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

Paul A Komesaroff and Ian H Kerridge

ABSTRACT

- In preparation for a national medical registration system, the Australian Medical Council has proposed a code of conduct ("the Code") that provides a comprehensive description of how doctors should behave.
- While containing much that will be widely acceptable to doctors, the Code has some major weaknesses:
  - Many of its provisions focus on values and aspirations of a very general nature and will be impossible to enforce.
  - It is based on a narrow, culturally specific view of medicine and ethics that does not reflect the multicultural diversity of Australian society.
  - It confuses the roles of ethics and law in medicine, leading to inappropriate and mistaken injunctions about decision making and responsibilities.
  - In place of the existing, effective, democratic and devolved (if imperfect) system of ethical and professional decision making, it threatens to establish a centralised, authoritarian regime.
  - Because of its limited, ideological view of medicine, its implementation would impoverish medical practice and erode the ability to respond to individual circumstances and needs.

MJA 2009; 190: 204–205

In preparation for the new national registration system for medical practitioners about to be introduced in Australia, the Australian Medical Council (AMC) has drafted a code of conduct ("the Code") that is likely to be adopted as a starting point by the proposed National Medical Board.[1] The Code has been compiled by an anonymous "expert working group", which drew heavily on a range of documents from around the world, most notably the *Good medical practice* code of conduct of the General Medical Council of the United Kingdom,[2] the codes of Australian state and territory medical boards, various statements and codes from Australian and New Zealand medical colleges and professional associations, and a select group of texts on ethics.

In the introduction, the Code declares itself to be describing "what is expected of all doctors registered to practise medicine in Australia" and setting "the standard of ethical and professional conduct expected of doctors". As Flynn explains in a recent article in the Journal,[3] the Code aims to define "clear, nationally consistent standards of practice" that can be applied to regulate standards of medical practice and used in the assessment of complaints and allegations of unprofessional conduct against doctors. In other words, the Code is not a mere statement of principles, a discussion document, or a hortatory guide for practitioners seeking to respond to the complexities of daily practice; it is a comprehensive statement of how doctors must behave that will be backed up by the force of law.

It should be stated immediately that most of the actual provisions of the Code appear on the surface to be benign. Indeed, many of its statements will be recognised as fundamental to good patient care. It is unlikely, for example, that anyone would object to recommendations that doctors "be courteous, respectful and honest" (3.2.1), "consider the balance of benefit and harm" (2.2.3), or "encourage patients to take interest in, and responsibility for, their health" (2.2.10), or to the view that provision of good patient care includes "assessing the patient's condition/s, taking account of the history ... the patient's views, and an appropriate physical examination [and] formulating a suitable management plan" (2.1) (see also 3.8 [openness and honesty] and 4.2 [respect for colleagues]).

However, this benign appearance is deceptive, for four main reasons. First, although these provisions are strong imperatives subject to legal sanction, it is very unclear how they could be enforced. What, for example, would be the standards of proof underlying actions relating to the obligations to "seek to act as a positive role model for your fellow team members" (4.4.4) or to "treat each patient as an individual" (3.2.3)?

Second, and more fundamentally, the Code overtly bases itself on a concept of ethics that it refers to as the "traditional" "core ethical principles and qualities of good doctors" (1.4). This is curious, as the core ethical principles referred to do not have an ancient lineage (particularly justice and respect for autonomy, which are relatively recent constructions, at least in health care), and the virtues referred to represent just one reading of virtue ethics.[4] The view that medical practice rests on the four ethical pillars of "respecting a patient's autonomy", "beneficence", "non-maleficence" and "justice", which originated in the United States in the 1960s and has characterised the highly individualistic and culturally specific form of contemporary American bioethics, has been the subject of extensive critiques that draw attention to different accounts of morality, communication, relationships and social meaning. As these debates show, principles can sometimes help clarify regions of substantial contemporary agreement, but they are just one element of moral decision making and their significance should not be overstated.[5]

The basic commitment of the Code to a narrow, inadequately founded ideology has strong implications. Of particular note is the emphasis on outcomes and a disregard for the processes of dialogue across cultural, religious and philosophical perspectives that shape ethical decisions and professional behaviour. This, in turn, reflects a lack of appreciation of the significance of the multicultural diversity of Australian society.[6] The discussion of consent in the Code demonstrates the consequences of this cultural narrowness (3.5), there being no allowance for the possibility of different cultural standards of disclosure or the key role in some cultures of family and group decision making.

The third reason why the Code cannot be regarded as purely benign is that it contributes to an insidious, creeping authoritarianism that — at least in the case of medical practice — threatens to erode the core values of a culture that has developed over many years. Under the banner of "good practice", it is proposed to

supplant a devolved and democratic, if somewhat clumsy, system of ethical and professional decision making with a centralised, narrowly defined legislative charter with punitive force assembled out of a collection of codes and guidelines from around the world.

To argue in this way is not to claim that every aspect of existing practice is beyond reproach. Quite the contrary: medical ethics and professional behaviour are vigorous and fecund battlegrounds for argument and controversy about contending social values, cultural attitudes, philosophical perspectives and religious beliefs. Many practitioners, including we ourselves, are fully committed to the struggle to enhance doctors' awareness of their ethical obligations and to improve behaviour in all the areas covered in the draft Code. What is at stake is the nature of the processes that underlie ethical and professional discourse.

