH, McMillian DJ, Rosenthal MD, Weishaar MD. Risk determination for patients with direct access to physical therapy in military health care facilities. J Orthop Sports Phys Ther. 2005;35:674-678.
25) Welch E. Red flags in medical practice. Clinical Medicine. 2011;11:251-253.
26) Budtz CR, et al. The prevalence of serious pathology in musculoskeletal

physiotherapy patients – a nationwide register-based cohort study. Physiotherapy. 2021;112:96-102.

27) Decary S, Fallaha M, Pelletier B, Fremont P, Martel- Pelletier J, Pelletier JP, Feldman DE, Sylvestre MP, Vendittoli PA, Desmeules F. Diagnostic validity and triage concordance of a physiotherapist compared to physicians' diagnoses for common knee disorders. BMC Musculoskeletal Disorders. 2017;18:445.
28) Matifat E, Perreault K, Roy JS, Aiken A, Gagnon E, Mequignon M, Lowry V, Décary S, Hamelin B, Ambrosio M, et al. Concordance between physiotherapists and physicians for care of patients with musculoskeletal disorders sending to the emergency department. BMC Emergency Medicine. 2019;19:67.
29) Downie F, McRitchie C, Monteith W, Turner H. Physiotherapist as an alternative to a GP for musculoskeletal conditions: A 2-year service evaluation of UK primary care data. British Journal of General Practice. 2019;69:314-320
30) Leerar P, Boissonnault WG, Domholdt E, Roddey T. Medical screening by physical therapists for patients with low back pain [abstract]. J Orthop Sports Phys Ther. 2005;35:A29.
31) Riddle DL, Hillner BE, Wells PS, et al. Diagnosis of lower-extremity deep vein thrombosis in outpatients with musculoskeletal disorders: a national survey study of physical therapists. Phys Ther. 2004;84:717-728.
32) Jette DU, Ardleigh K, Chandler K, McShea L. Decision-making ability of physical therapists: physical therapy intervention or medical referral. Phys Ther. 2006;86:1619-1629.
33) Keller F. et al. Diagnostic and decision-making abilities of Swiss physiotherapists in a simulated direct access setting, Physiotherapy Theory and Practice. 2022. DOI:10.1080/09593985.2022.2077269.
34) The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. 2014. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf
35) World Physiotherapy. Physiotherapist Education Framework. 2021. https://world.physio/sites/default/files/2021-07/Physiotherapist-education-framework-FINAL.pdf. (accessed April 2, 2022)
36) American Physical Therapy Association. Levels of patient access to physical therapist services in the US.

https://sapiensmoves.files.wordpress.com/2022/01/apta-feb-2021_direct-access-by-state-map.pdf (accessed May 1, 2022)

37) Finucane LM, Downie A, Mercer C, Greenhalgh SM, Boissonnault WG, Pool-Goudzwaard AL, Beneciuk JM, Leech RL, Selfe J. International Framework for Red Flags for Potential Serious Spinal Pathologies. J Orthop Sports Phys Ther. 2020;50:350-372.
38) Judd DB, Kim DH. Foot fractures misdiagnosed as ankle sprains. Am Fam Physician. 2002;68:785-794.
39) Hatch RL, Hacking S. Evaluation and management of toe fractures. Am Fam Physician. 2002;68:2413-2418.
40) Hasselman CT, Vogt MT, Stone KL, Cauley JA, Conti SF. Foot and ankle fractures in elderly white women. Incidence and risk factors. J Bone Joint Surg Am. 2003;85:820-824.
41) Rammelt S, Zwipp H. Calcaneus fractures: facts, controversies, and recent developments. Injury. 2004;35:443-461.
42) Boyko EJ, Ahroni JH, Davignon D, Stensel V, Prigeon RL, Smith DG. Diagnostic utility of the history and physical examination for peripheral vascular disease among patients with diabetes mellitus. J Clin Epidemiol. 1997;50:659-668.
43) McGee SR, Boyko EJ. Physical examination and chronic lower-extremity ischemia: a critical review. Arch Intern Med. 1998;158:1357-1364.
44) Halperin, JL. Evaluation of patients with peripheral vascular disease. Thrombosis Research. 2002;106:V303-311.
45) Hooi JD, Stoffers HE, Kester AD, Rinkens PE, Kaiser V, van Ree JW, Knottnerus JA. Risk factors and cardiovascular diseases associated with asymptomatic peripheral arterial occlusive disease. The Limburg PAOD Study. Peripheral Arterial Occlusive Disease. Scand J Prim Health Care. 1998;16:177-182.
46) Leng GC, Fowkes FG, Lee AJ, Dunbar J, Housley E, Ruckley CV. Use of ankle brachial pressure index to predict cardiovascular events and death: a cohort study. BMJ. 1996;313:1440-79.
47) Constans J, Boutinet C, Salmi LR, Saby JC, Nelzy ML, Baudouin P, Sampoux F, Marchand JM, Boutami C, Dehant V, Pulci S, Gauthier JP, Cacareigt-Bourdenx V, Barcat D, Conri C. Comparison of four clinical prediction scores

for the diagnosis of lower limb deep venous thrombosis in outpatients. Amer J Med. 2003;115:436-440.

48) Bustamante S, Houlton, PG. Swelling of the leg, deep venous thrombosis and the piriformis syndrome. Pain Res Manag. 2001;6:200-203.
49) Bourne RB, Rorabeck CH. Compartment syndromes of the lower leg. Clin Orthop. 1989;240:97-104.
50) Swain R. Lower extremity compartment syndrome: when to suspect pressure buildup. Postgraduate Medicine. 1999:105.
51) Ulmer T. The clinical diagnosis of compartment syndrome of the lower leg: are clinical findings predictive of the disorder. Orthop Trauma. 2002;16:572-577.
52) Gupta MN, Sturrock RD, Field M. A prospective 2-year study of 75 patients with adult-onset septic arthritis. Rheumatology (Oxford). 2001;40:24-30.
53) Stulberg D, Penrod M, Blatny R. Common bacterial skin infections. Am Fam Physician. 2002;66:119-124.
54) Ahmed F. Headache disorders: differentiating and managing the common subtypes. Br J Pain. 2012;6:124-132.
55) Downie A, Williams CM, Henschke N, Hancock MJ, Ostelo RW, de Vet HC, Macaskill P, Irwig L, van Tulder MW, Koes BW, Maher CG. Red flags to screen for malignancy and fracture in patients with low back pain. Br J Sports Med. 2014;48:1518.
56) Ramanayake RPJC, Basnayake BMTK. Evaluation of red flags minimizes missing serious diseases in primary care. J Family Med Prim Care. 2018;7:315-318.
57) Henschke N, Maher CG, Refshauge KM. A systematic review identifies five "red flags" to screen for vertebral fracture in patients with low back pain. J Clin Epidemiol. 2008;61:110-118.
58) Goodman CC, Snyder TEK. Screening for immunologic disease. In: Differential Diagnosis for Physical Therapists: Screening for Referral. 5th ed. St Louis, MO: Elsevier/ Saunders; 2013.
59) World Physiotherapy. Standards of Physical Therapy Practice. https://world.physio/sites/default/files/2020-07/G-2011-Standards-practice.pdf. (accessed April 2, 2022)
60) Lackenbauer W, Janssen J, Roddam H, Selfe J. Is keep/refer decision making an integral part of national guidelines for the physiotherapy profession within

Europe? A review. Physiotherapy. 2017;103:352-360.
61) Electronic Health Record Sharing System. https://www.ehealth.gov.hk/filemanager/content/pdf/common/ehrss_leaflet_hcprof_rbac.pdf
62) Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf
63) Medical Council of Hong Kong. Code of Professional Conduct for the Guidance of Registered Medical Practitioners https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_2016.pdf
64) Physiotherapists Board. Conduct and Discipline. https://www.smp-council.org.hk/pt/en/content.php?page=cd_di2. (accessed April 2, 2022)

Appendix 1. Membership List of the Working Group on Implementation of Modified Referral System for Physiotherapy Services

Capacity	Name
Chairperson	Ms Mandy MAK Man-yu *Clinical Service Coordinator (Allied Health), New Territories West Cluster, Hospital Authority*
Representative nominated by the Hong Kong College of Orthopaedic Surgeons	Dr Wilson LI *Senior Consultant, Queen Elizabeth Hospital, Hospital Authority*
Representative nominated by the Hong Kong Medical Association	Dr CHENG Pui-lam *Specialist in Orthopaedics and Traumatology in Private Practice*
Representative nominated by the Li Ka Shing Faculty of Medicine, the University of Hong Kong	Dr Victoria WONG Wing-yee *Associate Dean (Clinical Affairs), Li Ka Shing Faculty of Medicine, the University of Hong Kong*
Representative nominated by the Faculty of Medicine, the Chinese University of Hong Kong	Professor Samuel LING Ka-kin *Assistant Professor (Clinical), Department of Orthopaedics & Traumatology, Faculty of Medicine, the Chinese University of Hong Kong*
Representative nominated by Hong Kong Physiotherapy Association	Professor Marco PANG Yiu-chung *Professor, Department of Rehabilitation Sciences, the Hong Kong Polytechnic University*
Representative nominated by Hong Kong Physiotherapists' Union	Mr Kenneth AU YEUNG Kin *Physiotherapist in Private Practice*

Representatives from relevant sectors	Mr Daniel LO Tsz-chiu *Chief Manager (Allied Health, Cluster Service Division), Hospital Authority* Dr CHUNG Wai-man *Physiotherapist in Private Practice* Mrs Eleanor CHAN WONG Yee *Chairman, Heep Hong Society* Professor Margaret MAK Kit-yi *Associate Dean, Faculty of Health and Social Sciences, the Hong Kong Polytechnic University*
Lay members	Mr Stephen LAM Wai-hung *Vice Chairman, Hong Kong Alliance of Patients' Organizations Limited* Mr CHAN Wing-kai *Chairman, the Hong Kong Asthma Society* Mr Tim PANG Hung-cheong *Community Organizer, Society for Community Organization* Ms Abigail WONG Kei-yee *Barrister-at-law*

Chairpersons/Members who have retired or resigned:-

Dr Clement CHAN Kam-ming

Dr Josephine IP Wing-yuk

Dr Edwin LEE Wai-chi

Professor Joseph LUI Cho-ze

Ms Anna Bella SUEN Mei-yee

Professor Kris WONG Wai-ning

Professor Patrick YUNG Shu-hang, MH, JP

Appendix 2. Direct access: global data

World Physiotherapy regions	Full direct access (both Private and public sectors)	No direct access	Private direct access only	Public direct access only	Grand Total
Africa	52%	10%	29%	10%	100%
Asia Western Pacific	38%	31%	27%	4%	100%
Europe	10%	27%	63%	0%	100%
North America Caribbean	25%	50%	25%	0%	100%
South America	27%	27%	45%	0%	100%
Grand Total	**28%**	**27%**	**42%**	**3%**	**100%**

Appendix 3. Coverage of primary healthcare, screening for red flags/risk factors, and professional ethics in physiotherapy entry level education in Hong Kong

A. Primary healthcare and community-based rehabilitation

Hong Kong Polytechnic University		Tung Wah College	Hong Kong Metropolitan University	Caritas of Institute of Higher Education
BSc (Hons) PT	**MPT**	**BSc (Hons) PT**	**BSc (Hons) PT**	**BSc (Hons) PT**
• RS4741 Primary Health and Community Care • RS2660 Movement Science • RS3660 Exercise Science • RS2730 Musculoskeletal Physiotherapy I • RS3580 Musculoskeletal Physiotherapy II • RS3680 Musculoskeletal Physiotherapy III • RS4790 Musculoskeletal Physiotherapy IV • RS3770 Cardiopulmonary Physiotherapy I • RS3771 Cardiopulmonary Physiotherapy II • RS3730 Neurological Physiotherapy I • RS3731 Neurological Physiotherapy II • RS3790 Paediatric Neurology & developmental disabilities • RS4742 Physiotherapy in Mental Health • RS37500 Clinical Education II • RS47500 Clinical Education III-5	• RS5320 Primary Health and Community Care • RS5311 Musculoskeletal Physiotherapy I • RS5312 Musculoskeletal Physiotherapy II • RS5313 Manipulative Physiotherapy • RS5316 Cardiopulmonary Physiotherapy • RS5318 Neurological Physiotherapy I • RS5319 Neurological Physiotherapy II • RS5317 Paediatric Neurology & developmental disabilities • RS5305 Rehabilitation Psychology • RS5333 Clinical Education III • RS5334 Clinical Education IV • RS5335 Clinical Education V • RS5336 Clinical Education VI	• PHT1011 Introduction to Physiotherapy and Professional Ethics • PHT3016 Primary Health Care and Community-based Rehabilitation • PHT3012 Rehabilitation in Older People • PHT2010 Clinical Practicum I • PHT3020 Clinical Practicum II • PHT4060 Clinical Practicum VI	• PHSI N402F Primary Health and Community Care • PHSI N202F Movement Study and Exercise Science • PHSI N204F Clinical Neurology and Developmental Disabilities • PHSI N212F Clinical Practicum II • PHSI N301F Orthopaedics and Musculoskeletal Physiotherapy II • PHSI N303F Cardiopulmonary Physiotherapy • PHSI N304F Neurological Physiotherapy • PHSI N411F Clinical Practicum III • PHSI N412F Clinical Practicum IV • PHSI N413F Clinical Practicum V • PHSI N414F Clinical Practicum VI • PHSI N415F Clinical Practicum VII	• BPHY211 Physiotherapy in Mental Health • BPHY308 Physiotherapy for Advancing Age • BPHY309 Physiotherapy in Women's and Men's Health • BPHY402 Physiotherapy in Primary Health and Community Care • BPHY403 Physiotherapy in End of Life Care • BPHY404 Physiotherapy in Sports • BPHY407 Clinical Practicum VI

B. Screening for red flags/risk factors

Hong Kong Polytechnic University		Tung Wah College	Hong Kong Metropolitan University	Caritas of Institute of Higher Education
BSc (Hons) PT	**MPT**	**BSc (Hons) PT**	**BSc (Hons) PT**	**BSc (Hons) PT**
• RS2660 Movement Sciences • RS3660 Exercise Sciences • RS2730 Musculoskeletal Physiotherapy I • RS3580 Musculoskeletal Physiotherapy II • RS3680 Musculoskeletal Physiotherapy III • RS4790 Musculoskeletal Physiotherapy IV • RS3770 Cardiopulmonary Physiotherapy I • RS3771 Cardiopulmonary Physiotherapy II • RS3730 Neurological Physiotherapy I • RS3731 Neurological Physiotherapy II • RS3790 Paediatric Neurology & developmental disabilities • RS3830 Rehabilitation Psychology • RS4742 Physiotherapy in Mental Health	• RS5306 Movement Sciences • RS5307 Exercise Sciences • RS5311 Musculoskeletal Physiotherapy I • RS5312 Musculoskeletal Physiotherapy II • RS5313 Manipulative Physiotherapy • RS5316 Cardiopulmonary Physiotherapy • RS5318 Neurological Physiotherapy I • RS5319 Neurological Physiotherapy II • RS5317 Paediatric Neurology & developmental disabilities • RS5305 Rehabilitation Psychology • RS5314 Electrophysical Therapy I	• PHT1021 Assessment and Evaluation in Physiotherapy • PHT2023 Physiotherapy in Musculoskeletal Context I • PHT2024 Physiotherapy in Musculoskeletal Context II • PHT3026 Physiotherapy in Musculoskeletal Context III • PHT3027 Physiotherapy in Musculoskeletal Context IV • PHT3028 Physiotherapy in Neurological Context I • Year 3: PHT3029 Physiotherapy in Neurological Context II • Year 3: PHT3022 Physiotherapy in Paediatrics and Developmental Disabilities • PHT3024 Physiotherapy in Cardiorespiratory Context I • Year 3: PHT3025 Physiotherapy in Cardiorespiratory Context II • PHT2010 Clinical Practicum I (3 weeks)-general • PHT3020 Clinical Practicum II (4 weeks)-general • PHT3030 Clinical Practicum III (6 weeks)- MSK focus	• PHSI N204F Clinical Neurology and Developmental Disabilities • PHSI N303F Cardiopulmonary Physiotherapy • PHSI N202F Movement Study and Exercise Science • PHSI N205F Electrophysical Therapy and Advanced Technology in Rehabilitation • PHSI N203F Orthopaedics and Musculoskeletal Physiotherapy I • PHSI N301F Orthopaedics and Musculoskeletal Physiotherapy II • NURS N101F Human Anatomy and Physiology • BSCI A224F Rehabilitation Psychology • PHSI N303F Cardiopulmonary Physiotherapy • PHSI N304F Neurological Physiotherapy • PHSI N402F Primary Health and Community Care • PHSI N211F Clinical Practicum I	• BPHY107 Evidence-based Practice and Clinical Reasoning • BPHY109 Applied Exercise Science • BPHY204 Principles of Physiotherapy Practice • BPHY206 Musculoskeletal Physiotherapy I • BPHY205 Electrotherapy in Physiotherapy I • BPHY213 Musculoskeletal Physiotherapy II • BPHY207 Neurological Physiotherapy I • BPHY208 Cardiopulmonary Physiotherapy I • BPHY210 Clinical Practicum I • BPHY307 Physiotherapy in Paediatrics and Developmental Disabilities • BPHY302 Electrotherapy in Physiotherapy II • BPHY303 Neurological Physiotherapy II • BPHY304 Cardiopulmonary Physiotherapy II

• RS2670 Electrophysical Therapy I • RS3780 Electrophysical Therapy II • RS4910 Acupuncture for Physiotherapy Practice • RS27100 Clinical Education I • RS37500 Clinical Education II • RS47100 Clinical Education III-1 • RS47200 Clinical Education III-2 • RS47300 Clinical Education III-3 • RS47400 Clinical Education III-5 • RS47500 Clinical Education III-5	• RS5315 Electrophysical Therapy II • RS5333 Clinical Education III • RS5334 Clinical Education IV • RS5335 Clinical Education V • RS5336 Clinical Education VI	• PHT4040 Clinical Practicum IV (6 weeks)-Neuro focus • PHT4050 Clinical Practicum V (6 weeks)- Cardio focus • PHT4060 Clinical Practicum VI (6 weeks) – Primary care/ • Community setting	• PHSI N411F Clinical Practicum III • PHSI N412F Clinical Practicum IV • PHSI N413F Clinical Practicum V • PHSI N414F Clinical Practicum VI • PHSI N415F Clinical Practicum VII	• BPHY305 Musculoskeletal Physiotherapy III • BPHY313 Musculoskeletal Physiotherapy IV • BPHY306 Acupuncture for Physiotherapy Practice • BPHY311 Clinical Practicum II • BPHY312 Clinical Practicum III • BPHY405 Clinical Practicum IV • BPHY406 Clinical Practicum V

C. Professional ethics

Hong Kong Polytechnic University		Tung Wah College	Hong Kong Metropolitan University	Caritas of Institute of Higher Education
BSc (Hons) PT	**MPT**	**BSc (Hons) PT**	**BSc (Hons) PT**	**BSc (Hons) PT**
• RS386 Professional Ethics and Legal Issues • RS2730 Musculoskeletal Physiotherapy I • RS3580 Musculoskeletal Physiotherapy II • RS3680 Musculoskeletal Physiotherapy III • RS4790 Musculoskeletal Physiotherapy IV • RS3770 Cardiopulmonary Physiotherapy I • RS3771 Cardiopulmonary Physiotherapy II • RS3730 Neurological Physiotherapy I • RS3731 Neurological Physiotherapy II • RS3790 Paediatric Neurology & developmental disabilities • RS4742 Physiotherapy in Mental Health • RS27100 Clinical Education I • RS37500 Clinical Education II • RS47100 Clinical Education III-1 • RS47200 Clinical Education III-2 • RS47300 Clinical Education III-3 • RS47400 Clinical Education III-5 • RS47500 Clinical Education III-5	• RS5322 Professional Ethics and Legal Issues • RS5311 Musculoskeletal Physiotherapy I • RS5312 Musculoskeletal Physiotherapy II • RS5313 Manipulative Physiotherapy • RS5316 Cardiopulmonary Physiotherapy • RS5318 Neurological Physiotherapy I • RS5319 Neurological Physiotherapy II • RS5317 Paediatric Neurology & developmental disabilities • RS5305 Rehabilitation Psychology • RS5331 Clinical Education I • RS5332 Clinical Education II • RS5333 Clinical Education III • RS5334 Clinical Education IV • RS5335 Clinical Education V • RS5336 Clinical Education IV	• PHT1011 Introduction to Physiotherapy and Professional Ethics • PHT4002 Healthcare System and Management • PHT2010 Clinical Practicum I • PHT3020 Clinical Practicum II • PHT3030 Clinical Practicum III • PHT4040 Clinical Practicum IV • PHT4050 Clinical Practicum V • PHT4060 Clinical Practicum VI	• PHSI N402F Primary Health and Community Care • PHSI N211F Clinical Practicum I • PHSI N301F Orthopaedics and Musculoskeletal Physiotherapy II • PHSI N303F Cardiopulmonary Physiotherapy • PHSI N304F Neurological Physiotherapy • PHSI N411F Clinical Practicum III • PHSI N412F Clinical Practicum IV • PHSI N413F Clinical Practicum V • PHSI N414F Clinical Practicum VI • PHSI N415F Clinical Practicum VII	• BPHY212 Professional and Ethical Issues • GE202 • Ethics and Moral Issues • BPHY210 Clinical Practicum I • BPHY311 Clinical Practicum II • BPHY312 Clinical Practicum III • BPHY401 Management and Leadership in Health care • BPHY405 Clinical Practicum IV • BPHY406 Clinical Practicum V • BPHY407 Clinical Practicum VI

D. Quality Assurance framework under different physiotherapy education providers in Hong Kong

The Polytechnic University of Hong Kong

Our BSc (Hons) in Physiotherapy and Master in Physiotherapy (Entry-level) follow the quality assurance (QA) framework as stated by The Hong Kong Polytechnic University
Https://www.polyu.edu.hk/en/education/quality-assurance/

Specifically, the QA framework is composed of four levels: (1) institutional; (2) Faculty; (3) Departmental; and (4) Programme and subject level.

While the key mechanisms and processes can be found on the above website, we would like to give some details at the subject, programme, and departmental levels.

