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3 August 2018

Dr Joanne Katsoris
Executive Officer, Medical
AHPRA

Via email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris

MIGA Submission: Draft revised code of conduct -
Good medical practice: A code of conduct for doctors in Australia

MIGA welcomes the opportunity to make a Submission to the Board's consultation on its draft revised code of conduct – *Good medical practice: A code of conduct for doctors in Australia*.

A copy of its Submission is enclosed.

You can contact Timothy Bowen, telephone 1800 839 280 or email [redacted], if you have any questions about MIGA's Submission.

Yours sincerely

Timothy Bowen Senior Solicitor – Advocacy, Claims & Education	**Cheryl McDonald** National Manager – Claims & Legal Services

MIGA Submission

Medical Board of Australia

Draft revised code of conduct
Good medical practice: A code of conduct for doctors in Australia

August 2018

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3 August 2018

Medical Board of Australia - Draft revised code of conduct
Good medical practice: A code of conduct for doctors in Australia

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Executive Summary – MIGA's position

1. MIGA supports the review of the Board's *Good Medical Practice: A code of conduct for doctors in Australia.*

2. It does not see a need for significant changes to the code. On the whole the code remains helpful, clear, relevant and workable.

3. As the review has identified there are a range of issues which require comment or clarification in a revised code. MIGA is generally supportive of the intent behind the proposed amendments set out in the draft code and many of the changes which are proposed.

4. MIGA supports greater emphasis on eliminating bullying, harassment and discrimination, and attempts to deter vexatious complaints. These problems can have a very significant professional and personal impact on those affected.

5. Below MIGA sets out its responses to proposed changes to the code, and other issues which it considers require attention. In particular, it considers:
   - More is required in the code to deter vexatious complaints and to recognise the impact they can have
   - Issues of discrimination, bullying and sexual harassment are generally better dealt with at a local level (i.e. by hospitals or other health care providers) or, where relevant, a professional college / association or medical school
   - It is also important to recognise the limits of what most doctors can do in relation to clinical governance.

Web links

6. MIGA supports the greater use of web links within the draft code, allowing easier access to relevant references.

7. A number of web links in the footnotes do not contain full website details. The addresses should be spelt out in full for use in printed / hard copy versions of the code.

1.4 – Substitute decision-makers

In this code, reference to the term 'patient' also includes substitute decision makers for patients who do not have the capacity to make their own decisions. This can be the parents, or a legally appointed decision-maker.

8. A substitute decision-maker for a patient who lacks capacity to make their own decisions can be appointed by a patient, a tribunal / court, or by 'default', i.e. where the law provides for a range of people, usually family, carers or others close to the patient, to make decisions where there has been no formal appointment of a decision-maker.

9. Consequently the reference to a "*legally appointed decision-maker*" could be misread as meaning only those appointed by a patient, tribunal or a court.

10. It would also be helpful to recognise the role of guardians in this section.

11. MIGA proposes the second sentence of the paragraph in section 1.4 of the draft code be reworded to read:

    This can be the parents, ***a guardian or another decision-maker appointed by the patient, tribunal or court, or recognised by law ('default' decision-makers). The terminology for these appointments varies depending on the state or territory you are in****.*"

12. There should also be a footnote at the end of the paragraph reading:
    Various terms for default decision-makers include persons responsible, medical treatment decision-makers, statutory health attorneys and health attorneys.

3.2 - Good patient care

3.2.7 Only recommending treatments when there is an identified therapeutic need and a reasonable expectation of clinical efficacy and benefit for the patient.

13. The term 'therapeutic' is open to an overly narrow interpretation, i.e. excluding cosmetic medical and surgical procedures, or even a broader range of 'elective' treatments. Notably, it is a term not otherwise used in the draft code.

14. By comparison, under the Medical Board's *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*, '*cosmetic medical and surgical procedures*' are defined as:
    operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem.

    The term 'therapeutic' does not of itself sit easily with that definition.

