



CURIOSITY INTO CAPABILITY

NATIONAL SAFETY & QUALITY SUBMISSION

Professional patience, interpretive restraint and distress-tolerant care

A patient-safety standard for communication when people are unwell,
in pain, overloaded or neurodivergent

CORE PROPOSITION

Healthcare should not require a patient to perform calmness, warmth, deference or neurotypical social signalling as a condition of being heard. The professional task is to preserve care, interpret communication in context, and base safety decisions on specific observable evidence rather than interpersonal reaction.

Submission to

Australian Commission on Safety and Quality in Health Care

National Safety and Quality Health Service Standards - Third Edition Consultation

Submitted by NableU Community Systems Incorporated

September 2026

SUBMISSION NOTE

Purpose and central proposition

NableU submits that professional patience, interpretive restraint and early relational de-escalation should be explicit patient-safety competencies across Australian healthcare. The proposal applies to clinicians and to every patient-facing role that controls or influences access to care, including reception, booking, telehealth, triage and complaint functions.

The problem is not simply that some patients communicate differently. The deeper safety problem is that communication form is often treated as though it directly reveals intent, character or risk. Direct wording, profanity, repetition, interruption, increased volume, rapid speech, visible distress or refusal to agree are observations. They are not, by themselves, conclusions about motive or safety.

THE FRAMING RULE

Observation before interpretation. Function before judgement. Care before etiquette.

This submission therefore asks the Commission to create a professional patience standard: when communication is intense but care can still proceed safely, the workforce remains patient, curious and clinically focused; reduces avoidable cognitive and relational load; and does not make social conformity a precondition of care.

The current NSQHS third-edition draft already provides a strong foundation through person-centred practice, communication capability, prevention of escalation, identification of contributing factors and a defined high-risk category for “behaviours of concern”. [1] NableU asks the Commission to make explicit what should happen before a patient reaches that category.

The core problem is classification, not etiquette

Charged conduct labels compress several different questions into a single word: what happened, what it meant, whether it was intentional, whether it created risk, and whether the patient deserves a restrictive response. That compression is clinically unsafe because it can turn a contested social interpretation into a durable fact.

The standard should instead require a sequence: describe the communication; identify the clinical and situational context; ask what function the communication may be serving; test whether a simple adjustment changes the interaction; then assess any remaining safety significance from specific evidence.

A CLEARER MODEL

Separate communication form from safety significance

NableU proposes a four-layer model for patient-facing interactions. The most common error is jumping directly from Layer 1 to Layer 4.

Layer	Question	Examples
1. Observed form	What can another observer verify?	Direct wording; profanity; repeated point; interruption; rapid speech; increased volume; long pauses; limited eye contact; visible distress.
2. Context	What is happening to the person and around them?	Pain; uncertainty; long delay; fatigue; sensory load; trauma activation; executive-function burden; unfamiliar process; loss of agency.
3. Function	What is the communication trying to achieve?	Get an answer; stop an overwhelming exchange; obtain clarity; establish a boundary; restore predictability; make urgency understood; seek help.
4. Safety significance	Is there specific conduct that creates material risk or makes safe care impossible?	Assess from concrete words/actions, physical conduct, proximity, objects, attempts at harm, stated intent and response to clear limits - not from style alone.

CLINICAL DISCIPLINE

The same communication form can arise from very different causes. The workforce should test meaning rather than assume it.

No emotional performance requirement

A patient should not have to sound calm, warm, deferential, grateful or socially polished before a professional will continue to listen. Those are social performances, not clinical prerequisites.

This matters for everyone who seeks care while unwell, but it is especially important where pain, fear, executive dysfunction, trauma, sensory overload or neurodivergence change how information is processed and expressed. Autistic adults report substantial communication barriers in primary care, including not feeling understood, difficulty communicating with doctors and reception staff, and the need for direct language, written communication and adequate processing time. [5][6][7]

Healthcare is intentionally asymmetric

The professional and the patient have equal human dignity, but they do not occupy identical roles in the encounter. The clinician or healthcare worker is trained, paid and operating inside a system whose purpose is to care for people whose physical, cognitive or emotional capacity may be reduced. The patient may be there precisely because ordinary regulation is harder.

