



Shared code of conduct: public consultation

Introduction

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

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

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

Publication of responses

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

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

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 These submissions will not be published on the website or elsewhere.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

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

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

Please do **not** publish my responses

About your responses

Are you responding on behalf of an organisation?

- Yes
 No

Please provide the name of the organisation.

Indigenous Allied Health Australia (IAHA)

Which of the following best describes your organisation?

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

Please describe your organisation.

Aboriginal and Torres Strait Islander health workforce and capacity development organisation

Your contact details

First name:

[REDACTED]

Last name:

[REDACTED]

Email address:

[REDACTED]

Which of the following best describes you?

This question was not displayed to the respondent

Q45. Please describe.

This question was not displayed to the respondent

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

This question was not displayed to the respondent

Q46. Please describe.

This question was not displayed to the respondent

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

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

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

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

IAHA strongly supports the application of a common Code to Conduct for health practitioners and the emphasis it places on patient care as the primary objective, with lesser focus on the details of specific clinical or other aspects of health practice. The principles as described are clear. The short form description, accompanying precis and further detail in the body of the Code provide options to meet users' specific needs. If a reader of the Code requires further information, they might be referred to additional resources held on the Ahpra website or elsewhere. Specific comments on aspects of the Principles follow: 1.2 Providing good care (page 30) Point b) could also reference cultural safety and point k) could add patient resources/strengths as potential resources available to practitioners. 1.3 Decisions about access to care Point d) could be split into 2 parts - "... treatment; and not provide..." this may help emphasise clinical considerations from considerations open to bias or assumptions about particular groups. Both need to be considered without being conflated. There is a large body of evidence of Aboriginal people (among others) receiving very differential treatment to non-Indigenous Australians, apparently associated with stereotyping and assumptions. 4. "Working with patients" - The elements of respect, trust and effective communication might be extended to include an expectation these should apply across the services and systems in which practitioners work. 4.6 Complaints (page 36): we suggest adding a reminder for practitioners that a complaint should not impact the quality of care or treatment of the complainant moving forward. 4.10 Working with multiple patients (page 38): Suggest this advice be expanded to consider patient perspectives clearly and to consult with them/seek cultural advice – such as whether it is culturally appropriate for females and males to be in the same room; whether cultural norms forbid some members of a family (same sex or otherwise) from being present together etc. 5.2 Teamwork and collaboration (page 39): IAHA strongly supports an emphasis on team-based care in the Code. Without implying anything reduced the onus on practitioners to meet this aspect of the Code, there are serious issues where health system operations, funding and other arrangements do not support and can inhibit practitioner teamwork and collaboration. This is an area where practitioners might require some assistance or resources to ensure they comply as best they can. • For example, a patient with complex and multiple co-morbidities may require treatment from several medical, nursing and allied health practitioners. Assuming the patient has access to these professionals (which is unlikely in many situations) the medical practitioner (in private and community settings especially) may be the only practitioner able to access funding to support treatment. • The Code rightly (in terms of patient care) would expect participation by, for example a physio, nutritionist and psychologist, but some or none of them might be paid to participate. This is a particular risk for people with limited personal financial resources. Similarly, communication between health practitioners between and across sectors appears to lack the necessary practical systemic supports (policy, procedural, resourcing or other) to enable practitioners to meet the Code's expectations. • The 2021-22 Commonwealth Budget measure to introduce a limited number of consultation items under MBS for allied health practitioners, will help, but not resolve this issue. Similarly, a renewed focus on this aspect of the Code may lead to an increase in referral activity (with the most obvious and trackable being MBS referrals). Monitoring and reporting of this sort (by Dept Health if not Ahpra) may help to identify improvements in collaborative practice and/or potentially highlight situations where health workforce and service shortages are impeding practitioners capacity to apply the Code in practice. There is a case for Ahpra and the Boards to identify these issues and refer them to Departments and Ministers. 6. Working within the healthcare system – notwithstanding one view that the "healthcare system" encompasses any service setting where a (registered) practitioner provides professional care, it may be useful to clarify this in the Code, noting aged care and disability services for example. 6.1: Use healthcare resources wisely - (especially points c and d.- re: equitable allocation and use of resource): these are both extremely important from a policy, service level and systems view and, while individual practitioners should certainly consider and adhere to these aspects of the Code, there could be a stated expectation that others with decision-making and allocation responsibilities across the system to enable practitioners to exercise this obligation. 6.2: Health Advocacy: the health disparities and associated factors identified in 6.2 are important. The intersecting implications of these factors, together with resourcing profiles and decisions have a direct impact on such disparities. As with 6.1, individual practitioners have a responsibility to practice with regard to these factors and to seek out practical assistance to address the disparities and impacts in their care: but the onus must be shared with policy, service and system administrators. It would be appropriate for reference to be made to the issue and reasonable expectations for practitioners to be enabled to deliver more equitable care and outcomes This broader obligation might be references but not necessarily detailed in this Code of Conduct. A further point to add in the Code (in 6.2, and other sections), is to recognise patient strengths, including those of family, community and culture in delivering responsiveness and effective care. 7.3 Maintaining and developing professional capability (page 42). Suggest a sentence be added to include changes in practice and context setting, including population and cultural settings/engagement. 11 and 11.1 – Research (page 49): In line with Ahpra and the National Boards' commitment to improve cultural safety in health practice, there is also a need to reinforce cultural safety in the design and conduct of health and medical research. The NHMRC has taken steps to improve quality of engagement and impact of research with and for Aboriginal and Torres Strait Islander people, however further improvement in all aspects of research activity, is needed. Researchers could be encouraged to refer to other sites, such as Ethics Hub | Lowitja Institute and to note the likelihood that most health and medical research will have implications, at least indirectly to Aboriginal and Torres Strait Islander people, in respect of issues such as Indigenous data sovereignty and the increasing focus on genomics etc.

