Commentary on the Draft Revised Good Medical Guide: A Code of Conduct for Doctors in Australia[1]

1. Thank you for the opportunity to comment upon the draft revised Good Medicine Guide: A Code of Conduct for Doctors in Australia. The authors of this commentary are lawyers with qualifications and research interests in medical law, bioethics, and human rights. Our comments focus upon three areas of the revised code, namely those falling under the heading of 'Professionalism', 'Decisions about access to medical care', and 'Culturally safe and respectful work practices'.

2. We note the preference of the Board to revise the Code in order to set explicit standards for the ethical and professional conduct of doctors. Section 39 of the *Health Practitioner Regulation National Law 2009* (Cth) permits the Code to be used in proceedings under it as evidence of what constitutes appropriate professional conduct or practice of the profession. Accordingly, the Code must provide clear principles for its standards and identify any areas of discretion the decision makers will have, and the matters they must take into account.

3. As such, our comments are directed towards what we perceive to be ambiguity or lack of detail in a number of sections in the draft revised Code that may impact upon the way in which standards may be interpreted and applied by decision makers in any disciplinary hearing of a doctor. Given the gravity of a disciplinary hearing and the potentially disastrous consequences it may have upon a doctor's livelihood, we feel it is appropriate to raise our concerns in this forum, and we are pleased to provide further clarification if required.

Professionalism

4. Section 2.1 notes that professionalism requires doctors to comply with the law. However some laws have not yet been interpreted by the courts, such as those that require doctors to refer for abortion notwithstanding a conscientious objection to it, or those that resolve tension between the need to avoid discrimination against patients yet respect the religious beliefs of the doctor. The draft revised Code fails to acknowledge these uncertainties and provide specific guidance for doctors. We will address these later in the submissions.[2]

5. Section 2.1 also suggests that the public comment and actions of doctors outside of work, including online comments that go against 'the profession's generally accepted views', could undermine community trust. It goes on to suggest that undermining community trust is evidence of an absence of best medical practice and may be considered unprofessional conduct. We suggest amending this paragraph otherwise its interpretation and/or application could produce an unjust result in the context of a complaint against a doctor.

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[1] Submitted by Anna Walsh, Michael McAuley & Michael Quinlan.
[2] We refer specifically to see sections 3.4.6and 3.4.7, which are preexisting sections of the Code.

6. The plain reading of this section suggests that community trust is to be elevated above other aspects of professionalism and good medical practice, however there is no basis for this. Community trust must co-exist not only with professionalism and good medical practice, but also with the fundamental rights and freedoms that all members of the community enjoy, such as freedom of conscience and belief and freedom of speech. Just like members of the community, doctors are entitled to hold and express diverse beliefs.

7. It is unclear how any decision maker could determine whether or not community trust had been undermined by something a doctor did or said publically. As no metrics are provided in the Code, there is a valid concern as to how such a conclusion could be drawn. The undermining of community trust is said to correlate with doctors holding views that diverge from the profession's 'generally accepted view', however strong arguments exist as to why questioning an established practice has been good for public health.

8. The Code does not define a 'generally accepted view' but in any case, minority opinions should not automatically be deemed to be evidence of poor medical practice. They may simply reflect diverse views and experiences of doctors that are consistent with the scientific knowledge. Historical examples exist where a peak medical body adopted a position on a new medical practice in the context of limited empirical data on its safety and long-term outcomes, but where time has proven that the minority opinion against it was correct.[3]

9. With a number of health issues being currently debated in the public square, such as abortion, euthanasia, and transgender treatment, doctors should not fear reprisals for sharing views on these matters. Indeed they may have medical experience and expertise that would benefit the debate. In addition, doctors should not fear reprisals for 'whistle blowing' on activities that seek to improve the culture within medical practice and the safety of the public through reporting adverse health events or harmful practices.

10. The Code recognizes at 4.8.2, the need to respect diverse beliefs amongst colleagues. Doctors who hold a minority opinion on a morally controversial social issue, and who become involved with public debate, have a right to do so without fearing their public actions will place them in jeopardy of a finding of poor medical practice. Public debate on controversial issues requires the articulation of minority opinions by courageous people, and that includes members of the medical profession.[4] The Code should acknowledge this.

11. The finding of unprofessional conduct carries with it a civil penalty. Hence, we suggest that the final sentence in that section be amended to read, '*Behavior which could undermine community trust in the profession* ***may*** *be at odds with good medical practice* ~~*and may be considered unprofessional*~~*'* ***however the context in which the doctor's conduct or statement arises is a relevant matter to be taken into consideration when determining whether it represents unprofessional conduct.'***

[3] A classic example is the controversial 'deep sleep therapy' that resulted in the Chelmsford Inquiry.
[4] Recently, Dr. Pansy Lai's public statements on the safe school programs resulted in a campaign to correlate her opinion with poor medical practice, and a complaint to de-register her.

