SUBMISSION OF THE HUMAN RIGHTS LAW ALLIANCE (HRLA) TO THE MEDICAL BOARD OF AUSTRALIA (BOARD) IN RELATION TO THE DRAFT REVISED CODE OF CONDUCT, GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA (DRAFT REVISED CODE).

Introduction

1. HRLA is an alliance of lawyers committed to advocacy for the advancement of the fundamental human right of the freedom of thought conscience and religion and the cognate rights of the freedom of expression and association.
2. These fundamental rights are embodied in the *International Covenant on Civil and Political Rights* (**ICCPR**):
    a. Article 18:
    1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
    b. Article 19:
    1. Everyone shall have the right to hold opinions without interference.
    2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.
    c. Article 22:
        1. Everyone shall have the right to freedom of association with others, including the right to form and join trade unions for the protection of his interests.
3. The Board has invited comments in relation to the Draft Revised Code in the following terms:
    "The Board is inviting general comments on the draft revised code as well as feedback on the following questions.
    1. From your perspective, how is the current code working?
    2. Is the content and structure of the draft revised code helpful, clear, relevant and more workable than the current code?
    3. Is there any content that needs to be changed or deleted in the draft revised code?
    4. Is there anything missing that needs to be added to the draft revised code?
    5. Do you have any other comments on the draft revised code?"
4. HRLA will address these issues in this submission incorporating its responses in the submissions in relation to the specific areas of the Draft Revised Code that gives rise to concerns.

Current Code and its Working

5. The current Code in relation to the professional values and qualities of doctors provides, *inter alia*, as follows:
    "**1.4 Professional values and qualities of doctors**
    While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.
Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.
Doctors have a responsibility to protect and promote the health of individuals and the community.
Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.
Good communication underpins every aspect of good medical practice.
Professionalism embodies all the qualities described here, and includes self-awareness and self-reflection. Doctors are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to their profession."

6. While the guidelines set out above are anodyne and unobjectionable, the current complaint against Toowoomba doctor Dr David van Gend reported in the Daily Telegraph of 28 July 2018 indicate that activists will seek to press such guidelines beyond their intended application to suit their own agenda. As Miranda Devine says in the article:
" YOU know our culture has reached peak Kafka when a doctor is hauled before his medical board on professional misconduct charges for retweeting two tweets by a conservative Senate candidate promoting a book about gender ideology and one of my columns."[1]
7. This case indicates that in the current climate of activism by certain sections of Australian society, the current Code may be pressed to operate in such a way that it infringes on the fundamental human rights of thought, conscience and belief and the freedom of expression.
8. Considering solely the material in the public domain in relation to Dr van Gend, it is difficult to see how merely retweeting articles of the nature described by Devine: "One of Shelton's tweets was a selfie with American author Ryan Anderson from the conservative Heritage Foundation: 'A privilege to catch up with … the author of How Harry Became Sally. A must read for anyone trying to understand how to push back on radical gender indoctrination of our children.'
The other Shelton tweet was a retweet of a column of mine critical of gender fluidity classes in schools, titled SSM [same-sex marriage] has led exactly where we were warned it would"" could be construed as a breach of the Code.

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[1] https://www.dailytelegraph.com.au/rendezview/the-medical-board-has-become-the-censorship-board/news-story/e971dfbfdc41654033bc9c2d2a57be24?utm_source=Daily%20Telegraph&utm_medium=email&utm_campaign=editorial accessed 3 August 2018.

9. HRLA therefore submits that the Board should be vigilant to not allow the Code to be used as a tool to advance particular socio-political views and must ensure that its use is confined to matters of professional medical related related behaviour.

