Consultation paper

A National Code of Conduct for health care workers

March 2014

Australian Health Ministers' Advisory Council

This paper was prepared by the Victorian Department of Health, on behalf of the Australian Health Ministers' Advisory Council

Contents

Executive summary

In 2011, the Australian Health Ministers' Advisory Council (AHMAC) undertook a national consultation on *Options for the regulation of unregistered health practitioners*. The term 'unregistered health practitioner' is defined to include any person who provides a health service and who is not registered in one of the 14 professions regulated under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law) or registered under another state or territory registration regime.

The final report of the 2011 consultation was released in August 2013. The report found that the option of a single national Code of Conduct for unregistered health practitioners, with enforcement powers for breach of the Code was likely to deliver the greatest net public benefit to the community. The consultation found strong community and practitioner support for this option. An enforceable statutory code of conduct scheme already operates in NSW and South Australia and has been enacted in Queensland but not yet commenced.

In response to the report of the 2011 consultation, the Standing Council on Health (SCoH) agreed in principle on 14 June 2013 to strengthen state and territory health complaints mechanisms via a single national Code of Conduct to be made by regulation in each state and territory, and statutory powers to enforce the code by investigating breaches and issuing prohibition orders. Ministers also agreed to a nationally accessible register of prohibition orders and mutual recognition arrangements between states and territories to support national enforcement of the code.

To give effect to these decisions, Ministers asked AHMAC to undertake a public consultation on the terms of the first national Code of Conduct and proposed policy parameters to underpin nationally consistent implementation of the code, for consideration by Ministers.

The purpose of this consultation paper is to seek public comment on:

- the terms of a draft national Code of Conduct (National Code) for health care workers
- the legislative provisions necessary to apply and enforce the National Code, and the extent to which national uniformity is considered necessary or desirable
- proposed administrative arrangements for public access to information on prohibition orders issued by the state and territory health complaints entities that in future may be responsible for enforcing the National Code.

A draft National Code has been prepared for discussion, based on the codes that already apply in New South Wales and South Australia, with the term 'health care worker' used in place of 'unregistered health practitioner'.

Interested parties are invited to make submissions addressing the issues raised in the paper. Questions have been placed throughout the paper to assist with submissions and a Quick Response form is available to assist with framing responses. Use of this form is optional.

Consultation arrangements

Information

This consultation is being conducted under the auspices of AHMAC on behalf of state, territory and Commonwealth health ministers.

Further information on this consultation is available from:

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Email: Anne-Louise.Carlton@health.vic.gov.au

Copies of this consultation paper

This consultation paper is available online at the following address:
www.ahmac.gov.au

If you are unable to access the website and would like a copy of the paper, contact:

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Submissions

Written submissions commenting on the proposals in the consultation paper may be emailed to: practitioner.regulation@health.vic.gov.au

or mailed to:

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Melbourne 3001

Submissions should be received by: **Wednesday 30 April 2014**

To assist you in preparing your submission, a Quick Response form can be downloaded at:
www.ahmac.gov.au

Note: All submissions will be considered public documents and will be posted on the AHMAC website above, unless marked 'private and confidential'.

1. Overview

1.1 Background

This is the second stage of a project that commenced in 2011 when AHMAC undertook a national consultation on options for the regulation of unregistered health practitioners.

In 2007, the NSW Parliament enacted legislation to strengthen public protection of health consumers who use the services of unregistered health practitioners. The NSW scheme established an enforceable Code of Conduct for unregistered health practitioners, with powers for the NSW Health Care Complaints Commission to investigate breaches of the Code and issue prohibition orders when there is a risk to public health or safety.

The objective of the 2011 AHMAC consultation was to consider:

- whether there is a need for strengthened regulatory protections for consumers with respect to the services provided by unregistered health practitioners in those states and territories without a statutory code of conduct for unregistered health practitioners; and
- if further public protection measures are required, what these should be, how they should be structured and administered, and the extent to which national uniformity in the regulatory arrangements is necessary and desirable.

The final report of the 2011 consultation was released in August 2013 under the title *Final Report: Options for regulation of unregistered health practitioners* (the Final Report). The Final Report found that the option of a single national Code of Conduct for unregistered health practitioners, with enforcement powers for breach of the Code is likely to deliver the greatest net public benefit to the community. The consultation found strong community and practitioner support for this option. In addition to the regime in operation in NSW, an enforceable statutory code of conduct regime commenced operation in South Australia in 2013, and has been enacted in Queensland and is expected to commence in 2014.

On releasing the Final Report, all state, territory and Commonwealth health ministers sitting as the Standing Council on Health (SCoH) agreed in principle to strengthen state and territory health complaints mechanisms via:

- a single national Code of Conduct for unregistered health practitioners, to be made by regulation in each state and territory, and statutory powers to enforce the Code by investigating breaches and issuing prohibition orders;
- a nationally accessible web based register of prohibition orders; and
- mutual recognition of state and territory issued prohibition orders.

Ministers agreed that under the proposed arrangements, each state and territory would be responsible for:

- enacting new (or amending existing) legislation and regulations to give effect to the national Code of Conduct, the national register of prohibition orders, and mutual recognition of prohibition orders across state boundaries;
- determining a suitable local body to receive and investigate breaches of the Code of Conduct and issue prohibition orders, noting that existing health complaints

commissions already have statutory roles to investigate complaints about unregistered health practitioners but only NSW and South Australia have a code of conduct and prohibition order powers.

To give effect to these decisions, SCoH asked AHMAC to undertake a public consultation on the terms of the first national Code of Conduct and proposed policy parameters to underpin nationally consistent implementation of the Code, for consideration by Ministers.

1.2 Why strengthen regulation?

The term 'unregistered health practitioner' is taken to refer to any person who provides a health service and is not a registered health practitioner in one of the 14 professions regulated under the National Law. These practitioners are subject to a range of other regulations, including consumer laws, therapeutic goods laws and drugs and poisons regulations. Many of these practitioners also voluntarily belong to professional associations or voluntary professional registers, which may impose sanctions for unprofessional conduct or refuse membership to practitioners who do not meet their professional or ethical standards. In some cases, 'co-regulatory' arrangements also apply to their practice, such as the provider recognition requirements under Medicare Australia, private health insurers, workers compensation and transport accident insurance arrangements.

Although the vast majority of unregistered health practitioners practise in a safe, competent and ethical manner, the Final Report concluded that there is a small but significant number of practitioners who engage in unprofessional conduct of a serious nature, thereby placing their clients at risk. If such practitioners were registered, their conduct might result in the cancellation or suspension of their registration. These practitioners often are not members of professional associations and therefore mechanisms to discipline or provided guidance in the case of less serious ethical or professional breaches are not available.

There have been a number of cases where formerly registered health practitioners have been deregistered, or let their registration lapse, but have 'rebranded' their practise and continued to offer services which are not subject to regulation under the National Law. There is also some evidence to suggest that recidivist practitioners move between jurisdictions in order to avoid regulatory scrutiny.

Although all instances of harm to health service users cannot be prevented, the Final Report concluded that a nationally consistent Code of Conduct applied to unregistered health practitioners, with enforcement powers for breach of the code in each state and territory, was likely to deliver a net public benefit to the community. The key benefits of such a system are:

- It captures all practitioners whether or not they choose to be members of self-regulating professional associations
- It sets common minimum standards of practice, regardless of the profession, occupation or nature of the practice
- It targets enforcement action to those practitioners who avoid their ethical or professional responsibilities
- It presents a relatively cost-effective method of addressing the most harmful conduct and, over time, is expected to lead to an overall improvement in standards of practice and a better informed public.

1.3 Who has an interest in this consultation?

This consultation paper has been prepared to assist community consultation on the proposed terms for the first National Code of Conduct for health care workers (the National Code).

The National Code, once implemented in each state and territory, is expected to prescribe minimum standards of professional conduct for any person who provides a health service which is not subject to regulation under the National Law. In some circumstances this will include health practitioners registered under the National Law, to the extent that they provide services that are unrelated to or outside the typical scope of practice of their registration as a health practitioner.

Interested parties are invited to comment on the proposed terms for the National Code, and related policy and implementation issues. Interested parties include:

- health care workers and health practitioners
- health consumers and consumer representative groups
- health service provider organisations
- education providers
- other regulatory bodies.

The term 'health care worker' is used here to describe any person who provides a 'health service' within the meaning of a state or territory's health complaints legislation. A discussion of terminology used in the draft National Code, including use of the term 'health care worker' is in section 3.3 of this paper.

Occupational groups that are expected to be subject to the National Code include, **but are not limited to**:

- allied health assistants
- anaesthetic technicians
- audiologists and audiometrists
- birth attendants, doulas and others who provide labour/birth support, antenatal and post-natal care
- clinical perfusionists
- complementary and alternative medicine (CAM) practitioners
- counsellors and psychotherapists
- dental technicians and dental assistants
- dermal therapists
- dietitians
- homoeopaths
- hypnotherapists
- massage therapists
- music therapists, art, dance and drama therapists

- naturopaths and herbalists
- nursing assistants and personal care workers
- optical dispensers
- orthoptists
- orthotists and prosthetists
- paramedics, ambulance officers and first aid providers
- pharmacy assistants
- phlebotomists
- reiki practitioners
- sonographers
- speech pathologists

This is not an exhaustive list.

Registered health practitioners

Health practitioners who are registered in a profession under the National Law may also have an interest in this proposal. It is expected that registered health practitioners will be subject to the National Code in limited circumstances, where a registered health practitioner provides a health service that is unrelated to his or her registration. For example, a registered nurse who works as a massage therapist, or a registered chiropractor who works as a naturopath. De-registered and previously registered practitioners who continue to provide health services will also be subject to the National Code.

The professions regulated under the National Law are:

- Aboriginal and Torres Strait Islander health practice
- Chinese medicine
- chiropractic
- dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist)
- medical
- medical radiation practice
- nursing and midwifery
- occupational therapy
- optometry
- osteopathy
- pharmacy
- physiotherapy
- podiatry
- psychology

2. Draft National Code of Conduct

2.1 Overview

The draft National Code of Conduct is based on those Codes of Conduct that apply under statute in New South Wales and South Australia. A full version of the draft National Code is at Appendix 1. The NSW Code is at Appendix 3 and the SA Code is at Appendix 4.

In preparing this draft National Code, a number of other local and international codes have been reviewed, including codes of ethics and practice guides for both statutorily registered and self-regulating health professions, in Australia, New Zealand and the United Kingdom.

Although this draft National Code addresses many of the areas included in other codes of practice, it is different from other non-statutory codes in several key respects:

This National Code of Conduct is to set generally applicable minimum standards of professional conduct

Many codes of practice adopted by professional bodies are aspirational in nature, that is, they incorporate 'best practice' principles that are intended to guide practitioners in attaining the highest professional standards of practice. Such codes are often tailored to the requirements of the profession concerned, and contain guidance on areas such as qualifications, continuing professional development and other profession specific matters.

By contrast, this draft National Code is designed to protect the public by specifying minimum acceptable professional standards that are generally applicable to all health care workers, and below which they must not fall. As such, this draft National Code has been framed to be broadly applicable to all persons who provide health services, by capturing all the most important professional obligations.

This National Code of Conduct is to be enforceable under law

It is intended that once the terms of this National Code are settled, it will be made by regulation in each state and territory. Once this occurs, the National Code will be legally enforceable.

The purpose of a prohibition order is to protect the public from future harm, rather than to punish the individual. This means that the provisions of the National Code must be clear and able to be enforced. While there may be some variation in how each state and territory applies the National Code, it is anticipated that where a health care worker is found to have breached the National Code, and his or her conduct presents a serious risk to public health and safety, then a prohibition order will be issued.

Discretion is expected to be exercised with application of this National Code of Conduct

It is not intended that this National Code provide an exhaustive list of every specific professional obligation. Rather it sets broadly applicable standards which allow for a Commissioner, Ombudsman or tribunal to exercise discretion when considering the circumstances of a particular case. For this reason, terms such as 'reasonable' and 'appropriate' have been used in place of a prescribed timeframe or set of conditions.

2.2 Proposed terms of National Code of Conduct

This section sets out for consultation purposes the clauses proposed for inclusion in the National Code. Comments are provided on each clause in the boxed sections, along with questions to assist with submissions. A Quick Response form is available electronically on the AHMAC website.

Appendix 1 sets out the full text of the draft National Code of Conduct, with the explanatory information contained in this section removed.

Definitions

health care worker means a natural person who provides a health service, whether or not the person is registered under the *Health Practitioner Regulation National Law*.

health service is a service that is defined as a health service under relevant state or territory law for the purposes of applying this Code of Conduct.

health complaints entity means an entity established under state or territory legislation whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

Discussion:

It is intended that the National Code apply to individuals who provide health services, but not to corporate bodies. However, not all individual health care workers will be subject to the National Code of Conduct (see 'Application of this Code' below).

The definition of what constitutes a health service is expected to be set out in each state and territory's health complaints legislation. A discussion of options for defining 'health service' is in section 3.2 of this paper.

The terminology 'health care worker' has been used in place of other terms such as 'unregistered health practitioner' or 'health service provider'. For a discussion of terminology, see section 3.3 of this paper.

What are your views?

How should the class or classes of person that are to be subject to this National Code be identified?

Is the term 'health care worker' an acceptable term to use to describe to whom the National Code of Conduct applies, or is another term such as 'unregistered health practitioner' or 'health practitioner' preferable, as currently used in NSW and South Australia?

Application of this Code

This Code applies to the provision of health services by:

1. health care workers who are not subject to the scheme for registration under the *Health Practitioner Regulation National Law*, including de-registered practitioners; and
2. health care workers who are registered health practitioners under the Health Practitioner Regulation National Law and who provide health services that are unrelated to their registration.

Discussion:

The intent of this clause is to make clear the classes of health care worker that are to be subject to the National Code as it applies in each state and territory. The clause is based on Clause 2 of the NSW Code of Conduct except that the term 'health care worker' is used in place of 'unregistered health practitioner' (see discussion of terminology in section 3.2 of this paper).

The NSW Code applies to two classes of practitioner – those who are not registered under the National Law, and those who are registered, but who are providing health services unrelated to their registration. This is the approach adopted above.

However, an alternative approach would be for the National Code to apply to all persons who provide health services, regardless of whether they are registered under the National Law. Then when a complaint is lodged about a registered practitioner, with either the relevant Health Complaints Entity (HCE) or the National Board, as occurs under current arrangements, the HCE and the National Board would liaise and agree on which entity is best placed to handle the complaint. If they agreed for the National Board deal with the matter, then the provisions of the National Law would apply. If they agree for the HCE to deal with the matter, then the provisions of the relevant state or territory HCE legislation would apply, and the Commissioner would have available the power to issue a prohibition order for breach of the National Code. Such an approach would enable the National Board and the HCE to agree on the quickest and most effective course of action for addressing the risk to public health and safety.

What are your views?

Is the proposed scope of application of the National Code acceptable?

Is it preferable that the Code of Conduct apply to all health care workers whether registered or not? If so, what are the potential advantages and disadvantages of this approach?

1. Health care workers to provide services in a safe and ethical manner

1. A health care worker must provide health services in a safe and ethical manner.
2. Without limiting subclause 1, health care workers must comply with the following:
   a) A health care worker must maintain the necessary competence in his or her field of practice
   b) A health care worker must not provide health care of a type that is outside his or her experience or training, or provide services that he or she is not qualified to provide
   c) A health care worker must only prescribe treatments or appliances that serve the needs of clients
   d) A health care worker must recognise the limitations of the treatment he or she can provide and refer clients to other competent health care workers in appropriate circumstances
   e) A health care worker must recommend to clients that additional opinions and services be sought, where appropriate
   f) A health care worker must assist a client to find other appropriate health care services, if required and practicable
   g) A health care worker must encourage clients to inform their treating medical practitioner (if any) of the treatments or care being provided
   h) A health care worker must have a sound understanding of any possible adverse interactions between the therapies and treatments being provided or prescribed and any other medications or treatments, whether prescribed or not, that he or she is, or should be, aware that a client is taking or receiving, and advise the client of these interactions.