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?

The suggested use of patient to cover other terms (such as customer, client etc) should be handled carefully. It may be feasible provided the scope of meaning is well and comprehensively articulated up front. Issues to note include: Health practitioners are very active across other major service systems such as aged care, disability services, mental health, childhood development etc. where the term patient may be used rarely and the term may be rejected by users of some of those services as pejorative or inaccurate. Some people may feel the term inappropriately labels them and their circumstances. For many Aboriginal and Torres Strait Islander people concepts of health and wellbeing are inherently tied to the broader wellbeing of their family and community. IAHA believes it is imperative that the Code reinforces practitioner understanding, attitudes and behaviours that are a) patient-centric and deal with the whole person while also b) work with the individual in the context of their family and community context and perspectives. This is consistent with the Code's expectations around cultural safety. Consequently, if the term "patient" is to be applied as the standard, users of the Code would need to be very aware patient refers to more than an individual. Also, under Cultural safety for all communities (page 32) – suggest point c) could read acknowledge the family, social, economic, cultural etc" (and, again, this also be a feature of policy and service decision-making)

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?

IAHA strongly supports the reinforced material on Aboriginal and Torres Strait Islander health and cultural safety. This is an important step in making clear the expectations that apply to health practitioners and the system more broadly. This should result increased effort to address the cultural and structural barriers to quality health care access, including racism. IAHA notes the content has been drawn from the important and extensive development and consultation process overseen by the Ahpra Aboriginal and Torres Strait Islander Strategy Group, working with Aboriginal and Torres Strait Islander stakeholders among others. The agreed outcomes of that process should be respected. IAHA agrees with the National Boards' assessment (page 16) of the importance and potential impact of the Code in this respect. While the new Code clarifies expectations the content primarily addresses the risk of deficient practice to date and describes a standard of care that practitioners should have been aiming to meet. IAHA also notes the comments on the nature of racism in the paper, including the importance of recognising systemic and other forms of racism, which need not be overt. Exclusion can be reinforced by the absence of culturally identifiable materials and information, deficits-based assumptions and stereotypes. An example of behaviour that can reinforce the impact of racism: a survey of IAHA found that many members had experienced public incidents in the work and education space which they considered to be racist. In a significant number of cases someone else would intervene to provide support, but that support would rarely come from a non-Indigenous person. Recent matters considered by the Medical Board, for example, also illustrate the devastating impact practitioner assumptions can have on Aboriginal and Torres Strait Islander people. Such incidents continue to be reported across the health system, despite efforts to address the problem. It is imperative that the Code provides and is supported by very clear and comprehensive resources and practices to avert further incidents of this kind. Point 3.4 End-of-life care – suggest culturally appropriate be replaced with safe – consistency of terminology, especially important at this stage. Point c) could add understandings and beliefs. Case Studies and guidance with the purpose of increasing practitioners understanding of this issue could be a valuable complement to the Code.

