

11 April 2013

New Zealand Medical Association
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Consultation on update to the Code of Ethics for the New Zealand Medical Profession

Thank you for your letter of 6 March 2013, and the opportunity to comment on the proposed changes to the New Zealand Medical Association's (the NZMA) Code of Ethics for the New Zealand Medical Profession. We note that the changes proposed have been made follow an internal review.

Set out below are our comments on the proposed amendments and on other aspects of the Code of Ethics that we consider may benefit from comment from this Office.

Recommendation 2 – sexual relationships

Recommendation 2 provides that it is unethical for doctors to have sexual relationships with current patients and, in most instances, former patients. The ethical standard recognises that the doctor-patient relationship is not equal and is based on trust. A sexual relationship between a doctor and their patient breaches trust, and may harm both the patient and the doctor. Sexual involvement with a patient can also impair a doctor's clinical judgement

We note that the Medical Council of New Zealand publication *Sexual Boundaries in the doctor-patient relationship* (October 2009), provides standards in respect of breaches of "sexual boundaries", which are broader in application than "sexual relationships". A breach of sexual boundaries includes "... any words, behaviour or actions designed or intended to arouse or gratify sexual desires" and, "is not limited to genital or physical behaviour". The Medical Council publication also incorporates "any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate or unprofessional."

There have been several complaints made to this Office recently where the doctor concerned breached sexual boundaries through inappropriate sexual behaviour such as sending text messages of a sexual nature to their patient. In our view, such behaviour is also ethically reprehensible. In the age of new technology that allows relationships between doctors and patients to take on new forms, we consider that it would be timely for the NZMA to review Recommendation 2 with a view to expanding the scope of its application to include breaches of "sexual boundaries" falling short of actual sexual relationships.

Recommendations 11 and 12 – communication and information provision

Recommendation 11 states that doctors should ensure that patients are involved in understanding the nature of their problems, "within the limits of their capacities". We consider that referring to "the limits of their capacities" sounds condescending (a view

already expressed in the 15 November 2007 submission made by this Office on the then review of the NZMA Code of Ethics). We recommend that the proviso to this recommendation be amended, so that the recommendation is that doctors should ensure, as far as possible, that patients are involved in understanding the nature of their problems. If a patient has limited capacity, a doctor should take steps to provide information in a form, language and manner appropriate to the patient to assist the patient to understand.

Recommendation 12 states that doctors should, “within reason, provide adequate information to their patients about their assessment and available treatments”. This recommendation falls short of the legal standard under the Code of Health and Disability Services Consumers’ Rights 1996 (the Code) to ensure that consumers are fully informed. We consider that, to avoid confusion, the ethical standard in relation to information provision should equate with the legal standard. Accordingly, we recommend that the NZMA remove the words “within reason” from Recommendation 12. We also recommend that the ambit of the obligation be extended beyond only the provision of information about the doctor’s assessment and treatment options to include all information that the consumer needs to make an informed choice and give informed consent, as per Right 6 of the Code.

Recommendation 22 – assistance with benefits

It would be helpful if this recommendation is extended to specify that doctors 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 the forms.

Recommendation 23 – remote consultation

This newly proposed recommendation provides that, when undertaking remote consultation, a doctor should always exercise their judgement as to whether diagnosis and treatment by this means is appropriate. We support the inclusion of this new recommendation. In a recent case, the Commissioner found a doctor in breach of Right 4(1) of the Code for prescribing codeine to his patient over the telephone, without first establishing that the patient had a known allergy to codeine, and for prescribing antibiotics to the same patient over the telephone without first undertaking a clinical review of the patient. The doctor’s management of his patient in that case illustrates the potential risk of managing a patient without access to relevant clinical data.

Recommendation 26 – consent

Recommendation 26 provides, “When patients are not capable of making an informed choice or giving informed consent, doctors should consider any previously expressed preferences from the patient, the wishes of the family, guardian or other appropriate person, and consult with colleagues before making management decisions ...”

Right 7(4) of the Code sets out the legal position in respect of providing services to consumers who are not themselves competent to consent to those services. When consumers are not competent to make an informed choice or give informed consent, a doctor should first establish whether the consumer has a valid advance directive that provides consent to the services proposed. If there is no valid advance directive, a doctor should establish whether there is anyone available who is legally entitled to consent to services on that consumer’s behalf. The class of people legally entitled to consent to services on a consumer’s behalf include welfare guardians, enduring powers of attorney for personal care and welfare, and the guardians of children. Family members do not automatically have a right to consent to services on the behalf of another family member unless they also fall into one of the classes of people legally entitled to consent, as set out above.

Where no valid advance directive applies, and no one who is legally entitled to consent on the consumer's behalf is available, services may only be provided to a consumer who is not themselves competent to consent where the proposed services are in the best interests of the consumer, and where the other provisions of Right 7(4) of the Code are met.

