Submission to the Public Consultation on *Good Medical Practice*

31 July 2018

To the respected members of the board,

First of all, thank you all for your time and public service, irrespective of your decision in this matter. Your contribution to the functioning of our country is substantial and appreciated.

My concern is that respect for a person and their medical best interests - taken to mean longevity and health - may potentially be made mutually exclusive by the claim of overriding cultural beliefs, as implied in Section 4.8 of the draft Good Medical Practice. This is unnecessary, and raises subjective claims and opinions (interpretations of culture) and potentially transitory allegiances to such (i.e. lifestyle choice or self- identification) above the practice of valuing the continued physical then psychological well-being of the patient as the paramount concern of the medical practitioner. This practice was established for good reason, ensuring a consistency of approach in treatment for all, without prejudice or bias. This belief in itself is cultural, as note 4.8 implies, and this longstanding culture among medical practitioners, if a medical

practitioner who gives allegiance to this culture should be used, should have the final say on all decisions - otherwise the proposal's intended aim of cultural respect for others requires a self- defeating negation of the practitioner's own core cultural beliefs, both to their own psychological harm and the tangible harm of the patient.

Democracy is a culture, as are all representative bodies, etc. And all are challenged in their application, even legitimacy, by other cultures in our environment. So what determines the prominence of one culture in a given area over another? My hope is its track record, imperfect though it may be, shows overall it has provided better outcomes than in states where demonstrable self-interest, and alternative cultures of physical health, have prevailed. Women, the very young, the elderly, and those disagreeing with the majority view have been, and are reportedly still currently, exploited, disparaged or denied care, in various cultures today. A culture of care (or non-care) may be established by the proposed changes in clause 4.8 that actively and tangibly harms patients beyond the cultural feelings and beliefs of relatives. Especially if the patient has themselves renounced those beliefs, but is at that time unable to communicate. The spectre of widespread vaccination refusals, female circumcision or child transgender operations according to relatives' wishes are not negated in the current wording, and may even be actively encouraged, to the potential

great regret of, and irreversible consequence to, the patient themselves.

So on the basis of clause 4.8 I respectfully ask the board to either reject the draft code of practice, irrespective of what other, positive, aspects may be in it, or adopt an additional option of removing clause 4.8 and all other text associated with its subject matter of culture or beliefs.

Sincerely,

Nathan Wilson