Ahpra & National Boards

Report on public consultation on review of the shared Code of conduct

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Contents

Background on the shared Code of conduct

Purpose of the shared Code of conduct

The shared Code of conduct (shared code) 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 because it can help them understand what behaviour they can expect from a registered health practitioner and assess whether their care met professional standards.

The following National Boards have a shared code, most in the same form and five with minor variations:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Chiropractic Board of Australia
- Dental 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

The shared code was first developed in mid-2010 for the start of the National Registration and Accreditation Scheme (National Scheme). The first version of the shared code was adapted from the Medical Board of Australia's Code of conduct Good medical practice. A revised version was published in March 2014[1] after a review.

In 2017 the relevant National Boards started a scheduled review of the shared code. In 2018 the review was paused while the definition of cultural safety for the National Scheme was developed. National Boards and Ahpra launched the Aboriginal and Torres Strait Islander Health and Cultural Strategy which includes the definition in early 2020.

Purpose of the report on public consultation

This report describes the consultation process for the review of the shared code, summarises the responses received from public consultation and how these responses were considered in the development of the revised shared code.

[1] By most National Boards.

Development of the revised shared Code of conduct

As part of the development of the revised shared code the National Boards considered the objectives of the National Scheme, the guiding principles set out in the National Law and the Regulatory principles for the National Scheme (regulatory principles). In developing the shared code, the National Boards aimed to:

- protect the public by ensuring National Boards' expectations of professional standards are clearly communicated
- consider the potential risks to the public including members of the community vulnerable to harm and to Aboriginal and Torres Strait Islander Peoples
- strengthen their risk-based approach to the shared code, and
- work with practitioners and their representatives and consumers to develop a clear, contemporary and user-friendly shared code.

The Australian Health Practitioner Regulation Agency's (Ahpra) Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) provided advice on the cultural safety content in the revised shared code. The Strategy Group consists of Aboriginal and Torres Strait Islander health sector leaders and representatives from:

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

The revised shared code includes the definition of cultural safety for use within the National Scheme. The definition was developed by the Strategy Group in partnership with the National Health Leadership Forum following consultation in 2019. The consultation report on the definition of cultural safety is published on the Past consultations page.

How we consulted

The National Boards carried out preliminary consultation with key stakeholders in mid-2020. The Commonwealth Office of Best Practice Regulation (OBPR) was consulted during preliminary consultation to assess the potential for any significant regulatory impacts. The OBPR advised that a Regulation Impact Statement was not needed.

National Boards worked with several professional associations and consumer health groups to carry out focus groups with practitioners and members of the public about the shared code in 2020 and 2021.

Public consultation on the shared code was open from 11 May 2021 to 6 July 2021 to ensure wide-ranging consultation on proposed changes. The public consultation was announced in a media release, news items on Ahpra's and each participating National Board's webpage, promoted on social media and via email to National Board and Ahpra stakeholders. National Boards and Ahpra invited feedback from practitioners, stakeholders and the community.

Information about public consultation included in the announcements explained how stakeholders could participate and included a link to the Ahpra public consultation webpage. The Ahpra webpage included a link to the public consultation paper and an online questionnaire as well as a narrated presentation. The option to give written feedback via email was also available.

The public consultation paper asked open-ended questions about the content, structure and useability of the shared code in addition to some questions about specific issues. Questions were also included about possible adverse cost impacts and unintended consequences for members of the community vulnerable to harm and for Aboriginal and Torres Strait Islander Peoples. Responses to these questions have been addressed in the Patient and Consumer Health and Safety Impact Assessment and published on the Past consultations page.

National Boards and Ahpra sincerely thank the members of the public, practitioners and stakeholders for their feedback on the revised shared code.

Overview of public consultation responses

Feedback was received from 65 external stakeholders showing strong engagement and interest in the content matter and proposed changes. A breakdown of submissions by source is outlined in Table 1. 36 responses were received via the online survey and 29 via email. One submission received from a medical practitioner addressed wider issues about the National Scheme and was not specific to the consultation.

Further breakdown of submissions indicating the stakeholders' profession are included in Tables 2 and 3.

Table 1: Breakdown of submissions

Source	No. of submissions
Commonwealth/state/territory department	10
Consumer organisation	4
Healthcare organisation	36
Ombudsman	1
Practitioner	10
Public	3
Student	1
Total	**65**

Table 2: Submissions from healthcare organisations

Number of submissions from organisations by profession.

Profession	No. of submissions
Aboriginal and Torres Strait Islander Health Practice	1
Chinese Medicine	3
Chiropractic	1
Dental	5
Medical Radiation Practice	4
Nursing & Midwifery	1
Occupational Therapy	1
Osteopathy	1
Optometry	2
Paramedicine	1
Pharmacy	7
Physiotherapy	4
Podiatry	2
Multiprofession	3
Total	**36**

Table 3: Practitioner and student submissions by profession

Number of submissions from individuals by profession.

Profession	No. of submissions
Chinese medicine	1
Dental	2
Medical	1
Medical radiation practice	1
Optometry	1
Pharmacy	2
Physiotherapy	1
Chinese medicine/medical radiation practice – dual registered	1
Student – Medical radiation practice	1
Total	**11**

Analysis of responses

A thematic analysis was carried out of feedback received from the public consultation. The analysis is included in Table 4 below.

