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Medical Council of New Zealand
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Council's review of *Good Medical Practice*

Thank you for providing me with the opportunity to comment on the Medical Council of New Zealand's (the Council) review of *Good Medical Practice*. I apologise for the delay in my response.

I am glad that you found the comments made by Senior Legal Advisor Helen Davidson in her letter of 23 May 2012 helpful to your review, and it is pleasing to see that the comments made have prompted proposals for new standards and points of discussion with the profession. I commend you on your initial work in reviewing *Good Medical Practice*. After considering the latest consultation draft, I have the following further comments.

Professionalism principles

The consultation draft restructures *Good Medical Practice* around the principles of caring for patients, respecting patients, working in partnership with patients and colleagues, acting ethically, and accepting the obligation to maintain and improve standards. These principles reflect areas of practice in which the Council expects doctors to demonstrate competence. The principles and their sub-principles correlate with the vision I have been communicating to the health sector during my time as Health and Disability Commissioner, which is a consumer-centered system built on the concepts of seamless service, patient engagement, transparency, and an empowering culture. Accordingly, I support the restructuring of the document in this way.

However, I note that the sub-principles under "working in partnership with patients and colleagues" focus predominantly on what it means to work in partnership with patients; the only sub-principle in respect of working in partnership with colleagues is to "maintain the trust of colleagues, and treat them politely and considerately". I wonder whether this single sub-principle sufficiently captures what it means to work in partnership with colleagues, and whether it may be beneficial to provide further sub-principles here. This may include, for example, the importance of being available to colleagues, and communicating effectively with colleagues when sharing patient care.

Caring for patients

It is proposed that this section of the document will outline the standards for providing good clinical care, safe practice in an environment of resource limitation, record keeping, drug prescribing, providing care to oneself or close friends/family, and treating people in emergencies. I have the following minor comments to make on this section:

- The section “providing good clinical care” states that good clinical care is provided when, among other things, a doctor adequately assesses their patient’s condition, including taking account of their patient’s history. I refer you to Ms Davidson’s comment in the first bullet point on page two of her 23 May 2012 letter to you, which addresses the importance of reading patient’s notes in this regard. Given the regularity with which this basic step of good care appears to be missed, I recommend the standard specifically refer to reading patient notes. That could include, for example, wording the standard as follows: “Adequately assessing the patient’s condition, taking account of the patient’s history and his or her views, reading the patient’s notes, and examining the patient as appropriate”.
- I support replacing the term “relevant clinical findings” with the broader term “relevant clinical information” in the section relating to record keeping for the reasons outlined in the document.
- The section on prescribing drugs or treatment notes that when prescribing without a face-to-face consultation, it is reasonable practice to “complete a prescription for a patient if you have *access* to the patient’s notes and are providing cover ...” (my emphasis). In my view, before prescribing without a face-to-face consultation, a practitioner must have more than “access” to the patient’s notes; the practitioner must actually read and review those notes. In a case I am currently investigating, a woman was repeatedly re-prescribed the pill by three general practitioners in her practice without regular face-to-face consultations and reviews. The general practitioners all had access to each other’s notes (which in this case were sparse), but one doctor in particular did not review the notes. Had he done so, the doctor may have been prompted to review the patient’s risk profile for the medication, which was high. The case illustrates the importance of not just having access to notes, but reading and reviewing those notes and using them to guide safe patient care.

Respecting patients

It is proposed that this section of the document will outline the standards of establishing and maintaining trust, cultural competence, personal beliefs and the patient, involving relatives, carers and partners, dealing with adverse outcomes, reporting of alleged abuse, and ending a professional relationship. For the reporting of alleged abuse, a new standard is proposed, the second part of which states, “You should inform the patient’s parents or guardians of your intention to report your concerns ...”. The requirement to inform a patient’s parents or guardians is not applicable in the case of an adult, who may or may not have a legally appointed guardian. Accordingly, this standard may benefit from some clarification, in that this part of the standard only applies in the case of children.

