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Executive Officer,  
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To whom it may concern

**Re: Public Consultation – Good Medical Practice**

Thank you for providing an opportunity for public consultation on the 2018 revision of the Board Code of Good Medical Practice. I respectfully offer the following comments in the hope that this may be of some value in the redrafting of the Code.

In general terms the Medical Board's GMP provides a sound basis for medical practitioners moral, legal and sociocultural obligations.

As to whether it is working – this is very difficult to answer in any definitive way. The Code itself is largely invisible – in practice, in UG and PG education and within institutions. While this could suggest it functions largely as a metric against which practitioners can be judged when variant practice is reported, an alternative view is that the best codes of ethics and the best laws are invisible because the norms they embody are already adopted by practitioners in their day-to-day work. In others words they are unconscious norms.

For the most part the Code is clear and reads well although the language varies starkly at certain points – particularly in the section dealing with culturally safe practice. This section is also repetitive and a little full of jargon.

*Specific Comments:*

1. Page 7. Doctors have a duty to protect and promote health of individuals and communities. This is sometimes an impossible task and not always concurrently desirable. Suggest adding something like: 'While in most situations the interests of individuals and communities converge, there are times when the interests of one override the other – for example where access to high-cost medications or transmissible infections are of concern.'
2. Page 9. Discrimination is used as a pejorative term but this is not always the case and the term can mean to make a considered judgement. Discrimination may also be appropriate and ethical – eg taking steps to positively discriminate in favour of someone who lacks access to care. Consider rephrase to, 'Your decisions about patients access to medical care must be unbiased and not inappropriately or unjustly discriminate against a person or population.'
3. 3.4.4. Stop at 'clinical need' as effectiveness is highly subjective and a matter of disputation regarding evidence.



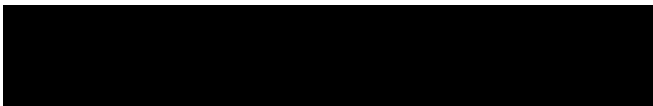
4. 3.4.6 and 3.4.7 Conscientious objection is often claimed in situation where it is inappropriate – with evidence from Australia and OS that doctors may claim to refuse to treat someone with HIV/AIDS or someone who is LGBTI on the grounds that it is the right to conscientiously object. So – suggest add something like: ‘Recognising that the situations in which conscientious objection is ethically acceptable are defined by cultural norms and law.’
5. Sections 4.3 and 4.5 – suggest combine under header Communication and Consent. Hugely repetitive and ethically redundant.
6. 4.3.6 collapse into 4.3.4 as it is subsumed under 4.3.6 and just provides a legal ‘definition’ of risk (materiality).
7. 4.9. This section starts with capacity – which may no longer be appropriate given the International Convention of Rights of People with a Disability and the shift in law from capacity to supported decision-making. Consider starting with something like: Doctors should act in ways that support patient’s involvement in decision-making – including those who lack or may have limited capacity.
8. Section 4.1.2. Should there be something here on offering patients a second opinion in situations where there is uncertainty or conflict about the appropriate management or about the goals of treatment or where there is concern that there has been an error or inadvertent harm or wherever a patients request one?? (Needs some word-smithing.)
9. Section 4.11.2 delete ‘get advice from medical insurer’ – not really an ethical responsibility – a risk management one and one that may not be in the patient’s best interest.
10. Section 4. Include a point of ensuring and arranging appropriate follow-up to ensure resolution of the adverse event and to enable another opportunity for the patient to discuss their experience.
11. Given the Medical assistance in dying is now legal in one state and is likely to become so in other states and territories there is now an ethical and legal obligation to make patients aware of this when they ask about their options at the end of life (at least in Victoria). The Code must be consistent with public norms and Australian laws – not just those that ‘suit’ the medical profession. So...suggest include something like the following ie 4.13.13. ‘Sensitively responding to and discuss medical assistance in dying where this is raised by the patient and available as a legal option for patients at the end of life and where this is consistent with the doctor’s own values.’ (Then footnote Victorian Act)
12. Section 5.4 – Good section but the experience of women in medicine and surgery suggests that this is not enough. Consider adding a point that requires that doctors advocate eg ‘Advocating for workplace reform to ensure that colleagues, students and patients are not discriminated against, either as a function of the actions of an individual or as a function of the policies, processes or structures of an organisation, institution, facility or service.’
13. Section 7. Add: ‘Understanding the impact of waste and practicing in ways that avoids waste and promotes efficient and sustainable healthcare services.’
14. Section 7: Add: ‘Understand the factors that may lead to over-diagnosis and over-treatment and taking steps to avoid this.’
15. Section 7.3: Would be important to add here refugees and people seeking asylum – many of whom have been terribly harmed by government policy. So: Suggest add ‘refugees and asylum seekers’ to the list of those who are discriminated against and add ‘political’ to the reasons why people may be discriminated against ie social, economic, cultural. Also suggest adding something that lays out ‘an ethical obligation for doctors to provide health care to people in their care – irrespective of the country from which they come, the reasons that has led them to be in Australia, the political or health policies that apply to them, their citizenship or capacity to pay.’ (Or something like this?) The medical community has been superb in speaking out for the welfare of asylum seekers and children in detention – surely this must be noted as an ethical obligation for Australian doctors!



16. Section 7.4.2. Should this mention 'including vaccination to avoid nosocomial infection of patients.'
17. Section 8.3. This makes safe workplaces all doctors responsibility. What about adding something that says 'Advocating for the creation of safe workplaces for the benefit of patients, carers, students and colleagues.'
18. Section 10. The code includes note that the Board may take action against a complainant. Given that Board may action may follow many breaches – suggest delete from this section – this is a Code not a warning document.
19. Note re Section 10.8. I would love to see the Board act against the many doctors who currently are in breach of many of the requirements – eg all those advertising autologous cellular therapies!!
20. Section 10.12. Indemnity insurers really don't give advice on conflict of interest. Suggest delete.
21. Section 13.3. Generally when doctors are involved in recruiting their own patients to research they are involved in this should be done by a third party because of the risks of coercion. HRECs also often demand this. So suggest add an addition point: 'Recognising that the power differential between a doctor and her/his patients may be coercive and mitigate against free and voluntary decisions to participate in research and taking steps to ensure that patients decisions and voluntary – including through use of third parties to obtain consent where appropriate.' (Or something like this.)

I commend the Board for the work done thus far on the Code and would be happy to speak further about any of my suggestions should that be of value.

Sincerely,



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