Q49.

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

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

The response to the previous question is relevant here. Again, there may be value in adding Case Studies to help practitioners identify situations where their own beliefs (e.g. religious, in relation to sexual conduct etc) might influence their treatment of a patient. In such cases, the Code could give guidance, at least in terms of an obligation to refer, to ensure patient's rights, health and wellbeing are not compromised. In terms of bullying and harassment, this could be seen as a component of practice where a practitioner chooses to not consult with other practitioners who are, or should be, involved in patient's care. This fundamentally relates to the quality of care provided to the person receiving care and their rights, but also has implications in terms of a lack of respect and exclusion of other practitioners where clinical considerations might strongly indicate consultation is required. The Code might be drawn on as a way to promote better quality, patient-outcome driven collaboration, with monitoring and analysis to identify the extent of the issue and a program to be developed to address it.

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

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

Refer to comments above.

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

Is this section clear? Why or why not?

IAHA appreciates the rationale for this requirement and supports it in-principle. However, there will; be circumstances, especially in close culturally connected, small and/or isolated communities where access to health services and practitioners is extremely limited, especially culturally safe services. In these circumstances people and practitioners may have little alternative to working with family or close kinship members. Further, there will also be situations in communities where it is not appropriate culturally for a practitioner to treat an individual, and this also serious risks in terms of access to care. These issues might be explored in supporting material to the Code. Additionally, Ahpra and the Boards might consider whether these risks (especially for communities with limited health service access) should be assessed in terms of Ahpra's role in protecting the health of the public, or whether the matter might be raised with another authority to address.

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

Plain English is essential. Other, more diverse means of communication should also be used to promote access, understanding and use of the Code by many communities, especially those who are most disadvantaged with regard to health care access and outcomes now. Clear, concise pictorial, spoken or other materials informing the public about the Code should be considered, in consultation with representative stakeholders.

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

The code is reasonably clear and concise for a mainstream audience. Further support material and approaches, such as identified in response to question 7 above would improve the Code.

