

10 July 2007

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Dear Mr Thorn

### **Review of *Good Medical Practice***

I refer to Philip Pigou's letter of 30 May 2007. Thank you for the opportunity to comment on the draft revised Good Medical Practice publication and for extending the time for comments until mid-July.

This publication is an excellent resource for medical practitioners. I am pleased to see that it is being reviewed, improved and updated. The changes are timely and appropriate. For the electronic version, it would be helpful to have links to other relevant Council statements or guidance.

#### **Introduction – duties and responsibilities**

I suggest that the Code of Health and Disability Services Consumers' Rights (the Code) should be referred to in the general introduction, rather than only in the communication section.

There are a few places in the draft which refer to doctors working within the limits of their competence (eg in the introduction, paragraph three and paragraph 38). It would also be appropriate to refer to "working within their scope of practice".

Doctors should respect a patient's right to both confidentiality and privacy – currently the introduction does not mention privacy.

#### **Health Practitioners Disciplinary Tribunal**

I note that the Health Practitioners Disciplinary Tribunal (referred to in the 'How *Good Medical Practice* applies to you' section) should not have an apostrophe after Practitioners.

#### **Good clinical care**

In point eight of paragraph three, I suggest that it should refer to treatment being in the patient's best interests. This paragraph seems to envisage repeat prescriptions being permissible in rather limited situations. I query whether such a narrow approach really reflects best practice. More flexibility would seem warranted in some situations, for example where a doctor has an established relationship with a patient who has a good understanding of his or her condition and whose condition is stable. My paramount concern would always be that prescribing is appropriate, but the fiscal impact on patients if they had to make an appointment for each repeat prescription should also be acknowledged. I **enclose** a copy of an article of mine from September

2005 on this subject which highlights concerns expressed to this Office by a doctor regarding restrictions on repeat prescribing.

The intent of paragraph four could be further clarified. It is certainly desirable that doctors advise on the effects of lifestyle choices such as smoking, alcohol consumption, diet etc. However, the sentence regarding advice on possible outcomes of “their treatments” is slightly ambiguous. It is not clear whether these treatments are complementary ones initiated by the patients.

### **Communication**

There are numerous references throughout the document (eg paragraphs two and nine) to taking patients’ views into account. In my view this guidance does not go far enough – a patient’s views and opinions should be an essential consideration in any treatment decision. Doctors need to recognise a patient’s own experience and knowledge of their condition.

In paragraph 9 it is stated that doctors should explain the benefits to patients of being the subject of education or research. Clearly there are both benefits and risks of being involved in research and a doctor would be expected to explain risks as well as benefits. Also, it would be preferable to refer to a patient being a participant in research, rather than the subject of it. I note that the last two bullet points of this paragraph appear to double up with points addressed on the previous pages.

### **Relatives, carers and partners**

It may be helpful to specifically mention in this section a patient’s right to a support person under Right 8 of the Code. The role of legal representatives (such as welfare guardians and holders of enduring powers of attorney) could also be included, either here or perhaps in the communication section.

### **Decisions about access to medical care**

I appreciate that there will be some situations where doctors feel that their beliefs may affect their treatment of a patient. However, I would expect that such situations will be very limited. In my view, this section should set out an expectation that doctors should try not to let their beliefs affect their treatment of patients. Where a doctor does feel unable to treat a patient, it is incumbent upon them to be proactive and act promptly in making a referral to another doctor and facilitating a transfer of care. I have received informal reports of situations where an anti-abortion doctor purported to offer such assistance to patients seeking termination of a pregnancy, and then delayed doing so until a point when it was more problematic for the patient to have the procedure.

There is clearly a need for sensitivity in such situations, as patients are likely to feel as though they are being judged by the doctor – whether on moral, religious or other grounds.

### **Ending a professional relationship**

It would be helpful to give more guidance as to the circumstances when it is appropriate to end a professional relationship with a patient. It is disappointing to hear of instances where a doctor has ended the relationship simply because the patient has made a complaint. Doctors should be encouraged to attempt to resolve issues where possible, rather than simply ending the professional relationship.

**Delegation and referral**

I agree that sharing of patient information in order to achieve continuity and quality of care should be promoted. However in paragraph 42 it is not clear why it always be necessary for a specialist to tell a patient's general practitioner *before* starting treatment. The emphasis should be on appropriate consultation with the patient's GP or other provider (subject always to the patient's consent) and, where care is being transferred once the provider has finished treating that patient, a clear and coordinated transfer.

**Decisions about access to medical care**

While I appreciate the point that is being made in this paragraph, it appears to contradict other statements about doctors making the care of their patient the first concern. In contrast, the statement *Best practice in an environment of resource limitation* makes it clear that the patient should be the first concern.

**Scholarship**

In paragraph 50, it would be helpful to explain that that the level of supervision must be appropriate given the situation and the level of competence of those being supervised.

**Research**

It would be preferable to refer to properly accredited ethics committees, rather than properly constituted ones. In relation to the final bullet point in paragraph 54, all concerns about the research should be reported – not just those relating to fraud and misconduct.

**Professionalism**

I suggest that the guidance set out in paragraph 63 would fit better after paragraph 58. In relation to the last point in paragraph 63, it may be preferable to simply refer to registration authorities in general, as issues may relate to practitioners registered with authorities other than the Nursing Council and Medical Council.

**Financial and commercial dealings**

I suggest that the guidance in paragraph 77 could be clarified to make it clear that doctors must declare any interest in goods or services provided by themselves or by another person or entity. I **enclose** an article from July 2006 on this issue, which includes details of a decision that a doctor had breached the Code for failing to disclose interest in products sold by a company.

I trust that these comments are of assistance.

Yours sincerely

Ron Paterson  
**Health and Disability Commissioner**