Continuous monitoring and reviews

- Subject Level
  - Subject team will review their teaching content after each semester (subject leaders and their teams can also initiate changes in teaching content and assessment methods in order to ensure the teaching materials and assessment approaches are up-to-date and evidence-based)
- Programme level
  - Physiotherapy (PT) programme meeting will be held regularly (approximately every 6 weeks) during the academic year to discuss subject- and programme-related matters among staff members)
  - Subject Assessment Review Panel will be held after each semester to discuss and evaluate the quality of student assessment results and make suggestions to subject leaders regarding assessment-related matters in each subjects
  - Board of Examiners meeting will be held after each semester to evaluate the overall performance of students in each year, and determine final awards to students.
  - PT programme leaders need to prepare an annual report to summarize various educational-related issues to the senior management in the department.
- Departmental level
  - Departmental Learning and Teaching Committee (DLTC) is composed of Department Head, Associate Head, Undergraduate Programme Leaders (both PT and Occupational Therapy (OT)), staff representatives, student representatives from both programmes. The DLTC meeting will be held every six months to discuss education-related initiatives and strategic planning for the taught PT and OT programmes.
  - Departmental Undergraduate Programme Committee (DUPC) and Departmental Master (Entry-level) Programme Committee (DMPC) are comprised of Department Head, Associate Head, Programme Leaders (PT and OT), Clinical Education Co-coordinators (PT and OT), representatives of Year Coordinators (PT and OT), and representatives from local stakeholders (e.g., Hospital Authority, NGOs, PT and OT associations, etc.). The Committee will meet at least twice a year to discuss and review curriculum including academic regulations, admission policy, assessment, and examination, teaching and learning matters, quality of teaching staff and quality of graduate, satisfaction of graduates and their employers, etc.
  - A departmental academic advisor (DAA) is also appointed every 3 years. The DAA is an overseas prominent scholar in the PT field. He/she will evaluate the curriculum, teaching materials and assessment methods annually. The DAA will also check the fulfillment of the intended learning objectives, as well as evaluate the syllabus of the taught subjects and definitive programme document, etc.
- Additionally, Large scale of Curriculum review can be initiated by the Department Head to set up an Independent Panel that comprises Department Head, Associate Head, Programme Leaders, local stakeholders (e.g., employers, representatives from professional bodies) and overseas experts in physiotherapy practice and education to review our PT curriculum. This kind of review will include the evaluation of quality of taught subjects, teaching materials, teaching pedagogies, teaching equipment. The panel will also evaluate the quality of teaching staff, quality of graduates, feedback from employers, and benchmarking with similar programmes at renowned universities globally, etc.)

Tung Wah College

Tung Wah College

BSc (Hons) in Physiotherapy Programme

Quality Assurance Mechanisms:

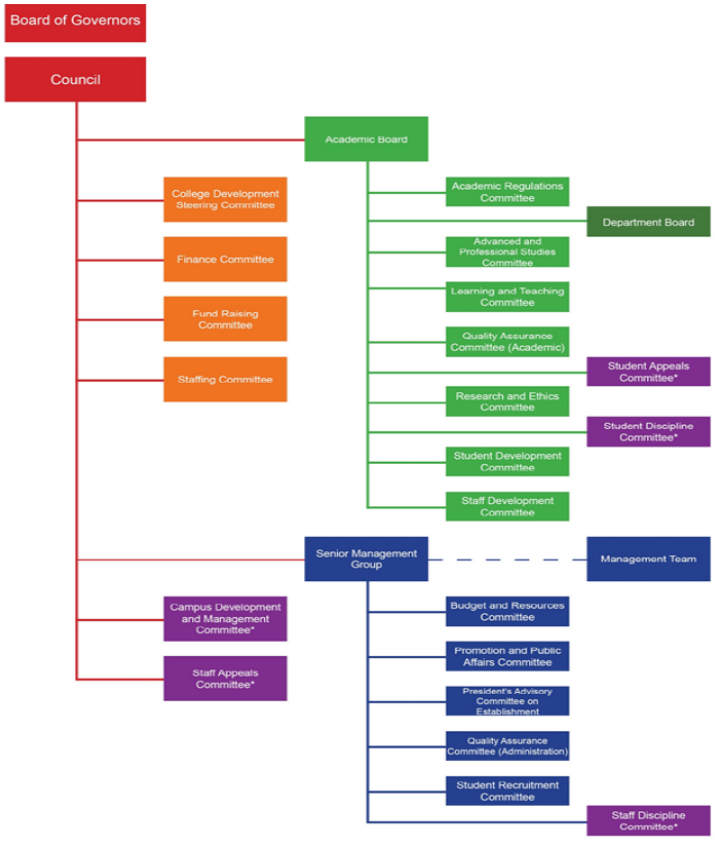
1. The programme received accreditation from the HKCAAVQ in 2018 for 5 years and is currently undergoing re-accreditation process in 2022-23 academic year
2. The programme has been approved for professional accreditation by the Physiotherapists Board and SMPC. There will be re-accreditation process in the future.
3. Tung Wah College has stringent QA mechanisms that all programmes must follow. These include the submission and review of the following:
   - Course Review reports for all courses in every semester
   - Annual Programme Review Report
   - Course and Teaching Evaluation (CTE) – to obtain students' feedback and comments on all courses in each semester
4. Quality Assurance of Course Teaching and Assessments in PT programme:
   - Two external examiners (EE) are appointed (one in Australia and one in Japan) to review the assessment scripts of High, Mid, and Low scores in each course in each semester.
   - The EE will provide comments on the appropriateness of the test papers and questions, and the standards of the students' performance in the assessments.
   - The EE also provides an annual report on the organisation and performance of the whole programme for each academic year.
5. Programme Advisory Committee
   - The role of Programme Advisory Committee (PROAC) is to provide School and Programme Leader with intelligence and insights into the market needs, and the trend and policies in respect of learning and manpower needs in local and international communities, with an aim to ensure that School's programmes are current and relevant to industry, business and society.
   - Members consist of 1 academic professor from overseas university, 1-2 members of local physiotherapy community such as senior physiotherapist from HA and from major NGO, PT department manager from private hospital, 1-2 members from professional association such as the HKPA
   - The committee meets once a year and gives advice on the progress and development of the programme
   - There are also regular meetings of the School Board (Internal meetings- with all programme leaders in MHS), and the School Advisory Board (with external members for all MHS programmes in different disciplines).
6. Quality assurance on Clinical Practicum (CP)
   - Regular meetings are held between the PT programme team with the main stakeholders for discussing and reviewing the arrangement of Clinical Practicum. These include:
   - HA head office coordinators for PT clinical placements
   - Clinical Educators in each Clinical Education Unit in HA hospitals
   - Clinical educators in NGO and private clinics and hospitals
   - At least 1 Visiting lecturer is assigned to each group of students for all clinical practicum
   - Students will fill in CTE forms for each CP and the scores and comments will be reviewed by the Clinical Coordinator to make continuous improvements for future CPs.

The Caritas Institute of Higher Education

Quality Assurance of Bachelor of Science (Honours) in Physiotherapy Programme at the Caritas Institute of Higher Education

Institutional QA Mechanisms and Procedures

The organizational structure of the CIHE is given below:



(f) On the recommendation of the Academic Board, to appoint examiners to conduct examinations for academic awards;

(g) In consultation with the Academic Board, to review the academic delivery of the

Board of Governors

Terms of Reference:

programmes and courses of the Institute;

(h) To delegate any of its powers to any members of the Council or to any committee thereof or to any officer or lecturer; and

(i) To do all such other acts and things as may be requisite to perform any duty which the Board of Governors may delegate to the Council.

Composition:

Chairperson
To be appointed by the Board of Management of Caritas-Hong Kong (neither the Chairperson nor the Vice-Chairperson shall be Chairperson or Vice-Chairperson of the Board of Governors)

Vice-Chairperson
To be appointed by the Board of Management of Caritas-Hong Kong (neither the Chairperson nor the Vice-Chairperson shall be Chairperson or Vice-Chairperson of the Board of Governors)

Treasurer
To be appointed by the Board of Management of Caritas-Hong Kong

Ex-officio Members
- The Institute President
- The President of the Joint CIHE/CBCC Students' Union

Members
- 3 members of full-time staff to be elected by and from among their members, at least 2 of whom shall be members of the Academic Board
- At least 2 but not more than 3 members of the Board of Governors, nominated by the Board of Governors
- At least 3 but not more than 4 persons appointed by the Council who shall be neither public officers nor employees of the Institute or members of the Board of Governors
- At least 3 but not more than 5 persons appointed by the Board of Management of Caritas-Hong Kong who shall be persons considered to have had relevant experience in higher education in Hong Kong or elsewhere of whom no more than 3 shall be members of the Board of Governors
- At least 3 but not more than 4 persons appointed by the Board of Management of Caritas-Hong Kong who shall be persons considered to have had relevant experience in commerce or industry in Hong Kong and shall not be members of the Board of Governors

In attendance
Provost
Vice-President (Academic and Quality Assurance)
Vice-President (Research and Technology)
Vice-President (Resources and Finance)
Director, Student Affairs

Secretary

Vice-President (Administration) and Secretary

Academic Board (AB)

Terms of Reference:

The Academic Board shall regulate the academic affairs of the Institute subject to the financial control of the Council, and shall have the power:

(a) to exercise final authority in making decisions on all academic matters within the Institute;

(b) in consultation with the academic departments, to provide programmes and courses leading to academic awards to be conferred by the Institute, and such other programmes and courses as may be thought desirable, to direct and regulate the instruction and education in the Institute and to stimulate the advancement of knowledge by research and publication;

(c) to keep the quality of all programmes and courses under constant review;

(d) to direct the manner in which examinations of the Institute shall be conducted and to make recommendations on the appointment of external examiners as and when necessary;

(e) to approve the appointment of members of the Advisory Committees;

(f) to decide on candidates for academic awards, scholarships, prizes and other awards or marks of distinction;

(g) to regulate the admission of students to programmes and courses offered by the Institute;

(h) to advise the Council on the provision of facilities for educational and other academic matters;

(i) to recommend to the Council, as necessary, the provision of additional programmes and courses and the establishment of additional teaching posts or appointment of additional staff member;

(j) to provide for the welfare and discipline of students;

(k) to expel any offending student or to require any student on academic grounds to terminate his/her studies at the Institute;

(l) to suspend any student, provided that the President may, if he/she thinks it necessary in any case, peremptorily exercise a like power of suspension pending the decision of the Academic Board in that case;

(m) to determine the academic calendar for each academic year, save the dates of meetings of the Board of Governors and the Council;

(n) to approve any lectures, programmes and courses for persons who are not members of the Institute;

(o) to draw up any necessary regulations regarding academic affairs, the general well-being and control of students, for the approval of the Council;

(p) to give advice on any matter which may be referred to it by the Council;

(q) to delegate any of its powers to any member of the Academic Board or any committee thereof or to any officer or lecturer; and

(r) to do all such other acts and things as may be requisite to give effect to the powers conferred on the Academic Board by the Institute's Constitution.

Composition:

Chairperson
President, CIHE

Vice-Chairperson
Provost

Ex-officio Members
- Vice-President (Academic and Quality Assurance)
- Vice-President (Administration) and Secretary
- Vice-President (Research and Technology)
- Vice-President (Resources and Finance)
- Registrar
- Director, Centre for Advanced and Professional Studies
- Director, Student Affairs
- Librarian
- Student Representative: President, CIHE Students' Union
- Deans or Associate Deans of Schools

Members
One full-time academic staff member to be elected from each School

In attendance
Director, Information Technology Services
Director, Centre for Excellence
Associate Registrar

Secretary
Registrar

Advisory Committee

1 Terms of Reference:

1.1 Role

At Caritas Institute of Higher Education (CIHE) and Caritas Bianchi College of Careers (CBCC), an Advisory Committee is set up for each academic school/department. The role of the Advisory Committee is to act as an interface between the academia, industry, commerce, government and community at large and the school/department concerned of CIHE/CBCC.

1.2 Duties and Responsibilities

1.2.1 An Advisory Committee shall normally meet at least once a year to provide advice on the planning and reviewing of the following aspects of the work of the respective academic school/department:

(a) the mode (full-time, part-time day, evening), level and length of courses/ programmes offered by the academic school/department to serve the local needs;
(b) the relevance of the syllabuses of all courses offered by the academic school/department in relation to the changing needs in and nature of potential employment of graduates of CIHE/CBCC;
(c) the number of graduates of each programme likely to be needed for local employment;
(d) the adequacy of equipment and other resources of the academic school/department to fulfil local needs;
(e) the development of teaching and other activities carried out jointly by the academic school/department and the appropriate sector of the community;
(f) investigation, consultancy and other services given by the academic school/department;
(g) the assistance which the community can give to further the objectives of CIHE/CBCC in the subject concerned by way of practical training facilities, the provision of part-time teaching staff and equipment, the award of scholarships, student-fellowships, etc.

1.2.2 An Advisory Committee shall receive a review report from the respective academic school/department on an annual basis. It shall liaise with other relevant academic and professional bodies for the educational needs of the programmes/courses offered by the respective academic school/department. It shall also provide relevant information to the respective academic school/department and assist the school/department to respond to the short-term and long-term needs of the Hong Kong community.

1.2.3 An Advisory Committee shall send minutes of its meetings to the Provost for subsequent referral to the relevant boards and committees.

2 Term of Service:

Advisory Committee members are normally appointed for a term of two academic years, subject to renewal. While no regulation is provided for the maximum number of years an individual can serve, the respective academic school is encouraged to look for new persons for appointment.

3 Composition and Membership: 9-6

3.1 Typically, an Advisory Committee shall comprise

Chairperson
(If the appointment of a chairperson for the Advisory Committee is deemed appropriate*) To be nominated by the School Dean (Associate Dean)/Department Head (Associate Head) concerned and appointed by the Academic Board (AB)

Convener
The School Dean (Associate Dean)/Department Head (Associate Head) concerned

Members
To be nominated by the School Dean (Associate Dean)/Department Head (Associate Head) concerned and appointed by the AB

Secretary
To be appointed by the School Dean (Associate Dean)/Department Head (Associate Head) concerned

Observers and Advisers
The Chairperson/Convener may invite any persons to attend any meeting as observers

* It may not be appropriate to always appoint a chairperson for an Advisory Committee; an exemplar situation is when the school/department concerned offers study programmes of a wide variety of disciplinary areas. Also, under such a situation the Convener may not always invite all the advisers to attend an Advisory Committee meeting, but may sometimes invite to a meeting only those advisers whose professional backgrounds are relevant to the items for discussion in that meeting.

3.2 The size of an Advisory Committee shall depend on a number of factors, e.g. the number of relevant programmes/courses, student population, the range of disciplines involved, etc. Such a committee shall normally consist of 4-10 members.

3.3 The membership shall include a range of expertise and experience from various appropriate sectors of the Hong Kong community and appropriate professional bodies.

3.4 Advisory Committee members shall not be staff of CIHE/CBCC and shall not concurrently be the External Examiners of the relevant programme(s)/ course(s). It is not preferable for a person to serve on more than one Advisory Committee of CIHE/CBCC, unless the appointment is justifiable.

4 Appointment Procedures:

4.1 Before March each year, the School Dean (Associate Dean)/Department Head (Associate Head) concerned (who is also the Convener of the Advisory Committee) shall either

(a) request the incumbent Advisory Committee members whose terms of office will expire at the end of the academic year to continue to serve in the following two academic years; or
(b) look for new or past members.

4.2 The Chairperson of the Advisory Committee, if appointed, could be consulted for suitable member nominations.

4.3 By late March, the School Dean (Associate Dean)/Department Head (Associate Head) concerned should have sought the agreement of the incumbent or prospective members to serve in the following two academic years. It should however be made clear to the prospective members that the approach is not a commitment and will be subject to the Institute/College appointment procedures.

4.4 The Vice-President (Academic and Quality Assurance) will send to the School Deans (Associate Deans)/Department Heads (Associate Heads) blank nomination forms (see Attachment 1) for appointment / reappointment of Advisory Committee members. By the end of March, the Deans (Associate Deans)/Heads (Associate Heads) should complete and return the forms (with curriculum vitas where available) to the Vice-President (Academic and Quality Assurance) for further processing before passing them to the Quality Assurance Committee (Academic) [QAC-Academic] for consideration.

4.5 The QAC-Academic will normally meet in April to consider and recommend suitable Advisory Committee members to the AB for appointment / reappointment.

4.6 The Vice-President (Academic and Quality Assurance) will prepare letters of appointment for the President's signature together with reply slips for indication of acceptance. Upon receipt of reply slips from the appointed Advisory Committee members, the Vice-President (Academic and Quality Assurance) will complete Part B of the nomination forms and send a copy of each to the School Dean (Associate Dean)/Department Head (Associate Heads) concerned.

4.7 The School Deans (Associate Deans)/Department Heads (Associate Heads) are requested to notify the Vice-President (Academic and Quality Assurance) of any changes in the personal details of their Advisory Committee members

Examiners Committee

Introduction

In CIHE, an Examiners Committee (EC) should be formed under the delegation / empowerment of the academic school concerned and it should directly report to the Academic Regulations Committee (ARC). The major duties of an EC include the discussion and the approval/endorsement of assessment-related matters at the school level, such as the approval of the examination papers before examinations, the review and endorsement of the course marks after examinations, and the recommendation for academic awards to the graduands of programmes offered through the academic school

Terms of Reference:

(a) To maintain the academic standard of the programmes/courses of studies at a level appropriate to the academic awards

(b) To approve examination papers after taking into consideration the comments, views and recommendations of the External Examiners

(c) To determine students' assessment results, after taking into consideration the comm views and recommendations of the External Examiners

(d) To exercise general supervision over the continuous assessment system

(e) To approve the form and timing of reassessment for non-examination –oriented cou

(f) To consider special cases in relation to examinations and to grant reassessment u special circumstances as deemed appropriate

(g) To consider other special cases in relation to assessment or academic regulation referred by the Registrar

(h) To consider student appeals against assessment results as referred by the Registrar

(i) To review and assess the progress of students and to report on its decision (includin recommendations for academic awards) to the Institute

Composition

Chairperson
Dean/Associate Dean of the School

Members
- Examiners

In attendance
All academic staff responsible for the teaching of the courses

Secretary
To be elected from the members

Observers and Advisers
The Chairperson may invite any persons to attend the meeting as observers or advisers

Programme Committee

Terms of Reference:

A Programme Committee should be established for each full-time study programme of th Institute, with the aim to provide a forum for discussion between staff and students on issue concerning the design of the programme curriculum, and the teaching, learning an assessment of the programme. These issues include:

(a) The programme curriculum;
(b) The teaching and learning arrangements;
(c) The assessment arrangements;
(d) The learning experiences of the students;
(e) The other supportive arrangements for the programme delivery; and
(f) Other relevant matters concerning the design and delivery of the programme.

Composition:

Chairperson
Programme Leader

Members
- All full-time academic staff members of the programme in that particular academic yea
- One full-time student representative from each year of study

Secretary
A staff member from the Host School of the Programme

Guidelines for Annual Review of Programmes and Courses

1 Introduction

At Caritas Bianchi College of Careers (CBCC) and Caritas Institute of Higher Education (CIHE), each full-time study programme and the General Education (GE) courses are reviewed annually by the Programme Committee concerned, which produces an *Annual Programme Report*. The Quality Assurance Committee (Academic) [QAC-Academic] considers the Report submitted to it via the Host Department concerned, and endorses the Report with relevant improvements suggested to the programme for the approval of the Academic Board (AB). The process, as depicted in Figure 1, ensures that the Institute systematically analyses all pertinent information and identifies areas where modifications are necessary or desirable for the study programmes/courses concerned.

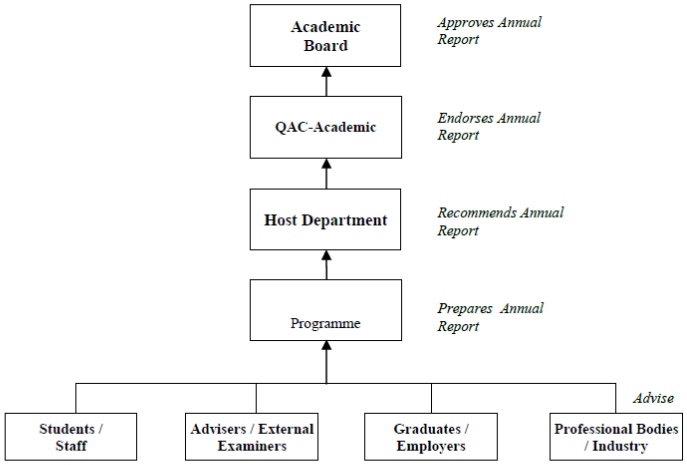


Figure 1 - The Annual Programme Review Process

2 Roles and Procedures

2.1 Programme Leader

The Programme Leader is charged with the responsibility of managing the on-going academic review and development of the programme. He/she should ensure that the necessary data and information is assembled and that a *draft Annual Programme Report* is presented for the discussion of the Programme Committee before submission to the Host Department. He/she is also responsible for ensuring that comments or advice given by the Host Department, the QAC-Academic, the AB or any other relevant parties are taken into consideration in the Annual Programme Review.

2.2 Programme Committee

The Programme Committee comprises all the academic staff members teaching the programme in the reporting academic year, as well as student representatives. During the review of the programme, the Programme Committee should consider the draft Annual Programme Report prepared by the Programme Leader, review critically all aspects of the operation of the programme and discuss any proposed changes. The Report should then be revised on the basis of the agreements and/or comments made by the committee.

The Programme Committee shall also consider proposing appropriate improvements to the programme at the Programme level.

2.3 Host Department

The Host Department shall consider the Annual Programme Report submitted by the Programme Leader and shall:

(a) endorse the Report, or
(b) endorse the Report subject to minor amendments, or
(c) return the Report with comments to the Programme Committee which shall later submit a revised report.

The Host Department shall also consider proposing appropriate improvements to the programme at the Department level.

2.4 Quality Assurance Committee (Academic)

The Annual Programme Report recommended by the relevant academic department shall then be considered by the QAC-Academic for endorsement. In endorsing the Report, the QAC-Academic shall ascertain that the objectives of the review have been achieved and that relevant issues are being properly addressed.

The QAC-Academic shall also consider proposing appropriate improvements to the programme at the Institute level.

2.5 Academic Board

Report endorsed by the QAC-Academic shall be submitted to the AB for its final approval.

With the assistance of the QAC-Academic, the AB shall also monitor the implementation of the improvements proposed for the programme at the Programme / Department / Institute levels.

3. The Annual Programme Review Process

Minutes of Advisory Committee meetings and External Examiners' reports are copied to the Programme Leader	By early November
Registrar provides basic statistical data to Programme Leader	By late November

Programme Leader drafts the Annual Programme Report (the Report)	By late February
Programme Committee discusses the draft Report and suggest revisions before submission	By early March
Host Department considers and recommends the Report	By mid March
QAC-Academic considers and endorses the Report	By late March
AB approves the Report	By early/late Apri

4. Content of the Annual Programme Report

4.1 The Annual Programme Report should draw upon evidence and information from the following sources:

(a) Statistical data provided by the Registrar on student admissions/ promotions and examination results.

