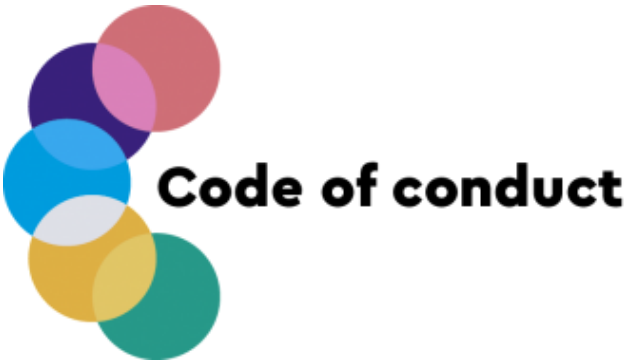

Shared code of conduct: public consultation

Introduction

The Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Chiropractic, Dental, Medical Radiation Practice, Occupational Therapy, Optometry, Osteopathy, Paramedicine, Pharmacy, Physiotherapy and Podiatry Boards of Australia (National Boards) have a shared code of conduct (shared code), most in the same form and some with minor variations.

The National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) are seeking feedback about a proposed revised shared code (revised shared code).

Please ensure you have read the public consultation papers before answering this survey, as the questions are specific to the revised shared code.

Publication of responses

The National Boards and Ahpra publish submissions at their discretion. We generally publish submissions on our websites to encourage discussion and inform the community and stakeholders. Please advise us if you do not want your submission published.

We will not place on our websites, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

The National Boards and Ahpra can accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or want us to treat all or part of it as confidential.

Published submissions will include the names (if provided) of the individuals and/or the organisations that made the response unless confidentiality is requested.

Please select the box below if you do **not** want your responses to be published.

- [ ] Please do **not** publish my responses

About your responses

Are you responding on behalf of an organisation?

- (●) Yes
- ( ) No

Please provide the name of the organisation.

Australian Pharmacy Council

Which of the following best describes your organisation?

- ( ) Health services provider
- ( ) Professional indemnity insurer
- ( ) Legal services provider
- ( ) Professional body (e.g. College or Association)
- ( ) Education provider
- ( ) Regulator
- ( ) Government
- ( ) Ombudsman
- (●) Other

Please describe your organisation.

Accreditation Authority

Your contact details

First name:

[redacted]

Last name:

[redacted]

Email address:

[redacted]

Which of the following best describes you?

This question was not displayed to the respondent

Q45. Please describe.

This question was not displayed to the respondent

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Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

This question was not displayed to the respondent

Q46. Please describe.

This question was not displayed to the respondent

The following questions will help us to gather information about the revised shared Code of conduct.

Please ensure you have read the public consultation papers before responding, as the questions are specific to the revised shared code.

The revised shared code includes high-level principles to provide more guidance to practitioners especially when specific issues are not addressed in the content of the code.

Are shorter, more concise principles that support the detail in the revised shared Code preferable or are longer, more comprehensive principles a better option? Why?

The Australian Pharmacy Council (APC) supports the use of shorter more concise principles to support the detail in the revised Code. There is opportunity to align with, and give prominence to, the NRAS principles (which we note were recently under consultation) by strengthening the proposed principles in the Revised Code. Health professional conduct should help achieve the Scheme's purpose and objectives. This could be reflected through consistent language and terminology between the overarching NRAS principles and those prosed in the Revised Code. In some cases, addendum articulating the link to the NRAS principles may be useful. For example, the current NRAS Principle 3 states that the Scheme protects the public by "ensuring only health practitioners who are trained and qualified to practise in a competent and ethical manner are registered". This NRAS principle is sub assumed under Principle 1 of the Revised Code, Item 1.2 a "Good practice includes that you ensure you maintain adequate knowledge and skills to provide safe and effective care."

In the revised shared code, the term 'patient' is used to refer to a person receiving healthcare and is defined as including patients, clients, consumers, families, carers, groups and/or communities'. This is proposed in order to improve readability of the code and to support consistency for the public.

