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Public consultation on Good medical practice

Thank you for the opportunity to provide input into the Medical Board of Australia draft revised *Good medical practice: A code of conduct for doctors in Australia* (the draft code).

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 75,000 healthcare practitioners and students around Australia.

We have reviewed the draft code and provide the following comments in response to the consultation questions.

1. From your perspective how is the current code working?

Codes of medical practice are an important tool for setting standards about acceptable professional conduct. The current *Good medical practice: a code of conduct for doctors in Australia* ("the Code") generally provides important guidance for doctors about appropriate professional standards. We have found it useful in providing advice and assistance to our members. However, our experience is that:

a) there is a general lack of awareness among the profession about the contents of the code, and some do not know if its existence;
b) doctors do not appreciate that the code sets the standard against which their practice will be evaluated; and
c) some doctors do not appreciate that non–compliance with the code may expose them to disciplinary action.

2. Is the content and structure of the draft revised code helpful, clear, relevant and more workable than the current code?

The code should be a standard setting, principles-based document which guides doctors' practice while giving them the flexibility to use their own professional judgement in applying the standards when caring for their patients.

Rather than clearly espousing some general principles about what amounts to good practice, our impression is that the draft code seeks to deal with every possible interaction between a doctor and a patient and set guidance about how this is to occur. By including

this level of detail in the draft code, we are concerned that the code has become too prescriptive. Rather than being a useful guide for doctors prospectively, it risks becoming useful only as a means by which doctors will be judged after the event.

Some of the content of the code is difficult to understand. Some clauses are too wordy and confusing, and it is not clear how they would work in practice (for example clause 4.8.4). Some clauses appear to be aspirational, while others are quite prescriptive, and we are concerned that this will cause further confusion. This heightens the risk of unfair disciplinary action.

The increased length of the draft code (from 22 pages to 31 pages) is also a concern. We believe that it is too long and will lose relevance for doctors as a guide to appropriate conduct.

Some clauses in the draft code (particularly those dealing with bullying) refer to aspects of good medical practice which appear to exceed obligations under current laws. In our view, the code of medical practice should complement existing legislation and regulations, not create new or different rules.

Further details about these concerns are included below.

3. Is there any content that needs to be changed or deleted in the draft revised code?

We have specific comments about the following sections in the draft code.

Professionalism

Some of our members have expressed concern about the potential implications of this section particularly the cautions around making public comment.

We understand the sentiment behind reminding practitioners of the need to acknowledge and consider the effect of comments and actions outside work. However, the clause potentially applies to any statement that a doctor might make whether in a professional or personal setting. It is unclear what comment it is intended to apply to. As currently drafted the section could apply to personal opinions about clinical and ethical issues and/or personal opinions about non-clinical issues, including about political issues, such as climate change or immigration policy.

We are concerned that in the absence of a definition of "public comment", this clause could expose doctors to claims of unprofessional conduct merely for stating a differing view about any issue, medical or otherwise.

Clause 3.2.8 follows on from this and states that good medical practice involves:

"Acknowledging the profession's generally accepted views and informing your patient when your personal opinion and practice does not align with these."

We are not certain how this would work in practice, and how a doctor ascertains "the profession's generally accepted views" on a matter. While this might be fairly straightforward on some issues, on other issues there may be reasonable and important

opposing views which doctors should be free to express without exposing themselves to claims of non-compliance with the code and disciplinary action.

It is also not clear how the requirements in section 2 and clause 3.2.8 interact with clause 3.4.6 regarding conscientious objection.

It is also not clear how this section will work with the Medical Board of Australia's social media policy, and other sections of the code (for example 4.8.4).

The section also includes the statement that "[p]rofessionalism includes self-reflection." We agree that self-reflection is an important aspect of good medical practice. However media reports and concerns surrounding the English case of Dr Bawa-Garba has highlighted the need to ensure that self-reflective comments cannot be used against a doctor in any legal action.

We suggest that these issues be clarified in the final version of the code.

Culturally safe and respectful practice

We agree that it is important to highlight in the code the need for culturally safe and respectful practice. However, section 4.8 is complicated and confusing, and it may have unintended consequences.

For example, Clause 4.8.1 states that "*only the patient and/or their family can determine whether or not care is culturally safe and respectful".* This is an extremely wide clause and we anticipate that its application in practice may be problematic. The use of "only" in this clause is quite dogmatic and we suggest that it be removed. We also recommend replacing the word "determine" for example with the word "guide".