(b) If available, initial statistics of employment/further study for the recent batches of graduates.

(c) Comments and suggestions contained in reports from advisers, external examiners, or other information sources.

(d) Relevant views of students obtained through the Programme Committee, the Course and Teaching Evaluation (CTE) or other informal means.

(e) Relevant views of staff teaching on the programme.

(f) Views expressed by employers/potential employers/relevant professional bodies.

(g)

(h) If applicable, comments made by the accreditation panel when the programme was last accredited.

(i) Comments of the Host Department / QAC-Academic / AB at the last Annual Programme Review.

4.2 The report should consist of the following three distinct sections:

(a) Cover Sheet

The cover sheet gives summary information on the programme and the members of the Programme Committee in the reporting academic year (see Annex 1).

(b) Main Text

Detailed guidelines on writing the Main Text of the Report are given in Section 5. A template of the suggested content is given in Annex 2 for reference.

(c) Appendices

Where appropriate, details of the data and information referred to in the Main Text should be included as appendices of the Report. Under normal circumstances, only the Cover Sheet and the Main Text will be submitted to the QAC-Academic and the AB, the appendices will be kept by the academic department concerned for records.

5. Writing the Annual Programme Report

5.1 The Main Text of an Annual Programme Report should be precise and not lengthy (i.e. less than 8 A4 pages). Unnecessary details or descriptions should be avoided.

5.2 The Main Text should provide a concise critical analysis and commentary on the operation of the programme during the previous academic year and identify the desirable changes to be made, including:

(a) the appropriateness and achievement of the programme's aim and objectives;

(b) suggestions for the improvement of the curriculum, teaching and learning methods, and assessment methods;

(c) admission and quality of students and attrition;

(d) suggestions for staff additions, staff development and resource support.

It should analyze and address those issues pertinent to the operation and progress of the programme which it has identified from the sources of evidence mentioned in Section 4.1 above. Any anomalous statistics or critical comment from external sources should be discussed.

5.3 The Main Text should be presented in accordance with the template shown in Annex 2. It should be a summary of discussion by the Programme Committee which addresses the following issues:

(a) Admissions/Promotions

The following basic statistics of the programme in the reporting academic year:

- Number of admissions;
- Number of withdrawals;
- Number of students on academic probation;
- Attrition Rate;
- Promotion Rate.

Number of students graduated from the programme and the Cohort Success Rates for the recent few cohorts of student for the programme.

The view of the Programme Committee on the above information (if any), in particular:

- Admission statistics: Are there any anomalies or problems revealed by t figures? Is the quality of admittees satisfactory? What steps can be tak to improve any adverse situation revealed by the statistics?
- Admission policies and recruitment process: Which of the policies arrangements need to be reviewed or improved? Are the admission a promotion requirements appropriate?
- Are the Attrition Rate, Promotion Rate and Cohort Success Ra acceptable? How do they compare with those of the previous academ year (if any)? What are the reasons for the higher/lower rates? What ste can be taken to improve the situation?

(b) Assessment of Students and Academic Standards

The following data for each course of the programme in the reporting academic year can be placed in the appendices as background information:

- The academic staff teaching the course;
- Number of students taking the final examination;
- Highlights of assessment methods employed.

The academic results of students in each course and the analysis of the academic quality of students in terms of grade point average (GPA) can also be placed in the appendices.

Referring to the appendices, a summary on the assessment of students and their performance should be provided in the Main Text. Examples of issues to be addressed include:

- Are the assessment methods employed on the course effective? What difficulties/problems have emerged in assessing students? What innovative assessment methods have been introduced? Are there any anomalies shown in statistics on academic results of students? Are the academic standards of students satisfactory?

- How have the feedback/comments of any of the advisers, external examiners, professional bodies, programme staff, students and employers been addressed? What follow-up or improvement may be necessary?

(c) Programme Structure and Curriculum

The Main Text should include an overall review of the programme structure and curriculum. Examples of issues to be addressed include:

- How far have the aim and objectives of the programme been met? What are the proposed changes to the programme structure and why? What are the views and suggestions from advisers, external examiners, teaching staff, students and others?

- If changes were made to the programme structure and curriculum in the previous academic year what are the outcomes?

(d) Teaching and Learning

The Main Text should include an overall review of the teaching and learning process. Examples of issues to be addressed include:

- Are the teaching methods effective? What new teaching methods will be introduced and why? How have students been encouraged to take responsibility for learning? How has innovative teaching been encouraged?

- If changes were made to the teaching and learning process in the previous academic year what are the outcomes?

(e) Management of the Programme

The Main Text should include an overall review of the management of the programme. Examples of issues to be addressed include:

- How has the programme been managed? Has the Programme Committee operated effectively as a team? What revisions to management structure, or the terms of reference of Committees/Boards, or role of Programmer Leader/Adviser/External Examiner/any other relevant person are required?

- If changes have been made to the programme management structure in the year under review what would have been the outcomes?

(f) Staff and Resources Support

The Main Text should also include an overall review of the staff and resources support of the programme. Examples of issues to be addressed include:

- What staff development activities were undertaken by programme staff in the year under review? How have they impacted on the programme? What further training is required? What is the impact of the resources made available on programme outcomes?

(g) Action Plans

In the Main Text there should be a summary of the action plan for the next academic year. The summary should assist the readers of the Report by drawing their attention to the list of goals to be achieved, together with the suggested actions (to be taken at the Programme/Academic Department level and the Institute level, respectively) and a time schedule for their achievement.

Hong Kong Metropolitan University

Appendix III-1.1.4 Programme Review and Validation Committee (PRVC)

A. Terms of Reference

1. To consider any proposal from a School Board for a new programme of study which leads to, or articulates into, an award of a degree or postgraduate degree. Consideration will take into account the programme's academic validity, standard and quality as predicted in the proposal within the context of tertiary education in Hong Kong and the aims and objectives of the University.

2. To make recommendations to the Senate as to the acceptability of the proposal including recommendations for amendments to the programme.

3. To consider the revalidation of a programme at the regular intervals set by Senate. PRVC will ascertain whether:

- the programme has established the academic validity, standard and quality as predicted during the initial validation or the last revalidation,

- the conditions and/or recommendations set during the initial validation or last revalidation have been addressed appropriately and,

- the proposed continued development of the programme will maintain these in the future within the current context.

4. To make recommendations to the Senate as to the acceptability of the proposal for the continued offering and development of the programme including recommendations for amendments to the programme.

B. Constitution

Chairman	Provost
Ex-officio Members	Deans of each School (except LiPACE)
	Director of Quality Assurance
Members	One representative from Senate
External Programme Assessor	For each programme under validation or revalidation, the external programme assessor (EPA)* appointed by the Senate
Secretary	Registrar
Recording Secretary	Quality Assurance Manager
External Programme Assessor	* Where a programme involves a number of disciplines that cannot be reviewed by a single EPA, Schools may propose to the Senate the appointment of more than one EPA. The EPA would be nominated by the School for appointment by the Senate at least 3 months before the PRVC validation/ revalidation meeting on the programme.

C. Membership

Chairman	Prof. KWAN Ching Ping Reggie
Ex-officio Members	Prof. KWONG Che Leung Charles
	Prof. AU Kai Ming Alan
	Prof. LEE Wai Sum Amy
	Prof. CHUNG Wai Yee Joanne
	Prof. WANG Fu Lee Philips
	Ms. CHOI Bik Yee Agnes
Members	Prof. TSANG Wai Nam William (6/20 - 5/22)
Secretary	Ms. CHOI Bik Yee Agnes
Recording Secretary	Ms. CHAN Sze Nga Christy

Appendix III-1.1.5 Internal Validation Committee (IVC)

A. Terms of Reference

1. To examine submissions from School Boards for programme-related changes, and consider programme proposals from School Boards that are not stipulated as part of the coverage of the Programme Review and Validation Committee, and make recommendations to Senate;

2. To examine academic issues related to course presentation, including but not limited to new course proposals, course reports and annual school reports, and make recommendations to Senate;

3. To discuss and examine any other matters referred to it by the Chairman of Senate.

B. Constitution

Chairman	Provost
Members	Deans or nominee (except LiPACE)
	Director of Quality Assurance
	Registrar or nominee
	One representative from the Senate
Secretary	Quality Assurance Manager

C. Membership

Chairman	Prof. KWAN Ching Ping Reggie
Members	Prof. KWONG Che Leung Charles
	Prof. AU Kai Ming Alan
	Prof. LEE Wai Sum Amy
	Prof. WANG Fu Lee Philips
	Prof. CHUNG Wai Yee Joanne
	Ms. CHOI Bik Yee Agnes
	Ms. CHOI Bik Yee Agnes
	Dr. YIM Pui Yu Eunice (6/21 - 5/22)
Secretary	Ms. CHAN Sze Nga Christy

FOR REFERENCE ONLY

Guidelines on duties and appointment of Advisory Peer Groups (APG)

1. Terms of reference

1.1. To advise the programme team on the initial development of the programme in order that the programme team can aim to produce a programme of equivalent standing, standard and quality to equivalent programmes offered elsewhere. In particular, to advise on:

(a) the curriculum for the proposed programme;

(b) the provisional content of individual courses;

(c) any specific requirements that should be set for the award of the associated qualification; and

(d) the contents of the Detailed Programme Proposal (DPP) to be used in the validation process.

1.2. Annually to review with the programme team the progress in the development of the programme with particular reference to:

(a) the suitability of new courses to meet the roles set for them in the Detailed Programme Proposal (DPP);

(b) the response of the team to problems arising during presentation;

(c) student performance on individual courses and within the programme; and

(d) proposed changes to the programme.

1.3. To advise the programme team on the programme review and revalidation at the regular intervals set by Senate. In particular, to advise on:

(a) the appropriateness and currency of the curriculum;

(b) the success of achieving the aims and objectives through the courses presented;

(c) whether graduates (if any) have the expected characteristics and level of understanding as planned; and

(d) future changes required to maintain its standing, standard and quality in comparison with equivalent programmes offered elsewhere.

2. Establishment and membership

2.1. A School shall establish an Advisory Peer Group to assist in the design, development and evaluation of a programme (or set of programmes) in order to establish and maintain high and comparable academic standards within the local context.

2.2. Membership will be proposed by the programme team, vetted by the School Board and approved by the Dean. Details of membership will be supplied to Senate for noting. Senate reserves the right to appoint further APG members.

2.3. An APG will consist of at least four members.

2.4. An APG member will normally be appointed for a period of six years.

3. Criteria for appointment of APG

3.1. Advisory Peer Group members should be recognised experts in the proposed field(s) of study and may be chosen from other tertiary institutions, the professional community, employers and government as appropriate.

3.2. APG members may be serving External Examiners (EE)*, course assessors or programme examiners, or may have served in one of these capacities in the past.

*Note: Any External Examiner who concurrently serves as an EPA is *not* allowed to be serving the APG for the same programme(s) undergoing validation/ revalidation at the same time.

4. Mode of operation

4.1. The Advisory Peer Group will meet with the programme team under the chairmanship of the Dean (or his/her nominee).

4.2. Meetings will usually be held annually except during the preparation of the Detailed Programme Proposal (DPP) for which more frequent meetings may be required.

4.3. The programme team is expected to seek the views of the APG concerning any significant changes^ requiring implementation between annual meetings, although this may be done by circulation.

4.4. At least two members of the APG must be present at the meetings.

4.5. The School will be responsible for servicing the meetings of the APG.

^Note: Significant changes refer to any proposed revisions to the programmes that result in changes in programme structure or learning outcomes. APG views should be obtained when proposing such significant changes. As for minor changes, APG shall be informed in the annual meetings.

Rights

5.1. For the design of a new programme, the APG shall be provided with:

(a) a proposed set of aims, objectives and intended learning outcomes (ILO) for the programme;

(b) a list of all courses proposed for the programme;

(c) the proposed structure of the programme upon which regulations for the award will be based;

(d) a description of the proposed syllabus for each course;

(e) an explanation of the role to be played by each course in fulfilling the aims, objectives and intended learning outcomes (ILO);

(f) the proposed teaching and assessment strategy to be adopted for each course and for the programme as a whole;

(g) the minutes of the associated School Board meetings;

(h) the proposed schedule for presenting courses;

(i) the academic support planned for the programme; and

(j) the expected route to be taken by students through the courses.

5.2. For the annual review of a programme the APG shall be provided with:

(a) the reports of the programme team (or equivalent) on each semester's course reports;

(b) any new courses offered with particular reference to their role in fulfilling the aims and objectives established in the Detailed Programme Proposal (DPP);

(c) any proposed changes to the programme and their effect on the original aims, objectives and intended learning outcomes (ILO) as set out in the DPP; and

(d) a sample of graduation profiles where appropriate.

5.3. For the initial review of a revalidation submission of an existing programme, the APG shall be provided with:

(a) the programme team revalidation report as defined by Senate;

(b) any course material on request;

(c) any course report;

(d) the External Examiners reports for all presentations since the validation or last revalidation;

(e) the minutes of the associated School Board meeting;

(f) details of the academic backgrounds of those responsible for the presentation and support of the courses; and

(g) samples of marked assessment material on request.

5.4. The views of the APG will be reported through minutes of meetings to:

(a) the School Board for annual meetings;

(b) the School Board and Programme Review and Validation Committee (PRVC) for the programme validation/revalidation process; and

(c) the School Board and Internal Validation Committee (IVC) for considering other programme proposals or requests of programme curriculum changes.

Honorarium

6.1. An APG member will receive an honorarium of HK$2,200 for one three-year term appointment.

6.2. To compensate for expenses a meeting fee of HK$220 will be paid.

FOR REFERENCE ONLY

Guidelines on duties and appointment of External Programme Assessors (EPA)

1. Appointments

1.1. As part of any validation/ revalidation exercise for each programme leading to the award of a degree, an External Programme Assessor (EPA) will be appointed. This individual will be responsible for providing Programme Review and Validation Committee (PRVC) with expert advice on the validation/ revalidation of the programme. Where an articulated set of programmes exists, the same EPA will act for the complete set.

1.2. Nomination by the School should normally be made at least three months prior to the meeting of the PRVC that considers the programme.

1.3. Appointment is made by the Senate.

1.4. Appointment as a member of the PRVC will be only for the stipulated validation/ revalidation exercise, although there are no restrictions on the number of re-appointments for any individual.

2. Criteria for appointment as EPA

2.1. The External Programme Assessor (EPA) is expected to be an individual of high academic standing in the discipline/specialization covered by the programme undergoing validation/revalidation. The individual should normally be of professorial rank or hold/have held the position of head of department/faculty, or substantive administrative position.

2.2. Academic experts residing outside of Hong Kong can also be considered as the EPAs, and should be provided with normal compensation for travel and accommodation plus per diem for attending the PRVC meeting.

2.3. The External Examiners (EE) currently serving the University can be nominated by the Schools as EPAs, on the condition that the same EE/EPA cannot be serving the Advisory Peer Group (APG) for the same programme(s) undergoing validation/ revalidation at the same time, to ensure considerable level of independence of the APG and EPA in the programme review process.

3. Duties and responsibilities

3.1. The EPA is expected to provide the Programme Review and Validation Committee (PRVC) with expert advice on the academic standard of the programme under review.

3.2. The EPA will be required to submit a written report to include his/her comments on the programme being reviewed.

3.3. The EPA will be a member of PRVC for the validation/revalidation of the programme and will be required to attend the meeting of PRVC to facilitate discussion.

3.4. For the validation of a new programme, the EPA is expected to consider the programme's academic validity, standard and quality as predicted in the proposal

within the context of tertiary education in Hong Kong and the aims and objectives of the University. The EPA is expected to take into consideration the following aspects when commenting on the programme in the written report:

(a) local relevance and appropriateness of the programme, its academic standing with reference to local/ international standard;

(b) the suitability of the programme objectives and intended learning outcomes (ILO) with reference to the nature of the award;

(c) the suitability of the proposed curriculum and of the individual constituent courses in achieving the stated learning outcomes and in matching the Qualifications Framework (QF) level being pitched at;

(d) the likely ability of the Programme Team, School and the University to support the programme, with consideration of e.g. sustainability of the programme, the need for new staff/course development;

(e) the anticipated standard of graduates, and their comparative standing with reference to graduates of similar or equivalent programmes on offer elsewhere; and

(f) the views expressed by the Advisory Peer Group (APG) during their initial review of the programme

3.5. For the revalidation of an existing programme, the EPA is expected to review the structure, balance, relevance, overall content and development of the programme in order to ascertain:

(a) whether the programme has established the academic validity, standard and quality as predicted during the initial validation or the last revalidation, with reference to local/ international standard;

(b) whether the conditions and/or recommendations set during the initial validation or the last revalidation have been addressed appropriately; and

(c) whether the proposed continued development of the programme will maintain these in the future within the current context.

3.6. For the revalidation of an existing programme, the EPA is expected to conduct an investigation of the programme with particular reference to the following in the written report:

(a) the progress in the development of the programme over the associated period;

(b) the progress in meeting the aims, objectives and intended learning outcomes (ILO);

(c) the response to any recommendations or conditions set after the preceding validation/revalidation;

(d) the current and future relevance of the aims, objectives and intended learning outcomes (ILO) of the programme and of its content;

(e) the plan for the continued development and/or presentation of the programme including its support;

(f) the performance of students and graduates;

(g) the views expressed by the Advisory Peer Group (APG) during the annual reviews of the programme and essentially during the latest review of the revalidation submission; and

(h) the feedback from External Examiners (EE)*

*Notes: Where an EPA of the programme concurrently serves as the EE of the courses under the same discipline/specialization, the EPA in this case should be expected to provide a holistic view and make comments on the coherence between the programme and the courses under the same discipline/specialization.

4. Rights

4.1. For the validation of a new programme, the following should be available for the EPA to see (either as part of or in addition to the Detailed Programme Proposal (DPP) which should have been endorsed by the School Board):

(a) a set of aims, objectives and intended learning outcomes (ILO) for the programme;

(b) a list of all courses proposed for the programme;

(c) the structure of the programme upon which regulations for the award will be based;

(d) a description of the proposed syllabus for each course;

(e) an explanation of the role to be played by each course in fulfilling the aims, objectives and intended learning outcomes (ILO);

(f) the teaching and assessment strategy to be adopted for each course and for the programme as a whole;

(g) the minutes of the associated Advisory Peer Group (APG) and School Board meetings;

(h) proposed schedule for presenting courses;

(i) the academic support planned for the programme; and

(j) the expected route to be taken by students through the courses.

4.2. For the validation of a new programme, the EPA may opt to meet with:

(a) the programme team; and/or

(b) the Advisory Peer Group (APG).

4.3. For the revalidation of an existing programme, the following should be available for the EPA to see (either as part of or in addition to the revalidation submission which should have been endorsed by the School Board):

(a) the programme team revalidation report as defined by Senate;

(b) any course material on request;

(c) any course report;

(d) the External Examiners reports for all presentations since the validation or last revalidation;

(e) the minutes of the associated Advisory Peer Group (APG) meetings for the annual reviews and the consideration of the revalidation report;

(f) the minutes of the associated School Board meeting;

(g) details of the academic backgrounds of those responsible for the presentation and support of the courses; and

(h) samples of marked assessment material on request.

4.4. For the revalidation of an existing programme, the EPA may opt to meet with:

(a) the programme team;

(b) the External Examiners (EE);

(c) students and graduates;

(d) tutors; and/or

(e) the Advisory Peer Group (APG).

5. Honorarium

An EPA will receive an honorarium of HK$10,000 for each Detailed Programme Proposal or each revalidation submission being reviewed.

Appendix 4. Professional indemnity insurance for physiotherapists in Hong Kong

Broker	Sagacity Asia Insurance Brokers Limited*	MI Insurance Brokers Ltd	Meritus Insurance Consultant Ltd.*	Medial Protection Society
Limit of indemnity per claim or in aggregate	$7,500,000-$10,500,000	For HKPU members: $10,000,000-12,000,000 For non-HKPU members: $750,000-10,000,000	$12,000,000-$14,000,000	N/A
Deductible per claim	$10,000	For HKPU members: $5,000 For non-HKPU members: $10,000	$7,000	$0
Annual premium	$2,002-2,202	For HKPU members: $1,800-2,000 For non-HKPU members: $4,800-6,500	$1,980-$2,200	$5,260

*for HKPU members only

Appendix 5. Professional indemnity insurance for physiotherapists in Australia

Membership category	Membership fee with insurance	Membership fee without insurance
Full-time public sector	AUD 765 = HKD 4,282	
Full-time private practice	AUD 1,055 = HKD 5,905	AUD 800 = HKD 4,478
Part-time public sector	AUD 585 = HKD 3,274	
Part-time private practice	AUD 775 = HKD 4,338	AUD 600 = HKD 3,358

Remarks:

- AUD 20,000,000 limit of indemnity per claim for Professional Indemnity, Public and Products Liability
- AUD 2,000,000 additional cover to support inquiries and investigations relating to allegations of abuse
- AUD 50,000 Cyber Liability coverage for both your own costs as well as third party losses
- Unlimited run-off cover when you have a leave of absence or retire
- Cover for Telehealth (if within one's scope of practice)

Reference: https://australian.physio/membership/categories-fees

Appendix 6. Professional indemnity insurance for physiotherapists in Canada

HUB

Risk & Insurance | Employee Benefits | Retirement & Private Wealth

PhysioSure

Your PhysioSure Professional Liability Insurance renews on July 1, 2021. To avoid a gap in coverage, please renew by July 1 at 12:01 a.m.

Please note due to changes within the program and the current insurance market conditions the following 2021-2022 policy and premium changes will apply

New 2021-2022 Professional Liability Policy Premiums

- All premiums are now 100% minimum and retained – which means there is no return premium for mid-term cancellations.

Professional Liability Insurance – Registered Physiotherapist/Physiotherapy Resident

- $5,000,000 per claim / $5,000,000 aggregate limit
- Ontario members - $263.00 annual premium
- Non-Ontario members - $235.00 annual premium

Professional Liability Insurance – Physiotherapy Assistant

- $2,000,000 per claim / $2,000,000 aggregate limit
- Ontario members - $160.00 annual premium
- Non-Ontario members - $135.00 annual premium
- $3,000,000 limit is also available

All of the above options include $10,000 of Privacy and Security Breach Expense Coverage ($1,000 deductible now applicable to all cyber options)

Appendix 7. The Enquiry Professional indemnity insurance for physiotherapists from popular insurance companies that are providing professional indemnity insurance in Hong Kong

Noted as discussed, all physiotherapist shall only work within their scope of profession in physiotherapy.

