From: [redacted]
To: medboardconsultation
Subject: Public consultation on draft revised code of conduct, Good medical practice: A code of conduct for doctors in Australia.
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Public consultation on draft revised code of conduct, Good medical practice: A code of conduct for doctors in Australia.

Released: 13 June 2018
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To the Medical Board of Australia:

I am writing a submission to express my views, as a current medical practitioner in rural NSW, on the proposed changes to the document: "Good Medical Practice – A Code of Conduct for Doctors in Australia".

I disagree with the Board's statement that it "is not proposing significant changes to the current code". There are certain sections and wordings in the proposed changes which will have the potential to significantly impact the capacity of doctors in Australia to exercise their rights to freedom of speech, freedom of religious belief, and to decline to participate in medical processes or procedures which conflict with their conscience or with good medical practice.

I will detail the particular areas in the proposed document which cause me and other colleagues concern.

Point 1:

1.4 Professional Values and Qualities of Doctors (2009 Code) is now being changed in the proposed document to:
2.1 (2018 Code) with insertion of paragraph 4:

> **Community trust in the medical profession is essential. Every doctor has a responsibility to behave ethically to justify this trust. The boundary between a doctor's personal and public profile can be blurred. As a doctor, you need to acknowledge and consider the effect of your comments and actions outside work, including online, on your professional standing and on the reputation of the profession. If making public comment, you should acknowledge the profession's generally accepted views and indicate when your personal opinion differs. Behaviour which could undermine community trust in the profession is at odds with good medical practice and may be considered unprofessional.**

The final sentence ("Behaviour which could undermine community trust in the profession is at odds with good medical practice and may be considered unprofessional.") is particularly disturbing. Unprofessional conduct should relate to unsafe medical practices, not to a doctor holding an opinion about ethical issues. Having a difference of opinion from "the profession's generally accepted views" should not be deemed unprofessional conduct. In many areas of medical practice, particularly with new technologies and changes to legislation regarding contentious issues such as euthanasia, embryonic procedures and abortion, there are a variety of views held by medical practitioners. To stifle healthy debate or suppress freedom of speech regarding such issues is not in the best interests of anyone in the community. Likewise, placing doctors under the threat of misconduct charges for expressing an opinion is entirely inappropriate. After all, Australia is still a democratic country where all citizens should have their legal rights to respectfully express their views protected, and this includes medical professionals.

In summary, this final sentence should be deleted and, in fact, so should the entire Paragraph 4, which contributes little to the overall document, and is likely to cause numerous vexatious complaints with little benefit to public safety and good medical practice in the community.

Point 2:

1.4 Professional values and qualities of doctors (2009)

Paragraph 5

Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact

on the doctor–patient relationship and on the delivery of health services.

Is now being changed in the proposed document to:

2.1 Professional values and qualities of doctors (2018)

Paragraph 6

Good medical practice is patient-centred. It involves understanding that each patient is unique, working in partnership with them and adapting what you do to address their needs and reasonable expectations. This includes culturally safe and respectful practice: being aware of your own culture and beliefs and respectful of the beliefs and cultures of others; and recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.

Replacing the term "cultural awareness" with "culturally safe and respectful practice" raises difficulties with interpreting what the latter phrase means. Awareness means that doctors should take the time and effort to understand the context that patients live in, and their personal belief systems. "Culturally safe" may imply that doctors should not challenge cultural practices, even if they are in opposition to good medical outcomes. For example, in some cultures, women are prevented from having information about or access to contraception. It may still be appropriate for a doctor to raise the issue of contraception with a woman if it is medically appropriate, even if it may not be regarded by some as "culturally safe" to do so. Respect for a patient should not mean that a doctor is hindered from presenting options for medical interventions for a patient to consider.

In summary, the original Paragraph 1.4 should be retained and no alteration made.

Point 3:

2.4 Decisions about access to medical care

2.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability or other grounds, as described in antidiscrimination legislation.

Is now being changed in the proposed document to:

3.4 Decisions about access to medical care

3.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, gender identity, sexual orientation, disability or other grounds, as described in anti-discrimination legislation.