15. MIGA proposes that section 3.2.7 of the draft code be reworded to read:
    Only recommending treatments when there is an identified therapeutic need ***or a clinically recognised treatment,*** *and a reasonable expectation of clinical efficacy and benefit for the patient.*

4.2 - Doctor–patient partnership

4.2.3 Protecting patients' privacy and right to confidentiality, unless release of information is required by law or by public-interest considerations.

16. The references to release of information be "*required*" by law or "*public interest considerations*" are capable of both causing uncertainty and of unduly narrow interpretations.

17. There are situations where information can be appropriately released on legal or ethical grounds, but is not required to be released. These can include situations of imminent or other serious risk of harm outside any mandatory reporting obligations.

18. In addition it is debatable whether there is any duty, as opposed to a discretion, to release information on public interest grounds.

19. MIGA proposes the following rewording of section 4.2.3 of the draft code:
    Protecting patients' privacy and right to confidentiality, unless release of information is required by law, or ***otherwise permitted*** *by* ***law or*** *public-interest considerations.*

20. Where similar wording is used in the paragraph under the heading '4.4 Confidentiality and privacy', a consistent amendment should be made to that paragraph of the draft code.

4.4 - Confidentiality and privacy

4.4.5 Being aware that there are complex issues related to genetic information and seeking appropriate advice about its disclosure.

21. There are guidelines made under the *Privacy Act* dealing with this issue - NHMRC, *Use and disclosure of genetic information to a patient's genetic relatives under Section 95AA of the Privacy Act 1988 (Cth).*

22. MIGA recommends these guidelines be referred to in a footnote to the sub-section, and a web link provided to them, i.e. www.nhmrc.gov.au/guidelines-publications/pr3

4.5 - Informed consent

4.5.2 Obtaining informed consent or other valid authority (such as a medical power of attorney) and taking into account any advanced care directive (or equivalent) before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research.

23. MIGA has concerns about the use of the term 'informed consent' in this sub-section of the draft code, as:
    - In this context it conflates the concepts of 'consent' and 'informed consent' – although the section as a whole deals with 'informed consent', this sub-section deals with having appropriate legal authority to provide health care, which is a question of consent only
    - Use of the term 'informed consent' in this context could create confusion around what is legally required, which is consent only, and what is appropriate professional practice or discharge of a duty of care, which is informed consent.

24. In addition:
    - 'Informed consent' is not an alternative to an authority to provide health care from another source, such as an advance care directive – use of the latter only arises if a patient lacks capacity to provide consent
    - 'Medical power of attorney' is a uniquely Victorian term, and is no longer the terminology for such appointments made since March this year, which is now 'Medical treatment decision-maker'
    - Advance care directives are not only required to be taken into account, but generally must be followed if valid, clear and applying to the circumstances at hand
    - Advance care directives are known by different names in various Australian states and territories
    - There may be additional requirements, such as tribunal / court consent or ethics committee approval, before certain research is conducted.

25. To address the above issues, MIGA proposes sub-section 4.5.2 of the draft code be reworded to read:
    Obtaining consent ***from the patient (or if they lack capacity via an advance care directive or appropriate substitute decision-maker)*** *before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research* ***(which itself may require authority or approval from elsewhere)****.*

26. There should also be a footnote to the term 'advance care directive', indicating that these are known by a variety of terms throughout Australia, including advance health directive, health directive and advance personal plan.

4.6 - Children and young people

4.6.4 Being alert to children and young people who may be at risk, and notifying appropriate authorities, as required by law.

27. MIGA is concerned that this section of the draft code could be read as a mandatory requirement to notify any risk of harm.

28. It considers the sub-section should be reworded to read:
    Being alert to children and young people who may be at risk, and notifying appropriate authorities, ***when required by relevant laws where the doctor practices*****.**

4.9 - Patients who may have additional needs

4.9.4 Recognising that there may be a range of people involved in their care, such as carers, family members, a guardian or a medical agent with power of attorney, and involving them when appropriate or required by law, being mindful of privacy considerations.

29. The term "*medical agent with power of attorney*" is a uniquely Victorian term, and not used for appointments made since March this year.