The Medical Board of Australia recognises a power imbalance in the doctor-patient relationship and requires doctors to listen to patients, respond to their concerns and preferences, and communicate effectively. [3] Ahpra's Shared Code requires patient-centred, non-judgmental communication and specifically cautions against unprofessional language in records or correspondence. [4]

PROFESSIONAL ASYMMETRY

The patient is not required to become the more regulated participant before care can continue. Professional regulation is part of the service being provided.

This is not a claim that patients have no agency or responsibility. It is a claim about where professional competence sits. The worker should be able to absorb a greater range of non-dangerous communication variation than an ordinary social counterpart, because the worker has training, institutional support, role clarity and a duty to preserve the care objective.

Supportive accountability, not moralisation

NableU's own systems work uses the principle of supportive accountability: responsibility and support are not opposites. People remain accountable for what they do, while systems remain accountable for creating the conditions in which successful behaviour is realistically possible. [13]

Applied to healthcare, this means a service can set precise safety boundaries while still asking whether its own process, wording, delay, ambiguity or refusal of an accessible communication method increased the difficulty of the interaction. Accountability should answer "what needs to change next?" rather than "who is the bad person?"

RECIPROCAL SUPPORT

Professional patience must be organisationally supported

Professional patience has an emotional and cognitive cost. NableU does not propose that workers should simply absorb that cost. A system that expects staff to remain patient-focused during high-strain encounters has a corresponding responsibility to provide enough staffing, supervision, relief, peer connection and recovery capacity for that professionalism to be sustainable.

The solution is therefore not to protect the patient by neglecting the worker, or to protect the worker by requiring the patient to suppress distress. It is to support both parties at the point where each needs support. The patient needs interpretive restraint and continued access to care during the encounter. The worker needs organisational backing, a place to process the encounter afterwards, and confidence that they do not have to carry the residue of demanding work alone.

RECIPROCAL SUPPORT, ASYMMETRIC RESPONSIBILITY

Support the patient during the interaction. Support the worker after the interaction. Improve the system before the next interaction.

Stage	Primary responsibility	What good support looks like
Before the interaction	Organisation	Adequate staffing; clear communication pathways; predictable administration; access to senior support; realistic workloads; systems that reduce avoidable friction.
During the interaction	Professional + organisation	Professional patience; interpretive restraint; one clear issue at a time; practical communication adjustment; access to backup or a senior colleague when needed.
After the interaction	Organisation	Protected opportunity to step away where practicable; supervisor or peer check-in; reflective debrief; recovery time; workload adjustment where needed; access to psychological support; review of system contributors.
Before recurrence	Organisation + team	Convert the encounter into learning: clarify pathways, fix process friction, improve staffing or handover, record helpful adjustments, and support the next worker to succeed.

Worker experience is real - but it belongs in the right channel

A worker may leave an interaction upset, depleted, unsettled or frustrated. Those responses are real and deserve organisational support. They should not, however, be converted into a durable character judgement about the patient. The clinical or incident record should contain observable facts, clinically relevant context, the professional response and the outcome. The worker's own emotional processing should have a separate and legitimate home in supervision, peer support, reflective review or workplace wellbeing systems.

DOCUMENTATION SAFEGUARD

Support the worker privately. Record the patient objectively.

This separation protects both sides. It validates the worker's experience without allowing one person's understandable reaction to become a prejudicial label that follows the patient into later care. It also allows supervisors to identify whether workload, staffing, unclear procedures, repeated exposure or service design contributed to the strain.

Safe Work Australia identifies poor support and high emotional demands as psychosocial hazards in health care and social assistance. Its guidance recommends organisational controls including access to supervisors, regular team discussion, spaces to step away after emotionally demanding situations, recovery time, and post-incident debriefing rather than treating psychological strain as simply part of the job. [17][18]

NableU uses "debrief" in a broad operational and reflective sense, not as a compulsory trauma-processing intervention. Support should be proportionate and choice-based. A recent systematic review of healthcare staff support after patient-safety incidents found that workers commonly wanted peer support, practical guidance and professional mental-health support, while evidence for any single intervention remained mixed. That supports a layered menu of support rather than one mandatory response. [19]

Interpretive language can itself create clinical risk

Clinical and incident records are not passive descriptions. They shape the expectations of the next worker. Research on medical-record language shows that clinician wording can transmit negative attitudes and influence subsequent care. [10]

For communication events, the national standard should therefore require evidence-preserving language. Record the event at the level at which it can be checked by another observer.

