The Australian Medical Council draft code of professional conduct: good practice or creeping authoritarianism?

John B Myers

To the Editor: The expert working party that developed the Australian Medical Council (AMC) draft code of professional conduct referred to by Komesaroff and Kerridge[1] was chaired by Joanna Flynn, past President of the Victorian Medical Practitioners Board (MPB [Vic]). Herein lies the crunch. The AMC is surely meant to be an independent and objective body — yet if it is aligned with the MPB (Vic), how can this be the case?

Komesaroff and Kerridge state that the appendices to the AMC's draft code "quote extensively (without attribution) the conclusions of guidelines developed by the Royal Australasian College of Physicians" and that "in the AMC's version, the evidence, context and argumentation are omitted and the recommendations are presented as legally binding".[1] If this is the case, there is cause to question the integrity of the drafters of the code, to fear the code's implications, and to request "that the whole process that gave rise to it be rigorously reconsidered".[1]

Plagiarism cannot be condoned. To attribute honestly and give credit where credit is due is central to ethical practice, scientific discovery, education, accountability and learning. Similarly, context matters. In my opinion, integrity, the basis of ethics and morality, is measured by the extent to which context is valued and conceded. Ethical conduct demands both honesty and integrity.

Doctors and the public, and government surely, place their trust in the AMC to objectively evaluate governing practices, laws and regulations, such as the *Health Professions Registration Act 2005* (Vic) ("the HPR Act"), under which the MPB (Vic) operates, as well as professional conduct. Yet the authors of the AMC draft code fail to address the issue of the accountability of regulatory bodies and the fact that the HPR Act contains no benchmark for excellence: because context is omitted from the Act, "unprofessional conduct" cannot be defined and becomes relative. This leaves it open for any third party, including members of the regulatory authority itself, to abuse doctors and patients by being dismissive of the patient's view (and thus, context), while claiming to protect patients and guide doctors.

By contrast, the *Medical Treatment Act 1988* (Vic), which is not mentioned in the AMC draft code, provides a benchmark for excellence in clinical practice with reference to both doctors and patients. This Act specifies (a) that the wishes of the patient to refuse treatment be respected, and (b) that medical practitioners who act in good faith in accordance with the patient's expressed wishes be protected from any civil or criminal liability or disciplinary action by the regulatory board.[2]

As doctors, we are the naturally appointed advocates of our patients' health preferences and wellbeing. Ensuring that choices are made for the patient's benefit requires honesty and integrity at all levels of government.[1,3,4] When a failure occurs in the system, it is imperative to have avenues of awareness, transparency, protection and evaluation available through public action and professional debate.[1,3,5]

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1 Komesaroff PA, Kerridge IH. The Australian Medical Council draft code of professional conduct: good practice or creeping authoritarianism? *Med J Aust* 2009; 190: 204-205.
2 Biegler P, Stewart C, Savulescu J, Skene L. Determining the validity of advance directives. *Med J Aust* 2000; 172: 545-548.
3 Myers J. Ethics and professional medical opinion and guardianship and administration legislation. *Intern Med J* 2006; 36: 540-541.
4 Justice Buchanan and Justice Nettle. Supreme Court of Appeal. Leave application. Myers v Medical Practitioners Board of Victoria [2007] VSCA 163.
5 Sweet MA, Chapman S, Moynihan RN, Green JH. CHAMP: a novel collaboration between public health and the media. *Med J Aust* 2009; 190: 206-207. ❑

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In reply: The debate about the proposed national code of conduct ("the Code") has raised a number of important issues, including those highlighted by Myers. The original draft aroused serious concern in the community about the potential role of a centralised bureaucracy with the power to enforce a set of precepts derived from a narrow, largely discredited, philosophical perspective. Although the revised draft now circulated for public comment is admittedly less objectionable than its predecessor, significant concerns remain relating to both its form and its content.

The main issues are still the purpose and role of the Code and the confusion between ethical and legal discourses on which it is based. In a multicultural society in which pluralism and diversity are themselves regarded as inherently valuable, the very concept of a unitary set of criteria that define good practice is questionable. In this setting, the proper roles of codes of conduct and of ethics are not to enforce particular kinds of outcomes, but rather to inform and enrich practice. If the Code were devised as an educational process to stimulate clinicians to reflect critically on their existing practices and underlying values, it would be much more likely to change behaviour and increase community wellbeing.

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