

# 19 The New Zealand Medical Association code of ethics

## Preliminary statement

The profession of medicine has a duty to maintain and improve the health of the people and reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community. In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients. This document represents a further stage in that evolutionary process.

This document does not purport to set out rigid, immutable rules. It revises the Code of Ethics and provides guidelines endorsed by the Council of the New Zealand Medical Association. The Code will be reviewed at regular intervals and, to this end, comment and feedback is invited (Comments should be sent to: New Zealand Medical Association, PO Box 156, Wellington).

The basis of the moral framework for medical practice has been developed gradually over several thousand years, and is therefore well established, whereas guidelines for professional behaviour must reflect the changing social and cultural environment in which doctors practise. The moral basis for practice has its expression through what is commonly termed medical ethics. Integral to an ethical basis for professional practice is the overriding acceptance of an obligation to patients, and recognition of their autonomy. (The NZMA strongly favours retention of the word "patient" because it reflects accurately the nature of the relationship between a doctor and the person seeking help). (The NZMA recognises no distinction, in terms of accountability, between conventional and alternative medicine when practised by a registered medical practitioner. All treatments should be subject to the same standards in respect of the rigour with which they are subjected to scientific testing and the ethics applicable to their use).

Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, non-maleficence, and justice. Autonomy recognises the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognising resource constraints. Non-maleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources. In New Zealand today, there is also an increasingly wide recognition of the principle of partnership - between doctor and patient; profession and society; and different cultures as an important aspect of the ethos of professional practice.

The concept of the autonomy of doctors also needs to be considered, although this principle has always been tempered with common sense and recognition of the duty to act within the limits of one's own capabilities. Some ethicists are beginning to argue for a fifth principle, namely, the duty of doctors in some

circumstances to recognise the need to work in collaborative groups, sharing their skills, experience and judgement with others. In today's world, doctors have an increased ethical responsibility to participate in reviewing formally their own and others' work to maintain standards of practice.

The concept of accountability, as applied to the medical profession, needs to encompass a widening set of relationships and contexts. An increasing number of statutory and commercial organisations interact with doctors in relation to issues of accountability. Increasingly, doctors are experiencing difficulty in balancing the requirements of their primary obligation to individual patients and families with their responsibilities to the wider community. Many commercial concepts, including that of intellectual property and that of contracting with various funding bodies, are challenging aspects of medical organisation and professional practice. (The concept of intellectual property and its protection is relatively recent. The patenting of inventions based on an individual's thinking and research is becoming widespread. The ethical issues related to this are at present being defined and the present code cannot encapsulate any established pattern).

Changes in the context of medical practice are reflected in new sections on Medical Responsibilities in Prioritising Care and on Medicine and Industrial Action to address the exquisite dilemmas that doctors find themselves in as participants in the tension between the welfare of the individual patient and the good of all other patients.

Faced with this complex and changing situation, the New Zealand Medical Association affirms its adherence to certain ethical principles. Patients have a legal right (under the Health and Disability Commissioner's Code of Patient Rights) to services that comply with ethical standards such as this Code of Ethics. The Association accepts responsibility for delineating standards of ethical behaviour expected of doctors in New Zealand and has consulted widely in the development of this Code.

The NZMA urges Members and all doctors to follow the standards set out below.

## Principles

All medical practitioners, including those who may not be engaged directly in clinical practice, will acknowledge and accept the following Principles of Ethical Behaviour:

1. Consider the health and well being of the patient to be your first priority.
2. Respect the rights, autonomy and freedom of choice of the patient.
3. Avoid exploiting the patient in any manner.
4. Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.
5. Protect the patient's private information throughout his/her lifetime and following death, unless there are overriding considerations in terms of public interest or patient safety.
6. Strive to improve your knowledge and skills so that the best possible advice and treatment can be offered to the patient.