Record	Why it matters
Exact words where materially relevant	Preserves content without assigning motive.
Volume, pace, repetition and interruption as observable features	Separates communication form from judgement.
Who the words were directed toward and what issue was being discussed	Preserves function and context.
Physical position, movement, distance and contact	Allows genuine safety significance to be assessed.
What explanation, pause, adjustment or boundary the worker used	Makes the professional response part of the clinical record.
What changed after that intervention	Shows whether the interaction was responsive to care or accommodation.

RECORD THE EVENT, NOT THE CHARACTER

“Used profanity while describing the waiting time; repeated the request for an explanation; remained seated; accepted written follow-up after a pause” carries far more safety information than a one-word character judgement.

EVIDENCE

The external evidence supports patience, relationship and communication

This proposal does not depend on NableU's lived experience alone. Multiple evidence streams support the mechanism.

Patient-clinician relationship affects health outcomes

A 2026 systematic review and meta-analysis of 28 randomised trials involving more than 18,000 patients found that clinician-focused interventions that strengthen the patient-clinician relationship produced small but significant improvements across healthcare outcomes. [9] Earlier systematic reviews similarly associate patient-centred communication and empathy with therapeutic alliance, reduced distress, satisfaction and clinical outcomes. [8][11]

Autistic adults report mutual communication mismatch

Recent primary-care research describes communication difficulties as mutually situated between autistic patients and non-autistic providers rather than simply as patient deficits. Autistic adults valued patient, non-judgmental and direct communication, adequate processing time and being genuinely listened to. They described care deteriorating when clinicians hurried or misunderstood their communication. [5]

Cross-sectional evidence also shows very large differences in reported access barriers: autistic respondents were much more likely than non-autistic respondents to report difficulty visiting a GP when needed, difficulty using the telephone, difficulty communicating with doctors and reception staff, and avoidance or delay because they did not feel understood. [6]

Provider expectations can misread autistic presentation

Research on sensory and communication barriers reports that providers sometimes interpret autistic body language and communication through neurotypical expectations, producing misunderstanding even in verbally capable adults. [7] Primary-care guidance likewise notes that very direct language and atypical non-verbal communication can be misread socially and recommends concrete language, time to process and longer appointments where needed. [12]

SYSTEM MECHANISM

How professional impatience can manufacture the next problem

The critical mechanism is interactive. A patient starts with a healthcare need and reduced bandwidth. A delay, unclear answer, repeated form, inaccessible channel or perceived contradiction increases cognitive load. The patient becomes more direct or emphatic. If the worker responds by policing manner rather than repairing communication, another demand is added. The patient then has to manage the original healthcare problem and defend the legitimacy of how they are expressing it.

1	2	3	4	5	6
Health need / reduced bandwidth	Process friction / loss of clarity	More direct or intense expression	Manner becomes the focus	Load and dysregulation rise	Care relationship fragments

The professional response is therefore not external to the event. It is one of the causal variables. A standards framework that records only the patient’s presentation and not the workforce response cannot reliably distinguish an intrinsic problem from an interaction-created one.

SYSTEM DESIGN QUESTION

Did the service reduce the load, restore clarity and preserve agency - or did it add another conflict?

NABLEU EVIDENCE

Lived-experience case series: repeated interaction pattern

NableU relies on a documented case series involving unrelated health services from 2023 to 2026. It is not offered as prevalence evidence or as a request for the Commission to determine fault. It is used as a sentinel series: repeated observations that expose a candidate systems failure and allow it to be tested against independent research and standards.

