From: [redacted]
To: medboardconsultation
Subject: Public consultation on Good medical practice
Date: Friday, 17 August 2018 1:32:28 PM
Attachments: RACGP Submission - Code of conduct August 2018.pdf
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Dear Dr Flynn and colleagues,
Please find attached the Royal Australian College of General Practitioners (RACGP) submission to the public consultation on Good medical practice.
We would like to stress that the phrasing regarding professionalism and adhering to the 'general accepted view' of the profession is unreasonable and not supported by the RACGP.
In addition, while we understand that Good medical practice is directed towards the medical profession, we believe that there should be some acknowledgement (perhaps as a broader piece of work) that patients also have responsibility for their care. Good medical practice involves decision making between practitioners and their patients.

Should you wish to discuss the RACGP submission further, please do not hesitate to contact me.
Kind regards,

[redacted]
Policy, Practice and Innovation

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We recognise the traditional custodians of the land and sea on which we work and live.

RACGP
Royal Australian College *of* General Practitioners

Healthy Profession.
Healthy Australia.

17 August 2018

Dr Joanna Flynn AM
Chair, Medical Board of Australia
medboardconsultation@ahpra.gov.au

Dear Dr Flynn,

Draft revised Good medical practice: A code of conduct for doctors in Australia

The Royal Australian College of General Practitioners (RACGP) thanks the Medical Board of Australia (MBA) for the opportunity to provide comments on the draft revised Good medical practice: A code of conduct for doctors in Australia (the code).

The RACGP represents more than 38,000 members working in or towards a career in general practice. The RACGP is responsible for defining the nature of the discipline, setting the curriculum for education and training, maintaining high standards of quality practice, and supporting general practitioners (GPs) in their pursuit of clinical excellence.

As noted by other medical professional bodies, while these changes may appear minor, even minor changes can have consequences for medical practitioners. This is particularly the case given that '*serious or repeated failure to meet these standards may have consequences for* [a doctors] *medical registration'*.

The RACGP is supportive of most changes to the code, which appear to reflect the RACGP's competency profile and curriculum. However, in reviewing the code the RACGP has also identified some issues that should be addressed before the code is finalised. The RACGPs comments on the draft revised code of conduct relate to both existing and additional content.

1. General Practitioner as central coordinator of care

The RACGP is pleased to see the retention of section *6.2 Coordinating care with other doctors*, specifically sub-sections *6.2.2 Facilitating the central coordinating role of the general practitioner*, and *6.2.3 Advocating the benefit of a general practitioner to a patient who does not already have one.*

The RACGP sees it as the role of all health professionals, not just medical practitioners, to facilitate the central coordinating role of GPs and communicate the benefits of having a regular GP to patients. The majority of the Australian Health Practitioner Regulation Agency (AHPRA) National Boards respective codes of conduct acknowledge the importance of seeing a GP regarding a health professionals own health. However, they do not reflect the same acknowledgement regarding the importance of a GP for patients.

The RACGP recommend that sections 6.2.2 (previously 4.5.2) and 6.2.3 (previously 4.5.3) are reflected in the codes of conduct for all AHPRA National Boards.

2. Recognition of system and institutional influences

Section *1.1 Purpose of the code,* identifies that the code is '*addressed to doctors, and also intended to let the community know what they can expect from doctors*', as such, the code focuses on a doctor's individual responsibilities. While the RACGP acknowledges the need to focus on the individual responsibilities, acknowledging the impact and influence of system and institutional influences where appropriate would greatly enhance the code. This is particular relevant in section *4 Working with patient*s and section *11 Ensuring doctors' health*.

For example, section *11.2.6* states that *'recognising the impact of fatigue on your health and your ability to care for patients, and endeavouring to work safe hours wherever possible'*. While it is important that medical practitioners work to identify fatigue, this is frequently a direct result of health systems and rosters which make it difficult for doctors to opt-out of providing care or take a day off because they are tired.