With the addition of the terms: "gender identity" and "sexual orientation", the description of these as "medically irrelevant" may or may not be appropriate. Gender identity and sexual orientation may be very relevant to risk factors for psychological distress, incidence of drug addiction, sexually transmitted diseases (and therefore screening for these), and the medical and surgical side=effects of reassignment medical or surgical treatments.
It is not up to any external body to determine what is or is not "medically irrelevant" for various population groups. Doctors need to relate to individual

patients whose sex, religion, disability, sexual orientation or gender identity MAY place them at increased risk of medical or surgical complications, disease processes or drug side-effects. Threatening doctors with "anti-discrimination legislation" for raising such issues or discussing evidence-based medical options with a patient is not in the best interests of the patients in their care.
In summary, I believe it is preferable to either retain the 2009 wording, or to add "where medically irrelevant", to ensure that doctors can make sound professional choices about what issues to raise with individual patients in their specific circumstances in the best interests of those patients.

Point 4:

3.7 Culturally safe and sensitive practice

Good medical practice involves genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes. This includes:

3.7.1 Having knowledge of, respect for, and sensitivity towards, the cultural needs of the community you serve, including those of Indigenous Australians.

3.7.2 Acknowledging the social, economic, cultural and behavioural factors influencing health, both at individual and population levels.

3.7.3 Understanding that your own culture and beliefs influence your interactions with patients.

3.7.4 Adapting your practice to improve patient engagement and health care outcomes

Is now being changed in the proposed document to:

4.8 Culturally safe and sensitive practice

Culturally safe and respectful practice requires you to understand how your own culture, values, attitudes, assumptions and beliefs influence interactions with patients and families, the community, colleagues and team members. Good medical practice is culturally safe and respectful. This includes:

4.8.1 Understanding that only the patient and/or their family can determine whether or not care is culturally safe and respectful.

4.8.2 Respecting diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among colleagues and team members.

4.8.3 Acknowledging the social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population levels.

4.8.4 Adopting practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based on assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs).

4.8.5 Supporting an inclusive environment for the safety and security of the individual patient and their family and/or significant others.

4.8.6 Creating a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including patients, colleagues and team members.

There are several serious problems with the new proposed wording:

Firstly, "sensitive practice" being replaced by "respectful practice" and "good health outcomes" being replaced by "culturally safe and respectful" both raise the problems I described in Point 2 above. As a doctor, it is appropriate to be sensitive regarding a patient's background, culture and beliefs, yet still raise issues or medical options which may challenge the patient to consider new possibilities. Ultimately, good medical practice is about improved health outcomes for individuals and communities, and this may sometimes mean challenging patient views on vaccination, diet, alcohol or drug use, and many

other issues. The doctor's role is not to collude with a patient's possible poor health choices, but to sensitively raise options for improved evidence-based outcomes.

Secondly, in the proposed wording of 4.8.1, the use of word "only" is patently wrong. It is not just up to a patient and their family to determine whether care is medically appropriate. There are numerous situations in which patients (who may include children, or those who may be subject to a cultural power imbalance) may be dominated by their family to either accept or reject various treatments or procedures. Examples include failure to be vaccinated, female genital mutilation, under-age marriage (which may technically include rape), and many other cases where health care is inappropriate because of the dominating opinion or misinformation of a patient and/or their family. Doctors have a duty of care to ensure that patients are protected, informed and given optimal medical input, and this may sometimes involve engaging with the family to sensitively challenge inappropriate attitudes or beliefs.

Thirdly, 4.8.2 again confuses respect for the patient with respecting and going along with beliefs that maybe antithetical to good medical practice. The opening of 3.7 "Good medical practice involves genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes**"** is a far better summary of what is required.

Fourthly, 4.8.5 and 4.8.6 (covered by 3.7.4 of the 2009 Code) are both unclear with many possible interpretations and potential conflicts, and should be deleted.

In summary, 4.8 of the draft 2018 Code is unsound and should be completely replaced by 3.7 of the 2009 Code.

<u>Final summary:</u>

I believe the 2009 Code is comprehensive and vastly superior in terms of defining good medical practice than the 2018 Draft Code and that the spirit, meaning and wording of the 2009 Code should be retained.

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