The Medical Board of Australia
Re. Public Consultation on *Good Medical Practice*
July 2018

Dear Sir/Madam,

I wish to highlight several very serious problems with the proposed new section, **4.8 Culturally safe and respectful practice**, found on page 12 of the draft Code of Conduct.

Objective good outcomes replaced by subjective "cultural safety"

Section 3.7 of the existing Code of Conduct states that the goal of "efforts to understand the cultural needs and contexts of different patients" is "to obtain good health outcomes".[1] This goal of obtaining "good health outcomes" has been removed from the proposed new section, which simply declares that "good medical practice is culturally safe and respectful".

This is a significant and troubling change. Under the existing Code of Conduct, the objective of good medical practice is to obtain a positive health outcome for the patient. Culturally sensitive practice serves this overall priority. By contrast, under the proposed new section, "cultural safety" has become an end in itself. Furthermore, the proposed new section makes it clear that what is "culturally safe" is subjective and defined exclusively by the patient (4.8.1).[2]

Good medical practice seeks to achieve a good health outcome for patients. In working towards a good health outcome, doctors must sometimes challenge aspects of a patient's behaviour or lifestyle that are detrimental to good health. Often, the behaviours that we challenge are the products of culture, or are deeply embedded in culture. Obvious examples include excess alcohol intake, smoking, unsafe sexual practices, sedentary habits, and poor diets leading to obesity.

If subjectively defined "cultural safety" is made paramount, doctors may find themselves unable (or unwilling) to question certain practices or beliefs that are not consistent with good health outcomes. To illustrate this starkly, we can pose the question: would a medical profession that prioritises "cultural safety" rather than "good health outcomes" be permitted to criticise foot-binding, or female genital mutilation? Less extreme examples might include anti-vaccination beliefs, the practice of "free-birthing", and reliance on "alternative therapies" or "traditional medicine" to treat serious disease. A doctor who challenges a patient in one of these areas, seeking to avoid a bad health outcome, could easily be accused of violating a patient's "cultural safety".

Confusing the concept of "safety" in medical practice

The term "culturally safe" is itself problematic. When we speak about "safe medical practice", we are referring to practice that minimises physical harm—that is, morbidity and mortality. "Unsafe" medical practice is practice that is negligent, incompetent or reckless, resulting in avoidable death and debility. This ordinary sense of the word "safe" is found, for example, in sections 2.2.2 and 6.2 of the existing Code of Conduct.

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[1] See also point 3.7.4 in the existing Code of Conduct: "Adapting your practice *to improve patient engagement and healthcare outcomes*" (emphasis added). This point has been dropped from the proposed new code.

[2] 4.8.1 would apparently provide litigious individuals with a "blank cheque" to make complaints about a doctor's practice.

The words “safe” and “safety” appear in the proposed section 4.8 six times. Throughout this proposed section, “safety” has a very different meaning. Here, practice that is “unsafe” merely causes offence and emotional discomfort.

This blurring together of two vastly different ideas in the Code of Conduct is unhelpful. On the one hand, calling offence-giving “unsafe” risks trivialising the real issues of safety and harm that arise in medicine, which can be matters of life and death. Conversely, there is the possibility that doctors facing complaints about “culturally unsafe” practice will come to be viewed in a similar light to doctors who cause tangible harm through negligence and malpractice. Will a doctor who makes a racially insensitive remark be sanctioned as severely as a doctor who performs botched surgery leading to loss of life or limb? Both have engaged in “unsafe” medical practice, have they not?

Inclusion of “gender identities” is problematic

The proposed new section includes “diverse … gender identities” (4.8.2) under the heading of “cultural safety”. This is highly problematic, even setting aside the fact that the concepts of “gender identity” and “transgender” are hotly contested in our society. As medical doctors, our practice must fundamentally be based in biological (anatomical and physiological) reality.

Suppose a biologically female patient who identifies as a male presents to a doctor for a health check-up. If the doctor is interested in good health outcomes for this patient, the doctor would recommend that the patient undergoes cervical screening. In this scenario, it is conceivable that the male-identifying patient might accuse the doctor of mis-gendering “him”, thereby violating “his” “cultural safety”.[3] The proposed revision to the Code of Conduct would lend support to the patient’s accusation, and compel the doctor to defend his or her clinical advice.

And similarly, a biologically male patient who identifies as a female, could justifiably accuse a doctor of violating “her” “cultural safety” if the doctor recommended an assessment of “her” prostate gland.

I am also concerned that points 4.8.1 and 4.8.2, taken together, could justify a patient’s demand that a doctor assist him or her in “transitioning gender”, whether through prescription of medication or referral for surgery. Due to the extremely controversial nature of so-called “gender reassignment” interventions, many doctors would be unwilling to participate in them. If the proposed section 4.8 is adopted, a doctor who declines to assist a patient in this fashion could very well be accused of violating the patient’s “cultural safety”.

Summary

The proposed new section to the Code of Conduct (4.8) is seriously flawed. Where the existing Code of Conduct (section 3.7) enjoins doctors to practice in a culturally “sensitive” manner in order to achieve “good health outcomes”, the proposed section removes the goal of “good health outcomes” and sets patient-defined “cultural safety” as the goal of care. The result of this is that doctors would be prevented from helping patients towards objective good health outcomes, whenever doing so would encroach upon a patient’s subjective “cultural safety”.

[3] Cf. https://www.telegraph.co.uk/news/2018/01/14/women-identify-men-not-offered-routine-nhs-breast-cancer-screening/

In addition, if “diverse gender identities” is included in this section as a matter of “cultural safety”, this would have the effect of deterring doctors from providing care to patients that is appropriate to their anatomical and physiological needs.

While it is important for doctors to exercise sensitivity towards a patient’s culture, describing inadequate cultural sensitivity as “unsafe” conflates offence-giving with harmful malpractice.

In their overall thrust, these proposals significantly alter the dynamic of the doctor-patient relationship. The doctor’s role as a trained professional is undermined, and their basic obligation to pursue positive health outcomes for their patients is subverted. Patients are given an unprecedented degree of control over the agenda, as the sole arbiters of what is and isn’t “culturally safe” care—to which doctors are required to conform. The everyday practice of medicine will become burdened by fear of offending against cultural beliefs and preferences.

The proposed section 4.8 should be rejected, and section 3.7 in the existing Code of Conduct should be retained in its place. At very least, further consultation and debate should occur before revisions of this magnitude are implemented.

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(*Please withhold my name if this submission is made publicly available*.)