Do you support the use of the term 'patient' as defined for the revised shared code or do you think another term should be used, for example 'client' or 'consumer'? Why or why not?

Consideration about the appropriate term to use for persons accessing health care has been a long-standing debate and is the subject of several publications in both peer reviewed and the grey literature. There are divergent views about this among groups that view themselves as either patient or consumer or carer centred organisations. Readability of the code should therefore not be the driving consideration for selection of one term over the other. In this case, it may be useful for terminology to be determined by those who consume health care services so that it is all inclusive. This is particularly important if the NRAS is to be viewed as serving the public and contributing to patient safety as opposed to being a pro-health professional body. It is APC's opinion that targeted consultation with health care users is needed.

The revised shared code includes amended and expanded content on Aboriginal and Torres Strait Islander health and cultural safety that uses the agreed definition of cultural safety for use within the National Registration and Accreditation Scheme. (Section 2 Aboriginal and Torres Strait Islander health and cultural safety).

Is this content on cultural safety clear? Why or why not?

We note that The Aboriginal and Torres Strait Islander Health Strategy Group has provided advice on the cultural safety content in the revised shared code, and we are satisfied with their recommendation.

Q49.
Sections 3.1 Respectful and culturally safe practice, 4.1 Partnership, 4.9 Professional boundaries and 5.3 Bullying and harassment include guidance about respectful professional practice and patient safety.

Does this content clearly set the expectation that practitioners must contribute to a culture of respect and safety for all? e.g. women, those with a disability, religious groups, ethnic groups.

Cultural Safety reflects and emphasis health professional behaviour and practice in relation to our First Nation peoples. It acknowledges the injustice that Aboriginal and Torres Strait Islanders peoples have experienced and is an expression of a very specific determination to address the resulting adverse health consequences for our First Nations peoples. It may be worthwhile to consider the possibility of using other terms when referring to provision of care for culturally and linguistically diverse groups other than First Nations peoples. For example, culturally responsive care is defined and used by several State Departments of Health in their guidelines. Ahpra acknowledges that the definition of cultural safety for Aboriginal and Torres Strait Islander Peoples is specific for their status as First Nations Peoples and this should not be diminished.

Statements about bullying and harassment have been included in the revised shared code (Section 5.3 Bullying and harassment).

Do these statements make the National Boards'/Ahpra's role clear? Why or why not?

In our view, the statement on bullying and harassment (5.3) requires further review. The statement acknowledges that discrimination and bullying adversely affect individual health practitioners and can increase risks to patient, yet "Concerns about disrespectful behaviour are often best handled locally, however where bullying and harassment is affecting public safety there may be grounds for regulatory action". Several studies that have evaluated the bullying phenomenon within the health-care workforce have pointed to serious consequences to health workers, patients, and relevant stakeholders (Carter M et al 2019), (Chatziioannidis I et al 2018). In these and other studies in non-health care settings, the primary barriers to reporting bullying have included the perception that nothing would change, not wanting to be seen as troublemaker, the seniority of the bully and the impact of reporting the bullying and harassment. It is therefore of concern that the code suggests that bullying should be handled locally, and that regulatory action would only be taken when public safety is compromised. The APC believes that bullying and harassment should be a matter that is reportable and actionable to Ahpra given the negative impact on patient safety.

The revised shared code explains the potential risks and issues of practitioners providing care to people with whom they have a close personal relationship (Section 4.8 Personal relationships).

Is this section clear? Why or why not?

The intent of this section is sufficiently clear.

Is the language and structure of the revised shared code helpful, clear and relevant? Why or why not?

We are satisfied that the language and structure of the shared code is helpful clear and relevant noting our comments above.

The aim is that the revised shared code is clear, relevant and helpful. Do you have any comments on the content of the revised shared code?