The RACGP recommend that phrasing regarding system and institutional influences is included within relevant sections identified above and also included as an overarching statement in section *1.5 Austral Australia and Australian medicine.*

The code should strike a balance between recognising system influences and the role of the medical practitioner.

3. Clinical governance - responsibility for the follow up health services (such as tests)

Members of the RACGP have previously raised frustrations regarding the code inability to clearly identify the responsibility of health professionals in following-up results for health services or tests they have ordered for patients. This is particularly a concern for GPs who, as the central coordinators of care, often refer patients to another health professional. Responsibility for the timely review and action on tests and results ultimately rests with the health professional who ordered the test. However, expectations of who is responsible for follow-up can become blurred – especially if the patient's interaction with the secondary service is ad hoc.

The code should explicitly outline that medical practitioners have responsibility for following up the health service they initiate. This will ensure that GPs are not expected to follow up tests (or other services) that they may not be aware of.

The code should also explicitly state that all test results, and in particular clinically significant test results, are communicated to the patients regular GP.

4. Mandatory reporting

The RACGP and many other health professional bodies have previously raised issues with the mandatory reporting requirements of medical practitioners. Mandatory reporting can discourage doctors from seeking medical assistance, particularly in circumstances where medical assistance is needed most.

The Council of Australian Governments (COAG) Health Council (CHC) has recently acknowledged the adverse effects of mandatory reporting requirements, and as a result have committed to reviewing the relevant legislation.

To ensure the longevity of the code, the RACGP suggests the document simply state that doctors must comply with reporting requirements as they are outlined in legislation, rather than explicitly referring to mandatory reporting requirements.

5. Professionalism

The RACGP believes that the expectation that doctors must always acknowledge the profession's generally accepted views and indicate when their personal opinion differs is unreasonable. The medical profession's 'accepted view' is not always a clear consensus, especially given the fast evolving nature of the medical environment. It is unrealistic to expect doctors to consciously apply this rule at all times.

The RACGP perceives the wording in draft section *10. Professional behaviour (previously section 8)*, as sufficient in guiding professionalism and therefore sees no need for the additional professionalism section (draft section 2).

6. Cultural safe and respectful practice

The RACGP supports the expansion to draft revised section *4. Working with patients* to include section *4.7 Aboriginal and Torres Strait Islander Peoples' health* and *4.8 culturally safe and respectful practice.* However, these sections would be improved by acknowledging system and institutional influences.

The RACGP recommends additional phrasing that indicates medical practitioners should, where possible and within their sphere of influence, ensure that systems and institutions are responsive to the needs of Aboriginal and Torres Strait Islander patients.

To improve clarity, statements relating to clinical care (4.7.1 and 4.7.3) should be grouped together. Subsequent points would focus on patient advocacy and recognition of wider system/institutional influences.

7. Discrimination, bulling and sexual harassment

The RACGP supports the underlying principles in the new discrimination, bulling and sexual harassment section of the code. However, the section fails to acknowledge abuse of power differentials as the main cause of harassment and bullying.

The concept of power differentials should also be considered in section *10.2 Professional Boundaries.*

8. Continuing professional development

The RACGP sees that section *9.2.5 Engaging in performance development and appraisal processes associated with your role,* relates more to the practice/organisational performance review process as opposed to the concept of continuing professional development.

The RACGP considers that including this phrasing as part of the continuing professional development section may cause some confusion regarding a medical practitioner's obligations to fulfil their continuing professional development requirements, as opposed to fulfilling their performance appraisal requirements at the practice/organisation level.

9. Vexatious complaints

The RACGP supports the additional content discouraging medical practitioners from placing vexatious complaints against other health professionals. This section should be replicated in the codes of conduct mandated by all AHPRA National Boards.

If you have any questions regarding these matters, please contact myself or [redacted] – Advocacy & Funding on [redacted]
or at [redacted]

Yours sincerely

[redacted]

Dr Bastian M Seidel
President