Discussion:

The intent of this clause is to make clear that health care workers must practise in a safe and ethical manner. It sets out a number of overarching requirements with respect to professional conduct, some of which are expanded upon in other sections of the draft National Code.

This clause is based largely on the NSW Code (Clause 3) and the South Australian Code (Clause 2) except that the last two subclauses in the NSW and SA Codes that deal with the provision of first aid and emergency assistance are instead dealt with in Clause 5 of this draft National Code. This is in order to give these matters more prominence.

This clause requires that health care workers provide treatment or care in a manner that does not harm their clients, in accordance with the professional and behavioural standards that both their colleagues and the broader community regard as acceptable.

Subclauses 2(a) and (b): When clients seek health care services, they expect health care workers to have expertise in treating illness or providing care. It is therefore essential that health care workers maintain competence in their field and recognise the limits of their competence.

Subclause 2(c): Clients expect that health care workers will place the interests and health care needs of their patients first and ahead of their own financial interests.

Subclauses 2(d): Clients expect that health care workers will refer to other appropriate practitioners in circumstances where they are unable to provide the necessary treatment or care, or where the treatment or care they provide proves ineffective.

Subclauses 2(e) and (f): A client's best interests may be served by obtaining alternate opinions from other health care workers, and that in circumstances where a health care worker is unable to treat or care for a client due to lack of skills or expertise, or other ethical matters, they should assist the client in finding alternative competent treatment or care.

Subclause 2(g): Where a person is under the regular care of a medical practitioner for a serious and/or chronic complaint and also receiving other forms of treatment from an unregistered health practitioner, this additional treatment may not be disclosed to their treating medical practitioner. There are concerns in particular about the risk of adverse interactions between some types of unorthodox treatments and orthodox pharmaceutical medicines or treatments. The risk of adverse interactions is expected to be reduced if clients make their treating medical practitioners or other health practitioners aware of the full range of treatments they are receiving.

While health care workers cannot ensure that their clients do inform their treating medical practitioner of any unorthodox treatments they are receiving, they can encourage their clients to do so. Providing this encouragement, along with an explanation of the importance of avoiding adverse reactions can be an important step in overcoming any reluctance the client may have.

Subclause 2(h): This clause relates to the previous clause, and addresses the need for health care workers to take responsibility for becoming informed of any other treatments a client may be receiving, and any possible interactions those treatments may have with the treatments they prescribe.

Note that in response to feedback from the NSW Health Care Complaints Commissioner (NSW HCCC), this subclause has been modified from the NSW Code to add the words 'or should be'.

What are your views?

Should the National Code include a minimum enforceable standard that addresses the provision of services in a safe and ethical manner?

If so, do these subclauses cover all the principal professional obligations that should apply to any health care worker, regardless of the type of treatment or care they provide?

2. Health care workers to obtain consent

Prior to commencing a treatment or service, a health care worker must explain to a client the treatments or services he or she is planning to provide, including any risks involved, and obtain the consent of the client, guardian or other relevant person.

Discussion:

The intent of this clause is to make clear the legal requirement that all health care workers must obtain the consent of the client before providing any treatment or care.

This is a new clause that is not contained in either the NSW or South Australian Codes and has been included in response to feedback from stakeholders.

Consent to treatment and the requirement to warn of material risk prior to treatment (sometimes referred to as informed consent) is dealt with in the common law. There is a substantial amount of case law in this area. As part of the duty of care, health care workers are obliged to provide such information as is necessary for the client to give consent to treatment, including information on all material risks of the proposed treatment.

Without the informed consent of a client, the health care worker risks legal liability for a complication or adverse outcome, even if it was not caused by his or her negligence.

The issue of consent to health care is complex. The law recognises that there are circumstance where an individual may not be capable of giving informed consent (for example, due to diminished capacity), or where consent to treatment may not be required (for example, in an emergency).

The law does not set an age at which an individual is capable of giving consent. In considering whether a minor is a capable of consenting to treatment, health care workers need to consider the circumstances of each case and seek advice if necessary.

Most state and territory Health Departments issue guidelines on consent to health care.

This clause addresses what some view as a gap in the NSW/SA Codes. Given the complexities of the common law with respect to consent to treatment, the question arises whether this area can be adequately addressed as a minimum enforceable standard within the Code, or is best left to the common law, government issued guidelines and professional association codes of practice.

What are your views?

Should the National Code include a minimum enforceable standard that addresses consent to health care?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Should this clause also address the complexities of consent in situations in which an individual is not able to give consent, or in which consent is not required?

3. Appropriate conduct in relation to treatment advice

1. A health care worker must accept the right of his or her clients to make informed choices in relation to their health care, including the right to refuse treatment.
2. A health care worker must not attempt to dissuade a client from seeking or continuing medical treatment.
3. A health care worker must communicate and co-operate with colleagues and other health care workers and agencies in the best interests of their clients.

Discussion:

The intent of this clause is to make clear the obligations on all Code-regulated health care workers to act appropriately when providing treatment advice to their clients. It is based on the NSW Code (Clause 7) and the SA Code (Clause 6) except that subclause 7(4) of the NSW Code (subclause 6(4) of the SA Code) is dealt with separately as Clause 4 of the draft National Code, to give the matters it addresses more prominence.

The final report of the 2011 consultation on *Options for the regulation of unregistered health practitioners* documented a number of cases where unregistered health practitioners had either failed to refer clients to a medical practitioner when necessary, or had actively discouraged clients from seeking or continuing medical treatment, resulting in poor health outcomes and, in at least one case, a preventable death.

Subclause 1 makes clear the obligation of all Code-regulated health care workers to respect the right of clients to make informed choices in relation to their health care, including the right to obtain a second opinion, to seek additional treatment from other health care workers, or to refuse treatment.

Subclause 2 is intended to impose an obligation on all Code-regulated health care workers not to dissuade or discourage clients from seeking or continuing conventional medical treatment. This clause has been modified from the NSW Code, with 'treatment by a registered medical practitioner' replaced with 'medical treatment' in order to broaden its application to recognise that other health practitioners may provide medical treatment. In the *Guardianship and Administration Act 1986* (Vic) 'medical treatment' is defined as *'*medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by, or under, the supervision of a registered practitioner'. This definition is broader than 'treatment by a registered medical practitioner', capturing treatment by a wider range of health care workers.

Subclause 3 recognises that treatment is often cooperative and that health outcomes are improved when there are good relationships between treating health care workers.

What are your views?

Should the National Code include a minimum enforceable standard that addresses the provision of treatment advice?

If so, is this clause expressed in a way that will best capture the conduct of concern?

4. Health care workers to report concerns about treatment or care provided by other health care workers

A health care worker who reasonably believes that another health care worker has placed or is placing clients at serious risk of harm in the course of providing treatment or care must refer the matter to [Insert name of relevant state or territory health complaints entity].

Discussion:

The intent of this clause is to impose a mandatory reporting obligation on all Code-regulated health care workers to report to the responsible health complaints entity when they become aware that another health care worker is placing clients at serious risk of harm in the health care context. This clause expands upon subclause (4) of Clause 7 of the NSW Code (subclause 6 (4) of the SA Code), 'Appropriate conduct in relation to treatment advice'.

A mandatory reporting obligation applies to registered health practitioners under the National Law, however the provisions are worded differently. Under the National Law, all registered health practitioners are required to notify the Australian Health Practitioner Regulation Agency (AHPRA) if they become aware that another registered health practitioner has behaved in a way that constitutes 'notifiable conduct'. In the National Law, notifiable conduct is defined as follows:

notifiable conduct, in relation to a registered health practitioner, means the practitioner has—

(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
(b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
(d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Concerns have been raised about whether this clause may generate complaints that are motivated less by the desire to protect the public and more by personal interest (for example, by competing business interests). While all health complaints entities have powers to dismiss complaints that are frivolous, vexatious or lacking in substance, some stakeholders are of the view that the Code should include a clause that prohibits the making of complaints that are frivolous, vexatious or lacking in substance. Others have argued that this is not a matter that should be addressed in the Code since it not an issue of public protection.

What are your views?

Should the National Code include as a minimum enforceable standard a mandatory reporting obligation for all health care workers to report other health care workers who in the course of providing treatment or care place clients at serious risk of harm?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Should the wording more closely reflect the mandatory reporting provisions imposed on registered health practitioners under the National Law?

Should the National Code include a subclause which prohibits health care workers from making complaints that are frivolous, vexatious or lacking in substance?

5. Health care workers to take appropriate action in response to adverse events

1. A health care worker must take appropriate and timely measures to minimise harm to clients when an adverse event occurs in the course of providing treatment or care.
2. Without limiting subclause (1), a health care worker must:
   a) ensure that appropriate first aid is available to deal with any adverse event
   b) obtain appropriate emergency assistance in the event of any serious adverse event
   c) promptly disclose the adverse event to the client and take appropriate remedial steps to reduce the risk of recurrence
   d) report the adverse event to the relevant authority, where appropriate.

Discussion:

The intent of this clause is to impose a minimum enforceable standard on Code-regulated health care workers to deal with adverse events that occur during treatment or care in a way that ensures that clients and others are suitably protected.

This clause expands upon the content of subclauses 3 (2) (i) and (j) of the NSW Code (subclauses 2 (j) and (k) of the SA Code). It includes two new subclauses 2(c) and (d) which are intended to impose minimum enforceable standards on Code-regulated health care workers to deal with adverse events in a way that minimises the harm to the client and the risk of recurrence, and discharges the health care worker's obligations with respect to reporting adverse events.

What are your views?

Should the National Code include a minimum enforceable standard that addresses appropriate conduct in dealing with emergencies and adverse events?

If so, is this clause expressed in a way that will best capture the conduct of concern?

6. Health care workers to adopt standard precautions for infection control

1. A health care worker must adopt standard precautions for the control of infection in the course of providing treatment or care.
2. Without limiting subclause (1), a health care worker who carries out skin penetration or other invasive procedure must comply with the [insert reference to the relevant state or territory law] under which such procedures are regulated.

Discussion:

The intent of this clause is to make clear the legal requirement that applies to all health care workers to prevent the transmission of infectious diseases by adopting universal infection control procedures.

Any health care worker who carries out skin penetration or other invasive procedures, including dry needling or colonic irrigation, is required to comply with the relevant laws that apply in the state or territory within which they provide services. While health care workers can be prosecuted for failure to comply with such laws, inclusion of this subclause in the National Code provides an additional regulatory tool to protect against future harm and deal with health care workers who demonstrate a pattern of poor practice.

This clause is based on the NSW Code (Clause 6) and the SA Code (Clause 5) with the addition of a reference to 'other invasive procedure'.

The term 'standard precautions' is widely used to describe infection control measures that include:

- hand hygiene, before and after every episode of client contact
- the use of personal protective equipment
- the safe use and disposal of sharps
- routine environmental cleaning
- reprocessing of reusable medical equipment and instruments
- respiratory hygiene and cough etiquette
- aseptic non-touch technique
- waste management
- appropriate handling of linen.

These 'standard precautions' are contained in the National Health and Medical Research Council (NHMRC) *Australian Guidelines for the Prevention and Control of Infection in Healthcare*. Similar guidelines are issued by state and territory health departments and health employers.

What are your views?

Should the National Code include a minimum enforceable standard that addresses the adoption of infection control procedures?

If so, is this clause expressed in a way that will best capture the conduct of concern?

7. Health care workers diagnosed with infectious medical conditions

1. A health care worker who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.
2. Without limiting subclause (1), a health care worker who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the necessary steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

Discussion:

The intent of this clause is to strengthen public protection where Code-regulated health care workers with infectious diseases are treating or caring for clients, in order to minimise the risk of transmission.

This clause is based on the NSW (Clause 4) and SA Code (Clause 3).

What are your views?

Should the National Code include a minimum enforceable standard that addresses health care workers diagnosed with infectious medical conditions?

If so, is this clause expressed in a way that will best capture the conduct of concern?

8. Health care workers not to make claims to cure certain serious illnesses

1. A health care worker must not claim or represent that he or she is qualified, able or willing to cure cancer or other life threatening or terminal illnesses.
2. A health care worker who claims to be able to treat or alleviate the symptoms of cancer or other life threatening or terminal illnesses must be able to substantiate such claims.

Discussion:

The intent of this clause is to provide additional protection for individuals with life threatening illnesses who may be particularly vulnerable to exploitation by unscrupulous health care workers who claim to cure cancer and other terminal illnesses.

This clause is based on the NSW Code (Clause 5) and SA Code (Clause 4) but has been expanded to include a reference to 'life threatening' illnesses.

As detailed in the final report on *Options for the regulation of unregulated health practitioners*, there have been a number of high profile cases of harm in Australia involving health care workers who have advertised that they are able to cure cancer. In some cases the health care workers concerned have been prosecuted under consumer complaints legislation for false, misleading or deceptive advertising. However this process has been lengthy, and has not adequately protected the public from 'repeat offenders'.

Subclause 1 is intended to set a minimum enforceable standard that advertising cures for cancer and other terminal illnesses is unacceptable and will allow the responsible HCE to take effective action to prevent the health care worker from continuing to do so.

Subclause 2 is intended to set a minimum enforceable standard that acknowledges that Code-regulated health care workers may legitimately make claims as to their ability to treat or alleviate the symptoms of cancer and other terminal illnesses. As with all claims made by health care workers, any claim to be able to treat and alleviate the symptoms of such illnesses must be able to be substantiated.

These subclauses deal with a specific kind of misrepresentation. General issues concerning misrepresentation are dealt with in clause 9 below.

What are your views?

Should the National Code include a minimum enforceable standard that addresses claims to cure or treat life threatening and terminal illnesses?

If so, is this clause expressed in a way that will best capture the conduct of concern?

9. Health care workers not to misinform their clients

1. A health care worker must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or the qualifications, training or professional affiliations he or she holds.
2. Without limiting subclause (1):
   a. a health care worker must not use his or her possession of a particular qualification to mislead or deceive clients or the public as to his or her competence in a field of practice or ability to provide treatment
   b. a health care worker must provide truthful information as to his or her qualifications, training or professional affiliations
   c. a health care worker must not make claims either directly to clients or in advertising or promotional materials about the efficacy of treatment or services he or she provides if those claims cannot be substantiated.

Discussion:

The intent of this clause is to support health service users to make informed choices about their health care. Members of the public have a right to accurate and timely information about the efficacy of a treatment, along with any other information which may assist them in making an informed decision, such as the qualifications, training or professional affiliations of a health care worker. This clause brings together Clause 3(2)(b)(b2) and Clause 12 of the NSW Code (Clause 11 of the SA Code) except that the words 'if asked about those matters by clients' have been removed from subclause 2b, to broaden its scope, following preliminary consultation with health complaints entities.

Some stakeholders have argued that the National Code should specifically prohibit health care workers from using particular professional titles that may mislead or deceive clients as to their competence, for example, courtesy titles such as 'Professor' or 'Doctor'. However, use of professional titles is already regulated under the National Law[1] and there are offences for unauthorised use of protected titles. These offences do not restrict the use of courtesy titles and it is proposed that the National Code adopt a similar approach, that is, to capture in a general way, misrepresentation as to qualifications.

What are your views?

Should the National Code include a minimum enforceable standard that addresses misinformation and misrepresentation in the provision of health products and services?

If so, is this clause expressed in a way that will best capture the conduct of concern?

[1] Under s116 of the *Health Practitioner Regulation National Law 2009*, it is an offence for a person who is not a registered health practitioner to take or use a title which could be reasonably understood to mean that the person is a registered health practitioner.

10. Health care workers not to practise under the influence of alcohol or drugs

1. A health care worker must not provide treatment or care to clients while under the influence of alcohol or unlawful drugs.
2. A health care worker who is taking prescribed medication must obtain advice from the prescribing health practitioner or dispensing pharmacist on the impact of the medication on his or her ability to practise and must refrain from treating or caring for clients in circumstances where his or her capacity is or may be impaired.

Discussion:

The intent of this clause is self-explanatory. A health care worker who provides treatment or care while under the influence of drugs or alcohol places the safety of his or her clients at risk. Also, there are a number of prescription and over the counter medicines that may individually or in combination with other medicines impair the ability of a health care worker to safely provide services to their clients.