Service	Original healthcare issue	Observed pathway	Standards question
Castle Hill Medical Centre / Dr Luke Ryan	Chronic-pain care; additional video-platform and administration burden.	The access issue and communication strain became intertwined; the therapeutic relationship later ended.	Could a lower-friction pathway and greater patience have preserved care?
The Haven Family Medical Practice	Clinical notes later used outside the immediate consultation.	Concern that subjective social interpretation entered the record and shaped downstream understanding.	Should records preserve observable facts and context rather than social judgement?
Hills Family General Practice / Dr Walid Jammal	New-patient intake; repeated information; disability disclosure; request for management escalation.	Communication intensity increased while the intake problem remained unresolved; the prospective patient relationship was declined.	What would have happened if the process failure had been owned and simplified early?
Elevate Health Clinic	Calendar/reminder adjustment and service administration.	The dispute intensified over time; later messages included personally directed profanity; care was ended.	Can a graduated communication plan prevent early friction becoming a relationship-ending conflict?
My Mirror psychology	Long therapeutic relationship; calendar and recurring-booking access need.	A manual workaround had existed; the issue recurred; communication intensity increased and the service later ceased.	How should an established psychological service use known disability context before the relationship fractures?
Westmead Chronic Pain Service	Referral discussion; advice of an approximately 8-10 month wait.	The patient swore while reacting to the wait; the call shifted away from the referral and ended before disability context could be explained.	Should expression of distress become a separate conduct dispute when the clinical interaction can otherwise continue?

WHAT THE CASES ACTUALLY SHOW

The recurring feature is not one particular word or tone. It is a system losing sight of the healthcare objective once communication stops matching ordinary social expectations.

Independent clinical material

An independent 2025 forensic psychiatric assessment documents autism and ADHD alongside communication and emotional-regulation difficulty, overwhelm under service conflict, abrupt language and swearing, and reduced frustration tolerance. [14] This is person-specific evidence, not a generalisation about autistic people. Its relevance is that communication repeatedly interpreted socially had a clinically documented disability and regulation context.

A treating psychologist’s support material likewise identifies ADHD and autism as lifelong neurodevelopmental conditions affecting social-emotional reciprocity, impulsivity and executive function, and records the additional functional impact of trauma-related distress. These materials reinforce the need to assess function and context rather than infer intent from presentation.

NableU and ProcessAbility conceptual work

The ProcessAbility Neurodivergent Interaction Manual develops a transferable rule: separate what the person is doing from what the observer thinks it means; restore clarity and agency; use one instruction or question at a time; and reassess after communication and sensory adjustments. [15] Although written for police interaction, the systems mechanism transfers directly to healthcare because both domains involve asymmetrical authority, stress, rapid interpretation and high downstream consequences.

Conquests of the Impossible provides the wider philosophical basis through cognitive equity and supportive accountability: equal treatment is not equal access when people face radically different cognitive costs, and accountability is most effective when the conditions for successful action are also supplied. [13]

Principle	Healthcare translation
Observation before interpretation	Record communication form and context first; infer meaning only after evidence and clarification.
Cognitive equity	Do not make identical communication processes the test of equal access where cognitive costs differ materially.
Restore agency	Explain what can be decided now, what cannot, who holds the decision, and what happens next.
Reduce the load	One issue at a time; fewer simultaneous demands; written follow-up; processing time; predictable channels.
Supportive accountability	Keep specific boundaries while also supplying the conditions that make successful communication more likely.
Reassess after adjustment	Treat the professional response as a variable. If clarity or accommodation changes the interaction, record that learning.

WHY THIS MATTERS

These principles shift the question from “How do we control the patient’s presentation?” to “What conditions make accurate communication and safe care possible?”

PROPOSED STANDARD

Recommended wording for the third edition

PROFESSIONAL PATIENCE AND INTERPRETIVE RESTRAINT

The health service ensures that clinical and non-clinical workers can maintain professional composure and patient focus when communication is direct, intense, repetitive, profane, emotionally expressive or otherwise atypical.

The workforce does not infer intent, character or safety significance from communication style alone. Staff assess observable conduct, clinical and situational context, communicative function, and the person's response to clarification, time, reduced cognitive load or reasonable communication adjustment.

Where no immediate safety-significant conduct is present, the workforce uses patient-centred clarification, adequate processing time, accessible communication and relational de-escalation before limiting communication or access to care.

