Submission to the
Australian Health Ministers’
Advisory Council

A response to the consultation paper
A National Code of Conduct for
health care workers

by the

Australian Register of Homœopaths Ltd.

May 2014
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Summary

The Australian Register of Homœopaths Ltd. (AROH), the peak body for the homœopathic profession in Australia, has prepared this discussion paper in response to the Consultation paper for the draft National Code of Conduct for Health Care Workers prepared by the Victorian Department of Health on behalf of the Australian Health Ministers’ Advisory Council.

This submission presents AROH’s response to the points of discussion set out in the Consultation paper. AROH’s response to each of the points of discussion is limited in scope to how each point will impact the registrants of AROH and the effect this may have on the practice of homœopathy in Australia.

Currently, AROH has a Code of Professional Conduct which each registrant must comply with. This Code and the National Competency Standards for Homœopathy can be found on the www.aroh.com.au/Policies.

AROH is making a number of recommendations with a focus on the introduction of a single national Code of Conduct for unregistered practitioners. In addition, AROH recommends the term health practitioner followed by the modality, the example being Health Practitioner (Homœopath), be adopted. Furthermore, AROH also recommends that the Code by extending in its scope, making it applicable to all health practitioners, both complementary and alternative medicine and general practitioners in an equitable way.
In June 2013, 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.

To give effect to these decisions, Ministers asked the Australian Health Ministers’ Advisory Council (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 the first national Code of Conduct (National Code) for healthcare workers, having regard to a draft National Code based on the Codes of Conduct that already apply in NSW and South Australia
- 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 are, or in the future may be responsible for enforcing the National Code.

Interested parties are invited to make submissions addressing the issues raised in the paper. Questions placed throughout the paper in the ‘What are your views?’ sections are reproduced here to assist with submissions.

Please note that use of this quick response form is optional and all written submissions to the consultation will be considered.

The full version of the consultation paper is available at the following address:

Contact Details

Name: Australian Register of Homœopaths Ltd
Address: PO Box 1614 Wollongong DC NSW 2500
Email: exec@aroh.com.au

Are you a:

- Consumer of health services
- Health care worker (please specify type)
- Registered health practitioner (please specify type)
- Employer of health care workers
- Professional association
- Education provider
- Regulator
- Other – Please state:

**Other: An industry specific (Homœopathic) practitioner Registration Board**

If you are a professional association, can you provide an estimate of the number of health care workers you believe to be practising in your profession or field?

The Australian Register of Homœopaths currently has 540 registrants
**Section 2.2 – Proposed terms of National Code**

**Definitions**

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

  **As a health practitioner.**

- Is the term ‘health care worker’ an acceptable term to use to describe to whom the National Code applies, or is another term such as ‘unregistered health practitioner’ or ‘health practitioner’ preferable, as in NSW and South Australia?

  **No, the term health care worker is not an acceptable term to AROH.**

  **The preferred term is health practitioner.**

**Application of this Code**

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

  **The scope is acceptable.**

  A possible disadvantage with the proposed National Code is the statement ‘....who provides health services that are unrelated to their registration’? It is difficult to determine whether certain services are related to a practitioner’s registration or not. In Australia, medical practitioners use a variety of therapeutic approaches including counselling, herbs, homœopathy, and non-mainstream therapies - this may not be related to their registration as a general practitioner. The provision of such services is covered by Medicare, so long as the service includes the features required on the Item descriptor. If this National Code also applies to AHPRA registered practitioners, then it would be a useful exercise to ensure that those professions’ Codes are at least as demanding as this Code. It would therefore not intrude on their practice, yet provide the intended safeguard when these practitioners are operating on the margin of their scope of practice. In addition, every practitioner would be aware that they will be subject to this Code, as well as their own. The current proposal has a grey area which means that practitioners may presume they are subject to only one Code, and a regulator takes a different view.
• Is it preferable that the National Code apply to all health care workers whether registered or not? If so, what are the potential advantages and disadvantages of this approach?

Yes, if implemented, it should apply to all health workers, whether registered or not.

