# Public consultation

May 2021

## Consultation on the review of the shared Code of conduct


**Summary**

The shared Code of conduct sets out the standards of professional conduct the National Boards expect and is used by Boards to evaluate practitioners' conduct. Practitioners have a professional responsibility to be familiar with and to apply this code.

The shared code is an important document for the public as it can help them understand what behaviour they can expect from a registered health practitioner and assess whether their care met professional standards.

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 (the shared code), most in the same form and some with minor variations.

National Boards and Ahpra are reviewing the shared code to ensure it stays up-to-date and is an effective regulatory tool that contributes to patient safety. The revised code aims to be relevant and useful for practitioners and more accessible to the public.

While we are not suggesting major changes to the shared code, the proposed improvements are informed by research and international benchmarking, consultation on the definition of cultural safety, our regulatory experience and feedback from stakeholders.

The main changes proposed to the revised shared code are:

- Adding principles as an overarching guide
- Setting high-level expectations which can be supported by further guidance if required
- Adding content on Aboriginal and Torres Strait Islander health and cultural safety
- Adding guidance about bullying and harassing, vexatious complaints, clinical governance and setting performance targets that could impact on patient safety
- Reducing repetition by removing some content and blending other content
- Adding hyperlinks to help the reader source further information.

More information about the proposed changes and tables showing where changes have been made are included in this consultation paper. The consultation is open until **6 July 2021**.



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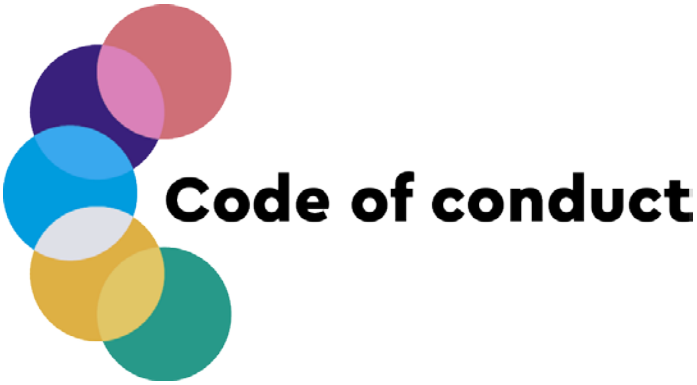
Ahpra and the National Boards regulate these registered health professions: Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medical, medical radiation practice, midwifery, nursing, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry and psychology.




## Public consultation

The National Boards are releasing this public consultation paper for feedback on a draft revised shared code.

You are invited to give feedback on the draft revised shared code at Attachment A.

## Providing feedback

Feedback can be provided by completing the online survey available on our website.

If you are unable to complete the online survey you can give feedback in a Word document also available on our website to ahpra.consultation@ahpra.gov.au.

Feedback is required by close of business on **6 July 2021**.

## Publication of submissions

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 of the individuals and/or the organisations that made the submission unless confidentiality is requested.**

## Next steps

After public consultation closes, the National Boards will review and consider all feedback from this consultation before making decisions about the implementation of the proposed framework and supporting documents.

# Contents

# Consultation paper

## Background

There are 15 National Boards in the National Registration and Accreditation Scheme (the National Scheme):

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Chiropractic Board of Australia
- Dental Board of Australia
- Medical Board of Australia
- Nursing and Midwifery Board of Australia
- Medical Radiation Practice Board of Australia
- Occupational Therapy Board of Australia
- Optometry Board of Australia
- Osteopathy Board of Australia
- Paramedicine Board of Australia
- Pharmacy Board of Australia
- Physiotherapy Board of Australia
- Podiatry Board of Australia, and
- Psychology Board of Australia.

The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with each of the National Boards to implement the National Scheme which has maintaining public safety at its heart.

National Boards regularly review their standards, codes and guidelines to make sure they remain relevant, contemporary and effective.

## Overview

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 (the National Boards) are reviewing the shared code of conduct (the shared code).

The shared code was first developed in preparation for the National Scheme commencing in mid-2010. It was adapted from the Medical Board of Australia's Code of conduct Good medical practice. The shared code was reviewed and a revised version published in March 2014. The same version of the shared code is used by most of the National Boards undertaking this review. Five Boards use a version of the shared code with some minor profession-specific differences.

## Development of the revised shared code

Research, data and regulatory experience are informing the revised shared code.

The review aims to develop a shared code that:


The revised shared code is informed by:

- research and international benchmarking
- the consultation on the definition of cultural safety for use within the National Scheme
- the Nursing and Midwifery Board of Australia's (NMBA) literature review and its revised codes
- input from National Boards
- feedback from national- and state-based Registration and Notifications Committees
- input from key stakeholders
- input from multiprofession practitioner focus groups
- operational input, including workshops and surveys of notifications staff
- professional and performance panel hearing outcomes, and tribunal and court decisions involving the *Code of conduct*, and
- surveys of practitioners' and the public's awareness of the shared code.

Analysing this information led to the proposed changes in the shared code outlined in this consultation paper.

## Key changes in the revised shared code

### Rationale for proposed changes

The National Boards are aware that consistency in regulatory approaches can facilitate patient and practitioner understanding, support inter-professional practice, and contribute to safety and quality of healthcare. The Boards are also aware that changes to the shared code impact on practitioners, other stakeholders and staff who need to become familiar with the changes. Accordingly, the Boards are only proposing changes where they have identified real improvements to clarify expression, reduce duplication, streamline and remove unnecessary information and address gaps in content.

The review has benefited from an integrative literature review carried out by the NMBA to inform reviews of its codes of conduct for nurses and midwives. Ahpra's Research Unit has also conducted further research building on this report to consider sources relevant to this multi-profession review.

Tables summarising the high-level differences between the current shared codes of conduct and the draft revised shared code are at Attachment B1 – B3.

### Inclusion of principles

The revised shared code is structured around principles to guide behaviour, especially when an issue is not specifically addressed in the shared code. Each of these principles are followed by practical

guidance about how to apply them in practice. A one-page summary of the principles is included at the beginning of the shared Code (page 6).

The inclusion of principles is supported by the NMBA literature review that noted 'a recognition that core principles lie at the heart of what constitutes safe and high-quality care, which transcend nuanced differences between individual professionals and professions.

**Inclusion of content on Aboriginal and Torres Strait Islander health and cultural safety**

The revised shared code includes revised and expanded content on Aboriginal and Torres Strait Islander health and cultural safety using the agreed definition of cultural safety for use within the National Registration and Accreditation Scheme.

**Advice from the Aboriginal and Torres Strait Islander Health Strategy Group**

The Aboriginal and Torres Strait Islander Health Strategy Group has provided advice on the cultural safety content in the revised shared code. The group consists of Aboriginal and Torres Strait Islander health sector leaders and representatives from:

- Health Professions Accreditation Collaborative Forum
- National Boards
- NSW health professions councils, and
- Ahpra and its management board (Agency Management Committee).[1]

Co-Chaired by Mr Karl Briscoe, CEO of the National Aboriginal and Torres Strait Islander Health Worker Association and Ms Julie Brayshaw, Chair of the Occupational Therapy Board of Australia, the group provides advice on how best to develop the National Scheme's strategy, and define its role, in ensuring patient safety for Aboriginal and Torres Strait Islander Peoples in Australia's health system. The group's agreed vision is: Patient safety for Aboriginal and Torres Strait Islander Peoples in Australia's health system is the norm, as defined by Aboriginal and Torres Strait Islander Peoples. The group developed the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025, the Statement of Intent and baseline definition of cultural safety for the National Scheme (in partnership with the National Health Leadership Forum).

**Definition of cultural safety**

The public consultation on the definition of cultural safety for use within the National Scheme closed on Friday 24 May 2019. You can find out more about this consultation here. The final definition provides a foundation for embedding cultural safety within the revised shared code.

**Minor changes to language and content**

The review provides an opportunity to reorganise content to reduce duplication and make the sequence more logical and to make minor changes to refine and clarify wording and expression.

The language has been revised to speak directly to practitioners and emphasise the personal relevance of the revised shared code. The revised shared code explains what good practice involves and aims to reinforce patient-centred care, drawing on the best available evidence.

[1] Ahpra and National Boards work together to regulate Australia's 700,000 registered health practitioners. Part of this work includes setting the standards, codes and guidelines that all registered health practitioners in Australia must meet. There are 15 Accreditation Authorities in the National Scheme working with National Boards and Ahpra to accredit courses of study. They are represented on the Strategy Group by the Health Professions Accreditation Collaborative Forum.

**New content**

The following new content has been included to respond to issues identified in reviews and enquiries. The case studies below illustrate how the new information in the code might be used.

**1. Bullying and harassment**

Recent reviews have identified bullying and harassment as important issues that must be addressed in the workplace.

A new section on bullying and harassment is included in the revised shared code to provide more clarity about practitioners' responsibilities in relation to bullying and harassment and the importance of addressing the issue in the workplace and to clarify the role of the National Boards/Ahpra.

The section clarifies that a complaint (notification) should only be made to Ahpra when there is ongoing and/or serious risk to public safety.

**Case study – Bullying and harassment**

Sam is a physiotherapist who believes Rowan has been repeatedly and unfairly critical of Sam's work. Sam's performance has not suffered and there is no negative impact on patient safety however Sam is stressed and upset. A colleague has supported Sam to make a complaint to management so that the issue with Rowan can be dealt with in line with the organisation's relevant policies.

Sam reviews the content about bullying in the code and understands that if there is no risk to public safety the best option is to follow local organisational policies to address her concern and that there is no need to make a notification to the relevant National Board.

**2. Risk management and clinical governance**

Key stakeholders, practitioner focus groups and Ahpra's operational staff have identified a need for additional clarification about practitioners' responsibilities in relation to clinical governance.

Feedback suggests that the revised shared code should call out the responsibilities of practitioners who have clinical leadership or management responsibilities.

**Case study 1 – Risk management and clinical governance**

Joanne is an occupational therapist employed as manager in a small health facility. When she reviews the facility's policy and procedure manual, she notices that the procedure for staff to report concerns about risks and incidents has not been updated for some time and it is no longer clear how concerns should be raised and dealt with.

Joanne has recently reviewed the code and understands that as a manager she has a responsibility to ensure that the procedure is updated and that all staff are made aware of how to report any concerns.

**Case study 2 – Risk management and clinical governance**

Shane is a dentist who practises in a small dental practice. He knows that the code includes information about ensuring systems are in place for managing risks to reduce error and improve patient safety.

Shane asks the practice manager to attend a risk management course and to develop a risk management policy for the practice, taking into account material published by the professional association and the practice's insurers. He also speaks with his fellow practitioners and they agree to hold regular meetings with all practice staff to discuss any issues that have occurred in the practice that have or may have led to patient harm. They agree that the outcome of these meetings is not to attribute blame but to find ways to prevent the same issues occurring in future.

## 3. Vexatious complaints or notifications

A recent literature review[2] commissioned by Ahpra notes that there is limited understanding among stakeholders about vexatious complaints.

Although the literature review notes that the available evidence indicates the proportion of vexatious reports is low, it also notes that vexatious complaints can have a negative impact on public safety and practitioners.

The revised shared code provides guidance about vexatious complaints (notifications).

**Case study 1 – Vexatious complaints or notifications**

Sam visits a practitioner some distance from her home. She is concerned that the care she received may have placed her at risk. Sam raises her concerns with the practitioner. She is frustrated because the practitioner asked her to drive back to the practice but will now not discuss her concerns and a heated discussion occurs.

Sam is worried that the practitioner may have placed Sam's health at risk but is concerned that it will look like she is trying to get back at the practitioner if she complains.

Sam reads the 'Vexatious notifications and complaints' section of the shared code. It explains that a complaint motivated by genuine concern about patient safety is not considered vexatious and she feels more confident about making a complaint.

[2] Reducing, identifying and managing vexatious complaints – Melbourne School of population and global health Nov 2017

**Case study 2 – Vexatious complaints or notifications**

Felicity's patient tells her about the treatment she recently received from another practitioner who works nearby. Felicity is worried that the practitioner may have placed the public at risk by providing treatment that does not meet professional standards. The patient does not want to make a complaint.

Felicity only has the patient's account of the treatment provided. As the other practice is close to Felicity and the practitioner is in the same profession, Felicity is unsure whether her complaint might be seen as vexatious.

Felicity reads the 'Vexatious notifications and complaints' section of the code. It explains that a complaint motivated by genuine concern about patient safety is not considered vexatious.

## 4. Business practices that are inconsistent with the code

National Boards and focus groups with practitioners have identified a need for guidance for practitioners who are employers about performance targets and/or business practices that are inconsistent with the code.

The revised shared code includes content to better address this need and clarify National Boards' expectations.

**Case study – Business practices**

John is an employee at a small podiatry practice. The practitioner who employs John sets a performance target that John must sell more of the therapeutic products stocked in the practice. John reviews his patient numbers and informs his employer that to achieve the target he would need to sell products to some patients who do not have any signs or symptoms that indicate clinical need.

John and his employer know that the code states that good care includes the quality use of therapeutic products based on the best available evidence and the patient's needs. They agree that that this performance target is not appropriate.

## 5. Minor changes to language and content

The review provides an opportunity to reorganise content to reduce duplication, making the sequence more logical and making minor changes to refine and clarify wording and expression.

The language in the revised shared code speaks directly to practitioners and emphasises the personal relevance of the revised shared code. The revised shared code explains what good practice involves and aims to reinforce patient-centred care, drawing on the best available evidence.

