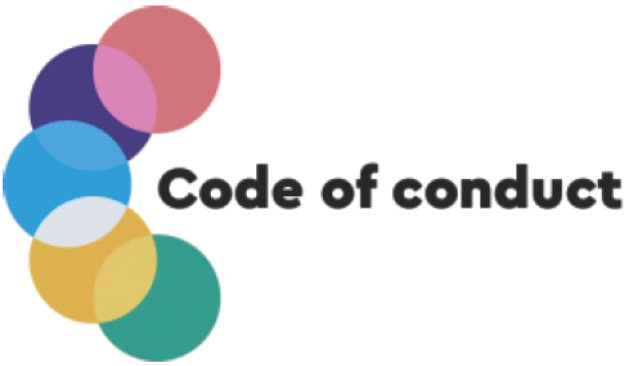

Shared code of conduct: public consultation

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 These submissions will not be published on the website or elsewhere.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

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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.

Organisation culture consultancy

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.

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.

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?

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?

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?

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.

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?

Feedback, as invited, on ‘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?’ Introduction May we suggest that there is room for improvement, indeed, there is an opportunity (and we think, a need) to inject a new way of thinking about - and a new paradigm for - achieving the prevention and elimination of bullying, harassment, etc (negative, disrespectful and harmful behaviours generally). Without wishing to be unduly challenging or at all offensive, the understanding and knowledge of best practice reflected and detailed in section 5.3 of the revised Code – particularly the thinking and advice about how to tackle, reduce and eliminate bullying and harassment - reflects the twentieth century HR paradigm and mindset. The world’s understanding of the problem, its awareness of the limitations and ineffectiveness of top down power/authority/leadership/hierarchy /discipline-based approaches and the world’s awareness of proven effective new approaches to addressing the problem and of the importance of pro-active measures to prevent the problem arising, have changed and progressed in the last 20 years. The new bottom-up thinking is scientifically validated and has been demonstrated effective and proven through on-the-ground research in a range of organisational settings. It is excellent that the revised Code is addressing the problem of bullying and harassment. (Had the Code not addressed bullying etc, it would have been incumbent on me - having spent years of a PhD project reading the world’s literature on bullying and harassment and how to address/prevent such behaviours - to bring to your attention that the problem is much more prevalent in the medical/health/hospital sector than in any other economic or service sector internationally and then to try to persuade you that that your Code is a wonderful opportunity and vehicle for addressing this major problem in contemporary workplaces. So, now that I don’t need to do that, it is great and a pointer to the professionalism and capabilities of your team.) What is missing in section 5.3 of the revised Code As mentioned earlier, there is a gap in the revised Code, as currently drafted, in its awareness of and understanding about what can be, should be and needs to be done about the bullying and harassment problem in workplaces – namely, to prevent it happening. The approach set out in the Code does not mention the possibility and desirability of taking steps to pro-actively prevent – and so to eliminate – bullying and harassment from being experienced. The Code is therefore missing the crucial opportunity and need to deliver on the Code’s call (at 5.3 d.) for practitioners to ‘act to eliminate bullying and all its forms in the workplace’. To eliminate something, one needs to stop it from happening. Bullying and harassment can be prevented from happening and consequently can be eliminated, but the Code provides no guidance on how to achieve such elimination of the problem. How bullying etc can be prevented – through pro-active ‘empowered group process’ The best practice empowered group process approach to preventing and eliminating bullying and harassment in the workplace, in all its forms - negative, disrespectful, harmful behaviours of any kind - is described below. The first step to prevent bullying, etc to get the workgroup or team – (i) to reflect, then discuss – share their own stories about - their best experiences of workplaces they have known and also share their thoughts on ideal behaviours/culture/expectations /relationships/communications at work (ii) to articulate, prioritise (vote on) and agree on (and document) their (i.e. this group’s) priority, ideal, expected behaviours, etc (iii) subsequently, to meet regularly for some reflective conversation on whether everyone feels safe to speak up in this group and how they (the group) think they are going in bringing their agreed expectations to life (iv) to take it in turns during those regular reflective conversations to contribute and speak to circulated materials (e,g, articles on EI, having ‘I feel…’ P.E.T. ‘difficult conversations’), thoughts or tools for building and strengthening a workplace where it is safe to speak up and have all the conversations you and/or the group needs to have (v) to then address and work on any shortfalls, issues, etc. This is a science-based approach and it has been demonstrated to be effective We would be happy to provide you with: (a) relevant scientific papers that underpin this proactive, positive psychology-based approach; with (b) a critique of the limitations of authority-based (ex post facto, inquiry and power/authority/compliance/threat/discipline-based approaches to shaping human behaviour and to dealing with human behaviour and relationship issues (characterised by the approach/mindset currently adopted by and reflected in this part of the revised Code - viz. ‘…escalate your concerns’, ‘…refer concerns to Ahpra’) and (c) details of our research on the effectiveness of pro-active, empowered group processes with regular reflective conversations, in preventing and eliminating bullying and harassment in various work settings. In summary Since humans know how to prevent and eliminate bullying and harassment in workplaces, may we suggest it would be helpful if section 5.3 were revised to set out how to do that. Specifically, this could be done by inserting in steps 5.3.a. to 5.3. h an additional item that spells out the process for preventing bullying and harassment. The current 5.3.g. statement on Ahpra’s role, would be revised to state words along the line that ‘following the workplace stakeholder groups’ efforts to address and prevent the problem recurring, escalate your concerns or refer concerns to the National Boards/Ahpra’.

