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?

The amalgamating the codes of conduct of multiple and separate healthcare disciplines is supported.

More concise details on the similarities, and further elaboration on the exceptions or exclusions would be helpful.

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?

Although the term **consumer** indicates a change in labelling preferences the term is not supported beyond its application in for example *consumer representation committees* or *networks*.

The labelling preference is less clear when it comes to patient or client as role theory argues that social roles are guided by social norms, are often reciprocal, as in the dyad of individual seeking healthcare and their health professional and an individual may have multiple roles in different settings and therefore the same individual may have a different preference for the application of client and patient.

For example, when public oral health provided in community settings client is generally used and demonstrates the emphasises the collaboration of the therapeutic relationship as equals.

Patient implies a deficit or 'sick role' concept and would be expected to be less acceptable in a "patient centred care approach.

Preferences are thus likely to be both contextually and individually determined.

A more difficult but important question is whether labelling has behavioural implications for how healthcare recipients are treated, and the quality of care received.

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?

A good addition

Clear and like the self reflection and responsibility

How is it expected that a practitioner demonstrate acknowledgement of a) colonisation .. b) racism …?

No reference or expectation for Cultural safety training

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.

Yes principle based approach is important

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 a good addition.

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?

Yes

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

Case Study 1 Vexatious complaints

The case studies are confusing when the person refers to themselves by name e.g. 'Sam is worried that Sam's health may be at risk...' Need revising

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?**

Content appropriate and clear

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

Use greater diversity of names in case studies.

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.**
11. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.**
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.**
None of concern
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 of concern

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?
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?

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?