The Draft Revised Code

10. **HRLA considers that paragraph 2.1 of the Draft Revised Code needs amending.** It provides:
    2.1 **Professional values and qualities of doctors.**
    While individual doctors have their own personal beliefs and values, there are certain professional values that underpin good medical practice.
    Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be honest, ethical and trustworthy and comply with relevant laws.
    Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.
    Community trust in the medical profession is essential. Every doctor has a responsibility to behave ethically to justify this trust. The boundary between a doctor's personal and public profile can be blurred. As a doctor, you need to acknowledge and consider the effect of your comments and actions outside work, including online, on your professional standing and on the reputation of the profession. If making public comment, you should acknowledge the profession's generally accepted views and indicate when your personal opinion differs. Behaviour which could undermine community trust in the profession is at odds with good medical practice and may be considered unprofessional.
    Doctors have a responsibility to protect and promote the health of individuals and the community.
11. The underlined portion of the paragraph 2.1 is new. The portion highlighted in yellow, HRLA submits should be **deleted** for the following reason:
    a. The effect of this addition is that individual doctors are to take into account the ill-defined and nebulous concept of profession's generally accepted views before making public comment. This presupposes that the profession has a homogenous view on all issues. That is an impossibility. The Draft Revised Code ranges wider than in relation to medical matters, and on its face applies to any matters that a doctor may wish to make a public comment. The views of the profession on topics like immigration or tax cuts for banks or the resignation of the arch bishop –are diverse and there will never be a generally accepted position. Moreover if there is, it will be irrelevant as doctors are no more qualified to speak on these matters as plumbers, farmers or restaurant owners;
    b. Such a provision is open to abuse by activists who wish to enforce a particular view on some contentious topic on the profession and the community. The Dr van Gend is a case in point;
    c. To make such a wide and undefined concept as the "profession's generally accepted views" and the attendant obligation to take those views into account before making public comment are obligatory on the profession, which will be

the effect of the Code is adopted, by virtue of section 41 of the Health Practitioner Regulation National Law (HPNRL):

"**Use of registration standards, codes or guidelines in disciplinary proceedings**

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession"

is open to challenge as being beyond the power of the Board.

d. Any Code the Board adopts must be that which it is authorised to do by the HPNRL. The HPNRL must therefore be carefully considered.

e. The following sections are relevant:

Section 3 Objectives and guiding principles

(1)The object of this Law is to establish a national registration and accreditation scheme for—(a)the regulation of health practitioners; and(b)the registration of students undertaking—(i)programs of study that provide a qualification for registration in a health profession; or(ii)clinical training in a health profession.

(2)The objectives of the national registration and accreditation scheme are—(a)to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and(b)…; and(c)to facilitate the provision of high quality education and training of health practitioners; and(d)…; and(e)…; and(f)to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

(3)The guiding principles of the national registration and accreditation scheme are as follows—(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;(b)…;(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Section 35 Functions of National Boards

(1)The functions of a National Board established for a health profession are as follows—(a)to register suitably qualified and competent persons in the health profession and, if necessary, to impose conditions on the registration of persons in the profession; (b)…;(c)to develop or approve standards, codes and guidelines for the health profession, including—(i)the approval of accreditation standards developed and submitted to it by an accreditation authority; and(ii)the development of registration standards for approval by the Ministerial Council; and(iii)the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession;(d)…;(f)…;(g)…;(h)…; and(ii)health matters in relation to students registered by the Board;(i)to refer matters about health practitioners who are or were registered under this Law or a corresponding prior Act to responsible tribunals for participating jurisdictions;(j)…to oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertaking and suspensions imposed on the

registration of the practitioners or students;(k)…;(l)…;(m)…;(n)…;(o)… (p)… (q) to do anything else necessary or convenient for the effective and efficient operation of the national registration and accreditation scheme ;(r) any other function given to the Board by or under this Law.
(2)…

Section 39 Codes and guidelines

A National Board may develop and approve codes and guidelines—(a) to provide guidance to the health practitioners it registers; and (b) about other matters relevant to the exercise of its functions.

