Code of conduct review - submission template

The National Boards are inviting general comments on a revised shared *Code of conduct* (revised shared code) as well as feedback on the following questions. There are three questions (14 – 16) specific to the Chiropractic or Medical Radiation Practice Boards of Australia. They are not relevant to all stakeholders but have been included to provide an overview of the scope of the review. All questions are optional and you are welcome to respond to as many as are relevant or that you have a view on.

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?

Shorter and more concise principles are preferable because they are more likely to be read. It would be beneficial to include a clear summary at the start of the Code. Longer, more comprehensive principles are also important as they provide less room for differing interpretations of the principle and provide clearer and more specific guidance.

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?

No, we do not support the term 'patient' having such breadth of scope, particularly we do not support the inclusion of family members and carers. Although carers and families of the person or group receiving care are important stakeholders and should be involved in the care, especially when they are formally the substitute decision maker, they are NOT the patient. The patient should be treated as an independent person or group and engage autonomously to the best of their ability.

It is an important safeguarding measure to work directly with the individual receiving care as much as possible, as research and the Royal Commission into Family Violence have identified healthcare as providing a 'window of opportunity' for identifying and responding to abuse and sometimes this abuse can be perpetrated by a carer or family member. It is important to acknowledge that healthcare providers are recognised as providing a safe, supported, and confidential environment, thus, patients sometimes see this opportunity as an appropriate time and place to disclose their abusive situation to a trusted person and this opportunity should be protected.

Carers and family members should only be called upon as a substitute decision maker when absolutely necessary or when measures are in place to ensure the person/group receiving care are also given adequate opportunities to raise any concerns they have in a safe and supported environment. Holistic safety and wellbeing is an important part of healthcare.

It is appropriate to include terms such as 'consumer', 'service user', 'client' in the definition for 'patient'.

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?

Yes, it highlights possible unsafe practice and puts the onus on the practitioner to recognise and address this.

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.

Generally, the Code does set the expectation that practitioners must contribute to a culture of respect and safety, although there is no mention of women/females throughout the Code. The references to 'gender identity' do arguably cover the need for gender appropriate care for women, although this is not specified. There is not enough emphasise given to minority populations such as people who identify as non-binary or gender diverse. For minority populations to be given the considered care they need, the Code should provide additional guidance on best practice for supporting these population groups.

Populations impacted by disability can sometimes have specific physical needs, the Code needs to mention the need for physical accessibility to be considered.

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?

Yes, they clearly and concisely frame the expectations of the Code.

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 will be clearer if it says **"…**providing care to those in a close personal relationship WITH YOU…"

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

Yes, it is.

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?**

No

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

No
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.**
None that we are aware of.
11. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.**
Yes, the inclusion of a parent, substitute decision maker or carer in the definition of 'patient' places too much emphasise on stakeholders other than the recipient of care. This can be oppressive to the patient and in some cases even increase the risk of issues such as elder abuse or carer neglect. The 'window of opportunity' healthcare provides in the identification of abuse such as family violence also needs to be considered. Thus, the recipient of care should always be considered first and foremost as an independent person or group even when they do have support people involved in their care.
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.**
Yes, see response to question 11 and 2.
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 are aware of.

Additional questions about the Chiropractic Board of Australia's code of conduct

The following questions are specifically about the Chiropractic Board and its changes to the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

14. 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?
NA
15. 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?
NA

Additional question about the Medical Radiation Practice Board of Australia's code of conduct

The following question is specifically about the Medical Radiation Practice Board and their current version of the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

16. 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?
It is okay to remove the appendix, but there should be a section which refers (or links) Medical Radiation Practitioners to the 'Professional capabilities for medical radiation practices'. It would also be appropriate to include similar links for other professions covered in the Code. The reason for this is that practitioners looking for the professional capabilities for their practice will often need to familiarise themselves with the Code as well, so it should be encouraged that these documents are read in conjunction with one another.