7. Adhere to the scientific basis for medical practice while acknowledging the limits of current knowledge.
8. Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient.
9. Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease.
10. Accept a responsibility to assist in the protection and improvement of the health of the community.
11. Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.
12. Accept a responsibility for maintaining the standards of the profession.

## Recommendations

Given the complexities of doctor-patient relationships, and the increasing difficulties brought about by the need for rationing of resources and direct intervention of third-party providers of funding, no set of guidelines can cover all situations. The following set of recommendations is designed to convey an overall pattern of professional behaviour consistent with the principles set out above in the Code of Ethics.

### Responsibilities to the patient

1. Doctors should ensure that all conduct in the practice of their profession is above reproach. Exploitation of any patient, whether it be physical, sexual, emotional, or financial, is unacceptable and the trust embodied in the doctor-patient relationship must be respected.
2. Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power. Sexual relationships between doctors and their patients or students fall within this category. The NZMA is mindful of Medical Council policy in relation to sexual relationships with present and former patients or their family members, and expects doctors to be familiar with this. The NZMA considers that a sexual relationship with a current patient is unethical and that, in most instances, sexual relations with a former patient would be regarded as unethical, particularly where exploitation of patient vulnerability occurs. It is acknowledged that in some cases the patient-doctor relationship may be brief, minor in nature, or in the distant past. In such circumstances and where the sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred. Any complaints about a sexual relationship with a former patient therefore need to be considered on an individual basis before being considered as unethical.
3. Doctors should ensure that every patient receives appropriate available investigation into their complaint or condition, including adequate collation of information for optimal management.
4. Doctors should ensure that information is recorded accurately and is securely

- maintained, with due regard to the challenges of the modern electronic era.
5. Doctors should seek to improve their standards of medical care through continuing self-education and thoughtful interaction with appropriate colleagues.
  6. Doctors have the right, except in an emergency, to refuse to care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and that the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.
  7. When a patient is accepted for care, doctors should render medical service to that person without discrimination (as defined by the Human Rights Act).
  8. Doctors should ensure that continuity of care is available to all patients, whether seen urgently or unexpectedly, or within a long-term contractual setting, and should assure themselves that appropriate arrangements are available to cover absence from practice or hours off duty, informing patients of these.
  9. Doctors should ensure that patients are involved, within the limits of their capacities, in understanding the nature of their problems, the range of possible solutions, as well as the likely benefits, risks, and costs, and should assist them in making informed choices.
  10. Doctors should ensure that patients are promptly informed of any adverse event or error that occurred during care for which the doctor has individual or direct overall responsibility.
  11. Doctors should recognise the right of patients to choose their doctors freely.
  12. Doctors should recognise their own professional limitations and, when indicated, recommend to patients that additional opinions and services be obtained, and accept a patient's right to request other opinions. In making a referral to another health professional, so far as practical, the doctor should have a basis for confidence in the competence of that practitioner.
  13. Doctors should accept the right of a patient to be referred for further management in situations where there is a moral or clinical disagreement about the most appropriate course to take.
  14. Doctors should keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient or in those unusual circumstances when it is clearly in the patient's best interests or there is an overriding public good, including the risk of serious harm to another person. If there is any doubt, doctors should seek guidance from colleagues or an appropriate ethics committee.
  15. When appropriate, doctors should communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information. Patients should be made aware of this information sharing which enables the delivery of good quality medical care. Where a patient expressly limits possession of particular information to one practitioner, this must ordinarily be respected. Patients should be made aware in advance, if possible, where there are limits

to the confidentiality which can be provided.