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?

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

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?

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

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.

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

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.

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 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.

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.

From: [redacted]
To: AHPRA.Consultation
Subject: Consultation/feedback on revised Code of Conduct for 12 practitioner professions
Date: Monday, 31 May 2021 10:03:49 PM

Feedback, as invited, on

'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?'

Introduction

May we suggest that there is room for improvement, indeed, there is an opportunity (and we think, a need) to inject a new way of thinking about - and a new paradigm for - achieving the prevention and elimination of bullying, harassment, etc (negative, disrespectful and harmful behaviours generally).

Without wishing to be unduly challenging or critical, the understanding and knowledge of best practice reflected and detailed in section 5.3 of the revised Code – particularly the thinking and advice about how to tackle, reduce and eliminate bullying and harassment - reflects the limited, out-dated, twentieth century, HR, hierarchy/authority/power/-based, top-down, compliance (i.e. it involves threats & punishment) paradigm and mindset*. *(*'This is how those above you require you to behave! You will be punished if you don't behave like we require!*)

The world's …

- understanding of the problem
- awareness of the limitations and ineffectiveness of top-down, power/authority/leadership/hierarchy/discipline-based approaches in winning human cooperation and compliance, and
- the world's awareness in the 21st century of proven effective new approaches to addressing the problem and
    - particularly, of the importance of building organisational members' sense of ownership of the creation, maintenance and continuous improvement of the required culture and of taking pro-active measures to prevent the problem arising,
        - have changed and progressed in the last 20 years.

The new, bottom-up thinking and our methodology detailed below are scientifically validated and has been demonstrated effective and proven through real-world research in a range of organisational settings.

(i) An aside – a compliment, if I may – on your tackling the problem of bullying in this revised shared Code: Also (ii) some elaboration & commentary on (professional validation

of) my earlier draft submission (of 17 May 21)

It is excellent that the revised Code is addressing the problem of bullying and harassment. (Had the Code not addressed bullying etc, it would have been incumbent on me - having spent years of a PhD project reading the world's literature on bullying and harassment and how to address/prevent such behaviours - to bring to your attention that the problem is much more prevalent in the medical/health/hospital sector than in any other economic or service sector internationally and then to try to persuade you that that your Code is a wonderful opportunity and vehicle for addressing this major problem in contemporary workplaces. So, now that I don't need to do that, it is great! - and a pointer to the awareness, professionalism, courage and capabilities of your team.)

A colleague of significant professional standing, along with a substantial medical and managerial pedigree, has provided, in response to my earlier submission, the following explanation for and perspectives on the extent of the phenomenon of bullying in the medical sector:

'You have captured well that healthcare culture in particular is dominated by hierarchical structure that leads to an authority gradient that is very difficult to overcome. This is very strong in health and is related to our (societies) acceptance of the medical profession as having considerable influence on the content of their work (autonomy), over the work of other health professionals (authority) and as institutional experts in all matters relating to health in wider society (sovereignty). This may have been appropriate in the past but in a climate of high technology, increasing access to electronic resources, job designs requiring multiple competing priorities and a growing body of informed consumers this culture needs to be reframed from individual practitioner autonomy to team autonomy (that includes the consumer). Noting this as you have in your paper is important.

What is missing in section 5.3 of the revised Code

As mentioned earlier, there is a gap in the revised Code as currently drafted, in its awareness of and understanding about what can be, should be and needs to be done about the bullying and harassment problem in workplaces – namely, to **prevent it happening**. The approach set out in the Code does not provide guidance on taking steps to pro-actively prevent – and so to eliminate – bullying and harassment from being experienced.