The APC has additional suggestions for consideration as follows: Advertising (8.5) It may be useful to also reference the relatively new Therapeutic Goods Advertising Code in this section Therapeutic goods advertising code | Therapeutic Goods Administration (TGA). The Pharmacy Board of Australia in particular may wish to include this reference as it is relevant for the pharmacy profession. Misconduct related to registration examinations and assessment by the intern/student. Section 10 addresses teaching, supervising, and assessing with regard to practitioners' expectations towards colleagues and students. This section does not cover misconduct by interns in relation to registration examinations. Intern pharmacists hold provisional registration while they practise under supervision and must successfully complete both a written and oral examination to achieve general registration. Currently, misconduct in relation to a registration examination may be handled as general fitness to practice, but there may be opportunity to include a reference to student/intern misconduct.

Do you have any other feedback about the revised shared code?

The APC has additional suggestions for consideration as follows: Advertising (8.5) It may be useful to also reference the relatively new Therapeutic Goods Advertising Code in this section Therapeutic goods advertising code | Therapeutic Goods Administration (TGA). The Pharmacy Board of Australia in particular may wish to include this reference as it is relevant for the pharmacy profession. Misconduct related to registration examinations and assessment by the intern/student. Section 10 addresses teaching, supervising, and assessing with regard to practitioners' expectations towards colleagues and students. This section does not cover misconduct by interns in relation to registration examinations. Intern pharmacists hold provisional registration while they practise under supervision and must successfully complete both a written and oral examination to achieve general registration. Currently, misconduct in relation to a registration examination may be handled as general fitness to practice, but there may be opportunity to include a reference to student/intern misconduct.

The National Boards are also interested in your views on the following questions about the potential impacts of the proposed revisions to the shared Code of conduct.

Would the proposed changes to the revised shared Code result in any adverse cost implications for practitioners, patients/clients/consumers or other stakeholders? If yes, please describe.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for vulnerable members of the community? If so, please describe them.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

The next two questions are about the Chiropractic Board and its changes to the revised shared code of conduct. They are not relevant to all stakeholders but you are welcome to give feedback if you are interested.

Do you wish to read the questions and provide feedback about the Chiropractic version of the revised shared code?

- (●) No
- ( ) Yes

The Chiropractic Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code of conduct has minor edits, extra content in its Appendices and additional content relating to modalities.

Many of these expectations relating to the Appendices are referred to more broadly in the revised shared code and/or are largely replicated in other relevant board documents such as the recently revised Guidelines for advertising a regulated health service (Appendix 1) and the FAQ: chiropractic diagnostic imaging (Appendix 2). It is proposed that the appendices and section on modalities be removed and additional guidance on these areas be presented in additional guidelines or similar.

Noting that the principles and expectations in the current appendices and modalities section are addressed broadly in the revised shared code and other relevant documents do you think it is necessary to keep the additional information in the Appendices and modalities section? Why or why not?

This question was not displayed to the respondent

If you think keeping the extra information is necessary, do you support that the information be presented as a guideline, or similar, rather than as an appendix to the revised shared code? Why or why not?

This question was not displayed to the respondent

The next question is about the Medical Radiation Practice Board and its current version of the revised shared code of conduct. It is not relevant to all stakeholders but you are welcome to give provide feedback if you are interested. Do you wish to read the questions and provide feedback about the Medical Radiation Practice version of the revised shared code?

- (●) No

◯ Yes

The Medical Radiation Practice Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code has extra content in its Appendix A. Appendix A includes expectations specific to medical radiation practitioners about providing good care, effective communication and radiation protection. Many of these expectations are referred to in the Professional capabilities for medical radiation practice (the capabilities), which set out the minimum skills and professional attributes needed for safe, independent practice in diagnostic radiography, nuclear medicine technology and radiation therapy. The Board is proposing to remove Appendix A from the revised code as the content duplicates content included in other documents such as the capabilities.

Do you think the extra information in Appendix A should be presented in a guideline or similar, noting that the expectations specific to medical radiation practitioners are referred to in the capabilities? Why or why not?

This question was not displayed to the respondent

Q24.

Thank you!

Thank you for participating in the public consultation.

Your answers will be used by the National Boards and Ahpra to improve the proposed revised shared Code of conduct.