

Normative lessons: codes of conduct, self-regulation and the law

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The advent of national registration of doctors allowed the development, by the Australian Medical Council (AMC), of *Good medical practice: a code of conduct for doctors in Australia*¹ during 2008 and 2009. The AMC Code will provide standards against which complaints about doctors to the new Medical Board of Australia (MBA) (<http://www.medical-board.gov.au/>) will be determined.

Public consultation on the initial draft resulted in changes to the content, wording and general style of the final AMC Code.² A critique by Komesaroff and Kerridge, published in the *Journal*,³ found the initial draft wanting, because (a) it amounted to a quasi-legal, not an ethical code; (b) it adhered to a narrow, “inadequately founded ideology” (known as bioethical principlism); (c) it would contribute to a “creeping authoritarianism” that would threaten the core values of medical culture; and (d) implementing such a prescriptive code would consequently distort and impoverish medical practice. The components of their critique constitute a general view, against which this article clarifies the fundamental normative role, and the legal status and enforceability of professional ethical codes.

The draft AMC Code’s preamble anticipated that it would be adopted by the MBA and “apply in the regulation of medical practice in the future”. The regulatory role was underlined by the frequent use of “You must ...” clauses in cases of an overriding duty or principle, and of “You should ...” clauses in relation to implementing such duties, or in cases where *prima facie* duties might be attenuated by exceptions or constraining factors. During the consultation process, this strong imperative tone was condemned, particularly by the medical profession. For example, the joint submission by the Australian Medical Association (AMA)⁴ accused the AMC Code drafters of rendering professional ethics as “merely a script for interaction with a client”, of assuming that there is an absence of ethical principles within the profession, and assuming “to lower core principles which are entrenched in the profession” by documenting “prescriptively behavioural guidelines”. According to the submission, the draft AMC Code’s prescriptivity would undermine medical professionalism and trust in doctors, patronise and alienate the profession, and limit the use of professional judgement and clinical independence in relation to individual patients and circumstances. The AMA joint submission implied that there would be conflicts between what the rules of the AMC Code required and the best interests of patients, and called for a more supportive and less prescriptive tone, with imperative phraseology restricted to situations agreed to have no exceptions.

The AMC working group accepted the perception of an unduly authoritarian tone and the emphasis in the AMC Code on regulatory purposes at the expense of guidance for doctors as key issues raised in the AMC consultation process.² The final consultation draft and the finished AMC Code capitulated to the criticisms of creeping authoritarianism, regulatory primacy, lack of support for medical professionalism, and focus on bioethical principlism. As a result, the imperative “You must ...” phrases were replaced by various specifications of good medical practice. So “You must maintain adequate records” became “Good medical practice involves maintaining adequate records”, and “A good doctor–

ABSTRACT

- *Good medical practice: a code of conduct for doctors in Australia* provides uniform standards to be applied in relation to complaints about doctors to the new Medical Board of Australia.
- The draft Code was criticised for being prescriptive. The final Code employs apparently less authoritative wording than the draft Code, but the implicit obligations it contains are no less prescriptive.
- Although the draft Code was thought to potentially undermine trust in doctors, and stifle professional judgement in relation to individual patients, its general obligations always allowed for flexibility of application, depending on the circumstances of individual patients.
- Professional codes may contain some aspirational statements, but they always contain authoritative ones, and they share this feature with legal codes.
- In successfully diluting the *apparent* prescriptivity of the draft Code, the profession has lost an opportunity to demonstrate its commitment to the *raison d’être* of self-regulation — the protection of patients.
- Professional codes are not opportunities for reflection, consideration and debate, but are outcomes of these activities.

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patient partnership requires high standards of personal conduct. You must [inter alia] treat each patient as an individual” became “A good doctor–patient partnership requires high standards of professional conduct. This involves [inter alia] treating each patient as an individual”.

