Submission to the public consultation on the draft revision of *Good Medical Practice: A code of conduct for doctors in Australia*

Thank you for this opportunity, as a doctor working in Australia for 30 years, to make my objection clear to elements of the proposed revised Code of Conduct.

I respect the Board's vital role in ensuring that doctors are competent to deliver health services. I reject the Board's role, as foreshadowed in the revised Code, in censoring the free speech of doctors on matters of public importance.

It is of deep concern that the culture of the Board would even allow such a draft to be composed. Who is it in the bureaucracy of AHPRA that would seek to politicise the Board in this way? Or is it the Board itself that seeks this new power, aspiring to be an arbiter not just of clinical competence but of political correctness? If that is the case, the Board will have become a menace to the civil liberties of citizens who are also doctors.

I trust it is not the case, and that my medical colleagues on the Board, who may have had no part in the drafting of this revision, will go through it line by line and erase any trace of coercion of a doctor's freedom of thought, conscience and political communication.

This will involve two essential steps:

1. Removing the threat of 'unprofessional conduct' charges where a dissenting doctor speaks out in good faith on any matter of public importance.

2. Restricting access to the complaints mechanism to include *only* the patient and close family members of the patient, in order to stop political activists harassing doctors who express views that offend the activists.

These two principles apply to a number of similar sections of the draft revision and should be implemented consistently throughout. For brevity, I focus on just two of the sections: 2.1 and 4.8.

Section 2.1 and the chilling of debate

The new paragraph 4 in Section 2.1 reads:

> *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.*

I welcome the intervention by the AMA in its submission on the draft revised Code, especially its comments on this most intimidating section:

> [2.1] may be considered by some doctors to be a significant overreach of the Board's authority. It could be interpreted as trying to control what doctors say in

> the public arena by stifling doctors' right to publicly express both personal and professional opinions while also undermining doctors' contribution to the diversity of public opinion, debate and discourse. It would be unprecedented for a regulatory authority's Code of Conduct to attempt to control a doctor's public expression of opinion in a context which may not impact on the standard or quality of direct patient care or the wider health system nor reflect a lack of medical professionalism.

Section 2.1 is open to abuse in two ways.

First, a politicised Board would have the power to intimidate doctors into silence on any matters that the Board, in its absolute discretion, considers contrary to the "reputation of the profession" - a malleable notion that would closely conform to the political / moral / social preferences of Board members.

Second, such a Board would have the mechanism to harass dissenting doctors via an enhanced version of the present system of 'weaponised complaint'. For it will not be lost on ideological activists that a doctor who attracts complaints from "the community" is, on the face of it, "undermining community trust in the profession". Such a trap by activists is easily sprung.

The troubling question is this: does the Board actually desire such a mechanism of politicised complaints as a way of coercing its less 'progressive' doctors into silence? If so, I repeat, the Board has become a menace to the deep liberties of a free society.

And again, I trust that is not the case, and members of the Board simply do not appreciate how motivated groups will use this provision (as they presently use provisions in the Social Media Guidelines, which also needs the Board's attention) to wage complaint-lawfare against doctors who hold, in their view, unacceptable opinions.

I am well acquainted with the "community" of serial complainants and offence-takers who are deeply motivated on political / moral issues of the day. I have been their target in various forums during the debate on same-sex 'marriage', on the teaching of gender fluidity in schools, on the questions of euthanasia and unrestricted abortion, and other questions of public importance.

The Code should not invite this predictable abuse of process from such activists; it should not establish a mechanism whereby doctors can be worn down by "a process which is the punishment", repeatedly required to answer to AHPRA for yet another activist's ideologically motivated complaint.

That is why I ask that the two essential changes, mentioned above, be enacted: that there be no provision for the Board to discipline doctors for dissenting in good faith on matters of public importance; and that there be no provision for anybody (e.g. an activist) who is not associated with the doctor's actual provision of health services to lodge complaints.

