01/08/2018

Dear Medical Board of Australia,

Please find the petitions below requesting for the 2018 draft Code of Conduct to not be adopted.

https://www.ipetitions.com/petition/protect-good-medical-practice-in-australia-2

https://www.change.org/p/australian-health-practioner-regulation-agency-stop-proposed-change-to-medical-board-code-of-conduct

Thank you for this public consultation on the draft revisions to the Code of Conduct. Indeed, as the Medical Board acknowledges, “the National Law requires National Boards to ensure there is wide-ranging consultation on the content of any proposed registration standard, code or guideline”. Of great concern, there appears to have been little publicity in the public arena from the Medical Board about the draft revisions to the Code, and no published consultation submissions on the Medical Board website, such that it could subsequently appear in the public eye that this National Law has not been upheld. This is of concern because this could bring subsequent undesirable public disrepute and legal difficulties for both the medical profession and the Medical Board. It remains to be seen whether this present submission will be published on the Medical Board website (please withhold personal identifying details). Particularly, the lack of apparent public consultation is of great concern especially as the Code purports to have been “developed after wide consultation with the medical profession and the community” (section 1.1 of the draft Code), and may have serious “consequences for your medical registration” (1.2) - evidently addressed in the second person to doctors and referring to doctors’ medical registration.

The draft Code is deeply concerning, especially as it provides for the restriction and even removal of independent clinical decision-making, freedom of conscience, and freedom of speech for doctors. This is both serious and dangerous to “good medical practice”. It would be dangerous and unbalanced to mandate that clinicians should have no say in what is culturally appropriate, so that medical consultations are unilateral “discussions”in which doctors’ views are altogether silenced. The words “culturally safe and respectful”(4.8) could seem to be deceptively benign, and that is precisely what makes those words dangerous. For only patients or patients’family members to be allowed to“determine whether or not care is culturally safe and respectful”(4.8.1), with the threat of serious “consequences for your medical

registration” (1.2), is to silence treating clinicians in terms of expressing their opinion on anything that is culturally disputed. Indeed, doctors could be removed from the discussion by deregistering them, for differing from their patients or families on culturally disputed topics in society such that patients or families can make claims of not feeling “culturally safe”.

Such silencing of open discussion could include any number of medical topics and public health issues discussed in society, both currently and in the future, including suicide, physician-assisted suicide, euthanasia, abortion, infanticide (if legalised), culturally expected demands for antibiotics versus antimicrobial stewardship (common discussions), alternative views on vaccination (which has implications for population health, such that doctors should not be silenced from advocating for vaccinations by providing medical evidence and reasoning, although some patients or families may not initially or ever be believers in vaccination), complementary and alternative healthcare (there are patients who refuse to take prescribed medications in preference for herbal and non-pharmacological management, and may believe their preferred care to be “culturally safe”), cultural expectations of abuse of alcohol and other drugs (including smoking where this is still culturally entrenched), cultural practices regarding opiate misuse, cultural expectations of female genital mutilation, culturally safe penile subincision and urethrotomy, culturally safe sex reassignment surgery and hormonal medications for patients who may not find it culturally safe to hear about associated increased risks of hormone-induced cancers and a range of complications, domestic violence or sexual abuse of children, sexual education of children, child health in detention centres for asylum seekers, refugee health, electronic health records, reproductive technologies, whole-body cryotherapy for athletes, and the list goes on. Culturally disputed topics in medicine abound, and previous generations have handled robust discussion on smoking, aseptic practices in surgery, hand hygiene, vaccination, and many other major healthcare advances, even though patients may have disagreed vehemently with doctors based on culturally accepted views, and initial proponent doctors may have been dismissed or silenced in their societies. Medical safety and quality in healthcare actually relies on robust discussion, that may be counter-cultural, and not all culturally-held beliefs may be “good medical practice”. Who should decide? Should only the patient or the family decide? In a multicultural society, which culture should decide?