16. Where a doctor is performing an assessment on behalf of a third party, the patient must be clearly informed of who the third party is, the purpose of the assessment and the limits of confidentiality. Where the assessment occurs in the context of a treating relationship, the patient should be made aware that the doctor is ethically obliged to provide a complete and professional report.
17. When it is necessary to divulge confidential patient information without patient consent this must be done only to the proper authorities, and a record kept of when reporting occurred and its significance.
18. Doctors should recommend only those diagnostic or screening procedures which seem necessary to assist in the care of the patient and only that treatment which seems necessary for the well being of the patient.
19. When requested or when need is apparent, doctors should provide patients with information required to enable them to receive benefits to which they may be entitled.
20. Doctors should be aware of statutory provisions and the codes of the Privacy Commissioner, the Human Rights Commissioner and the Health and Disability Commissioner, and the requirements of the Medical Council of New Zealand.
21. Doctors should accept that autonomy of patients remains important in childhood, chronic illness, ageing, and in the process of dying.
22. 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 colleagues before making management decisions, which may include recourse to the courts for determination.
23. Doctors should bear in mind always the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. In such inevitable terminal situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.
24. Doctors should be prepared to discuss and contribute to the content of advance directives and give effect to them. In the case of conflicts concerning management, doctors should consult widely within the profession and, if indicated, with ethicists and legal authorities.
25. In relation to transplantation and requests for organ donation, doctors should accept that when death of the brain has occurred, the cellular life of the body may be supported if some parts of the body might be used to prolong or improve the health of others. They should recognise their responsibilities to the donor of organs that will be transplanted by disclosing fully to the donor or relatives the intent and purpose of the procedure. In the case of a living donor, the risks of the donation procedures must be fully explained. Doctors should ensure that the determination of death of any donor patient is made by doctors who are in no way concerned with the transplant procedure or associated with the proposed recipient in a way that might exert any influence upon any decisions made.

## **Professional responsibilities**

26. Doctors have both a right and a responsibility to maintain their own health and well being at a standard that ensures that they are fit to practise.
27. Doctors should seek guidance and assistance from colleagues and professional or healthcare organisations whenever they are unable to function in a competent, safe and ethical manner. When approached in this way doctors should provide or facilitate such assistance.
28. Doctors have a responsibility to assist colleagues when they are unwell or under stress.
29. Doctors have a general responsibility for the safety of patients and should therefore take appropriate steps to ensure unsafe or unethical practices on the part of colleagues are curtailed and/or reported to relevant authorities without delay.
30. Doctors have a responsibility to participate in reviewing their own practice and that of others.
31. When appropriate doctors should make available to colleagues, with the knowledge of the patient, a report or summary of their findings and treatment relating to that patient.
32. When working in a team environment, doctors have a responsibility to behave co-operatively and respectfully towards team members.
33. Doctors should recognise that the doctor/patient relationship has a value and should not be disturbed without compelling reasons. Disruption of such a relationship should, wherever possible, be discussed in advance with an independent colleague.
34. Doctors should avoid impugning the reputations of colleagues. In normal circumstances, information about colleagues divulged as a part of quality assurance exercises (including peer groups) should remain confidential.
35. Doctors should accept a share of the profession's responsibility toward society in matters relating to the health and safety of the public, health promotion and education, and legislation affecting the health or well being of the community.
36. Doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Where doctors are working within a health service they should first raise issues in respect of that service through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly.
37. Doctors should not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty.
38. Doctors should recognise the responsibility to assist courts, commissioners, commissions, and disciplinary bodies, in arriving at just decisions. When doctors are providing expert opinions, the doctor has a duty to assist the body impartially on relevant matters and to confine such opinion within their area of expertise.
39. Doctors should certify or give in evidence only that which has been personally verified when they are testifying as to circumstances of fact.