Finally, a smaller point regarding this exhortation in 2.1:

> *If making public comment, you should acknowledge the profession's generally accepted views and indicate when your personal opinion differs*.

That is both impractical and condescending.

Impractical, because one cannot preface every dissenting remark online or in public argument with some ritualised acknowledgement of the traditional owners of professional consensus, its enforcers past and present. That is not how self-respecting argument works in the real world.

Condescending, because it carries the clear implication that the profession's "generally accepted view" is the correct position, and one's "personal opinion" is a fringe view, not to be taken seriously. But one only asserts one's "personal opinion" against the dominant paradigm if one believes the "generally accepted view" to be mistaken, and in the real world of public argument one does not defer submissively to a position one considers wrong.

Take one example. Last year, five of us drafted a rigorous dissenting document against the AMA's "Position Statement on Marriage Equality", particularly its "suppression of unfavourable evidence and the uncritical promotion of favourable evidence concerning consequences for children". We published it online at www.CritiqueAMA.com and quickly attracted some 700 Australian doctors, including 36 professors and associate professors as well as 6 past state AMA presidents as signatories. Our critique was evidence-based and courteous, but deeply critical of the "generally accepted view" as presented by the AMA.

The AMA never answered the substance of our critique. Indeed, its main response was to promote in its publications a petition of some 1500 medical students and doctors who compared our concerns about same-sex parenting to the attitudes of racists. Why should we then be required to defer, even as a formality required by section 2.1, to the AMA's ideologically compromised, clinically misleading but "generally accepted" view?

An argument stands or falls on its own merit, which is determined by the quality of evidence and reasoning, not by the prevailing professional consensus, even on medical matters – just ask Semmelweis – and certainly not on deeply political/moral matters.

The Code of Conduct should not require, on pain of charges of "unprofessional conduct", ritualised deference to the prevailing consensus.

Recommendation:

Section 2.1 should be rejected and the current Code's wording retained.

Section 4.8 and 'group identity' politics

> *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.*
>
> *4.8.4 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).*

Those of us who follow 'anti-discrimination tribunal' cases know that the notion of feeling "safe" in the workplace is a new and exciting mechanism for policing attitudes and generating complaints against insufficiently 'progressive' staff. The revised Code will add tension to the workplace, empowering complaints by a more PC employee against a more conservative fellow worker for making the former feel "unsafe" on matters of "*gender, disability, race, ethnicity, religion, sexuality, age or political beliefs*".

It gives new power to patients who are passionate about their particular identity and hypersensitive to any perceived insensitivity to inflict procedural grief on well-meaning doctors – and the validity of their "offence-taking" is unquestionable, since 4.8.1 makes them sole arbiters of "whether or not care is culturally safe and respectful".

We do not need more workplace stress and spurious offence-taking distracting from our medical practice.

The notion of "safe spaces" in 4.8 is straight from the leftist playbook of playing the victim in order to intimidate those with "privilege". This cringeworthy section belongs in a Greens political document, not a Code for competent medical practice.

It also sets up potential conflicts between the cultural demands of our diverse patient base, and the ethical demands of good medical practice. As others have noted, this clash could occur, for example, over the cultural traditions of female sex-selection abortion or female genital mutilation.

The doctor is not a servant of the demanding patient but a partner who may at times respectfully disagree. No provision in the Code should give the patient or their family the whip hand over the doctor where such cultural / ethical disagreements might arise.

Recommendation:

Section 4.8 should be rejected and the current Code's wording at 3.7 retained.

Conclusion

I sincerely ask the Board not to grant itself extra powers, embedded in this draft, to entrap and intimidate doctors who express dissenting political or moral views in public. That is not what the Board's mandate entails – the protection of patients from incompetent or corrupt doctors.

If the public comes to perceive the Medical Board of Australia as politicised, as another elite government-appointed agency seeking to patrol the boundaries of acceptable opinion and to intimidate citizens' freedom of speech and thought, that perception will do more to damage "community trust in the profession" than anything a dissenting doctor could ever do.

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