Links to the current codes of conduct:

- Current Aboriginal and Torres Strait Islander Health Practice Board of Australia Code of conduct
- Current Chinese Medicine Board of Australia Code of conduct
- Current Chiropractic Board of Australia Code of conduct
- Current Dental Board of Australia Code of conduct
- Current Medical Radiation Practice Board of Australia Code of conduct
- Current Occupational Therapy Board of Australia Code of conduct
- Current Optometry Board of Australia Code of conduct
- Current Osteopathy Board of Australia Code of conduct
- Current Paramedicine Board of Australia Code of conduct
- Current Pharmacy Board of Australia Code of conduct
- Current Physiotherapy Board of Australia Code of conduct
- Current Podiatry Board of Australia Code of conduct

## Options

### Option one - Status quo

The current version of the shared code was published in 2014[3] and is being reviewed. While available information suggests the shared code is working reasonably well, several developments have provided a number of opportunities to improve it. These include adding 11 principles to guide behaviour, revising content on cultural safety to reflect expert feedback from the Aboriginal and Torres Strait Islander Health Strategy Group, the addition of the agreed definition of cultural safety for use within the National Scheme and including new content on bullying and harassment and clinical governance.

Maintaining the current shared code would miss these opportunities for improvement and mean that the code could become progressively less contemporary and relevant.

### Option two – Develop a revised shared code

Adopting the revised shared code will ensure that it continues to be relevant, contemporary, based on the best available evidence and aligned with international best practice. It will capture the opportunities that would be missed in option one. It considers the feedback from key stakeholders, National Boards, practitioners and relevant Ahpra staff on how the shared code can be more accessible, relevant and helpful.

A contemporary shared code will provide consumer, regulatory, employer and professional bodies with clear guidance about the National Boards' expectations of the professional conduct of the practitioners they regulate.

### Preferred option

The National Boards prefer option two.

## Estimated impacts of the revised code

The impacts on practitioners, businesses and other stakeholders arising from the changes proposed in the revised code are expected to be small as the changes proposed focus on providing additional explanation and clarification. Stakeholders will need to familiarise themselves with the revised Code but National Boards have added principles to guide behaviour and streamlined content to reduce duplication.

[3] The Optometry Board of Australia's version of the shared code was published in 2010

National Boards' aim is that the revised Code will benefit patient and consumer health and safety, especially vulnerable members of the community. The revised draft Code includes expanded guidance on Aboriginal and Torres Strait Islander health and cultural safety. The proposed changes include more information about National Board's expectations that practitioners respect the diverse cultures, beliefs, gender identities, sexualities and experiences of people and adopt practices that respect diversity, avoid bias, discrimination and racism.

National Boards and Ahpra will undertake wide-ranging consultation with patient safety, consumer and Aboriginal and Torres Strait Islander organisations to gather feedback about the proposed changes.

Any unintended impacts raised during consultation will be considered and actions taken to mitigate any potential negative impacts for health care users, particularly for Aboriginal and Torres Strait Islander Peoples and vulnerable members of the community.

The Code of conduct is scheduled for regular review and National Boards and Ahpra will monitor for any unintended impacts that may arise as a result of the proposed changes. The Patient and Consumer Health and Safety Impact Statement at page eleven has more information about the National Boards' assessment of the potential impacts of the proposed revised shared Code.

### Questions for consideration

The National Boards are inviting general comments on a revised shared *Code of conduct* (revised shared code) as well as feedback on the following questions. There are three questions (14 – 16) specific to the Chiropractic or Medical Radiation Practice Boards of Australia. They are not relevant to all stakeholders but have been included to provide an overview of the scope of the review. All questions are optional and you are welcome to respond to as many as are relevant or that you have a view on.

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?**

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?**

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?**

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.**

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| 5. Statements about bullying and harassment have been included in the revised shared code (Section 5.3 Bullying and harassment).<br>**Do these statements make the National Boards'/Ahpra's role clear? Why or why not?** |
| 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).<br>**Is this section clear? Why or why not?** |
| 7. **Is the language and structure of the revised shared code helpful, clear and relevant? Why or why not?** |
| 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?** |
| 9. **Do you have any other feedback about the revised shared code?** |
| 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.** |
| 11. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.** |
| 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.** |
| 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.** |

## Additional questions about the Chiropractic Board of Australia's code of conduct

The following questions are specifically about the Chiropractic Board and its changes to the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

14. 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?**

15. **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?**

## Additional question about the Medical Radiation Practice Board of Australia's code of conduct

The following question is specifically about the Medical Radiation Practice Board and their current version of the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

16. 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?**

## Relevant section of the National Law

The relevant sections of the National Law are Sections 39, 40 and 41.

## Attachments

Attachment A – draft revised shared code of conduct
Attachment B1 – summary of changes between the current common shared code of conduct and the revised shared code (including minor specific differences in the Medical Radiation Practice and Pharmacy codes)

Attachment B2 – summary of proposed changes between the current Chiropractic code of conduct and the revised shared code

Attachment B3 – summary of proposed changes between the current Optometry code of conduct and the revised shared code

# National Boards' Patient and Consumer Health and Safety Impact Statement – revised shared Code of conduct

May 2021

## Statement purpose

The National Boards' Patient and Consumer Health and Safety Impact Statement (Statement)[4] explains the potential impacts of a proposed registration standard, code or guideline on the health and safety of the public, vulnerable members of the community and Aboriginal and Torres Strait Islander Peoples.

The four key components considered in the Statement are:

1. The potential impact of the proposed revisions to the shared Code of conduct on the health and safety of patients and consumers particularly vulnerable members of the community including approaches to mitigate any potential negative or unintended effects
2. The potential impact of the proposed revisions to the shared Code of conduct on the health and safety of Aboriginal and Torres Strait Islander Peoples including approaches to mitigate any potential negative or unintended effects
3. Engagement with patients and consumers, particularly vulnerable members of the community about the proposal
4. Engagement with Aboriginal and Torres Strait Islander Peoples about the proposal.

The National Boards' Health and Safety Impact Statement aligns with the National Scheme's *Aboriginal and Torres Strait Islander Cultural Health and Safety Strategy 2020-2025*, the *NRAS Strategy 2020-25* and reflect key aspects of the revised consultation process in the *AManC Procedures for developing registration standards, codes and guidelines and accreditation standards*.

**Below is our initial assessment of the potential impact of a proposed revision to the shared Code of conduct on the health and safety of patients and consumers, particularly vulnerable members of the community, and Aboriginal and Torres Strait Islander Peoples. This assessment will be updated after consultation feedback.**

**1. How will this proposal impact on patient and consumer health and safety, particularly vulnerable members of the community? Will the impact be different for vulnerable members compared to the general public?**

The National Boards have carefully considered the impacts the proposed revised shared Code of conduct could have on patients' and consumers' health and safety, particularly on vulnerable members of the community in order to propose a preferred option for consultation. The preferred option is based on best available evidence, best practice approaches and monitoring of the current shared Code of conduct. Our engagement through consultation will help us to better understand possible outcomes and meet our responsibilities to protect patient safety and health care quality.

[4] This statement has been developed by Ahpra and the National Boards in accordance with section 25(c) and 35(c) of the *Health Practitioner Regulation National Law* as in force in each state and territory (the National Law). Section 25(c) requires Ahpra to establish procedures for ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice. Section 35(c) assigns the National Boards functions to develop or approve standards, codes and guidelines for the health profession including the development of registration standards for approval by the Health Council and that provide guidance to health practitioners registered in the profession. Section 40 of the National Law requires National Boards to ensure that there is wide-ranging consultation during the development of a registration standard, code, or guideline.

**2. How will consultation engage with patients and consumers, particularly vulnerable members of the community?**

In line with our consultation processes the National Boards are undertaking wide-ranging consultation. We will engage with patient and consumer bodies, peak bodies and other relevant organisations as well as individual patients and consumers through planned focus groups to get input and views from vulnerable members of the community.

**3. What might be the unintended impacts for patients and consumers particularly vulnerable members of the community? How will these be addressed?**

The National Board has carefully considered what the unintended impacts of the draft revised shared Code of conduct might be, as the consultation paper explains. Consulting with relevant organisations and vulnerable members of the community will help us to identify any other potential impacts. We will fully consider and take actions to address any unintended impacts for patients and consumers that may be raised during consultation particularly for vulnerable members of the community.

**4. How will this proposal impact on Aboriginal and Torres Strait Islander Peoples? How will the impact be different for Aboriginal and Torres Strait Islander Peoples compared to non-Aboriginal and Torres Strait Islander Peoples?**

The National Boards have carefully considered any potential impact of the draft revised shared Code of conduct on Aboriginal and Torres Strait Islander Peoples and how the impact compared to non-Aboriginal and Torres Strait Islander Peoples might be different in order to put forward the proposed option for feedback in the consultation paper. National Boards have engaged with the Aboriginal and Torres Strait Islander Health Strategy Group to develop the guidance about Aboriginal and Torres Strait Islander health and cultural safety contained in the draft revised shared Code of conduct.

National Boards believe that the preferred option outlined in this consultation paper will promote the health and cultural safety of Aboriginal and Torres Strait Islander Peoples without creating disproportionate burden on registered practitioners. Further engagement through consultation will identify other potential impacts of the proposed changes and help us to meet our responsibilities to protect patient safety and health care quality for Aboriginal and Torres Strait Islander Peoples.

**5. How will consultation about this proposal engage Aboriginal and Torres Strait Islander Peoples?**

The National Boards have committed to the National Scheme's Aboriginal and Torres Strait Islander Cultural Health and Safety Strategy 2020-2025 which focuses on achieving patient safety for Aboriginal and Torres Islander Peoples as the norm, and the inextricably linked elements of clinical and cultural safety.

As part of our consultation process, we have worked with the Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) Secretariat to help us find the best way to meaningfully engage with Aboriginal and Torres Strait Islander Peoples. We have also invited the Strategy Group to comment on the proposal. We are continuing to engage with Aboriginal and Torres Strait Islander organisations and stakeholders in order to get input from Aboriginal and Torres Strait Islander Peoples.

**6. What might be the unintended impacts for Aboriginal and Torres Strait Islander Peoples? How will these be addressed?**

The National Boards have consulted with the Aboriginal and Torres Strait Islander Health Strategy Group and have carefully considered what might be any unintended impacts of the draft revised shared Code of Conduct as identified in the consultation paper. Continuing to engage with relevant peak bodies and Aboriginal and Torres Strait Islander Peoples will help us to identify any other unintended impacts. We will consider and take actions to address any other unintended impacts for Aboriginal and Torres Strait Islander Peoples that may be raised during consultation.

## 7 How will the impact of this proposal be actively monitored and evaluated?

Part of National Boards' work in keeping the public safe is ensuring that all standards, codes and guidelines are regularly reviewed. National Boards' will monitor and regularly review the shared Code of conduct to check it is working as intended.

# Statement of assessment – National Boards' statement of assessment against Ahpra's Procedures for the development of registration standards, codes and guidelines, and principles for best practice regulation

May 2021

## Revised shared Code of conduct

The Australian Health Practitioner Regulation Agency (Ahpra) has Procedures for the development of registration standards, codes and guidelines. These procedures have been developed by Ahpra in accordance with Section 25 of the Health Practitioner Regulation National Law (the National Law) as in force in each state and territory, which requires Ahpra to establish procedures for the purpose of ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice.

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) are participating in the review of the shared *Code of conduct* (the shared code).

Below is the National Boards' assessment of the proposal for a revised shared code against the three elements outlined in the Ahpra procedures.

### 1. The proposal takes into account the National Scheme's objectives and guiding principles set out in Section 3 of the National Law

**National Boards' assessment**

The National Boards consider that the proposed revised shared code meets the objectives and guiding principles of the National Law.

The proposal considers the National Scheme's key objective of protecting the public by setting out the ethical and professional standards of conduct expected of health practitioners to ensure that only those who practise competently and ethically are registered. The revised Code includes principles and expanded content to strengthen its effectiveness and public protection.

The revised shared code also supports the National Scheme to operate in a transparent, accountable, efficient, effective and fair way. The proposal gives clear guidance on the Boards' expectations of health practitioners, and there are protective actions that can be taken under the National Law if a practitioner does not fulfil these expectations.

The proposal considers the National Scheme's objective to facilitate the provision of high-quality education and training of health practitioners by setting out the standards expected of health practitioners who are teaching, supervising and assessing.

## 2. The consultation requirements of the National Law are met

**National Boards' assessment**

The National Law requires wide-ranging consultation on proposed codes and guidelines. The National Law also requires National Boards to consult each other on matters of shared interest.

National Boards are ensuring that there is a wide-range consultation about the revised shared code in accordance with the Consultation process of National Boards available on the Ahpra website. The Boards are ensuring that there is public exposure to the proposal and the opportunity for public comment via an eight-week public consultation. This includes publishing a consultation paper on the websites of Ahpra and the National Boards participating in the review and informing health practitioners and the community of the review via the Boards' electronic newsletters and a social media campaign.

The National Boards will consider the feedback they receive when finalising this shared code.

## 3. The proposal considers the following principles for best practice regulation

**National Boards' assessment**

In developing the revised shared code, the National Boards have considered principles for best practice regulation.

The Boards have taken care not to propose unnecessary regulatory burdens that would create unjustified costs for the profession or the community.

The Boards make the following assessment specific to each of the principles expressed in the Ahpra procedures.

### A. Whether the proposal is the best option for achieving the proposal's stated purpose and protection of the public

National Boards' assessment

The National Boards consider that their proposal is the best option for achieving the stated purpose. The proposed revised shared code does not propose significant changes to the current ethical and professional standards of conduct expected of health practitioners. The addition of principles and expanded content makes the code clearer for practitioners and the public.

The revised shared code is based on the best available evidence and aligned with international best practice, ensuring the code is current and relevant to the contemporary role and scope of health practitioner practice.

The proposal would protect the public by making clear the standards of ethical and professional conduct expected of health practitioners by the Boards, their professional peers and the community. The proposal would provide additional guidance and clarity for health practitioners.

### B. Whether the proposal results in an unnecessary restriction of competition among health practitioners

National Boards' assessment

The proposal is unlikely to restrict competition as the proposed revised shared code would apply to all health practitioners registered by the 12 National Boards participating in this review and has a very similar scope to the codes of conduct for the other three health professions in the National Scheme.

