



Good Medical Practice: A Draft Code of Professional Conduct

**Consultation Submission to the working party of the
Australian Medical Council**

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CONSULTATION PAPER

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The Mental Health Coordinating Council (MHCC) is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW representing the views and interests of over 200 NGOs. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development.

The organisation consults broadly across all sectors in order to respond to legislative reform, and sits on numerous National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC is a member of the NSW Health Complaints Commission Consumer Consultative Committee. MHCC also manages and conducts research projects, develops collaborative programs on behalf of the sector, and is an accredited training and professional development provider for the sector.

- We note that item 1.2 of the code refers to the anticipation that the code will be adopted by the new national medical board. We wish to draw the AMC's attention to our concerns with regards to complaints handling aspects of the proposed National Registration and Accreditation Scheme for Health Practitioners under the COAG agreement. We have provided a part of our submission to the Practitioner Regulation Committee attached as Appendix 1.
- MHCC propose that whilst statements and definitions in the Code of Professional Conduct reasonably describe the standards of ethical and professional conduct that the profession and community might expect, we strongly encourage attention be paid to the language used. We propose that the Code better reflects a socially inclusive model of practice that minimises (as far as possible) the power imbalance that exists between doctor and patient.

1.4 Core ethical principles and qualities of good doctors

Respect: we suggest this be defined reflecting a broader use of language that respects the essential humanity, diversity, worth and dignity of all people, and the promotion of this value in the work doctors undertake. Likewise, the definition of *core ethical principles and qualities of good doctors* needs to not merely *respect a patient's autonomy and the right of individuals to make their own decisions...* but to promote patient autonomy, encourage patients to make decisions on their own behalf, protect patients' rights, including the right to informed consent. MHCC also propose that doctors should be actively encouraging patients to ask questions and offering information rather than adopting a passive, paternalistic or merely respectful stance.

We note that this concept is addressed in the fundamental quality of *patient-centredness*. However, we suggest in *recognition* of the power imbalance between patient and doctor (3.2.7) that the *patient-centredness* quality needs to be proactively promoted. This can be particularly important in cultural and ethnic contexts, and in doctor-patient relationships with marginalised members of the community such as the homeless, people with disability including psychiatric disability and those who have suffered trauma and abuse.

3.6 Children & vulnerable patients

MHCC are particularly concerned with regards to the language used in item 3.6 of the Code. We ask the AMC to consider the appropriateness of lumping *Children & vulnerable patients* together under one heading. We suggest that people with *disabilities and the elderly* might judge this as very patronising language.

Society has placed doctors on a pedestal as ‘experts’, the professional culture frequently supports this view, and they not unnaturally turn to their specialist expertise and training to ‘fix’ a problem.¹ People with disability, whatever their impairment, are demanding that their disability be viewed through their lived experience: that they are the experts in what they need, and that society and the medical profession must not impose its definitions of normality.

Doctors and service providers respect and respond to individual perspectives, recognising how the ‘*medicalisation*’ of disability has disempowered the very people they have sought to support. Doctors must be alert to their subjective perception of *vulnerability*, disability and capacity and seek to minimise barriers to autonomy.

We note that the term *vulnerable* is nowhere defined in any of the State’s Medical Practices and other relevant Acts. MHCC propose that consideration be paid to using defined terminology in the various Acts, so as to provide consistent meaning.

Further, in relation to item 3.6 we suggest that greater detail be provided regarding principles that apply to children and young people with regards to confidentiality, privacy and mandatory reporting. Item 3.6.1 talks about *safeguarding and protecting*, whereas item 3.6.2 talks about being *aware of the welfare of children at risk*. Whilst acknowledging that mandatory reporting is entrenched in the law, we suggest that the item 3.6.2 is weak language describing the duty of care obligations under the law.

We would also support codes of conduct for the reporting of domestic violence to be outlined in the code although it is not mandatory, and refer to protection of the notifier.

3.5 Informed Consent

MHCC suggest that item 3.5 include content regarding the complexity of informed consent when dealing with patients under the various Acts, such as the NSW Mental Health Act 2008, and the NSW Guardianship Act 1987.

¹ Oliver, M. (1990). The Individual and Social Models of Disability. Paper presented at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians UK, p.3.

3.7 Relatives, carers and partners

In item 3.7 the Code refers to *relatives, carers and partners*. MHCC propose caution with regard to the hierarchy of those 'close' to a patient. Frequently patients do not want certain family members consulted or informed, and professionals need to be aware of the role of carers, particularly young carers and de-facto partners. Similarly, attention should be paid to children and some people from culturally and linguistically diverse communities, i.e. women and others less empowered in the community. We suggest the appropriate order might be **partners, carers and families**.