Health care workers who are taking prescription drugs that may affect their ability to treat or care for clients are advised to obtain advice from the prescribing practitioner or dispensing pharmacist.

This clause is based on NSW Code (Clause 8) and the South Australian Code (Clause 7).

What are your views?

Should the National Code include a minimum enforceable standard that addresses the provision of treatment or care to clients while under the influence of alcohol or drugs?

If so, is this clause expressed in a way that will best capture the conduct of concern?

11. Health care workers with certain mental or physical impairment

1. A health care worker must not provide treatment or care to clients while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that places or is likely to place clients at risk of harm.
2. Without limiting subclause (1), if a health care worker has a mental or physical impairment that could place clients at risk, the health care worker must seek advice from a suitably qualified health practitioner to determine whether, and in what ways, he or she should modify his or her practice, including stopping practice if necessary.

Discussion:

The intent of this clause is to protect the health and safety of clients by requiring a Code-regulated health care worker who suffers from a physical or mental impairment to consider whether their impairment may impact adversely on their capacity to provide safe and competent treatment or care to clients, and if it does, to take appropriate steps cease or modify their practice. Impairment includes addiction to alcohol or other drugs, including prescription medicines.

Subclause 1 is based on the NSW Code (Clause 9) and the SA Code (Clause 8), but has been expanded to capture impairments that 'are likely to place' clients at risk of harm.

Subclause 2 is a new clause that is intended to set a minimum enforceable standard with respect to the actions expected of Code-regulated health care workers who have impairments that adversely affect their capacity to provide treatment or care.

What are your views?

Should the National Code include a minimum enforceable standard that addresses health care workers who suffer from physical or mental impairments that may impact their provision of treatment or care to their clients?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Is subclause 2 necessary, or does subclause 1 sufficiently capture the behaviour of concern?

12. Health care workers not to financially exploit clients

1. A health care worker must not financially exploit their clients.
2. Without limiting subclause (1):
   a) a health care worker must only provide services or treatments to clients that are designed to maintain or improve clients' health or wellbeing
   b) a health care worker must not accept or offer financial inducements or gifts as a part of client referral arrangements with other health care workers
   c) a health care worker must not accept financial inducements or gifts from the suppliers of medicines or other therapeutic goods or devices
   d) a health care worker must not ask clients to give, lend or bequeath money or gifts that will benefit the health care worker directly or indirectly.

Discussion:

The intent of this clause is to set a minimum enforceable standard that protects clients from financial exploitation by health care workers.

This clause is based on NSW Code (Clause 10) and the SA Code (Clause 9), but has been expanded with the addition of subclause 2(d) to capture specific types of financial exploitation that may not be captured by the NSW or SA Codes. This additional clause is drawn from the Medical Board of Australia's Code of Conduct.

There are a number of ways in which health care workers may exploit their clients for financial gain. The most obvious is in the supply of services, medications and equipment which are for purposes other than for the benefit of the client. Particularly vulnerable to this type of exploitation are clients with terminal or other serious illnesses and those in situations of long term dependence or care. Anecdotal evidence suggests there are cases where clients have been pressured, either tacitly or otherwise, to bequeath money either directly to their health care worker, or to other individuals or organisations recommended by the health care worker. A serious conflict of interest occurs where a health care worker stands to gain financially from the death of a client.

Offering or accepting financial inducements for referring clients to particular practitioners or suppliers of goods or medicines may indicate that the health care worker is motivated by self-interest to make those recommendations or referrals, rather than the interests of the client.

What are your views?

Should the National Code include a minimum enforceable standard that addresses financial exploitation of clients?

If so, is this clause expressed in a way that will best capture the conduct of concern, particularly in relation to the treatment or care of elderly, disabled and seriously or terminally ill clients?

13. Health care workers not to engage in sexual misconduct

1. A health care worker must not engage in behaviour of a sexual or close personal nature with a client.
2. A health care worker must not engage in a sexual or other close personal, physical or emotional relationship with a client.
3. Before engaging in a sexual or other close personal, physical or emotional relationship with a former client, a health care worker should ensure that a reasonable period of time has elapsed since the conclusion of the therapeutic relationship.

Discussion:

The intent of this clause is to set a minimum enforceable standard in relation to sexual misconduct by health care workers.

This clause is based on the NSW Code (Clause 13) and the SA Code (Clause 12). However it has been expanded with the addition of subclause 1, in order to capture boundary violations such as unwelcome sexual advances made by the health care worker that cannot be characterised as a 'relationship' with the client. Such conduct is not explicitly referred to in the NSW or SA Codes.

Subclauses (1) and (2): The community expects the highest level of integrity from health care workers. Any Code-regulated health care worker who engages in sexual activity with a current client would be guilty of sexual misconduct. The treatment or caring relationship between a health care worker and their client relies on a high degree of trust. Clients are often in a vulnerable position, and personal involvement with a client betrays that trust and clouds the worker's judgement.

Examples of sexual behaviour are:

- sexual, personal or erotic comments
- comments about a person's private life, sexuality or the way they look
- sexually suggestive comments or jokes
- repeated requests to go out
- requests for sex
- sexually explicit emails, text messages or posts on social networking sites
- inappropriate touching, including with the implication that is has a therapeutic benefit
- not charging or billing for treatment, unrelated to financial hardship.

These subclauses do not specifically refer to sexual or physical assault. These are criminal offences, which should be captured by Clause 1 of this draft National Code. It is proposed that expanding the definition of 'prescribed offences' would also enable Health Complaints Commissioners to deal with Code-regulated health care workers who are charged with or found guilty of such offences – see discussion in section 3.3 of this paper.

Subclause (3): It is not possible to specify a particular period of time that must elapse between the end of a treatment or caring relationship and the commencement of a personal or sexual relationship. A Code-regulate health care worker who finds him or herself contemplating a personal relationship with a former client should seek the advice of senior colleagues to address the important ethical issues.

What are your views?

Should the National Code include a minimum enforceable standard that prohibits sexual misconduct by health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Should the draft National Code be strengthened to specifically address sexual or physical assault in the health care setting, or is the preferred approach to rely on Clause 1 and subclause 13(1) above and/or expand the definition of 'prescribed offences'?

14. Health care workers to comply with relevant privacy laws

A health care worker must comply with the relevant privacy laws that apply to clients' health information, including the *Privacy Act 1988* (Cth) and the [insert name of relevant state or territory legislation].

Discussion:

The intent of this clause is to make clear the legal requirement that applies to all health care workers to comply with relevant state and territory privacy laws that protect the privacy and confidentiality of client information.

This clause is based on the NSW Code (Clause 14) and the SA Code (Clause 13).

Although all health care workers are legally required to comply with privacy laws, inclusion of this clause is expected to provide additional safeguards for the public, in the event that a health care worker repeatedly breaches privacy laws. Including this clause in the draft National Code would allow the responsible health complaints entity to take action against Code-regulated health care workers to prevent further breaches.

What are your views?

Should the National Code include a minimum enforceable standard in relation to breaches of client privacy by health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

15. Health care workers to keep appropriate records

1. A health care worker must maintain accurate, legible and up-to-date clinical records for each client consultation and ensure that these are held securely and not subject to unauthorised access.
2. A health care worker must take necessary steps to facilitate clients' access to information contained in their health records if requested.
3. A health care worker must facilitate the transfer of a client's health record in a timely manner when requested to do so by the client or their legal representative.

Discussion:

The intent of this clause is to set minimum enforceable standards of conduct for Code-regulated health care workers in relation to keeping appropriate client records.

This clause captures the content of NSW Code (Clause 15) and the SA Code (Clause 14) but with the addition of two subclauses to deal with access to and transfer of information in health records.

Subclause 1: The health care record is the basic vehicle for communication among members of the health care team. Records are also kept for a variety of other purposes, a number of which are unrelated to client care, for example, for accounting or tax purposes, or to satisfy legal requirements. However, the primary purpose of a health record is to ensure that accurate and relevant information on a client's care and history is maintained, to assist with ongoing treatment and to ensure continuity of care when a client's care transfers to another health care worker. It is also an important audit tool to monitor quality of care.

Accurate, legible and contemporaneous records are also an extremely valuable tool for a health care worker to use to address client concerns about their treatment, or in defending themselves against an allegation of negligence.

Subclauses 2 and 3: While states and territories generally have legislation that affords a client the legal right to access the information contained in their health record, these subclauses are intended to provide an additional avenue for enforcing minimum standards with respect to access to and transfer of records.

What are your views?

Should the National Code include a minimum enforceable standard in relation to clinical record keeping by health care workers and client access to and transfer of their health records?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Are subclauses 2 and 3 necessary, or does subclause 1 sufficiently capture the conduct of concern?

16. Health care workers to be covered by appropriate insurance

A health care worker must ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

Discussion:

The intent of this clause is to set a minimum enforceable standard that requires all Code-regulated health care workers to hold, or be covered by appropriate professional indemnity insurance.

This clause is based on the NSW Code (Clause 16) and the SA Code (Clause 15).

Appropriate indemnity insurance ensures that clients who are injured as a result of misadventure associated with health care are able to receive fair and sustainable compensation. The costs to a seriously injured client can be substantial and in the absence of adequate compensation through insurance arrangements, these costs are born by the individual and their family and by the community, due to additional calls on the social security system, the public health care system and other government services. The health care worker concerned may also bear significant, possibly financially crippling costs associated with defending legal action and in payment of compensation to an injured client.

As the National Code is intended to cover a wide range of health care workers with different risk profiles, it is not appropriate for the National Code to specify the level of insurance cover that would be required. Code-regulated health care workers who are employees would be expected to be covered by their employer's insurance arrangements. Those who are in independent private practice would be expected to hold insurance in their own name and to ensure that their level of cover is adequate for the type of health services they provide and the associated level of risk. Advice is generally available from professional associations on such matters.

What are your views?

Should the National Code include a minimum enforceable standard in relation to the professional indemnity insurance obligations of health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Is this clause likely to impose unreasonable compliance costs on health care workers?

17. Health care workers to display code and other information

1. A health care worker must display a copy of each of the following documents at all premises where the health care worker carries on his or her practice:
   a) a copy of this Code of Conduct
   b) any relevant qualifications that the health care worker possesses
   c) a document that gives information about the way in which clients may make a complaint to [insert name of state or territory health complaints entity].
2. Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.
3. This clause does not apply to any of the following premises:
   a) the premises of any entity within the public health system (as defined in the [insert name of relevant state or territory legislation])
   b) private health facilities (as defined in [insert name of relevant state or territory legislation])
   c) premises of the [insert name of ambulance service] as defined in ([insert name of relevant state or territory legislation])
   d) premises of approved aged care service providers (within the meaning of the *Aged Care Act 1997* (Cth)).

Discussion:

The intent of this clause is to require Code-regulated health care workers to display information that informs clients of the standard of service the health care worker is required to meet, and the avenue available to the client in the event that the standards are not met.

This clause is based on the NSW Code (Clause 17) except that subclause (1) has been expanded to require that health care workers display any relevant qualifications, as in the introductory paragraphs of the SA Code.

Requiring Code-regulated health care workers to display qualifications increases transparency and provides additional information to clients, placing the onus on the health care worker to provide such information, rather than on clients to ask.

What are your views?

Should the National Code include a minimum enforceable standard in relation to display of the National Code, qualifications and avenues for complaint? If so, is this clause expressed in a way that will achieve this intent?

Should there be a requirement, as in the SA Code, for health care workers to display their qualifications?

Are the exemptions to the requirement to display the National Code and qualifications appropriate?

Where exemptions apply, should there be a requirement to display the Code electronically, for example, on a website?

2.3 Items not included in the draft National Code of Conduct

1. Sale and supply of optical appliances

Clause 18 of the NSW Code sets a minimum enforceable standard in relation to the sale and supply of optical appliances in NSW. This clause has not been included in this draft National Code.

Discussion:

A restriction on the sale and supply of optical appliances is contained in Clause 18 the NSW Code but is not in the SA Code. An equivalent of Clause 18 has not been included in the draft National Code.

It is intended that the National Code set minimum enforceable standards that are generally applicable to all Code-regulated health care workers. The sale and supply of optical appliances is dealt with differently in each state and territory, and regulation of this area of practice is considered best left to each state and territory to determine.

What are your views?

Is this an acceptable approach to dealing with regulation of the sale and supply of optical appliances?

2. Health care workers required to have a clinical basis for treatments

Clause 11 of the NSW Code and Clause 10 of the SA Code of Conduct states 'A health practitioner must have an adequate clinical basis for treatment'. This clause has not been included in this draft National Code.

Discussion:

There are a number of clauses in this draft National Code that address how health service users can be well informed about the nature of the treatments they are considering, and to deal with health care workers who attempt to mislead about the scientific basis or otherwise of their treatments. For instance:

Clause 8 of this draft National Code is framed to protect health service users from Code-regulated health care workers who attempt to exploit vulnerable clients by making claims to cure certain serious illnesses.

Clause 9 of this draft National Code is framed to protect health service users from Code-regulated health care workers who make false claims about the efficacy of a treatment.

The term 'adequate clinical basis' is not defined in the NSW or SA Codes. However, the term 'clinical basis' with respect to the provision of a health care service is generally taken to mean that there is an evidence-base or well documented peer-reviewed assessment of the efficacy of a particular treatment, in accordance with the scientific method.

Determining what is 'evidence based' and an 'adequate clinical basis' is problematic. For instance, it is often assumed that the treatments offered by medical and allied health professionals are evidence based and that those offered by complementary or alternative medicine practitioners are not. However, this is not always the case.

There are gaps in the evidence base for both orthodox and unorthodox treatments. On the one hand, due to factors such as the limits of technology or research capability at the time a treatment regime became embedded, many conventional treatments may be only loosely based on evidence. Were such treatments subjected to the modern gold standard of randomised controlled clinical trials, they may be shown not to have 'an adequate clinical basis'. On the other hand, many health care workers who operate under alternative paradigms are applying the scientific method to test their treatments. Even in well researched fields, recent reports suggest that confirmation bias has contributed to a lack of critical appraisal of what are now widely adopted health guidelines, despite the existence of contradictory evidence. Such reports highlight the subjectivity of evidence-based practice.

There are many health care workers who operate under a paradigm that is different to the dominant paradigm of Western biomedicine. It is not intended that the National Code be applied to prevent such health care workers from continuing to offer their services to the public, or to restrict the choices available to consumers. Consumers are entitled to choose to use health services that do not have a strong evidence base, or those that operate under a different paradigm to that of Western biomedicine.

Of the nine professional codes of practice reviewed, only one included a requirement that a treatment should have an adequate clinical or evidential basis - the Dietitians Association of Australia's *Statement of Ethical Practice*. The former Medical Board of Victoria, in their *Guide for Medical Practitioners* (1999), contained guidance for medical practitioners who provided alternative or complementary therapies as an adjunct to conventional medical treatments. The guide advised practitioners that 'Special care must be taken to inform patients when therapy is unproven and to fully inform patients of any risks associated with such therapy.' This statement recognises the lack of high quality evidence regarding the safety and efficacy of some forms of complementary medicine, without seeking to restrict consumers' rights to access it.

During the 2011 consultation on *Options for the Regulation of Unregistered Practitioners,* a number of submissions voiced objections to regulatory schemes which 'legitimise quackery'. The terms 'pseudo-medicine' and 'pseudo-science' were also used to distinguish complementary medicine from 'legitimate' or 'science-based' medicine. The distinctions are not so easy to draw in practice. If this clause is included in the National Code, there is a risk that health care workers could be subject to frivolous or vexatious complaints simply on the basis that the complainant has an ideological objection to complementary medicine.

What are your views?

Is the proposed approach adopted in this draft National Code appropriate given the complexities of determining what treatments do and do not have 'an adequate clinical basis'?

Should the National Code include an additional clause along the following lines 'A health care worker must take special care when a treatment they are offering to a client is experimental or unproven, to inform the client of any risks associated with the treatment'? If so, how should complexities with identifying which treatments are 'unproven' be dealt with?

3. Implementation - Legislation

3.1 Overview

Health Ministers have asked AHMAC to undertake a public consultation on the terms of the first national Code of Conduct and on the proposed policy parameters to underpin nationally consistent implementation of the National Code.