2. Does a pre-existing diagnosis a must for going to a physiotherapist
Physiotherapists do not require diagnosis or referrals from other medical profession to take cases. It is agreed that having a referral from other medical profession will help to target a patient's symptom much faster. However, all physiotherapist shall provide medical judgements & treatments according to their medical training and profession.

Ok to extend cover for providing service by physiotherapists that without prior doctor referral or diagnosis. No additional premium would be charged.

Best regards,

CHUBB

Edward Li
Assistant Underwriter, Financial Lines

Chubb Insurance Hong Kong Limited
39/F, One Taikoo Place, 979 King's Road, Quarry Bay, Hong Kong
O +852 3191 6366 F +852 2560 3565
E edward.li@chubb.com
www.chubb.com/hk

Chubb. Insured.™

Re: LIU Medical Malpractice Liability Insurance Premium Enquiry on Physiotherapy Direct Access Service

Dear Kenneth,

Please see the below email from Liberty Speciality Markets Hong Kong Limited for your reference.

Quote
The risk exposure is slightly higher than before as the diagnosis responsibility is transferred to the physiotherapists but I believe the physiotherapists are eligible to diagnose in a perspective of physiotherapy and would not render services that are beyond the scope of practice. As such, we would not charge an additional premium based on the new proposed guideline from the Physiotherapist Board.

Besides, we are grateful if HKPU can provide us with the new proposed guideline and any change of scope of practice.

Hope the above can help.

Appendix 8. Consultation with stakeholders

Date	Event	Organiser
April 2017	Survey on direct access (1004 people from general public as study participants)	HKPA
Aug-Sept 2018	Survey on direct access (1749 people from general public and 587 registered physiotherapists as participants)	HKPA
Nov 6, 2021	Direct access forum (80 participants)	HKPU
Nov 10, 2021	Direct access online forum Keynote speaker: Jonathon Kruger, CEO, World Physiotherapy (109 participants)	HKPA
Jan 27, 2022	Direct access online open forum (70 participants)	HKPA (co-organisers: HKPU, Hong Kong PolyU, Caritas Institute of Higher Education, Hong Kong Metropolitan University, Tung Wah College)
Jan 28, 2022	Online meeting with Dr. David Lam Tzit-yuen (elected Legislative Council member for Medical and Health Services)	Department of Rehabilitation Sciences, Hong Kong Polytechnic University Joint Conference of Hong Kong Health Care Professional Organization (HKPA is a member organisation)

Date	Event	Organiser
Feb 14, 2022	Preliminary proposal submitted to PT Board Chairman for soliciting feedback from stakeholders	---
March 1, 2022	Support from patients' organisations obtained	---
March 26, 2022	Direct access online open forum (310 participants)	HKPA & HKPU (co-organisers: Hong Kong PolyU, Caritas Institute of Higher Education, Hong Kong Metropolitan University, Tung Wah College)
May 4, 2022	Online meeting	Working Group on Implementation of Modified Referral System for Physiotherapy Services, PT Board
July 17,2022	Online meeting	Working Group on Implementation of Modified Referral System for Physiotherapy Services, PT Board

Appendix 9. Letters of support and position statement from patients' organisations

Letter dated 1.3.2022 from 長期病患者關注醫療改革聯席

香港灣仔皇后大道東 182 號
順豐國際中心 2 樓
物理治療師管理委員會
主席
鄺祖盛先生, MH　　（電郵：ptb@dh.gov.hk）

鄺主席鈞鑑：

有關：直接接受物理治療服務

由三十多個病人自助組織及關注病人權益團體組成的「長期病患者關注醫療改革聯席」(下稱「聯席」)，一直致力推動醫療改革，使病人得益。

根據 2021 年施政報告，特區政府建議修改法例，容許免醫生轉介而讓市民選擇直接接受物理治療等的醫療專業服務，避免延誤治療。　貴會作為管理物理治療服務的專業規管團體，將可能需要修訂相關的專業守則。聯席特此來函向　閣下表達以下意見。

聯席認同「直接接受物理治療服務」這大方向，認為可以減少病人因需醫生轉介而延誤治療的情況，亦可免卻有明確物理治療需要的病人需花費額外費用才取得轉介文件等。

在具體運作上，現時物理治療服務涉及基層健康、醫療及復康治療等醫療服務層面，日後在落實「直接接受物理治療服務」時，必須有詳細的指引及規範，以免在落實時影響病人權益。

另外，物理治療服務現由不同界別及機構（如：私營醫療機構、個別私營物理治療師、公立醫院、社會服務機構等）提供，日後在落實「直接接受物理治療服務」時，必須考慮提供服務機構的實際情況，容許各界別及機構在不違反新修訂的法例及專業守則下，自行制訂提供物理治療服務的安排。

聯席期望　貴會可就如何落實「直接接受物理治療服務」，提出詳細的建議，讓病人組織仔細閱讀後，再給予意見，以期更能反映病人的要求。

如有任何查詢，歡迎致電 27139165 聯絡聯席召集人，香港社區組織協會幹事彭鴻昌先生。

敬祝

鈞安！

長期病患者關注醫療改革聯席 謹上

二零二二年三月一日

聯席成員團體：B27 協進會（強直性脊椎炎病人自助組織）、一同夢慈善基金會（自閉症/特殊教育需要人士自助組織）、同路人同盟（綜合癌症科病人自助組織）、自強協會（肢體殘疾人士及照顧者資源中心）、自閉症人士福利促進會（自閉症人士及家屬自助組織）、利民社區網（精神病復元人士自助組織）、恆康互助社（精神病康復者自助組織）、香港女障協進會（殘疾婦女自助組織）、香港小腦萎縮症協會（小腦萎縮症病友及家屬自助組織）、香港肌健協會（肌肉萎縮病人自助組織）、香港肌無力協會（重症肌無力症病人自助組織）、香港兔唇裂顎協會（唇顎裂患兒及家屬自助組織）、香港知足協會（肢體發育不全患者自助組織）、香港社區組織協會（病人權益協會）、香港柏金遜症會（柏金遜症患者及家屬自助組織）、香港哮喘會（哮喘病人自助組織）、香港馬凡氏綜合症協會（馬凡氏綜合症病人互助組織）、香港骨髓移植復康會（骨髓移植病人互助組織）、香港強脊會（強直性脊椎炎病人自助組織）、香港復康會社區復康網絡（殘疾人士復康機構）、香港復康聯盟（殘疾人士組織）、香港傷殘青年協會（殘疾人士復康機構）、香港銀屑病友會（銀屑病友互助組織）、香港衞聰聯會（職業性失聰工友自務組織）、家盟（精神病復康者家屬自助組織）、專注力不足/過度活躍症(香港)協會（專注力不足/過度活躍症家長自助組織）、康和互助社聯會（精神病復康者自助組織）、彩色之家（紅斑狼瘡病人互助小組）、腎友互助協會（腎科病人互助組織）、華樂會（前列腺癌病人組織）、愛滋健康關注社（愛滋病感染者自助組織）、新健社（中風患者及家屬互助社）、腦同盟 （腦損病人自助組織）、慧進會（腦部受損及中風患者與家屬互助組織）、樂德會（痛症患者自助組織）、癌症策略關注組（關注癌症治療組織）、關注精神聯盟（精神病患者及家屬自助組織）、關懷愛滋（愛滋病感染者服務機構）

Letter dated 11.7.2022 from 長期病患者關注醫療改革聯席 (Patients' Position statement)

香港灣仔皇后大道東182 號
順豐國際中心2樓
物理治療師管理委員會
主席
鄺祖盛先生, MH （電郵：ptb@dh.gov.hk）

鄺主席鈞鑑：

有關：直接接受物理治療服務

由三十多個病人自助組織及關注病人權益團體組成的「長期病患者關注醫療改革聯席」（下稱「聯席」），一直致力推動醫療改革，使病人得益。聯席於本年3月1日曾發信表達對於「直接接受物理治療服務」的意見。就此議題的最新發展，聯席現再提出以下意見，懇請考慮。

聯席認為，「直接接受物理治療服務」涉及兩項重要原則：

一、 病人選擇權

病人的選擇權是病人基本權利之一，醫療人員應該尊重病人選擇病人自己認為合適的醫療服務，同時不應假設病人不懂作出選擇，甚或替代病人作出選擇。聯席因此認為「直接接受物理治療服務」體現了病人的選擇權，醫療制度應容許病人選擇「經醫生轉介」或「直接接受」物理治療。

二、 基層醫療健康的發展

政府銳意推動基層醫療健康，以促進市民更方便接觸所需的醫療健康服務及更快捷介入處理常見的健康問題（如一般肌肉骨骼痛症）。「直接接受物理治療服務」可增加基層醫療健康服務的提供者及市民處理健康問題的接觸點，經初步評估，如情況在物理治療的專業範圍內，便可儘快得到跟進處理，如超出其範圍，也可儘快得到專業意見，尋求其他合適治療。聯席因此認為「直接接受物理治療服務」配合著基層醫療健康的發展，理應實行。

聯席認為，「直接接受物理治療服務」的具體運作，涉及以下四方面：

一、 有關「直接接受物理治療服務」所適用的醫療層級

聯席認為既然基層醫療健康亟待發展，醫療系統應容許市民就物理治療可處理的常見身體健康問題上，在社區提供物理治療服務的機構內（如地區康健中心、院舍、社會服務機構及私營的物理治療診所等），即使沒有既有診斷（pre-existing diagnosis），也可直接接受物理治療服務。

二、 有關「直接接受物理治療服務」所適用的治療範圍

聯席相信物理治療有其專業培訓，理應可以作出身體狀況評估（assessment），判斷病人的身體狀況是否合適接受物理治療、是否超越物理治療的專業範圍及是否需要轉介至其他相關醫療專業跟進。聯席認為物理治療師以「直接接受物理治療服務」方式（即病人在沒有既有診斷及沒有醫生轉介的情況下）治療病人時，只需確定病人的健康問題在基層醫療層級內及沒有不可接受物理治療的身體狀況，便可提供服務，令物理治療師服務病人時更具彈性。

三、 有關「直接接受物理治療服務」的時期限制

聯席相信任何專業的醫療人員均會按照其專業標準提供服務，同樣，物理治療師將根據病人的治療需要，在適當的療程及時間內提供治療。另外，物理治療的療程與其他醫療專業一樣，較難為治療進展定立確實界線。

然而，為保障病人，聯席認為，「直接接受物理治療服務」的病人，在接受治療的第三十日或某一定的治療次數後仍未完成治療，物理治療師必須撰寫進度報告，列明治療開始時的身體狀況、第三十日的身體狀況、治療進展、估計完成治療的尚餘次數等，並必須提示病人，如有需要可尋求醫生診斷（diagnosis），甚至轉介病人接受醫生治療（treatment）。該進度報告必須保存於物理治療機構內及上載到病人的醫健通，並免費向病人提供報告副本，待病人決定是否繼續接受物理治療，抑或轉而尋求醫生意見。

至於在基層醫療健康服務內的非「直接接受物理治療服務」的病人，即該病人有已知診斷或曾因同一診斷接受物理治療，而其接受物理治療的目的為保持僅有身體機能、減慢衰退情況，則物理治療師無需於第三十日撰寫進度報告。

四、 有關「直接接受物理治療服務」對病人的保障機制

為保障病人權益，聯席認為物理治療師以「直接接受物理治療服務」形式提供服務時，必須妥善保存紀錄，以在有需要時作為相關證明。有關紀錄文件包括：

1. 在「直接接受物理治療服務」開始前，向病人講解治療目標、治療程序、預計成效、風險及中止治療權利後，由病人簽署接受治療同意書；
2. 上述「進度報告」；
3. 在完成整個治療後，撰寫治療總結，列明治療開始時的身體狀況、治療完結時的身體狀況、治療目標達成程度、治療期間的特別狀況等。

上述紀錄文件必須保存於物理治療機構內及上載到病人的醫健通，並免費向病人提供文件副本。聯席認為，病人獲取文件副本，以及其他醫護人員可於醫健通了解病人接受物理治療的情況，將產生制衡作用，有助保障病人權益。

聯席期望 貴會可儘快審視「直接接受物理治療服務」的具體方案，並提交予輔助醫療業管理局討論。聯席更期望能儘快落實「直接接受物理治療服務」，使病人得益。如有任何查詢，歡迎致電**27139165** 聯絡聯席召集人，香港社區組織協會幹事彭鴻昌先生。

敬祝

鈞安！

長期病患者關注醫療改革聯席 謹上

二零二二年七月十一日

聯席成員團體：B27 協進會（強直性脊椎炎病人自助組織）、一同夢慈善基金會（自閉症/特殊教育需要人士自助組織）、同路人同盟（綜合癌症科病人自助組織）、自強協會（肢體殘疾人士及照顧者資源中心）、自閉症人士福利促進會（自閉症人士及家屬自助組織）、利民社區網（精神病復元人士自助組織）、恆康互助社（精神病康復者自助組織）、香港女障協進會（殘疾婦女自助組織）、香港小腦萎縮症協會（小腦萎縮症病友及家屬自助組織）、香港肌健協會（肌肉萎縮病人自助組織）、香港肌無力協會（重症肌無力症病人自助組織）、香港兔唇

裂顎協會（唇顎裂患兒及家屬自助組織）、香港知足協會（肢體發育不全患者自助組織）、香港社區組織協會（病人權益協會）、香港柏金遜症會（柏金遜症患者及家屬自助組織）、香港哮喘會（哮喘病人自助組織）、香港馬凡氏綜合症協會（馬凡氏綜合症病人互助組織）、香港骨髓移植復康會（骨髓移植病人互助組織）、香港強脊會（強直性脊椎炎病人自助組織）、香港復康會社區復康網絡（殘疾人士復康機構）、香港復康聯盟（殘疾人士組織）、香港傷殘青年協會（殘疾人士復康機構）、香港銀屑病友會（銀屑病友互助組織）、香港衞聰聯會（職業性失聰工友自務組織）、家盟（精神病復康者家屬自助組織）、專注力不足/過度活躍症(香港)協會（專注力不足/過度活躍症家長自助組織）、康和互助社聯會（精神病復康者自助組織）、彩色之家（紅斑狼瘡病人互助小組）、腎友互助協會（腎科病人互助組織）、華樂會（前列腺癌病人組織）、愛滋健康關注社（愛滋病感染者自助組織）、新健社（中風患者及家屬互助社）、腦同盟 （腦損病人自助組織）、慧進會（腦部受損及中風患者與家屬互助組織）、樂德會（痛症患者自助組織）、癌症策略關注組（關注癌症治療組織）、關注精神聯盟（精神病患者及家屬自助組織）、關懷愛滋（愛滋病感染者服務機構）

Appendix 10. Position statement of doctor members of the Working Group

1. If direct access, or patients' "self-referral" to physiotherapy service, is to take place without prior medical consultation (including a holistic assessment with a medical diagnosis reached), it will change the health care seeking behavior and model of healthcare in Hong Kong fundamentally, i.e. patients will have direct access to the ultimate healthcare provider without going through the primary care practitioner who is able to discuss the pros and cons of every available therapy options, and start a conversation with the patient, taking into account the context of the individual's background and history, and not assuming that there is a single 'best' option for everyone even with the same condition. In our opinion, this is not in the best interest of patients, as this amounts to self-prescription for medical therapy (drug therapy, physical therapy, occupational therapy, orthosis therapy, …are all validated medical therapy for a variety of musculoskeletal disorders, with each of their associated benefits and limitations, and can be used in isolation or combination, according to the clinical judgement of an attending physician). The society needs to discuss and debate in depth as well as in detail before such fundamental changes are to be implemented.

2. The so called "freedom of choice" mentioned by some members to support direct access is not a valid argument, as all medical decisions should be an informed choice. Self-prescribed "direct access" to one sort of medical therapy, however, is not indeed an informed choice, as the explanation of risks and benefits is provided by the service provider themselves, which is therefore prone to bias and potential conflict of interest.

3. In Hong Kong and many societies around the world, the right of prescription is limited to medical practitioners, who are, in turn, made accountable for our decisions. Rights should follow responsibilities. Is the Hong Kong public, and the healthcare service providers, ready to take up responsibilities of "self-prescription" to all sorts of medical therapies/diagnostics? If we look at some parts of the world where direct access to medical therapy is carried out to a limited extent, we can easily appreciate how much preparatory, education, and consultation work have been done before its implementation. Take the example of the United Kingdom, a set of musculoskeletal decision support tools were co-designed by an Expert Advisory Group, consisting of people with arthritis (patients' groups), general practitioners, physiotherapists, policymakers, academics and decision support experts, before its implementation. The musculoskeletal decision support tools, for example, were reviewed by the Royal College of General Practitioners (RCGP), the Chartered Society for Physiotherapy (CSP), and the British Orthopaedic Association (BOA), and were tested in clinical practice at some designated centres, before promulgating to other NHS facilities. These tools set out the treatment options for that particular condition and summarise what is known about the potential benefits and risks of each therapeutic option. They are intended to facilitate discussion, and not to guide people towards a particular option. Together with the NICE guidelines and quality standard for relevant conditions, these tools help to actively involve the patients in the medical decision making process, without any potential bias.

4. As a pilot trial, we may consider allowing limited direct access to physiotherapy on the condition that "if a patient experiences symptoms similar to a past episode for which he/she has been seen by a physician and referred to the physiotherapist for management of the same problem before", while more discussion on the pros and cons of direct access to various forms of medical therapy and diagnostics is planned for the society.

Appendix 11. Summary of opinions received from various stakeholders

Opinions collected **before** the meeting of Working Group on 12 July 2022

Stakeholders	Opinion
Physiotherapists	Proposed two circumstances for referral back to medical consultation and exemptions to the 120-day limitations with specific client groups: 1. The patient/client exhibits signs or symptoms beyond the scope of practice of a physiotherapist 2. The patient/client does not show measurable improvement with respect to the primary complaints within 120 days of initiating physiotherapy intervention
Doctors	• Proposed a limited direct access model: past episode seen by a physician and referred to physiotherapy • Concurred with the position statement of orthopaedic members of the board that this "will change the health care seeking behavior and model of healthcare in Hong Kong fundamentally" and has broad implications • Recommend a phase approach, beginning with a pilot trial in selective practice settings, such as District Health Centres • For medical social collaboration, a pilot test of the Direct Access Model for physiotherapy service for selected medical conditions in a well-controlled healthcare setting (e.g. District Health Centres) is warranted before its full implementation • A holistic review and consultation with all the stakeholders should be undertaken at an early stage as it has profound implications on other professions • Education institutions should explain how their physiotherapy programmes would be enhanced to cater for the new development arising from the implementation of direct access • The proposal should address the concern of delayed medical diagnosis or treatment, patient safety, and legal liability issues, however remote • The Code of Practice should cover the professional responsibilities and liabilities arising from direct access • The medical profession is subject to strict regulations against medical canvassing, if direct access is to be implemented, the PT profession should be subject to the same level of scrutiny as a matter of public interest

Stakeholders	Opinion
Patients	• Patients' rights of choosing direct access to physiotherapy should be respected • Direct access to physiotherapy will facilitate the development of the primary healthcare system • Physiotherapists are professionally trained and are capable of assessing patients' situations • First contact for physiotherapy is beneficial for a timely management in primary healthcare settings • Cases without pre-existing diagnosis should also be allowed direct access to physiotherapy • A model requiring pre-existing diagnosis and previous referral of the same diagnosis is not a direct access approach • For patients receiving "direct PT service", if there is no apparent progress starting from the 30th day of or after certain times of treatment, physiotherapists need to write progress report sand advise patients to see doctors. If needed, they should make referral for treatment • For patients not receiving "direct PT service" (i.e. health maintenance), physiotherapists are not required to write progress report after 30 days of treatment • For patients receiving "direct PT service", proper documentation must be made and stored in the clinic and eHealth platform. Patients have right to request for copies of these records • Number of day for referring to medical consultation could be reduced to a shorter period for patient without pre-existing diagnosis • Maximum number of physiotherapy treatment session for referring to medical consultation is also required • Proposed referral back to hospitals or doctors in the event of (i) deterioration of patient's situation to a point beyond the scope of PT and (ii) no apparent progress within 30 days or 8-10 times of treatment • Should provide clearer definition of settings for direct access • Should elaborate on the exclusion of primary healthcare settings in Hospital Authority • Should provide the Chinese definition of red flag cases • Evaluation of the direct access for monitoring is required • Private clinic is a part of primary healthcare setting which should be included with direct access • Written consent from patient for direct access is proposed • Discharge summary and utilization of eHealth platform are required for facilitation of clinical hand over • Concerned about liabilities and insurance issue for physiotherapists

Stakeholders	Opinion
Supplementary Medical Professions Council Members (including comments at meeting on 23 June 2022)	• The Working Group should reconsider the way of elaboration of primary healthcare settings • To elaborate further on following issues:- ➢ Patient safety ➢ Professional training ➢ Health literacy of the general public on PT service ➢ Defer canvassing ➢ Insurance • It is still high risk for patients if no medical diagnosis is conducted before PT treatment as there are many scenarios that patients or physiotherapists may misjudge the situation • The final version to be submitted to the Council must be the proposal worked out by the Working Group and endorsed by the PT Board

Opinions collected **after** the meeting of Working Group on 12 July 2022

Stakeholders	Opinion
Ms. Eleanor CHAN (HKPU)(1st reply) **Physiotherapist**	First contact practitioners • PT graduates are well-equipped to be the first contact practitioners • Suggested putting the above as one of the evaluation elements into the 3-year implementation review Pre-requisites for direct access • Regardless of no. of sessions, a progress report should be mandatory • By professional judgement, PTs always need to note down the significant changes of clients' conditions
Mr. Daniel LO (HA) **Executive or Allied Health Manager**	Qualifications • PT register is divided into Part I and II, where Part I is further divided into Part Ia and Ib • As Part Ia registration requires one year of post-qualification recognized experience, it is reasonable to consider only PTs under Part 1a for direct access • In HA, all newly recruited PTs (most of them are fresh graduates) will undergo three years of structured training/exposures, as well as CPD activities • Upon completion of training, the PTs will become competent practitioners to practice in HA Application of direct access in HA • HA is the major organization managing public health care services, with its operation and service delivery models designed to suit HA's needs • Based on patients' needs, the clinical team would refer patients for various allied health services • In view of HA's operation, the direct access would not be applicable to the HA, and HA would not participate in any pilot scheme as suggested by individual members

