



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 These submissions will not be published on the website or elsewhere.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

Health Consumers Tasmania

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.

Health Consumers Tasmania is the first peak health consumer organisation in Tasmania. We provide an independent, informed and representative consumer voice, by respectfully engaging with health service providers to improve the health and wellbeing of all Tasmanians. Founded on partnerships, we influence the Tasmanian health system to better meet the needs of patients, carers and our communities. We work alongside the Tasmanian community and health industry to build a more co-operative, fairer and consumer centred health service in our state.

Your contact details

First name:

[REDACTED]

Last name:

[REDACTED]

Email address:

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?

Generally, Health Consumers Tasmania prefer Option 2 which includes the addition of the high-level Principles at the start of the Code of Conduct.

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?

Health Consumers Tasmania acknowledges that many different members of the community who use health services have a different preference for how they are referred to. From the perspective of Health Consumers Tasmania, a community organisation that seeks to empower patients and carers, we find the term 'patient' rather than 'client' or 'consumer' to imply a paternalistic, top down approach to health treatment rather than an equal consumer-practitioner partnership. The term patient is not in accordance with person centred care Principles and fails to recognise the patient as a consumer with lived experience. Other possible terms we support using include: - person using health services; - people using health services; and - person centred care. Health Consumers Tasmania considers we should have one Charter of Health Care Rights that is relented to both industry practitioners and consumers as this will place all rights within the one overarching document.

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?

Health Consumers Tasmania recognises and applauds the work undertaken by Ahpra's Aboriginal and Torres Strait Islander working groups, and the efforts made to get to this point. We support the introduction of the term cultural safety, but note this Principle can not be left up to chance or the Code alone to be implemented. The training that comes along side this Principle is incredibly important if it is to be actualised. We note Ahpra is starting to roll out that training. Without that accompanying training, Principle 2 is non-specific in its application and relies on the practitioner acknowledging the harmful effects of colonialisation and ongoing white-ism endemic in every day life. These effects are not well understood by the majority of Australians and it is not a subject that is widely discussed in media, school curricula or previous practitioner training. Australians largely grow up with little reference to it, its' application or affects. Migrants may have even less knowledge of the way in which First Nation people have been and continue to be affected. We do suggest that the Principle can be enhanced by adding words to help "actualise it" and place it in context. This is something that is achieved in Principle 3 for example, as it highlights the application to health care users. Possible wording that could be added to Principle to are • Health consumers, • health consumers and their families or carers, • colleagues and the community

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.

These sections are unclear in the statement of Principles, the consultation paper and in this template. Language differences that define the groups to be included under this section changes between different sections. Age and disability are not highlighted as important and there is little focus on the specific needs of each group despite a raft of evidence that outlines specific age or disability condition illnesses. Page 32, section 3.1(b) appears to exclude age or disability differences entirely. These differences are just as important as any other cultural differences. An overarching definition may assist in clarifying what cohorts of people fall within these sections. The lumping of questions and statements about different Principles and major sections when they refer to different cohorts together makes answering this question difficult. Section 3.1 relates to patients and section 5.1 relates to colleagues and practitioners with section 5.3 bounding back to patients. Please also see the answer to question 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?

This question does not make Ahpra's role clear. Section 5.1 refers to respect for colleagues and other practitioners. The examples highlighted in pages 7-9 of the consultation paper all provide examples of positive engagement and resolution of an issue that might occur in-house. Yet in real life, this is not always the case. Ahpra has failed to provide a clear pathway for resolution or outline it's role beyond provision of these case studies and in situations where agreement has not been reached. Section 8.2 acts as a deterrent for practitioners to report to their National Boards or Ahpra when discussing complaints that may be deemed vexatious. A practitioner may be genuine in their desire for good patient outcome yet be deemed by others to not be sincere in their beliefs. There is a need to explain the determination process further and with less draconian language and negative sanctions. Ahpra acknowledges that vexatious complaints account for less than 1% of all complaints so there is no real need to use this sort of language. The inclusion of 'Ahpra acknowledges that vexatious complaints are rare (less than 1% of all complaints)' would provide better context to this section. The consultation paper recognises that there are clear differences in the roles, scope of practice and responsibilities between managers, researchers and practitioners yet does not appear to recognise that in smaller practices these roles may be performed by the same person. Nor does it recognise the power imbalances systemic within these roles when performed separately in larger practices. In larger practices, particularly those that are linked nationally and owned by external stockholders not otherwise affiliated with the industry, priorities for profit enhancement may have little to do with person centred care. Ahpra's Code of Conduct fails to recognise these inequities and give guidance to the practitioner. In failing to recognise these power imbalances, Ahpra not only fails to provide guidance to it's practitioner base, it fails to acknowledge the need for monitoring compliance. Section 5.2, particularly I can only be enacted with the expressed permission of the consumer. Subsections (d) and (f) should only be enacted with the specific expressed permission of the consumer. Sections 5.3 and 5.4 are not clearly aligned with Principle 5 or with the examples outlined on pages 7-9. There is no clear pathway for practitioners to progress issues arising from breaches of 8.10(i) beyond the practice.

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?

No. Section 4.9.(c) in particular needs to be broader and include the consumer, their carer, guardian, spouse, or the parent of a vulnerable consumer rather than a 'child patient'. There are many adult consumers who require guardians or carers for a whole range of reasons including mental incapacity. These may be close relatives of the consumer who is at risk.

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

The numbering, headings, etc are not clearly related to corresponding individual Principles so the document is unclear. Principle 7 should acknowledge lived experience of the consumer first and foremost. Lived experience does not appear to be clearly acknowledged in the Code. Principle 8, there is no definition of 'ethical' or 'honest' and therefore the Principle lacks meaning. Principle 9 – typo page 26. It is not listed as a Principle. Principle 11 focusses on research but without attention to seeking consumer engagement and permission.