30. To reflect this and the diversity of terminology used, MIGA proposes this sub-section of the draft code be reworded to read:
    *Recognising that there may be a range of people involved in their care, such as carers, family members, a guardian or a **substitute decision-maker**, and involving them when appropriate or required by law, being mindful of privacy considerations.*

4.10 - Relatives, carers and partners

4.10.2 With appropriate consent, being responsive in providing information.

31. There can be situations, including under the *Privacy Act 1988* (Cth) and various state legislation, where the release of information to relatives, carers and partners can be justified without patient consent.

32. Accordingly MIGA proposes the sub-section be amended to read:
    *With appropriate consent **or where otherwise justified**, being responsive in providing information.*

4.13 End-of-life care

4.13.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

33. Given patients can express a refusal of treatment via an advance care directive (or its equivalent) if they lack capacity, MIGA proposes the sub-section be amended to read:
    *Accepting that patients have the right to refuse medical treatment or to request a withdrawal of treatment already started, **which can also be expressed via an advance care directive or its equivalent**.*

5.4 Discrimination, bullying and sexual harassment

5.4.10 Referral of concerns about discrimination, bullying or sexual harassment to the medical board when there is ongoing and/or serious risk to patients, students, trainees, colleagues or healthcare teams (in addition to mandatory reporting obligations).

34. MIGA has significant concerns about proposed referrals of concerns about discrimination, bullying and sexual harassment amongst healthcare professionals and students to the Medical Board.

35. It acknowledges the need for issues of discrimination, bullying and sexual harassment on the one hand, and risks to patients on the other, to be appropriately dealt with. However, it does not believe the Medical Board would normally be the appropriate body to handle these types of matters. This is even more so for matters involving students, trainees, colleagues or healthcare teams.

36. MIGA considers these matters are better handled locally, ie by a hospital, clinic or other practice context, or by a specialist college, university or other education provider, depending on the circumstances in question.

37. The National Law is not designed to deal with matters relating to discrimination, bullying and sexual harassment. It cannot address the complexities which these matters often involve, particularly systemic issues or appropriate performance management issues. Where the primary consideration of the Board / AHPRA is protection of the public, its involvement in these matters is potentially problematic. The inevitable risk is that Board / AHPRA processes would focus on individuals, not addressing the core issues or the risk to patients, and offering risks of unduly punitive steps against individual doctors. This is particularly so given the issues arising in relation to vexatious complaints, which can have a discriminatory, bullying or harassment component.

38. Such matters are best handled by entities who have appropriate jurisdiction and relationships with the relevant parties. For instance, that would usually be:
    - Specialist colleges for issues involving trainees and supervisors, and possibly also for those between colleagues
    - Hospitals for those within healthcare teams
    - Hospitals and / or medical schools for those involving students.

39. If this sub-section is to remain, MIGA considers that:
    - No referral should be made unless there is a significant risk to patient safety which cannot be reasonably remediated through local or other mechanisms
    - It is necessary to provide detailed guidance for the profession on the limited circumstances in which a referral should be made, and how such matters are to be handled by the Board / AHPRA, developed in consultation with key professional stakeholders, including MIGA.

8.2 - Risk management

8.2.1 Acknowledging that all doctors share responsibility for clinical governance.

40. MIGA acknowledges that all doctors share some level of responsibility for clinical care.

41. The relative level of responsibility any doctor has is reflective of their position and comparative degree of influence. MIGA is concerned that the proposed sub-section does not reflect adequately this reality.

42. In addition, the term '*clinical governance*' could be interpreted to mean the management of a hospital, clinical or other health facility. This is not something many doctors outside ownership or management have any degree of control or influence over. Instead, their control and influence is limited to 'on the ground' care.

43. MIGA proposes the sub-section be reworded to read:
    Acknowledging that all doctors share ***some level of*** *responsibility* ***around the delivery of health care in the context in which they practice, commensurate with their position and degree of influence****.*

8.3 - Doctors' performance — you and your colleagues

44. Given the section deals with doctors' performance and health, MIGA proposes the section heading be reworded to read "*8.3 Doctors' performance and health – you and your colleagues*".

10.4 - Vexatious complaints

45. Given the damaging impact of vexatious complaints, MIGA believes it is important to emphasise this; that they are unacceptable and explain how the good faith protections under s 237 of the National Law will not apply to such complaints.