Currently, in some areas of health care, registration with a recognised national body is NOT compulsory but only advisable. The National Code, if applied to anyone proposing/claiming to deliver a health benefit should practice within a given set of rules of conduct. This will safeguard the public.

• Disadvantage: determining who are exempt from this

If a person is exempt from this code, then this person should not give health advice. We advise that no such category of persons be established.

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

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

Yes.

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

More clarification is needed as a concept not covered is: A health care worker should apply their professional capacities to improve the health and well-being of their clients, and in so doing, attempt to minimise physical and emotional harm.

Sub clauses1.2 (d): states “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”

AROH would like to see this sub clause expanded from “…to other competent health care workers…” to other competent health care workers and/or medical practitioner, where appropriate.
In addition, sub clauses 1.2 (e) and (f) of the discussion questions say: “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”. For a health care worker to give an opinion about the modality of practice of another health care worker assumes knowledge/expertise in the field the health care worker may not be registered for. As for “...finding alternative competent treatment or care.” this requires a degree of understanding of a broad spectrum of modalities, the qualifications and training of other practitioners and could well be placing a very heavy burden on health care workers.

This sub clause does not clearly express ‘who’ thinks other health care is appropriate, and it is not clear whether 'required' applies to the assistance, or to the appropriate services. Is a health care worker obliged to assist a client to find other services if the worker doesn’t think it is appropriate, but the client does? This could be better expressed as: A health care worker must assist a client to find other health care services, if such assistance is necessary and practicable, and the worker considers the health care services to be appropriate. Replacing the word “assist” with “advice” maybe more appropriate.

Sub clause 1.2 (g) in the discussion questions says: A health care worker must encourage clients to inform their treating medical practitioner (if any) of the treatments or care being provided. A similar clause should be added to the Code applying to medical practitioners as well.

2. Health care workers to obtain informed consent

- Should the National Code include a minimum enforceable standard that addresses informed consent? If so, then how should it be framed and how should the complexities of informed consent in emergencies and with respect to minors be dealt with?

  Yes, the National Code should include informed consent. This should be applicable to both health care workers and medical practitioners.

- Is this clause expressed in a way that will best capture the conduct of concern?
The word 'significant' should be added: 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 significant risks involved, and obtain the consent of the client, guardian or other relevant person.

This part of the discussion questions is missing and has been added to AROH’s response:

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?

Yes.

3. Appropriate conduct in relation to treatment advice

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

- If so, is this clause expressed in a way that will best capture the conduct of concern?
  
  No. Sub clause 3.2 says “A health care worker must not attempt to dissuade a client from seeking or continuing medical treatment.” This should be applied to medical professional as well as health care workers. We constantly hear from patients that medical practitioners attempt to dissuade patients from treatments about which the medical practitioner is not qualified or registered to practice.

  This concept should be broadened to: A health care worker must not attempt to dissuade a client from seeking or continuing treatment that is outside their own scope of practice, understanding or experience. This clause should be included in the Codes of AHPRA professionals also.

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

- 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?
Yes, if it poses a serious or fatal risk.

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

  No. 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 should refer the matter to the relevant state or territory health complaints department.

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

  Yes. Vexatious reporting does 'harm' members of the public. Frivolous and vexatious reporting should be subject to penalties.

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

- 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?

  Sub clause 5.2 a: “ensure that appropriate first aid is available to deal with any adverse event”

  This is an unrealistic requirement. Adverse events are not necessarily the result of treatment, they may simply be synchronous, or occur whilst taking the history from the patient, or while they are in the waiting room. This should be reworded: a) ensure that appropriate first aid is available to deal with common as well as serious known adverse events resulting from treatment. It is to be noted that all AROH registrants have to have a current first aid certificate with CPR.

  Sub clause 5.2 d: “report the adverse event to the relevant authority, where appropriate.”

