

15 November 2007

Dr John Adams  
Chairman  
NZMA  
Ethics Committee  
P O Box 156  
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Dear Dr Adams

### **Review of the NZMA Code of Ethics**

Thank you for your letter of 1 October 2007 inviting feedback on the revised draft Code of Ethics.

I think the revised draft Code of Ethics is looking very good. I like many of the changes. I am also pleased to see that some of my suggestions (by letter dated 15 March 2007) have been included.

As mentioned previously, it may be helpful to include a section in the preliminary statement section noting that patients have a legal right (under the HDC Code) to services that comply with ethical standards such as the Code of Ethics.

What follows are my specific comments on the revised draft Code of Ethics.

### **Responsibilities to the Patient**

#### *Sexual relations with former patients*

I still consider that this section needs to state clearly that in most instances sexual relations with a former patient will be unethical.

#### *Withdrawing care*

In my view doctors should not withdraw care and end a therapeutic relationship without good reason. I find it disappointing that I continue to hear of instances where doctors end therapeutic relationships because the patient made a complaint. Where a doctor does withdraw care, they should be proactive in making a referral to another doctor. Recommendation 6 would be improved by stating that:

- a) The fact that a patient has made a complaint is not a basis for withdrawing care; and

- b) If a doctor decides that it is necessary to withdraw care because of an irreparable breakdown in the patient-doctor relationship, he or she must help the patient find an alternative source of care before withdrawing care.

#### *Communication*

The way in which recommendation 9 is worded does not put appropriate emphasis on a doctor's obligation to communicate effectively, provide full information and obtain informed consent. Stating that doctors should ensure that patients are involved in understanding the nature of their problems does not go far enough. Referring to "the limits of their capacities" sounds condescending.

#### *Open disclosure*

I am pleased to see that the draft Code of Ethics includes a responsibility for doctors to inform patients of any adverse event or error. I suggest that it should be re-worded slightly to say "for which the doctor has *individual or* direct overall responsibility."

In my view this responsibility should also extend beyond situations where the doctor has direct overall responsibility for the patient's care. It is conceivable that a doctor may become aware of an adverse event or error caused by another health practitioner of which the patient is not aware. In these circumstances there should still be a responsibility to disclose this event or error to the patient.

#### *Confidential information*

The previous version of recommendation 14 acknowledged that there would be instances where a doctor would be required by law to disclose information that would otherwise be kept confidential. I suggest that the current recommendation should also acknowledge this point. It can be a difficult area for doctors and I am sure that guidance on balancing the duty of confidentiality with other obligations would be helpful. If a doctor is obliged to provide a patient's information to a third party, then where possible he or she should advise the patient of the disclosure – preferably beforehand.

#### *Assistance with benefits*

As previously indicated, I suggest that Recommendation 18 should be extended to specify that doctors also have a responsibility to assist patients in making ACC claims or applying for benefits by providing required information in a timely manner and assisting in the completion of forms. This assistance is of considerable importance to patients.

#### *Incompetent patients*

Recommendation 21 should recognise that there may be other suitable persons with an interest in the patient's welfare who are not the family or other authorised agent. Also, the term "authorised agent" is not particularly clear in this context. Does it mean the holder of an enduring power of attorney or welfare guardian? As you will appreciate, from a legal perspective such people are not agents of the patient.

The reference to patients not being capable of "understanding" is slightly confusing. It would be preferable to refer to a patient's ability to make an informed choice and give informed consent.

This recommendation should also state that consideration should be given to the best interests of the consumer as required under right 7(4) of the HDC Code.

#### *End of life care*

I note the addition to recommendation 22. While I agree with the sentiment of the addition, it should be noted that the patient (where competent) must give informed consent to such treatment. It is not just a decision for the doctor to make.

#### *Organ donation*

This section will need to be revised when/if the Human Tissue Bill is passed. This recommendation would be clearer if it addressed living donors and dead donors separately. The rights of living donors are set out in Right 7(10) of the HDC Code. The situation regarding dead donors is covered by the Human Tissue legislation.

#### **Professional responsibilities**

I am pleased to see that additions have been made to this section to recognise the responsibility of doctors to behave co-operatively with towards team members and to assist colleagues who are unwell, under stress or seeking guidance.

As stated in my previous comments, I consider that doctors have a professional responsibility to ensure that staff they employ are appropriately qualified and competent to provide the relevant services. I also remain of the view that there should be some recognition of the importance of patients participating in the development, delivery and evaluation of services.

#### *Unsafe services*

It is pleasing to see a clear statement that doctors have an ethical obligation to take action if they become aware of unsafe services. In relation to recommendation 28 I would suggest that the last sentence form a separate responsibility. A doctor's participation in reviewing their own practice seems quite different than the responsibility to address unsafe or unethical practices.

There seems to be some overlap between recommendations 28 and 34. Also, it may be helpful to provide clearer guidance as to expectations in such situations. For example raising matters with the relevant registration body or employer.

#### *Impugning reputation of other doctors*

With reference to recommendation 32, I consider that a doctor should avoid impugning the reputation of other providers – not just doctors.

#### *Endorsements*

Recommendation 38 should make it clear that where doctors have a financial interest in a commercial organisation their interest must be declared to patients. As it is currently worded, it is ambiguous as to who the declaration must be made to. Also, the new text added to this recommendation almost seems to encourage doctors to make endorsements. Rather than saying "Doctors should endorse products" it would be preferable to state that "If endorsing a product, doctors should ....".

### *Gifts*

As previously stated, I consider that recommendation 42 should be strengthened to state that doctors should not accept any gift or gratuity from a pharmaceutical company.

### **Research**

I remain of the view that this section should at the outset have clear statement that the needs of patients take priority over research and that patients should not be put at unreasonable risk for the sake of research.

As commented previously, this section seems to be suggesting that doctors carry out steps that would be a 'double up' with the activities of ethics committees.

### **Teaching**

Recommendation 52 states that teaching involving direct patient contact must be undertaken "whenever possible" with the consent of the patient. This recommendation should be strengthened, as should recommendation 53. In my view there are very limited circumstances where teaching involving direct patient contact should take place without the consent of the patient (or guardian). Under right 6(1)(d) of the HDC Code, patients have a right to be informed of any proposed participation in teaching or research.

Where teaching involves a patient in a permanent vegetative state I suggest that it is the family/whanau that should be consulted rather than nursing or medical colleagues.

### **Medical Responsibilities in Prioritising Care**

This recommendation correctly notes that a doctor's primary responsibility is to the patient. The recommendation should make it clear that doctors have a responsibility to provide the best standard of care possible with the available resources. Doctors also have an ethical obligation to advocate on behalf of patients for appropriate resources.

Recommendation should specifically state that patients should be told of treatments available in both the public and private systems.

Recommendation 56 would seem to fit better within this section.

### **Medicine and industrial action**

This recommendation appears to be drafted from the perspective of justifying participation in industrial action. Withdrawal of services as part of industrial action is harmful to patients and will compromise care to patients. In my view, the starting point should be that such action is unethical unless the industrial action is very clearly for purposes that will improve patient care and safety. Further guidance on this point would be helpful. Strikes in the past have involved matters such as meal allowances and remuneration, which would seem to beg the question of how such issues link to patient care and safety. Would it be regarded as ethically acceptable to go on strike for higher remuneration on the basis that if doctors are not paid well enough they will leave New Zealand and patients will be adversely affected?

I trust that these comments are of assistance and look forward to seeing the new Code of Ethics.

Yours sincerely

Ron Paterson  
**Health and Disability Commissioner**