The AMA supported the final AMC Code, as the drafters had taken on board its suggested modifications and inclusions, including the importance of professional judgement and individual patient circumstances, and the commitment of the profession to high ethical and professional standards.^{5,6} But what is the difference between the alternative expressions in the draft and final AMC Codes? While statements about what good medical practice *involves*, rather than what doctors *must do*, might sound as if they provide more latitude for professional judgement, this is simply not the case. In the alternative expressions, the difference is merely that the imperative is implied rather than explicit. A statement such as “Good medical practice involves maintaining adequate records” surely leaves no room for maintaining inadequate ones, as long as doctors want to practice good medicine. In addition, the fact that the draft AMC Code did state that doctors must treat patients as individuals also undermines the claim that it failed to allow for professional judgement and clinical independence in relation to individual patients.

The contention that authoritative codes threaten core professional cultural values, such as judgement and independence, and will thereby impoverish practice, is mistaken. It demonstrates a

failure to comprehend the nature of ethical codes by conflating their status and role with those of ethics as an academic and social discipline and activity. For example, Komesaroff and Kerridge claim that law and ethics are distinct: that law regulates and stabilises existing relationships and power structures in a global and abstract way, while ethics is about communication between individuals, establishing rules relating to agreed needs and a shared conscience, and is necessarily local and contextual.³ However, when we think of the Hippocratic Oath,⁷ the World Medical Association (WMA) International Code of Medical Ethics (Declaration of Geneva),⁸ or the AMA Code of Ethics,⁹ in all cases we strike statements of broad ethical principle — ethical imperatives. Authoritative codes are a *sine qua non* of the professions, because their members profess a certain set of values, commitments and obligations. Codes of ethics are centrally concerned with normative authority, even though academic debate continues about the source of that authority.

The Hippocratic Oath and the WMA Code cast their imperatives as first-person commitments, such as “I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan”,⁷ and “I will respect the secrets that are confided in me, even after the patient has died”.⁸ The AMA, which claims to accept “the responsibility for setting the standards of ethical behaviour expected of doctors”, also provides “a body of ethical principles to guide doctors’ conduct in their relationships with patients, colleagues and society”.⁹ Interestingly, the ethical principles that make up its code of ethics are no less imperative than the ten commandments. For example, the AMA Code obliges doctors to “Treat your patient with compassion and respect”, “Maintain accurate contemporaneous clinical records” and so on. These are no different from the “You must ...” locutions of the draft code of conduct.

Ethical codes can lean towards the prescriptive or the aspirational; most include both sorts of exhortation. The codes mentioned so far are more prescriptive than aspirational, although they contain some aspirational elements. For example, the Hippocratic Oath enjoins physicians to carry out their lives and their art in purity and according to divine law. The WMA Code requires physicians to maintain, by all the means in their power, the honour and the noble traditions of the medical profession. The more prescriptive a code provision, the more likely it is to be legally enforceable.¹⁰ It is incorrect to infer from the fact that the draft and final AMC Codes contain much that is prescriptive, that the enforceability of the more aspirational aspects poses a problem,³ because the aspirational aspects and ideal value statements are not intended to have any legal or quasi-legal effect.¹¹ However, the more prescriptive elements of codes of professional ethics have had legal implications for a long time. Noncompliance with aspects of professional ethical codes may result in disciplinary proceedings, and the standard of care in civil proceedings may sometimes refer to standards enunciated in ethical codes.¹²

This said, some prescriptive elements of ethical codes have recently been incorporated into legislation. For example, the imperative that health professionals act appropriately has been incorporated into the *Health Practitioners (Professional Standards) Act 1999* (Qld) in a more detailed format, covering clinical incompetence, unprofessional behaviour, provision of unnecessary services and other unprofessional conduct. In addition, perceived failures in internal professional regulation (self-regulation) have helped prompt the translation of ethical obligations into specifically legal ones. The best recent example of this is the mandatory

reporting legislation in New South Wales (*Medical Practice Act 1992*, s. 71A) and Queensland (*Medical Practitioners Registration Act 2001*, s. 166), which will also be incorporated into the legislation covering national registration (*Health Practitioner Regulation National Law Act 2009* [Qld], ss. 140–143). Professional medical bodies resisted the mandatory reporting legislation, insisting on the efficiency of existing ethical obligations to report lapses in competence or conduct of colleagues.^{12,13} This was similar to the perception of the prescriptivity of the draft AMC Code as an unnecessary and unreasonable overriding of entrenched professional principles.