  Further clarification of the words “relevant” and “appropriate” is necessary. As stated, this can be open to interpretation. This should be accompanied by educational material concerning what the reporting obligations are that this clause is attempting to support.
6. Health care workers to adopt standard precautions for infection control
   • Should the National Code include a minimum enforceable standard that addresses the adoption of infection control procedures?
     Yes.
   • If so, is this clause expressed in a way that will best capture the conduct of concern?
     Yes. Adoption of infection control procedures must be enforceable.

7. Health care workers diagnosed with infectious medical conditions
   • Should the National Code include a minimum enforceable standard that addresses health care workers diagnosed with infectious medical conditions?
     Yes.
   • If so, is this clause expressed in a way that will best capture the conduct of concern?
     Yes.

8. Health care workers not to make claims to cure certain serious illnesses
   • Should the National Code include a minimum enforceable standard that addresses claims to cure or treat life threatening and terminal illnesses?
     Yes.
   If so, is this clause expressed in a way that will best capture the conduct of concern?
   
   Sub clause 8.1 may be re-worded as “A health care worker must not claim to be qualified, or alleviate the symptoms of cancer or other life threatening or terminal illnesses, unless such claims can be substantiated.”

   More clarification on “substantiate” is required as to the type of substantiation that is acceptable.

9. Health care workers not to misinform their clients
   • Should the National Code include a minimum enforceable standard that addresses misinformation and misrepresentation in the provision of health products and services?
     Yes.
   • If so, is this clause expressed in a way that will best capture the conduct of concern?
     Yes.

10. Health care workers not to practise under the influence of alcohol or drugs
   • 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?
Yes.
• If so, is this clause expressed in a way that will best capture the conduct of concern?

Yes.

11. Health care workers with certain mental or physical impairment

• 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?

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

Yes.
• Is sub clause 2 necessary, or does sub clause 1 sufficiently capture the behaviour of concern?

Sub clause 2 is necessary.

12. Health care workers not to financially exploit clients

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

Yes.
• 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?

Yes.

13. Health care workers not to engage in sexual misconduct

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

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

See comments below.

• 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 expand the definition of ‘prescribed offences’ and rely on clauses 3 and 4?

Sub clause 13.3 The word “reasonable period of time” is open to interpretation. A standard form may be required with preconditions that would imply that a satisfactory period had elapsed. This form should require signatures of both parties and a witness.

“Examples of sexual behaviour are: not charging or billing for treatment, unrelated to financial hardship” - Non-profit/charity workers
who are practitioners/voluntary workers may also provide their services without charging, which does not necessarily indicate a sexual relationship. The same applies to varying one’s charges for services under special circumstances like financial hardship or senior citizens— as this is not related to the context of sexual assault.

14. Health care workers to comply with relevant privacy laws

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

  Yes.

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

  Yes.

15. Health care workers to keep appropriate records

- 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?

  The above statement may also include the following: This requirement may be subject to reasonable fees being paid by the client for copying and transmission purposes, excepting emergency situations.

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

  Yes.

- Are sub clauses 2 and 3 necessary, or does sub clause 1 sufficiently capture the conduct of concern?

  Sub clause 2 and 3 are necessary.

16. Health care workers to be covered by appropriate insurance

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

  Yes.

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

  Yes.

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

  Yes, but an essential one.
17. Health care workers to display code and other information

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

See comments below.

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

No.

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

This requirement should be a requirement for ALL medical and health professionals. It is inappropriate to require this of the one group, but not the other. Public and private hospitals are places that generate the highest volume of clients and thus, highest number of complaints against health practitioners.

Sub clause 17.2 Display of the Code “in a position and manner that makes them easily visible to clients entering the relevant premises” is impractical for logistic and aesthetic reasons. It becomes more problematic in practices where the space is shared between 2 or more practitioners of the same or different health modalities. To make the NSW Code of Conduct large enough to be legible requires a considerable amount of wall space, which is both unattractive and commercially insensitive.

It would be reasonable to require only a sign providing contact details of the regulator, and how the Code can be accessed. Availability of the Code of conduct and avenues for complaint should be displayed and if anyone requires to view these documents may request the health care worker for a copy. Failing which, a display of a copy in a visible area in the premises should be sufficient.