### C. Whether the proposal results in an unnecessary restriction of consumer choice

#### National Boards' assessment

The National Boards' consider that the proposal will not result in any unnecessary restrictions of consumer choice as the proposed revised shared code would apply to all health practitioners registered by the 12 National Boards participating in this review.

The proposal has the potential to improve consumers' confidence that all health practitioners registered by the 12 National Boards participating in this review are held to the same standards of ethical and professional standards of conduct.

### D. Whether the overall costs of the proposal to members of the public and/or registrants and/or governments are reasonable in relation to the benefits to be achieved

#### National Boards' assessment

The National Boards have considered the overall costs of the proposed revised shared code to members of the public, health practitioners and governments, and concluded that the likely costs are minimal as the Boards are not proposing significant changes.

If approved, the proposed revised shared code will provide practitioners with clear, consistent principles that underpin good practice. This benefit outweighs any minimal costs related to health practitioners and other stakeholders needing to become familiar with the revised shared code.

### E. Whether the proposal's requirements are clearly stated using plain language to reduce uncertainty, enable the public to understand the requirements, and enable understanding and compliance by registrants

#### National Boards' assessment

The National Boards are committed to a plain English approach that will help health practitioners and the public understand the standards of professional conduct expected by the relevant Board, their professional peers and the community.

### F. Whether the National Boards have procedures in place to ensure the proposed registration standard, code or guideline remains relevant and effective over time

#### National Board's assessment

The National Boards will review the shared code at least every five years, including an assessment against the objectives and guiding principles in the National Law and the principles for best practice regulation.

However, the Boards may choose to review the shared code earlier, in response to any issues which arise, or new evidence which emerges to ensure its continued relevance and workability.

# Code of conduct

**May 2021**

Code of conduct for:

Aboriginal and Torres Strait Islander Health Practitioners

Chinese medicine practitioners

Chiropractors

Dental practitioners including Dentists, Dental specialists, Dental hygienists, Dental prosthetists, Dental therapists and Oral health therapists

Medical radiation practitioners

Occupational therapists

Optometrists

Osteopaths

Paramedics

Pharmacists

Physiotherapists

Podiatrists and Podiatric surgeons

Australian Health Practitioner Regulation Agency
National Boards
GPO Box 9958 Melbourne VIC 3001 Ahpra.gov.au 1300 419 495

Ahpra and the National Boards regulate these registered health professions: Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medical, medical radiation practice, midwifery, nursing, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry and psychology.

## About the National Boards and Ahpra

The 15 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students, setting the standards that practitioners must meet, and managing complaints (notifications) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme (the National Scheme), under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and Ahpra is to protect the public.

## About this code

The *Code of conduct* (the code) was developed by 12 National Boards under section 39 of the National Law to protect the public.

It sets out the standards of professional conduct the National Boards expect and is used by Boards to evaluate practitioners' conduct. Practitioners have a professional responsibility to be familiar with and to apply this code.

If you are receiving care or treatment from a registered health practitioner covered by this code, it will help you understand the behaviour you can expect.

Any person or organisation can raise a concern about a registered health practitioner by contacting Ahpra. Ahpra's website has more information about raising a concern about a health practitioner.

This code replaces the National Boards' previous code.

## A note on terminology

This code uses 'patient' to mean a person receiving health care from a registered health practitioner. The term 'patient' includes 'clients' and 'consumers'. Depending on the context of practice and recognising the importance of patient-centred care, the term patient can also extend to families and carers, and to groups and/or communities as users of health services.

See also the Definitions section of this code.

## Acknowledgements

This code has drawn on relevant aspects of the Medical Board of Australia's Good medical practice and the Nursing and Midwifery Board of Australia's Codes of conduct. This Code uses the definition of cultural safety developed for use in the National Scheme by the Scheme's Aboriginal and Torres Strait Islander Health Strategy Group in partnership with the National Health Leadership Forum.

# Contents

## Code of conduct principles

*A summary of the principles of the revised code (designed to be printed).*

**Principles**

The following principles set out the National Boards' expectations of the practitioners they regulate.

1. **Put patients first – Safe, effective and collaborative practice**

   Principle 1: Practitioners should practise safely, effectively and in partnership with patients and colleagues, using patient-centred approaches, and informed by the best available evidence to achieve the best possible patient outcomes.

2. **Aboriginal and Torres Strait Islander health and cultural safety**

   Principle 2: Practitioners should consider the specific needs of Aboriginal and Torres Strait Islander Peoples and their health and cultural safety, including the need to foster open, honest and culturally safe professional relationships.

3. **Respectful and culturally safe practice**

   Principle 3: Respectful, culturally safe practice requires practitioners to have knowledge of how their own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. Practitioners should communicate with all patients in a respectful way and meet their privacy and confidentiality obligations including when communicating online.

4. **Working with patients**

   Principle 4: Basing relationships on respect, trust and effective communication enables practitioners to work in partnership with patients. Practitioners should maintain effective and professional relationships with their patients and provide explanations that enable patients to understand their care.

5. **Working with other practitioners**

   Principle 5: Good relationships with colleagues and other practitioners strengthen the practitioner-patient relationship, collaboration and enhance patient care.

6. **Working within the healthcare system**

   Principle 6: Practitioners have a responsibility to contribute to the effectiveness and efficiency of the healthcare system.

7. **Minimising risk to patients**

   Principle 7: Risk is inherent in healthcare, so minimising risk to patients is an important part of practice. Good practice involves putting patient safety, which includes cultural safety, first. Practitioners can minimise risk by maintaining their professional capability through ongoing professional development and self-reflection and understanding and applying the principles of clinical governance, risk minimisation and management in practice.

8. **Professional behaviour**

   Principle 8: Practitioners must display a standard of professional behaviour that warrants the trust and respect of the community. This includes practising ethically and honestly.

9. **Maintaining practitioner health and wellbeing**

   It is important for practitioners to maintain their health and wellbeing. This includes seeking an appropriate work–life balance.

10. **Teaching, supervising and assessing**

    Principle 10: Practitioners should support the important role of teaching, supervising and mentoring practitioners and students in order to develop the health workforce.

11. **Ethical research**

    Principle 11: Practitioners should recognise the vital role of evidence-based and ethical research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of research participants.

## Introduction

This code sets out National Boards' expectations about professional behaviour and conduct for registered health practitioners. In the context of the practitioner-patient relationship, practitioners have a duty to put the care of patients first and to practise safely and effectively. Maintaining a high level of professional competence and conduct is essential for good care.

There are many ways to practise a health profession in Australia. Practitioners have critical roles in caring for people who are unwell, helping people to recover, and seeking to keep people well. This code covers these roles. For practitioners with roles that involve little or no contact with patients, not all of this code may be directly relevant, but the underpinning principles will still apply.

While individual practitioners have their own personal beliefs and values, there are certain professional values on which all practitioners are expected to base their practice. The professional values and behaviours in this code apply to practitioners' conduct in every setting, including in-person, during technology-based consultations including online and remote prescribing, and electronically, e.g. social media, digital health and so on.

The code includes 11 principles of conduct. Each principle is followed by practical information about how to apply it in practice. Underpinning the code is the expectation that practitioners will use their professional judgement to achieve the best possible outcomes in practice.

### Purpose of the code

This code is a principles-based document that gives important guidance to practitioners about the National Boards' expectations of their professional conduct. It is a key part of the regulatory framework that each National Board establishes for the profession(s) it regulates in order to protect the public and progress the other objectives of the National Law. By defining National Boards' expectations of professional conduct, the code supports patients' interests, good patient care and the delivery of appropriate, effective services within an ethical framework.

### Scope of the code

This code:

- describes and reinforces the professional conduct that most registered health practitioners already demonstrate
- provides a framework for professional conduct and supports individual practitioners in the challenging task of providing good healthcare and fulfilling their professional roles
- assists National Boards in their regulatory role by setting and maintaining principles and standards of good practice – Boards will use this code when evaluating practitioners' professional conduct.[5] If professional conduct varies significantly from this code, practitioners should be prepared to explain and justify their decisions and actions. Serious or repeated failure to meet this code may have consequences for registration
- is a resource to help enhance the culture of professionalism in the Australian health system: for example, in practitioner education; orientation, induction and supervision of students; and by administrators and policy makers in hospitals, health services and other institutions, and
- as a guide to the public and health service users about what good practice is and the conduct they should expect from health practitioners.

The code is also a reference for co-regulatory authorities about the standards of professional conduct that National Boards expect.

### What this code does not do

Practitioners must understand their legal obligations and always act in accordance with the law. The code is not a substitute for legislation and case law, e.g. privacy, child protection, medicines and workplace health and safety laws. If there is any conflict between the code and the law, the law takes

[5]Under section 41 of the National Law the code may be used to evaluate a practitioner's professional conduct when a complaint (notification) is made about them, as one of a range of relevant factors taken into account on a case-by-case basis.

precedence. Practitioners must also be aware of and meet the other standards, guidelines and policies of their National Board which this code complements.

This code is not an exhaustive study of professional ethics or an ethics guide. It articulates the National Boards' expectations about ethical and professional conduct, but not the standards of clinical practice within individual health professions or disciplines. These clinical standards are generally found in other documents issued by the relevant National Boards and/or professional bodies.

While good healthcare respects the rights of patients, this code is not a charter of rights.[6] The focus of this code is on good practice and professional behaviour. It is not intended as a mechanism to address:

a. disputes between professional colleagues, e.g. in relation to termination of business relationships and disputes over patients, or

b. employment issues e.g. workplace or industrial disputes, which do not raise broader patient safety concerns.

### Professional values and qualities

When providing care, practitioners have a duty to make patient care their first concern and to practise safely and effectively. Professionalism embodies all the qualities described below, including self-awareness and self-refection. These qualities underpin, and are further expanded on in, the guidance provided throughout the code.

a. Practitioners must be ethical and trustworthy. Patients trust practitioners because they believe that, in addition to being competent, practitioners will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on practitioners to protect their confidentiality.

b. Practitioners have a responsibility to protect and promote the health of individuals and the community.

c. Good practice is centred on patients. It involves practitioners understanding that each patient is unique and working in partnership with patients, adapting what they do to address the needs and reasonable expectations of each person. This includes cultural awareness: being aware of their own culture and beliefs, being respectful of the beliefs and cultures of others and recognising that these cultural differences may affect the practitioner–patient relationship and the provision of services. As well as avoiding discrimination, good practice also includes being aware that differences such as gender, sexuality, age, belief systems and other attributes may influence care needs.

d. Effective communication in all forms underpins every aspect of good practice.

e. Practitioners are expected to reflect regularly on whether they are practising effectively, on their relationships with patients and colleagues, and on their own health and wellbeing.

f. Practitioners have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to maintaining public confidence in the profession.

g. Scopes of practice vary according to different roles; for example, practitioners, researchers and managers will all have different scopes of practice. Practitioners have a responsibility to recognise and work within the limits of their skills and competence.

h. Practitioners should be committed to safety and quality in healthcare.[7]

### Substitute decision-makers

In this code, reference to 'patients' also includes substitute decision-makers for patients who do not have the capacity to make their own decisions. These can be parents, guardians, a person nominated

[6] An example of a charter of rights is the Australian charter of healthcare rights issued by the Australian Commission on Safety and Quality in Health Care.
[7] See the Australian Commission on Safety and Quality in Health Care, the National Safety and Quality Health Service Standards, and the references section at the end of this code.

by the patient or a legally appointed decision-maker. If in doubt, seek advice from the relevant guardianship authority.

## 1. Put patients first – Safe, effective and collaborative practice

Principle 1: Practitioners should practise safely, effectively and in partnership with patients and colleagues, using patient-centred approaches, and informed by the best available evidence to achieve the best possible patient outcomes.

### 1.1 Providing good care

Patient care is your primary concern in clinical practice. Providing good care includes that you:

a. assess the patient, taking into account their history, views and an appropriate physical examination where relevant. The history includes relevant psychological, social and cultural aspects, and available electronic records such as My Health Record

b. formulate, record and implement a suitable management plan (including providing treatment and advice and, where relevant, arranging investigations and liaising with other treating practitioners)

c. facilitate coordination and continuity of care

d. recognise and work within the limits of your skills and competence, and refer a patient to another practitioner when this is in the best interests of the patient

e. recognise that healthcare decisions are the shared responsibility of the treating practitioner and the patient who may wish to involve their family, carer/s and/or others, and

f. recognise and respect the rights of patients to make their own decisions about their current and future health care.

### 1.2 Good care

Maintaining a high level of professional competence and conduct is essential for good care.

Good practice includes that you:

a. ensure you maintain adequate knowledge and skills to provide safe and effective care

b. ensure that, when moving into a new area of practice, you have sufficient training and/or qualifications to achieve competency in that new area

c. maintain adequate records (see Section 8.3 Health records)

d. consider the balance of potential benefit and harm in all clinical management decisions

e. communicate effectively with patients to ensure they have enough information to make an informed decision about their care (see Section 3.2 Effective communication)

f. provide treatment options that are based on the best available information and are not influenced by financial gain or incentives

g. practise within an evidence-based and patient-centred framework

h. take steps to alleviate the symptoms and distress of patients, whether a cure is possible or not

i. support the right of the patient to seek a second opinion

j. consult and take advice from colleagues when appropriate

k. make responsible and effective use of the resources available to practitioners (see Section 6.1 Wise use of healthcare resources)

l. ensure that your personal views do not adversely affect the care of a patient

m. reflect on your practice and your decisions and actions in providing good and culturally safe care, and

n. facilitate the quality use of therapeutic products based on the best available evidence and the patient's needs.

### 1.3 Decisions about access to care

Your decisions about access to care must be free from bias and discrimination.