Working in partnership with patients and colleagues

It is proposed that this section of the document will outline the standards of assessing patients’ needs and priorities, supporting self care, information, choice of treatment and informed consent, advance directives, support people, advertising, working with colleagues, management, being accessible, going off duty, treating information as confidential, sharing information with colleagues, continuity of care, and mentoring, teaching, appraising and assessing doctors and students. I have the following comments to make on this section:

- In supporting self care, you have asked whether a section on a doctor’s duties in relation to public health should also be included, which would outline duties in respect of the

information that doctors are required to give patients on the effect of their life choices on their health and wellbeing, support in making changes to enhance their health, and the offering of appropriate preventative measures. In respect of the Code of Health and Disability Services' Rights (the Code), the focus is on the information that a reasonable consumer would expect to receive (Right 6(1)). There is a strong argument that a reasonable consumer would wish to receive relevant public health information when being advised on their health by their health practitioner, although whether such a duty exists in terms of the Code will depend on the particular circumstances of the case.

- Paragraph 31 provides that in most situations a doctor should not provide treatment unless the patient has received “all the relevant information”. While in simple terms this is not inaccurate, the requirement in the Code is that a health practitioner provides all the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive (Right 6(1)), which may or may not go beyond what a provider assesses to be “all the relevant information”. The information provided should also include information about the patient’s condition, as well as the treatment options.
- You have asked whether there are any situations where it might be acceptable for a doctor to delay sharing information with a patient about his or her condition, because the doctor believes, for example, that it might cause unwarranted stress. The Code sets out requirements in relation to the need to provide information and the type of information to be provided, but is silent on the timing of the delivery of that information, other than the fact that it needs to be given before a consumer can make an informed choice and give informed consent to treatment. While information should always be provided in a timely manner, the focus in the Code is on the environment and way in which such conversations take place (Right 5). Particular circumstances may arise when a delay in providing a consumer with information about their condition until an appropriate environment is available is reasonable. However, it is not clear that a separate standard in *Good Medical Practice* is required to cover this potentially rare scenario.
- You have asked for comment on the ambit of the expectation that a doctor will be aware of, and be able to provide advice to their patient on, other medical treatments that may be available. In particular, whether a doctor treating a patient who expresses an interest in alternative medicines should be expected to advise the patient about treatment options even when the doctor believes those options to be ineffective or even fraudulent. As noted above, the focus in Right 6(1) of the Code is on the information that a reasonable consumer would expect to receive, including information about the options available. In addition, Right 6(3)(c) provides that every consumer has the right to honest and accurate answers to questions relating to services, including how to obtain an opinion from another provider (which may include how to obtain an opinion from an unregistered provider or provider of alternative therapies). While a doctor should not provide specific information about treatment options that they do not have specialist knowledge about, a doctor should, regardless of their personal views, accept a patient’s interest in alternative therapies and be prepared to discuss the availability of such treatment options with the patient.
- With regard to the use of medical titles, as set out in paragraph 36, I wonder whether the standard requires further clarification that it does not just apply in the case of advertising, as could be argued by its inclusion under the heading “Advertising”. This was an issue that

caused some confusion in a recent complaint file, which you may recall this Office communicated about with you.

- On the basis of two recent complaints to HDC relating to the use of medical titles, you have asked what titles doctors should use (and in what contexts, for example, consent forms) to assist patients in understanding a doctor's knowledge, skills and expertise. I draw your attention to Ms Davidson's comment on this matter on page 4 of her letter of 23 May 2012. Whatever titles are used, it is important that consumers understand what the relevant title represents in terms of the training and experience of the particular practitioner (including on consent forms). I note that I have recently published an opinion (09HDC01565) which involved a case where a patient was not informed that his neurosurgery was to be performed by two neurosurgical registrars and not the consultant. I commented that a patient considering surgery always has the right to receive the information that a reasonable patient in that patient's circumstances would expect to receive which, in many circumstances, will include information as to who will be performing the surgery.
- You have asked whether additional duties should be included that intend to ensure that all members of a team feel confident and supported in raising concerns and are treated respectfully, and to provide support to junior doctors. As noted in Ms Davidson's letter of 23 May 2012, I strongly support the inclusion of such duties.
- I support the inclusion of the new duties under the new heading "continuity of care", and I consider it useful to include the supplementary guidance on transferring and referring patients. You have asked for comment on what the duties of a referring doctor and a doctor accepting a referral should be, and who should have overall responsibility for ensuring that the test is conducted and the results reported.