Stakeholders	Opinion
Dr. Wilson Li (HKAM)(1st reply) Dr. Josephine IP (HKMA) Dr. Victoria WONG (HKU) Dr. Samuel LING (CUHK)(1st reply) **Doctor** *Enclosures (Annex 1a-1d)*	<u>General comments</u> • There has not been a "consensus" due to opposition from significant portion of members • Main arguments from the opposing views should be listed explicitly • Patients' groups also have the concern over the "lack of a holistic assessment followed by a medical diagnosis which is in turn followed by a formulated multidisciplinary treatment plan" • The use of terms "medical practitioners" and "healthcare providers" is not consistent <u>Pilot scheme</u> • In the UK, a pilot scheme was launched for Advanced Practice Practitioners (APPs), with long-time discussion across healthcare professions and clear clinical pathway provided • For HK, a pilot scheme should be launched which is limited to cases of musculoskeletal or neurological conditions in selected well-controlled healthcare setting (e.g. DHCs), where medical social collaboration is possible • A thorough discussion among all stakeholders and across the whole society should be conducted first
Mr. Tim PANG (Patients' Alliance on Healthcare Reform) (1st reply) **Patient** *Enclosure (Annex 2)*	<u>General comments</u> • Patients' groups do not share the concern over the "lack of a holistic assessment followed by a medical diagnosis which is in turn followed by a formulated multidisciplinary treatment plan" • Patients' groups do not share the concern over the "missed diagnosis and therefore delayed treatment" • Patients are confident in PTs' assessment and treatment • He has already addressed doctors' concerns at the last meeting with no opposite views received, which showed a "deliberative consensus" • Not only opposition views, supporting views should also be listed • "Cross-disciplinary" describes the collaboration between PT and doctors on a mutual respect basis, as opposed to "multidisciplinary approach" which usually implies domination by doctors • Despite issues to be discussed, a proposal should be made as the first step
Prof. Marco PANG (HKPA)(1st reply) **Physiotherapist**	<u>Pilot scheme</u> • No need to launch a pilot scheme • In the UK, direct access is only for APPs but also PTs • APPs in the UK is an "extended scope of practice" of physiotherapists with extra rights (e.g. diagnosis, blood test, etc.), while they are not asking to create APPs in HK • In many countries, direct access was open to PTs in all settings when it first started • PTs has all along been liable to disciplinary actions in case of malpractice, whether there is direct access or not

Stakeholders	Opinion
	<u>Pre-requisites for direct access</u> • No need to launch a two-tier system • PT curriculum fully equips all PT graduates to manage direct access • In many countries, direct access was open to all registered PTs when it first started
Prof. Margaret MAK (PolyU) **Physiotherapist** *Enclosure (Annex 3)*	<u>General comments</u> • A well-established clinical decision-making pathway for PT management of patients is in place (see attachment) • Competency in making a PT diagnosis is fundamental of PT management • Screening for potential risks is a routine part of PT assessment • Referral would be made if a patient needs further investigation or is of a red/yellow flag case • Clinical reasoning and formulation of PT diagnosis has been incorporated into the curriculum since 1980s
Mr. Kenneth AU YEUNG (Private practice) (1st reply) **Physiotherapist** *Enclosure (Annex 4)*	<u>General comments</u> • All members had equal opportunity to express their opinions, and 100% consensus is almost impossible • Various concerns (e.g. education, curriculum changes, legal and insurance liabilities) have been discussed in details • PT curriculum has comprehensive coverage of knowledge, including patient screening and identification of red flags • PTs has all along been liable to disciplinary actions in case of malpractice, whether there is direct access or not • Insurance premium will not increase significantly according to insurance companies • Patient's opinion should be respected as they are the ultimate users
Mr. CHAN Wing-kai (Hong Kong Asthma Society) **Patient**	<u>General comments</u> • All members' views should have already been expressed at previous meetings • Direct access will save much medical recourses and greatly benefit the patients, especially the grassroots • Patients' groups' view of supporting direct access is important • Clear directives/guidelines on how to classify cases with or without prior medical diagnosis should be provided • The Code of Practice would be amended to cope with direct access <u>Pilot scheme</u> • Did not agree with limiting direct access to musculoskeletal or neurological cases only • Boundary for cases applicable to direct access would be covered in relevant guidelines to be drafted
Dr. Wilson LI (HKAM)(2nd reply) **Doctor**	<u>General comments</u> • All views raised at previous meetings, both supporting and opposing, should be recorded accurately, which is also echoed by Ms. Abigail WONG

Stakeholders	Opinion
	• In response to Mr. Tim PANG, the remark "shared by patients' group" originates from Mr. Stephen LAM, who once quoted an example of his friend whose treatment was delayed <u>Pilot scheme</u> • At the meeting, he and Dr. Samuel Ling explicitly asked for recording in the minutes their opposition to the proposal, and there are prerequisites to direct access (e.g. establishment of a clinical pathway, curriculum changes, public consultation and education, litigation and insurance issues) • Opined that it has not reached the stage of a sudden jump to direct referral • Advocated a more prudent approach of piloting stage first, acting on the consensus model first (cases with pre-existing diagnosis)
Dr. Samuel LING (CUHK)(2nd reply) **Doctor**	<u>General comments</u> • To allow cases with pre-established diagnosis for direct access is a “majority opinion” instead of a “consensus” • Direct access model in other countries (e.g. Thailand and Indonesia) are not applicable to HK due to difference in situations • Direct access has to be done in a structured and controlled step-by-step manner with regular reviews and due diligence <u>Re-evaluation of PT curriculum</u> • Necessary precautions are necessary to ensure that public health is adequately protected • Proposed that the current physiotherapy education curriculum needs to undergo proper re-evaluation, which would give the public a peace of mind <u>Accreditation of current PTs</u> • Proper accreditation for current physiotherapists is a prerequisite • Should draft a more structured timeline for implementation accreditation and CPD continuous education
Ms. Abigail WONG (Lay member) **Lawyer**	<u>General comments</u> • The discussion has been an open and healthy one, and it is normal for members to have different opinions • Proposed a more simple and neutral term "view" instead of "consensus" • It would be fine so long as the drafting approach in the proposal itself, as and when modified/redrafted to create the final product, reflects the views of the parties involved • Agreed to differentiate "medical practitioners" from "healthcare providers” to avoid confusion • When the outline of the model which represents the majority view is done, we can move on to examine how to revise the Code of Practice and how to express the scope of practice

Stakeholders	Opinion
Ms. Eleanor CHAN (HKPU)(2nd reply) **Physiotherapist**	<u>First contact practitioners</u> • Local PT programmes have been well-recognized by developed countries internationally • Experienced academic professionals have assured the PT programmes have well equipped graduates to be first contact practitioners <u>General comments</u> • Despite the evolving hard work and extensive membership recruitment of the working group in the last 13 years, there have been hurdles from the medical parties, undermining the health autonomy of Hong Kong people • Encouraging to see Thailand and Indonesia has overcome medical dominance and realized direct access • Constructive and protective suggestions have been received from patient's groups • Should not let unsupported issues override the readiness and timely implementation of direct access in HK • It is the majority consensus to accomplish the historical mission of direct access in HK
Prof. Margaret MAK (PolyU)(2nd reply) **Physiotherapist** *Enclosure (Annex 5)*	<u>First contact practitioners</u> • PT curriculum has been designed with reference to World Physiotherapy (formerly WCPT) to educate students to be first contact practitioners (https://world.physio/sites/default/files/2021-07/Physiotherapist-education-framework-FINAL.pdf) • WCPT Guidelines (see attachment) state that "Physical therapists are able to act as first contact practitioners, and patients/clients may seek direct services without referral from another health care professional." • Regular curriculum reviews are conducted to ensure the curriculum is up-to-date and benchmarked with overseas entry level programmes
Mr. Stephen LAM (Hong Kong Ankylosing Spondylitis Association) **Patient**	<u>Pre-requisites for direct access</u> • For cases without pre-existing diagnosis, PTs need to write progress report and advise whether referral to doctors is required within 30 days/10 sessions of treatment • Upload documentation to eHRSS <u>General comments</u> • All members have expressed their views substantially at the Working Group • Patients understand their own situation the best • Patients' groups' view of supporting direct access is important and should not be ignored • Patients' autonomy should be respected • Regardless of the presence of pre-existing diagnosis, PTs are capable of providing safe and effective treatment within their scope of practice

Stakeholders	Opinion
Prof. Marco PANG (HKPA)(2nd reply) **Physiotherapist**	<u>General comments</u> • In Thailand and Indonesia, it is not customary for PTs to purchase malpractice insurance • In HK as well as other well-developed countries, it is required for PTs to purchase malpractice insurance, which further safeguards the interests of both patients and PTs
Dr. CHUNG Wai-man (Private practice) (1st reply) **Physiotherapist**	<u>General comments</u> • All parties agreed that direct access is feasible and appropriate to be implemented in HK • Despite different opinions and various models proposed, a consensus has been reached that direct access should be supported • HK has decades of PT clinical practice and well-developed PT training programmes, the standards of local PTs are undoubtedly high and world-recognized <u>On-field PT service</u> • Patients in principle support direct access if there is a good monitoring and governing system • PTs have been for many years treating athletes on-field and, if needed, would refer them to doctors, for which no single incident / mal-practice has been reported • PTs working in community setting have no difficulty in managing acute musculoskeletal disorders <u>Concerns over missed diagnosis</u> • According to existing overseas figures provided previously, the incidence rate of adverse events after direct access implementation in other countries is extremely low • In case of malpractice, PTs would be held liable by the existing bodies such as the PIC of PT Board
Mr. Kenneth AU YEUNG (Private practice) (2nd reply) **Physiotherapist**	<u>Pre-requisites for direct access</u> • Screening and identification of red flags are well covered in the entry-level PT training programmes • No need to launch a two-tier system • No need to impose post-graduation experience limitation • Agreed with mandatory capacity training course before conducting direct access
Dr. Wilson Li (HKAM)(3rd reply) Dr. Josephine IP (HKMA) (2nd reply) Dr. Victoria WONG (HKU)(2nd reply) Dr. Samuel LING (CUHK)(3rd reply) **Doctor**	<u>Pre-requisites for direct access</u> • As for exemption of pre-existing diagnosis, doctor members opposed to this on grounds of patients' safety, as the lack of a prior holistic assessment for possible underlying medical conditions would deprive patients of their right to get advice from doctors • As for exemption of history of PT referral of the same diagnosis, doctor members opined that this (prior referral on same condition) and those with a pre-existing diagnosis are the two conditions that might be worthwhile for piloting direct access • As for limitation of days and sessions of PT treatment, the suggestion “the progress report with treatment progress,

Stakeholders	Opinion
	recommendation for medical consultation should be given for the case without pre-existing diagnosis upon 30 days of physiotherapy consultation or 10 PT sessions" should be read as "all cases with progress report mentioning lack of progress or worsening symptoms, recommendation.....PT sessions, whichever is less" • As for patient consent, a detailed informed consent with explanation of the pros and cons of direct access, including the lack of a holistic assessment and a medical diagnosis, and the formulation of a comprehensive multidisciplinary management plan should be clearly stated • As for other pre-requisite requirements (e.g. two-tier system, post-graduation experience, capacity training), doctor members strongly opined that direct access should be considered only in selected conditions where clear management guidelines with protocol driven algorithms, and that training courses for accredited first contact practitioners with a monitoring system should be in place for each selected condition before the implementation of direct access
Prof. Margaret MAK (PolyU)(3rd reply) **Physiotherapist**	<u>First contact practitioners</u> • PT training programmes equip graduates to handle direct access • PTs are competent in formulating the major problems within the scope of PT by a holistic biomedical-psycho-social holistic clinical reasoning approach • PTs have the knowledge to prescribe the best treatment to patients based on best current research evidence and patient values • In other countries with direct access, none is limited to a few clinical conditions with "protocol driven algorithms"
Ms Mandy MAK (Working Group Chairman) **Physiotherapist**	**Summary of Members' opinions** <u>Without pre-existing diagnosis</u> • The consultation period is limited to 30 calendar days or 10 visits whichever occurs first • A medical referral is required for the extension of PT treatment beyond 30 calendar days or 10 visits whichever occurs first • A progress report for medical consultation is required upon the above consultation period (i.e. 30 calendar days or 10 visits) • PTs should provide a discharge summary to patient • This progress report and discharge summary should be uploaded to eHealth platform for ensure continuity of patient care across different health care providers <u>Pre-requisite requirements</u> • All PTs should attend a training program as a pre-requisite requirement of conducting direct access service. • Only PTs who have at least 2000 hours of clinical practice are accepted for the enrollment of this training program • Only PTs who completed this program and passed the examination would be accredited to deliver PT service under direct access

Stakeholders	Opinion
Mr. Tim PANG (Patients' Alliance on Healthcare Reform) (2nd reply) **Patient**	<u>Pre-requisites for direct access</u> • As for exemption of pre-existing diagnosis, patient members satisfy with the doctor members' additional measures in protecting patient's safety, serving patient's best interest and not depriving patient's right to information and right to choose
Prof. Marco PANG (HKPA)(3rd reply) **Physiotherapist**	<u>Pre-requisites for direct access</u> • Fully aware of the potential concerns raised by other stakeholders about the pre-requisite requirements • Compromise from all parties is needed • Agreed with the measures described in Ms Mandy MAK's summary
Mr. Kenneth AU YEUNG (Private practice) (3rd reply) Ms. Eleanor CHAN (HKPU)(3rd reply) Dr. CHUNG Wai-man (Private practice) (2nd reply) **Physiotherapist**	<u>Pre-requisites for direct access</u> • Agreed to compromise to move things forward • Agreed with the measures described in Ms Mandy MAK's summary
Prof. Margaret MAK (PolyU)(4th reply) **Physiotherapist**	<u>Pre-requisites for direct access</u> • Agreed to compromise to move forward to finalizing of the proposal • Agreed with the measures described in Ms Mandy MAK's summary

Appendix 12: Training program for Direct Access

Pre-requisite criteria for applying: 2000 hours of clinical practice

Course Objectives:

Upon completion of this course, you will be able to:

1. Explain the essential features of the direct access model;
2. Understand the revised Code of Practice (i.e. patient referral system, dissemination of information to the public and patients, canvassing);
3. Explain what written consent is required when delivering direct physiotherapy service without referral;
4. Explain what documentation is required when delivering direct physiotherapy service without referral;
5. Know the operation of eHealth Platform for documentation (i.e. progress report and discharge summary).

No. of hours: 8

CPD Points: 8 points

Course content

No. of hours	Topic	Class format
1	Code of Practice related to direct access model	Lecture
1	Written consent and documentation	Lecture
3	Documentation: Operation of eHealth Platform	Lecture and Practical
1	Code of practice related to dissemination of information the public and patients, and canvassing	Lecture
2	Case studies	Lecture and Discussion

Examination:

The examination will consist of multiple choice questions and short answers (1 hour). ONLY those participants who have completed the course and passed the exam would be accredited to deliver physiotherapy service without referral (i.e. direct access).

Appendix 13. Red flags (Examples of patients' characteristics, complaints, signs and symptoms that may be recognized as "red flags" and the possible conditions that may be indicated. When such signs and symptoms are found, the physiotherapist will alert or consult the medical doctors.)

Red flags for spinal pain	Possible condition
• Constant, progressive and non-mechanical pain 痛感持續、持續惡化、非力學相關疼痛 • Previous history of cancer 曾經患上癌症 • Unexplained weight loss (eg,10 lbs or more in 6 months) 沒有原因的體重下降（6個月內下降10磅或以上）	Spinal metastasis, tumor脊椎轉移腫瘤, 脊椎腫瘤
• Prolonged use of corticosteroids 長期服用皮質類固醇 • Significant trauma (major in young, minor in elderly) 重大創傷 (年輕人嚴重受傷、老年人輕微受傷) • Previous history of spinal fracture 曾經患有脊椎骨折 • History of osteoporosis 曾經患有骨質疏鬆症 • Female 女性 • Age >70y.o. 年紀大於70歲 • Thoracic pain 胸痛	Vertebral fracture 脊椎骨折
• IV drug abuse/immunosuppression 靜脈注射藥物濫用/ 免疫抑制 • Persistent fever/systematically unwell 持續發燒/ 全身不適 • Recent history of bacterial infection/spinal infection 最近曾經患有細菌感染/脊椎骨髓炎	Spinal infection 脊椎骨髓炎
• Urinary/bowel disturbance/retention/incontinence 膀胱功能障礙/ 尿液滯留/ 失禁 • Saddle anaesthesia 馬鞍式感覺喪失 • Widespread or progressive motor weakness in the legs or gait disturbance 廣泛的/ 持續下肢肌無力/ 步態異常	Cauda equina syndrome 馬尾症候群
• Bilateral numbness of feet/hands 雙手/雙腳麻痺 • Gait disturbance步態異常 • Positive Babinski sign 巴賓斯基反射陽性 • Clonus 陣攣	Spinal cord compression 脊髓壓迫
• Heartburn 胃灼熱 • Indigestion 消化不良 • Difficulty in swallowing 吞咽困難 • nausea/ vomiting 嘔吐感/嘔吐 • change in stools and bowel habits 排便習慣改變	Gastrointestinal condition 腸胃狀況

Additional red flags for neck pain	
• Severe neck stiffness 頸部嚴重僵硬 • Fever 發燒	Meningitis 腦膜炎
• Paraesthesia 感覺異常 • Headache 頭痛 • 5Ds: Diplopia 複視, dizziness頭暈 (vertigo, light-headedness, giddiness), drop attacks 墜落性發作, dysarthria 構音障礙, dysphagia 吞嚥困難	Cervical artery dysfunction 頸椎動脈功能異常
• Major trauma 重大創傷 • History of rheumatoid arthritis, ankylosing spondylitis, or Down's Syndrome 曾經患有類風濕性關節炎/ 僵直性脊椎炎/ 唐氏綜合症 • Long tract neurological signs (e.g., exaggerated tendon reflexes, pathological reflexes, spasticity) 長束神經系統體徵 (例如：過度反射、病理反射、痙攣) • Dizziness 頭暈 • Vertigo 眩暈 • Nystagmus 眼球震顫	Cervical ligament instability 頸椎韌帶不穩定
Additional red flags for thoracic pain	
• Chest pain 胸痛 • Left neck/shoulder pain 左頸/肩痛 • Pallor 蒼白 • Sweating 流汗 • History of coronary artery disease 曾經患有冠狀動脈疾病 • History of 3 highs 曾經患有三高 • Men>40y.o., Women>50y.o. 男士年過40歲，女士年過50歲	Heart condition 心臟病
• Chest pain 胸痛 • Cough 咳嗽 • Difficulty in breathing 呼吸困難 • History of respiratory disorder 曾經患有呼吸系統疾病 • History of deep vein thrombosis 曾經患有深層靜脈血栓	Lung condition 肺疾病
Red Flags for extremity problem	
• Recent trauma 近期創傷 • Totally unable to bear weight immediately after injury 在受傷後，無法承受重量 • Inability to move the affected area 不能移動受影響部位 • Bruising, joint effusion, haemarthrosis 瘀, 關節積水, 關節積血	Fracture 骨折

• Snap/pop associated with injury 在受傷時有聲響 • Palpable gap in tendon 肌腱在觸診時有斷裂	Tendon rupture 肌腱斷裂
• Recent injury/immobilization 近期受傷/不能活動 • History of smoking曾經吸煙 • Redness and swelling over the leg 下肢有紅及腫 • Increased warmth of the swollen and painful area 腫及痛位置溫度上升 • Pain during standing or walking 站立或步行時有痛楚	Deep vein thrombosis 深層靜脈血栓\
• History of blunt trauma/crush injury 曾經受到鈍性創傷/輾壓損傷 • 5 Ps: paraesthesia of toes; paresis (footdrop); pain (anterior tibia); pallor and pulseless 典形症狀5p: 神經感覺遲純(腳指), 麻痺(足下垂), 疼痛(小腿前側), 蒼白, 及無脈搏	Compartment syndrome 腔室症候群
• Fever 發燒 • Swelling, redness of joint 關節腫, 紅 • Heat on palpation 觸診時有熱 • Severe pain on movement, reluctant to move 活動時有嚴重痛楚, 不情願活動 • Skin over affected area appears tight or stretched, redness受影響部份皮膚緊繃或拉緊, 潮紅 • Skin rash begins suddenly and spreads quickly within 24 hours 皮膚突然產生紅印及在24小時內迅速擴散	Infectious condition (eg, septic arthritis, cellulitis) 感染狀況 (例如敗血性關節炎, 蜂窩組織炎)
Additional red flags for headache	
• Sudden onset of headache 突然產生的頭痛 • New onset/ change in headache in patients who are aged over 50 or with history of cancer/HIV 50歲以上曾患有癌症或帶有人體免疫力缺乏病毒之患者, 並有新發/頭痛改變 • Severe headache (eg, disturbed sleep, thunderclap seconds to 5 mins to peak headache intensity) 嚴重頭痛 (例如: 睡眠障礙, 雷擊頭痛數秒至五分鐘不等至最強強度) • Headache subsequent to head trauma 頭部創傷後相關頭痛 • Neurological signs/symptoms 神經系統表癥/症狀	Headache secondary to other underlying medical condition 因其他醫療原因產生的頭痛

• Vomiting, dizziness or altered consciousness嘔吐, 頭暈及意識狀態改變 • Systemic signs (eg, fever, night sweats) 全身系統症狀 (例如: 發燒, 夜汗) • Headache that changes with posture or precipitated by exertion or Vasalva Manoeuvre • Headache becomes more severe or frequent 頭痛惡化或逐漸頻密 • New-onset headache during or after pregnancy 懷孕期間或懷孕後初發頭痛	
Additional red flags for pain	
• Findings from objective examination are not consistent with patient complaints 客觀評估結果與病人申訴有差異	Pain may have psychological origin 受心理因素影響的痛楚
• Recent trauma with new observable deformity 近期創傷伴有新可觀察的畸形	Severe trauma that requires medical follow-up 需接受醫學跟進的嚴重創傷
Other red flags	
• Weakness or numbness of the face, arm or leg 面部, 上肢或下肢無力或麻痺 • Visual disturbance 視覺受損 • Balance/gait disturbance 平衡/步態異常 • Slurred speech 言語不清	Transient ischemic attack or minor stroke 短暫腦缺血發作(小中風)或輕度中風

References:

Please refer to references #28-49 in the main proposal.

Appendix 14: Access rights to eHRSS functions of Physiotherapists

Ordinary control:

- Personal identification and demographic data
- Allergies and adverse drug reactions
- Diagnosis
- Procedures
- Medication
- Encounters / appointments
- Clinical note / summary
- Immunisation records
- Radiology reports
- Healthcare referrals

Restricted control:

- Birth records
- Laboratory reports
- Other investigation reports

(Source: The eHealth Record Office of the Government of the Hong Kong Special Administrative Region. Access control. https://www.ehealth.gov.hk/en/whats-ehealth/access-control.html. (accessed August 10, 2022))

Appendix 15A. Written consent of receiving direct physiotherapy service for patient who is not under the proposed code of practice 13.5

I, (name)_____, declare that I have not received physiotherapy service for the same or similar condition within the last 6 months.