Good practice includes that you:

a. treat patients with respect at all times

b. not prejudice the care of a patient because you believe that the behaviour of the patient has contributed to their condition

c. not engage in any form of discrimination

d. investigate and treat patients based on clinical need and the effectiveness of the proposed investigations or treatment, and not provide unnecessary services or encourage the indiscriminate or unnecessary use of health services

e. keep yourself and others safe when caring for patients. While you should take action to protect yourself, your colleagues and staff, if a patient poses a risk to health or safety, the patient should not be denied care if reasonable steps can be taken to keep others safe, and

f. not allow your moral or religious views or conscientious objection to deny patients access to healthcare, recognising that you are free to decline to provide or participate in that care yourself. In such a situation, it is important to respectfully inform the patient (where relevant), your employer and other relevant colleagues, of your objection and ensure the patient has alternative care options.

### 1.4 Treatment in emergencies

Treating patients in emergencies requires practitioners to consider a range of issues, in addition to providing best care. Good practice means you should offer assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care, and continue to help until your services are no longer needed.

## 2. Aboriginal and Torres Strait Islander health and cultural safety

Principle 2: Practitioners should consider the specific needs of Aboriginal and Torres Strait Islander Peoples and their health and cultural safety, including the need to foster open, honest and culturally safe professional relationships.

### 2.1 Aboriginal and/or Torres Strait Islander health

Aboriginal and Torres Strait Islander Peoples have inhabited and cared for the land as the first peoples of Australia for millennia, and their diverse histories and cultures have uniquely shaped our nation. Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life [8].

Understanding and acknowledging factors such as colonisation and its impact on Aboriginal and Torres Strait Islander Peoples' health, helps inform care. In particular, Aboriginal and Torres Strait Islander Peoples bear the burden of gross social and health inequity. It is for these reasons that cultural safety in the context of Aboriginal and Torres Strait Islander health needs to be specifically considered.

[8] National Aboriginal Health Strategy Working Party 1989, National Aboriginal Health Strategy, Canberra.

### 2.2 Cultural safety for Aboriginal and Torres Strait Islander Peoples

Supporting good practice and the health of Aboriginal and Torres Strait Islander Peoples also includes cultural safety. For Aboriginal and Torres Strait Islander Peoples, the National Scheme's definition of cultural safety is as follows:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.
>
> Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

To ensure culturally safe and respectful practice, you must:

a. acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
b. acknowledge and address individual racism, your own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
c. recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community
d. foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

See the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 and the National Safety and Quality Health Services Standards.

## 3. Respectful and culturally safe practice

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| Principle 3: Respectful, culturally safe practice requires practitioners to have knowledge of how their own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. Practitioners should communicate with all patients in a respectful way and meet their privacy and confidentiality obligations including when communicating online. |

### 3.1 Cultural safety for all communities

Australia is a culturally and linguistically diverse nation. Section 2 (above) defines cultural safety for Aboriginal and Torres Strait Islander Peoples specifically for their status as First Nations Peoples. Culturally safe and respectful practice is also important for all communities.

To ensure culturally safe and respectful practice, good practice includes that you:

a. understand that only the patient and/or their family can determine whether or not care is culturally safe and respectful
b. respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among your team members
c. acknowledge the social, economic, cultural, historic and behavioural factors influencing health – at the individual, community and population levels
d. adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)
e. support an inclusive environment for the safety and security of the individual patient and their family and/or significant others, and
f. create a positive, culturally safe work environment through role modelling, and support the rights, dignity and safety of others, including patients and colleagues.

### 3.2 Effective communication

Positive professional relationships are built on effective communication between a practitioner and the patient they are caring for.

Good practice includes that you:

a. communicate courteously, respectfully, compassionately and honestly with patients, their nominated partner, substitute decision-maker, carers, family and friends

b. consider the age, maturity and intellectual capacity of young people and other groups that may have additional needs, and provide information in a way that they can understand

c. are aware of health literacy issues, and take health literacy into account when communicating with people

d. make arrangements, whenever possible, to meet the specific language, cultural, and communication needs of patients and their families, by using translating and interpreting services where necessary, and being aware of how these needs affect understanding

e. endeavour to confirm a patient understands any information communicated to them

f. encourage and support patients to be well-informed about their health, and respect the right of patients to choose whether to participate in treatment or accept advice

g. clearly and accurately communicate relevant and timely information about the patient to colleagues, within the bounds of relevant privacy requirements, and

h. be non-judgemental and do not refer to people in a non-professional manner verbally or in correspondence/records, including refraining from behaviour that may be interpreted as bullying or harassment and/or culturally unsafe.

### 3.3 Confidentiality and privacy

You have ethical and legal obligations to protect the privacy of patients. Patients have a right to expect that you will hold information about them in confidence, unless the release of information is required or authorised by law[9], or is required to facilitate emergency care.

To protect privacy and confidentiality, good practice includes that you:

a. respect the confidentiality and privacy of patients by seeking informed consent before disclosing information, including formally documenting such consent where possible

b. provide surroundings to enable private and confidential consultations and discussions, particularly when working with multiple people at the same time, or in a shared space

c. never access records when not professionally involved in the care of the person and/or authorised to do so

d. ensure that all staff are aware of the need to respect the confidentiality and privacy of patients, and refrain from discussing patients in a non-professional context

e. be aware of the requirements of the privacy and/or health records legislation that operate in the relevant states or territories, and apply them to information held in all formats, including electronic information

f. be aware that there are complex issues relating to genetic information, and seek appropriate advice about disclosure of this information

g. do not transmit, share, reproduce or post any person's information or images, even if the person is not directly named or identified, without first getting written and informed consent. See also the Social media guidance.

h. recognise a patient's right to access information contained in their health records, help them access it, and promptly facilitate the transfer of health information when requested by the patient, in accordance with local policy, and

[9] See also the Australian Privacy Principles

i. facilitate arrangements for the transfer or management of all health records in accordance with the legislation governing privacy and health records, when closing or relocating a practice.

### 3.4 End-of-life care[10]

You have a vital role in helping the community deal with the reality of death and its consequences.

In providing culturally appropriate end-of-life care, good practice includes that you:

a. understand the limits of healthcare in prolonging life, and recognise when efforts to prolong life may not be in the best interest of the patient

b. accept that the patient has the right to refuse treatment, or request withdrawal of treatment, while ensuring they receive relief from distress

c. respect diverse cultural practices and beliefs related to death and dying

d. facilitate advance care planning and provide end-of-life care where relevant and in accordance with local policy and legislation, and

e. take reasonable steps to ensure support is given to patients and their families, even when it is not possible to meet their expectations or wishes, especially if different views exist.

## 4. Working with patients

Principle 4: Basing relationships on respect, trust and effective communication enables practitioners to work in partnership with patients. Practitioners should maintain effective and professional relationships with their patients and provide explanations that enable patients to understand their care.

### 4.1 Partnership

A good partnership between you and your patient requires high standards of personal conduct.

Good practice includes that you:

a. be courteous, respectful, compassionate and honest

b. treat each patient as an individual

c. encourage and support patients to be well-informed about their health, and to use this information wisely when they are making decisions, caring for themselves and managing their health, including through informed consent processes, and

d. recognise that there is a power imbalance in the practitioner–patient relationship, and do not exploit patients physically, emotionally, sexually or financially (also see Section 4.9 Professional boundaries and Section 8.11 Financial and commercial dealings).

### 4.2 Informed consent

Informed consent is a person's voluntary decision about healthcare that is made with knowledge and understanding of the benefits and risks involved.

Good practice includes that you:

a. provide information to patients in a way they can understand before asking for their consent (see Section 3.2 Effective communication)

b. give the patient enough time to ask questions and make informed decisions

c. act according to the patient's capacity for decision-making and consent, including when caring for children and young people, based on their maturity and capacity to understand, and the nature of the proposed care, and consider the need for the consent of a parent, guardian or other legal representative

[10] See also the Australian Commission on Safety and Quality in Health Care - End-of-Life Care

d. get informed consent from the patient or where the patient does not have the capacity, from their parent, carer, guardian or other substitute decision-maker and take into account any advance care directive (or similar) before carrying out any examination or investigation, providing treatment (this may not be possible in an emergency), or involving patients in teaching or research[11], including providing information on material risks and expected outcomes

e. discuss fees in a manner appropriate to the professional relationship and address the costs of all required services and general agreement about the level of treatment to be provided, preferably before the service is provided

f. inform your patients of the benefits, as well as associated costs or risks, when referring them for further investigation or treatment, which they may wish to clarify before proceeding, and

g. document consent appropriately, including considering the need for written consent for procedures which may result in serious injury or death.

### 4.3 Children, young people and other patients who may have additional needs

Some patients have additional needs. These patients may include for example, children and young people, older people, those living with physical and/or cognitive disability, those with impaired decision-making capacity and those who are otherwise vulnerable and/or at higher risk, for example from family violence.

Good practice includes that you:

a. place the interests and wellbeing of the patient first

b. meet the relevant mandatory reporting legislation imposed to protect groups particularly at risk, including reporting obligations about the aged, child abuse and neglect

c. be aware that increased advocacy may be necessary to ensure just access to healthcare

d. ensure when communicating that you:

- treat the patient with respect and listen to their views
- encourage questions and answer those questions to the best of your ability
- provide information in a way the patient can understand
- recognise the role of parents, carers or guardians and, when appropriate, encourage the patient to involve their parents, carers or guardians in decisions about care, and
- remain alert to patients who may be at risk, and notify appropriate authorities as required by law. This includes when a parent or guardian is refusing treatment for their child or young person and this decision may not be in the best interests of the child or young person.

### 4.4 Relatives, carers and partners

Good practice includes that you:

a. be considerate to relatives, carers, partners and others close to the patient, and respectful of their role in the care of the patient, and

b. with appropriate consent, or where otherwise permitted, be responsive in providing information (also see Section 3.2 Effective communication).

### 4.5 Adverse events and open disclosure

When a person is harmed[12] by healthcare (adverse events), practitioners have a responsibility to be open and honest in communication with the patient to review what happened and to report appropriately.

When something goes wrong, good practice includes that you:

a. document the adverse event or incident

[11] See sections 10 Teaching, supervising and assessing and 11 Ethical Research
[12] From the Australian Commission on Safety and Quality in Healthcare's Australian Open Disclosure Framework: 'adverse event' means an incident in which a person receiving health care was harmed.

b. recognise what has happened and report the incident to the relevant authority as appropriate

c. act immediately to rectify the problem, if possible, including seeking help and advice if needed

d. apply the principles of open disclosure[13] and non-punitive approaches to incident management

e. explain to the patient and relevant individuals as promptly and fully as possible in accordance with open disclosure policies, what has gone wrong, how it happened, how it might affect them and what is being done to prevent it from happening again

f. listen to the patient, acknowledge any distress and provide appropriate support, including referral

g. comply with any relevant policies, procedures and reporting requirements, and seek advice from an employer or professional indemnity insurer if you are unsure about your obligations

h. review adverse events and implement changes to reduce the risk of recurrence (see Section 7 Minimising risk), and

i. ensure patients have access to information about the processes for making a complaint (notification) (for example through the relevant Health Complaints Commissioner or National Board/Ahpra website.

### 4.6 Complaints

Patients have a right to complain about their care.

When a complaint is raised good practice includes that you:

a. acknowledge the patient's right to complain

b. provide information about the complaints system

c. work with the patient to resolve the issue, locally where possible

d. ensure the complaint does not affect the patient's care adversely; in some cases, it may be advisable to refer them to another practitioner, and

e. when notified of a complaint (notification) made to a regulator such as the National Board/Ahpra, work cooperatively with the regulator to provide a prompt, open and constructive response including an explanation, and

f. comply with relevant complaints (notifications) legislation, policies and procedures.

### 4.7 Ending a professional relationship

In some circumstances, the relationship between a practitioner and a patient may become ineffective or compromised and may need to end. Good practice involves ensuring that the patient is informed adequately of your decision to end the relationship and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information.

### 4.8 Personal relationships

Good practice includes recognising the potential conflicts, risks and complexities of providing care to those in a close personal relationship. Providing care to anyone you have a close personal relationship with, for example close friends, work colleagues and family members; can be inappropriate because of the lack of objectivity, possible discontinuity of care and risks to the practitioner or patient.

If you are required to provide care to someone in a close relationship, good practice requires that you:

a. keep adequate records

b. maintain confidentiality

c. carry out an adequate assessment

d. get appropriate consent to the circumstances which is acknowledged by you and the patient

[13] See Australian Commission on Safety and Quality in Healthcare's Australian Open Disclosure Framework

e. do not allow the personal relationship to impair clinical judgement, and
f. maintain the patient's option to discontinue care at all times.

### 4.9 Professional boundaries

Professional boundaries allow you and your patient to engage safely and effectively in a therapeutic relationship. Professional boundaries mean the clear separation that should exist between professional conduct aimed at meeting the health needs of patients and your own personal views, feelings and relationships which are not relevant to the therapeutic relationship.

Professional boundaries are integral to a good practitioner–patient relationship. They promote good care for patients and protect both parties.

Good practice includes that you:

a. recognise the inherent power imbalance in the patient-practitioner relationship and maintain professional boundaries

b. be clear about the professional boundaries that must exist in professional relationships for objectivity in care, and avoid conflicts of interest, as well as under-or over-involvement

c. never use your position to establish or pursue a sexual, exploitative or otherwise inappropriate relationship with anybody under your care; this includes those close to the patient, such as their carer, guardian, spouse, or the parent of a child patient

d. recognise that sexual and other personal relationships with people who have previously been your patients are usually inappropriate, depending on the extent of the professional relationship and the vulnerability of a previous patient, and

e. do not express personal beliefs to patients in ways that exploit their vulnerability, or that are likely to cause them distress.

You need to be aware of and comply with any guidelines of your National Board in relation to professional boundaries.

### 4.10 Working with multiple patients

When you are considering treating multiple patients simultaneously in class or group work, or more than one patient at the same time, you should consider whether this mode of treatment is appropriate to the patients involved, including whether it could compromise the quality of care and whether confidentiality and privacy can be provided.