f. It is difficult to see how a part of a Code which purports to require doctors to consider such a broad and ill-defined concept as the "profession's generally accepted views" on all or potentially all topics within the purview of the Objects of the HPNRL, the functions of the Board and hence the Board's power to develop and approve codes.
g. This is particularly the case once it is appreciated that the Board's powers to develop and approve Codes is circumscribed not only by the HRNRL but by the constitutionally mandated implied freedom of political communication.
h. It is clear that the implied freedom of political communication operates as a burden on administrative and regulation making power.[2]
i. The Draft Revised Code if adopted in its current form, HRLA submits may improperly burden the implied freedom about political matters that is mandated by the constitution and essential for the working of Australian democracy. The Code itself may be suitable being directed to a legitimate objective, the portion here under consideration may not be necessary, because of its broad application and its and ill-defined terms.
j. Further there are many examples in medical history of views which were contrary to the "generally accepted views of the medical profession" being proved to be correct. A modern case in point is the history of the cochlear ear implant. In the article "The cochlear implant: Historical aspects and future prospects" Adrien A. Eshraghi, Ronen Nazarian, Fred F. Telischi, Suhrud M. Rajguru, Eric Truy, and Chhavi Gupta say[3] "The initial reaction to CIs by auditory scientists and by otologists other than the developers was highly critical. Many of these experts offered categorical statements that CIs could not possibly restore any useful hearing, primarily because the patterns of stimulation and neural responses provided with the CIs of the time were incredibly crude and distorted compared with the patterns and responses observed in animals with normal hearing. For example, Dr. Merle Lawrence, Ph.D., who was an eminent auditory scientist, said that "direct stimulation of the auditory nerve fibers with resultant perception of speech is not feasible" (cited in Wilson and Dorman, 2008)." Many other experts expressed similar

[2] *Wotton v The State of Queensland* (2012) 246 CLR 1; *Bennett v President, Human Rights and Equal Opportunity Commission* [2003] FCA 1433 involved a challenge to the validity of a public servant regulation prohibiting a government employee from disclosing any 'information about public business or anything of which the employee has official knowledge', unless with approval, or in the course of their duties. The regulation was held invalid as improperly burdening the freedom, [100]–[101]; *Chief of the Defence Force v Gaynor* [2017] FCAFC 41, [104]-[111](Perram Mortimer and Gleeson JJ); *Starr v Department of Human Services* [2016] FWC 1460.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4921065/ accessed 3 August 2018.

views. However, pioneers persisted in the face of this intense criticism and provided the foundations for today's devices."[4]

k. The section of the Code currently under consideration would have required those pioneers to acknowledge the generally accepted and fundamentally wrong views of the medical profession and the advancement of the science would have been prejudiced.

l. Another example is that of the recovered memory epidemic of the 1990s. In the article "Recovered and false memories" by Daniel B. Wright, James Ost and Christopher C. French[5] say "In 1995 the recovered memory debate was near its most vociferous height. Hundreds of people were recovering memories of childhood sexual abuse (CSA), sometimes in therapies where it was believed that repressed or dissociated memories had to be recovered in order for the person to 'heal'. Many of the people who recovered these memories confronted the person whom they remembered abusing them, and some cases ended up in the criminal courts with successful prosecutions. However, there were those who questioned whether all such memories should be accepted as accurate reflections of real events (e.g. Loftus, 1993). It was argued that some, perhaps even most, of such recovered memories might in fact be false memories produced, at least in part, by the therapists themselves…. (after analysing the research that then ensued they say) We believe:
that what appear to be newly remembered (i.e. recovered) memories of past trauma are sometimes accurate, sometimes inaccurate, and sometimes a mixture of accuracy and inaccuracy;
that much of what is recalled cannot be confirmed or disconfirmed;
that, because of these two beliefs, reports of past trauma based on such recovered memories are not reliable enough to be the sole basis for legal decisions.

m. Again this advance and the restraint on what was a social epidemic, was because researchers acted against the widely accepted views at the time. The section of the Code currently under consideration will restrict such action.

12. The relevant section should be deleted.
13. **HRLA considers that paragraph 3.7 of the Draft Revised Code needs amending.**
14. It currently provides:

3.7 Culturally safe and sensitive practice

Good medical practice involves genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes. This includes: 3.7.1 Having knowledge of, respect for, and sensitivity towards, the cultural needs of the community you serve, including Aboriginal and Torres Strait Islander Australians and those from culturally and linguistically diverse backgrounds. 3.7.2 Acknowledging the social, economic, cultural and behavioural factors influencing health, both at individual and population levels. 3.7.3 Understanding that your own culture and beliefs influence your interactions with patients and ensuring that this does not unduly influence your decision-making. 3.7.4 Adapting your practice to improve

[4] Ibid.
[5] https://thepsychologist.bps.org.uk/volume-19/edition-6/recovered-and-false-memories accessed 3 August 2018 (the journal of the British Psychological Society).

patient engagement and healthcare outcomes. 4.8 Culturally safe and respectful practice
Culturally safe and respectful practice requires you to understand how your own culture, values, attitudes, assumptions and beliefs influence interactions with patients and families, the community, colleagues and team members. Good medical practice is culturally safe and respectful. This includes: 4.8.1 Understanding that only the patient and/or their family can determine whether or not care is culturally safe and respectful. 4.8.2 **Respecting diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among colleagues and team members.** 4.8.3 Acknowledging the social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population levels. 4.8.4 **Adopting practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based on assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs).** 4.8.5 Supporting an inclusive environment for the safety and security of the individual patient and their family and/or significant others. 4.8.6 Creating a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including patients, colleagues and team members.