40. Doctors should not allow their standing as medical practitioners to be used inappropriately in the endorsement of commercial products. When doctors are acting as agents for, or have a financial or other interest in, commercial organisations or products, their interest must be declared. If endorsing a product, doctors should use only the proper chemical name for drugs, vaccines and specific ingredients, rather than the trade or commercial name. Any endorsement should be based on specific independent scientific evidence, and that evidence should be clearly outlined.
41. Doctors should not use secret remedies.
42. Advances and innovative approaches to medical practice should be subject to review and promulgation through professional channels (including ethics committees) and medical scientific literature. Doctors should accept responsibility for providing the public with carefully considered, generally accepted opinions when presenting scientific knowledge. In presenting any personal opinion contrary to a generally held viewpoint of the profession, doctors must indicate that such is the case, and present information fairly.
43. Doctors should accept that their professional reputation must be based upon their ability, technical skills and integrity. Doctors should advertise professional services or make professional announcements only in circumstances where the primary purpose of any notification is factual presentation of information reasonably needed by any person wishing to make an informed decision about the appropriateness and availability of services that may meet his or her medical needs. Any such announcement or advertisement must be demonstrably true in all respects and contain no testimonial material or endorsement of clinical skills. Qualifications not recognised by appropriate New Zealand statutory bodies should not be quoted.
44. Doctors should exercise careful judgement before accepting any gift, hospitality or gratuity which could be interpreted as an inducement to use or endorse any product, equipment or policy. Doctors must not allow gifts to influence clinical judgement. In all cases of doubt, advice should be sought from relevant professional organisations.

## **Research**

45. Before initiating or participating in any clinical research, doctors should assure themselves that the particular investigation is justified in the light of previous research and knowledge. Any proposed study should reasonably be expected to provide the answers to the questions raised. There must be an assessment of predictable risks and burdens in comparison with foreseeable benefits to the participants or to others. All studies involving patients should be subject to the scrutiny of an appropriately constituted ethics committee which must be independent of the investigator and the sponsor, and any kind of undue influence.
46. Doctors should be assured that the planning and conduct of any particular study is such that it minimises the risk of harm to participants. When comparing active treatments, the control group should receive the best

- currently available and accepted treatment, in accordance with a reasonable body of medical opinion.
47. A placebo-controlled trial may be ethically acceptable, even if an established therapy is available for a certain condition, under the following circumstances:
- The established treatment has never been demonstrated to be effective by evidence-based criteria; or
  - Where for compelling and scientifically sound methodological reasons its use is necessary to determine the efficacy or safety of a prophylactic, diagnostic or therapeutic method; or
  - Where a prophylactic, diagnostic or therapeutic method is being investigated for a minor condition and the patients who receive placebo will not be subject to any additional risk of serious or irreversible harm; There must be a robust mechanism for curtailing the trial should at any stage the treatment group be demonstrated (by adequate statistical methods) to be different from the placebo group.
48. Patient consent for participating in clinical research (or permission of those authorised to act on their behalf) should be obtained in writing only after a full written explanation of the purpose of that research has been made, and any foreseeable health hazards outlined. Opportunity must be given for questioning and withdrawal at any time. When indicated, an explanation of the theory and justification for double-blind procedures should be given. Acceptance or refusal to participate in a clinical study must never interfere with the doctor-patient relationship or access to appropriate treatment. No degree of coercion is acceptable.
49. Boundaries between formalised clinical research and various types of innovation have become blurred to an increasing extent. Doctors retain the right to recommend, and any patient has the right to receive, any new drug or treatment which, in the doctor's considered judgement, offers hope of saving life, re-establishing health or alleviating suffering. Doctors are advised to document carefully the basis for any such decisions and also record the patient's perception and basis for a decision. In all such cases the doctors must fully inform the patient about the drug or treatment, including the fact that such treatment is new or unorthodox, if that is so.
50. In situations where a doctor is undertaking an innovative or unusual treatment on his or her own initiative, he or she should consult suitably qualified colleagues before discussing it with, or offering it to, patients. Doctors should carefully consider whether such treatments should be subject to formal research protocols.
51. It is the duty of doctors to ensure that the first communication of research results be through recognised scientific channels, including journals and meetings of professional bodies, to ensure appropriate peer review. Participants in the research should also be informed of the results as soon as is practicable after completion.
52. Doctors should not participate in clinical research involving control by the funder over the release of information or results, and must retain the right to

publish or otherwise release any findings they have made. Doctors involved as principals in research should not participate if they do not have access to the base data. Negative as well as positive results should be published or otherwise made publicly available. Any dispute or ethical issue which may arise in respect of the research should be considered openly, e.g. by consultation with the appropriate ethics committee.

