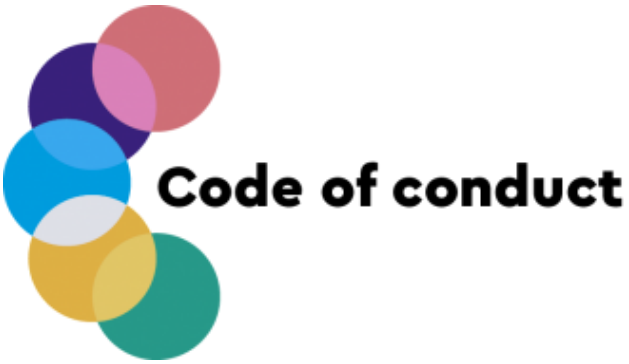

Shared code of conduct: public consultation

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 These submissions will not be published on the website or elsewhere.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

Org name. Please provide the name of the organisation.

This question was not displayed to the respondent

Org type. Which of the following best describes your organisation?

This question was not displayed to the respondent

org other?. Please describe your organisation.

This question was not displayed to the respondent

Your contact details

First name:

Katie

Last name. Last name:

Harris

Email address:

[redacted]

Which of the following best describes you?

- ○ I am a health practitioner
- ○ I am a member of the community
- ○ I am an employer (of health practitioners)
- ◉ Other

Please describe.

Student radiographer

Prac type.

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?

Longer more comprehensive principles are better because they leave less room for ambiguity. A detailed contents page and use of the CTR-F keyboard shortcut (Comand - F on MacBook) makes longer bodies of text almost as easy to navigate as shorter ones. Given that this code will primarily be accessed digitally, it makes sense to have a more comprehensive document.

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?

I prefer 'patient'. This term keeps the patient/healthcare worker relationship distinct from the financial relationship of the patient and clinic/hospital. The patient is a 'patient' of the health care worker and a 'client' of the hospital.

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?

I liked that it clarified what health care workers can do to promote cultural safety. I felt it went into the right amount of detail.

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.

I think this section, along with the health advocacy section, are missing something. Speaking as a patient, the family of a patient, and a student radiographer, I have observed a shocking prevalence of discrimination against obese/fat patients throughout the healthcare system. There is almost a vindictive cruelty present. Technically, this comes under discrimination against disability, but often obesity isn't acknowledged as a disability, and I think this point needs to be clearer. As a student, I'm aware that obese patients are more difficult. As the family of a patient, I know that punishing them for being fat doesn't make them skinny, it just makes them avoid the health care system. As a patient with an interest in the research around obesity, I know many health care practitioners are misinformed about the condition, and treat it as though it is the patient's fault. Some even think that they are helping fat people by being cruel to them.

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?

Yes

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?

Yes

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

The only issue I found was in the Code of Conduct principles, all the descriptions start with 'Principle #:' except Principle 9. I don't think it needs to start with 'Principle #:', but if it does, the format should be consistently applied.

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?

I've already stated that I think it needs to clarify that disrespect towards heavier patients isn't appropriate in an earlier section. Other than that, nothing else jumps out at me.

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

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.

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

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.

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.

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

13appendices?.
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

14guideline?. **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?

Yes. While most or all of the information in Appendix A is represented in the professional capabilities, it is scattered throughout the document. Having it compiled into a guideline makes it more accessible.

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.