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 of Conduct is not clear, relevant or helpful to consumers though it may be for practitioners. There appears to be no guidance within the consultation paper as to how the Code is to be used, shared or communicated with consumers by their practitioners. Tasmania, Northern Territory and rural and remote areas in particular have a low level of literacy. The Principles need to be adjusted to ensure that they are relevant and accessible to these groups. At the moment, they are not. To assist the development and application of the revised Code of Conduct, Health Consumers Tasmania organised and hosted three focus groups for the Ahpra Tasmanian State Manager. They were held in Hobart, Burnie and Launceston. From our perspective, the central findings from these focus groups were that: - People with limited access to health care, such as in rural/regional Tasmania, are nervous to act on their rights given the impact it could have on their health treatment. - In many cases, if a person is uncomfortable or distressed by the treatment they receive they will try and find another service to access, and they won't make a notification. In some rare cases, especially in those communities that experience significant violence (which are parts of Tasmania) a consumer experiencing distress will resort to shouting, offensive language and potentially violence (punching) to express their "complaint" as they would never know how to access a formal notifications system. - The easiest way to inform consumers of the standards to which they should be treated is by providing easy-English advertising in the practices providing health services, in the waiting room and the treatment room. And given not all consumers can read, it is important some of the advertising is communicated in other forms, such as waiting room television ads and access to interpret channels. - Community groups that assist people who are at most risk of poor health treatment, for example neighbourhood houses who assist people on a low income or with disability, provide a gateway to delivering face to face education sessions to consumers about what their rights are when accessing a practitioner. - At the commencement of a first consultation, the practitioner should explain to the consumer what their rights are and standard of care they can expect, and what to do if they feel their rights have not been met. The practitioner should also hand the consumer a brochure with this message in writing, so they can read it again at a later stage. - Consumers are highly unlikely to look the Code of Conduct via the internet, unless they have a certain level of education, and have had something happen that would cause them to query their health treatment. Other points Health Consumers Tasmania have specifically in response to the revised Code of Conduct are: - Section 8.9 (b) is unclear and lacks detail as to who is entitled to ask for information (with or without a patients consent) and practical steps that enable the practitioner to ascertain this information. - Section 10.3 (d) outlines consumer consent which is integral to all supervisory practice. It needed to be the first point under section 10 not the last. - Section 11.1(a) needs to be expanded to highlight jurisdiction. - Section 11.2 does not require that the practitioner needs to first seek consent from the consumer when undertaking research.

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

Because the individual boards have community representation rather than consumer representation, there appears to have been little real focus on consumers within this document. The way that the consultation has been written is paternalistic and geared towards practitioners. A statement of consumer rights needs to be developed as part of the Code. A Code of Conduct that does not actively engage with consumer rights or seek to address and incorporate a Consumer Charter of Rights is merely paying lip service to the needs of their consumers. Making changes to the Code is a small step towards improving consumer confidence in Apha affiliated professions. More needs to be done to: (a) Increase the range of professions registered by Apha. Given the issues highlighted in the recent Royal Commissions in Aged Care Quality and Safety, there has been no inclusion of aged care workers under the Apha umbrella. Social workers aged care workers, dietitians, audiologists, speech therapists, psychotherapists and counsellors, in addition to many complementary and alternative health care practitioners fall outside of this legislation and therefore are not aligned to the Statement of Principles, Code of Conduct or any investigative or sanctioned action at either a State or National level. (b) While health complaints against registered health practitioners are governed at a national level by the Health Practitioner Regulation National Law, in Tasmania there is still no legislative basis for health consumers to satisfactorily resolve their complaints about unregistered health practitioners. More needs to be done by Apha to bring states into alignment on this and other outstanding issues such as the adoption and enforcement of a legally binding National Code of Conduct for all Health Care Workers which was agreed in 2015. (c) The Australian Commission on Safety and Quality in Health outlines the Charter of Health Care Rights and was endorsed by all Health Ministers in 2019 but have yet to be implemented in Tasmania. This Amendment does not sufficiently address the issue. More needs to be done by Apha to bring states into alignment on this. (d) Ensure that Apha and all affiliated Bodies have appropriately mandated patient representatives and patient safety bodies as part of their Board membership and outside of the re-negotiation of Codes, Guidelines and Standards. At present, they have non-clinical input from community professionals, but this does not address the need for consumer (patient) input into process that will benefit them.

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.

Not to our knowledge

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

There is the potential that they will add to confusion among consumers where the issues outlined are not sufficiently addressed. The inclusion of Apha and all affiliated Bodies to have appropriately mandated consumer representatives and consumer safety bodies as part of their Board(s) membership and outside of the re-negotiation of Codes, Guidelines and Standards is important for consumer care and safety. At present, they have non-clinical input from community professionals, but this does not address the need for consumer (patient) input into process that will benefit them. Ensuring consumer representative as part of the renegotiation is a step towards risk mitigation.

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.

The Code, as it is currently written, has the potential to create confusion amongst whom it applies to and when it should be applied as outlined above. There needs to be greater consistency within the document as it applies to various vulnerable groups particularly older people and First Nation peoples

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.

Yes. Principle 2 is non specific in it's application and relies on the practitioner acknowledging the harmful effects of colonialization and ongoing white-ism endemic in every day life. These effects are not well understood by the majority of Australians and it is not a subject that is widely discussed in media, school curricula or practitioner training (though we agree it should be). Australians largely grow up with little reference to it, its' application or effects. Further, many First Nation people do not openly identify their cultural identity whereas the Code requires acknowledgment of it in the first instance. Principle 2 can therefore only be implemented in conjunction with specific training of practitioners in this area. This is not something that can left up to chance or the code alone.

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.