The health service does not require patients to perform calmness, warmth, deference or neurotypical social signalling as a condition of being heard or receiving care.

Records distinguish observable behaviour from interpretation and include relevant context, professional response and outcome.

Where specific conduct creates a material safety risk or makes safe care impossible, any restriction is proportionate, evidence-based, reviewed, and accompanied by appropriate continuity-of-care planning.

Define safety-significant conduct positively

Rather than relying on broad conduct labels, the standards should define the threshold operationally. Safety-significant conduct is conduct that creates an identifiable and material risk to a person or makes the safe delivery of care impracticable, established through specific observable acts, words and circumstances.

Examples may include an attempt to cause physical harm; a stated intention to cause harm supported by context indicating immediacy or capability; use or presentation of a weapon; unsafe physical encroachment after a clear and comprehensible boundary; or conduct that continues to make safe care impossible after reasonable, practicable communication adjustments.

KEY SAFEGUARD

Intensity is not the threshold. Evidence is the threshold.

Recommended wording for workforce support

WORKFORCE SUPPORT FOLLOWING HIGH-STRAIN INTERACTIONS

The health service recognises that patient-centred care can involve sustained emotional and cognitive demand and ensures that workers are supported to maintain professional, patient-focused practice.

The health service provides proportionate access to supervision, peer support, reflective

debriefing, recovery time, workload relief and psychological support where required.

Support processes provide an appropriate place for workers to discuss and process their own experience without transferring subjective emotional responses or character judgements into the patient's clinical record.

Clinical and incident documentation distinguishes observable behaviour and clinically relevant risk from the worker's personal experience or interpretation of the interaction.

Following significant communication breakdown, the health service considers patient, workforce, environmental and service-design factors together and identifies opportunities to reduce recurrence.

Workforce support is designed as part of psychosocial risk management and service quality, not as an expectation that individual workers absorb demanding encounters without adequate organisational containment.

IMPLEMENTATION

What patient-facing staff should be trained to do

1. Keep the healthcare objective visible even when the interaction becomes emotionally difficult.
2. Use one speaker, one issue and one clear next step where cognitive load is high.
3. Allow processing time; do not fill every pause or repeat more loudly.
4. Ask what communication method helps rather than requiring a diagnostic explanation before trying a simple adjustment.
5. Use direct, literal and non-judgmental language; avoid correcting social style when safety and care can continue.
6. Acknowledge the substantive concern before redirecting the interaction.
7. Distinguish profanity, repetition, volume and directness as communication features rather than conclusions about intent.
8. Record what occurred, what the worker did, and what changed after clarification or adjustment.
9. Escalate safety controls only when specific observable evidence justifies them.
10. Preserve continuity of care even when communication arrangements need to change.

A practical response script

EXAMPLE

"I can hear that this matters and you do not need to sound calm for me to keep listening. I am going to deal with one point at a time. First, this is what I can do now. Then I will explain the next step. If written information or a pause would make this easier, tell me."

This script does not concede the patient's factual position. It preserves agency, reduces ambiguity and avoids adding a social-performance dispute to the healthcare problem.

MEASUREMENT AND LEARNING

Measure whether the system preserves care under strain

A training module is not evidence that culture has changed. NableU recommends outcome measures that examine what happens when communication becomes difficult.

Measure	What it reveals
Encounters ended because communication style became the focus	Whether low-risk relational friction is becoming an access barrier.
Use of objective observational language in incident and clinical records	Whether interpretive contamination is reducing.
Communication adjustments attempted before access was limited	Whether professional patience is operational rather than aspirational.
Care delayed, transferred or lost after communication breakdown	Whether interaction management is creating clinical harm.
Patient-reported sense of being heard and understood	Whether person-centred communication is functioning under stress.
Worker-reported ability to maintain composure and resolve high-strain interactions	Whether the standard improves workforce capability as well as patient experience.
Worker access to supervision, peer support and recovery after high-strain encounters	Whether professional patience is being resourced rather than merely demanded.
Exposure frequency combined with staffing, breaks and recovery capacity	Whether psychosocial risk is being managed at the system level.
Repeat complaints involving the same communication pathway	Whether organisational learning is actually occurring.

