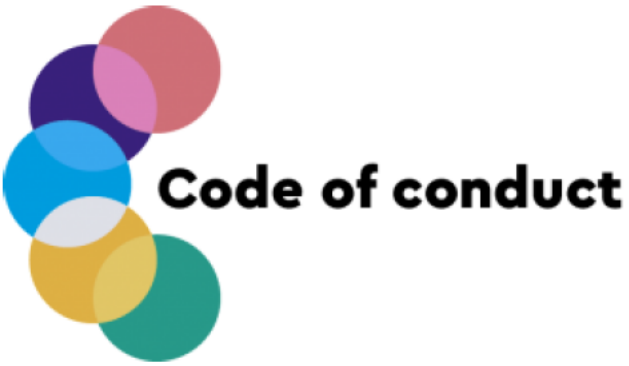

Shared code of conduct: public consultation

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 These submissions will not be published on the website or elsewhere.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

Australian Physiotherapy Association

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.

This question was not displayed to the respondent

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?

The APA supports the adaption of shorter, high level principles in the revised shared Code of Conduct (Code). Although we acknowledge the risk of subjective interpretation with overarching principles, we feel this is the most appropriate way to outline the expectations of health practitioners. A less prescriptive Code of Conduct allows for guidance on issues which may not get specific attention within the code. It is our opinion the revised shared Code is enhanced by retaining much of the previous code and adding new principles.

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?

Overall, the APA supports adopting the term ‘patient’ as this is a commonly used term across different Ahpra professions. We believe this definition reflects and encompasses the role of a physiotherapist in providing a quality of clinical care service across a range of both primary, preventive and rehabilitative health care settings. It is our opinion this term would fit reasonably well in health care settings across the spectrum including public and hospital settings and private practice. The APA however understands different workplaces and settings may use different terms and it therefore may be difficult to reach a shared agreement and consensus across the diversity of practices

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?

The APA strongly supports the inclusion of principles specific to Aboriginal and Torres Strait Islander health and culturally safe care and are pleased with the priority given to the associated principles. We agree with the intent of Principle 2, in that culturally safe care of Aboriginal and Torres Strait Islander peoples requires an understanding and acknowledgement of the impact of colonisation and the factors which contribute to ill health. We however feel further emphasis needs to be placed on the importance of self-reflection in ensuring practitioners provide culturally safe care. In Section 2.2, we suggest an additional point be included under 'To ensure culturally safe and respectful practice, you must' which addresses the need for self-reflection in relation to culturally safe practice.

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 APA feels the content outlined under these sections set the expectations of practitioners to contribute to a culture of respect and safety for all. We are pleased the revised shared Code acknowledges the importance of cultural safety for those of Culturally and Linguistically Diverse backgrounds in addition to Aboriginal and Torres Strait Islander peoples. As with our comments regarding cultural safety for Aboriginal and Torres Strait Islander peoples, self-reflection is also important when working with those from Culturally and Linguistically Diverse backgrounds. This includes reflecting on one's own culture, attitudes and beliefs and the impact this has on the provision of care. As such we would also recommend the importance of self-reflection be included in Section 3.1 under 'To ensure culturally safe and respectful practice, good practice includes that you'. In Section 3.1 we would recommend the removal of point d, 'adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race ethnicity, religion, sexuality, age or political beliefs)'. These requirements are already legislated, and it is currently mandatory for practitioners to not make an unjust or prejudicial distinction in the treatment of different categories of people when treating patients. By including this point, and also using the term adopt, it implies that these practices are not currently a legal requirement and up until now has been optional to undertake them. The APA believes the revised shared code makes it clear how practitioners must behave in relation to boundary violations however there is some ambiguity regarding relationships with ex-patients. Examples which address boundary crossings with ex-patients may be of benefit to practitioners.

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?

It is our opinion Section 5.3 provides adequate explanation of the role of the practitioner regarding bullying and harassment however the role of the National Boards'/Ahpra aren't clear. We suggest that it may be useful to provide some further description of the role of the National Boards' in dealing with bullying and harassment complaints. This could include additional guidance on the circumstances and thresholds in which a scenario is considered to extend to affecting public safety and requires notification. We also feel information on the support the National Boards' provide to practitioners in these circumstances would be beneficial. As Ahpra and the National Boards' have jurisdiction over incidents occurring in the workplace we suggest further clarity between the workplace, including travel to and from appointments, online and mobile services, and broader public safety settings. This may assist practitioners in reporting complaints of bullying and harassment to the relevant bodies. This could be supported with a link in the Code to further guidance, including case studies to illustrate the differences, and threshold questions that practitioners can use, to support their understanding of the differences. Further guidance should also be included in '5.3c - understand social media is sometimes used as a mechanism to bully or harass, and you should not engage in, ignore or excuse such behaviour'. We would recommend a link is included in the revised shared code to further examples which elaborate on different social media scenarios that may be less overt or obvious, supported with additional guidance for practitioners. The process and protocols for escalation should also be further explained in '5.3f - escalate your concerns if an appropriate response does not occur'. This should include additional guidance on the most appropriate person to escalate concerns when an appropriate response does not occur.

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?

We feel this section outlines the risks of providing care to those who a practitioner has a close personal relationship with and why this should be avoided. Overall we agree with the principles of good practice in this section however feel practitioners should be advised to seek approval of a third party payers if fees are to be charged. This is to avoid potential issues with third party payers who may not be willing to fund treatments where there is a close personal relationship between practitioner and patient.

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

The APA believes the language and structure of the revised shared Code is clear and easy to understand. We have no further comments regarding this.

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 APA believes the revised shared Code is clear, relevant and helpful. We have no further comments regarding this.

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

The APA commends Ahpra and the National Boards' on the work undertaken to update the revised shared Code. We believe the revised shared Code is written in a way which is clear and easy to understand and, overall, outlines the expectations of practitioners. In addition to the comments outlined in this submission, the APA would recommend the following inclusions. In 'Section 4.7 Ending relationships', we recommend commentary outlining practitioners are unable to end a relationship on the basis of prejudice. We also suggest an additional point in 'Section 11.1 Research ethics' ensuring any research relating to Aboriginal and Torres Strait Islander populations is undertaken in accordance with the NHMRC Aboriginal and Torres Strait Islander code of conduct.

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.

We don’t believe the revised shared code will result in any significant adverse cost implications for practitioners, consumers or other stakeholders.

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

The APA are unable to foresee any negative or unintended effects of the revised shared Code.

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.

It is hoped the revised shared Code will result in improved care for vulnerable members of the community. The APA is unaware of any negative or unintended effects.

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 APA supports the addition of specific principles related to Aboriginal and Torres Strait Islander health and cultural safety. The concept of cultural safety is different for other aspects of clinical care and therefore there may be instances of practitioners resisting the need to change. This may have negative effects on Aboriginal and Torres Strait Islander peoples, such as reduced access to culturally appropriate services, which is contrary to the aims of the revised shared Code.

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.