46. MIGA proposes the following changes to this new section in the draft code:
    - A new fourth sentence be added to the first paragraph under the 'Vexatious complaints' heading (before "*Good medical practice involves…*") as follows:
        Vexatious complaints can have significant effects on the health, well-being and practice of those affected. They are unacceptable.
    - A new second sentence be added to the second paragraph, so it would read:
        The Board may take regulatory action against a medical practitioner who makes a vexatious notification about another health practitioner. ***Vexatious complaints also lack the legal protections for complaints made in good faith. Those adversely affected could take legal action against the complainant, such as via a defamation claim****.*

10.5 - Medical records

47. In MIGA's experience, doctors can be unsure of their obligations around clinical record-keeping, which can vary depending on purpose and location.

48. It would be helpful for the code to make reference to the range of record-keeping obligations which doctors face.

49. MIGA proposes the following additional sub-section:
    10.5.10 Being aware of legal and other obligations around record-keeping, including by Medicare and under various state and territory laws. You should seek advice from your professional college, association or professional indemnity insurer if you are uncertain of your obligations.

10.7 - Advertising

50. Given the range of advertising regimes which doctors may be subject to, MIGA proposes that the first paragraph under the heading 'Advertising' be reworded to read:
    …All advertisements (including on social media) must conform to relevant competition and consumer protection legislation, ***therapeutic goods legislation****, the advertising provisions in the National Law and Guidelines for advertising…*

51. In addition, the section should contain a footnote reference to AHPRA's advertising resources.

10.9 - Medical reports, certificates and giving evidence

52. For the sake of clarity, where doctors are sometimes asked to complete cremation certificates, MIGA proposes that these certificates also be referred to in the first paragraph under the heading 'Medical reports, certificates and giving evidence'.

11.2 - Your health

11.2.3 *Seeking help if you are suffering stress, burnout, anxiety or depression*

53. MIGA is concerned that this creates an expectation that doctors will seek professional assistance for any and all issues of stress, burnout, anxiety or depression which arise.

54. There will be many situations where these issues can be managed without the need for professional help.

55. In MIGA's view, the key question is whether such issues may significantly affect a doctor's performance or put patient safety at risk. Those are the situations where there is properly an expectation that a doctor will seek help.

56. MIGA proposes the sub-section be re-worded to read:
    Seeking help if you are suffering stress, burnout, anxiety or depression ***which is significantly affecting your practice and / or which may put patient safety at risk****.*

11.3 - Other doctors' health

11.3.2 Notifying the Medical Board of Australia if you are treating a doctor whose ability to practise is impaired and has placed, or may place patients at risk. This is always a professional responsibility and in some jurisdictions, may be a statutory responsibility under the National Law.

57. Given the confusion in the medical profession around interpreting mandatory reporting obligations, it is imperative that these obligations be stated clearly.

58. The term 'impairment' under s 5 of the National Law includes both a clinical condition and adverse impact on practice. There is a significant risk that reference to 'impairment' alone, without more, might mean doctors interpret it as relating to a clinical condition only.

59. MIGA proposes that the sub-section be reworded to read:
    Notifying the Medical Board of Australia if you are treating a doctor:
    - *whose ability to practise is impaired****, which occurs if they have a physical or mental impairment, disability, condition or disorder that detrimentally affects or is likely to detrimentally affect their capacity to practice medicine; and***
    - *has placed, or may place patients at risk.*

    This is always a professional responsibility and in some jurisdictions, may be a statutory responsibility under the National Law.

60. MIGA has concerns about the lack of specificity and guidance around the professional obligations on treating doctors to report doctors under their care.

61. As observed in its submission to the COAG Health Council consultation on treating practitioner mandatory reporting, MIGA believes there needs to be clearer guidelines on ethical and professional reporting obligations of treating doctors. It sees this as something to be developed in conjunction with the intended review of the Board's mandatory notification guidelines, following the outcome of anticipated reforms around treating practitioner mandatory reporting.

62. In relation to sub-section 11.3.3, MIGA suggests adding that doctors consider seeking advice from their professional indemnity insurer in addition to a doctors' health program.