### 4.11 Closing or relocating a practice

When closing or relocating a practice, or when you retire or move between practices, good practice includes that you:

a. give advance notice if possible and as early as possible, and

b. facilitate arrangements for the continuing care of all current patients, including the transfer or appropriate management of all patient records, while following the law governing privacy and health records in the jurisdiction.

## 5. Working with other practitioners

Principle 5: Good relationships with colleagues and other practitioners strengthen the practitioner-patient relationship, collaboration and enhance patient care.

### 5.1 Respect for colleagues and other practitioners

Good care is enhanced when there is mutual respect and clear communication between all health professionals involved in the care of the patient.

Good practice includes that you:

a. communicate clearly, effectively, respectfully and promptly with colleagues and other practitioners caring for the patient

b. acknowledge and respect the contribution of all practitioners involved in the care of the patient, and

c. behave professionally and courteously to colleagues and other practitioners at all times, including when using social media.

### 5.2 Teamwork and collaboration

Many practitioners work closely with a wide range of other practitioners, with benefits for patient care.

Effective collaboration is a fundamental aspect of good practice and teamwork. Good patient care requires coordination between all treating practitioners. Healthcare is improved when there is mutual respect and clear, culturally safe communication, as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's health professions. Working in a team or collaboratively does not alter your personal accountability for professional conduct and the care you provide.

When working in a team or collaboratively, good practice includes that you:

a. understand your role and attend to the responsibilities associated with that role

b. advocate for a clear delineation of roles and responsibilities, including that there is a recognised team leader or coordinator even though care within the team may be provided by different practitioners from different health professions within different models of care

c. communicate effectively with other team members or practitioners, including to support continuity of care

d. inform patients about the roles of team members or other practitioners, and be clear who has ultimate responsibility for coordinating the patient's care

e. act as a positive role model for team members, and

f. support students and practitioners receiving supervision, and others within the team.

### 5.3 Bullying and harassment

There is no place for discrimination (including racism)[14], bullying[15] and harassment, including sexual harassment[16], in healthcare in Australia. Respect is a cornerstone of good practice and of patient safety. It is a feature of constructive relationships between practitioners, their peers and colleagues on healthcare teams, and with patients. Discrimination, bullying and harassment adversely affect individual health practitioners, increase risk to patients and compromise effective teamwork by healthcare teams. 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.

Good practice includes that you:

a. never engage in, ignore or excuse bullying and harassment

b. recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards colleagues and other people

c. understand social media is sometimes used as a mechanism to bully or harass, and you should not engage in, ignore or excuse such behaviour

d. act to eliminate bullying and harassment, in all its forms, in the workplace

[14] Discrimination occurs when a person, or a group of people, is treated less favourably than another person or group because of their background or certain personal characteristics. Australian Human Rights Commission (AHRC) (2014) Workplace discrimination, harassment and bullying, www.humanrights.gov.au/employers/good-practice-good-business-factsheets/workplace-discriminationharassment-and-bullying.
[15] The Fair Work Amendment Act 2013 defines workplace bullying as repeated unreasonable behaviour by an individual towards a worker which creates a risk to health and safety (AHRC, 2014).
[16] Sexual harassment is broadly defined as unwelcome sexual conduct that a reasonable person would anticipate would offend, humiliate or intimidate the person harassed (AHRC, 2014).

e. take appropriate action if you are in a leadership/management role

f. escalate your concerns if an appropriate response does not occur

g. refer concerns about discrimination, bullying or sexual harassment to National Boards/Ahpra when there is ongoing and/or serious risk to patients, students, trainees, colleagues or healthcare teams (in addition to mandatory reporting obligations), and

h. support colleagues who report bullying and harassment.

For additional guidance see the Australian Human Rights Commission Fact sheet.

### 5.4 Delegation, referral and handover

Good practice includes that you:

a. take reasonable steps to ensure that any person to whom you delegate, refer or hand over to has the qualifications and/or experience and/or knowledge and/or skills to provide the care needed

b. understand that, although as delegating practitioner you will not be accountable for the decisions and actions of those to whom you delegate, as delegating practitioner you remain responsible for the overall management of the patient and for the decision to delegate, and

c. always communicate sufficient information about the patient and the treatment needed to enable the continuing care of the patient.

## 6. Working within the healthcare system

Principle 6: Practitioners have a responsibility to contribute to the effectiveness and efficiency of the healthcare system.

### 6.1 Use healthcare resources wisely

It is important to use healthcare resources wisely.

Good practice includes that you:

a. ensure the services you provide are appropriate, necessary and likely to benefit the patient

b. uphold the right of patients to gain access to the necessary level of healthcare, and, whenever possible, help them to do so

c. support the transparent and equitable allocation of healthcare resources, and

d. understand that your use of resources can affect the access other patients have to healthcare resources.

### 6.2 Health advocacy

There are significant disparities in the health status of various groups in the Australian community. These disparities result from social, cultural, historic, geographic, environmental, physiological and other factors. Some groups who experience health disparities include Aboriginal and/or Torres Strait Islander Peoples; people with disabilities; those who are gender or sexuality diverse; and those from socially, culturally and linguistically diverse backgrounds including asylum seekers and refugees.

In advocating for community and population health, good practice includes that you use your expertise and influence to protect and advance the health and wellbeing of individuals, as well as communities and populations.

### 6.3 Public health

Practitioners have a responsibility to promote the health of the community through disease prevention and control, education and, where relevant, screening.

Good practice includes that you:

a. understand the principles of public health, including health education, health promotion, disease prevention and control, and health screening, and use the best available evidence in making practice decisions

b. participate in efforts to promote the health of the community, including through effective infection prevention and control and appropriate use of antibiotic medication, and

c. be aware of your obligations in disease prevention, including screening and reporting notifiable diseases.

## 7. Minimising risk to patients

Principle 7: Risk is inherent in healthcare, so minimising risk to patients is an important part of practice. Good practice involves putting patient safety, which includes cultural safety, first. Practitioners can minimise risk by maintaining their professional capability through ongoing professional development and self-reflection and understanding and applying the principles of clinical governance, risk minimisation and management in practice.

### 7.1 Risk management

Good practice in relation to risk management includes that you:

a. practise cultural safety as detailed in Sections 2 and 3

b. understand the importance of clinical governance[17] and your obligations, where relevant

c. participate in quality assurance and improvement systems where available

d. develop processes that minimise the risk of harm to patients and/or respond to adverse events, if you practise in a setting where local systems are not in place

e. participate in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events to the relevant authority where applicable

f. ensure systems are in place for raising concerns about risks to patients, if you have clinical leadership/management responsibilities

g. work in practice and within systems to reduce error and improve the safety of patients

h. support colleagues who raise concerns about the safety of patients, and

i. take all reasonable steps to address the issue if there is reason to think that the safety of patients may be compromised.

### 7.2 Practitioner performance

The welfare of patients may be put at risk if a practitioner is performing poorly.

If there is a risk, good practice includes that you:

a. recognise and take steps to minimise the risks of fatigue, including complying with relevant state and territory occupational health and safety legislation

b. follow the guidance in Section 9.1 (Your health) if you know or suspect that you have a health condition that could adversely affect your judgement or performance

c. take steps to protect patients from being placed at risk of harm posed by a colleague's conduct, practice or ill health (see Section 9.2 Other practitioners' health)

d. comply with statutory reporting requirements, including mandatory reporting requirements under the National Law

e. take appropriate steps to assist a colleague to get help if you have concerns about their performance or fitness to practise, and

[17] See ACSQHC National Model Clinical Governance Framework

f. seek advice from an experienced colleague, your employer/s, practitioner health advisory services, professional indemnity insurers, the National Boards/Ahpra or a professional organisation if you are not sure what to do.

### 7.3 Maintaining and developing professional capability

Maintaining and developing appropriate and current knowledge, skills and professional behaviour are core aspects of good, culturally safe practice, requiring self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes to continually develop professional capabilities. These activities must continue through a practitioner's working life as science and technology develop and society changes.

### 7.4 Continuing professional development (CPD)

Development of knowledge, skills and professional behaviour must continue throughout a practitioner's working life. Good practice involves you keeping knowledge and skills up to date to ensure that you continue to work within your competence and scope of practice. The National Law requires practitioners to do CPD. You should refer to your National Board's registration standard and guidelines on CPD for details of these requirements.

## 8. Professional behaviour

Principle 8: Practitioners must display a standard of professional behaviour that warrants the trust and respect of the community. This includes practising ethically and honestly.

### 8.1 Reporting obligations

Practitioners have statutory responsibility under the National Law to report certain matters to the National Boards/Ahpra: please refer to the Board's guidelines on mandatory reporting and Sections 130 and 141 of the National Law. Practitioners also have professional obligations to report to the National Boards/Ahpra and their employer/s if they have had any limitations placed on their practice.

Good practice includes that you:

a. are aware of these reporting obligations

b. comply with any reporting obligations that apply to your practice, and

c. seek advice from your National Board, professional indemnity insurer or other relevant bodies if you are unsure about your obligations.

### 8.2 Vexatious notifications and complaints

A vexatious complaint (notification) is one without substance, made with an intent to cause distress, detriment or harassment to a practitioner named in the notification. Legitimate complaints (notifications) are motivated by genuine concerns about patient safety.

Good practice includes that you:

a. raise genuine concerns about risks to patient safety to the appropriate authority (locally and/or the relevant National Board) and comply with mandatory reporting requirements, and

b. do not make complaints (notifications) that are vexatious or not in good faith about other health practitioners. These claims may be viewed as unprofessional conduct or professional misconduct and the Board may take regulatory action.

### 8.3 Health records

Maintaining clear and accurate health records is essential for the continuing good care of patients. You should be aware that some National Boards have specific guidelines in relation to records.

Good practice includes that you:

a. keep accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners

b. ensure that records are held securely and are not subject to unauthorised access. This includes protecting the privacy and integrity of electronic records

c. ensure that records show respect for patients and do not include demeaning or derogatory remarks

d. ensure that records are sufficient to facilitate continuity of care

e. make records at the time of events or as soon as possible afterwards

f. recognise the right of patients to access information contained in their health records and facilitate that access, and

g. promptly facilitate the transfer or management (including disposal) of health information in accordance with legislation on privacy and health records when requested by patients, or when closing or relocating a practice.

### 8.4 Insurance

You have a statutory requirement to ensure that you have appropriate professional indemnity insurance (PII) arrangements in place when you practise (see your National Board's PII arrangements registration standard).

### 8.5 Advertising

Advertisements for services can provide useful information to patients. However, advertising should not be false, misleading or deceptive, offer inducements, use testimonials, create an unreasonable expectation of benefit or encourage the indiscriminate or unnecessary use of regulated health services.

Good practice involves complying with the National Law (explained in the National Boards' Guidelines for advertising regulated health services) and relevant Commonwealth, state and territory legislation on consumer protection, fair trading and therapeutic goods advertising, and ensuring that any promotion of therapeutic products is ethical.

### 8.6 Legal, insurance and other assessments

When a practitioner is contracted by a third party to provide a legal, insurance or other assessment of a person who is not their patient, the usual therapeutic practitioner–patient relationship does not exist. In this situation, good practice includes that you:

a. apply the standards of professional behaviour described in this code to the assessment; in particular, be respectful, alert to the concerns of the person and ensure the person's consent

b. explain to the person your area of practice, role and the purpose, nature and extent of the assessment to be conducted

c. anticipate and seek to correct any misunderstandings the person may have about the nature and purpose of your assessment and report

d. provide an impartial report (see Section 9.8 Reports, certificates and giving evidence), and

e. recognise that if you discover an unrecognised, serious health issue during the assessment, you have a duty of care to inform the patient or their treating practitioner.

### 8.7 Reports, certificates and giving evidence

The community places a great deal of trust in registered health practitioners. Consequently, some practitioners have been given the authority to sign documents such as sickness or fitness for work certificates on the assumption that they will only sign statements that they know, or reasonably believe, to be true.

Good practice includes that you:

a. be honest and not misleading when writing reports and certificates, and only sign documents believed to be accurate

b. take reasonable steps to verify the content before you sign a report or certificate, and do not omit relevant information deliberately

c. if agreed, prepare or sign documents and reports within a reasonable and justifiable timeframe, and

d. make clear the limits of your knowledge and do not give opinion beyond those limits when giving evidence, whether in person or in a document.

### 8.8 Your work history

When providing information about your work history, good practice includes that you:

a. provide accurate, truthful and verifiable information about your work history, experience and qualifications, and

b. do not misrepresent by misstatement or omission your work history, experience, qualifications or position.

Also see Section 10.2 Assessing colleagues in relation to providing references for colleagues.

### 8.9 Investigations

Practitioners have responsibilities and rights relating to any legitimate investigation of their practice or that of a colleague. In meeting these responsibilities, it is advisable to seek legal advice or advice from a professional indemnity insurer.

Good practice includes that you:

a. cooperate with any legitimate inquiry into the treatment of a patient and with any complaints procedures that apply to your work

b. disclose to anyone entitled to ask for it, information relevant to an investigation into your own, or a colleague's conduct, performance or health, and

c. assist the coroner when an inquest or inquiry is held into the death of a patient by responding to the coroner's enquiries and by offering all relevant information.

### 8.10 Conflicts of interest

Patients rely on the independence and trustworthiness of practitioners for any advice or treatment offered. A conflict of interest in practice arises when a practitioner, entrusted with acting in the interests of a patient, also has financial, professional or personal interests or relationships with third parties which may affect or be perceived to affect their care of the patient.

Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise or might reasonably be perceived by an independent observer to compromise the practitioner's primary duty to the patient, practitioners must recognise and resolve this conflict in the best interests of the patient.