As noted in Ms Davidson's letter of 23 May 2012, I consider that seamless patient care requires that doctors act to ensure that their concerns (leading to referral to a specialist *or* for tests) are being appropriately actioned, for the reasons set out in that paragraph. As noted in my recently published opinion 10HDC00454, responsibility lies with the practitioner making the referral to take reasonable steps to follow up on that referral to check that it is actioned appropriately. In that case, I also considered the role of the specialist receiving the referral. I commented that the specialist receiving the referral also has a responsibility to the patient in receiving the referral. I stated:

"The responsibility for managing the referral of patients between primary and secondary care does not fall solely on the shoulders of the primary care physician. While there is a clear division of responsibility in the management of patients following specialist referral, it is essential that general practitioners and specialists work together to ensure quality and continuity of care for patients.

I also refer you to my recently published opinion 09HDC01883, which examines the responsibilities of a referring DHB and a DHB receiving the referral and provides further guidance on my view that both a referrer and a person/agency receiving a referral owe duties of care to handle those referrals appropriately.

- You have asked to what extent specialists treating a patient should make themselves available to the patient's GP to discuss ongoing care and treatment that fall outside the GP's area of expertise. In my view, it is critical for continuity of care that a specialist makes him or herself available to provide information to a patient's GP if that information is critical for the ongoing management of that patient's care. This is particularly so given that *Good Medical Practice* places an obligation on a patient's principal health provider (usually a patient's general practitioner) to maintain continuity of care.

Acting ethically

It is proposed that this section of the document will outline the standards for integrity in professional practice, sexual and emotional boundaries, writing reports, giving evidence and signing documents, financial and commercial dealings, and conflicts of interest. Some sections of the standards for financial and commercial dealings have been removed, because the Council statement *Doctors and health related commercial organisations* provides more explicit advice on these issues. As such, it is proposed that the standards relating to not encouraging or pressuring patients to give, lend, bequeath money or gifts to a doctor or to other people or organisations will be removed. However, it does not appear that these standards are covered in the above named statement. In my view, these are useful standards that align well with Right 2 of the Code, which accords consumers the right to freedom from financial exploitation. Consequently, I recommend that thought is given to keeping these standards in the document.

Accepting the obligation to maintain and improve standards

It is proposed that this section of the document will outline the standards for applying knowledge and experience to practice, research, maintaining and improving professional practice, keeping up to date, openness and investigatory or legal processes, raising concerns about patient safety, concerns about premises, equipment, resources, policies and systems, a doctor's health, disclosing concerns to Council, being open about concerns and restrictions on practice, and supporting colleagues. I have the following minor comments to make about this section:

- I recommend that you retain the standard that requires practitioners to put the protection of the participants' interests first when designing, organising or carrying out research, because of its fundamental importance.
- I do not support the inclusion of a standard that requires doctors to support research by encouraging patients to participate. A doctor's foremost responsibility is the care of his or her patient; a requirement to encourage patients to participate in research may not always align with this.
- I support the new standards included in the section "Raising concerns about patient safety".

Additional consultation questions

You have asked whether there are any additional areas in which *Good Medical Practice* should provide advice, for example, patient-centered care, patient safety, issues relevant to doctors in training, evidence-based practice and/or human rights. In my view, patient-centered care and patient safety are fundamental to good medical practice. However, they are not stand alone standards, but principles that should guide everything a practitioner does. The

revised draft *Good Medical Practice* already reflects these principles across the different standards that it applies.

You have asked whether *Good Medical Practice* should capture issues of patient choice “when it comes to their right to see their preferred doctor”. I note that this is covered in Right 7(8) of the Code, which provides that “Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable”.