The Code is therefore missing the crucial opportunity and need to deliver on the Code's call (at 5.3 d.) for practitioners to 'act to eliminate bullying and all its forms in the workplace'. To eliminate something, one needs to stop it from happening. Bullying and harassment can be prevented from happening and consequently can be eliminated, but the Code provides no guidance on how to achieve such elimination of the problem.

How bullying etc can be prevented – through pro-active 'empowered group process'

The best practice, pro-active ***empowered group process*** approach to preventing and eliminating bullying and harassment in the workplace, in all its forms - negative, disrespectful, harmful behaviours of any kind - is described below.

The steps to **prevent bullying,** etc involve inviting the workgroup or team: –

(i) to reflect, then discuss – share their own stories about - their best experiences of workplaces they have known and also share their thoughts on ideal behaviours/culture/expectations /relationships/communications at work;

(ii) to articulate, prioritise (by voting), agree on (thereby building their ownership of) and document their (i.e. this group's) priority, ideal, expected behaviours, values, or principles, etc;

(iii) subsequently, to meet regularly for some reflective conversation on whether everyone feels safe to speak up in this group and how they (the group) think they are going in bringing their agreed, desired, expectations of workplace behaviours to life;

(iv) for a limited period, to work with a facilitator, coach or mentor to enhance the group's skills in [A] creating a trust-based, safe workplace where everyone feels confident that it is safe to speak up respectfully and have all the conversations the group members need to have and also skills in [B] straight talk or speaking up (voicing); having 'a difficult conversation' (where a person is challenged about their behaviour but in such a respectful, compassionate, non-blaming manner that the relationship with them is warmed, not eroded); emotional and social intelligence, authentic behaviour and reflective conversation;

(v) during those regular reflective conversations members take it in turns to contribute to the group's awareness and understanding of the concepts listed in (iv) above – they effectively coach each other to deepen everyone's awareness and skills – by sharing, circulating and discussing materials (positive feedback, articles, experiences, stories, insights, etc) that drive the continuous improving of how they are experiencing their workplace

(vi) from time to time, as required, to then address and work on any shortfalls, issues, challenges, opportunities, etc.

This is a science-based approach and it has been demonstrated to be effective

We would be happy to provide you with: (a) relevant scientific papers that underpin this proactive, positive psychology-based approach; with (b) a critique of the limitations of authority-based (ex post facto, inquiry and power/authority/compliance/threat/discipline-based approaches to shaping human behaviour and to dealing with human behaviour and relationship issues (characterised by the approach/mindset currently adopted by and reflected in this part of the revised Code - viz. *'…escalate your concerns', '…refer concerns to Ahpra')* and (c) details of our research on the effectiveness of *pro-active*, *empowered group processes* with regular reflective conversations, in preventing and eliminating bullying and harassment in various work settings.

To summarise my suggested addition to Section 5.3

Since we humans do know how to prevent and eliminate bullying and harassment in workplaces, may we suggest it would be helpful if section 5.3 were revised to set out how to do that.

Specifically, this could be done by inserting in steps 5.3.a. to 5.3. h. an additional item that spells out the process for preventing bullying and harassment. The current 5.3.g. statement on Ahpra's role, could also be revised to state words along the line that 'following the workplace stakeholder groups' efforts to address and prevent the problem recurring, escalate your concerns or refer concerns to the National Boards/Ahpra'.

Furthermore…

In discussing my suggestion above with professional medical colleagues, it has become clear that there is a need also for additional training to support the pro-active, preventive culture-shaping approach outlined above.

The training needs that we see are:

i. Training at all levels in the use of different strategies that contribute to overcoming these cultural problems.
    a. Structured communication tools encourage clearer communication and provide those at the lower levels of the authority gradient with a safe non-threatening way of communicating their concerns or point of view. I think tools such as SBAR or CUS would enhance this.
    b. Practitioners need self-awareness and skills training and coaching in avoiding, minimising, dissolving, removing, etc any negative impacts or consequences of power, hierarchy and status differentials.
ii. As well, education must be incorporated into all health professionals' training programs that gives them an understanding of the authority gradients and hierarchies that lead to barriers to good communication, teamwork and patient safety.
iii. Broader education for consumers would also give people knowledge and skills that may facilitate changes in society's acceptance of cultural status differentials – e.g. respectfully challenging; asking for help to better understand, etc.
iv. Consumers (patients, families) need education and coaching support to make them feel authorised, confident and supported to speak up and be in a true partnership with their health practitioners.

May 2021

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