This section identifies for discussion the key policy parameters that need to be settled in order for states and territories to give effect to the National Code of Conduct.

Similarities and differences in state and territory health complaints legislation are identified and the implications for implementation of a National Code are discussed.

Comment is invited on the extent to which there is a need for national uniformity in the legislation that gives effect to the National Code in each state and territory. Where national uniformity is considered desirable, comment is also invited on the preferred approach.

The key policy parameters addressed below are:

- Scope of application of the National Code
- Terminology
- Who can make a complaint
- Grounds for making a complaint
- Timeframe for lodging a complaint
- Commissioner's 'own motion' powers
- Interim prohibition orders
- Who is empowered to issue prohibition orders
- Grounds for issuing a prohibition order
- Application of a 'fit and proper' person test
- Publication of prohibition orders and public statements
- Application of interstate prohibition orders
- Right of review of prohibition orders
- Penalties for breach of a prohibition order
- Information sharing powers
- Powers to monitor compliance with prohibition orders
- Regulation making powers and the role of the Code.

3.2 Scope of application of the National Code

There are two ways in which the scope of application of the National Code will be set in legislation. Firstly, by the definitions contained in the National Code, which describe the types of providers and services that are to be covered by the National Code. Secondly, by

the provisions of the legislation which confer powers on the relevant health complaints entity to administer and enforce the National Code.

In particular, how key terms such as 'health care worker' (or equivalent term) and 'health service' are defined in legislation will determine the scope of application of the National Code.

There is considerable variability across state and territory legislation in the definition of key terms that determine the general scope of powers of each health complaints entity.

For instance, a range of terms are used in state and territory legislation, including:

- Health service
- Health service provider
- Provider
- Registered provider
- Health practitioner
- Health professional
- Nationally registered health practitioner
- Registered health practitioner
- Unregistered health practitioner

Appendix 2.1 and Appendix 2.2 set out the various state and territory legislative provisions that are relevant to this consultation. While there is some commonality across jurisdictions in how key terms are framed, there are also significant differences which have consequences for application of the National Code.

These issues of definition are examined below. Definitions of 'health care worker' and 'health service' are proposed for the purposes of this consultation.

Definition of a 'health care worker'

In order to apply the National Code of Conduct, each jurisdiction's legislation will need to identify and define the class of persons who are to be subject to the Code.

The NSW and SA Codes use the term 'unregistered health practitioner' to describe and define the class of persons subject to their Codes.

During the 2011 consultation on *Options for the regulation of unregistered health practitioners*, some stakeholders expressed strong objections to use of the term 'unregistered health practitioner' to describe persons expected to be subject to the proposed National Code. They argued that:

- use of such a term did not accurately represent the level of regulation many practitioners are subject to
- many of the 'unregistered' professions have rigorous self-regulatory regimes, including codes of conduct and disciplinary procedures
- use of the term 'unregistered' implied a lack of professionalism and performance oversight within the profession.

Terminology is important because of the image it presents to the public. Use of the term 'unregistered' may be problematic, not only for the reasons given above, but also because, as in NSW and South Australia, the scope of the regime is intended to cover registered health practitioners to the extent that they practise beyond the usual scope of practice of their (registered) health profession. Use of the term 'unregistered' when the Code applies to registered health practitioners in certain circumstances may be a source of confusion.

Some have also expressed the view that the terminology 'health practitioner' implies a minimum educational requirement or level of qualification. The term 'health care worker' is intended to make clear that the National Code will apply to those who provide 'care' and 'support' in a health setting, as well as those who provide 'treatment' in independent practice.

On the other hand, some are of the view that use of the term 'unregistered health practitioner' most clearly differentiates between those providers and types of treatment and services that are intended to be captured by this regime, and those that are regulated under the National Law (and therefore out of scope).

Views are sought on suitable terminology for describing the class or classes of person to be captured by the Code regime. One option is to describe such persons as 'health care workers', to distinguish them from health practitioners regulated under the National Registration and Accreditation Scheme. There may be other options.

What are your views?

What terminology is preferred to identify and define the class or classes of person who are to be subject to the National Code of Conduct?

Is the term 'unregistered health practitioner' appropriate?

Is the term 'health care worker' acceptable, or is another term preferable?

Definition of a 'health service'

There are considerable differences across jurisdictions as to what constitutes a 'health service'.

Queensland legislation has the broadest definition, capturing services for 'maintaining, improving, restoring or managing peoples' health and wellbeing'. The ACT definition also includes a reference to 'maintaining or improving…comfort or wellbeing'. The South Australian definition is framed to include a service designed to 'promote human health'. The Tasmanian definition refers to services that are provided 'for the benefit of human health', as does the Northern Territory definition that refers to a service provided 'for, or purportedly for, the benefit of the health of a person'.

Arguably such broadly framed definitions that include references to 'wellbeing' capture a range of recreation and lifestyle services, including beauty therapy, personal trainers, fitness instructors, yoga and meditation services, life coaches or even ski instructors.

The NSW and Victorian definitions are somewhat narrower. These definitions state that 'a health service includes…', followed by examples. There is considerable overlap in the list of examples between NSW and Victoria. Use of the word 'includes' means that the list of examples is not meant to be all inclusive in that there may be other services that the responsible health complaints entity determines to be health services that are not listed in the definitions.

The Western Australian definition does not list specific types of service, rather it refers to services provided 'by way of' diagnosis or treatment of a disorder, preventative care, palliative care and so on. The Director of the Western Australian Health and Disability Services Complaints Office has advised that in applying the definition, procedures carried out by a cosmetic surgeon, unless reconstructive, would not be considered a 'health service'; likewise any cosmetic or beauty therapy treatments carried out by a health care worker would not be considered a health service.

Boundary between 'health care' and 'social care': Some legislative definitions do not distinguish between health care and social care services, in that they capture services provided to support activities of daily living for those in accommodation support services, as well as those services such as wound management or medication administration that are provided within or as part of that accommodation services and are more clearly health services. For instance, the Tasmanian definition captures services provided 'for the accommodation of persons who are aged or have a physical or mental dysfunction'. The South Australian definition also captures accommodation services for such persons, including 'social, welfare, recreation or leisure services' delivered as part of such accommodation services. Such definitions arguably capture everything that happens in accommodation services for people with intellectual disability, including services provided to people in supported independent living.

How administrative support services are dealt with: A related issue is how administrative and other support services that are delivered as part of a health service are dealt with. Most state and territory definitions capture such services in some way although the terminology used varies. Administrative and other support services are variously described as 'welfare', 'administrative', 'ancillary' or 'support' services that are 'directly related to' (NT); 'necessary to implement' (NSW); 'if provided as part of' (Tas); 'where those services affect' (Vic); 'complementary to' (WA) the provision of a health service.

A few definitions include specific reference to 'laboratory services', while most do not. The Tasmanian definition requires the laboratory services to be 'provided in support of a health service' whereas the South Australian definition does not include such a qualifier.

Geographic limitations: The ACT and Northern Territory definitions require the health service to be provided within their respective territories. The definitions in other jurisdictions do not specifically limit where the health service is provided. This may mean that a health care worker based in one jurisdiction who provides a service via telemedicine to a client in another jurisdiction may be captured within the definitions in both.

Inclusions and exclusions: Most state and territory definitions make provision for a service to be defined as a 'health service' by prescribing it in regulation.

Most definitions do not specifically mention volunteers. In the Northern Territory and the ACT, the definition of 'provider' makes specific reference to a volunteer who provides a health service. In South Australia, volunteers are not specifically captured in the definition of health service providers, but are defined separately. The South Australian legislation exempts volunteers from the complaints process in the event that a complaint 'relates to an act or omission of a volunteer while working for another person or body'. In such circumstances, the complaint is taken to be a complaint against the other person or body.

The South Australian definition of a health service specifically excludes 'the process of writing, or the content of, a health status report'.

Discussion

Differences in definition reflect in part differences in the scope of powers of state and territory health complaints entities. For instance, in South Australia, the Commissioner receives and deals with complaints about both health and community services. In Western Australia, the scope of the regime covers complaints about both health and disability services.

Differences in application of the regime across jurisdictions raise a number of issues:

Mutual recognition: If different definitions of what constitutes a health service are adopted, this may present difficulties for mutual recognition of prohibition orders, that is, the application of prohibition orders across state and territory borders. For instance, a prohibition order issued in one jurisdiction may be open to challenge in a second jurisdiction if the legislative bases for issuing such prohibition orders differ.

Public education: Public and health care worker education will be an important element of effective implementation of the regime. If there are differences in how the National Code applies in each jurisdiction, there will be costs incurred for professional associations in educating their members about the different arrangements in each state and territory. Similarly, community education may be more challenging and costly.

Data collection and reporting: Making comparisons across jurisdictions in the application of the National Code will be more difficult if data is not collected, maintained and reported in a consistent manner.

These issues raise the threshold question of whether there is a need for consistency in the way the definition of a health service is framed, in order to provide for consistency in application of the National Code across jurisdictions. An agreed national definition of a health service implemented in every state and territory legislation would:

- facilitate consumer and health care worker education
- facilitate application of mutual recognition of prohibition orders across state and territory borders
- enable comparison across jurisdictions of data on complaints handling and prohibition orders, and the performance of the regulatory arrangements in general.

There are three options for dealing with issues of definition of a health service:

Option 1: Each jurisdiction determines the scope of application of the National Code and determines its own definition of what constitutes a health service.

Option 2: A single national definition of ‘health service’ is agreed and given effect in each jurisdiction’s legislation.

Option 3: A single national definition of ‘health service’ is agreed and implemented in each jurisdiction’s legislation, but only for the purposes of application of the National Code of Conduct. This definition would then sit alongside a broader definition of health service that applies for other functions of the health complaints entity under the jurisdiction’s complaints legislation.

A single national definition of a ‘health service’ has been framed for the purposes of this consultation. It has been adapted from the definition that the Australian Law Reform Commission’s *Review of Australian Privacy Law and Practice* (ALRC 108) recommended be adopted by the *Privacy Act 1988* (Cth).

A health service is defined as:

(a) an activity performed in relation to an individual that is intended or claimed (expressly or otherwise) by the individual or the service provider to:

(i) assess, predict, maintain or improve the individual's physical, mental or psychological health or status;

(ii) diagnose the individual's illness, injury or disability; or

(iii) prevent or treat the individual's illness, injury or disability or suspected illness, injury or disability;

(b) a health-related disability, palliative care or aged care service; or

(c) a surgical or related service; or

(d) the prescribing or dispensing of a drug, medicinal preparation, aid or piece of equipment for therapeutic use; or

(e) support services necessary to implement any services referred to in paragraphs (a) to (d).

Note that two changes have been made to the ALRC recommended definition:

- Clause (d) has been expanded to capture aids and equipment, and medicines prescribed and dispensed by any person, not just a pharmacist; and
- a new Clause (e) has been added.

However, given there are substantial differences between jurisdictions in the scope and application of their complaints systems generally, adoption of a uniform national definition may not be achievable without considerable reworking of complaints arrangements in some jurisdictions.

What are your views?

How important is national consistency in the scope of application of the National Code of Conduct, particularly with respect to the definition of what constitutes a 'health service'?

If consistency is considered necessary, how should 'health service' and 'health care worker' be defined?

Is there a need to include a reference to 'volunteer' in the definition of provider/health service provider?

3.3 Application of a 'fit and proper person' test

Currently there are limited legislative powers under the NSW and South Australian regimes to take action to protect the public from future harm in circumstances where a person's conduct unconnected with their provision of health services suggests that they are not 'fit and proper' to provide health services. There is extensive case law on what constitutes 'fit and proper' and the circumstances in which a fit and proper person test has been applied to health practitioners.

In NSW, the Health Care Complaints Commission (HCCC) is able to issue a prohibition order where a health practitioner has committed a 'relevant offence'. A relevant offence is defined to include offences under:

- Part 7 of the *Public Health Act 2010* (NSW)

- *Fair Trading Act 1987* (Cth)
- *Competition and Consumer Act 2010* (Cth) (that relates to the provision of health services).

Similarly, in South Australia, 'prescribed offence' is defined to include offences under:

- Australian Consumer Law (SA)
- Part 3 of the *Criminal Law Consolidation Act 1935* (SA)
- *Public Health Act 2011* (SA).

The NSW HCCC has advised of a gap in the powers of the Commissioner, in circumstances where the public may be at risk but where no breach of the Code of Conduct has been found on investigation. Such circumstances might include, for example, where an unregistered health practitioner has been convicted of a serious sex or violence offence, for instance, possession of child pornography. Although the NSW Commissioner would be able to investigate such persons on his own motion or in response to a complaint, if there is no evidence that the person has breached the Code, the Commissioner has no grounds on which to issue a prohibition order, even where he considers the public to be at risk.

There may be similar limitations under the Queensland Code regime. Under the Queensland *Health Ombudsman Act 2013*, prohibition orders are issued by the Queensland Civil and Administrative Tribunal (QCAT). In issuing a prohibition order, QCAT must decide whether, based on the health practitioner's health, conduct or performance, the practitioner poses a serious risk to the public. Arguably, like the NSW HCCC, QCAT would not have the power to issue a prohibition order on the basis of conduct that occurs outside of the person's practice.

In the SA Code regime, the powers of the Commissioner are slightly broader in that a conviction for an offence under the Criminal Code of South Australia would then trigger the Commissioner's powers to issue a prohibition order, if the public were at serious risk of harm. This provision might be relied upon in the circumstances outlined above.

Another area of concern is where a health practitioner whose registration has been cancelled under the National Law for professional misconduct 're-brands' himself or herself and continues to provide health services using a different title. Examples might include a de-registered psychologist who practises as a psychotherapist or a midwife who practises as a home birth attendant. Unless a prohibition order is issued at the time the practitioner's registration is cancelled, there is no provision for a National Board to go back to the tribunal at a later date to seek a prohibition order.

Under the NSW and SA Code regimes, in the absence of a breach of the Code, there are no powers to issue a prohibition order where a health practitioner's registration has been cancelled under the National Law, or where a person has committed an offence under the National Law, even where there is significant and continuing risk to public health and safety.

There are three options for providing powers for a health complaints entity or tribunal to deal with circumstances where a health care worker has not breached the Code, but has engaged in conduct that would suggest he or she is not fit and proper to provide a health service:

Option 1: Include 'fit and proper person' test in the National Code

Under this option, a fit and proper person test would be incorporated into the National Code itself, providing grounds for a health complaints entity or tribunal to find a breach of the code, triggering the power to issue a prohibition order.

Option 2:Include legislative powers to apply a 'fit and proper person' test

NSW and South Australian health complaints legislation currently provide the following grounds for issuing a prohibition order:

1. A practitioner must have breached the Code of Conduct for unregistered health practitioners; or
2. A health practitioner must be guilty of a relevant/prescribed offence; and
3. There is a significant risk to public health and safety.

Under this option, each jurisdiction's legislation would contain provisions that empower the health complaints entity (or tribunal) to issue a prohibition order in circumstances where no breach of the Code of Conduct has occurred, but where a criminal conviction or a pattern of convictions indicates the person is not fit and proper to provide health services, and where the health complaints entity or tribunal reasonably believes there is a serious risk to the public.

Option 3: Expand the list of what constitutes a 'prescribed offence'

Under this option, the definition of 'prescribed offence' or 'relevant offence' could be expanded in state or territory health complaints legislation to include offences under respective state and territory criminal codes, as well as offences under the National Law. This would enable a prohibition order to be issued even though the Code has not been breached.

What are your views?

Should there be power to issue a prohibition order on the grounds that a person is not a fit and proper person to provide health services where they present a serious risk to public health and safety?

Is there a preferred option for enabling the application of a fit and proper person test?

Is consistency across jurisdictions considered important in the approach adopted?

3.4 Who can make a complaint

Every state and territory health complaints statute contains a provision that establishes who is legally entitled to make a complaint. A health complaints entity cannot accept a complaint and deal with it unless the person making the complaint fits within a category of person under the applicable provision.

Appendix 2.1 sets out the relevant state and territory provisions. There is some variation across states and territories in how these provisions are framed and who is able to make a complaint.