I fully understand that:

- I am receiving direct physiotherapy treatment services without a referral.
- I may continue to receive direct physiotherapy treatment services for a period of up to 10 visits or 30 calendar days, whichever occurs first, after which time a physiotherapist must discontinue physiotherapy treatment.
- If physiotherapy is required beyond 10 visits or 30 calendar days, whichever occurs first, I will need to consult a registered medical practitioner to obtain a referral first.
- If my condition requires healthcare services beyond the scope of physiotherapy practice, or any change of conditions which deem other healthcare intervention necessary, the physiotherapist is obligated to discontinue physiotherapy service immediately and advise me to consult a registered medical practitioner.
- I have the right to discontinue physiotherapy service at my own discretion and opts to consult a registered medical practitioner any time during the course of physiotherapy service for a holistic assessment.
- Physiotherapy services without a referral might not be covered by my health insurance.
- A physiotherapy assessment is not a medical diagnosis by a doctor.
- The physiotherapist is required to provide me with a written discharge summary upon my request.

Signature of patient: _____ Date: _____

Name of physiotherapist: _____

Signature of physiotherapist: _____ Date: _____

本人，(姓名)_____，申報本人並沒有因同一或相近的健康問題而在六個月內接受過物理治療服務。

本人完全明白：

- 本人將會接受免轉介物理治療服務。
- 本人最多可持續接受免轉介物理治療 10 次，或 30 個日曆日，以先到者為準，而此期限之後物理治療師必須停止為本人提供物理治療服務。
- 如本人接受共 10 次物理治療，或在首次物理治療服務 30 個日曆日後，以先到者為準，本人仍需接受物理治療服務，本人將會需要諮詢註冊西醫以取得物理治療轉介信。
- 如本人的申訴已超出物理治療的範疇而需要其他醫療專業介入，或因健康狀況有任何轉變而物理治療師認為本人有物理治療以外的醫療需要，物理治療師有責任即時終止物理治療服務及建議本人諮詢註冊西醫。
- 本人有權利在物理治療服務過程中任何時候按本人意願終止物理治療服務，並諮詢註冊西醫，以得到更全面的醫療評估。
- 免轉介物理治療服務的費用，有機會不可在本人的保險計劃中提出索償。
- 物理治療評估並非醫生的醫學診斷。
- 物理治療師會在病人要求下，在終止物理治療服務時提供書面摘要。

病人簽署：_____　　日期：_____

物理治療師姓名：_____

物理治療師簽署：_____　　日期：_____

Appendix 15B. Written consent of receiving direct physiotherapy service for patient who is under the proposed code of practice 13.5

I, (name)_____, declare that I have not received physiotherapy service for the same or similar condition within the last 6 months.

I fully understand that:

- I am receiving direct physiotherapy treatment services without a referral.
- If my condition requires healthcare services beyond the scope of physiotherapy practice, or any change of conditions which deem other healthcare intervention necessary, the physiotherapist is obligated to discontinue physiotherapy service immediately and advise me to consult a registered medical practitioner.
- I have the right to discontinue physiotherapy service at my own discretion and opts to consult a registered medical practitioner any time during the course of physiotherapy service for a holistic assessment.
- Physiotherapy services without a referral might not be covered by my health insurance.
- A physiotherapy assessment is not a medical diagnosis by a doctor.
- The physiotherapist is required to provide me with a written discharge summary upon my request.

Signature of patient: _____ Date: _____

Name of physiotherapist: _____

Signature of physiotherapist: _____ Date: _____

本人，(姓名)_____，申報本人並沒有因同一或相近的健康問題而在六個月內接受過物理治療服務。

本人完全明白：

- 本人將會接受免轉介物理治療服務。
- 如本人的申訴已超出物理治療的範疇而需要其他醫療專業介入，或因健康狀況有任何轉變而物理治療師認為本人有物理治療以外的醫療需要，物理治療師有責任即時終止物理治療服務及建議本人諮詢註冊西醫。
- 本人有權利在物理治療服務過程中任何時候按本人意願終止物理治療服務，並諮詢註冊西醫，以得到更全面的醫療評估。
- 免轉介物理治療服務的費用，有機會不可在本人的保險計劃中提出索償。
- 物理治療評估並非醫生的醫學診斷。
- 物理治療師會在病人要求下，在終止物理治療服務時提供書面摘要。

病人簽署：_____　　日期：_____

物理治療師姓名：_____

物理治療師簽署：_____　　日期：_____

Appendix 16A. Proposed amendments to section 6.2.1 and 6.2.2 of part III of Code of Practice (Rules of Good Communication and Information Dissemination)

In red: Substantial differences from PT Board Code of Practice are highlighted in red.
In green: covered in other sections of the PT Board Code of Practice

	Physiotherapists (PT) Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Proposed amendment to existing PT Board Code of Practice**
Rules of Good Communication and Information Dissemination (6.2 of PT Board Code of Practice)	6.2.1 Any information provided by a physiotherapist to the public or his clients must be— (a) accurate; (b) factual; (c) objectively verifiable; and (d) presented in a balanced manner (when referring to the efficacy of a particular intervention, both the advantages and disadvantages should be set out). 6.2.2 Such information must not— (a) be exaggerated or misleading; (b) be comparative with other physiotherapists; (c) claim undue superiority over other physiotherapists; (d) aim to solicit or canvass for clients; (e) be laudatory; (f) be sensational or unduly persuasive; (g) arouse unnecessary concern or	23.1 Any information provided by a chiropractor to the public or his patients must be – (a) accurate; (b) factual; (c) objectively verifiable; (d) presented in a balanced manner (when referring to the efficacy of particular treatment, both the advantages and disadvantages should be set out); and (e) readily comprehensible by lay persons not trained in chiropractic. 23.2 Such information must not – (a) be exaggerated or misleading; (b) be comparative with other chiropractors; (c) claim superiority over other chiropractors; (d) claim to have exclusive or unique services, techniques or	**Addition to the end of 6.2.1:** (e) readily comprehensible by lay persons not trained in physiotherapy. **Addition to the end of 6.2.2:** (j) guarantee success of treatment; (k) include material that would reasonably be regarded as unprofessional; (l) induce people to use his/her services by offering free or discounted services. **Additional clauses as 6.2.4, 6.2.5 and 6.2.6:** 6.2.4 A physiotherapist must practise in his/her registered name. 6.2.5 A physiotherapist should avoid

	distress; (h) generate unrealistic expectations; or (i) disparage other physiotherapists (fair comments excepted).	products; (e) aim to solicit or canvass for patients; (f) be laudatory; (g) be persuasive or sensational; (h) arouse unnecessary concern or distress; (i) generate unrealistic expectations; (j) guarantee success of treatment;[3] (k) disparage other chiropractors (fair comments excepted); (l) include material that would reasonably be regarded as unprofessional; (m) abuse the trust of patients or members of the public nor exploit their lack of knowledge about their health[4] or chiropractic matters; or (n) put pressure on people to use his services;[5] (o) induce people to use his services by offering free or discounted services. 23.3 A chiropractor must practise in his registered name. 23.4 A chiropractor should avoid generating, through interviews with the media, publicity (about himself or his practice) which may be regarded as bringing the	generating, through interviews with the media, publicity (about himself/herself or his/her practice) which may be regarded as bringing the profession into disrepute. A physiotherapist giving interview to the media should request that the draft article be made available for him to confirm the contents before publication to ensure that there will not be infringement of this Code. 6.2.6 If a physiotherapist has any interest in a particular product or service, he/she must disclose such interest to the patient or audience before making any comment on the product or service.

		profession into disrepute. A chiropractor giving interview to the media should request that the draft article be made available for him to confirm the contents before publication to ensure that there will not be infringement of this Code. 23.5 If a chiropractor has any interest in a particular product or service, he must disclose such interest to the patient or audience before making any comment on the product or service.	
Canvassing	Refer to Appendix B		

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf
[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf
[3]Covered in 6.4.1 (f) in Code of Practice of the Physiotherapists Board of Hong Kong
[4]Covered in 6.4.1 (d) in Code of Practice of the Physiotherapists Board of Hong Kong
[5]Covered in 6.4.1 (e) in Code of Practice of the Physiotherapists Board of Hong Kong

Appendix 16B. Proposed amendments to section 6.2.3 of part III of Code of Practice (Practice promotion)

In Red: Substantial differences from PT Board Code of Practice

Physiotherapists (PT) Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Proposed amendment to existing PT Board Code of Practice**
6.2.3.1 Practice promotion means publicity for promoting the professional services of a physiotherapist, his physiotherapy practice or his group, which includes any means by which a physiotherapist or his physiotherapy practice is publicized, in Hong Kong or elsewhere, by himself or anybody acting on his behalf or with his forbearance (including the failure to take adequate steps to prevent such publicity in circumstances which would call for caution), which objectively speaking constitutes promotion of his professional services, irrespective of whether he actually benefits from such publicity. 6.2.3.2 Practice promotion excludes communication with registered professionals including medical practitioners, dentists, Chinese medicine practitioners, chiropractors, nurses, midwives, pharmacists, medical laboratory technologists, radiographers, physiotherapists, occupational therapists, optometrists and other healthcare professionals.	24.1 Practice promotion means publicity for promoting the services of a chiropractor, his chiropractic practice or his group. It includes any means by which a chiropractor or his chiropractic practice is publicized, in Hong Kong or elsewhere, by himself or anybody acting on his behalf or with his forbearance (including the failure to take adequate action to prevent such publicity in circumstances which would call for caution), which objectively speaking constitutes promotion of his professional services, irrespective of whether he actually benefits from such publicity. 24.2 Communication with other healthcare professionals not involving canvassing for patients does not constitute practice promotion. 24.3 Practice promotion by a chiropractor, or by anybody acting on his behalf or with his forbearance, to the public (i.e. people who are not his patients) must comply with section 25.1	**Additional clauses as 6.2.3.4, 6.2.3.5 and 6.2.3.6:** 6.2.3.4 Package services or pre-payment schemes should be avoided, as such arrangement will bind the patient to accept physiotherapy services in the future which may become not clinically indicated. 6.2.3.5 Letters of gratitude or announcements of appreciation from grateful patients or other persons identifying the physiotherapist should not be published in the media or made available to members of the public. A physiotherapist should take all practical steps to discourage any such publicity. 6.2.3.6 A physiotherapist should not distribute indiscriminately his visiting cards, announcements or circulars to persons (other than healthcare professionals) unless they specifically ask for such documents.

6.2.3.3 Practice promotion by individual physiotherapists, or by anybody acting on their behalf or with their forbearance, to people who are not their clients must comply with section 6.3.	of this Code. 24.4 Package services or pre-payment schemes should be avoided, as such arrangement will bind the patient to accept chiropractic services in the future which may become not clinically indicated. If the treatment is clinically indicated and for valid reasons such arrangement has to be made, the arrangement:- (a) must cover not more than 10 visits or 12 months; (b) must provide for a cooling-off period of not less than 1 week, within which the patient can withdraw from the arrangement without penalty; and (c) must include a stated policy governing refund of payment for services which have not yet been rendered. 24.5 Letters of gratitude or announcements of appreciation from grateful patients or other persons identifying the chiropractor should not be published in the media or made available to members of the public. A chiropractor should take all practical steps to discourage any such publicity. 24.6 A chiropractor's services must not be promoted by means of unsolicited visits, telephone calls, fax, electronic communications or publications by the	

	chiropractor or persons acting on his behalf or with his forbearance. 24.7 A chiropractor should not distribute indiscriminately his visiting cards, announcements or circulars to persons (other than healthcare professionals) unless they specifically ask for such documents. 24.8 A chiropractor must not, in connection with his practice, hold out to the public that:- (a) he is specialized in a particular area; (b) he has special attributes endorsed by the Council or other authorities (e.g. experience, skill, status, appointment, position).	

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf

[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf

Appendix 16C. Proposed amendments to section 6.3 of Part III of the Physiotherapist Board Code of Practice (Dissemination of Service Information to the Public)

In Red: Substantial differences from PT Board Code of Practice

	PT Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Code of Professional Conduct for the Guidance of Registered Medical Practitioners[3]**	**Proposed amendment/addition to the PT Board Code of Practice**
Introduction	A physiotherapist, whether in private or public service, may provide information about his professional services to the public only in the ways set out below.	Nil, potentially refer to point 24 Practice promotion	A doctor, whether in private or public service, may provide information about his professional services to the public (i.e. persons other than his patients as defined in section 5.2.4.1) only in the ways set out below. Where the provision refers to medical practice groups, it means a group in which all doctors in the group practice in the same premises and are governed by a genuine management structure.	
Signboard (Section 6.3.1, 6.3.1.1 - 6.3.1.4 in PT Board Code of Practice)	6.3.1 Signboards 6.3.1.1 Signboards include any signs and notices exhibited by a physiotherapist to identify his practice to the public. 6.3.1.2 Physiotherapists in group practice, i.e., physiotherapists practising in the same premises under the same business entity or	A. Signboards 1. Signboards include any signs and notices displayed by a chiropractor to identify his practice to the public. 2. A chiropractor in group practice may display either his own individual signboard or a shared signboard of the group.	5.2.3.1 Signboards Signboards include any signs and notices exhibited by a doctor to identify his practice to the public. Doctors in group practice may exhibit either their own individual signboards or a shared signboard. Both individual and shared signboards must comply with the requirements set out in Appendix A.	**Additional clause to be added to the end of 6.3.1.2:** Signboards should be purely informational. Illumination is allowed only to the extent required to enable the contents to be read. Signboards must not be used to attract attention by ornate design, blinking lights or other devices.

	organization, may exhibit either their own individual signboards or a shared signboard. The size limit must not exceed 2m^2 (for individual signboard) and 3m^2 (for shared signboard). A physiotherapist is permitted to display— (a) up to 2 signboards on or next to the door for immediate access to his clinic; and (b) (i) for a ground floor clinic: one signboard on building exterior below first floor level; or (ii) for a clinic on other levels: one signboard on building exterior at the floor level of the clinic, and one signboard each at up to 2 building entrances. 6.3.1.3 A signboard may carry only the following information— (a) name of the physiotherapist in Chinese and English; (b) the term “Registered Physiotherapist (註冊物理治療師)”; (c) name and logo of the physiotherapy practice (if applicable); (d) qualifications recognized by the Board in the approved	3. Signboards should be purely informational, and must not be used to attract attention by ornate design, blinking lights or other devices. Permitted contents 4. A signboard may carry only the following information:- (a) chiropractor’s registered name in Chinese and English, with the appropriate prefix Dr / Mr / Mrs / Ms / Miss / 脊醫; (b) the statutory titles ‘Registered Chiropractor (註冊脊醫)’ or ‘Chiropractor (脊醫)’; (c) other titles approved by the Council, including ‘ 脊骨神經科醫生’ (provided that this title can only be used in circumstances which will not mislead others to believe that the chiropractor is a medical doctor) (d) name and logo of the chiropractic practice (for group practice); (e) qualifications accepted by the Council as quotable qualifications (in the	Signboards should not be ornate. Illumination is allowed only to the extent required to enable the contents to be read. Blinking lights are not allowed. A signboard may carry only the following information:- (a) Name of the doctor with the prefix Dr. (西醫 / 男西醫 / 女西醫) or the Chinese suffix “醫生 / 醫 師 ”, and the title “registered medical practitioner” (註冊醫生 / 註冊西醫) . (b) Name of the practice. (c) Quotable qualifications approved by the Council. (d) Specialist title approved by the Council. (e) Name and logo of the medical establishment with which the doctor is associated. (Only bona fide logos which are graphic symbols designed for ready recognition of the medical establishment may be displayed.) (f) Consultation hours. (g) Indication of the location of the practice in the building. A doctor should not allow his name to appear on any signboard which carries merchandise or service promotion. He should not allow the placement of his signboard in a way which gives the appearance that he is associated with other signboards	

	English and/or Chinese forms; (e) consultation hours; (f) contact telephone number(s)/e-mail address; (g) practice website; and (h) address. 6.3.1.4 A physiotherapist should not allow his name to appear on any signboard which carries merchandise or service promotion. He should not allow the placement of his signboard in a way which gives the appearance that he is associated with other signboards which do not comply with section 6.3.1.	approved Chinese and English abbreviated forms); (f) consultation hours; (g) telephone and fax number(s); (h) indication of the location of the clinic in the building. Permitted number 5. A chiropractor or a group clinic is permitted to display:- (a) two signboards, either on or beside the door at the immediate entrance to the clinic; and (b) signboards on exterior of the building:- (i) for a clinic with direct access from pavement: one signboard below first floor level; or (ii) for a clinic with no direct access from pavement (in a building with 23 only one public entrance): one signboard at floor level of clinic, and one signboard adjacent to public entrance of building; or (iii) for a clinic with no direct access from pavement (in a building with more than one public entrance): one signboard at floor level of clinic, and one	which do not comply with section 5.2.	

		signboard adjacent to a public entrance of building at up to 2 entrances. Permitted size 6. The size of a signboard is the aggregate area of all surfaces containing service information, including all borders. 7. The size limits for individual signboards are: (a) for a signboard permitted under paragraph 5(a) above: not exceeding 1 m^2 ; (b) for a signboard permitted under paragraph 5(b) above: not exceeding 1 m^2 (if at ground floor level), 1.5 m^2 (if at mezzanine or first floor level), or 2 m^2 (if above first floor). 8. The size limits for shared signboards are: (a) for a clinic with 2 chiropractors: not exceeding 2 m^2; (b) for a clinic with 3 or more chiropractors: not exceeding 3 m^2 .		
Building directory boards (Section 6.3.1.5	6.3.1.5 The particulars of a physiotherapist may be entered on the building	9. A chiropractor may have one entry on each building directory board maintained		

in PT Board Code of Practice)	directory boards maintained by the building management. An entry may contain the same information which may appear on signboards. Each entry must conform to the standard size for every other entry on the directory board.	by the building management. A chiropractor's entry must be of the same standard size as all other entries, and may include only the permitted contents for signboards.		
Directional Noices	Nil	10. Directional notices reasonably required for directing patients to the location of the clinic may be displayed inside the building in which the clinic is situated. Each notice must not exceed 0.1 m^2 including all borders, and may contain only the name of the chiropractor, the permitted prefix and the room number of the clinic. The number of notices must not be more than reasonably necessary for directing patients to the location of the clinic.		**Additional clauses as 6.3.1.6:** Directional notices reasonably required for directing patients to the location of the clinic may be displayed inside the building in which the clinic is situated. Each notice must not exceed 0.1 m^2 including all borders, and may contain only the name of the chiropractor, the permitted prefix and the room number of the clinic. The number of notices must not be more than reasonably necessary for directing patients to the location of the clinic.
Notices of consultation hours	Nil	11. A chiropractor is permitted to display one separate notice of		**Additional clauses as 6.3.1.7:**

		consultation hours not exceeding 0.2 m^2 including borders, provided that this information is not already shown on any other signboard or notice. The notice may only contain his name and consultation hours, and should be placed in reasonable proximity to his clinic.		A physiotherapist is permitted to display one separate notice of consultation hours not exceeding 0.2 m^2 including borders, provided that this information is not already shown on any other signboard or notice. The notice may only contain his/her name and consultation hours, and should be placed in reasonable proximity to his/her clinic.
Stationery (Section 6.3.2.1 in PT Board Code of Practice)	6.3.2.1 Stationery (visiting cards, letterheads, envelopes, prescription slips, notices, etc.) may only contain those particulars which may appear on signboards.	1. Practice stationery includes all stationery (e.g. business cards, letterheads, envelopes, appointment cards) used by a chiropractor in connection with his practice of chiropractic. 2. Practice stationery may contain only the following information: (a) all information currently permitted for signboards; (b) map showing location of clinic; (c) pager number(s), e-mail address, practising address(es); (d) practice website address; (e) names of partners, assistants and	5.2.3.2 Stationery Stationery (visiting cards, letterheads, envelopes, prescription slips, notices etc.) may only carry the following information:- (a) Name of the doctor with the prefix Dr. (西醫 / 男西醫 / 女西醫) or the Chinese suffix "醫生 / 醫師". (b) Name of the practice. (c) Names of partners, assistants or associates in the practice. (d) Quotable qualifications and appointments and other titles approved by the Council. (e) Specialist title approved by the Council. (f) Name and logo of the medical establishment with which the doctor is associated. (Only bona fide logos which are graphic	**<u>Amendment of 6.3.2.1 as:</u>** 6.3.2.1 Practice stationery includes all stationery (e.g. business cards, letterheads, envelopes, appointment cards) used by a physiotherapist in connection with his/her practice of physiotherapy. Practice stationery may contain only the following information: (a) all information currently permitted for signboards; (b) map showing location of clinic; (c) pager number(s), e-mail address, practising address(es); (d) practice website address;

		associates of the practice. 3. A chiropractor may include in his visiting cards and letterheads the description 'CPD-certified' or '持續專業發展達標認證' in the form specified by the Council only if he has been awarded a Certificate of Continuing Professional Development by the Council which is then in force.	symbols designed for ready recognition of the medical establishment may be displayed.) (g) Consultation hours. (h) Telephone, fax, pager numbers and e-mail address. (i) Address(es) and location map of the practice.	(e) names of partners, assistants and associates of the practice.
Announcements in mass media	Nil	Nil	5.2.3.3 Announcements in mass media Commencement and Altered Conditions of Practice Announcements of commencement of practice altered conditions of practice (e.g. change of address, or partnership etc.) are permissible only in newspapers provided that all announcements are completed within two weeks of the commencement/change taking place AND comply with section 5.2.1 of this Code. The size of the announcement must not exceed 300cm2 and the announcement may contain only the information specified in section 5.2.3.2 together with the date of the commencement or alteration of the conditions of practice. Photographs are not	

			allowed. Examples of permitted announcements are given in Appendix B. Similar announcement via other media including printing, mailing, broadcasting and electronic means is not permitted. Other announcements Letters of gratitude or announcements of appreciation from grateful patients or related persons identifying the doctor concerned should not be published in the media or made available to members of the public. A doctor should take all practical steps to discourage any such publications.	
3. Telephone directories published by telephone companies (Section 6.3.4.1 - 6.3.4.2 in PT Board Code of Practice)	6.3.4.1 Entries in telephone directories published by telephone companies in respect of subscribers to their telephone services may be listed under the appropriate descriptive heading. 6.3.4.2 Telephone directory entries may only carry the information permitted under section 6.3.1.3.	4. A chiropractor may have his entry listed in telephone directories published by telephone companies in respect of subscribers to their telephone services. The entry may be listed under the appropriate descriptive heading. The entry may contain the same information permitted for practice stationery. 5. A chiropractor's entry in	5.2.3.4 Telephone directories published by telephone companies Entries in telephone directories published by telephone companies in respect of subscribers to their telephone services may be listed under the appropriate descriptive heading e.g. medical practitioners, physicians and surgeons. Doctors included in the Specialist Register may have their names listed under the appropriate specialty. Telephone directory entries may only carry the following information:-	**<u>Additional clause as 6.3.4.3:</u>** 6.3.4.3 A physiotherapist's entry in a telephone directory should be purely informational, and must not be used to attract attention or to advertise the physiotherapist's services by ornate design or other devices.

