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AHPRA & the National Boards

Revised Shared Code of Conduct

Submission by OSTEOPATHY AUSTRALIA

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INTRODUCTION

Osteopathy Australia thanks the AHPRA and the National Board for the opportunity to lodge a submission addressing the consultation paper *on the revised shared code of conduct.*

OSTEOPATHY AUSTRALIA

Osteopathy Australia is the professional association for the osteopathy industry in Australia. We act by representing the interests of osteopathy students, osteopaths, osteopathy as a profession, and consumer's rights to access osteopathic services.

We promote standards of professional behaviour over and above the requirements of AHPRA registration. A vast majority of osteopathy students and registered osteopaths are members of Osteopathy Australia.

Our core work is liaising with state and federal government, and all other statutory agencies, professional bodies, and private industry regarding professional, educational, legislative, and regulatory issues for the osteopathy profession. As such, we have close working relationships with the Osteopathy Board of Australia (OBA) and the Australian Health Practitioner Regulation Agency (AHPRA), to which this submission is addressed. We also maintain strong working relationships with other professional health bodies through our collaborative work with Allied Health Professions Australia (AHPA) and specific working initiatives with individual allied health peak bodies.

As an organisation we establish diverse working groups, develop collaborative projects, and receive a vast amount of written and verbal feedback regarding the state of the osteopathy industry, its educational institutions and all manner of associated quality and governance issues. We receive this feedback from students, registered osteopaths, and osteopathy academic staff. We draw on our extensive experience in responding to AHPRA’s inquiry.

We address your questions within our submission.

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1. 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 shorter, more concise principles are a useful introduction to the broader document. They are a crystallisation of the key overarching principles for practitioners to consider when reading through more detailed section later in the document. It would be useful if all codes and guidelines highlighted the overarching but specific regulatory obligations at the start of each document.
2. 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?**
Osteopathy Australia does not prefer one term over the other. Frequently referring to several interchangeable terms within sentences greatly reduces the readability of documents. It is important that whichever term is used, it is defined, it is used consistently through all codes and guidelines, all communications and on the AHPRA website. Ensuring consistency across all documents, website and other regulatory publications would greatly streamline communications and increase understanding. If we had to choose one term from the examples provide (client or consumer or patient) we would be inclined to use patient. Only for one reason as hat it does intrinsically define healthcare use and participation; unlike terms such as client or consumer that can apply in any/many situations.
3. 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?

It will always be difficult, within three or four paragraphs, for the code of conduct to capture the importance of Aboriginal and Torres Strait Islander health and cultural safety and its implications within the national registration and accreditation scheme. Having said that, the overall wording is fairly clear and understandable but the tone in certain sentences may not be.

For instance, 2.2b. *To ensure culturally safe and respectful practice, you must acknowledge and address individual racism, your own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism.*

Why we do not dispute that all of these things occur, to frequently, it is written in a context that assumes that everyone reading the code of conduct has inherent racism and bias; which can be disengaging for those already committed to culturally safe and respectful practice.

We acknowledge that many people may have a long journey ahead for changing inherent bias and the code should be written in a way that engages those who are or have already undertaken that journey. The wording style under 3.1 is preferable.

4. 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 etc.

3.1 Respectful and culturally safe practice plus 4.1 partnership
The content for both sections could be improved by adding an introductory paragraph and closing paragraph that encompasses patient need and why the good practice items listed contribute to the respect and safety for patients.

Section 4.9 and section 5.3 do this quite well.

4.9 professional boundaries
The content under section 4.9, with its opening and closing paragraphs is much better at setting the expectations that practitioners must contribute to a culture of respect and safety for patients.

The use of opening and closing paragraphs in this section helps highlight what it means for the practitioner to introduce good practice. The use of such appropriate introductory and closing paragraphs should also be used also in 3.1 and 4.1.

5.3 bullying harassment
As with 4.9, the use of an introductory paragraph improves the section.

As we highlight in Question 5, we recommend that if you're going to use an example of discrimination, then it may be better to either footnote or list all the legal forms of discrimination, not just one.

5. 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?

The statements in the code about bullying and harassment are quite clear around the difference between good practice and what may require the national boards or AHPRA to be involved.

We do recommend that if you are going to use one example of discrimination, then it may be better to either footnote or list all examples of discrimination.

6. 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?

Appears adequate.

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

The language and structure of the revised code of conduct is much clearer and more user-friendly than previous versions.

8. **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?**

No

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

No

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The National Boards are also interested in your views on the following specific questions:

10. **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.**

None that are easily identifiable at this stage.

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

None that are easily identifiable at this stage.

12. **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.**

None that are easily identifiable at this stage.

13. **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.**

We will leave comment to those better qualified to comments on the effects on Aboriginal and Torres Strait Islander Peoples.