The Primary and Community Healthcare Standards already require services to analyse complaints for safety and quality improvement and ask how patients and families are involved in complaint review. [2] Communication-related complaints should therefore be treated as high-resolution process data, not merely correspondence to be closed.

REQUESTED ACTION

What NableU asks the Commission to do

1. Add an explicit professional-patience and interpretive-restraint action to the Person-Centred Practice Standard.
2. State that communication style alone does not establish intent, character or safety significance.
3. Create a “no emotional performance requirement”: patients are not required to appear calm, warm, deferential or neurotypical before staff continue to listen and provide care.
4. Require clinical and incident records to separate observable communication features from interpretation and to document context, professional response and outcome.
5. Define any safety threshold using specific observable conduct rather than broad interpersonal labels.
6. Require patient-facing workforce training in processing time, direct communication, cognitive-load reduction, neurodivergent communication and early relational de-escalation.
7. Require incident review to consider the service’s own contribution to escalation, including inaccessible processes, repeated information demands, ambiguity, delay and unnecessary correction of social style.
8. Require continuity-of-care planning whenever communication arrangements or service access are restricted.
9. Require organisations to support workers after high-strain encounters through proportionate supervision, peer support, reflective debriefing, recovery capacity and access to psychological support where needed.
10. Require workforce-support processes to be separate from patient characterisation: subjective worker experience should be processed through support systems while patient records remain objective and contextual.
11. Require psychosocial risk controls that address staffing, workload, access to backup, repeated emotional demand and recovery time so professional patience is resourced rather than merely demanded.
12. Extend the same principle across primary/community healthcare, GP reception, psychology, allied health, telehealth and specialist administration.
13. Use complaints and lived-experience evidence to measure whether services remain patient-first and worker-supportive when interactions become high-strain.

Closing position

Patient-centred care is easy to claim when the patient is calm, articulate, agreeable and socially conventional. The real test is whether the system remains patient-centred when pain, fear, overload, disability or prolonged process failure makes communication harder.

Professional patience does not mean permissiveness. It means accuracy. It means not converting style into intent, not converting discomfort into risk, and not converting a strained interaction into a character judgement. It means using the professional’s greater regulatory capacity to preserve the healthcare objective for as long as safe care remains possible.

That professional capacity must itself be supported. A fair system does not solve patient distress by transferring unlimited emotional load to workers, and it does not solve workforce strain by making emotional conformity a condition of care. It distributes support according to role and need: the patient

receives patience and interpretive restraint; the worker receives supervision, recovery and organisational backing; the service learns from the interaction and reduces the chance of recurrence.

NABLEU RECOMMENDATION

Support the patient in the encounter. Support the worker after the encounter. Improve the system before the next encounter.

APPENDIX A

Evidence register - NableU lived-experience material

The case-series material below is used as systems evidence, not as findings of wrongdoing. It is retained in the underlying correspondence and complaint records and can be supplied to the Commission if required.

ID	Material	Date	Relevance
CE1	Castle Hill Medical Centre / Dr Luke Ryan	2023-2025	Chronic-pain care; video and administrative accessibility; communication breakdown; care relationship ended.
CE2	The Haven Family Medical Practice	2024	Complaint and HCCC review material concerning disability consultation and subjective social descriptors in clinical records.
CE3	Hills Family General Practice / Dr Walid Jammal	May 2025	New-patient intake friction; repeated information; disability disclosure; communication strain; prospective care declined.
CE4	Elevate Health Clinic	July 2025	Calendar/reminder adjustment dispute; communication intensity increased; provider ended care.
CE5	My Mirror psychology	2023-2026	Established therapy relationship; known calendar/booking need; manual workaround; recurring access dispute; service cessation.
CE6	Westmead Chronic Pain Service	August 2026	Waiting-list discussion; distress expression; call ended; detailed written communication-adjustment request.
CE7	Dr Richard Furst - independent forensic psychiatric report	2025	Person-specific clinical evidence linking autism/ADHD with communication, executive-function and emotional-regulation difficulty.
CE8	ProcessAbility Consulting - Neurodivergent Interaction Manual	26 August 2026	Observation-before-interpretation, cognitive-load reduction, communication adjustment and reassessment model.
CE9	Conquests of the Impossible	2026 edition	Cognitive equity and supportive accountability as the philosophical basis for differentiated support with retained agency.