		a telephone directory should be purely informational, and must not be used to attract attention or to advertise the chiropractor's services by ornate design or other devices.	(a) Name of the doctor. (b) Gender of the doctor. (c) Language(s)/dialect(s) spoken. (d) Name of the practice. (e) Names of partners, assistants or associates in the practice. (f) Affiliated hospitals. (g) Availability of emergency service and emergency contact telephone number. (h) Quotable qualifications and appointments approved by the Council. (i) Specialist title approved by the Council. (j) Consultation hours. (k) Telephone, fax, pager numbers and e-mail address. (l) Address(es) of the practice. The characters of all the entries should be uniform, i.e. of the same size, not bold-type, and not in italic etc.	
4. Practice websites (Section 6.3.5, 6.3.5.1 - 6.3.5.2 in PT Board Code of Practice)	6.3.5 Practice websites 6.3.5.1 A physiotherapist may publish his professional service information in either his practice website or the website of a physiotherapy practice group. 6.3.5.2 The website may carry only the following— (a) information which is permitted on signboard	1. A chiropractor may publish his practice information in his practice website and/or the website of a bona fide chiropractic practice group in which he practises. 2. A practice website should be purely informational, and must not be used to attract attention or to advertise the chiropractor's services by	5.2.3.5 Practice websites A doctor may publish his professional service information in his practice website and/or the website of other medical practice group(s) of which he is a bona fide member. The website may carry only the service information which is permitted on doctors directories under section 5.2.3.7. The same rules on doctors directories in	**<u>Additional clauses as 6.3.5.3 and 6.3.5.4:</u>** 6.3.5.3 A practice website should be purely informational, and must not be used to attract attention or to advertise the physiotherapist's services by ornate design or other devices. There must not be any hyperlink between a physiotherapist's practice website and any other

	under section 6.3.1.3; and (b) information on physiotherapy and related service provided under a physiotherapist's practice or by a physiotherapy practice group. The information provided must comply with sections 6.2.1 and 6.2.2.	ornate design or other devices. **There must not be any hyperlink** between a chiropractor's practice website and any other websites (including the chiropractor's personal website and public education website). Devices such as pay-per-click or pay-for-priority listing service of internet search engines are not allowed. 3. A practice website cannot include interactive discussion or commentary areas, e.g. 'forums' or 'chat rooms'. 4. A practice website may carry only the practice information currently permitted for practice stationery.	electronic format also apply to practice websites. **Hyperlinkage may be established** between the website and specialist doctors directories in which the doctor's name is listed.	websites (including the physiotherapist's personal website and public education website). Devices such as pay-per-click or pay-for-priority listing service of internet search engines are not allowed. 6.3.5.4 A practice website cannot include interactive discussion or commentary areas, e.g. 'forums' or 'chat rooms'.
Service information notices	Nil	Appendix D 1. A chiropractor may display at the exterior of his office a Service Information Notice setting out the chiropractic services	5.2.3.6 Service information notices A doctor may display at the exterior of his office a service information notice bearing the fee schedules and the medical services provided by him. The service information	**Additional clauses as 6.3.7:** 6.3.7 Service information notices 6.3.7.1 A physiotherapist

		provided by him and the consultation and treatment fees. The displayed fees must truly reflect his normal charges. 2. Such notice should be purely informational, and must not be used to attract attention or to advertise the chiropractor's services by ornate design or other devices. 3. Such notice must comply with the following guidelines:- Location of Notice - At the exterior of the clinic, on or immediately next to the door of the entrance for patients Number and Size of Notices - Maximum 2 notices - Maximum A3 size Format of Notice - Plain text only - No graphic illustration Permitted Contents of	notice must comply with the guidelines set out in Appendix C.	may display at the exterior of his office a Service Information Notice setting out the physiotherapy services provided by him/her and the consultation and treatment fees. The displayed fees must truly reflect his normal charges. 6.3.7.2 Such notice should be purely informational, and must not be used to attract attention or to advertise the physiotherapist's services by ornate design or other devices. 6.3.7.3 Such notice must comply with the following guidelines:- Location of Notice - At the exterior of the clinic, on or immediately next to the door of the entrance for patients Number and Size of Notices - Maximum 2 notices - Maximum A3 size Format of Notice - Plain text only

		Notice - All information currently permitted for signboards and practice stationery - Gender of the chiropractor - Language(s) / dialect(s) spoken - Chiropractic services provided by the chiropractor - Range of consultation and treatment fees - Affiliated hospitals		- No graphic illustration Permitted Contents of Notice - All information currently permitted for signboards and practice stationery - Gender of the chiropractor - Language(s) / dialect(s) spoken - Chiropractic services provided by the chiropractor - Range of consultation and treatment fees - Affiliated hospitals
Doctors directories	Nil	Not applicable	5.2.3.7 Doctors directories A doctor may provide information about his professional services to the public through doctors directories published by professional medical organizations approved by the Council for that purpose. A doctors directory must comply with the guidelines set out in Appendix D. A doctor who provides information for publication, or permits publication of such information, in a doctors directory has a personal responsibility to ensure that the directory is in	**<u>Additional section as 6.3.9:</u>** Adapted from Appendix D of the Code of Professional Conduct for the Guidance of Registered Medical Practitioners **(refer to Appendix 16G of this proposal)**

			compliance with the guidelines.	
Public Education Website	Nil	Public education website 5. A chiropractor may set up a public education website for dissemination of chiropractic information for the benefit of the general public. The public education website must be kept separate from the practice website, and cannot publish any information relating to the chiropractic practice of the chiropractor (except the fact that he is a chiropractor and his professional qualifications approved by the Council). There must not be any hyperlink between the public education website and the practice website. 6. Information published in the website must be informative, educational and professional. Unlike chiropractic journals which are mainly read by chiropractors, contents of public education website are not peer-reviewed and the general public can have		**<u>Additional clauses as 6.3.8:</u>** 6.3.8 Public education website 6.3.8.1 A physiotherapist may set up a public education website for dissemination of physiotherapy information for the benefit of the general public. The public education website must be kept separate from the practice website, and cannot publish any information relating to the physiotherapy practice of the physiotherapist (except the fact that he/she is a physiotherapist and his/her professional qualifications approved by the Board). There must not be any hyperlink between the public education website and the practice website. 6.3.8.2 Information published in the website must be informative, educational and professional. Unlike

		no idea of the accuracy of the information. A chiropractor who publishes information on new chiropractic discoveries or treatment in a public education website should ensure that:- (a) the relevant chiropractic innovation has been adequately tested; (b) a balanced view is given; (c) the innovation is of proven value; and (d) the information is honest, factual and accurate.		physiotherapy journals which are mainly read by physiotherapists, contents of public education website are not peer-reviewed and the general public can have no idea of the accuracy of the information. A physiotherapist who publishes information on new physiotherapy discoveries or treatment in a public education website should ensure that:- (a) the relevant physiotherapy innovation has been adequately tested; (b) a balanced view is given; (c) the innovation is of proven value; and (d) the information is honest, factual and accurate.
Printed Media (Section 6.3.6, 6.3.6.1 - 6.3.6.3 in PT Board Code of Practice)	6.3.6 Newspapers, magazines, journals and periodicals 6.3.6.1 A physiotherapist may publish his service information in bona fide newspapers, magazines,	Appendix F Service Information Notice in Printed Media 1. A chiropractor may publish his service information in bona fide	5.2.3.8 Newspapers, magazines, journals and periodicals A doctor may publish his service information in bona fide newspapers, magazines, journals and periodicals for the purpose of enabling the public to make an	

	journals and periodicals for the purpose of enabling the public to make an informed choice of physiotherapy services and physiotherapist. 6.3.6.2 A publication published for the predominant purpose of promotion of products or services is not regarded as a bona fide newspaper, magazine, journal or periodical for this purpose. 6.3.6.3 A physiotherapist who publishes his service information in these publications must ensure that— (a) the published information includes only the information which is permitted under sections 6.3.1.3 and 6.3.5.2(b); (b) his professional capacity is not made used of to advertise health-related products/services and reasonable steps are taken to prevent the publication of	newspapers, magazines, journals and periodicals for the purpose of facilitating the public to make an informed choice of chiropractors. 2. A publication published for the predominant purpose of promotion of products or services is not regarded as a bona fide newspaper, magazine, journal or periodical and is not acceptable for this purpose. 3. Such notice should be purely informational, and must not be used to attract attention or to advertise the chiropractor's services by ornate design or other devices. 4. Such notice must comply with the following guidelines:- Number and Size of Notices - Maximum 1 notice in same issue of a publication - Maximum size is 300cm2 Format of Notice - Plain text only - No graphic	informed choice of doctors. A publication published for the predominant purpose of promotion of the products or services of a doctor or other persons is not regarded as an acceptable newspaper, magazine, journal or periodical for this purpose. A doctor who publishes his service information in these publications must ensure that:- (a) the published information includes only the information which is permitted in Service Information Notices and Doctors Directories; (b) the same rules as to terminology of procedure and operations for Service Information Notices and Doctors Directories are complied with, and no questionable terminology is adopted; (c) a written undertaking is secured from the publisher that his service information will not be published in a manner which may reasonably be regarded as suggesting his endorsement of other medical or health related products/services, such as publication in close	

	his service information in a manner which may reasonably be regarded as suggesting his endorsement of health-related products/services, such as publication in close proximity to advertisements for health-related products/services; (c) the published information does not exceed the size limit of 300cm^2, and not more than one notice is published in the same issue of a publication; and (d) a proper record of the published information and the arrangements for its publication is kept for two years.	illustration Permitted Contents of Notice - All information currently permitted for 'Service Information Notice on Exterior of Clinic' 5. The chiropractor must obtain from the publisher a written confirmation that his service information notice will not be published in a manner which may reasonably be regarded as suggesting his endorsement of other chiropractic or health related products/services (such as publication in close proximity to advertisements for those products/services). 6. The chiropractor must keep a proper record of the published notice and the arrangements for its publication (e.g. contract, invoice, receipts) for at least three years. He must produce such record to the Council when required to do so.	proximity to advertisements for those products/services; (d) the published information does not exceed the size limit of 300 cm2 , and not more than one notice is published in the same issue of a publication; and (e) a proper record of the published information and the arrangements for its publication is kept for two years.	

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-

council.org.hk/pt/file/pdf/221305297-E.pdf
[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf
[3]Medical Council of Hong Kong. Code of Professional Conduct for the Guidance of Registered Medical Practitioners https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_2016.pdf

Appendix 16D. Proposed amendments to section 6.4 of part III of Code of Practice (Dissemination of service information to patients)

In Red: Substantial differences from PT Board Code of Practice.

Physiotherapists (PT) Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Proposed amendment to existing PT Board Code of Practice**
A patient of a physiotherapist means someone who has, at any time, consulted that physiotherapist, a partner in his physiotherapy practice, or a physiotherapist in a practice which that physiotherapist has taken over, and whose name appears in the records of the practice. 6.4.1 A physiotherapist may provide information about his service to his patients provided that such information— (a) is not disseminated in such a way as to constitute practice promotion to patients not under his care; (b) conforms with sections 6.2.1 and 6.2.2; (c) does not involve unsolicited canvassing by post, fax, telephone, personal visit or electronic communication, etc.; (d) does not abuse the patient's trust or exploit his lack of knowledge; (e) does not put the patient under undue pressure; and (f) does not offer guarantees to cure particular conditions.	25.2.1 A chiropractor may also provide information about his professional services to his patients through other channels, provided that such information complies with the rules set out in section 23 and 24 of this Code, in particular:- (a) it does not constitute practice promotion to persons who are not his patients; (b) it does not involve intrusive visits, telephone calls, fax or electronic communications by himself or by people acting on his behalf; (c) it does not abuse the patient's trust or exploit his lack of knowledge; (d) it does not put the patient under undue pressure. 25.2.2 A chiropractor's patient for this purpose means a person:- (a) who has consulted him or another chiropractor in his group practice (i.e. a group in which all chiropractors are governed by a genuine management structure) or a practice which he has taken over; and (b) whose personal and contact information is in the patient records.	**Additional clauses as 6.4.5 and 6.4.6:** 6.4.5 A physiotherapist who has made or will make any change in the circumstances of his practice (e.g. consulting hours, clinic address) may notify his patients of the change. 6.4.6 A notice reminding a patient of the time which has elapsed since his previous consultation should only be sent if the patient has given prior agreement to receive such reminders.

6.4.2 A notice must be exhibited in the waiting area of the clinic to inform patients of their right to ask for a quotation of the fees involved before accepting any intervention. 6.4.3 A physiotherapist may provide information about the acceptance of credit facilities inside his clinic. 6.4.4 Where a physiotherapist recommends a patient to use or buy a medical product/healthcare device, he should explain the indication, benefit, associated risks and side effects of the product/device to the patient.	25.2.3 A chiropractor who has made or will make any change in the circumstances of his practice (e.g. consulting hours, clinic address) may notify his patients of the change. 25.2.4 A notice reminding a patient of the time which has elapsed since his previous consultation should only be sent if the patient has given prior agreement to receive such reminders.	
6.5 Unsolicited Visits or Telephone Calls to Members of Public Physiotherapists' services may not be promoted by means of unsolicited visits, telephone calls, fax, electronic communications or publications, etc. by physiotherapists or persons acting on their behalf or with their forbearance.	24.6 A chiropractor's services must not be promoted by means of unsolicited visits, telephone calls, fax, electronic communications or publications by the chiropractor or persons acting on his behalf or with his forbearance.	
7. Depreciation of other physiotherapists The depreciation of the professional skill, knowledge, services or qualifications of another physiotherapist or other physiotherapists may lead to	14. Disparagement of other chiropractors 14.1 It is unethical for a chiropractor to make unjustifiable comments which, either directly or by implication, undermine trust in the professional competence or integrity of another	2.3 The depreciation of the professional skill, knowledge, services or qualifications of another optometrist, either expressly or by implication, must be avoided.

disciplinary proceedings and should be carefully avoided in relation to a member of any other associated profession.	chiropractor. 14.2 When a chiropractor is called upon to express a view about another chiropractor's professional practice (such as in the course of professional audit or peer review, or when patients ask for a second opinion), it is appropriate for the chiropractor to make honest comments provided that the comments are carefully considered and can be justified, offered in good faith, and intended to promote the best interest of the patient.	

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf

[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf

Appendix 16E. Proposed amendment to section 6.6 of Part III of Code of Practice (Physiotherapy Health Education Activities)

In Red: Substantial difference from PT Board Code of Practice

PT Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Code of Professional Conduct for the Guidance of Registered Medical Practitioners[3]**	**Proposed amendment/addition to the PT Board Code of Practice**
6.6 Physiotherapy Health Education Activities 6.6.1 It is appropriate for a physiotherapist to take part in physiotherapy health education activities, such as lectures and publications. However, he must not exploit such activities for promotion of his practice or to canvass for clients. Any information provided should be objectively verifiable and presented in a balanced manner, without exaggeration of the positive aspects or omission of the significant negative aspects. 6.6.2 A physiotherapist should take reasonable steps to ensure that the published or broadcasted materials, either by their contents or the manner they	26. Chiropractic health education activities 26.1 It is appropriate for a chiropractor to take part in bona fide chiropractic health education activities, such as lectures and publications. However, he must not exploit such activities for promotion of his practice or to canvass for patients. 26.2 Any information provided in such activities should be objectively verifiable and presented in a balanced manner, without exaggeration of the positive aspects or omission of the significant negative aspects.	6. Health education activities 6.1 It is appropriate for a doctor to take part in bona fide health education activities, such as lectures and publications. However, he must not exploit such activities for promotion of his practice or to canvass for patients. Any information provided should be objectively verifiable and presented in a balanced manner, without exaggeration of the positive aspects or omission of the significant negative aspects. 6.2 A doctor should take reasonable steps to ensure that the published or broadcasted materials, either by their contents or the manner they are referred to, do not give the impression that the audience is encouraged to seek consultation or treatment from him or organizations with which he is	Amendment to 6.6.3: Information given to the public should be authoritative, appropriate and in accordance with general experience. It should be factual, lucid and expressed in simple terms. It should not arouse unnecessary public concern or personal distress, or generate unrealistic expectations. Physiotherapists must not give the impression that they, or the institutions with which they are associated, have unique or special skills or solutions to health problems. Information should not be presented in such a way that it furthers the professional interests of the physiotherapists concerned, or attracts clients to use their physiotherapy services.

are referred to, do not give the impression that the audience is encouraged to seek consultation or intervention from him or organizations with which he is associated. He should also take reasonable steps to ensure that the materials are not used directly or indirectly for the commercial promotion of any physiotherapy or health related products or services. 6.6.3 Information given to the public should be authoritative and appropriate. It should be factual, lucid and expressed in simple terms. Physiotherapists shall not provide any information in such a way which may reasonably be regarded as an attempt to solicit clients to use their physiotherapy services.		associated. He should also take reasonable steps to ensure that the materials are not used directly or indirectly for the commercial promotion of any medical and health related products or services. 6.3 Information given to the public should be authoritative, appropriate and in accordance with general experience. It should be factual, lucid and expressed in simple terms. It should not arouse unnecessary public concern or personal distress, or generate unrealistic expectations. Doctors must not give the impression that they, or the institutions with which they are associated, have unique or special skills or solutions to health problems. Information should not be presented in such a way that it furthers the professional interests of the doctors concerned, or attracts patients to their care.	

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf

[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf

[3]Medical Council of Hong Kong. Code of Professional Conduct for the Guidance of Registered Medical Practitioners https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_2016.pdf

Appendix 16F. Proposed amendment to section 8 of part III of the Physiotherapists Board Code of Practice (Canvassing)

In Red: Substantial difference from PT Board Code of Practice

PT Board Code of Practice[1]	**Chiropractors Council Code of Practice[2]**	**Proposed amendment to existing PT Board Code of Practice**
8.1 Canvassing for the purpose of obtaining patients, whether direct or indirect, done personally or by servant, agent or others, or association with or employment by persons or organizations which canvass, may lead to disciplinary proceedings. Except in an emergency the Board does not consider it permissible for a registered physiotherapist to call upon or communicate with any person who is not already a patient of his or her practice, with a view to providing advice or treatment unless expressly requested to do so by that person or by a parent or guardian of that person. Moreover the Board does not consider it permissible for a registered physiotherapist to canvass by means of the distribution of visiting cards other than as a result of a request for a card by an individual. 8.2 Association by physiotherapists with nursing homes, medical benefit societies, insurance companies etc. which advertise clinical and diagnostic services but which allow a free choice of physiotherapist does not violate the ethical code, but physiotherapists are warned that association with any such institution, company etc. which advertises clinical or diagnostic services to the general public and which directs	18.1 A chiropractor must not canvass for the purpose of obtaining patients, by himself, through persons acting on his behalf or with his forbearance, or through association with or employment by persons or organizations. Bona fide chiropractic health education activities complying with section 26 do not constitute canvassing, unless such activities are exploited for practice promotion or canvassing for patients. 18.2 Except in emergency, it is impermissible for a chiropractor to call upon or communicate with any person who is not already his patient with a view to providing advice or treatment, unless expressly requested to do so by that person or that person's parent or guardian. 18.3 A chiropractor's association with an institution (such as nursing home, medical benefit society, insurance company) which advertises clinical or diagnostic services to the general public and directs patients to particular chiropractors may constitute canvassing. 18.4 Sub-section 18.3 does not preclude a chiropractor from associating with an institution which:-	**Addition to the end of 8.1:** Bona fide physiotherapy health education activities complying with section 6.6 do not constitute canvassing, unless such activities are exploited for practice promotion or canvassing for patients. **Additional clause as 8.3:** 8.3 A physiotherapist having an arrangement with an institution under which patients (either as its employees, insured persons under an insurance scheme, or otherwise) are referred to him/her must ensure that its advertising and promotion of any scheme do not contravene this section, irrespective of whether he/she is in private or public practice or providing charitable services.

patients to particular physiotherapists may be regarded as canvassing. This does not preclude any physiotherapists or panel of physiotherapists from being employed by an organization, company, school etc. which does not advertise clinical or diagnostic services provided that the names of such physiotherapists are supplied only to bona fide employees, scholars and their families by the management.	(a) advertises clinical or diagnostic services to the general public, but gives to patients a free choice of healthcare practitioners (i.e. not restricted to particular practitioners or panels) as entitlement under the insurance plan or clinical benefit package; or (b) does not advertise clinical or diagnostic services to the general public, and provides the names of healthcare practitioners on its panel only to its bona fide employees and their families (i.e. as employees benefits). 18.5 A chiropractor having an arrangement with an institution under which patients (either as its employees, insured persons under an insurance scheme, or otherwise) are referred to him must ensure that its advertising and promotion of any scheme do not contravene this section, irrespective of whether he is in private or public practice or providing charitable services.	