Good practice includes that you:

a. recognise potential conflicts of interest that may arise in relation to initiating or continuing a professional relationship with a patient

b. act in the best interests of your patients when making referrals, and when giving or arranging treatment or care

c. inform your patients when you have an interest that could affect or could be perceived to affect patient care

d. recognise that pharmaceutical and other marketing may influence practitioners, and avoid ways in which your practice may be adversely influenced

e. do not ask for or accept any inducement, gift or hospitality from companies that sell or market pharmaceuticals or other products that may affect or be seen to affect the way you prescribe for, treat or refer patients

f. do not ask for or accept fees for meeting sales representatives

g. do not offer inducements to colleagues or enter into arrangements that could be perceived to provide inducements

h. do not allow any financial or commercial interest in a hospital, pharmacy, other healthcare organisation or company providing healthcare services or products to adversely affect the way in which patients are treated. When you or your immediate family have such an interest and that interest could be perceived to influence the care provided, you must inform your patients, and

i. do not set performance targets, quotas or engage in business practices that are inconsistent with this code, and/or may impact patient safety, if you employ other registered health practitioners.

### 8.11 Financial and commercial dealings

Practitioners must be honest and transparent in financial arrangements with patients.

Good practice includes that you:

a. do not exploit the vulnerability or lack of knowledge of patients when providing or recommending services

b. do not influence patients to give, lend or bequeath money or gifts that will benefit you directly or indirectly,

c. do not pressure patients to make donations to other people or organisations

d. do not accept gifts from patients other than tokens of minimal value such as flowers or chocolates, and, if you do accept a token gift, make a file note or inform a colleague if possible

e. do not become involved financially with patients; for example, through loans and investment schemes, and

f. be transparent in financial and commercial matters relating to work, including dealings with employers, insurers and other organisations or individuals, and in particular:

- declare any relevant and material financial or commercial interest that you or your family might have in any aspect of the care of the patient, and
- declare to patients any professional and financial interest in any product or service you might endorse or sell from your practice, and do not make an unjustifiable profit from the sale or endorsement.

## 9. Maintaining practitioner health and wellbeing

Principle 9: It is important for practitioners to maintain their health and wellbeing. This includes seeking an appropriate work–life balance.

### 9.1 Your health

Good practice includes that you:

a. attend a general practitioner or other appropriate practitioner to meet your health needs

b. seek expert, independent, objective advice when you need healthcare, and be aware of the risks of self-diagnosis and self-treatment

c. understand the importance of immunisation against communicable diseases

d. ensure you are immunised against any relevant communicable diseases

e. conform to the relevant state/territory legislation on self-prescribing, if you can prescribe

f. recognise the impact of fatigue on your health and ability to care for patients, and try to work safe hours whenever possible

g. be aware of and seek assistance from any relevant practitioner health program if advice or help is needed, and

h. do not rely on your own assessment of the risk you pose to patients if you know or suspect that you have a health condition or impairment that could adversely affect your judgement, performance or the health of patients. In this case:

- consult a medical or other practitioner as appropriate about whether, and in what ways, you may need to modify practice, and follow the treating practitioner's advice, and
- be aware of your responsibility under the National Law to notify the National Boards/Ahpra in relation to certain impairments.

### 9.2 Other practitioners' health

Health practitioners have a responsibility to help their colleagues maintain good health.

Good practice includes that you:

a. give practitioners who are patients the same quality of care provided to other patients

b. take action, including a mandatory or voluntary notification to Ahpra, if you know or reasonably believe that a registered health practitioner is putting patients at risk of harm by practising with an impairment. The Ahpra website has further information on raising concerns about a practitioner via a voluntary notification, and the thresholds for making a mandatory notification in the '*Guidelines: Mandatory notifications about registered health practitioners*'.

c. recognise the effect of fatigue on the health of colleagues, including those under supervision, and facilitate safe working hours wherever possible.

## 10. Teaching, supervising and assessing

Principle 10: Practitioners should support the important role of teaching, supervising and mentoring practitioners and students in order to develop the health workforce.

### 10.1 Teaching and supervising

In teaching and supervision roles, good practice includes that you:

a. seek to develop the skills, attitudes and practices of an effective and culturally safe teacher and/or supervisor

b. as a supervisor, recognise that the onus of supervision cannot be transferred

c. make sure that any practitioner or student under supervision receives effective oversight and feedback, and

d. avoid any potential for conflict of interest in teaching or supervision relationships that may impair objectivity and/or interfere with the supervised person's learning outcomes or experience. For example, do not supervise someone with whom you have a pre-existing non-professional relationship.

### 10.2 Assessing colleagues

Assessing colleagues is an important part of making sure that the highest standards of practice are achieved.

Good practice includes that you:

a. are honest, objective, constructive and culturally safe when assessing the performance of colleagues, including students, and do not put patients at risk by inaccurate or inadequate assessment, and

b. provide accurate and justifiable information promptly and include all relevant information when giving references or writing reports about colleagues.

### 10.3 Students

Students are learning how best to care for patients. Creating opportunities for learning improves their clinical practice and nurtures the future workforce.

Good practice includes that you:

a. model professional and ethical behaviour

b. treat students with respect and patience

c. make the scope of the student's role in patient care clear to the student, to patients, and to other members of the healthcare team, as well as documenting it when appropriate, and

d. inform patients about the involvement of students and get their consent for student participation while respecting their right to choose not to consent.

## 11. Ethical research

Principle 11: Practitioners should recognise the vital role of evidence-based and ethical research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of research participants.

Research involving humans, their tissue samples or their health information is vital to improve the quality of healthcare and reduce uncertainty for patients now and in the future, and to improve the health of the population as a whole. Research in Australia is governed by guidelines issued in accordance with the *National Health and Medical Research Council (NHMRC) Act 1992 (Cth)*. If you are carrying out research, you should familiarise yourself with and follow these guidelines.

Research involving animals is governed by legislation in states and territories and by guidelines issued by the NHMRC.

### 11.1 Research ethics

Being involved in the design, organisation, conduct or reporting of health research involving humans brings responsibilities for practitioners. These responsibilities include that you:

a. accord to participants the respect and protection that is due to them

b. act with honesty and integrity

c. ensure that any protocol for human research has been approved by a human research ethics committee, in accordance with the National Statement on Ethical Conduct in Human Research issued by the NHMRC (which addresses privacy issues, and refers to the need to consider relevant state, territory and federal privacy legislation)

d. disclose the sources and amounts of funding for research to the human research ethics committee

e. disclose any potential or actual conflicts of interest to the human research ethics committee

f. ensure that human participation is voluntary and based on informed consent and an adequate understanding of sufficient information about the purpose, methods, demands, risks and potential benefits of the research

g. ensure that any dependent relationship between practitioners and their patients is taken into account in the recruitment of patients as research participants

h. seek advice when research involves children or adults who are not able to give informed consent to ensure that there are appropriate safeguards in place, including ensuring that a person empowered to make decisions on the behalf of patients has given informed consent, or there is other lawful authority to proceed

i. adhere to the approved research protocol

j. monitor the progress of the research and report adverse events or unexpected outcomes promptly

k. respect the entitlement of research participants to withdraw from any research at any time and without giving reasons

l. adhere to the guidelines regarding publication of findings, authorship and peer review, and

m. report possible fraud or misconduct in research as required under the Australian Code for the Responsible Conduct of Research issued by the NHMRC.

Refer to the NHMRC, including the publications listed above, for more guidance.

### 11.2 Treating practitioners and research

When you are involved in research that involves patients, good practice includes that you:

a. respect the right of patients to withdraw from a study without prejudice to their treatment, and

b. ensure that a decision by patients not to participate does not compromise the practitioner-patient relationship or the care of the patient.

## References

The Australian Commission on Safety and Quality in Health Care provides guidance on a range of safety and quality issues. Information of relevance to health practitioners includes:

- health literacy
- open disclosure and incident management
- hand hygiene, and
- healthcare rights.

The National Health and Medical Research Council provides information on informed consent and research issues.

The Therapeutic Goods Administration provides information on therapeutic goods.

## Definitions

**Clinical governance** describes a systematic approach to maintaining and improving the quality of patient care within a clinical setting. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services.

**Cultural safety**

This definition of cultural safety was developed for use in the National Scheme by the Scheme's Aboriginal and Torres Strait Islander Health Strategy Group in partnership with the National Health Leadership Forum.

## Principles:

The following principles inform the definition of cultural safety:

- Prioritising the Council of Australian Government's goal to deliver healthcare free of racism supported by the National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- Improved health service provision supported by the Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health
- Provision of a rights-based approach to healthcare supported by the United Nations Declaration on the Rights of Indigenous Peoples
- Ongoing commitment to learning, education and training

## Definition:

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

**Delegation** involves one practitioner asking another person or member of staff to provide care on behalf of the delegating practitioner, while that practitioner retains overall responsibility for the care of the patient.

**Electronic** means any digital form of communication, including email, online meeting technologies, internet, social media, etc.

**Handover** is the process of transferring all responsibility for a patient's care to another practitioner.

**Notification (complaint)** is the way to raise a concern about a registered practitioner's professional conduct, performance, or health. More detailed information is published on Ahpra's Concerns about practitioners page.

**Providing care** includes, but is not limited to, any care, treatment, examination, advice, service or goods provided in respect of the physical or mental health of a person, whether remunerated or pro bono.

**Practice** means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. For the purposes of this code, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that have an impact on safe, effective delivery of health services in the health profession.

**Patient** means a person who has entered into a therapeutic and/or professional relationship with a registered health practitioner. The term 'patient' includes 'clients' and 'consumers'. It can also extend to their families and carers, and to groups and/or communities as users of health services, depending on context.

**Referral** involves one practitioner sending a patient to obtain an opinion or treatment from another practitioner. Referral usually involves the transfer (in part) of responsibility for the care of the patient, usually for a defined time and a particular purpose, such as care that is outside the referring practitioner's expertise or scope of practice.

**Social media** describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips, and includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), business search and review sites such as Word of Mouth and True Local, microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards. For the purposes of this code, practice is not restricted to the provision of direct clinical care.

**Vexatious notification** is a notification without substance that does not disclose, made with an intent to cause distress, detriment or harassment to a practitioner named in the notification. Vexatious notifications can come from anyone including patients, members of the public and other practitioners.

## Review

Date of issue: TBC

Date of review: This Code of conduct will be reviewed from time to time as needed. This is generally at least every five years.

# Summary of proposed changes to shared Code of conduct

May 2021

The table below summarises the changes between the current shared Code of conduct and the draft revised shared Code of conduct.

In summary, the key proposed changes are:

- adding clear principles to guide behaviour, especially when an issue is not specifically addressed in the code
- including revised and expanded content in a new section on Aboriginal and Torres Strait Islander health and cultural safety using the agreed definition of cultural safety for use within the National Registration and Accreditation Scheme (National Scheme)
- adding content to respond to issues identified in reviews and enquiries:
  - a new section on not engaging in bullying and harassment (including through making notifications)
  - new sections on not making vexatious complaints or notifications
  - clarifying responsibilities in relation to clinical governance
- reorganising some content to reduce duplication and make the sequence more logical
- making minor changes to refine and clarify wording and expression, and
- using more active language and changing most language to refer to “you” to personalise the code, making it speak more directly to practitioners, although continuing to refer to ‘practitioners’ in the introductory sections as the audience for those sections may be broader.

In the table below, rows that are unshaded indicate no content change has been made in the draft revised shared Code of conduct, except paragraph numbering. Rows that are shaded in grey show that content changes have been made in the draft revised shared Code of conduct.