The draft Code scarily proposes that doctors should be silenced not only in clinical consultations, but in public discussion. The real case of Dr David van Gend (featured in Australian news media, July 2018) being brought before the Medical Board for his conduct, for his retweets expressing concern about schoolkids being taught particular gender ideology, demonstrates that this is not simply scaremongering about a projected Orwellian society. If doctors do not recognise or agree with what Medical

Board members believe to be“generally accepted views” (2.1), under the draft Code, they could be censored and restricted by pressure from the Board, or even removed from discussion as a doctor by removing their medical registration. History has seen removal of intellectual figures from public discussion before, of course, such as that enacted by the Khmer Rouge at the hand of Cambodian communists - for one. However, although history may repeat itself, the Australian public may not welcome such a regime. It is concerning that if the Medical Board were to accept the 2018 draft Code, this may bring the medical profession into public disrepute. That is not what anybody surely wants.

Whilst evidence-based or evidence-informed practice, tailored to the individual patient, would surely be very relevant to “good medical practice”, it astonishingly receives a lack of mention in the draft Code. This may be a surprising standard to the medical community and the Australian public. Instead, the draft Code states that “good patient care” requires “acknowledging the profession’s generally accepted views and informing your patient when your personal opinion and practice does not align with these” (3.2.8), “ensuring that your personal views do not adversely affect the care of your patient” (3.2.14), and “referring a patient to another practitioner when this is in the patient’s best interests” (3.1.4). Who determines and defines what is “in the patient’s best interests”? What cultural, social, or economic analyses determine it? This is fraught with pitfalls, undermining the ability of a clinician to independently provide professional assessment and care. A doctor might wish to retain the care of a patient, but be under compulsion from the healthcare system and from the Medical Board to practice against conscience (for example, to withdraw care and deliver terminal sedation, or other forms of active euthanasia if legalised, according to “duty” as described in 4.13.4) or to otherwise refer the patient on so that someone else could enact that (3.1.4, 3.4.6, 3.4.7). This could be compelled by “generally accepted views”, according to which patients are devalued in society and by members of the profession, or by societal economics. Doctors who did not comply could face removal of their medical registration. This would be an Orwellian society indeed, enforced via a Code of Conduct.

On the one hand, health advocacy (7.3) recognises that certain groups in the Australian community may need particular health considerations and advocacy. Improving the health of such groups may require motivational interviewing to change habitual behaviour, which may include methods such as rolling with resistance. On the other hand, the draft Code identifies certain demographic groupings to be “medically irrelevant” in medical care, including “gender identity, sexual orientation” (3.4.3). However, gender identity may not be medically irrelevant, such as if a patient demands access to sex reassignment procedures which clearly have medical implications. Rather than being enabled to encourage a patient in a long-term

therapeutic relationship to consider significant medical considerations, the Medical Board might mandate ending of that professional relationship so that care and discussion could not continue (4.14).

The draft Code endangers and stifles doctors regarding independent clinical judgment and decision-making, freedom of conscience, freedom of speech, at the cost of their medical registration and thus their careers. It also endangers vulnerable patients at the hands of cultural opinion and cultural consensus that may not ultimately protect them.

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A sample of some of the concerning sections of the draft Code:

1.1 Purpose of the code

The code was developed after wide consultation with the medical profession and the community.

1.2 Use of the code

> to assist the Medical Board of Australia in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor's professional conduct can be evaluated. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration

2.1 Professional values and qualities of doctors

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.

3.1 Introduction

3.1.4 Referring a patient to another practitioner when this is in the patient's best interests.

3.2 Good patient care

3.2.8 Acknowledging the profession's generally accepted views and informing your patient when your personal opinion and practice does not align with these.

3.2.14 Ensuring that your personal views do not adversely affect the care of your patient.

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.[11]

3.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

3.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

4.8 Culturally safe and respectful 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.

4.13 End-of-life care

4.13.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

4.13.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

4.14 Ending a professional relationship

In some circumstances, the relationship between a doctor and patient may break down or become compromised (e.g. because of a conflict of interest), and you may need to end it. Good medical practice involves ensuring that the patient is adequately informed of your decision and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information.

7.3 Health advocacy [this is not so controversial, but inconsistencies within the draft Code of Conduct are described above]

There are significant disparities in the health status of different groups in the Australian community. These disparities result from social, economic, cultural, historic, geographic and other factors. In particular, Aboriginal and Torres Strait Islander Peoples bear the burden of gross social, cultural and health inequity.

Good medical practice involves using your expertise and influence to identify and address healthcare inequity and protect and advance the health and wellbeing of individual patients, communities and populations.