Table 4: Thematic analysis

Theme	Feedback
Principles	Most stakeholders supported including shorter, more concise principles. A small number of stakeholders suggested the principles could better align with content and some suggestions for minor edits to improve clarity and readability were given.
Term used to describe recipient of care	Most stakeholders preferred the term 'patient' or 'patient/client'. Remaining stakeholders supported various options including consumer, client, person/people or combinations of these terms.
Cultural safety	Including a separate section on cultural safety for Aboriginal and Torres Strait Islander Peoples was strongly supported. Several stakeholders commended National Boards for its inclusion. A small number of stakeholders recommended National Boards develop additional guidance about applying cultural safety in practice.
Respect and safety	Several stakeholders suggested including a more complete list of those who it is unlawful to discriminate against. Comments were included about the need to strengthen the references to 'discrimination' and to develop a single section about respect and safety rather than including guidance in relevant sections.
Bullying and harassment	Stakeholders suggested including more information about when and how National Boards will deal with bullying and harassment. Some stakeholders suggested that more detailed guidance should be included about how to address bullying and harassment and practitioner obligations in relation to bullying and harassment.
Personal relationships	Stakeholders recommended strengthening the guidance to more clearly call out that providing care to those in a close relationship should be avoided. Stakeholders suggested adding more detailed guidance about the risks associated with different types of close relationships, identifying other options prior to providing care to those in close relationships and referring the patient if care is discontinued.
Language, structure and content	Minor formatting changes were suggested to improve navigation. A review of language to promote consistent use of terms and the inclusion of additional definitions was suggested to improve clarity. Some minor edits to content were suggested to expand on guidance in the code and provide more information for practitioners, including: • adding references to other relevant and appropriate sources of guidance i.e. Ahpra and other relevant organisations • rewording or including guidance in some sections that emphasises the need to act.

Theme	Feedback
Other feedback	Some stakeholders recommended developing supplementary material to assist practitioners understanding and compliance with the shared code including: • culturally safe care • the obligation to refer if the practitioner's beliefs are impacting on or restricting patient care • providing care to those in a close personal relationship • informed consent, and • directing and/or inciting a practitioner to engage in unprofessional conduct/professional misconduct.
Awareness	Some stakeholders noted that the shared code is an important document that contributes to patient safety particularly for members of the community who are more vulnerable to harm. Many stakeholders noted that practitioners and the public would benefit from greater awareness of the shared code and its content. A few stakeholders noted that the shared code was developed with practitioners as the primary audience and recommended developing a version of the code for the public. Comments were also received that different stakeholder cohorts get information about healthcare via different channels and suggestions made to use varied approaches to promote the code.
Chiropractic version of the code	Stakeholders supported removing the profession-specific appendices in the current shared code from the revised shared code in favour of including the information in standalone resources where evidence supported the need for additional guidance.
Medical radiation practice version of the code	Stakeholders supported removing the profession-specific appendices in the current shared code from the revised shared code noting that information about capabilities are found in the professional capabilities for medical radiation practice. Stakeholders supported including profession-specific guidance in standalone resources where evidence supported the need for additional guidance.
Potential adverse cost implications and negative or unintended consequences	Stakeholders did not identify any significant adverse cost implications. It was suggested that some practitioners may need training in cultural safety. Stakeholders recommended that National Boards should promote the revised code and additional supporting resources to make the transition to the revised version easier. Stakeholders did not identify any negative or unintended consequences other than those raised in relation to topics above.

Summary of changes

The following is a high-level summary of the changes that have been made to the revised shared code following consultation.

1. Structuring the revised shared code around principles that are an overarching guide to behaviour especially when an issue is not specifically addressed in the shared code.
2. Replacing 'patient or client' with the single term 'patient' with a definition in the 'Note on terminology' section which includes consumers and clients.
3. Adding a section about culturally safe and respectful practice for Aboriginal and Torres Strait Islander Peoples that includes the National Scheme's definition of cultural safety.
4. Adding a section about discrimination, bullying and harassment.
5. Strengthening the section on providing care to someone in a close personal relationship.
6. Adding content about practitioners' responsibilities in relation to clinical governance, vexatious complaints/ notifications, cooperating with legitimate investigations and, for practitioners who are employers, about setting performance targets/business practices that are inconsistent with the shared code.
7. Reviewing references to complaints and notifications throughout the code to align with the *Concerns about practitioners* section of Ahpra's website.
8. Adding guidance to the advertising section to better align with content in the Guidelines for advertising a regulated health service (advertising guidelines) about offering a gift, discount or other inducement.
9. Edits to some content to emphasise the need to act.
10. Including additional references to other relevant and appropriate sources of guidance.
11. Reorganising content to reduce duplication, making the sequence more logical and making minor changes to refine and clarify wording and expression.
12. Revising headings, language, terminology and formatting throughout to improve plain language, readability and consistency.

Conclusion

National Boards have carefully considered a wide range of views on the proposed revised shared code. The National Boards have now approved the final version of the shared code and consider that the revised shared code more clearly explains National Boards' expectations of practitioners' conduct and is more contemporary and user-friendly.

Next steps

National Boards and Ahpra have identified that some of the feedback from public consultation (such as the development of case studies and additional explanatory material about specific topics) could be more appropriately addressed in separate resources.

This approach will allow for the resources to be updated more regularly, for consideration of post implementation monitoring, the development of profession-specific material where needed, and will ensure that the revised shared code does not increase in length or complexity.

National Boards and Ahpra will also develop specific resources for the public about the shared code.

The Boards and Ahpra will regularly review the shared code so that it stays current, relevant and effective.