In NSW and Queensland, any person may make a complaint. Both statutes list examples that make clear that lodging complaints is not restricted only to service users and their guardian or representative. Other persons can make complaints, including a practitioner with concerns about another practitioner, a member of parliament or the responsible Director-General or Minister for Health.

In other states and territories, the provisions are narrower, limiting who can make a complaint to service users and their guardian or representative. However, exceptions are provided for in some statutes, giving the responsible health complaints entity the discretion

to accept and deal with complaints from persons other than service users. For instance, the Tasmanian statute allows the Commissioner to accept a complaint if the Commissioner considers that in the circumstances of the particular case, another person 'should be permitted to make a complaint'. The South Australian statute similarly provides discretion for the Commissioner to accept a complaint from any other person 'in the public interest'.

What are your views?

How important is national consistency in who may make a complaint?

If consistency is considered important, is there a preferred approach for specifying in legislation who may make a complaint - for instance 'any person may make a complaint' (as in NSW and Queensland) or persons other than service users and their representatives, but with the discretion of the Commissioner following application of a public interest test?

3.5 Commissioner's 'own motion' powers

Some state and territory health complaints statutes contains provisions that enable the health complaints entity to investigate a matter that is not the subject of a complaint, or to keep dealing with a matter even where the complainant has withdrawn the complaint. The mechanism through which this is achieved is different in each jurisdiction.

For instance, the Queensland Ombudsman may carry out an investigation of a complaint, a systemic issue, or 'another matter, if the ombudsman considers an investigation of the matter is relevant to achieving an object of this Act'. In South Australia, the Commissioner may investigate 'on his or her own motion, any other matter relating to the provision of health or community services in South Australia'. Similarly, in Tasmania the Commissioner can investigate 'on his or her own motion, any other matter relating to the provision of health services in Tasmania'. In the ACT, the commission may, on its own initiative, consider an act or service about which a complaint could be made but has not, or any other matter related to the commission's functions. This is called 'commission-initiated consideration'.

In Northern Territory the Commissioner has the power to investigate an issue or question arising from a complaint or group of complaints, if it appears to the Commissioner to be a significant issue of public health or safety or public interest, or a significant question as to the practice and procedures of a provider.

No own motion powers are available to the health complaints entities in the Northern Territory, Victoria or Western Australia, although there are powers for Health Ministers in the North Territory and Western Australia to refer matters for investigation.

What are your views?

How important is national consistency with respect to the power for a health complaints entity to initiate an investigation of a matter on its own motion, without a complaint?

If consistency is considered important, should every state and territory health complaints entity have such 'own motion' powers?

3.6 Grounds for making a complaint

Every state and territory health complaints statute contains provisions that establish the grounds for making a complaint, that is, what a complaint may be about. Such provisions are

generally framed to enable the health complaints entity to determine whether a complaint is 'within jurisdiction' or not.

There is some variation across states and territories in how these provisions are framed and what types of complaint they capture. There are three different approaches.

In NSW and Queensland, the provisions are quite brief, and terms are used that mirror to an extent those used in the National Law that apply to registered practitioners. In Queensland, the provision states simply that 'A health service complaint is a complaint about a health service or other service provided by a health service provider', and gives some examples that include: 'the health, conduct or performance of a health care worker while providing a health service' (terms used in the National Law). The NSW statute says that a complaint may be about 'the professional conduct of a health practitioner', including any alleged breach by the practitioner of the Code of Conduct that is made by regulation in that state.

In statutes of Northern Territory, South Australia, Tasmania, Victoria and Western Australia, the grounds for making a complaint are that the health service provider (which includes an individual health practitioner) has 'acted unreasonably'. Most statutes then set out an extensive list of examples of where, for the purposes of lodging a complaint, a provider might be considered to have 'acted unreasonably'. These include: failing to provide a health service; discontinuing provision of a health service; failing to exercise due skill and care; failing to provide adequate information or informed consent; and unreasonably disclosing information to a third person.

In ACT, a person may complain to the Commission about a health service that 'is not being provided appropriately' or is inconsistent with 'the health code', the 'health provision principles' or with 'a generally accepted standard of health service delivery expected of providers of the same kind as the provider'.

Some jurisdictions also refer to other standards documents or legislation, such as the 'health code' and the National Standards for Mental Health Services in ACT, the 'Carers Charter' in Northern Territory and Western Australia, the 'Charter' in South Australia and Tasmania.

There are advantages and disadvantages of each approach. A threshold question is whether national uniformity in the grounds for making a complaint about a Code-regulated health care worker is necessary and desirable. If so, there may be advantages in adopting the same terminology as that which applies to registered health practitioners under the National Law, such as references to 'professional conduct' and 'health, performance and conduct'.

What are your views?

How important is national consistency in the grounds for making a complaint?

If consistency is considered important, is there a preferred approach for defining the grounds for making a complaint and what terminology is preferred?

3.7 Timeframe for lodging a complaint

Some state and territory health complaints statutes specify the time limit within which a complaint must be lodged, and others do not. For instance, in South Australia a complaint must be made within two years from the day on which the complainant first had notice of the circumstances giving rise to the complaint, however the Commissioner has broad discretion to extend the period in a particular case. The same time limit applies in Western Australia

and the Northern Territory, ‘unless there is good reason for delay’. In Victoria, the time limit is 12 months, again ‘unless there is good reason for delay’.

In NSW, Queensland, ACT and Tasmania, no time limit is specified in legislation.

Views are sought on whether there is a need for national consistency with respect to the time frame for lodging a complaint, and if so, whether a time limit should be specified, what this should be, and whether there should be discretion for the health complaints entity to accept complaints beyond the time limit and in what circumstances.

What are your views?

How important is national consistency in relation to the timeframe within which a complaint must be lodged?

If consistency is considered important, is there a preferred approach, that is, should a time limit be specified, and if so, what should it be and should there be discretion to extend it and in what circumstances?

3.8 Interim prohibition orders

In the three states that have enacted enforceable statutory Code regimes, the responsible health complaints entity has the power to issue an interim prohibition order. However, different approaches have been taken in statute with respect to the grounds on which an interim order may be made, the process for issuing the order, and the maximum time period for which the order applies.

In NSW, the grounds for issuing an interim prohibition order are:

- during an investigation, and
- the Commissioner has formed a reasonable belief that the practitioner has breached the code of conduct, and
- is of the opinion that the practitioner poses a serious risk to the health or safety of members of the public, and
- the making of an interim order is necessary to protect the health or safety of members of the public.

An interim order in NSW may be made for a maximum period of 8 weeks.

In South Australia the grounds for issuing an interim order are:

- a reasonable belief that the code has been breached, OR that the practitioner has ‘committed a prescribed offence’ and
- that action is necessary to protect the health or safety of members of the public.

An interim order may be made for a maximum period of 12 weeks.

In Queensland, the Health Ombudsman has the power to issue an interim prohibition order, if he or she is satisfied, on reasonable grounds, that the practitioner poses serious risk to persons because of the practitioner’s health, conduct or performance. The statute includes examples of serious risk that include financial exploitation and making false and misleading claims about qualifications or the benefits of treatment. No maximum period is specified for issuing an order. Instead, an interim order is in place until it is revoked by the Ombudsman, or set aside by the tribunal.

The grounds that apply in South Australia are, arguably, wider than those in NSW and Queensland, to the extent that the Commissioner can issue an interim order where a practitioner has committed a 'prescribed offence', which includes offences under the criminal law in that state.

In Queensland, a 'show cause' process is required, either before or at the time the interim order is issued. Under this process, the Ombudsman must give notice of the order (or proposed order) to the practitioner, and afford the practitioner the right to make submissions orally or in writing. In NSW and South Australia, the respective commissioners must give notice of the order to the practitioner at the time it is issued, but no 'show cause' process is specified.

What are your views?

How important is national consistency with respect to the issuing of interim prohibition orders?

If consistency is considered important, what is the preferred approach with respect to the grounds for issuing an interim order, the process and the maximum time period?

3.9 Who is empowered to issue prohibition orders

In NSW and South Australia, the responsible commissioner both investigates and issues prohibition orders and interim prohibition orders. In Queensland, the Health Ombudsman is empowered to issue interim prohibition orders only, and it is the Queensland Civil and Administrative Tribunal (QCAT) which issues the ongoing prohibition orders, following a hearing.

The NSW and South Australian statutes do not specify that an unregistered health practitioner must be afforded the right to a hearing before a prohibition order is issued. However, the right of practitioners to procedural fairness is protected in NSW and South Australia in two ways. First, the NSW and South Australian commissioners have advised that as a matter of procedure, where the responsible Commissioner is considering issuing a prohibition order, the practitioner is afforded the right to be heard before the Commissioner makes a decision. Second, a practitioner who is aggrieved by a decision of the responsible Commissioner to issue a prohibition order has a right of appeal, in NSW to the Administrative Decisions Tribunal, and in South Australia to the Administrative and Disciplinary Division of the District Court.

Using the same entity to both investigate/prosecute breaches and impose sanctions (prohibition orders) has strengths and weaknesses. On the one hand, it allows a health complaints entity to respond quickly and effectively to public health risks presented by unregistered practitioners, more quickly than if the health complaints entity was required to prepare and prosecute a case before a tribunal or court to obtain a prohibition order. On the other hand, it treats registered and unregistered practitioners differently. Under the National Law, there is a 'separation of powers' between those who investigate and prosecute breaches of professional standards (the Australian Health Practitioner Regulation Agency), and those who hear and adjudicate matters and impose sanctions (a state or territory tribunal).

What are your views?

How important is national consistency with respect to the body that is conferred with powers to issue prohibition orders?

If consistency is considered important, which body should have the power to issue ongoing prohibition orders, the Commissioner or a tribunal?

3.10 Grounds for issuing prohibition orders

In the three states that have implemented an enforceable statutory code of conduct regime for unregistered health practitioners, different approaches have been taken in statute with respect to the grounds that must be met before a prohibition order may be issued.

In NSW, the grounds for issuing a prohibition order are:

- an investigation has been completed in accordance with the Act,
- the Commission finds the practitioner has breached the code of conduct or committed a 'relevant offence', AND
- is of the opinion that the practitioner poses a serious risk to the health or safety of members of the public.

In South Australia, while the terminology is slightly different ('prescribed offence' instead of 'relevant offence' and 'unacceptable risk' instead of 'serious risk'), the grounds are much the same. Arguably the term 'unacceptable risk' gives greater discretion to the South Australian commissioner than 'serious risk' in NSW.

In Queensland, the grounds for issuing a prohibition order are different. The tribunal may make a prohibition order where it decides the practitioner 'poses serious risk to persons' because of the practitioner's 'health, conduct or performance'. As with the interim prohibition orders, the statute lists examples such as: practising while intoxicated by alcohol or drugs; financial exploitation; sexual or improper personal relationships; discouraging a person from seeking clinically accepted care; and making false or misleading claims about qualifications or health benefits of a particular health service. While the tribunal is not required to find a breach of a code of conduct before it issues a prohibition order, it 'may have regard to a prescribed conduct document'. On the one hand this approach gives more discretion to the tribunal. On the other hand, by omitting any reference to 'prescribed offences' as a ground for issuing a prohibition order, arguably it limits the tribunal to considering matters that arise only in the course of the person's health practice.

What are your views?

How important is national consistency in the grounds for issuing a prohibition order?

If consistency is considered important, is there a preferred approach?

3.11 Publication of prohibition orders and public statements

In the three states that have implemented an enforceable Code regime for unregistered health practitioners, different approaches have been taken in statute with respect to the powers of the health complaints entity to issue public statements and warnings.

In NSW the Commission has the power to publish a 'public statement...in a manner determined by the Commission identifying and giving warnings or information about the

health practitioner and the health services provided by the health practitioner'. The Commission has the power to amend or revise a public statement.

In South Australia, the Commissioner has the power when an order is made to 'publish a public statement, in a manner determined by the Commissioner, identifying the prescribed health service provider and giving warnings or other such information as the Commissioner considers appropriate in relation to the health services...'. The Commissioner may vary or revoke an order.

In Queensland, the Health Ombudsman 'must' publish on a publicly accessible website of the Ombudsman a specified list of information about 'each current prohibition order'. This information is: the name of the health practitioner, the day the order took effect, and the details of the order.

The NSW and South Australian publication powers are, arguably, broader than in Queensland, to the extent that they enable a public statement to be issued that includes information that is not contained in a prohibition order.

The Queensland Health Ombudsman has powers to publish both interim prohibition orders and prohibition orders. There is no specific provision in the NSW and South Australian statutes that empower the respective commissioners to publish interim prohibition orders.

What are your views?

How important is national consistency in the publication of public statements that include the details of prohibition orders issued?

If consistency is considered important, is there a preferred approach?

3.12 Application of interstate prohibition orders

The Queensland statute was enacted in 2013 and includes provisions to enable prohibition orders issued interstate to be applied in Queensland. The statute includes powers for the Queensland Ombudsman to publish 'corresponding interstate orders', including interim prohibition orders. A 'corresponding interstate order' is one that is 'prescribed by regulation' and is made under a law of another state or territory and corresponds or substantially corresponds to an order made under the Queensland Health Ombudsman Act.

There are no similar provisions in NSW or South Australian statutes that enable prohibition orders issued by interstate HCEs or tribunals to apply in NSW or South Australia.

The approach adopted in Queensland requires that a regulation be made for an interstate issued prohibition order to apply in Queensland. Given that regulations have not yet been made, it is not known whether the Queensland regulation will prescribe classes of prohibition order, such as those issued under specified provisions of relevant interstate statutes, or whether each prohibition order that is issued will need to be separately prescribed by regulation before it applies in Queensland.

Under mutual recognition legislation that applied to registered health practitioners prior to enactment of the National Law, if a practitioner's registration was cancelled or suspended in one jurisdiction, or had conditions attached, the cancellation, suspension or conditions applied automatically in all other states and territories without the need for additional administrative or regulatory action. This provided a streamlined mechanism for protecting the public.

What are your views?

How important is national consistency in achieving application across Australia of prohibition orders and interim prohibition orders issued in each state and territory?

If consistency is considered important, is there a preferred approach for achieving mutual recognition of prohibition orders?

3.13 Right of review of a prohibition order

As outlined earlier, a practitioner who is aggrieved by a decision by a health complaints entity to issue a prohibition order has a right of appeal, in NSW to the Administrative Decisions Tribunal, and in South Australia to the Administrative and Disciplinary Division of the District Court.

In Queensland, the tribunal has powers to review an interim prohibition order issued by the Health Ombudsman. Appeals arising from a tribunal issued prohibition order lie to the Court of Appeal in Queensland.

The time period within which an application for review or appeal must be lodged is 28 days in NSW and Queensland, and within one month (or an extended period, at the discretion of the District Court) in South Australia.

What are your views?

How important is national consistency with respect to review rights for practitioners who are subject to a prohibition order?

If consistency is considered important, is there a preferred approach?

3.14 Penalties for breach of a prohibition order

In the three states that have implemented an enforceable statutory Code regime for unregistered health practitioners, different approaches have been taken in legislation with respect to the penalties that apply for breach of a prohibition order or interim prohibition order.

In NSW, the maximum penalty for breach of a prohibition order is 200 penalty units ($22,000) or imprisonment for 12 months or both. There are also offences for failing to inform a prospective client or their guardian prior to treatment of the terms of the order that applies, and failing to include details of the order in any advertising. The penalty for each of these offences is 100 ($11,000) penalty units or imprisonment for 6 months or both.

In South Australia, the maximum penalty is a fine of $10,000 or imprisonment for two years, or both.

In Queensland, the penalty for breach of a prohibition order or interim prohibition order is 200 penalty units. A penalty unit under the *Penalties and Sentencing Act* (Qld) is currently set at $110, making the maximum fine applicable $22,000.

What are your views?

How important is national consistency with respect to the offences and penalties that apply for breach of a prohibition order?

If consistency is considered important, what is the preferred approach?

3.15 Powers to monitor compliance with prohibition orders

In NSW, South Australia and Queensland statutes, there are no specific powers for a health complaints entity to monitor the compliance of an individual practitioner with the terms of a prohibition order or interim prohibition order. The number of prohibition orders issued each year is small, and the NSW and SA commissioners have advised that compliance has not been a particular problem to date.