To ensure consistency between the ethical and legal standards, and to avoid confusion amongst the profession, we suggest that Recommendation 26 be amended to provide as follows: “When patients are not capable of making an informed choice or giving informed consent, and no valid advance directive applies, doctors can obtain consent to services from a person who is legally entitled to consent on that patient’s behalf. If a person legally entitled to consent on the patient’s behalf is not available, doctors should only provide the services if the services are in the best interests of the patient, and should consider any previously expressed preferences from the patient ...”

Recommendation 41 – declaring interests

As currently worded, this recommendation is ambiguous about to whom the declaration of interest should be made. We suggest that the recommendation is amended to clarify that doctors should declare financial or other interests in commercial organisations or products to any potentially affected patients.

Recommendation 46 – social media

This newly proposed recommendation provides that doctors should exercise caution when using social media in a professional or private capacity. We consider it appropriate to update the Code of Ethics to include a recommendation regarding social media, and note that the Medical Council of New Zealand is also looking at these issues. We note that Recommendation 46 does not refer directly to doctors accessing patients’ social media but suggest this is something you may wish to include.

The Commissioner recently advised the Medical Council that, while he considers that accessing a patient’s social media in a professional capacity may be acceptable in certain limited circumstances, it should only be accessed once patient consent has been obtained. The Commissioner does not consider it ethically or professionally appropriate (except in emergency situations) for a doctor to access a patient’s social media for professional purposes without that patient’s consent. We therefore suggest that the newly proposed recommendation be amended to include the requirement for consent when accessing a patient’s social media.

The doctor-patient relationship is underpinned by the principles of transparency, confidentiality and trust. Social media does not change those principles; rather, it raises new questions about what is ethical and professional conduct in an era where digital connectivity is pushing the traditional parameters of professional boundaries and patient confidentiality.¹ Obtaining patient consent to access such information may prevent harm to the therapeutic relationship from accessing such information, regardless of the information being published in a public forum.

¹ For example, the majority of guidelines and standards published by overseas regulatory authorities and medical colleges discuss the use of social media in the context of maintaining professional boundaries (eg accepting a Facebook “Friend Request” from a patient) and patient confidentiality (eg publishing health information about a patient on Facebook or an internet blog) see: British Medical Association *Using social media: practical and ethical guidance for doctors and medical students*; College of Physicians and Surgeons of British Columbia *Professional Standards and Guidelines: Social Media and Online Networking Forums* (September 2010); General Medical Council *Confidentiality* (October 2009).

In considering whether to access a patient's social media and to obtain consent for that purpose, a doctor ought to consider the risks and benefits of such steps. This involves balancing the risk that the therapeutic relationship could be harmed by seeking that consent against the potential benefit the social media information may have on the doctor's ability to care for and treat that patient (bearing in mind that in diagnosing and treating a patient, a doctor must rely on objective and accurate clinical information, and the potential unreliability of social media information).²

It is difficult to envision the types of situations where it would be helpful for a doctor to access a patient's social media for professional purposes. However, in the very limited circumstances in which a doctor considers it appropriate to do so, the doctor should engage the patient in a clear and transparent conversation about why access to their social media information is necessary, and obtain the patient's consent. In many cases, such a conversation may obviate the need for the doctor to access the patient's social media as it may well lead to the patient providing that information themselves.

Recommendation 60 – teaching and consent

Recommendation 60 provides that if teaching involves a patient in a permanent vegetative state, the teacher should, if at all possible, consult with a nursing or medical colleague and a relative before “commencing the session”.

We refer you to the comment above regarding Recommendation 26, and the legal position with respect to obtaining consent before services are provided to a consumer who is themselves not competent to consent. In addition, Right 9 of the Code provides that the rights in the Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching. Accordingly, if it is proposed that teaching involve a person in a permanent vegetative state (or in any other state where the consumer is not competent to consent), consent to that teaching should be sought from the consumer's legal guardian and, if no such guardian is available, the consumer should not be involved in teaching unless the criteria in Right 7(4) of the Code are met.

We also note that both recommendations 60 and 61 provide that consent to teaching should be obtained, and sufficient information on the form and content of the teaching provided, “wherever possible”. Right 6(1)(d) of the Code provides that patients have a right to be informed of any proposed participation in teaching or research. From a legal perspective, there is no “wherever possible” qualification to that requirement. Accordingly, we recommend that recommendations 60 and 61 be strengthened because the recommendation that consent be obtained “whenever possible” is insufficient from an ethical and a legal viewpoint (as indicated in the earlier submissions of this Office dated 15 November 2007). There are very limited circumstances where teaching involving direct patient contact should take place without the consent of the patient (or legal guardian).

² Individuals use social media sites for various purposes; the information contained on those sites has been selected by the individual; and the ability to verify the accuracy of the information is limited.