Sub clause 17.1b: The relevant qualifications should be available on request and display of qualifications should be optional. There are registration bodies which verify qualifications. Instead, registration into the national register should be displayed in a visible location.
Items not included in the draft National Code of Conduct

1. Sale and supply of optical appliances

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

  **Not applicable to homœopathy.**

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

- 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’?

  **This item should not be included in the draft National Code of Conduct since the term “clinical basis” is open to interpretation.**

- 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?

  AROH would be happy to see an additional clause. AROH is of the impression that this clause is adequately covered for its registrants. AROH has a Standards of Practice document and a Code of Professional Conduct document that all Registrants must adhere to when providing health care services. Underpinning these documents is the National Competency Standards for Homœopathy. Nevertheless, it is to be noted that such a clause, if adopted, be equitably applied to all health care workers, both complementary and alternative medicine (CAM) and allopathic.

  At this stage AROH cannot recommend how to identify ‘unproven’ treatments, except to say that most modalities (allopathic and CAM) have ethical frameworks and it could be suggested to allow each modality’s professional associations to deal with this, otherwise a prescriptive method could be used as an official “gate-keeper” approach to restrict practice.
Section 3.2 - Scope of application of the National Code

Definition of a health care worker

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

- Is the term ‘health care worker’ acceptable, or is another term preferable?

  Health service and health practitioners or health care worker definitions may have to be modality specific with clear cut scopes of practice embedded into the National Code. Nevertheless, this type of definition could again be restrictive if legislated and thereby inadvertently or intentionally inhibit expansion of services of an individual.

  Homœopathy has a national registration body (AROH) and practitioners are nationally registered. So the use of the term “National health practitioner (AROH registered)” acknowledges the standard of education, ongoing Professional Development, and adherence to policies and codes.

Definition of a health service

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

  National consistency holds problems because of the capacity to implement sweeping restrictive national powers, yet it has benefits by harmonising legislation nationally.

  As one of the main purposes of this endeavour is to create consistency across the nation in order to avoid problem practitioners’ ability to reinvent themselves in a new location, it seems sensible to get a standard national definition for the application of this law.

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

  There should be a general name such as Health Practitioner then the modality specific designation should be added. For example: Health Practitioner (Homœopath). In this way the general public will be aware of the modality that the practitioner is working with. A register of
modalities, with educational standards and Registration standards and modality specific associations, can be available and attached to the National Code so the general public can see what Standards each modality upholds.

- Is there a need to include a reference to ‘volunteer’ in the definition of provider/health service provider

There is no reason why the law should apply differently to volunteers, except that this should be considered on a case by case basis, in dealing with complaints. The problem is that trained professionals can volunteer their services, so can un-trained people. The definition of a volunteer needs to be explained further.

Section 3.3 Application of a ‘fit and proper person’ test

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

Yes, there should be prohibition order - whether the test is placed within the Code or as in Option 2, it is important that it is only applied in cases where there is a significant risk to public health and safety. The committal of prescribed offences on their own is too blunt an instrument to discriminate where a health worker’s employment/livelihood is to be prohibited.

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

No.

- Is consistency across jurisdictions considered important in the approach adopted?

Yes.

Section 3.4 Who can make a complaint?

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

National consistency is important.

- If consistency is considered important, is there a preferred approach for specifying in legislation who may make a complaint?

It should be restricted to service users and their guardian or representatives. If anyone is allowed to make a complaint, it will invite
more frivolous complaints. If there are complaints made by a third party, it should be at the discretion of the Commissioner following application of a public interest test, before taking matter further.

Section 3.5 Commissioner's 'own motion' powers

- How important is national consistency with respect to the power for a Commissioner to initiate an investigation of a matter on his or her own motion, without a complaint?

National consistency is desirable, but not a necessity.

- If consistency is considered important, should all state and territory Commissioners have such 'own motion' powers?

Yes. Health practitioners possess qualifications in more than one health modality. Having a national consistency would help achieving this objective, across states and health modalities.