The NSW HCCC has advised that limited monitoring of compliance is undertaken and that a few breaches have been detected primarily by complainants and others notifying the HCCC. When the HCCC has been notified of a breach, swift action has been taken to address the breach. If the breach is serious, the HCCC has powers to initiate a prosecution through the Magistrates Court. To date, one prosecution has been initiated for breach of a prohibition order.

Arguably a prohibition order that attaches conditions to a practitioner's practice could contain conditions that require the practitioner to regularly report their compliance to the health complaints commissioner, thus enabling monitoring of compliance. This would require resourcing.

What are your views?

How important is national consistency with respect to powers to monitor practitioner compliance with prohibition orders issued?

If consistency is considered important, is there a preferred approach?

3.16 Information sharing powers

In South Australia and Queensland, legislative provisions regulate the sharing of information with other health complaints entities and regulators. While the provisions are worded differently, the effect is similar, to enable the sharing of confidential information between health complaints commissions, including information with respect to investigations and prohibition orders.

The South Australian Commissioner has the power to 'assist, and provide information to, a person concerned in the administration or enforcement of a law of the State, or a law of the Commonwealth or another state or territory of the Commonwealth, for purposes related to the administration or operation of that other law.'

The Queensland *Ombudsman Act 2013* contains a provision that requires confidentiality of information under the regime, and specifies the circumstances under which confidential information may be disclosed and to whom. These provisions enable confidential information to be disclosed 'to a government entity with functions that correspond to the functions of the health ombudsman under this Act'.

The NSW *Health Care Complaints Commission Act 1993* contains a provision which allows the HCCC or a member of staff of the HCCC to disclose information in exercising a function

of the Act to certain individuals and organisations, including any person or body regulating health service providers in Australia, any authority regulating health service providers in Australia and any investigating or prosecuting authority established by or under legislation.

What are your views?

How important is national consistency with respect to the sharing of confidential information between HCEs and with other regulators?

If consistency is considered important, what is the preferred approach?

4. Implementation – Administrative arrangements

4.1 Mutual recognition

Once each state and territory implements the National Code, following receipt and investigation of a complaint about a health care worker, the health complaints entity or tribunal may find that the health care worker has breached the National Code and that he or she poses a risk to the health or safety of members of the public. If the health complaints entity or tribunal finds that the health care worker's continued practice poses a risk to the health and safety of members of the public, the health complaints entity or tribunal may issue a prohibition order against that health care worker and make a public statement about the order issued.

It is intended that a prohibition order issued in one state or territory will apply in every other state or territory. To ensure that information about prohibition orders is readily accessible to members of the public and other health service providers including employers, it is proposed that prohibition orders be published and accessible nationally.

There are a number of options for ensuring timely public access to prohibition orders nationally.

Option 1

Under this option, each health complaints entity would be responsible for maintaining its own list of prohibition orders, accessible through its website. Each list would contain links to the lists of prohibition orders issued by health complaints entities in other states and territories.

A statement on each website could explain the operation of mutual recognition arrangements (that is, that prohibition orders issued in one jurisdiction apply in all jurisdictions; and the implications for health care workers practising or attempting to practise in more than one jurisdiction).

The advantage of this option is that it is relatively low cost, as it would make use of existing systems already in place in individual jurisdictions. The disadvantages are that members of the public would not be able to access a single national list of all prohibition orders at the one website, and the format of the information contained on each jurisdiction's website may differ sufficiently to cause confusion.

Option 2

Under this option, one state or territory would agree to host the national list of prohibition orders. Other jurisdictions would be responsible for providing information on prohibition orders in a timely manner. This option would require protocols to be established between health complaints entities for sharing information, including:

- an agreed format for publication of prohibition orders
- a possible template for presentation of material
- minimum content for published orders
- timing for provision of information

- arrangements for publication of interim prohibition orders.

The advantages of this option are that members of the public would be able to access a single national list of prohibition orders in one place, in a format that is uniform as far as possible. The disadvantage is that it would require a single health complaints entity to assume responsibility for maintaining the national register. Although operational costs could be shared by all health complaints entities, it is likely that the hosting jurisdiction would incur higher incidental costs.

Option 3

Under this option a common web portal would operate to enable public access to all decisions and prohibition orders made in participating states and territories. The web portal could be hosted on the server of one commission for technical maintenance. Each commission would provide a link to the portal from its own website. This would allow for comprehensive, comparable and searchable information to be provided to the public.

The portal would include a content management system where authorised users from each health complaints entity could access the portal to add information. Each health complaints entity would be responsible for ensuring accurate and up-to-date information was maintained on the site relating to all decisions and orders issued in that jurisdiction. Any costs incurred could be shared among the health complaints entity.

Once a decision was made and an order issued, the authorised officer from the relevant health complaints entity would be responsible for uploading the information to the web portal within a reasonable timeframe (for example, within one week of a decision being made).

The web portal would specify the minimum information to be provided by each health complaints entity, which could include:

- Name and surname of the health care worker
- Profession or area of service provided
- Summary of order
- Date of decision
- Link to full decision

The website could include an index of decision by year, and a search function or index by first and last name and area of service.

The advantages of this option are that the public would have access to a comprehensive national list of prohibition orders in one place in a uniform format. As the portal would be purpose-designed, it could contain usability features such as search fields and links to external websites (such as tribunal sites) containing full decisions. In this option, all jurisdictions would assume equal responsibility for maintaining the register. The disadvantages of this option are that the start-up costs would be greatest, and it relies on all health complaints entities presenting information in an agreed format for prohibition orders, to agreed timeframes. There would also be no external ‘oversight’ to ensure that accuracy and timeliness are being maintained.

What are your views?

What is the preferred option for facilitating public access to information about prohibition orders that are issued in each state and territory?

Are there any issues that need to be considered when designing and implementing such arrangements?

Appendix 1 - Draft National Code of Conduct for Health Care Workers

Definitions

health care worker means a natural person who provides a health service.

health service is a service defined as a health service under relevant State or Territory law for the purposes of application of this Code of Conduct.

health complaints entity means an entity established under state or territory legislation whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system.

Application of this Code

This Code applies to the provision of health services by:

1. health care workers who are not subject to the scheme for registration under the *Health Practitioner Regulation National Law*, including de-registered practitioners, and
2. health care workers who are registered health practitioners under the Health Practitioner Regulation National Law and who provide health services that are unrelated to their registration.

1. Health care workers to provide services in a safe and ethical manner

1. A health care worker must provide health services in a safe and ethical manner.
2. Without limiting subclause 1, health care workers must comply with the following:
   a) A health care worker must maintain the necessary competence in his or her field of practice
   b) A health care worker must not provide health care of a type that is outside his or her experience or training, or provide services that he or she is not qualified to provide
   c) A health care worker must only prescribe treatments or appliances that serve the needs of clients
   d) A health care worker must recognise the limitations of the treatment he or she can provide and refer clients to other competent health care workers in appropriate circumstances
   e) A health care worker must recommend to clients that additional opinions and services be sought, where appropriate
   f) A health care worker must assist a client to find other appropriate health care services, if required and practicable
   g) A health care worker must encourage clients to inform their treating medical practitioner (if any) of the treatments or care being provided
   h) A health care worker must have a sound understanding of any possible adverse interactions between the therapies and treatments being provided or prescribed and any other medications or treatments, whether prescribed or not, that he or she is, or should be, aware that a client is taking or receiving, and advise the client of these interactions.

2. Health care workers to obtain consent

Prior to commencing a treatment or service, a health care worker must explain to a client the treatments or services he or she is planning to provide, including any risks involved, and obtain the consent of the client, guardian or other relevant person.

3. Appropriate conduct in relation to treatment advice

1. A health care worker must accept the right of his or her clients to make informed choices in relation to their health care, including the right to refuse treatment.
2. A health care worker must not attempt to dissuade a client from seeking or continuing medical treatment.
3. A health care worker must communicate and co-operate with colleagues and other health care workers and agencies in the best interests of their clients.

4. Health care workers to report concerns about the conduct of other health care workers

A health care worker who reasonably believes that another health care worker has placed or is placing clients at serious risk of harm in the course of providing treatment or care must refer the matter to [Insert name of relevant state or territory health complaints entity].

5. Health care workers to take appropriate action in response to adverse events

1. A health care worker must take appropriate and timely measures to minimise harm to clients when an adverse event occurs in the course of providing treatment or care.
2. Without limiting subclause (1), a health care worker must:
   e) ensure that appropriate first aid is available to deal with any adverse event
   f) obtain appropriate emergency assistance in the event of any serious adverse event
   g) promptly disclose the adverse event to the client and take appropriate remedial steps to reduce the risk of recurrence.
   h) report the adverse event to the relevant authority, where appropriate.

6. Health care workers to adopt standard precautions for infection control

1. A health care worker must adopt standard precautions for the control of infection in the course of providing treatment or care.
2. Without limiting subclause (1), a health care worker who carries out skin penetration or other invasive procedure must comply with the [insert reference to the relevant state or territory law] under which such procedures are regulated.

7. Health care workers diagnosed with infectious medical conditions

1. A health care worker who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.
2. Without limiting subclause (1), a health care worker who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the necessary steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

8. Health care workers not to make claims to cure certain serious illnesses

1. A health care worker must not claim or represent that he or she is qualified, able or willing to cure cancer or other life threatening or terminal illnesses.

2. A health care worker who claims to be able to treat or alleviate the symptoms of cancer or other life threatening or terminal illnesses must be able to substantiate such claims.

9. Health care workers not to misinform their clients

1. A health care worker must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or the qualifications, training or professional affiliations he or she holds.
2. Without limiting subclause (1):
   a. a health care worker must not use his or her possession of a particular qualification to mislead or deceive clients or the public as to his or her competence in a field of practice or ability to provide treatment
   b. a health care worker must provide truthful information as to his or her qualifications, training or professional affiliations
   c. a health care worker must not make claims either directly to clients or in advertising or promotional materials about the efficacy of treatment or services he or she provides if those claims cannot be substantiated.

10. Health care workers not to practise under the influence of alcohol or drugs

1. A health care worker must not provide treatment or care to clients while under the influence of alcohol or unlawful drugs.
2. A health care worker who is taking prescribed medication must obtain advice from the prescribing health practitioner or dispensing pharmacist on the impact of the medication on his or her ability to practise and must refrain from treating or caring for clients in circumstances where his or her capacity is or may be impaired.

11. Health care workers with certain mental or physical impairment

1. A health care worker must not provide treatment or care to clients while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that places or is likely to place clients at risk of harm.
2. Without limiting subclause (1), if a health care worker has a mental or physical impairment that could place clients at risk, the health care worker must seek advice from a suitably qualified health practitioner to determine whether, and in what ways, he or she should modify his or her practice, including stopping practice if necessary.

12. Health care workers not to financially exploit clients

1. A health care worker must not financially exploit their clients.
2. Without limiting subclause (1):
   a) a health care worker must only provide services or treatments to clients that are designed to maintain or improve clients' health or wellbeing
   b) a health care worker must not accept or offer financial inducements or gifts as a part of client referral arrangements with other health care workers
   c) a health care worker must not accept financial inducements or gifts from the suppliers of medicines or other therapeutic goods or devices
   d) a health care worker must not ask clients to give, lend or bequeath money or gifts that will benefit the health care worker directly or indirectly

13. Health care workers not to engage in sexual misconduct

1. A health care worker must not engage in behaviour of a sexual or close personal nature with a client.
2. A health care worker must not engage in a sexual or other close personal, physical or emotional relationship with a client.
3. Before engaging in a sexual or other close personal, physical or emotional relationship with a former client, a health care worker should ensure that a reasonable period of time has elapsed since the conclusion of the therapeutic relationship.

14. Health care workers to comply with relevant privacy laws

A health care worker must comply with the relevant privacy laws that apply to clients' health information, including the *Privacy Act 1988* (Cth) and the [insert name of relevant state or territory legislation]

15. Health care workers to keep appropriate records

1. A health care worker must maintain accurate, legible and up-to-date clinical records for each client consultation and ensure that these are held securely and not subject to unauthorised access.
2. A health care worker must take necessary steps to facilitate clients' access to information contained in their health records if requested.
3. A health care worker must facilitate the transfer of a client's health record in a timely manner when requested to do so by the client or their legal representative.

16. Health care workers to be covered by appropriate insurance

A health care worker must ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

17. Health care workers to display code and other information

1. A health care worker must display a copy of each of the following documents at all premises where the health care worker carries on his or her practice:
   a) a copy of this Code of Conduct
   b) any relevant qualifications that the health care worker possesses
   c) a document that gives information about the way in which clients may make a complaint to [insert name of state or territory health complaints entity].
2. Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.
3. This clause does not apply to any of the following premises:
   a) the premises of any entity within the public health system (as defined in the [insert name of relevant state or territory legislation])
   b) private health facilities (as defined in [insert name of relevant state or territory legislation])
   c) premises of the [insert name of ambulance service] as defined in ([insert name of relevant state or territory legislation])
   d) premises of approved aged care service providers (within the meaning of the *Aged Care Act 1997* (Cth)).

Appendix 2.1 - State and Territory health complaints legislation - comparison of provisions

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
ACT *Human Rights Commission Act 2005* *Health Professionals Act 2004* *Health Records (Privacy and Access) Act 1997*	Health Services Commissioner	***health service*** is a service provided in the ACT to someone (the ***service user***) for any of the following purposes: (a) assessing, recording, maintaining or improving the physical, mental or emotional health, comfort or wellbeing of the service user; (b) diagnosing or treating an illness, disability, disorder or condition of the service user. (2) In applying this Act in relation to a health professional who is a veterinary surgeon, a ***health service*** is a service provided to an animal (the ***service user***) for any of the purposes mentioned in subsection (1) (a) or (b). (3) A ***health service*** includes— (a) a service provided by a health professional or health practitioner in the professional's capacity as a health professional or health practitioner; and (b) a service provided specifically for carers of people receiving health services or carers of people with physical or mental conditions.	Under the Human Rights Commission Act, when the complaint is a health services complaint – anyone.	Health service complaint: The service is not being provided appropriately or is not being provided. The person complaining believes that the provider of the service has acted inconsistently with specified standards: • the health code or health provision principles; • a generally accepted standard of health service delivery expected of providers of the same kind; • any standard of practice applying to the provider under the National Law or the or the *Health Professionals Act 2004* (ACT).	The commission may, on its own initiative, consider an act or service about which a person could make, but has not made, a complaint under this Act; or any other matter related to the commission's functions.
New South Wales *Health Care Complaints Act 1993*	Health Care Complaints Commissioner	**"health service"** includes the following services, whether provided as public or private services: (a) medical, hospital, nursing and midwifery services, (b) dental services, (c) mental health services, (d) pharmaceutical services, (e) ambulance services, (f) community health services,	A complaint may be made by any person including, in particular, the following: • the client concerned • a parent or guardian of the client concerned • a person chosen by the client concerned as his or her representative for the purpose of making the	The professional conduct of a health practitioner (including any alleged breach by the health practitioner of Division 1 or 3 of Part 7 of the *Public Health Act 2010* or of a code of conduct prescribed under section 100 of that Act). A health service which affects	The Commissioner may initiate a complaint under if it appears to the Commissioner that the matter that is the subject of the complaint: • raises a significant issue of public health or safety, or • raises a significant question regarding a health service that affects,