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

IAHA encourages Ahpra and the Boards to maintain a process of regular wide-ranging consultation, especially to capture detailed input from stakeholders who experience poor access to quality and safe health services and poorer outcomes as a result; Aboriginal and Torres Strait Islander people among others. This might require a broader and more active consultation process. This should be a priority and deliberate process of ongoing quality improvement. The paper notes (page 11) "The Code of conduct is scheduled for regular review and the National Boards and Ahpra will monitor for any unintended impacts that may arise as a result of the proposed changes." Revisions to the Code are meant to address very substantial discrepancies in the access, quality of services and outcomes achieved through Australia's health system. The agenda has been supported by Health Ministers. IAHA believe implementation of the Code should be monitored closely and supported actively, to ensure opportunities to clarify, refine, develop effective support materials and resources are acted on as a priority. There is a risk, for example, that some practitioners may be uncertain or feel incapable of delivering culturally safe and responsive care to Aboriginal and Torres Strait Islander people. With a more explicit expectation that they do meet such a standard, some may opt to avoid treating this population. That would be a perverse outcome and should be prevented. IAHA encourages implementation of an active and ongoing program of support and review, at least until a formal review is undertaken (in 2 or 3 years' time). Oversight of the process might sit with (or closely involve) Ahpra's Aboriginal and Torres Strait Islander Health Strategy Group. The process may identify and/or substantiate other issues that have adverse impacts on public health and the protection of it. Some of these may not be Ahpra's direct responsibility but will impact on how effectively Ahpra's activities translate to improved health and wellbeing for the community. IAHA supports the use of Case Studies, but questions the usefulness of the Case Studies provided (pages 7-9). It may be that the matters covered in the current Case Studies were identified in consultations or other enquiries and notifications to Ahpra. However, they seem to address relatively straightforward issues and may be of limited value to many practitioners dealing with more complex concerns. It may be helpful to add Case Studies that help practitioners navigate or deal with more complex situations; such as relate to cultural safety and responsiveness, practitioner roles in health advocacy; expectations around team-based patient-centred collaboration and the like. A more extensive and nuanced set of Case Studies might be developed and available as reference material to aid practitioners committed to applying the Code to best effect. IAHA suggests the Code include a section dealing with the scope of Ahpra's role in protecting the public. For example, does the protection extend to members of the public who are unable to, or who have no reasonable capacity to, access services provided by registered health professionals? If not, what are the limits of Ahpra's remit and those of the Code? Re: the Code not being a "charter of rights" (top of page 28): This section is potentially confusing and seems to accentuate what the Code is not. This paragraph might be usefully expanded to clarify what the Code means for members of the public in terms of access and treatment. If those matters are meant to be covered by the ACSQHC Charter, a clear statement of that, together with a description of how the Code and the Charter interrelate would be very helpful. As described in this section the "focus of the code is on good practice and professional behaviour" and is "not intended as a mechanism to address" disputes between professional colleagues or employment issues. Earlier, the Case Studies seem to include examples of where these issues are a focus. The next paragraph on page 28 begins "When providing care, practitioners have a duty to make patients care their first concern ..." but this is not a strong focus of the current Case Studies. Scope of the code (page 27): The Code should also make it clear up-front who practitioners and members of the public can go to if they feel the Code is not being applied/met.

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

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

There may be additional costs for some practitioners to ensure they meet the standards of the Code as proposed. IAHA agrees with the National Boards' Assessment (page 20) that the "likely costs are minimal". If significant concern is expressed by practitioners, several factors might be considered in shaping Apha and the Boards' response. • To what extent does the change impose an increase in expectations and acceptable practice and/or a clarification about the standard of care that should have applied already? • If there are legitimate extra costs for practitioners, how does the impact of those costs compare with the human and resource of not addressing the issue(s)? • In the above situation, what share of the cost should reasonably be borne by practitioners (individually and/or as a profession); Ahpra; governments; educators/regulators/CPD providers; the community? Importantly, any consideration of regulatory burden must take account of the purpose and effectiveness of that regulation. Ahpra's regulatory responsibilities exist to protect the public. Regulation must aim to achieve its purpose with the minimum imposition on practitioners. If public protection is not strengthened or is compromised through a change in regulation it cannot be justified. As noted elsewhere, the enhanced Code could lead to some practitioners becoming more reluctant to provide care in some situations. This would be a perverse and counter-productive outcome. Close monitoring and a plan for action is needed to ensure this does not occur. The downstream system and personal costs of poor quality and/or inadequate care should also be considered. The revised Code may incur some risks and costs within the National Scheme, however, an inadequate Code will increase the risk of costs being borne across the system (externally to NRAS), such as in preventable hospitalisations, lost of health and income by patients etc.

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

See above

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.

See above and response to Question 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.

See above, especially the response to Question 3 and other comments about health care access, safety, responsiveness and outcomes for Aboriginal and Torres Strait Islander people in Australia. It would be appropriate for the impact of the revised Code on these issues to be monitored closely, assessed and reported on in recognising its relevance to the National Cabinet and Council of Peaks agreement on Closing the Gap.

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

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

- No
 Yes

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

Many of these expectations relating to the Appendices are referred to more broadly in the revised shared code and/or are largely replicated in other relevant board documents such as the recently revised [Guidelines for advertising a regulated health service](#) (Appendix 1) and the [FAQ: chiropractic diagnostic](#)

[imaging](#) (Appendix 2). It is proposed that the appendices and section on modalities be removed and additional guidance on these areas be presented in additional guidelines or similar.

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

This question was not displayed to the respondent

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

This question was not displayed to the respondent

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

- No
 Yes

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

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

This question was not displayed to the respondent

Q24.

Thank you!

Thank you for participating in the public consultation.

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