The irony is that the alleged undermining of professionalism and patient trust by a more prescriptive code is a protest issued after the self-regulatory horse has bolted. The organised medical profession (as an independent profession) would have done better to settle for the draft AMC Code, rather than insisting on its apparently less prescriptive final format, as a statement of firm resolve about keeping its house in order. This is because the prescriptive elements of ethical codes are no less formally normative than legal obligations, although ethical and legal sanctions differ. The profession’s protests about behavioural prescriptivity and authoritarianism in the draft AMC Code seem to reflect the mistaken perception that the AMC Code was being imposed externally,¹⁴ and so the profession has lost an opportunity to demonstrate to the public that it is serious about self-regulation.

The insistence on less rhetorically imperative language was based on the alleged need to retain professional discretion and judgement, but there are no clauses in the AMC Code where this is relevant, and, contrary to the AMAs claim that the revised AMC Code was more responsive to individual patient circumstances, there are no differences between the draft and final AMC Codes in terms of this need. This is because in both draft and final versions, the imperative clauses are statements of principle that apply irrespective of individual patient circumstances. In subsequent correspondence, Komesaroff and Kerridge assert that the AMC Code remains a set of precepts derived from a narrow, largely discredited, philosophical perspective, that “the very concept of a unitary set of criteria that define good practice is questionable”, and that “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”.¹⁵

That bioethical principlism is “largely discredited” is a personal and quite idiosyncratic view.^{16–18} The definition of the proper role of codes as informing and enriching practice is narrow and historically inaccurate, and ignores the fact that even in plural societies, strong ethical consensus exists on numerous issues, particularly in professional areas. There is nothing local or contextual about the obligation of physicians to be courteous, respectful, compassionate and honest, or to facilitate advance care planning, or to ensure that the services they provide are necessary and likely to benefit the patient. Good medical practice involves doing all these things; doctors ought to do these things; doctors must do these things. If these alternative ways of stating what I contend to be the same thing are in fact distinct, then we are owed an explanation, from those who opposed the draft AMC Code’s imperative tone, of how professional discretion would operate in terms of the obligations mentioned.

Miola has provided a helpful typology of “medical ethics discourse” in the UK context, by identifying three different categories of discourse that serve distinct purposes.¹⁹ “Formal

discourse” refers to the General Medical Council as the only UK body empowered by statute to provide ethical advice to doctors. “Semi-formal discourse” emanates from professional groups such as the British Medical Association and the British royal medical colleges, whose advice does not have the same clout as the General Medical Council’s, but is nevertheless significant in a self-regulated profession. “Unofficial discourse” includes the large volume of discussion produced by the academic bioethics commentariat and other contributors to social and ethical debates.

While this hierarchy may not be precisely applicable in the Australian context, its general sense is clear and indicative. As Nietzsche famously stated in *Thus spoke Zarathustra*, “A table of values hangs over every people”,²⁰ and this is as true for the great professions, including medicine. The fact that values are debated and may change over time does not mean that, at any given time, a profession’s ethical code does not and should not function as a set of imperative “facts” that impose obligations on members. The final version of *Good medical practice: a code of conduct for doctors in Australia*, though somewhat linguistically diluted compared with earlier drafts, presents a strongly agreed set of imperatives against which the performance of members of the medical profession will be judged. It is at the stage when such judgements are made that there has always been room for discretion and for context to be taken into account. But codes are developed mainly to enforce particular kinds of outcomes. It is within Miola’s unofficial category of ethical discourse that we find the appropriate space in which to reflect, consider and debate, in order to inform and enrich practice.

Competing interests

None identified.

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