AMA TASMANIA
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8th August 2018

Dear Medical Board of Australia

I write in relation to the Medical Board of Australia, Public consultation on draft revised code of conduct, Good medical practice: A code of conduct for doctors in Australia. I wish to raise opposition to a number of the changes proposed to in the draft Code and request that the wording of the existing Code (dated March 2014) be retained. I particularly draw your attention to Section 2.1 (Professional Values and Qualities of Doctors) and Section 4.8 (Culturally Safe and Respectful Practice) and the newly introduced concept of "culturally safe practice".

The concept and descriptors of Culturally Safe practice

New provisions in Sections 2.1, 4.8 and elsewhere in the draft Code introduce the terminology of "culturally safe" practice. Section 4.8 (Culturally Safe and Respectful Practice) of the draft Code of medical practice states:

"Good medical practice is culturally safe and respectful. This includes understanding that only the patient and/or their family can determine whether or not care is culturally safe and respectful".

Whilst the general importance of a medical practitioner being aware and respectful of cultural differences is self-evidently an element of good medical practice, the concept of "cultural safety" and "culturally safe" practice is definitional, deriving from the sociology/social justice literature and/or the New Zealand Nursing context. As the Medical Board of Australia will be aware, "cultural safety" is therefore part of a broader sociological and socio-political context that includes many considerations and concepts that are neither explained within the terms of the draft Medical Board of Australia Good Medical Practice Code nor explicitly described with formal definitions and referencing.

How is a medical practitioner to objectively and prospectively determine what only the patient and/or their family can determine whether or not care is culturally safe and respectful so as to avoid being in breach of this provision? Clearly, the professional hazard associated with such an ill-defined and individually based injunction will have a chilling effect on appropriate doctor-patient counselling and discussions. Moreover, Section 4.8 extends the concept of cultural safety (in health care originally developed in the context of New Zealand Health Care for the Maori community) to a diverse range of additional purposes such that "cultures, beliefs, gender identities, sexualities, and experiences of people" that are to be captured by the "cultural safety" injunction.

A doctor's self-reflection and awareness of potential sources of personal bias, as well as their recognising the importance of diversity in the Australian community and within their practice, is part of good medical practice - including upholding principles of tolerance and respect for patient dignity and rights. To the extent that the provisions of Section 4.8 extend the requirements of good medical practice by injunctions premised by individual, group and cultural beliefs that may not be reasonably evident to the practitioner, they are quite at odds with the doctor undertaking appropriate patient evaluation, counselling and treatment based on objective evidence-based medical practice. In essence, the doctors consulting room is a place for evidence based practice and critical thinking, not a place for progressing divisive concepts derived from Critical Theory that will ultimately disadvantage patients and doctors alike.

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So whilst the intention of introducing Section 4.8 was no doubt well intended, the consequences of doing so within the context of interpretation of the term “cultural safety” as well as the sub-provisions of Sections 4.8 (4.8.1 - 4.8.6) are potentially antithetical to good medical practice as defined in 3.2 (particularly 3.2.6, 3.2.13), 3.4 (particularly 3.4.6), 4.2 (particularly 4.2.2, 4.2.5), 4.3 (particularly 4.3.2 - 4.3.6) and 4.5. By way of example, how would the injunctions of Section 4.8 relating to “cultural safety and respect” facilitate the doctor-patient discussion and counselling on potentially culturally sensitive and contentious issues that may make a patient feel "culturally unsafe" or "culturally disrespected" within the terms of Section 4.8 and consequently raise complaint against the doctor (eg. counselling and discussion on issues such as blood transfusion, contraception, immunisation, genital mutilation, gender reassignment in young people, dietary practices).

Unreasonable restrictions on speech

A separate concern in relation to the draft Code relates to unreasonable restrictions on free speech and the involvement of medical practitioners in public debate and formulation of public policy. Section 2.1 of the draft Code states “If making public comment, you should acknowledge the profession’s generally accepted views and indicate when your personal opinion differs.” This is an unreasonable expectation given its scope is neither limited to matters of established medical practice nor does it recognise the diversity of medical opinion on many clinical and public policy issues for which there are no “generally accepted views”. The language in the draft Code relating to public comment by medical practitioners should be removed and replaced by wording in line of the Chicago University statement of principles on free expression (https://freeexpression.uchicago.edu/page/statement-principles-free-expression). For example:

“The medical practitioner is fully committed to the creation and dissemination of knowledge across the spectrum of disciplines of the profession, and is free to promote a culture of intense inquiry and informed evidence based argument and public debate that generates lasting ideas of merit, which can inform public policy, community health and wellbeing, and regarding which members of the profession and community have a responsibility both to challenge and to listen.”

Best Regards
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