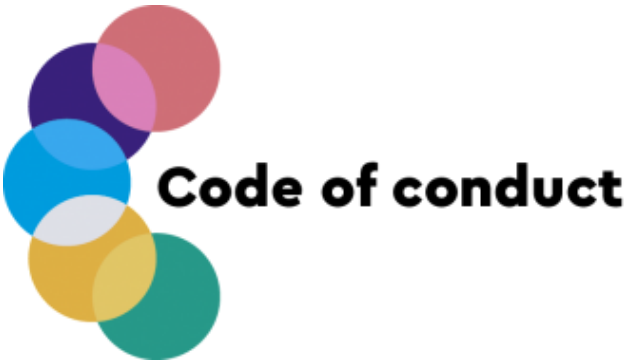

Shared code of conduct: public consultation

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 These submissions will not be published on the website or elsewhere.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

Pharmacists' Support Service

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.

A pharmacy profession specific health and well-being support service

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?

There needs to be adequate detail in the principles to enable clear interpretation and application to “real life” situations that arise in the practice of a practitioner. Profession-specific case studies would be useful, particularly in pharmacy which has distinct differences in practice and operation which can place pharmacists under pressure from others to conduct themselves in a way which is not aligned with their professional judgement and the Code. Profession-specific case studies will help to ensure that the subtle differences are understood by other professions, others within the profession and also the general public.

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?

'Person-centred care’ is the term being used elsewhere in national policy documents, however, prefer using ‘patient’ as opposed to ‘consumer’.

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?

No comment.

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 content of these sections sets a clear expectation around the importance of a culture of respect to enhance patient safety. However this would be enhanced by including in Section 5.2 Teamwork and Collaboration additional words to ensure clarity that registered health professionals have an individual responsibility to act in the best interests of the patient and that this must be respected. The autonomy of individual health practitioners to make decisions in relation to a patient's best interest must be emphasised. Bullying and harassment must not be used to try to pressure an individual practitioner to behave against their judgement about certain actions which may place a patient at risk. A practical example of this in pharmacy is when a prescriber or another healthcare practitioner such as a nurse or even another pharmacist may try to place pressure on a pharmacist to dispense a prescription despite the pharmacist expressing concern that the prescription may cause an adverse outcome for the patient due to dose or disease/drug interactions. The Pharmacists' Support Service is privy to reports from individual pharmacy practitioners that there are times when other health practitioners use threats and humiliation when a pharmacist raises concerns about patient safety.

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?

The Pharmacists' Support Service encourages Ahpra/National Boards to adopt a zero tolerance to bullying and harassment. Based on calls to our service we know that bullying and harassment is a significant problem in healthcare settings including pharmacy. We fully support these statements which are important due to the negative impact that bullying and harassment can have on patient safety, both directly to patients and through the impact of bullying and harassment on health professionals providing care to patients. While local action is the preferred first line option, the outcome is not always optimum. Escalation to Ahpra/National Board is an appropriate action when local action and actions such as independent mediation fail. The process of assessing notifications about bullying and harassment must be carefully considered. Pre-screening of notifications and a process of independent mediation may be necessary to minimise inappropriate or vexatious notifications which can cause significant distress to the health practitioner receiving the notification. There is also a potential for the notification volume to increase significantly which will delay the resolution of all notifications in a timely manner. A suitable pre-screening approach would be for the notifier to be required to align their report to the principles of bullying and harassment outlined by the Human Rights Commission. Likewise there could be a requirement for an independent mediation process to be undertaken. The aim of processes like these would be to decrease the likelihood of inappropriate and vexatious notifications.

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?

The code is clear on this however the varying legislation in different states and territories causes significant confusion in Australia, in particular in relation to the legislation governing prescribing for self and family members.

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

No comment.

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?

Whilst no specific comment, case studies should assist practitioners and the public have a better understanding on how to apply the Code.

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

No further comment.

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.

No comment.

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

1. As described above under question 5 while strongly endorsing the need for the code to include a section on bullying harassment there is a significant risk that inappropriate or vexatious notifications will be made. This needs to be addressed to protect those receiving a notification and also to manage the expectations of the notifier and the workload of Ahpra/National Boards. As described above this is best addressed through a specialised notification process which requires notifiers to align their report with the Human Rights Commission definition of bullying and harassment at the time of reporting and/or a process of independent mediation. 2. As described above, under question 4, there is a need to enhance the emphasis on the individual health practitioner's autonomy under Section 5.2 Teamwork and Collaboration with additional words to ensure clarity that registered health professionals have an individual responsibility to act in the best interests of the patient and that this must be respected. The autonomy of individual health practitioners to make decisions in relation to a patient's best interest also needs more emphasis. Pressure through misuse of authority or bullying and harassment must not be used to try to convince an individual practitioner to act against their judgement in relation to actions which may place a patient at risk. For example a pharmacist has the autonomy to decline to dispense a prescription if they believe it may place a patient at risk of harm and it is inappropriate for a prescriber or another health practitioner to harass or place pressure on them to act against the interests of the patient's safety. The general public also need to understand that a pharmacist has the right to decline to dispense a prescription if they believe it may place the patient at risk.

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.

No comment.

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.

No comment.

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.