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		(g) health education services, (h) welfare services necessary to implement any services referred to in paragraphs (a)-(g), (i) services provided in connection with Aboriginal and Torres Strait Islander health practices and medical radiation practices, (j) Chinese medicine, chiropractic, occupational therapy, optometry, osteopathy, physiotherapy, podiatry and psychology services, (j1) optical dispensing, dietitian, massage therapy, naturopathy, acupuncture, speech therapy, audiology and audiometry services, (k) services provided in other alternative health care fields, (k1) forensic pathology services, (l) a service prescribed by the regulations as a health service for the purposes of this Act.	complaint • a health service provider • a member of Parliament • the Director-General • the Minister.	the clinical management or care of an individual client.	or is likely to affect, the clinical management or care of an individual client, or • if substantiated, would provide grounds for disciplinary action against a health practitioner, or be found to involve gross negligence on the part of a health practitioner, or result in the health practitioner being found guilty of an offence under the *Public Health Act 2010*
Northern Territory *Health and Community Services Complaints Act*	Health and Community Services Complaints Commissioner	***health service*** means a service provided or to be provided in the Territory for, or purportedly for, the benefit of the health of a person and includes: (a) a service specified by the Regulations as being a health service; and (b) an administrative service directly related to a health service; but does not include a service specified by the Regulations as not being a health service.	A user of a health or community service or in some cases, their representative. The Minister or the Chief Executive of the agency responsible for the administration of the Public and Environmental Health Act. In some cases, a person the Commissioner is satisfied has sufficient interest in the subject matter of the complaint. A health or community service provider. Any other person, or any body, that, in the opinion of the Commissioner, should be	That a provider acted unreasonably: • in providing a health service or community service or • by not providing a health service or community service, or • in the manner of providing a health service or community service; • by denying or restricting a user access to his or her records; • not making available to a user information about the user's condition that the provider was able to make available; • in disclosing information in	The Commissioner may investigate a complaint if it is referred by the Minister or the Legislative Assembly. The Minister or Legislative Assembly may refer to the Commissioner any matter relating to a health service or community service. The Commissioner may, as he or she thinks fit, investigate an issue or question arising from a complaint or a group of complaints if it appears to the Commissioner: • to be a significant issue of public health or safety or public interest; or • to be a significant question

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
			able to make a particular complaint in the public interest.	relation to a user That the provision of a health service or community service or a part of a health service or community service was not necessary; That a provider or manager acted unreasonably in respect of a complaint made by a user about the provider's action not taking, or causing to be taken, proper action in relation to the complaint; or not properly investigating the complaint or causing it to be properly investigated. That a provider acted in disregard of, or in a manner inconsistent with the Code, Regulations etc. That an applicable organisation failed to comply with the Carers Charter.	as to the practice and procedures of a provider.
Queensland *Health Ombudsman Act 2013*	Health Ombudsman	(1) A ***health service*** is a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing. (2) A health service may be provided to a person at any place including a hospital, residential care facility, community health facility or home. (3) A health service includes a support service for a service mentioned in subsection (1). (4) Also, without limiting subsection (1), a health service includes— (a) a service dealing with public health, including a program or activity for— (i) the prevention and control of	Any person may make a health service complaint. *For example:* • an individual to whom a health service is provided • a parent, guardian or other representative of an individual to whom a health service is provided • a health practitioner with concerns about the health, conduct or performance of another practitioner.	A health service or other service provided by a health service provider. *For example:* • the health, conduct or performance of a health practitioner while providing a health service • the treatment or care provided to an individual by a health service organisation or employee of a health service organisation • the adequacy of a response by a health service provider to a complaint made to the provider about a particular service provided by an	The health ombudsman may carry out an investigation of a systemic issue relating to the provision of a health service, including an issue affecting the quality of a health service; or another matter, if the health ombudsman considers an investigation of the matter is relevant to achieving an object of the Act.

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		disease or sickness; or (ii) the prevention of injury; or (iii) the protection and promotion of health; and *Example of health service mentioned in paragraph (a)* - a cancer screening program (b) a service providing alternative or complementary medicine; and (c) a service prescribed under a regulation to be a health service. (5) A health service does not include a service prescribed under a regulation not to be a health service.		employee of the provider • the level of compliance by a health service provider with accepted standards of professional conduct, having regard to any relevant prescribed conduct documents	
South Australia *Health and Community Services Complaints Act 2004*	Health and Community Services Complaints Commissioner	***health service*** means— (a) a service designed to benefit or promote human health; or (b) a service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or who have a physical disability or mental dysfunction; or (c) a diagnostic or screening service; or (d) an ambulance service; or (e) a service to treat or prevent illness, injury, disease or disability; or (f) a service provided by a health professional; or (g) a service involving the provision of information relating to the promotion or provision of health care or health education; or (h) a service of a class included within the ambit of this definition by the regulations; or (i) a social, welfare, recreational or leisure service if provided as part of a service referred to in a preceding paragraph; or (j) an administration service directly	A user of a health or community service or in some cases, their representative. An MP or the Minister or the Chief Executive of the Department. In some cases, a person approved by the Commissioner. In some cases, a health or community service provider Any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint in the public interest.	That a health *or community* service provider: Has acted unreasonably: • by not providing a health or community service; • in the manner of providing a health or community service; • denying or restricting a user's access to records relating to the user; • in not making available to a health or community service user information about the user's condition that the health service provider was able to make available; • in disclosing information in relation to a health or community service user to a third person; • by failing to provide a health or community service user with sufficient information or a reasonable opportunity to make an informed decision;	The Commissioner may investigate— • any matter specified in a written direction given by the Minister • an issue or question arising from a complaint if it appears to the Commissioner to be a significant issue of public safety, interest or importance or to be a significant question as to the practice of a health or community service provider • on his or her own motion, any other matter relating to the provision of health or community services in South Australia.

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		related to a service referred to in a preceding paragraph, but does not include— (k) the process of writing, or the content of, a health status report; (l) a service of a class excluded from the ambit of this definition by the regulations; The following are examples of health services: • a service provided at a hospital, health institution or aged care facility; • a medical, dental, pharmaceutical, mental health, community health or environmental health service; • a laboratory service; • a laundry, dry cleaning, catering or other support service provided in a hospital, health institution or aged care facility.		or otherwise provided inadequate information about treatment, prognosis, further advice and education etc. • by not taking proper action in relation to a complaint made to him or her by the user about a provider's action of a kind referred to in this section; Has provided all or part of a health or community service that was not necessary or was inappropriate. Has failed to exercise due skill. Has failed to treat a health or community service user in an appropriate professional manner. Has failed to respect a health or community service user's privacy or dignity. Has acted in any other manner that is inconsistent with the Charter of Health and Community Services Rights; Has acted in any other manner that did not conform with the generally accepted standard of service delivery expected of a provider of the kind of service.	
Tasmania *Health Complaints Act 1995*	Health Complaints Commissioner	***health service*** means – (a) a service provided to a person for, or purportedly for, the benefit of human health – (i) including services specified in Part 1 of Schedule 1; but (ii) excluding services specified in Part 2 of Schedule 1; or (b) an administrative service directly	A user of a health or community service or in some cases, their representative. A minister, the Health Minister or the Secretary of the Health Department. In some cases, a person approved by the	That a health service provider: as acted unreasonably: • by not providing or health service; • in the manner of providing a health service; • by denying or restricting	The Commissioner may investigate • any matter specified in a written direction given by the Health Minister; • an issue or question arising from a complaint if it appears to the

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		related to a health service specified in paragraph (a); PART 1 – Services that are health services 1. A service provided at a hospital, health institution or nursing home. 2. A medical, dental, pharmaceutical, mental health, community health, environmental health or specialized health service or a service related to such a service. 3. A service provided for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction. 4. A laboratory service provided in support of a health service. 5. A laundry, dry cleaning, catering or other support service provided to a hospital, health institution, nursing home or premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction, if the service affects the care or treatment of a patient or a resident. 6. A social work, welfare, recreational or leisure service, if provided as part of a health service. 7. An ambulance service. 8. Any other service provided by a provider for, or purportedly for, the care or treatment of another person. 9. A service provided by an audiologist, audiometrist, optical dispenser, dietitian, prosthetist, dental prosthetist, psychotherapist, medical radiation science professional, podiatrist, therapeutic counsellor or any other service of a professional or technical nature provided for, or	Commissioner. In some cases, a health service provider. Any other person, or any body, that, in the opinion of the Commissioner, should be able to make a particular complaint.	access to records relating to the user or other information about the user's condition; or • in disclosing information in relation to a health service user; • by not taking proper action in relation to a complaint. Provided a health service or of part of a health service was not necessary; Failed to exercise due skill; Failed to treat a user in an appropriate professional manner or user's privacy or dignity; Failed to provide user with sufficient information or a reasonable opportunity to make an informed decision; or otherwise provided inadequate information about treatment, prognosis, further advice and education etc. Acted in any other manner that was inconsistent with the Charter.	Commissioner to be a significant issue of public safety or public interest; or to be a significant question as to the practice of a health service provider • on his or her own motion, any other matter relating to the provision of health services in Tasmania.

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		purportedly for, the care or treatment of another person or in support of a health service. 10. A service provided by a practitioner of massage, naturopathy or acupuncture or in another natural or alternative health care or diagnostic field. 11. The provision of information relating to the promotion or provision of health care or to health education. 11A. A service provided at a hospital or health institution for the temporary storage of human remains as defined in the *Burial and Cremation Act 2002*. 12. Any other service provided by a person registered by a registration board. PART 2 – Services that are not Health Services The provision of an opinion or the making of a decision for the purposes of a claim under the *Workers Compensation Act 1988*			
Victoria *Health Services (Conciliation and Review) Act 1987* *Health Records Act 2001*	Health Services Commissioner	***health service*** includes any of the following services— (a) medical, hospital and nursing services; (b) dental services; (c) psychiatric services; (d) pharmaceutical services; (e) ambulance services; (f) community health services; (g) health education services; (h) welfare and social work services necessary to implement any services referred to in paragraphs (a) to (g); (ha) therapeutic counselling and psychotherapeutic services; (hb) laundry, cleaning and catering services, where those services affect health care or treatment of a person	A user or their representative. In some cases, a provider may complain on behalf of a user. In some cases, a person with sufficient interest in the matter who is recognised by the Commissioner as a user's representative, when the user has died or is otherwise unable to appoint a representative.	That a provider of a health service (person or body or institution etc) has acted unreasonably: • by providing or not providing a health service for the user; or • in the manner of providing a health service. That a health care institution has acted unreasonably by not properly investigating or not taking proper action in relation to a complaint made to it about a provider.	No own motion powers

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		using or receiving a service referred to in this definition; (i) services provided by chiropodists, chiropractors, osteopaths, dietitians, optometrists, audiologists, audiometrists, prosthetists, physiotherapists and psychologists; (j) services provided by optical dispensers, masseurs, occupational therapists and speech therapists; (k) services provided by practitioners of naturopathy, acupuncture and in other alternative health care fields; (ka) services provided by Chinese herbal medicine practitioners, acupuncturists and Chinese herbal dispensers; (l) a service prescribed as a health service for the purposes of this Act— and includes any service provided by the Department of Health and the Secretary to the Department of Health.			
Western Australia *Health Services (Conciliation and Review) Act 1995*	Director, Health and Disability Services Complaints Office	***health service*** means any service provided by way of — (a) diagnosis or treatment of physical or mental disorder or suspected disorder; and (b) health care, including palliative health care; and (c) a preventive health care programme, including a screening or immunization programme; and (d) medical or epidemiological research, and includes any — (e) ambulance service; and (f) welfare service that is complementary to a health service; and (g) service coming within paragraph (a), (b) or (c) that is provided by a person who advertises or holds himself or herself out as a person who	A user, a user's recognised representative or in some cases, a provider of a health service.	A public provider has acted unreasonably in providing not providing a health service for the user; A provider has acted unreasonably in the manner of providing a health service for the user: • by denying or restricting the user's access to records kept by the provider and relating to the user; • in disclosing or using theusers health records or confidential information about the user; A manager has acted unreasonably in respect of a	The Director may investigate a complaint under the direction of the Health Minister if the Minister is of the opinion that the health or welfare of any person may be at risk, or it is in the public interest.

Jurisdiction	Commissioner	Definition of a health service	Who can make a complaint	Matters that may be the subject of a complaint	Own motion powers
		provides any health care or treatment; and (h) prescribed service, but does not include an excluded service.		complaint made to an institution by a user about a provider's action which is of a kind mentioned in paragraphs (a) to (e) by not properly investigating the complaint or causing it to be properly investigated; or not taking proper action on the complaint; A provider has acted unreasonably by charging the user an excessive fee; or otherwise acted unreasonably with respect to a fee; A provider that is an applicable organisation as defined in section 4 of the *Carers Recognition Act 2004* has failed to comply with the Carers Charter as defined in that section.	

Appendix 2.2 - Comparison of enforcement powers - NSW, SA and Qld

Jurisdiction	Interim prohibition orders	Prohibition orders	Power to publish	Right of appeal	Relevant/prescribed offences
New South Wales *Health Care Complaints Act 1993*	The Commission may, during any investigation of a complaint against an unregistered health practitioner, make an interim prohibition order in respect of the unregistered health practitioner, if it has a reasonable belief that the health practitioner has breached a code of conduct for unregistered health practitioners, and it is of the opinion that the health practitioner poses a serious risk to the health or safety of members of the public, and that an interim prohibition order is necessary to protect the health or safety of members of the public. An interim prohibition order may do one or both of the following: • prohibit the health practitioner from providing health services or specified health services • place conditions on the provision of health services or specified health services by the health practitioner. An interim prohibition order remains in force for a period of 8 weeks or a shorter	The Commission may issue a prohibition order if, following an investigation, it finds that the health practitioner has breached the Code of Conduct, or has been convicted of a relevant offence, and the Commissioner believes that the health practitioner poses a risk to the health or safety of members of the public. A prohibition order may prohibit the health practitioner from providing health services or specified health services for the period specified in the order, or permanently; or places conditions on the provision of health services or specified health services for the period specified in the order, or permanently.	The Commissioner may issue a public statement identifying and giving warnings or information about the health practitioner and health services provided by the health practitioner. Public statements may be issues after an investigation, even if a prohibition order is not issued. There appears to be no power to publish information on interim prohibition orders.	Appeals may be made to the administrative decisions tribunal about a decision that the practitioner has breached the Code of Conduct, about a public statement or about a prohibition order. Appeals much be made within 28 days of practitioner receiving notice.	'relevant offence' means: (a) an offence under Part 7 of the *Public Health Act 2010* , or (b) an offence under the *Fair Trading Act 1987* or the *Competition and Consumer Act 2010* of the Commonwealth that relates to the provision of health services.

Jurisdiction	Interim prohibition orders	Prohibition orders	Power to publish	Right of appeal	Relevant/prescribed offences
	period specified in the order.				
Queensland *Health Ombudsman Act 2013*	The health ombudsman may issue an interim prohibition order which prohibits the practitioner from providing any health service or a stated health service; or imposes stated restrictions on the provision of any health service, or a stated health service, by the practitioner. The health ombudsman may issue an interim prohibition if the health ombudsman is that because of the practitioner's health, conduct or performance, the practitioner poses a serious risk to the public; and it is necessary to issue the order to protect public health or safety. The health ombudsman may issue an interim prohibition order at any time, whether or not a complaint has been made in relation to the practitioner.	Prohibition orders are issued by QCAT if the tribunal decides that, because of the health practitioner's health, conduct or performance, the practitioner poses a serious risk to the public. Examples include: • practising the profession unsafely, incompetently or while intoxicated • financially exploiting clients • engaging in a sexual or improper personal relationships with clients • discouraging clients from seeking clinically accepted care or treatment • making false or misleading claims. QCAT may have regard to a prescribed conduct document, for example a Code of Conduct, but is not required to consider such a document. A prohibition order may prohibit the practitioner from providing any health service or a stated health service; or impose stated restrictions on the provision of any health service, or a stated health service, by the practitioner.	The health ombudsman must publish, on a publicly accessible website of the health ombudsman, the following information about each current prohibition order (including interim prohibition orders) • the name of the health practitioner • the day the order took effect • the details of the order. The health ombudsman must also publish, on a publicly accessible website of the health ombudsman, information about corresponding interstate interim orders of which the health ombudsman is aware. The health ombudsman may publish, on a publicly accessible website or in another way the health ombudsman considers appropriate, information about a decision of QCAT relating to an unregistered health practitioner.	If the health ombudsman decides to issue an interim prohibition order to a health practitioner, the practitioner may apply, as provided under the QCAT Act, to QCAT for a review of the decision. An application to QCAT for a review of the decision may be made within 28 days after that notice is given. Applications for review of a prohibition order made by QCAT must be made within 28 days after notice of the order is given, as provided under the QCAT Act. Appeals are made to the Court of Appeal.	There are no relevant or prescribed offences referred to in the Act.
South Australia *Health and*	The Commissioner may issue an interim probation order if an investigation into a health practitioner has	The Commissioner issue a prohibition order if, after an investigation, if the Commissioner is satisfied that	The Commissioner may publish a public statement in relation to a health practitioner, in a manner determined by the	A health practitioner may appeal against an interim prohibition order, a prohibition order or a public statement.	'Prescribed offence' is defined to include offences under: • Australian Consumer

Jurisdiction	Interim prohibition orders	Prohibition orders	Power to publish	Right of appeal	Relevant/prescribed offences
Community Services Complaints Act 2004	commenced, and the Commissioner has a reasonable belief that the practitioner has breached a Code of Conduct or committed a prescribed offence and, in the opinion of the Commissioner, action necessary to protect the health or safety of members of the public. The Commissioner may make an order prohibiting the practitioner from providing health services, or specified health services, for a period of 12 weeks or shorter, or make an order imposing conditions on the provision of health services, or specified health services, for a period of 12 weeks or shorter. The Commissioner may at any time vary or revoke the order.	the health practitioner has breached the Code of Conduct or been found guilty of a prescribed offence; and in the opinion of the Commissioner the practitioner poses an unacceptable risk to the health or safety of members of the public. The Commissioner make an order prohibiting the prescribed health service provider from providing health services, or specified health services, for a period specified in the order, or indefinitely; or make an order imposing conditions on the provision of health services, or specified health services, by the practitioner for a specified period, or indefinitely. The Commissioner may at any time vary or revoke the order.	Commissioner, identifying the health practitioner and giving warnings or such other information as the Commissioner considers appropriate.	The appeal must be made to the Administrative and Disciplinary Division of the District Court within 1 month after notification. On an appeal, the Court may confirm, vary or revoke an order or publication the subject of the appeal.	Law (SA) • Part 3 of the *Criminal Law Consolidation Act 1935* (SA) • *Public Health Act 2011* (SA).