15. The highlighted sections must be amended for the reasons set out below.
16. The fundamental tenet of Australian scientific medical practice is that it is evidence based. The highlighted section of the Draft Revised Code require doctors to respect views that may not be evidence based. Two matters which stand out are female genital mutilation and gender identity.
17. Female genital mutilation is illegal and condemned by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[6] Yet the Draft Revised Code on its face requires doctors to have respect to this cultural and religious belief. That is an untenable position for the Board to put doctors in.
18. Likewise the issue of gender identity and gender fluidity which underlies it, is not a scientific and evidence based. In their article Sexuality and Gender[7], Lawrence S. Mayer, Paul R. McHugh say in Part Three: **Gender Identity**
“● The hypothesis that gender identity is an innate, fixed property of human beings that is independent of biological sex — that a person might be “a man trapped in a woman’s body” or “a woman trapped in a man’s body” — is not supported by scientific evidence..
● Studies comparing the brain structures of transgender and non-transgender individuals have demonstrated weak correlations between brain structure and cross-gender identification. These correlations do not provide any evidence for a neurobiological basis for cross-gender identification.
● Compared to the general population, adults who have undergone sex-reassignment surgery continue to have a higher risk of experiencing poor mental health outcomes. One study found that, compared to controls, sex-reassigned

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[6] https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Female-Genital-Mutilation-(C-Gyn-1)-Nov17.pdf?ext=.pdf accessed 3 August 2018.
[7] https://www.thenewatlantis.com/publications/executive-summary-sexuality-and-gender accessed 3 August 2018.

individuals were about 5 times more likely to attempt suicide and about 19 times more likely to die by suicide.

● Children are a special case when addressing transgender issues. Only a minority of children who experience cross-gender identification will continue to do so into adolescence or adulthood.

● There is little scientific evidence for the therapeutic value of interventions that delay puberty or modify the secondary sex characteristics of adolescents, although some children may have improved psychological well-being if they are encouraged and supported in their cross-gender identification. There is no evidence that all children who express gender-atypical thoughts or behaviour should be encouraged to become transgender."

19. In his paper The Controversy over the Safe Schools Program – Finding the Sensible Centre[8], the current Dean of the Law School of the University of Queensland Professor Patrick Parkinson says, "A likely explanation for the exaggeration of transgender and intersex conditions is that it is regarded as necessary to support the authors' belief system to show that gender is 'fluid' and can even be chosen.
    This idea has its origins **not in science** but in philosophy (emphasis added). Leading gender theorist Judith Butler, for example, wrote in 1988 that '…gender is in no way a stable identity or locus of agency from which various acts proceed; rather, it is an identity tenuously constituted in time - an identity instituted through a stylized repetition of acts… Feminist theory has often been critical of naturalistic explanations of sex and sexuality that assume that the meaning of women's social existence can be derived from some fact of their physiology. In distinguishing sex from gender, feminist theorists have disputed causal explanations that assume that sex dictates or necessitates certain social meanings for women's experience."
20. The Draft Revised Code will require doctors to "respect" views which are not scientifically based and may be harmful to patients. That is not in accord with the objects of the HPRNL or the functions of the Board.
21. The highlighted sections should therefore be amended. HRLA suggests that there be an overriding proviso which says "Nothing in this section of the Code requires a doctor to respect practices which are, in the reasonably held view of a doctor not scientifically based and which may cause harm to a patient.

Conclusion

22. HRLA thanks the Board for the opportunity to provide this submission. Further submissions may be provided if that is considered necessary.

Dated 3 August 2018

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[8] The+Safe+Schools+Controversy+September+2016%255b1660743%255d.pdf accessed 3 August 2018.