EVIDENCE CAUTION

A longitudinal case series involving one principal lived-experience source cannot establish prevalence. Its value is signal detection: the repeated mechanism can be tested against external evidence, professional codes and national standards.

APPENDIX B

Selected evidence base

- [1] Australian Commission on Safety and Quality in Health Care. **NSQHS Standards Third Edition - Initial Draft** (2026). https://www.safetyandquality.gov.au/sites/default/files/2026-07/nsqhs-third-edition-initial-draft_1.pdf
- [2] Australian Commission on Safety and Quality in Health Care. **Primary and Community Healthcare Clinical Governance Standard** (2026). <https://www.safetyandquality.gov.au/national-standards/primary-and-community-healthcare-standards/clinical-governance-standard>
- [3] Medical Board of Australia. **Good medical practice: a code of conduct for doctors in Australia** <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>
- [4] Australian Health Practitioner Regulation Agency. **Shared Code of Conduct** <https://www.ahpra.gov.au/Resources/Code-of-conduct/Shared-Code-of-conduct.aspx>
- [5] Scheerer et al.. **Barriers and facilitators to primary healthcare encounters as reported by autistic adults: a qualitative study** (2025). <https://pmc.ncbi.nlm.nih.gov/articles/PMC11937071/>
- [6] Doherty et al.. **Barriers to healthcare and self-reported adverse outcomes for autistic adults: a cross-sectional study** (2022). <https://pmc.ncbi.nlm.nih.gov/articles/PMC8883251/>
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- [9] Neal et al.. **Interventions that strengthen the patient-clinician relationship improve healthcare outcomes: an updated systematic review and meta-analysis** (2026). <https://pubmed.ncbi.nlm.nih.gov/42250990/>
- [10] Park et al.. **Physician Use of Stigmatizing Language in Patient Medical Records** (2021). <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781937>
- [11] Pinto et al.. **Patient-centred communication is associated with positive therapeutic alliance: a systematic review** (2012). <https://pubmed.ncbi.nlm.nih.gov/22613237/>
- [12] Nicolaidis et al.. **Primary Care for Adults on the Autism Spectrum** (2016). <https://pmc.ncbi.nlm.nih.gov/articles/PMC4851469/>
- [13] Nathan Organ. **Conquests of the Impossible** (2026). NableU philosophical source: cognitive equity and supportive accountability. <https://conquestsoftheimpossible.com>
- [14] Dr Richard Furst, Consultant Forensic Psychiatrist. **Independent forensic psychiatric report concerning Nathan Organ** (2025). Confidential source. Only findings relevant to communication and functional regulation are relied upon.
- [15] ProcessAbility Consulting. **Neurodivergent Interaction Manual - Expanded Working Draft** (2026). NableU/ProcessAbility systems source: observation before interpretation, load reduction, communication adjustment and reassessment.
- [16] Australian Commission on Safety and Quality in Health Care. **NSQHS Standards Third Edition Consultation** (2026). Consultation closes 25 September 2026. <https://www.safetyandquality.gov.au/news-and-media/consultations/nsqhs-standards-third-edition-consultation>
- [17] Safe Work Australia. **Poor support - psychosocial hazards** (2026). Guidance on supervision, team support and debriefing after emotionally demanding tasks. <https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/mental-health/psychosocial-hazards/poor-support>
- [18] Safe Work Australia. **Psychosocial hazards - health care and social assistance** (2026). Health-sector guidance on job demands, support, recovery time, spaces to step away and post-incident debriefing. <https://www.safeworkaustralia.gov.au/book/health-care-and-social-assistance/hazards-risks-and-controls/psychosocial-hazards>
- [19] Systematic review. **Avoiding second victims in healthcare: what support do staff want for coping with patient safety incidents, what do they get and is it effective? A systematic review** (2024). Finds common staff preferences for peer support, practical guidance and professional mental-health support; effectiveness evidence varies by intervention. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12185930/>

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Submission prepared September 2026