We believe that an attempt such as this to define standards and to regulate medical practice through the imposition of a comprehensive and elaborate set of quasi-legal rules is likely to be counterproductive. It reflects a confusion between the roles of law and of ethics. The distinction between these two spheres is an ancient one, which derives from the separation of private and public realms that originally made society possible.[7] The legal apparatus aims to regulate and stabilise existing patterns of relationships and maintain power structures. Ethics involves communicative interchanges between individuals — the part of the social world that is experienced and shared and in which rules are fashioned in relation to agreed needs and a shared conscience. Law is global, abstract and universally applicable, while ethics is local, context-sensitive and highly dependent on interactions between individuals.[8]

The blurring of this critical distinction leads directly to the fourth major shortcoming of the Code: that its implementation would lead to a distortion and impoverishment of medical practice. The fine details of the conduct of clinical relationships cannot be represented in a set of injunctions relating to styles or outcomes of behaviour, no matter how elaborate. Although clinical practice may refer indirectly to universal principles, in its details it is singular and specific, responding to individual circumstances and needs. Like other kinds of professional and moral behaviour, it thrives on diversity, discontinuity and difference. This is especially true in the multicultural and pluralistic setting of Australian society.

The section of the Code dealing with end-of-life care illustrates this point well (3.9). This area of clinical care requires exquisite sensitivity on the clinician's part and covers a wide range of issues. These include the management of physical and psychological pain and the negotiation of mourning, bereavement, uncertainty and hope, often in rapidly shifting physical, psychological and emotional settings.[9] In end-of-life care, good practice does not involve following rules, no matter how carefully crafted those rules appear to be. It cannot be reduced to a set of injunctions declaiming the virtues of palliation, withdrawal of care and communication with families. Whether we like it or not, good end-of-life care involves a shared journey involving doctors, patients and families. It requires openness, flexibility, and an acceptance that the chasm of meaning opened up by death cannot be closed by technical behaviour, no matter how skilful it may be.[5]

There is a clear place for guidelines to help stimulate reflection and dialogue among the partners in ethical relationships. However, the status of such guidelines as advisory resources should be carefully preserved. Here too, the limitations of the Code as a universally applicable set of obligations are clearly demonstrated. For example, the appendices, which refer to relationships with industry and research, quote extensively (without attribution) the conclusions of guidelines developed by the Royal Australasian College of Physicians (RACP) (Appendices 1 and 2; see also section 11).[10] However, the RACP guidelines openly and explicitly state that they seek to provide evidence and arguments to empower doctors and patients to decide for themselves on the most appropriate courses of conduct. Detailed discussions are supplemented with advisory recommendations. In the AMC's version, the evidence, context and argumentation are omitted and the recommendations are presented as legally binding. This is a distortion of ethical discourse and, for the reasons given, is more likely to undermine than enhance ethical conduct.

Codes of conduct can foster and reinforce the strength and effectiveness of professional communities and moral norms and processes. However, they can also provide a vehicle for oversimplifying the moral world, stripping ethics of its context, and supporting an excessively rigid, restrictive and narrow moral regime. They can either expand the ability of individuals to make their own decisions and maximise their opportunities for ethical action, or they can claim authority beyond their capacity and encourage the belief that good practice simply involves following a formula or applying rules. We fear that the Code is not a progressive step forward and suggest that the whole process that gave rise to it be rigorously reconsidered.

Competing interests

None identified.

Author details

Paul A Komesaroff, MB BS, PhD, FRACP, Professor of Medicine and Director, Centre for Ethics in Medicine and Society[1]
Ian H Kerridge, FRACP, FRCPA, MPhil, Associate Professor of Bioethics and Director, Centre for Values, Ethics and the Law in Medicine[2]
1 Monash University, Melbourne, VIC.
2 University of Sydney, Sydney, NSW.
Correspondence: paul.komesaroff@med.monash.edu.au

References

1 Australian Medical Council, on behalf of the medical boards of the Australian states and territories. Good medical practice: a draft code of professional conduct. Canberra: AMC, 2008. http://goodmedicalpractice.org.au/wp-content/downloads/DraftCodeOfConduct.pdf (accessed Oct 2008).
2 General Medical Council. Good medical practice (2006). London: GMC, 2008. http://www.gmc-uk.org/guidance/good_medical_practice/index.asp (accessed Dec 2008).
3 Flynn JM. Good Medical Practice: developing an Australian code [editorial]. *Med J Aust* 2008; 189: 477-478.
4 Kerridge I, Lowe M, McPhee J. Ethics and law for the health professions. Sydney: Federation Press, 2005.
5 Komesaroff PA. Experiments in love and death. Melbourne: Melbourne University Press, 2008.
6 Jupp J, editor. The Australian people: an encyclopedia of the nation, its people and their origins. Cambridge: Cambridge University Press, 2001.
7 Habermas J. Between facts and norms: contributions to a discourse theory of law and democracy. Cambridge, Mass: MIT Press, 1996.
8 Komesaroff PA. The relationship between law and ethics in medicine. *Intern Med J* 2001; 31: 413-414.
9 Komesaroff PA. Uses and misuses of ambiguity: uses of ambiguity. *Intern Med J* 2005; 35: 632-633.
10 Komesaroff PA, Carney S, La Brooy J, et al. Guidelines for ethical relationships between physicians and industry. 3rd ed. Sydney: Royal Australasian College of Physicians, 2006.

(Received 19 Oct 2008, accepted 8 Dec 2008) ❑