29 July 2018

Medical Board of Australia

Dear Medical Board,

Re: Response to Draft Revised Good medical practice: a code of conduct for doctors in Australia

The period of consultation for this document was relatively short. Thus, some of my comments might be rushed. I apologise for any lack of clarity.

Purpose of the Code

On page 5, the Board states that

“No code or set of guidelines can ever encompass every situation or replace the insight and professional judgement of good doctors.”

The Board then proceeds to issue 31 pages of detailed, proscriptive, authorised behaviours in response to a wide variety of interactions. This suggests the opposite is true: that the Board would seek to adjudicate on every situation, and does not especially have faith in the concept of the autonomy or judgement of a good doctor.

Culturally safe practice

The Code fails to outline which are the fundamental basic cultural norms within Australian medical practice that people should broadly accept when attending for medical care in Australia.

Omissions

The Board is close to the processes of government, and the Code is heavily influenced by the overhang of public service intervention and language. There are problems with this association. In Australia, these problems are magnified because the Federal and State Governments are also the major health insurers or providers of medical services. Thus, not only is there temptation to interfere and control medical practice for political ends, but there may be an economic temptation to modify medical practice.

This means there are conflicts of interest for the current Medical Board that should be recognised.

Thus, while the Board is servile to statutory requirements, it makes no comment about the possibility, or the remedy in the event, that legislation may run contrary to good medical practice.

To this end, it is important to note what the Code overlooks in what otherwise appears to be an exhaustive attempt to list medical interactions.

For example, there is no comment on 2 issues:

1. Some State governments have enacted legislation to allow assisted suicide, and have included doctors in panels and as part of the prescribing process for assisted suicide. Indeed, by the Code's current standards, it will prosecute a doctor who self prescribes antibiotics but not one who supports, promotes, or deliberately prescribes a lethal dose of medication to a patient to procure a suicide. To my knowledge, the Board has not expressed any opinion on the role of doctors in this process. The Code, however, suggests that because it is legal, it therefore represents good medical practice. Unfortunately, legislatures have, and will, pass legislation that may contravene good ethical medical practice. So, what does the Board recommend is the appropriate action for doctors to undertake when similar laws are enacted? The Code would suggest that doctors should not only comply, but refrain from public comment.

"Behaviour (*public comment*) which could undermine community trust in the profession is at odds with good medical practice and may be considered unprofessional"

By the Code's definition, public comment by a doctor on legislation already passed may be considered unprofessional. Given the threat it raises, this is too vague in its current form. Such uncertainty causes doctors to be concerned about any involvement in public

debate about matters of great importance to medical practice. This, in turn, allows legislators the opportunity to determine the public discourse, and may result in uninformed legislation.

2. Governments, hospitals and insurers have considered systems for payment to doctors for non-service i.e the payment of bonuses or payment systems that encourage medical staff to reduce or avoid utilisation of services, drugs, other medical 'goods' even when these may not be in any given individual patient's interests. However, because they apply between a doctor and a population (rather than an individual), direct causal links are hard to establish. There is a difference between the provision of efficient use of resources, and reducing service expenditure for the purpose of achieving, for example, bonus payments. There is no comment by the Board on this matter.

The Code drifts, at times, into the language of a government department HR manual. That will cause good practitioners an increasing sense of unease about the possibility of a perceived contravention of a point of order among the very many listed.

Regards

Michael Montalto