

NATIONAL CODE OF PROFESSIONAL CONDUCT



WOMEN'S HEALTH VICTORIA

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Good Medical Practice: A Draft Code of Professional Conduct

INTRODUCTION

Women's Health Victoria is a statewide women's health promotion, information and advocacy service. We are a non government organisation primarily funded by sections of the Victorian Department of Human Services. We work with health professionals and policy makers to influence and inform health policy and service delivery for women.

The work of Women's Health Victoria is underpinned by a social model of health. We are committed to reducing inequities which arise from the social, economic and environmental determinants of health. These determinants are experienced differently by women and men. By incorporating a gendered approach to health promotion work that focuses on women, interventions to reduce inequality and improve health outcomes will be more effective and equitable.

The vision of Women's Health Victoria is for a society in which there is an accepted approach to health that is empowering and respectful of women and girls; one that recognises the importance of gender in determining health outcomes and utilises a sound gender analysis in policy making and in health and community service design.

We work towards achieving this vision by incorporating the principles of integrated health promotion. This is implemented by:

- Having a strong focus on working in partnership with other organisations and opinion leaders. We use credible tools to determine and strategically plan for the creation of new partnerships and the development of existing ones.

- Using a mix of health promotion interventions that are focused at the population level to achieve our vision – a significant amount of our activity is spread across evidence-based health information provision, policy support, advocacy, social marketing and sector based capacity building.
- Clearly defining our community of interest as individuals and organisations that work in areas which influence health outcomes. Our community of interest includes but is not limited to health promotion practitioners, service and information providers, policy and opinion leaders, and researchers and educators.

SUBMISSION

Women's Health Victoria welcomes the opportunity to participate in the Australian Medical Council's consultation process. Please accept the following submission in response to *Good Medical Practice: A Draft Code of Professional Conduct*.

1. Purpose of the Code

Women's Health Victoria (WHV) welcomes the development of this Code. In the move to a national registration process for medical practitioners it is important to also have national standards for the ethical and professional conduct expected of doctors by their professional peers and the community.

WHV particularly welcomes the inclusion of community in the development of this code and that the Code will be addressed to doctors and the community.

With increasing numbers of medical practitioners being educated overseas or who come from a diverse range of cultures with varying belief systems, an Australian standard of ethical and professional conduct will help to ensure continuity of practice and conduct among professionals.

A point to note is that the document appears to be based on the assumption that all doctors are in private practice. This is clearly not the case and would need to be addressed in a redraft.

2. Overriding duties and principles of good medical practice

We support the explanation in Section 1.2 of 'must and should'. The wording makes it clear that 'must' is an overriding duty and 'should' provides an explanation of how to meet the overriding duty.

WHV welcomes the explanation that reference to the patient also includes their legal agent or statutory decision maker. This is of particular importance where medical practitioners do not follow medical power of attorney instructions in medical intervention decision making.

3. Core principles

This part of the code is critical as the rest should flow from this.

The way in which the ethical pillars, fundamental qualities and then three other principles are constructed is confusing. The language is past tense: 'traditionally doctors have been expected etc' and 'doctors have also been expected' and then 'three other principles are key to good medical practice' etc. The three other principles comes in almost as an afterthought.

The use of 'must' and 'should' in this section would help to contextualise it as current and required practise.

WHV strongly supports patient-centredness as a principle. We recommend that section be significantly expanded on to specifically illustrate how doctors would meet this criterion.

4. Providing good care

Section 2.2 Good patient care needs to include a 'must' statement that reflects more specifically the introductory passage: 'referring a patient to another practitioner when this is in the patient's best interests'.

Point 2.2.6 is a passive statement that would better be worded: 'make known your support for the patients' right to a second opinion'.

We suggest two additional points aimed at professionals. The first could read: 'facilitate informed consent to treatment by providing time and information to the patient, ensuring that the format and language of the information is accessible to them'.

The second is directed at service provision in general. It is the inclusion of a statement about treatment facilities ensuring that they are welcoming to diverse communities and accessible to people with disabilities. Accessibility would include appropriate examination tables or couches for women with disabilities.

Point 2.4 should provide an explicit guideline for balancing the doctor's right to exercise a conscientious objection and the patient's right of access to medical care. This needs to include a reference to the patient's rights to access reproductive health services including contraception and termination of pregnancy services.

5. Working with patients

WHV supports the inclusion of specific statements around informed consent, including those pertaining to fees and charges, and practitioners whom a patient might be referred to. We suggest adding the following: 'including if the service is at no additional cost to the patient as it is Medicare bulk billed or provided by the public health system.'

Point 3.6, Children and vulnerable patients, appears to frame children as being equal to vulnerable patients. The points within this section would read better if they were framed

from the viewpoint of caring for vulnerable patients, which includes children. Each of the points could then be couched in terms of all patients who may be vulnerable.

We consider that Point 3.6.2 needs redrafting, and in this include recognition that those living with disabilities and the elderly may also be at risk from a person in a carer position.

Point 3.9 End-of-life care should include express provision for the doctor to facilitate and respect end of life decision making and advance medical orders and to recognise when a medical power of attorney is in place to be implemented.

6. Working with other health professionals

WHV welcomes the recognition of multidisciplinary health service provision. This section could be strengthened by emphasising that referral may involve transfer of whole and permanent responsibility of the patient, as in the case of a doctor with a conscientious objection to providing ongoing advice and services to women and men around birth control and termination of pregnancy.

7. Working within the health care system.

This section would be strengthened with the addition of a clause which encourages the development and application of knowledge about gender differences in health behaviour and health outcome.

Point 5.5 Culturally sensitive services - This section would be strengthened by making explicit that the interpretation of culture goes well beyond language and ethnicity. We suggest the following: 'recognition that the Australian population is highly diverse across and within many groupings including disability, gender, indigeneity, faith, ethnicity, language, age and sexual identity.'

8. Maintaining patient risk.

We support the inclusion of a clear and unequivocal responsibility on doctors to take all available steps when they 'have good reason to think' that patient safety 'is or may be compromised'. Point 6.2.5 should be split so that the sentence on open disclosure stands as a separate point. This point should relate to all doctors, not just those with management responsibilities. It needs to state that doctors must implement the principles of open disclosure and a non-punitive approach to adverse error management and share the learnings from such processes.

Point 6.4 Conduct and performance of colleagues sub point 6.4.3 assumes there is no role for discussing concerns with the employer if the doctor is an employee.

9. Maintaining good standards of medical practice

We support the statements in this section.

10. Professional behaviour

The clarity of this section is welcome. It clearly articulates that the onus of responsibility lies with the doctor. We suggest adding a clause into the Professional boundaries section, which states: 'you are required to make effective referral if your personal beliefs are a barrier to informed decision making by the patient.'

We strongly support clause 8.12 Conflicts of interest and the explanation of what constitutes a conflict, and the statement that doctors must resolve such conflicts in accordance with the best interests of the patient. The clarity of the statements in regard to referral, inducements, and fees for sales representatives or commercial interest is also welcome. It could be further strengthened by adding that a professionals' moral or religious views must not limit the range of services available to the community they service, particularly if she or he is a sole practitioner in a single doctor community.

11. Ensuring doctor's health

We support this clause.

12. Teaching, supervising and assessing

We support this clause.

13. Undertaking research

We support this clause.

Appendix 1, Independence from pharmaceutical and medical device promotion and advertising could be referred to in this section.