Attitudes about appropriate health care do differ due to cultural differences, and there is a wide range of cultural diversity in Australia. In some cases these attitudes can place patients, particularly children, at risk. Where there is a disagreement between a patient and a doctor about appropriate health care and that disagreement is based upon cultural differences, good medical practice should require a doctor to seek to communicate with a patient or their family and to explore appropriate medical practice while respecting a patient's cultural background. A practice that may be culturally acceptable to a patient or family may not be acceptable to the practitioner. Clause 4.8.1 as currently drafted suggests that the view of the patient or their family about what is appropriate treatment should take precedence and patients could rely on this clause to demand treatment that the doctor does not consider clinically appropriate and/or to complain that the doctor engaged in unprofessional conduct in this regard.

Clause 4.8.3 states that good medical practice acknowledges "*social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population level"*. We acknowledge that this clause is in the current version of the code and that it is a principle that doctors should aspire to. However we are not sure how this work in practice. Is a doctor required to make an acknowledgment in every consultation and what will this look like? What is the standard against which a doctor's "acknowledgement" will be measured?

Several of the clauses within this section refer to gender and sexuality which may not considered to fall within the common understanding of "culturally respectful practice".

To address these concerns, we suggest that it would be sufficient guidance for doctors to include in the code a general comment about culturally safe and respectful practice and to delete the particulars beneath it, as follows:

Culturally safe and respectful practice requires you to understand how your own culture, values, attitudes, assumptions and beliefs influence interactions with patients and their families and colleagues. Good medical practice is culturally safe and respectful and includes respecting all patients, colleagues and their beliefs.

End of life care

We do not believe it is the role of doctors to encourage organ donation as stated in clause 4.13.12. This should be a decision for a patient and/or a patient's family, and we are aware of situations where doctors have been criticised by patients and family members for discussing organ donation with them. We suggest that the words *"and encouraging"* be deleted from the draft code.

Bullying and harassment

We agree that there should be no place for discrimination, bullying and sexual harassment in the medical profession or health care. However, we have some concerns about section 5.4 as drafted.

We have received feedback from some of our members that it is preferable not to use the phrase "zero tolerance". This sets the bar extremely high in the context of managing of discrimination, bullying and sexual harassment in the workplace. It may be preferable to state that good medical practice involves "not tolerating discrimination, bullying and sexual harassment." We also note that harassment may not only be sexual, but could be based on race, gender identity etc.

Responsibilities on employers and employees for bullying, discrimination and sexual harassment in the workplace are set out in a range of state, territory and federal laws and employer policy. This is a complicated area of the law and disputes are usually adjudicated in specialist tribunals such as the Fair Work Commission or other discrimination tribunals. It is not clear how the code will articulate with other forums that deal with bullying, discrimination and sexual harassment. The principles outlined in the code would appear to add an additional layer of complexity to the management of claims and complaints in this area.

We are also concerned that some of the obligations referred to in this section may be more onerous than current legislation. There is no general statutory obligation under workplace legislation on employees to "do or say something" about discrimination, bullying and sexual harassment. Clause 5.4.10 suggests an obligation to report and notes this is in addition to mandatory reporting obligations. The preamble to the code states that it is not intended to give rise to additional rights and obligations, contrary to the wording of this clause. If this is the case, it is not appropriate that this be included in the code of conduct. It is a matter for legislation. This should be clarified so that doctors are not further confused about mandatory reporting obligations.

If discrimination, bullying and sexual harassment matters are now to be referred to the Medical Board (as contemplated by clause 5.4.10), there should be staff within AHPRA with expertise to manage these complaints.

Exemptions against bullying claims apply where employers have taken reasonable management action. We suggest that a statement to this effect in the code, outlining what does not amount to bullying. Legislation also specifies time limits for bringing bullying complaints. Time limits are not specified in the code. Further thought should be given to this before the draft code is finalised.

Vexatious complaints

We welcome the inclusion in the draft code of clause 10.4 which deals with vexatious complaints. The improper use of the complaints process has been an ongoing issue for Avant members for several years.[1] Examples include not only vexatious complaints made by patients against doctors but also inter and intra-professional disputes, including trainee and supervisor disputes, that can, in our experience, result in vexatious complaints.

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

Yours sincerely

[redacted]

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[1] See Georgie Haysom "Vexed problem of improper complaints" *Medical Journal of Australia Insight* 13 February 2017 https://www.doctorportal.com.au/mjainsight/2017/5/vexed-problem-of-improper-complaints/