8.11 Financial and commercial dealings

In item 8.11 the code emphatically states that Doctors *must... Not exploit... Not encourage* However in item 8.11.3 the work used is *Avoid* in relation to financial involvement such aswith patients. We propose that this word is not sufficiently forceful. And suggest the following as more appropriate:

Other than payment for professional services provided to patients, do not engage in financial involvement such as loans and investment schemes with patients.

MHCC thank the Australian Medical Council for giving us the opportunity to provide input into discussions regarding the Good Medical Practice: Draft Code of Professional Conduct, and look forward to the outcome of the AMC's deliberations.

Appendix 1

CONSULTATION PAPER Proposed arrangements for handling complaints, And dealing with performance, health and conduct matters

'The Mental Health Coordinating Council (MHCC) support the decision signed by COAG in March 2008 to create a national registration scheme for health professionals under one national board. However we understand that the original agreement was to create a single registration body for nine categories of health professionals. This was later amended to a national scheme with nine separate national registration boards to be formed for each category of professionals. We do not support this development. MHCC unable to understand the rationale for this amendment to the original concept, assume that it is based on the question as to who might be responsible for funding one national registration board, as opposed to responsibility falling to the separate professions to fund their own boards.

We support a national accreditation scheme since it seems entirely appropriate that a national body oversee clinical and registration accreditation standards of both local and overseas professionals, streamlining interstate movement of professionals. This is likely to bring benefits to consumers in terms of uniform verification, flexibility and enhanced access to health professionals in rural, regional and remote areas of Australia.

However, MHCC are extremely concerned that the proposed model for complaints handling will result in the onus being placed upon the complainant to gather the evidence necessary to investigate a complaint, since national registration boards do not have the capacity to exercise this duty, or necessarily possess the expertise and skills of dedicated professionals.

In NSW, the protective role is conducted by the Health Care Complaints Commission (HCCC), an independent body with teams of skilled experts to conduct assessments; refer complaints for resolution or conciliation or make decisions not to proceed; and to conduct investigations with legal experts to progress proceedings. The HCCC has a co-regulatory role with numerous registration boards. In any dispute, the two bodies can negotiate how a matter may proceed.

The Commission acts to protect public health and safety by resolving, investigating and prosecuting complaints about health care established under the Health Care Complaints Act 1993.

The Act defines the scope of the Commission's work, which is to:

- receive and assess complaints relating to health service providers in NSW
- resolve or assist in the resolution of complaints
- investigate serious complaints that raise questions of public health and safety
- prosecute serious complaints

The consultation paper suggests that protection of public health and safety by resolving, investigating and prosecuting complaints is to become the responsibility of the nine registration boards, which will be primarily comprised of members of the particular health profession. This may well lead to investigations conducted *in camera* with little or no access to legal representation or appeal processes for the complainant. Conversely, the professional under investigation may well be allowed a right of appeal to his/her registration board. This model of self-regulation is totally contrary to principals of natural justice; transparency; review and appeal.

MHCC suggest that the nine boards will not easily replicate the skills of an independent body such as the HCCC, and that this will result in either a duplication or absence of skills across the boards. Moreover, it will result in additional costs to practitioners which will likely be passed on to users of health services.

We suggest that the community will respond negatively to this perceived lack of transparency in the management of complaints, possibly framing it as a response by Governments to suppress widespread community concern about the safety of health service users, and paying little heed to calls to improve complaint and disciplinary processes.

MHCC propose that it is totally inappropriate for a body registering and regulating a profession to conduct any stage of assessment, investigation or prosecution of allegations of professional misconduct, non-adherence to codes of conduct, standards and guidelines and professional incompetence. Should such a system be established, we believe this will represent a retrograde step from the existing independent and transparent process serving consumer interests in NSW, to a protectionist self regulatory model in which responsibility may fall to the consumer to gather the evidence necessary to initiate and conduct proceedings. We are also concerned that consumers may find that they are less able to participate in proceedings or have access to review and appeal.

Whilst MHCC support the current NSW system as conducted by the HCCC, we propose nonetheless that the system be reviewed in the light of evidence in other jurisdictions in Australia and overseas. The objective being to develop a model that is even more transparent and accountable than the one currently operational in NSW.

MHCC respectfully ask Ministers to reflect on the proposed new arrangements under the COAG agreement, not only as politicians and parliamentarians but as consumers of health services. We ask them to consider the degree to which they would have confidence in an investigation into their own health complaints matters if conducted under the self-regulatory model outlined in the consultation paper, as opposed to the existing independent NSW model or an improved evidence based model.