Shared Code of Conduct Review

Date: Monday 5th July 2021

Lead Contributors

[redacted]

[redacted]

The Australasian College of Paramedicine (the College) welcomes the opportunity to make a submission in relation to the shared code of conduct review.

The College is the peak professional association supporting and representing over 11,000 paramedics and student paramedics from across Australia and New Zealand. Our members include paramedics at all clinical levels, paramedicine academics and researchers, student paramedics, doctors and nurses working in the emergency medicine field, non-paramedic qualified staff working in paramedicine, retrievalists, first responders and volunteers.

Code of conduct review - submission template

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?**
We support the use of high-level principles in the revised code. The combination of the shorter and more detailed explanations clarifies understanding of the Boards' intention. By adding extra detail there is a risk that the message may become drowned in the information and may lead to confusion.
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?**

The term 'patient' is the term that is most likely to be understood by the public to refer to people (and their family and support) accessing health care. As such it is appropriate.

However, we acknowledge that varied terms such as client are now used, and this move is linked to the empowerment of end users. It would be important therefore that this empowerment is supported through any terminology. This could occur through defining any terms used.

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?

This section is clear and easy to understand. Going beyond the definition and describing what culturally safe and respectful practice is, will be well received across the professions. We hope this leads to a greater level of understanding between clinician and patient, resulting in increased respect and trust.

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.

As section 2 provides a *definition* of cultural safety from Aboriginal and Torres Strait Islander Peoples via NRAS, it could be confusing to then use the same term in sections 3 and 4 that do not relate to Aboriginal and Torres Strait Islander Peoples. An extension to the preamble at the beginning of section 3 noting something similar to the following may be useful: *"the term cultural safety can also be used more broadly and applied to other diverse groups. In this regard there is not specific definition, but the following points provide examples of good practice"*

The content itself clearly sets the expectations of the Boards regarding a respect culture and overall safety. We feel, in particular, that sections 4.1(a) and 4.9(a) regarding the power imbalance between clinician and patient are highlighted effectively and comprehensively, given the potential for harm to patients when the power imbalance is utilised in a harmful way.

A small amendment to section 4.10 from *"when you are considering treating..."* to *"when you a choosing to treat..."* would appropriately exclude paramedic mass casualty incidents from this clause.

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

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

We feel that these statements do not adequately clarify the role of AHPRA and the Boards in response to bullying and harassment. It simply states that when such behaviour is affecting public

safety there is the possibility of regulatory action, and for clinicians to refer particularly egregious behaviour to AHPRA and the Boards for possible regulatory action; there is no clear definition of AHPRA's role. There could be grounds to either expand the section to provide more detail on the roles of AHPRA and the Boards, or conversely provide a link to documentation/policy etc that may explain further.

Section 5.2 (a) consider changing to "understand your role *and the roles of other team members* and attend to the responsibilities associated *with your* role".

Section 5.3 mentions social media but could be broadened to cover electronic media more broadly with specific comment toward social media. This would then encompass bullying and harassment via emails, etc.

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

   Is this section clear? Why or why not?

This section highlights the risks and issues of providing care to people with whom the clinician has a personal relationship. This is especially relevant though highlighting the key aspects of good practice in this setting.

The concern with listing *some* groups is that others are not included in the list. It should be clarified that this list is not exhaustive and that it is the role of the clinician to advocate for all individuals or groups who are subject to health disparities.

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

The language and structure are easy to follow and uncomplicated. It is clear and easy to read whilst maintaining a level of depth to ensure important points explained.

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?**

The format and content of the code is appropriate and does assist the reader (notwithstanding above points of critique). We particularly like the format of a synopsis of each principle followed by an expansion of each section to provide further information and guidance to further illustrate AHPRA and the Boards principle.

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

No further feedback.

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.**
No. Education of clinicians in relation to the new code could occur through normal continuing professional development. Socialisation of the new code to patients and other stakeholders may incur costs.
11. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.**
None that we envisage.
12. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for vulnerable members of the community? If so, please describe them.**
None that we envisage.
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.**
None that we envisage.