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| **Overview** | Removed – to reduce duplication |
| | Principles - addition of a summary of 11 high level-principles |
| Medical Radiation Practice Board of Australia only | Removal of medical radiation practice specific '*Appendix A Specific provisions for medical radiation practitioners*' as many of the expectations are referred to in the Professional capabilities for medical radiation practice. See questions 12 and 13 in consultation paper. |
| Paramedicine Board of Australia only | Removal of paramedicine specific text from the Overview relating to paramedics' obligation to ensure their and the public's safety before delivering clinical care as this is adequately dealt with elsewhere in the draft revised code. |
| Pharmacy Board of Australia only | Removal of pharmacy specific paragraph titled "Code of ethics for pharmacists" from the Overview section. Reference to ethical practice included under "Introduction" |
| **1. Introduction** | **Introduction** – numbering removed from entire introduction section<br>Some content moved from Overview and refreshed to reduce duplication |
| 1.1 Use of the code | Purpose of the code, Scope of the code, What the code does not do - minor wording changes to add clarity, sequence more logically and reduce duplication |
| 1.2 Professional values and qualities | Content refreshed |
| 1.3. Australia and Australian healthcare | Moved to new section (Section 2) |
| 1.4. Substitute decision-makers | Duplicate content removed |
| **2. Providing good care** | **1. Put patients first – safe, effective and collaborative practice** (renamed) |
| | **Principle 1** - added |
| 2.1. Introduction | 1.1 Providing good care – minor wording changes |
| 2.2. Good care | 1.2 Good care – minor wording changes and added references to evidence-based care and reflecting on practice |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| 2.3. Shared decision-making | Incorporated into Section 1.1 Providing good care |
| 2.4. Decisions about access to care | 1.3 Decisions about access to care – minor wording changes and some references to not discriminating removed, as now addressed in Introduction's Professional values and qualities and new Section 3 Respectful and culturally safe practice |
| 2.5. Treatment in emergencies | 1.4 No content change |
| | **2. Aboriginal and Torres Strait Islander health and cultural safety** – Section added |
| | **Principle 2 – added** |
| | 2.1 Aboriginal and/or Torres Strait Islander health – introduction wording adopted from the Code of conduct for nurses and Code of conduct for midwives, as recommended by Ahpra's Aboriginal and Torres Strait Islander Health Strategy Group. Definition of cultural safety, principles and 'how to' section incorporated using the agreed definition of cultural safety for use within the National Scheme |
| | 2.2 Cultural safety for Aboriginal and Torres Strait Islander Peoples – inclusion of the cultural safety definition for use in the National Scheme |
| | **3. Respectful culturally safe practice** – Section added |
| | **Principle 3 – added** |
| | 3.1 Cultural safety for all communities – wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.2 Effective communication – wording changes adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.3 Confidentiality and privacy – wording changes to reflect some additional material in the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.4 End of life care – wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| **3. Working with patients or clients** | **4. Working with patients** |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| 3.1. Introduction | **Incorporated in principle 4** |
| 3.2. Partnership | 4.1 Partnership – minor wording changes |
| 3.3. Effective communication | Moved to 3.2 |
| 3.4. Confidentiality and privacy | Moved to 3.3 |
| 3.5. Informed consent | 4.2 Informed consent – minor wording changes |
| 3.6. Children and young people | 4.3 Children, young people and other patients who may have additional needs (renamed) – minor wording changes and content about mandatory reporting included |
| 3.7. Culturally safe and sensitive practice | Moved to 3.1 |
| 3.8. Patients who may have additional needs | Incorporated into Section 4.3 Children, young people and other patients who may have additional needs |
| 3.9. Relatives, carers and partners | 4.4 Relatives, carers and partners – added reference to Section 3.2 Effective communication |
| 3.10. Adverse events and open disclosure | 4.5 Adverse events and open disclosure – minor wording changes to reflect the Australian Commission on Safety and Quality in Healthcare's Australian Open Disclosure Framework's definition of 'adverse event' and to provide more clarity for practitioners about how to respond and who to seek advice from when an adverse event occurs |
| 3.11. When a complaint is made | 4.6 Minor wording changes |
| 3.12. End-of-life care | Moved to 3.4 |
| 3.13. Ending a professional relationship | 4.7 No content change |
| 3.14. Understanding boundaries | 4.8 Personal relationships (renamed) – wording changes |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| | 4.9 Professional boundaries – minor wording changes |
| 3.15. Working with multiple clients | 4.10 Working with multiple patients (renamed) - no content change |
| 3.16. Closing or relocating a practice | 4.11 No content change |
| **4. Working with other practitioners** | **5. Working with other practitioners** |
| 4.1. Introduction | **Incorporated into principle 5** |
| 4.2. Respect for colleagues and other practitioners | 5.1 No content change |
| | 5.2 Teamwork and collaboration (renamed) – content from Sections 4.4. and 4.5 incorporated into new single section |
| | 5.3 Discrimination, bullying and harassment – new section includes wording adapted from the Medical and Nursing and Midwifery Boards of Australia's Codes of conduct |
| 4.3. Delegation, referral and handover | 5.4 No content change – definitions moved to Definitions section |
| 4.4. Teamwork | Incorporated into Section 5.2 Teamwork and collaboration |
| 4.5. Coordinating care with other practitioners | Incorporated into Section 5.2 Teamwork and collaboration |
| **5. Working within the healthcare system** | **6. Working within the healthcare system** |
| 5.1. Introduction | **Incorporated into principle 6** |
| 5.2. Wise use of health care resources | 6.1 Use healthcare resources wisely (renamed) - No content change |
| 5.3. Health advocacy | 6.2 No content change |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| 5.4. Public health | 6.3 Public health – added reference to using best evidence to make decisions about disease prevention and control and promoting community health through infection prevention and appropriate antibiotic use |
| **6. Minimising risk** | **7. Minimising risk to patients** (renamed) |
| 6.1. Introduction | **Incorporated into principle 7 – diagram removed as no longer necessary** |
| 6.2. Risk management | 7.1 Risk management – minor wording changes to clarify the importance of practitioners understanding obligations in relation to clinical governance, and that practitioners in leadership positions have a role to ensure systems are in place to enable risks to patient safety to be raised |
| 6.3. Practitioner performance | 7.2 Practitioner performance – points reorganised |
| **7. Maintaining professional performance** | Incorporated as section 7.3 |
| 7.1. Introduction | 7.3 Maintaining and developing professional capability |
| 7.2. Continuing professional development (CPD) | 7.4 No content change |
| **8. Professional behaviour** | **8. Professional behaviour** |
| 8.1. Introduction | **Incorporated into principle 8** |
| 8.2. Professional boundaries | Moved to 4.9 |
| 8.3. Reporting obligations | 8.1 No content change |
| | 8.2 Vexatious notifications and complaints – added new section including content from Medical Board of Australia's revised draft Code of conduct |
| 8.4. Health records | 8.3 Health records – minor wording change |
| 8.5. Insurance | 8.4 Insurance – minor wording change |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| 8.6. Advertising | 8.5 Advertising – minor wording change |
| 8.7. Legal, insurance and other assessments | 8.6 No content change |
| 8.8. Reports, certificates and giving evidence | 8.7 No content change |
| 8.9. Curriculum vitae | 8.8 Your work history (renamed) – no content change |
| 8.10. Investigations | 8.9 No content change |
| 8.11. Conflicts of interest | 8.10 Conflicts of interest – added reference to employers and performance targets and business practices |
| 8.12. Financial and commercial dealings | 8.11 Financial and commercial dealings – minor wording change |
| **9. Ensuring practitioner health** | **9. Maintaining practitioner health and wellbeing** (renamed) |
| 9.1. Introduction | **Incorporated into principle 9** |
| 9.2. Practitioner health | 9.1 Your health (renamed) – added content about immunising against relevant disease |
| 9.3. Other practitioner's health | 9.2 Other practitioners' health – clarifications to content about mandatory notifications to reflect the revised *Guidelines: Mandatory Notifications about registered health practitioners* and links to additional information provided |
| **10. Teaching, supervising and assessing** | **10. Teaching, supervising and assessing** |
| 10.1. Introduction | **Principle 10 - added** |
| 10.2. Teaching and supervising | 10.1 Teaching and supervising – minor wording change |
| 10.3. Assessing colleagues | 10.2 No content change |

| Current shared Code of conduct | Draft revised shared Code of conduct |
|---|---|
| 10.4. Students | 10.3 Added reference to modelling professional and ethical behaviour |
| **11. Undertaking research** | **11. Ethical research** (renamed) |
| | **Principle 11 - added** |
| 11.1. Introduction | Title removed – no content change |
| 11.2. Research ethics | 11.1 No content change |
| 11.3. Treating practitioners and research | 11.2 No content change |
| References | References – updated |
| Definitions | Definitions – updated including the addition of the agreed definition of cultural safety for use within the National Scheme, including principles. |
| Review | Review - updated |
| **General** | Minor wording changes throughout document following communications review to improve readability and reduce complexity of document. |

# Summary of proposed changes to Chiropractic Code of conduct

May 2021

The table below summarises the changes between the current Code of conduct for chiropractors and the draft revised shared *Code of conduct*.

In summary, the key proposed changes are:

- adding clear principles to guide behaviour, especially when an issue is not specifically addressed in the code
- including revised and expanded content in a section on Aboriginal and Torres Strait Islander health and cultural safety using the agreed definition of cultural safety for use within the National Accreditation and Registration Scheme (National Scheme)
- adding content to respond to issues identified in reviews and enquiries:
  - a new section on not engaging in bullying and harassment (including through making notifications)
  - new sections on not making vexatious complaints or notifications
  - clarifying responsibilities in relation to clinical governance
- reorganising some content to reduce duplication and make the sequence more logical
- making minor changes to refine and clarify wording and expression, and
- using more active language and changing most language to refer to “you” to personalise the code, making it speak more directly to practitioners, although continuing to refer to “practitioners” in the introductory sections as the audience for those sections may be broader.

In the table below, rows that are unshaded state no content change has been made in the draft revised shared Code of conduct, except paragraph numbering. Rows that are shaded in grey show that content changes have been made in the draft revised shared Code of conduct.

| Current Code of conduct for chiropractors | Draft revised shared Code of conduct |
|---|---|
| **Overview** | Removed – to reduce duplication |
| | Principles - addition of a summary of 11 high level-principles |
| **1. Introduction** | **Introduction** – numbering removed from entire introduction section<br>Some content moved from Overview and refreshed to reduce duplication |
| 1.1 Use of the code | Purpose of the code, Scope of the code, What the code does not do - minor wording changes to add clarity, sequence more logically and reduce duplication |
| 1.2 Professional values and qualities | Content refreshed |
| 1.3. Australia and Australian healthcare | Moved to new section (Section 2) |
| 1.4. Substitute decision-makers | Duplicate content removed |
| **2. Providing good care** | **1. Put patients first – safe, effective and collaborative practice** (renamed) |
| | **Principle 1 - added** |
| 2.1. Introduction | 1.1 Providing good care –- all areas considered to be broadly covered in shared code, wording aligned with shared code |
| 2.2. Good care | 1.2 Good care – all areas considered to be broadly covered in shared code wording aligned with shared code and added reference to reflecting on practice |
| 2.3. Shared decision-making | Incorporated into Section 1.1 Providing good care |
| 2.4. Decisions about access to care | 1.3 Decisions about access to care – minor wording changes and some references to not discriminating removed, as now addressed in Introduction's Professional values and qualities and new Section 3 Respectful and culturally safe practice |

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| 2.5. Treatment in emergencies | 1.4 No content change |
| | **2. Aboriginal and Torres Strait Islander health and cultural safety** – Section added |
| | **Principle 2 – added** |
| | 2.1 Aboriginal and/or Torres Strait Islander health – introduction wording adopted from the Code of conduct for nurses and Code of conduct for midwives, as recommended by Ahpra's Aboriginal and Torres Strait Islander Health Strategy Group. Definition of cultural safety, principles and "how to" section incorporated using the agreed definition of cultural safety for use within the National Scheme |
| | 2.2 Cultural safety for Aboriginal and Torres Strait Islander Peoples – inclusion of the cultural safety definition for use in the National Scheme |
| | **3. Respectful and culturally safe practice** – Section added |
| | **Principle 3 – added** |
| | 3.1 Cultural safety for all communities – wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.2 Effective communication – all areas considered to be broadly covered in shared code, wording changes adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.3 Confidentiality and privacy – all areas considered to be broadly covered in shared code, wording changes to reflect some additional material in the Nursing and Midwifery Board of Australia's Codes of conduct and wording added in relation to genetic information |
| | 3.4 End of life care – wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| **3. Working with patients** | **4. Working with patients** |
| 3.1. Introduction | **Incorporated in principle 4** |
| 3.2. Partnership | 4.1 Partnership – wording aligned with shared code |
| 3.3. Effective communication | Moved to 3.2 |

| | |
|---|---|
| 3.4. Confidentiality and privacy | Moved to 3.3 |
| 3.5. Informed consent | 4.2 Informed consent – all areas considered to be broadly covered in shared code, wording aligned with shared code and some content from Section 3.6 Informed financial consent incorporated |
| 3.6. Informed financial consent | Section removed – content included in Section 4.2 Informed consent |
| 3.7. Children and young people | 4.3 All areas considered to be broadly covered in shared code, children, young people and other patients who may have additional needs (renamed) – wording aligned with shared code |
| 3.8. Culturally safe and sensitive practice | Moved to 3.1 |
| 3.9. Patients with additional needs | Incorporated into Section 4.3 Children, young people and other patients who may have additional needs |
| 3.10. Relatives, carers and partners | 4.4 Relatives, carers and partners – added reference to Section 3.2 Effective communication |
| 3.11. Adverse events and open disclosure | 4.5 Adverse events and open disclosure – minor wording changes to reflect the Australian Commission on Safety and Quality in Healthcare's Australian Open Disclosure Framework's definition of 'adverse event' and to provide more clarity for practitioners about how to respond and who to seek advice from when an adverse event occurs |
| 3.12. When a complaint is made by a patient | 4.6 When a complaint is made (renamed) – minor wording changes |
| 3.13. End-of-life care | Moved to 3.4 |
| 3.14. Ending a professional relationship | 4.7 No content change |
| 3.15. Personal relationships | 4.8 Personal relationships – wording changes |
| | 4.9 Professional boundaries – minor wording changes |
| 3.16. Working with multiple patients | 4.10 Working with multiple patients (renamed) - no content change |
| 3.16. Closing or relocating a practice | 4.11 No content change |