[1] The Physiotherapists Board of Hong Kong. Code of Practice of the Physiotherapists Board of Hong Kong. https://www.smp-council.org.hk/pt/file/pdf/221305297-E.pdf

[2]Chiropractors Council of Hong Kong. Code of Practice for the Guidance of Registered Chiropractors. https://www.chiro-council.org.hk/file/pdf/CC%20Code%20of%20Practice_Jan_2017%20(Eng).pdf

Appendix 16G. Proposed guidelines on physiotherapists directories (Proposed additions to section 6.3 of the PT Board Code of Practice)

Code of Professional Conduct for the Guidance of Registered Medical Practitioners[1]	**Proposed Amendment to PT Board Code of Practice**
Appendix D Guidelines on Directories A doctor may disseminate his professional service through Doctors Directories published by professional medical organizations approved by the Medical Council for that purpose. He must ensure that the published consultation fees truly reflect his normal charges. He must also ensure compliance with the provisions of section 5.2.1 of the Code governing "Principles and rules of good communication and information dissemination". A Doctors Directory must comply with the following guidelines:- Parameters of Directory (a) A Directory should be open to all registered medical practitioners. Inclusion in a Directory should not be restricted to members of particular associations or organizations, except for Directories established and maintained by Colleges of the Hong Kong Academy of Medicine and recognized specialty associations, or with the special approval of the Council in individual cases. (b) Doctors may be categorized as specialist practitioners according to their specialties (i.e. practitioners included under the various specialties in the Specialist Register) and general practitioners. (c) Each registered medical practitioner should be given the same choice of information for inclusion in the same Directory. (d) Professional medical organizations fulfilling the following criteria may apply to the Council for approval to set up their Directories:-	**<u>Additional clauses as section 6.3.9:</u>** 6.3.9 Physiotherapists directories 6.3.9.1 A physiotherapist may provide information about his professional services to the public through physiotherapists directories published by physiotherapy professional associations approved by the Board for that purpose. 6.3.9.2 The physiotherapist must ensure that the published service fees truly reflect his/her normal charges. He/he must also ensure compliance with the provisions of section 6.1 of the Code governing "Principles for good communication and accessible information". 6.3.9.3 A Physiotherapists Directory must comply with the following guidelines:- Parameters of Directory (a) A Directory should be open to all registered physiotherapists. Inclusion in a Directory should not be restricted to members of particular associations or organizations, except for special approval of the Board in individual cases. (b) Each registered physiotherapist should be given the same choice of information for inclusion in the same Directory. (c) Professional physiotherapy organizations fulfilling the following criteria may apply to the Board for approval to set up their Directories:- (i) an established body which is legally recognized; (ii) non-profit sharing in nature; and

(i) an established body which is legally recognized; (ii) non-profit sharing in nature; and (iii) having the objectives of promoting health care and safeguarding the health interests of the community. (e) Approved organizations are responsible for verifying the accuracy of the information before publication. They should establish a mechanism for regular updating of the published information. (f) A medical practitioner providing information for publication in a Directory should ensure compliance with the relevant provisions in the Code. Format of Directory A Directory may be published in electronic or printed format. If in electronic format, it should be in a printable form. For printed format, the following rules should apply:- • Single color print • Uniform font size • Plain text only without graphic illustrations • Accentuation of particular entries by bordering, highlighting or otherwise is prohibited For electronic format, the following rules should apply:- • Single and uniform color font for particulars of individual doctor • Graphic illustrations limited to logos of organizations and those used to access different categories or locations of doctors • Accentuation of particular entries by blinking, bordering, highlighting or otherwise is prohibited • If possible, random listing of same category or location of doctors in each search is advisable Permitted Contents of Directory • All information presently permitted on signboards and	(iii) having the objectives of promoting health care and safeguarding the health interests of the community. (d) Approved organizations are responsible for verifying the accuracy of the information before publication. They should establish a mechanism for regular updating of the published information. (e) A physiotherapist providing information for publication in a Directory should ensure compliance with the relevant provisions in the Code. Format of Directory (a) A Directory may be published in electronic or printed format. If in electronic format, it should be in a printable form. (b) For printed format, the following rules should apply:- • Single color print • Uniform font size • Plain text only without graphic illustrations • Accentuation of particular entries by bordering, highlighting or otherwise is prohibited (c) For electronic format, the following rules should apply:- • Single and uniform color font for particulars of individual physiotherapist • Graphic illustrations limited to logos of organizations and those used to access different categories or locations of physiotherapist • Accentuation of particular entries by blinking, bordering, highlighting or otherwise is prohibited • If possible, random listing of same category or location of physiotherapist in each search is advisable Permitted Contents of Directory (a) All information presently permitted on signboards and stationery under sections 6.3.1 and 6.3.2 of the Code • District where the office of the physiotherapist is located

stationery under sections 5.2.3.1 and 5.2.3.2 of the Code
• District where the office of the doctor is located
• Passport-type photograph of the doctor
• Gender of the doctor
• Language(s)/dialect(s) spoken
• Medical services, procedures and operations provided by the doctor and range of fees
  ○ Only those procedures in which the doctor has received adequate training and which are within his area of competency may be quoted
  ○ The nomenclatures of procedures and operations should follow those promulgated by Colleges of the Hong Kong Academy of Medicine, whenever such a list is available
• Range of consultation fees, or composite fees including consultation and basic medicine for a certain number of days
• Affiliated hospitals
• Availability of emergency service and emergency contact telephone number
• Information on the doctor's participation in insurance/other payment scheme
 	
Distribution of Directory
Publishing organizations should distribute their Directories widely in order to facilitate public access to the Directories. Individual doctors may also make the Directory available to the public provided that no particular entries are highlighted, extracted, or drawn to the special attention of readers.
	• Passport-type photograph of the physiotherapist
	• Gender of the physiotherapist
	• Language(s)/dialect(s) spoken
	• Physiotherapy services provided by the physiotherapist and range of fees. Only those procedures in which the physiotherapist has received adequate training and which are within his/her area of competency may be quoted
	• Information on the physiotherapist's participation in insurance/other payment scheme
	
	Distribution of Directory
	(a) Publishing organizations should distribute their Directories widely in order to facilitate public access to the Directories.
	(b) Individual physiotherapists may also make the Directory available to the public provided that no particular entries are highlighted, extracted, or drawn to the special attention of readers.

[1] Medical Council of Hong Kong. Code of Professional Conduct for the Guidance of Registered Medical Practitioners https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_2016.pdf

Appendix 17. Core vs non-core CPD activities

CPD Sub-categories	Description
Core (C)	Activities directly related to the understanding or expansion of physiotherapy knowledge and skills including diagnosis, examination, intervention, outcome evaluation, biostatistics and epidemiology, and specialty development.
Non-core (N)	Activities not directly related but contributed to the understanding or expansion of physiotherapy knowledge and skills including health care management, Chinese Herbal Medicine, information technology, and communication skills.

長期病患者關注醫療改革聯席
有關物理治療轉介制度問卷調查報告

長期病患者關注醫療改革聯席（下稱「聯席」）由三十多個病人自助組織及關注病人權益組織組成，一直關注香港醫療的政策、制度、資源及服務。

（一）調查背景及目的

長期病患者或照顧者不時需要接受物理治療。根據香港物理治療師管理委員會頒佈的註冊《物理治療師專業守則》，物理治療師必須由醫生轉介下，才可診斷或治療的病人。因此，無論是疾病狀況未曾經醫生診斷，抑或已由醫生診斷，接受物理治療前，必須先求診醫生及獲醫生轉介才可。

不過，根據物理治療國際組織——世界物理治療（World Physiotherapy）在 2021 年所做的調查[1]，全球 117 個成員國/地區中，有 31%已實行全面的物理治療免轉介制度，即市民能夠在任何情況下選擇免轉介而直接接受物理治療（例如：英國、加拿大、澳洲、泰國、新加坡）；此外有 44%成員國/地區，市民在某些規範下能夠選擇免轉介而直接接受物理治療（例如：印尼、美國部分州屬、法國、意大利）；另外 25%成員國/地區，市民在任何情況下必須由醫生轉介才可接受物理治療（例如：菲律賓、馬來西亞、韓國），有關比例持續下降。

有意見認為香港現行物理治療的轉介制度，因必須取得醫生轉介，所以浪費額外金錢及時間，甚至延遲復康治療，並提出修改轉介制度，容許免轉介下直接接受物理治療（即：物理治療免轉介）；但亦有意見認為，現行制度必須先由醫生診斷，有需要才作轉介，可保障病人。就此，「聯席」希望透過是次問卷調查，了解長期病患者及照顧者對於物理治療的需要及對修訂物理治療轉介制度的意見。

（二）調查結果

「聯席」向病人組織及有關服務機構發出問卷，以網上及實體問卷形式，於 2022 年 12 月 1 日至 31 日期間進行調查，最終成功收回共 474 份問卷。

2.1 受訪者背景

受訪者以女性為主，佔受訪者超過七成（見表一）。近六成的受訪者為長期病患者，其餘為照顧者及一般市民（見表二）。受訪者的以年長者較多，年齡中位數62歲，超過六成為60-74歲（57.3%）及75歲或以上（5.1%）的長者。

2.2 受訪者的就醫情況

受訪者較多求診的專科為內科及老人科（47.5%）及骨科（35.7%）（見表四）。超過八成半的受訪者曾接受物理治療，反映並非長期病患者的受訪者中，也有接受

[1] https://world.physio/sites/default/files/2022-02/AMC2021-Global.pdf

物理治療的經驗（見表五）。近九成受訪者均知悉在香港接受物理治療需要由醫生轉介才可（見表六）。

受訪者接受物理治療的原因多數為「痛症」（73.4%），其次分別為「意外受傷」（28.8%）及「職業性勞損」（27.1%），因較為複雜的疾病而需接受物理治療的受訪者較少，如「腦神經系統疾病」不足一成半，心肺系統疾病不足半成（見表七）。數據反映物理治療需求較大的都是基層醫療而並非第二層醫療（即專科）的服務範疇。

近八成受訪者接受物理治療的機構是「醫院管理局轄下醫院或診所」，另有一半受訪者於「私家物理治療診所」（見表八）。另外，按接受物理治療的機構及原因作分類進行分析，在「醫院管理局轄下醫院或診所」因「痛症」或「意外受傷」，接受物理治療的比例分別為53.9%和46.4%；在「私家物理治療診所」的比例則為34.9%和38.8%（見表九）。

2.3 受訪者對物理治療轉介制度的意見

問卷以18句句子表達有關物理治療轉介制度的意見，當中有11句傾向直接為病人提供物理治療（即「物理治療免轉介」），另有7句為傾向現有轉介制度。受訪者對每句子可以1至5分，分別表達「極不同意」、「不同意」、「中立」、「同意」及「極同意」的意見，亦可選擇「不清楚」。分析時，另會對每句子計算平均分，分數低於3分顯示傾向不同意的立場，高於3分則顯示傾向同意的立場（見表十）。

受訪者對全數11句傾向「物理治療免轉介」的意見大多表示同意或極同意，比例由六成半至九成不等，當中共有7句句子的平均分達4分或以上，包括：

現時市民必須先求診醫生，取得轉介後才可接受物理治療，可能延誤康復進程（4.06）

香港市民應有自主權利去選擇經醫生轉介或直接使用物理治療的專業服務（4.16）

物理治療師能夠評估患者是否適合接受物理治療（4.06）

物理治療師憑專業的判斷，能適時為患者提供有效的治療方法（4.14）

物理治療師憑專業的判斷，能適時轉介患者到相應的專科醫生或醫療專業人員跟進（4.05）

物理治療免轉介能使患者適時接受物理治療，從而達致更好的治療效果（4.00）

物理治療免轉介可舒緩一般痛症病人到專科或醫院的求診，有助急症室或相關專科門診更集中服務有需要的患者（4.02）

結果顯示受訪者具傾向同意「物理治療免轉介」的立場，尤其對以上7句句子所顯示的自主選擇權利、物理治療師的專業能力、「物理治療免轉介」對治療的良好效果等，更明確表達同意的意見。

另外，受訪者對7句傾向現有轉介制度的意見，只有一成多至少於三成表示同意

或極同意的意見，當中有兩句句子的同意及極同意的比例均低於一成半：

由醫生轉介才可接受物理治療的做法不需要改變（13.3%）

物理治療免轉介會增加病人的健康風險，增加醫療負擔（13.3%）

此7句句子的平均分全數少於3分，當中尤以「由醫生轉介才可接受物理治療的做法不需要改變」最低分，只有2.18，更有七成受訪者不同意或極不同意此句子。結果顯示受訪者一般不認同現行轉介制度，亦不同意各項反對「物理治療免轉介」的意見，包括：會增加病人風險、增加濫用物理治療的誘因、醫生才有能力決定是否需要物理治療……等等。

整體而言，超過九成受訪者認為可選擇免轉介而直接接受物理治療，當中更有多於三成認為在任何情況下均可直接接受物理治療，無需有任何對「物理治療免轉介」有任何規範（表十一）。

2.4 對規範「物理治療免轉介」建議的意見

在六成認為在一些規範下可選擇免轉介而直接接受物理治療的受訪者中，對於早前物理治療管理委員會轄下修訂物理治療轉介制度工作小組提出的7項建議，均表示同意或極同意（表十二）。受訪者對以下兩項的建議有極高的同意及極同意的比例：

物理治療師必須將患者的治療詳情，作清晰紀錄，並上載到醫健通，方便其他醫療專業人員查閱及跟進患者情況（92.7%）

提供免轉介治療的物理治療師，必須修讀指定專業課程並成功考取資格，同時需強制持續專業進修（91.3%）

結果顯示，受訪者支持工作小組對「物理治療免轉介」提出的規範建議。

（三）總結及建議

從以上結果顯示，長期病患者及照顧者，甚至一般市民都支持「物理治療免轉介」，更顯示現時由醫生轉介才可接受物理治療的做法需要改變。如可在各項規範下實施「物理治療免轉介」，將有助落實基層醫療健康，盡早處理常見的健康問題，並有望減少對公立醫院的負荷。

因此，聯席作出以下建議：

1. 在政府即將向立法會的提出的立法議程中，盡快提出《輔助醫療業條例》的修訂，以配合「物理治理免轉介」制度；
2. 物理治療師管理委員會及輔助醫療業管理局應盡快修訂物理治療師專業守則，以便實施「物理治理免轉介」制度。

二零二三年一月八日

表一：性別

	頻率	百分比
男	132	28.2%
女	336	71.8%
合計	468	100%

表二：身份類別

	頻率	百分比
長期病患者	283	59.7%
照顧者	83	17.5%
一般市民	108	22.8%
合計	474	100%

表三：年齡組別

	頻率	百分比
39 歲或以下	48	10.6%
40-59 歲	123	27.1%
60-74 歲	260	57.3%
75 歲或以上	23	5.1%
合計	454	100%

年齡中位數 62 歲

表四：求診專科（***N=280***）

	頻率	百分比
內科及老人科	133	47.5%
腦內科	69	24.6%
外科	30	10.7%
婦產科	12	4.3%
骨科	100	35.7
眼科	55	19.6%
精神科	39	13.9%
痛症科	39	13.9%
耳鼻喉科	47	16.8%
心胸外科	16	5.7%
神經外科	18	6.4%
臨床腫瘤科	12	4.3%
家庭醫學科	23	8.2%
其他	7	2.5%

表五：你是否曾接受過物理治療

	頻率	百分比
是	406	85.7%
否	68	14.3%
合計	474	100%

表六：在你接受這項問卷調查前，
你是否知道在香港接受物理治療需要由醫生轉介？

	頻率	百分比
知道	420	88.6%
不知道	54	11.4%
合計	474	100%

表七：接受物理治療的原因（***N=406***）

	頻率	百分比
意外受傷	117	28.8%
痛症	298	73.4%
運動創傷	69	17.0%
腦神經系統疾病，例如：中風、腦腫瘤等	56	13.8%
心肺系統疾病	8	2.0%
職業性勞損，例如：腕管綜合症、脊椎勞損等	110	27.1%
其他	11	2.7%

表八：接受物理治療的機構（***N=406***）

	頻率	百分比
醫院管理局轄下醫院或診所	317	78.1%
非牟利社會服務機構	54	13.3%
私家醫院	22	5.4%
私家物理治療診所	206	50.7%

表九：各項接受物理治療的原因於各個機構的分布

	醫院管理局轄下醫院或診所 頻率／百分比	私家物理治療診所 頻率／百分比
痛症（*n=455*）	244／53.6%	159／34.9%
意外受傷（*n=196*）	91／46.4%	76／38.8%
運動創傷（*n=111*）	48／43.2%	54／48.6%
職業性勞損（*n=190*）	96／50.5%	74／38.9%
腦神經系統疾病（*n=82*）	47／57.3%	16／19.5%
心肺系統疾病（*n=13*）	7／53.8%	4／30.8%

表十：對物理治療轉介制度的意見

傾向「物理治療免轉介」的意見	**極不同意 1**	**不同意 2**	**中立 3**	**同意 4**	**極同意 5**	**不清楚**	**平均分**
現時市民必須先求診醫生，取得轉介後才可接受物理治療，是浪費治療費用及時間	2.7	9.3	18.8	32.1	35.4	1.7	3.89
現時市民必須先求診醫生，取得轉介後才可接受物理治療，可能延誤康復進程	*1.3*	*7.8*	*11.8*	***41.8***	***36.7***	*0.6*	***4.06***
香港市民應有自主權利去選擇經醫生轉介或直接使用物理治療的專業服務	*0.6*	*3.4*	*11.0*	***48.9***	***35.9***	*0.2*	***4.16***
香港市民有足夠的認知，自行決定是否直接使用物理治療服務	2.1	10.5	19.8	45.8	20.7	1.1	3.73
物理治療師能夠評估患者是否適合接受物理治療	*0.6*	*2.7*	*10.5*	***61.6***	***23.4***	*1.1*	***4.06***
物理治療師憑專業的判斷，能適時為患者提供有效的治療方法	*0.2*	*0.2*	*9.3*	***65.0***	***24.5***	*0.8*	***4.14***
物理治療師憑專業的判斷，能適時轉介患者到相應的專科醫生或醫療專業人員跟進	*0.2*	*1.1*	*13.5*	***61.8***	***21.3***	*2.1*	***4.05***
物理治療免轉介能使患者適時接受物理治療，從而達致更好的治療效果	*0.6*	*3.0*	*15.0*	***56.5***	***22.8***	*2.1*	***4.00***
物理治療免轉介能防止因延誤治療而增加病情的嚴重性及後遺症	0.6	6.1	15.8	52.7	21.5	3.2	3.91
物理治療免轉介可舒緩一般痛症病人到專科或醫院的求診，有助急症室或相關專科門診更集中服務有需要的患者	*0.6*	*3.4*	*12.7*	***58.2***	***23.0***	*2.1*	***4.02***
物理治療免轉介可為病人減省醫療費用	0.4	7.2	15.8	50.2	24.5	1.9	3.93

傾向維持現行制度的意見	極不同意 1	不同意 2	中立 3	同意 4	極同意 5	不清楚	平均分
香港市民應該一律由醫生決定是否需要物理治療	17.7	43.9	19.2	16.2	2.7	0.2	2.42
由醫生轉介才可接受物理治療的做法不需要改變	*27.0*	*43.2*	*15.8*	***11.2***	***2.1***	*0.6*	***2.18***
物理治療免轉介會增加患者因為物理治療師無法發現嚴重疾病而產生的健康風險	7.6	27.6	30.8	24.7	3.4	5.9	2.88
物理治療免轉介會間接延誤病人尋求醫生的醫治	8.2	37.6	24.5	22.2	3.2	4.4	2.73
經醫生轉介的物理治療會比物理治療免轉介的治療成效高	9.3	30.2	28.9	23.0	4.9	3.8	2.83
物理治療免轉介會增加病人的健康風險，增加醫療負擔	*10.3*	*44.9*	*25.9*	***11.4***	***1.9***	*5.5*	***2.47***
物理治療免轉介會引致患者接受物理治療的次數增加，成為濫用物理治療服務的誘因	10.8	39.0	25.7	16.7	2.5	5.3	2.59

表十一：整體而言，你對香港物理治療轉介制度的意見是

	頻率	百分比
在任何情況下，必須由醫生轉介（緊急情況除外），才可接受物理治療（即維持現存制度）	36	7.6%
在任何情況下，可選擇免轉介而直接接受物理治療	152	32.1%
在一些規範下，可選擇免轉介而直接接受物理治療	286	60.3%
合計	474	100%

表十二：對各項規範「物理治療免轉介」建議的意見

	極不同意 1	不同意 2	中立 3	同意 4	極同意 5
可進行免轉介的物理治療師必須具有最少 2000 小時的臨床經驗（註：物理治療師必須具有 1000 小時臨床經驗才能註冊）	0.7	3.1	26.0	56.9	13.2
免轉介物理治療只適用於基層醫療（即：處理社區內常見的健康問題的醫療服務）的服務對象	2.4	27.1	30.6	37.8	2.1
未經醫生診斷的個案，如在 30 天或 10 次療程後，必須取得醫生轉介信，才可繼續物理治療療程	3.5	24.0	33.3	34.4	4.9
求診者如於 6 個月內曾經以同一病患接受過物理治療，必須取得醫生的轉介信，才可接受治療	4.2	28.8	28.1	36.1	2.8
求診者如果有早前醫生的診斷（例如已中風的病人），其免轉介的物理治療期限和次數則不受限制	0.7	10.1	22.6	55.6	11.1
物理治療師必須將患者的治療詳情，作清晰紀錄，並上載到醫健通，方便其他醫療專業人員查閱及跟進患者情況	*0.3*	*0.7*	*6.3*	***53.5***	***39.2***
提供免轉介治療的物理治療師，必須修讀指定專業課程並成功考取資格，同時需強制持續專業進修	*0.3*	*0.7*	*7.6*	***58.3***	***33.0***

聯席成員團體：B27 協進會（強直性脊椎炎病人自助組織）、一同夢慈善基金會（自閉症/特殊教育需要人士自助組織）、同路人同盟（綜合癌症科病人自助組織）、自強協會（肢體殘疾人士及照顧者資源中心）、自閉症人士福利促進會（自閉症人士及家屬自助組織）、利民社區網（精神病復元人士自助組織）、恆康互助社（精神病康復者自助組織）、香港女障協進會（殘疾婦女自助組織）、香港小腦萎縮症協會（小腦萎縮症病友及家屬自助組織）、香港肌健協會（肌肉萎縮病人自助組織）、香港肌無力協會（重症肌無力症病人自助組織）、香港兔唇裂顎協會（唇顎裂患兒及家屬自助組織）、香港知足協會（肢體發育不全患者自助組織）、香港社區組織協會（病人權益協會）、香港柏金遜症會（柏金遜症患者及家屬自助組織）、香港哮喘會（哮喘病人自助組織）、香港馬凡氏綜合症協會（馬凡氏綜合症病人互助組織）、香港骨髓移植復康會（骨髓移植病人互助組織）、香港強脊會（強直性脊椎炎病人自助組織）、香港復康會社區復康網絡（殘疾人士復康機構）、香港復康聯盟（殘疾人士組織）、香港傷殘青年協會（殘疾人士復康機構）、香港銀屑病友會（銀屑病友互助組織）、香港衞聰聯會（職業性失聰工友自務組織）、家盟（精神病復康者家屬自助組織）、專注力不足/過度活躍症(香港)協會（專注力不足/過度活躍症家長自助組織）、康和互助社聯會（精神病復康者自助組織）、彩色之家（紅斑狼瘡病人互助小組）、腎友互助協會（腎科病人互助組織）、華樂會（前列腺癌病人組織）、愛滋健康關注社（愛滋病感染者自助組織）、新健社（中風患者及家屬互助社）、腦同盟 （腦損病人自助組織）、慧進會（腦部受損及中風患者與家屬互助組織）、樂德會（痛症患者自助組織）、癌症策略關注組（關注癌症治療組織）、關注精神聯盟（精神病患者及家屬自助組織）、關懷愛滋（愛滋病感染者服務機構）