Section 3.6 Grounds for making a complaint

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

National consistency is very important.

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

The main objective of this Code is to establish a benchmark of un/acceptable conduct. The complainants should be directed to compare the circumstance(s) for their concern with the Code, and include with their report where they perceive a breach to be.

Section 3.7 Timeframe for lodging a complaint

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

A national consistency in the time frame is necessary.

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

A timeframe of 12 months is considered to be adequate and needs to be specified. Circumstances can arise where a pattern of behaviour could be established from previously unreported circumstances in the more
distant past, which warrant investigation to corroborate a current report. Therefore the Commissioner should have discretion.

**Section 3.8 Interim prohibition orders**

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

  National consistency in issuing interim prohibition orders is not necessary.

- 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?

  The time limits should be related to the time the Commissioner could reasonably expect to have completed the legal process that ensures that justice is properly served. The purpose of the time limit is to expedite the legal process and as such dependant on the states. The maximum time period should be 8 weeks.

**Section 3.9 Who is empowered to issue prohibition orders**

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

  A national consistency is important for ease of understanding and transparency. In any other regard, consistency across States is not critical, but the provision of Natural Justice certainly is.

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

  It is reasonable that a Commissioner has the ability to issue interim prohibition orders, as well as investigate/prosecute cases. However, a separate body should hear cases (that are in dispute) and make decisions concerning ongoing prohibition orders. It is inappropriate for the one body to have the power to initiate complaints, investigate and decide the outcome, regardless of whether a further avenue for appeal is afforded. All health practitioners must be afforded the right to a hearing before a prohibition order is issued and a practitioner who is aggrieved by a decision should have the right of appeal.
Section 3.10 Grounds for issuing prohibition orders

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

  Not essential but is good sense, if prohibition in one State implies prohibition across the Nation, then the grounds for prohibition should be the same in all jurisdictions.

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

  A prohibition order should be given only if there is reasonable evidence that the Code may have been breached or the person “poses serious risk” to persons. It would be inappropriate to prevent someone from practising if the above is not the case. The conditions required in NSW are acceptable.

Section 3.11 Publication of prohibition orders and public statements

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

  See comments below.

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

  Prohibition orders should not be published as this is only a pre-judicial process. If published, the accompanying statement to a prohibition order should be limited to facts, excluding opinions. The jurisdiction of prohibition orders should be nationally applicable.

Section 3.12 Application of interstate prohibition orders

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

  National consistency is paramount.

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

  “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.” The above statement is acceptable.

Section 3.13 Right of review of a prohibition order

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

The right of review for practitioners, who are subject to a prohibition order, is very important. There should be national consistency.

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

Right to appeal is important. The time period within which an application for review or appeal must be lodged should be greater than 4 weeks. With the proviso that an interim prohibition order will operate in the interim, we think this period should be extended to 8 weeks.

Section 3.14 Penalties for breach of a prohibition order

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

National consistency is important for any breaches of a prohibition order.

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

The maximum penalty for breach of a prohibition order maybe 200 penalty units ($22,000) and prohibition from practise unless further professional development is undertaken and competency is proved which is accepted by the registration body. There should be no imprisonment.

Section 3.15 Powers to monitor compliance with prohibition orders

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

Not necessary.

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

N/A.
**Section 3.16 Information sharing powers**

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

  As information sharing powers are already in existence in each state, this can be widened to include similar powers in other states and territories.

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

  Equitable approach to all states and territories.

**Section 4.1 Mutual recognition**

- What is the preferred option for making publicly accessible information about prohibition orders that are issued in each state and territory?

  Option 3.

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

  As Option 3 would, from the outset, be designed to provide a uniform presentation that all participants would agree to work on, it would in all probability, provide the best outcome from the perspective of the user. Responsibility of ongoing administration, including changes, may be hampered by requiring meeting with participants from every State and Territory.

**Any other comments?**

Do you have any other comments to make about the draft National Code, policy parameters or administrative arrangements?

____________________________________________________________________

Would you like to be informed of the outcome of the consultation?  **Yes**  **No**