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|---|---|
| **4. Modalities** | Section removed as content covered broadly in Principle 1 Put patients first – practise safely, effectively and collaboratively and Section 8.1 Continuing professional development (CPD). See questions 12 and 13 in consultation paper. |
| **5. Working with other practitioners** | **5. Working with other practitioners** |
| | Wording from shared code incorporated into principle 5 |
| 5.1. Respect for colleagues and other practitioners | 5.1 No content change |
| | 5.2 Teamwork and collaboration (renamed) – content from 5.3 incorporated into new section and wording from shared code on coordinating care with other practitioners incorporated |
| | 5.3 Discrimination, bullying and harassment – new section includes wording adapted from the Medical and Nursing and Midwifery Boards of Australia's Codes of conduct |
| 5.2. Delegation, referral and handover | 5.4 No content change |
| 5.3. Working with other practitioners | Incorporated into Section 5.2 Teamwork and collaboration |
| 5.4 Delegation to unregistered staff, chiropractic students and assistants | Section removed as broadly covered in Section 5.3 Delegation, referral and handover |
| **6. Working within the healthcare system** | **6. Working within the healthcare system** |
| 6.1. Introduction | **Incorporated into principle 6** |
| 6.2. Wise use of health care resources | 6.1 Use healthcare resources wisely (renamed) - No content change |
| 6.3. Health advocacy | 6.2 Include reference to Aboriginal and Torres Strait Islander peoples and wording aligned with shared code |
| 6.4. Public health matters | 6.3 Public health (renamed) – added reference to using best evidence to make decisions about disease prevention and control and promoting community health through infection prevention and appropriate antibiotic use and wording aligned to shared code. Removed reference to Chiropractic specific Appendix 1. |
| 6.5 Provision of care in a healthcare facility | Section removed |
| **7. Minimising risk** | **7. Minimising risk to patients** (renamed) |

| | |
|---|---|
| 7.1. Introduction | **Incorporated into principle 7** |
| 7.2. Risk management | 7.1 Risk management – minor wording changes to clarify the importance of practitioners understanding obligations in relation to clinical governance, and that practitioners in leadership positions have a role to ensure systems are in place to enable risks to patient safety to be raised |
| 7.3. Chiropractor performance | 7.2 Practitioner performance (renamed) – points reorganised |
| **8. Maintaining professional performance** | Incorporated as section 7.3 |
| 8.1. Introduction | 7.3 Maintaining and developing professional capability |
| 8.2. Continuing professional development (CPD) | 7.4 No content change |
| **9. Professional behaviour** | **8. Professional behaviour** |
| 9.1. Introduction | **Incorporated into principle 8** |
| 9.2. Professional boundaries | Moved to 4.9 |
| 9.3. Reporting obligations | 8.1 No content change |
| | 8.2 Vexatious notifications and complaints – added new section including content from Medical Board of Australia's revised draft Code of conduct |
| 9.4. Health records | 8.3 All areas considered to be broadly covered in shared code, health records – wording aligned to shared code |
| 9.5. Insurance | 8.4 Insurance – minor wording changes |
| 9.6. Advertising | 8.5 Advertising – wording aligned to shared code and linked to Guidelines on advertising of regulated health services |
| 9.7. Legal, insurance and other assessments | 8.6 Legal, insurance and other assessments – all areas considered to be broadly covered in shared code, minor wording changes |
| 9.8. Reports, certificates and giving evidence | 8.7 All areas considered to be broadly covered in shared code. |

| | |
|---|---|
| 9.9. Curriculum vitae | 8.8 Your work history (renamed) – no content change |
| 9.10. Investigations | 8.9 Investigations – added content in relation to cooperation with complaints procedures and disclosure of information relevant to an investigation |
| 9.11. Conflicts of interest | 8.10 Conflicts of interest – added reference to employers and performance targets and business practices |
| 9.12. Financial and commercial dealings | 8.11 All areas considered to be broadly covered in shared code, financial and commercial dealings – added content in relation to gifts |
| **10. Ensuring chiropractors' health** | **9. Maintaining practitioner health and wellbeing** (renamed) |
| 10.1. Introduction | **Incorporated into principle 9** |
| 10.2. Chiropractor's health | 9.1 Your health (renamed) - added content in relation to practitioner's who are able to prescribe and about immunising against relevant disease |
| 10.3. Other practitioner's health | 9.2 Other practitioners' health – clarifications to content about mandatory notifications to reflect the revised *Guidelines: Mandatory Notifications about registered health practitioners* and links to additional information provided |
| **11. Teaching, supervising and assessing** | **10 Teaching, supervising and assessing** |
| 11.1. Introduction | **Principle 10** - added |
| 11.2. Teaching and supervising | 10.1 Teaching and supervising – minor wording change |
| 11.3. Assessing colleagues | 10.2 No content change |
| 11.4. Students | 10.3 Added reference to modelling professional and ethical behaviour |
| **12. Undertaking research** | **11. Ethical research** (renamed) |
| | **Principle 11** - added |
| 12.1. Introduction | Title removed – no content change |

| | |
|---|---|
| 12.2. Research ethics | 11.1 Research ethics - added content in relation to disclosure of conflicts of interest |
| 12.3. Treating practitioners and research | 11.2 Treating practitioners and research – All areas considered to be broadly covered in shared code, wording aligned with shared code |
| Acknowledgements | Section removed |
| References | References – wording aligned with shared code |
| Definitions | Definitions – updated including the addition of the agreed definition of cultural safety for use within the National Scheme |
| Review | Review – updated |
| Appendix 1 Guideline in relation to health activities performed by chiropractors in a public setting | Appendix removed See questions 12 and 13 in consultation paper. |
| Appendix 2 Guideline in relation to radiology/radiography | Appendix removed See questions 12 and 13 in consultation paper. |
| Appendix 3 Guideline in relation to duration and frequency of care | Appendix removed See questions 12 and 13 in consultation paper. |
| **General** | Minor wording changes throughout document following communications review to improve readability and reduce complexity of document. |

# Summary of proposed changes to Optometry Code of conduct

May 2021

The table below summarises the changes between the current Code of conduct for optometrists and the draft revised shared Code of conduct.

In summary, the key proposed changes are:

- adding clear principles to guide behaviour, especially when an issue is not specifically addressed in the code
- including revised and expanded content in a section on Aboriginal and Torres Strait Islander health and cultural safety using the agreed definition of cultural safety for use within the National Accreditation and Registration Scheme (National Scheme)
- adding content to respond to issues identified in reviews and enquiries:
  - a new section on not engaging in bullying and harassment (including through making notifications)
  - new sections on not making vexatious complaints or notifications
  - clarifying responsibilities in relation to clinical governance
- reorganising some content to reduce duplication and make the sequence more logical
- making minor changes to refine and clarify wording and expression, and
- using more active language and changing most language to refer to “you” to personalise the code, making it speak more directly to practitioners, although continuing to refer to “practitioners” in the introductory sections as the audience for those sections may be broader.

In the table below, rows that are unshaded state no content change has been made in the draft revised shared Code of conduct, except paragraph numbering. Rows that are shaded in grey show that content changes have been made in the draft revised shared Code of conduct.

| Current Code of conduct for optometrists | Draft revised shared Code of conduct |
|---|---|
| | Principles - addition of a summary of 11 high level principles |
| **Overview** | **Introduction** (renamed)<br>Content refreshed to reduce duplication and provide clarity<br>Describes: Purpose of the code, Scope of the code, What the code does not do, Professional values and qualities |
| Australia and Australian healthcare | Moved to new Section 2 Aboriginal and/or Torres Strait Islander Peoples |
| Substitute decision-makers | Duplicate content removed |
| **1. Providing good care** | **1. Put patients first – safe, effective and collaborative practice** (renamed) |
| | **Principle 1** - added |
| 1.1. Introduction | 1.1 Providing good care – minor wording changes |
| 1.2. Good care | 1.2 Good care – minor wording changes and added references to evidence-based, patient-centred care and reflecting on practice |
| 1.3. Shared decision-making | Incorporated into Section 1.1 Providing good care |
| 1.4. Decisions about access to care | 1.3 Decisions about access to care – minor wording changes and some references to not discriminating removed, as now addressed in Introduction's Professional values and qualities and new Section 3 Respectful and culturally safe practice |
| 1.5. Treatment in emergencies | 1.4 No content change |
| | **2. Aboriginal and Torres Strait Islander health and cultural** – section added |
| | **Principle 2 – added** |
| | 2.1 Aboriginal and/or Torres Strait Islander health – introduction wording adopted from the Code of conduct for nurses and Code of conduct for midwives, as recommended by Ahpra's Aboriginal and Torres Strait Islander Health Strategy Group. Definition of cultural safety, principles and "how to" section incorporated using the agreed definition of cultural safety for use within the National Scheme |

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|---|---|
| | 2.2 Cultural safety for Aboriginal and Torres Strait Islander Peoples – inclusion of the cultural safety definition for use in the National Scheme |
| | **3. Respectful culturally safe practice** – Section added |
| | **Principle 3 – added** |
| | 3.1 Cultural safety for all communities – wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.2 Effective communication – wording changes adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.3 Confidentiality and privacy – wording changes to reflect some additional material in the Nursing and Midwifery Board of Australia's Codes of conduct |
| | 3.4 End of life care – new section wording adopted from the Nursing and Midwifery Board of Australia's Codes of conduct |
| **2. Working with patients** | **4. Working with patients** |
| 2.1. Introduction | **Incorporated in principle 4** |
| 2.2. Partnership | 4.1 Partnership – minor wording changes |
| 2.3. Effective communication | Moved to 3.2 |
| 2.4. Confidentiality and privacy | Moved to 3.3 |
| 2.5. Informed consent | 4.2 Informed consent – minor wording changes and content from Section 2.6 Informed financial consent incorporated |
| 2.6 Informed financial consent | Section removed - content included in Section 4.2 Informed consent |
| 2.7. Children and young people | 4.3 Children, young people and other patients who may have additional needs (renamed) – minor wording changes, content about capacity for consent moved to Section 4.2 Informed consent and content about mandatory reporting included |
| 2.8. Culturally safe and sensitive practice | Moved to 3.1 |

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|---|---|
| 2.9. Patients who may have additional needs | Incorporated into Section 4.3 Children, young people and other patients who may have additional needs |
| 2.10. Relatives, carers and partners | 4.4 Relatives, carers and partners – added reference to Section 3.2 Effective communication |
| 2.11. Adverse events | 4.5 Adverse events and open disclosure (renamed) – minor wording changes to reflect the Australian Commission on Safety and Quality in Healthcare's Australian Open Disclosure Framework's definition of 'adverse event' and to provide more clarity for practitioners about how to respond and who to seek advice from when an adverse event occurs |
| 2.12. When a notification is made | 4.6 When a complaint is made (renamed)– minor wording changes |
| 2.13. Ending a professional relationship | 4.7 No content change |
| 2.14. Personal relationships | 4.8 Personal relationships - minor wording changes and addition of requirements for provision of care |
| | 4.9 Professional boundaries – wording changes (moved from Section 7.2) |
| 2.15. Closing or relocating a practice | 4.11 Closing or relocating a practice - wording streamlined |
| 2.16. Working with multiple patients | 4.10 Working with multiple patients - wording streamlined |
| **3. Working with other practitioners** | **5. Working with other practitioners** |
| 3.1. Introduction | **Incorporated into principle 5** |
| 3.2. Respect for colleagues and other practitioners | 5.1 No content change |
| | 5.2 Teamwork and collaboration (renamed) – content from Sections 3.4. and 3.5 incorporated into new single section and content in relation to social media and supervision added |
| | 5.3 Discrimination, bullying and harassment – new section includes wording adapted from the Medical and Nursing and Midwifery Boards of Australia's Codes of conduct |
| 3.3. Delegation, referral and handover | 5.4 No content change – definitions moved to Definitions section |
| 3.4. Teamwork | Incorporated into Section 5.2 Teamwork and collaboration |

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| 3.5. Coordinating care with other practitioners | Incorporated into Section 5.2 Teamwork and collaboration |
| **4. Working within the healthcare system** | **6. Working within the healthcare system** |
| 4.1. Introduction | **Incorporated into principle 6** |
| 4.2. Wise use of health care resources | 6.1 Use healthcare resources wisely (renamed) - No content change |
| | 6.2 Health advocacy – section added |
| 4.3. Public health | 6.3 Public health – added reference to using best evidence to make decisions about disease prevention and control and promoting community health through infection prevention and appropriate antibiotic use |
| **5. Minimising risk** | **7. Minimising risk to patients** (renamed) |
| 5.1. Introduction | **Incorporated into principle 7** |
| 5.2. Risk management | 7.1 Risk management – minor wording changes to clarify the importance of practitioners understanding obligations in relation to clinical governance, and that practitioners in leadership positions have a role to ensure systems are in place to enable risks to patient safety to be raised |
| 5.3. Practitioner performance | 7.2 Practitioner performance – points reorganised |
| **6. Maintaining professional performance** | Incorporated as section 7.3 |
| 6.1. Introduction | 7.3 Maintaining and developing professional capability |
| 6.2. Continuing professional development | 7.4 Continuing professional development (CPD) - content streamlined by referencing the CPD registration standards and guidelines and removing content found in those documents |
| **7. Professional behaviour** | **8. Professional behaviour** |
| 7.1. Introduction | **Incorporated into principle 8** |
| 7.2. Professional boundaries | Moved to 4.9 |

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|---|---|
| 7.3. Reporting obligations | 8.1 No content change |
| | 8.2 Vexatious notifications and complaints – added new section including content from Medical Board of Australia's revised draft Code of conduct |
| 7.4. Health records | 8.3 Health records – minor wording change |
| 7.5. Insurance | 8.4 Insurance – minor wording change |
| 7.6. Advertising | 8.5 Advertising – minor wording change |
| 7.7. Legal, insurance and other assessments | 8.6 No content change |
| 7.8. Reports, certificates and giving evidence | 8.7 Reports, certificates and giving evidence - minor wording changes |
| 7.9. Curriculum vitae | 8.8 Your work history (renamed) – minor wording changes |
| 7.10. Investigations | 8.9 No content change |
| 7.11. Conflicts of interest | 8.10 Conflicts of interest – added reference to employers and performance targets and business practices |
| 7.12. Financial and commercial dealings | 8.11 Financial and commercial dealings – minor wording change |
| **8. Ensuring health** | **9. Maintaining practitioner health and wellbeing** (renamed) |
| 8.1. Introduction | **Incorporated into principle 9** |
| 8.2. Personal health | 9.1 Your health (renamed) – added content about immunising against relevant disease |
| 8.3. Colleagues' health | 9.2 Other practitioners' health (renamed) – clarification to content about mandatory notifications to reflect the revised *Guidelines: Mandatory Notifications about registered health practitioners* and links to additional information provided |
| **9. Teaching, supervising and assessing** | **10. Teaching, supervising and assessing** |

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| 9.1. Introduction | **Principle 10 - added** |
| 9.2. Teaching and supervising | 10.1 Teaching and supervising – minor wording change and addition of content about conflict of interest in teaching and supervising |
| 9.3. Assessing colleagues | 10.2 No content change |
| 9.4. Students | 10.3 Students – addition of content about modelling professional and ethical behaviour |
| **10. Undertaking research** | **11. Ethical research** (renamed) |
| | **Principle 11 - added** |
| 10.1. Introduction | Title removed – no content change |
| 10.2. Research ethics | 12.1 No content change |
| 10.3. Treating optometrists and research | 12.2 Treating practitioners and research (renamed) - no content change |
| | References – included |
| | Definitions – updated including the addition of the agreed definition of cultural safety for use within the National Scheme |
| | Review - included |
| **General** | Minor wording changes throughout document following communications review to improve readability and reduce complexity of document. |