Appendix 3 - NSW Code of Conduct for unregistered health practitioners

Made under the Public Health (General) Regulation 2002, Schedule 3

1 Definitions

In this code of conduct:

health practitioner and ***health service*** have the same meaning as in the Health Care Complaints Act 1993.

Note. The *Health Care Complaints Act 1993* defines those terms as follows:

health practitioner means a natural person who provides a health service (whether or not the person is registered under the Health Practitioner Regulation National Law).

health service includes the following services, whether provided as public or private services:

(a) medical, hospital and nursing services,
(b) dental services,
(c) mental health services,
(d) pharmaceutical services,
(e) ambulance services,
(f) community health services,
(g) health education services,
(h) welfare services necessary to implement any services referred to in paragraphs (a)–(g),
(i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, and psychologists,
(j) services provided by optical dispensers, dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers,
(k) services provided in other alternative health care fields,
(l) forensic pathology services,
(m) a service prescribed by the regulations as a health service for the purposes of the *Health Care Complaints Act 1993*.

2 Application of code of conduct

This code of **conduct** applies to the provision of health services by:

(a) health practitioners who are not required to be registered under the Health Practitioner Regulation National Law (including de-registered health practitioners), and
(b) health practitioners who are registered under the Health Practitioner Regulation National Law who provide health services that are unrelated to their registration.

Note. Health practitioners may be subject to other requirements relating to the provision of health services to which this Code applies, including, for example, requirements imposed by Part 2A of the Act and the regulations under the Act relating to skin penetration procedures.

3 Health practitioners to provide services in safe and ethical manner

(1) A health practitioner must provide health services in a safe and ethical manner.
(2) Without limiting subclause (1), health practitioners must comply with the following principles:
    (a) a health practitioner must maintain the necessary competence in his or her field of practice,

(b) a health practitioner must not provide health care of a type that is outside his or her experience or training,

(b1) a health practitioner must not provide services that he or she is not qualified to provide,

(b2) a health practitioner must not use his or her possession of particular qualifications to mislead or deceive his or her clients as to his or her competence in his or her field of practice or ability to provide treatment,

(c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client,

(d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances,

(e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate,

(f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable,

(g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving,

(h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving,

(i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation,

(j) a health practitioner must obtain appropriate emergency assistance (for example, from the Ambulance Service) in the event of any serious misadventure during a client consultation.

4 Health practitioners diagnosed with infectious medical condition

(1) A health practitioner who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.

(2) Without limiting subclause (1), a health practitioner who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

5 Health practitioners not to make claims to cure certain serious illnesses

(1) A health practitioner must not hold himself or herself out as qualified, able or willing to cure cancer and other terminal illnesses.

(2) A health practitioner may make a claim as to his or her ability or willingness to treat or alleviate the symptoms of those illnesses if that claim can be substantiated.

6 Health practitioners to adopt standard precautions for infection control

(1) A health practitioner must adopt standard precautions for the control of infection in his or her practice.

(2) Without limiting subclause (1), a health practitioner who carries out a skin penetration procedure within the meaning of section 51 (3) of the Act must comply with the relevant regulations under the Act in relation to the carrying out of the procedure.

7 Appropriate conduct in relation to treatment advice

(1) A health practitioner must not attempt to dissuade clients from seeking or continuing with treatment by a registered medical practitioner.
(2) A health practitioner must accept the right of his or her clients to make informed choices in relation to their health care.
(3) A health practitioner should communicate and co-operate with colleagues and other health care practitioners and agencies in the best interests of their clients.
(4) A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner must refer the matter to the Health Care Complaints Commission.

8 Health practitioners not to practise under influence or alcohol or drugs

(1) A health practitioner must not practise under the influence of alcohol or unlawful drugs.
(2) A health practitioner who is taking prescribed medication must obtain advice from the prescribing health practitioner on the impact of the medication on his or her ability to practice and must refrain from treating clients in circumstances where his or her ability is or may be impaired.

9 Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not practise while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that detrimentally affects, or is likely to detrimentally affect, his or her ability to practise or that places clients at risk of harm.

10 Health practitioners not to financially exploit clients

(1) A health practitioner must not accept financial inducements or gifts for referring clients to other health practitioners or to the suppliers of medications or therapeutic goods or devices.
(2) A health practitioner must not offer financial inducements or gifts in return for client referrals from other health practitioners.
(3) A health practitioner must not provide services and treatments to clients unless they are designed to maintain or improve the clients' health or wellbeing.

11 Health practitioners required to have clinical basis for treatments

A health practitioner must not diagnose or treat an illness or condition without an adequate clinical basis.

12 Health practitioners not to misinform their clients

(1) A health practitioner must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or as to his or her qualifications, training or professional affiliations.
(2) A health practitioner must provide truthful information as to his or her qualifications, training or professional affiliations if asked by a client.
(3) A health practitioner must not make claims, either directly or in advertising or promotional material, about the efficacy of treatment or services provided if those claims cannot be substantiated.

13 Health practitioners not to engage in sexual or improper personal relationship with client

(1) A health practitioner must not engage in a sexual or other close personal relationship with a client.

(2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of their therapeutic relationship.

14 Health practitioners to comply with relevant privacy laws

A health practitioner must comply with the relevant legislation of the State or the Commonwealth relating to his or her clients' personal information.

15 Health practitioners to keep appropriate records

A health practitioner must maintain accurate, legible and contemporaneous clinical records for each client consultation.

16 Health practitioners to keep appropriate insurance

A health practitioner should ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

17 Certain health practitioners to display code and other information

(1) A health practitioner must display a copy of each of the following documents at all premises where the health practitioner carries on his or her practice:
   (a) this code of conduct,
   (b) a document that gives information about the way in which clients may make a complaint to the Health Care Complaints Commission, being a document in a form approved by the Director-General of the Department of Health.

(2) Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.

(3) This clause does not apply to any of the following premises:
   (a) the premises of any body within the public health system (as defined in section 6 of the *Health Services Act 1997*),
   (b) private hospitals or day procedure centres (as defined in the *Private Hospitals and Day Procedure Centres Act 1988*),
   (c) premises of the Ambulance Service of NSW (as defined in the *Health Services Act 1997*),
   (d) premises of approved providers (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

18 Sale and supply of optical appliances

(1) A health practitioner must not sell or supply an optical appliance (other than cosmetic contact lenses) to a person unless he or she does so in accordance with a prescription from a person authorised to prescribe the optical appliance under section 122 of the Health Practitioner Regulation National Law.

(2) A health practitioner must not sell or supply contact lenses to a person unless he or she:
   (a) was licensed under the *Optical Dispensers Act 1963* immediately before its repeal, or
   (b) has a Certificate IV in optical dispensing or an equivalent qualification.

(3) A health practitioner who sells or supplies contact lenses to a person must provide the person with written information about the care, handling and wearing of contact lenses, including advice about possible adverse reactions to wearing contact lenses.

(4) This clause does not apply to the sale or supply of the following:

(a) hand-held magnifiers,

(b) corrective lenses designed for use only in diving masks or swimming goggles,

(c) ready made spectacles that:

(i) are designed to alleviate the effects of presbyopia only, and

(ii) comprise 2 lenses of equal power, being a power of plus one dioptre or more but not exceeding plus 3.5 dioptres.

(5) In this clause:

cosmetic contact lenses means contact lenses that are not designed to correct, remedy or relieve any refractive abnormality or defect of sight.

optical appliance has the same meaning as it has in section 122 of the Health Practitioner Regulation National Law.

Concerned about your health care?

The Code of Conduct for unregistered health practitioners sets out what you can expect from your provider. If you are concerned about the health service that was provided to you or your next of kin, talk to the practitioner immediately. In most cases the health service provider will try to resolve them.

If you are not satisfied with the provider's response, contact the Inquiry Service of the Health Care Complaints Commission on (02) 9219 7444 or toll free on 1800 043 159 for a confidential discussion. If your complaint is about sexual or physical assault or relates to the immediate health or safety of a person, you should contact the Commission immediately.

What is the Health Care Complaints Commission?

The Health Care Complaints Commission is an independent body dealing with complaints about health services to protect the public health and safety.

Service in other languages

The Commission uses interpreting services to assist people whose first language is not English. If you need an interpreter, please contact the Translating and Interpreting Service (TIS National) on 131 450 and ask to be connected to the Health Care Complaints Commission on 1800 043 159 (9.00 am to 5.00 pm Monday to Friday).

More information

For more information about the Health Care Complaints Commission, please visit the website www.hccc.nsw.gov.au.

Contact the Health Care Complaints Commission

Office address: Level 13, 323 Castlereagh Street, SYDNEY NSW 2000 Post address: Locked Mail Bag 18, STRAWBERRY HILLS NSW 2012

Telephone: (02) 9219 7444 Toll Free in NSW: 1800 043 159 Fax: (02) 9281 4585 E-mail: hccc@hccc.nsw.gov.au

People using telephone typewriters please call (02) 9219 7555

Appendix 4 - SA Code of Conduct for unregistered health practitioners

Made under the Health and Community Services Complaints Variation Regulation 2013, Schedule 2

Code of Conduct for Unregistered Health Practitioners

Made under the Health and Community Services Complaints Regulations 2005

Unless exempt by the Regulations all unregistered health practitioners must display this Code of Conduct and the information for clients about how a complaint may be made to the Health and Community Services Complaints Commissioner. If an unregistered health practitioner has relevant qualifications, these qualifications must also be displayed. All of these documents must be displayed in a position and manner that makes them easily visible and accessible to a person entering the relevant premises.

This requirement to display material does not apply to the following premises:

- Premises of any hospital, whether public or private (within the meaning of the *Health Care Act 2008*).
- Premises of any health care service established or licensed under the *Health Care Act 2008.*
- Premises of any day procedure centre.
- Premises of the SA Ambulance Service Incorporated.
- Premises of an approved aged care services provider (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

Schedule 2 − Code of Conduct for Unregistered Health Practitioners

1 − Preliminary

What is an unregistered health practitioner?

An unregistered health practitioner is someone who provides a health service and who doesn't have to be registered with a registration authority in order to provide his or her service.

In this schedule an unregistered health practitioner is called a health practitioner.

In this schedule a service user is called a client.

2 − Health practitioners to provide services in a safe and ethical manner

This code requires that health practitioners provide services in a safe and ethical manner. This means that the health practitioner must:

(a) Maintain a reasonable level of competence in his or her field of practice.
(b) Not provide health services that are outside his or her experience or training.
(c) Not use his or her qualifications to mislead or deceive clients about his or her competence to provide a particular treatment.
(d) Only prescribe treatment or devices that serve the needs of the client.
(e) Recognise the limitations of treatments they can provide and, where appropriate, refer clients to other competent health service providers.
(f) Recommend that a client seek additional opinions or services where appropriate.
(g) Assist a client to find other suitable health care professionals where appropriate.

(h) Encourage a client to inform his or her medical practitioner (if any) of treatment received from the health practitioner.
(i) Have a sound understanding of any adverse interaction between the therapies and treatments provided or prescribed and any other medications or treatments the client might be taking or receiving.
(j) Ensure that appropriate first aid is available if needed during a consultation.
(k) Obtain appropriate emergency assistance (such as an ambulance service) in the event of any serious misadventure or outcome during a consultation.

3 − Health practitioners diagnosed with infectious medical condition

(1) Health practitioners who have been diagnosed with an infectious medical condition must:
(2) Ensure that any services provided do not put the client at risk.
(3) Take and follow advice from an appropriate medical practitioner regarding steps to avoid the possibility of transmission to clients.

4 − Health practitioners not to make claims to cure certain serious illnesses

(1) The health practitioner must not claim to be qualified, able or willing to cure cancer or other terminal illnesses.
(2) Health practitioners must not claim the ability to treat, alleviate or cure serious illnesses unless the claim can be substantiated.

5 − Health practitioners to take precautions for infection control

Health practitioners must take appropriate precautions for the control of infection while providing a service.

6 − Appropriate conduct in relation to treatment advice

(1) Health practitioners must not attempt to dissuade a client from seeking or continuing treatment by a registered medical practitioner.
(2) The health practitioner must accept a client's right to make an informed choice in relation to his or her own health care.
(3) Health practitioners should communicate and cooperate with colleagues and other health care practitioners and agencies in the best interests of the client.
(4) Health practitioners who have serious concerns about the treatment provided to a client by another health practitioner must refer the matter to the Health and Community Services Complaints Commissioner.

7 − Health practitioners not to practise under influence of alcohol or drugs

(1) Health practitioner must not provide services while intoxicated by alcohol or any other substance.
(2) The health practitioner on prescribed medication must obtain advice from the prescribing health practitioner on the impact that medication might have on his or her ability to practise and must not treat a client if his or her ability might be impaired.

8 − Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not provide a service while physically or mentally impaired, including if he or she is impaired by addiction to alcohol or a drug, or if his or her impairment may lead to the client being harmed.

9 − Health practitioners not to financially exploit clients

Health practitioners must not:

(1) Accept a financial inducement or gift for referring a client to another health practitioner or supplier of medications or therapeutic goods or devices.

(2) Offer a financial inducement or gift in return for a referral from another health practitioner.
(3) Provide a health service or treatment to a client unless they are designed to maintain or improve the client's health or wellbeing.

10 − Health practitioners required to have clinical basis for treatments

Health practitioners must have a valid clinical basis for treating a client. Health practitioners must not diagnose or treat an illness or condition unless there is an adequate clinical basis to do so.

11 − Health practitioners not to misinform clients

(1) Health practitioners must be truthful about their qualifications, training or professional affiliations if asked by a client.
(2) Health practitioners must not make claims, either directly or in advertising or promotional material, about the efficacy of treatments or services if the claims cannot be substantiated.

12 − Health practitioners not to engage in sexual or improper personal relationship with client

(1) Health practitioners must not engage in sexual or other close personal relationships with clients.
(2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of his or her therapeutic relationship.

13 − Health practitioners to comply with relevant privacy laws

Health practitioners must comply with State or Commonwealth laws relating to the personal information of clients.

14 − Health practitioners to keep appropriate records

Health practitioners must maintain accurate, legible and up to date clinical records of each client consultation.

15 − Health practitioners to keep reasonable insurance

Health practitioners should ensure that his or her practice has reasonable indemnity insurance.