4 Campion Street
Deakin, ACT 2600

T 02 6259 0431
F 02 6259 0462

E natoffice@acl.org.au
W acl.org.au

17th August 2016

Public Consultation on Good Medical Practice
medboardconsultation@ahpra.gov.au

Submission to Good Medical Practice: a code of conduct for doctors.

The Australian Christian Lobby welcomes the opportunity to participate in the public consultation on *Good Medical Practice: a code of conduct for doctors.*

We are pleased to contribute to this consultation as we recognise the importance of good medical practice and the trust which the community places in the medical profession.

The community trusts that doctors will operate within an ethical framework for the best interests of the patient. Some of the proposed changes to the Good Medical Practice code will challenge that relationship by removing the ethical judgment from the doctor and potentially lead to a mechanistic response to the provision of health care.

We wish to ensure that doctors are able to exercise their professional expertise and to provide good medical care which responds to the individual needs and concerns of their patients.

Please feel free to contact me if I can be of further assistance in the consideration of this matter. I would be pleased to meet to discuss our submission or any other aspect in respect to this review.

Yours sincerely,

[redacted]

Martyn Iles
Managing Director

Introduction

As professionals, doctors are required to abide by a code, based on ethical practice, to provide best patient care consistent with respect for persons and responsive to community needs and expectations.

Australia is a diverse community and its medical practitioners reflect that diversity. Society and medical practitioners draw on a variety of respected ethical traditions which do not necessarily have the same applications and outcomes. It is concerning therefore, that the proposed changes to the code will effectively narrow the parameters of autonomy of medical practitioners by limiting their free speech and potentially prescribing the manner in which they exercise their professional competence.

There are many areas of medicine in which there is no single generally accepted view. There is a divergence of views in treatment of the following:

- applications of cosmetic surgery;
- euthanasia and withdrawal of medical treatment;
- termination of pregnancy;
- pre-natal screening;
- treatment of gender dysphoria;
- use of puberty blockers during adolescence; among others.

The community trusts that doctors will operate within an ethical framework for the best interests of the patient. Some of the proposed changes to the Good Medical Practice code will challenge that relationship by removing the ethical judgment from the doctor and potentially lead to a mechanistic response to the provision of health care.

In particular, we wish to draw attention to the following sections in the proposed 2018 code:

2.1 Professional values and qualities of doctors: Paragraph 4
2.1 Professional values and qualities of doctors: Paragraph 6
4.8 Culturally safe and sensitive practice
3.3.3 Decisions about access to medical care.

2.1 Professional values and qualities of doctors: Paragraph 4

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.

One obvious problem is that this paragraph presumes that the medical profession is in agreement regarding the treatment of a broad range of medical situations, when in fact there is no single generally accepted view on a broad range of possible medical practices. If doctors make public comment from within their informed and responsible area of medical expertise they are contributing to a wider community debate. The community has a right to be informed of the diversity of opinion within the medical community and to benefit from different viewpoints by seeking a second opinion.

Medicine is a branch of science and many scientific developments have come about precisely because individuals have challenged the commonly held views of their own colleagues and their contemporary society. The ability to challenge commonly held views is the basis of scientific method and can lead to valuable breakthroughs. Galileo was punished for stepping outside of the community consensus of his day.

Doctors are free citizens and should be able to provide advice freely in a professional capacity, as well as voicing their opinions freely in a personal capacity. Given the highly-politicised nature of some medical debates, concerning sexual orientation and gender, for example, this paragraph would create the authority to potentially de-register a doctor who voiced contrary views, even if these views were expressed outside the consulting room. The petition against Pansy Lai in the marriage campaign last year called for her deregistration for her outspoken stance against same-sex marriage but his campaign failed because, as the AMA pointed out, they had no power to bring professional action against her exercising her freedom of speech. The proposed alteration would then seem to provide this authority to potentially punish a doctor professionally for the exercise of their free speech.

Recommendation: That this paragraph be removed from the Good Medical Practice (2018) code.