Decisions about access to medical care

12. Section 3.2.8 of the draft revised Code refers to the requirement to acknowledge the 'generally accepted view of the profession' and inform your patient when your personal views and practice do not align with these. We refer to previous comments regarding the need for decision makers in the complaints/disciplinary process to appreciate the differing contexts in which a generally accepted view of the profession may arise and how it may, or may not, be relevant to how medical advice about care is given by a doctor.

13. Section 3.4 of the draft revised Code notes that a doctor's decision about a patient's access to care should be free of bias and discrimination. Whilst section 3.4.3 prohibits refusal of service based on 'medically irrelevant grounds' and points to attributes found in anti-discrimination legislation, the Board should note the distinction between refusing service because of a legally protected personal attribute, and refusing to participate in a service based on the doctor's conscientious objection.

14. An example here would be the doctor who declines to refer a homosexual couple for IVF treatment because of a genuine belief that to purposively bring a child into the world without a mother and a father is not in the future child's best interests. Where the doctor does not decline to provide other care to the patient, and given the patient can seek a referral from another doctor, or may be able to self-refer for this service in some states, this scenario raises the issue of a conscientious objection rather than discrimination.[5]

15. There is worldwide controversy around what legal limits can be are placed on a doctor's right to conscientiously object to performing or participating in a service. Section 3.4.6 notes that doctors should be '…aware of [their] right not to provide or directly participate in in treatments to which [they] conscientiously object…' so long as they do not use the objection to 'impede access to treatments that are legal'. Section 3.4.7 provides that a doctor may not use their religious or moral beliefs to 'deny patient's access to care'.

16. Whilst section 3.4.6 is not new, the legal landscape has evolved since it was written. The requirement for 'mandatory referral' for abortion has been enacted in three of the seven jurisdictions of Australia.[6] Requiring a doctor to refer to a willing provider the doctor knows does not have a conscientious objection to abortion, creates a statutory duty on the doctor for indirect participation subject to civil penalty. What actions a doctor must do to discharge this duty is a legal issue that has not yet been explored by the courts.

[5] There many high profile legal cases overseas involving bakers and other service providers.
[6] See, eg, *Abortion Law Reform Act 2008* (Vic), s8; *Reproductive Health (Access to Terminations) Act 2013* (Tas), s6; *Termination of Pregnancy Law Reform Act 2017* (NT) s11.

17. In contrast to this, three jurisdictions of Australia recognize a health professional's right to exercise a full conscientious objection to participating in abortion and do not mandate referral.[7] The same situation applies to doctors who conscientiously object to referring for euthanasia in Victoria's *Assisted Dying Act 2017*. Thus, the Code's reference to 'direct participation' is controversial given this narrow interpretation of the term does not enjoy a consensus position in Australian law and it may produce confusion.

18. As the Code notes, it is not a substitute for the law, and where there is conflict between legislation and case law and the Code, the law takes precedence. Further, section 3.4.7 of the Code provides that doctors are 'free to decline to provide or participate' in care that conflicts with their moral or religious views. Coherence demands that the Code adopt a consistent construction to the term 'participation'. We recommend that the reference to 'direct' participation in section 3.4.6 be deleted so it is consistent with 3.4.7.

19. The balance of sections 3.4.6 and 3.4.7 state that any objection based on conscience, or moral or religious beliefs, must not result in 'impeding access to legal care' or 'denying patient's access to care'. Whist they indicate a general principle, there is no explicit action guidance to a decision maker. We suggest both sections conclude with: '***The ability of the patient to access the service from another doctor or to self refer for treatment is a relevant matter to be considered when determining whether this section has been breached.'***

Culturally safe and effective practices

20. In section 4.8.1, the change in the Code from 'respecting' one's culture, to ensuring 'culturally safe and effective practice' is problematic given some cultural practices have been widely determined to be inconsistent with good medical practice or even elevated to criminal behavior. An example is female circumcision. A criminal activity in some states,[8] a doctor cannot be involved with this practice, notwithstanding that the patient determines it to be culturally appropriate. The proposed change in wording ought not be adopted.

21. There may be other practices that are considered culturally appropriate by the patient, such as social sex selection abortion, but which may offend a doctor's conscience or not accord with their professional judgment of a medically necessary service. Common sense demands that the individual doctor be permitted to provide advice to patients in line with their beliefs about what is in the best interests of the patient, and in line with their conscience, without this being seen as culturally insensitive and discriminative.

[7] See, eg, *Health Act 1993* (ACT) s84; *Criminal Law Consolidation Act 1935* (SA) s82(A)(5); *Health Act 1911* (WA) s334(2).
[8] See, eg, *Crimes Act 1900* (NSW) s45.

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