### **Teaching**

53. Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors.
54. Teaching involving direct patient contact should be undertaken with sensitivity, compassion, respect for privacy, and, whenever possible, with the consent of the patient, guardian or appropriate agent. Particular sensitivity is required when patients are disabled or disempowered, e.g. children. 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.
55. Wherever possible, patients should be given sufficient information on the form and content of the teaching, and adequate time for consideration, before consenting or declining to participate in clinical teaching. Refusal by a patient to participate in a study or teaching session must not interfere with other aspects of the doctor-patient relationship or access to appropriate treatment.
56. Patients' understanding of, or perspective on, their medical problems may be influenced by involvement in clinical teaching. Doctors should be sensitive to this possibility and ensure that information is provided in an unbiased manner, and that any questions receive adequate answers. It may be appropriate for the doctor to return later to address these issues.

### **Medicine and commerce**

57. Commercial interests of an employer, health provider, or doctor must not interfere with the free exercise of clinical judgement in determining the best ways of meeting the needs of individual patients or the community, nor with the capacities of individual doctors to co-operate with other health providers in the interests of their patients, nor compromise standards of care or autonomy of patients in order to meet financial or commercial targets.
58. Where potential conflict arises between the best interests of particular patients and commercial or rationing prerogatives, doctors have a duty to explain the issues and dilemmas to their patients. Doctors should state quite clearly what their intentions are and why they advocate particular patterns of diagnosis, treatment, referral or resource use. Commercial arrangements that have the potential to impinge on the patient's care should be declared to the patient.
59. Doctors who provide capital towards health services in the private sector are entitled to expect a reasonable return on investment. Where there may be a

conflict of interests, the circumstances should be disclosed and open to scrutiny.

60. Like all professionals, doctors have the right to fair recompense for the use of their skills and experience. However, motives of profit must not be permitted to influence clinical judgement.
61. Doctors should insist that any contracts into which they enter, including those involving patients, be written in clear language such that all parties have a clear understanding of the intentions and rules.
62. Doctors who find themselves in a potentially controversial contractual or commercial situation should seek the advice of a suitable colleague or organisation.

### **Medical responsibilities in prioritising care**

63. Doctors have a primary responsibility to the individual patient, but also a concurrent responsibility to all other patients and the community. Doctors therefore have an ethical responsibility to manage available resources equitably and efficiently.
64. Rationing of resources must be open to public scrutiny and points of conflict identified and presented in a rational, non-biased manner to the public.
65. Patients must be able to trust their doctor to deal with their needs fairly and honestly. Doctors should, within reason, provide adequate information to their patients about their assessment and available treatments, including those not readily available.
66. In an environment of resource constraint, priorities need to be assigned to achieve the wisest use of limited resources. Doctors have a duty to work with others in developing rules to set priorities. Doctors also have a duty to abide by such rules, provided the rules conform to ethical principles. The rules should be just, open, valid, and reliable.

### **Medicine and industrial action**

67. It is recognised that certain extreme circumstances may lead to consideration of industrial action by doctors. Such action is not always unethical, even if it compromises care to individual patients, which is contrary to one of the ethical principles. However, a decision to take industrial action must be based on a reasonable expectation that the desired outcome will result in improved patient care and safety. A doctor's primary duty is to their patient, but the secondary duty to all other patients may mean that action has to be considered. In the case of industrial action, doctors should take care to minimise any detrimental effect on patient care. Services to preserve life and prevent permanent disability must always be provided. Self interest alone by individuals or the profession is not an ethical basis on which to take action.

*This code will undergo major review by May 2013. However, minor changes may be introduced before then in response to further alterations in the environment in which medicine is practised. To this end, the NZMA welcomes feedback and comment on this code at any time.*