The following sections 2.1. and 4.8 will be treated together:

2.1 Professional values and qualities of doctors: Paragraph 6

Good medical practice is patient-centred. It involves understanding that each patient is unique, working in partnership with them and adapting what you do to address their needs and reasonable expectations. This includes culturally safe and respectful practice: being aware of your own culture and beliefs and respectful of the beliefs and cultures of others; and recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.

The current draft has replaced "cultural awareness" with "culturally safe and respectful practice". What are the parameters for "culturally safe and respectful practice"?

4.8 Culturally safe and sensitive 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.*

In Item 4 "sensitive practice" being replaced by "respectful practice"; and "good health outcomes" replaced by "culturally safe and respectful";

While awareness of one's own cultural beliefs and practices and respect for the beliefs and cultures of others is important, there are times when good medicine involves addressing practices which may be culturally mandated, but which have serious and negative health consequences. The current draft has replaced "cultural awareness" with "culturally safe and respectful practice". What are the parameters for "culturally safe and respectful practice"? 'Culturally safe" is not necessarily good medical practice.

Australian medical practitioners are, hopefully, in agreement that practices such as female genital mutilation, hymen reconstruction, and sex-selective abortion, while culturally conditioned are not desirable practices in modern medicine. Women, especially, are caught between cultural expectations and their own desires for good health outcomes. Many of these issues require careful negotiation and a high degree of sensitivity in order to deliver the best possible health outcomes. Sometimes the desired outcomes are contrary to the cultural expectations.

"Respecting" can be taken to mean agreeing with, affirming, and accepting that good medical practice may not challenge false medical belief and inappropriate treatment. As part of good medical practice doctors are required to challenge a range of practices such as excess weight, excess alcohol, dangers of sexual behaviours etc – or at the very least to tell medical truth.

In the case of female genital mutilation, sex-selective abortions, and other practices, the family may coerce the patient into situations which are not compatible good medical practice. There are similar problems with the whole of item 4.8.

Recommendation:

That the wording of the 2009 code of "cultural awareness" be retained instead of "culturally safe and respectful practice" – as such practice may not be in the best interest of the patient.

3.3.3 Decisions about access to medical care

> *Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, gender identity, sexual orientation, disability or other grounds, as described in anti-discrimination legislation.*

This paragraph amends the previous paragraph 2.4.3 with the addition of "gender identity" and "sexual orientation". "Gender identity" and "sexual orientation" are not "medically irrelevant" to the holistic treatment of the patient. Indeed, many medical interventions are being requested by persons who identify as having "gender dysphoria". This is in itself a medical and/or psychological diagnosis and such patients present with specific treatment requirements and/or requests.

It is hoped that the inclusion of such identities is not intended to prescribe particular treatments. It must be strongly noted that many treatments offered to persons with gender dysphoria, such as puberty blockers are still highly experimental. There is no long-term data for the safety of such medication. This is an area where there is wide divergence of opinion amongst medical practitioners and paediatric experts.

There is no evidence to suggest that gender dysphoria is a biologically determined condition according to early studies of identical twins.[1] Further, evidence suggests that there is a resolution of gender dysphoria after puberty in children when they are not encouraged to impersonate the opposite sex.[2]

The American College of Pediatricians warns that:

> *We are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition … We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people. Policies that encourage—either directly or indirectly—such medical treatment for young people who may not be able to evaluate the risks and benefits are highly suspect, in our opinion.*[3]

Recommendation:
The wording of this paragraph ought to return to the earlier 2.4.3 (2009) "Gender identity" and "sexual orientation" should be removes as are not "medically irrelevant" to the holistic treatment of the patient. They are highly relevant in the provision of good medical care.

[1] American College of Pediatricians; Gender Dysphoria in Children, June 2017 https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children (Accessed 27 July 2018)
[2] Ibid.
[3] Ibid.

About Australian Christian Lobby

Australian Christian Lobby's vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 100,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.