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The Royal Australasian College of Physicians

Submission to the Medical Council of New Zealand on its revised statement Safe practice in an environment of resource limitation – July 2018

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Medical Council of New Zealand's (Council's) revised statement on safe practice in an environment of resource limitation (the statement).

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

In summary, our submission

- Is generally supportive of Council's proposed changes
- Identifies several minor opportunities for further clarification
- Makes suggestions which will improve the inclusivity and culturally safe practice of doctors
- Recommends Council adds a definition of equity or equality, depending which term Council applies to Principle Four.

Summary box at the outset

1. **Are there any other key points that should be included or omitted from the summary box?**

The RACP welcomes Council's introduction of a summary box in the revised draft of the statement. The RACP notes that the final bullet point discusses the ability to provide or discontinue treatment, and the need to discuss these changes or decisions with the patient. The RACP supports the addition of "and the patient's family/whānau" to this statement. This is particularly relevant to treatment and management discussions and decision-making where individual patients may not be able to provide informed consent. The RACP's End of Life position statement includes the following recommendations for physicians in clinical practice around documenting treatment choices when the patient's consent is not possible[1]:

- Provide clinical leadership to sensitively, openly and honestly discuss and document prognosis, treatment, end of life care and the patient's preferences, needs and values

- Actively seek to understand the wishes of patients nearing the end of life who are no longer capable of expressing them, including seeking documentation of advance care planning and consulting with family/whānau and carers

- Consult, involve and support the carers and family/whānau of a dying patient as required

Similarly, later on in the draft statement 16 refers to informing patients of the decision being made and the reasoning for this; reference to the patient's family/whānau is important in situations where the patient cannot, for whatever reason, consent.

Expanded 'Background'

2. **In your view, are there any other points that should be covered in 'Background'?**

The RACP notes that the background statements contained within the revised document are positioned as factual realities, rather than speculating on the causes or necessity of health services rationalisation. The addition of the sentence "because of its wide-ranging implications, rationing decisions require clinical input and leadership" emphasises the leadership role doctors have in clinical decision-making. The RACP

[1] The Royal Australasian College of Physicians. Improving care at the end of life: our roles and responsibilities. Sydney; The Royal Australasian College of Physicians; 2016. https://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-end-of-life-position-statement.pdf.

recommends that this sentence is augmented by highlighting that in a political environment of increasing pressure to ration health care, doctors play an increasingly important role of advising the public and in changing their own practice to critically apply ethical and fiduciary judgements to practice within this increasingly constrained environment.

Proposed changes to the section 'Ethical Principles'

3. **Do you agree with the proposed changes to the section on 'Ethical principles' as outlined above and set out in the draft?**

The RACP agrees with the definition to this section regarding doctors' commercial interests, and notes the footnote reference to another of Council's statements (Doctors and health related commercial organisations). The RACP finds that Council could consider expanding this reference to include Council's statement on advertising (2016), as there should not only be reference to health-related commercial organisations, but cover commercial relationships more broadly.

Principle Three relates to a doctor's responsibility to provide "the best standards of service possible" with the "resources available". The phrase "best standards of service possible" is, in the RACP's view, open to subjectivity and possible misinterpretation. The RACP recommends Council consider rewording this Principle as "doctors have a responsibility to try to maximise the health gains achievable within the resources available." In an environment of resource limitation, there is an ethical imperative to be efficient, as inefficiency is a loss of potential health gain.

Principle Four considers the perspective, world view, culture and implicit bias that influences how doctors interact with patients, their understanding of health, wellness and clinical decision-making. The RACP notes that the Principle refers to resources being used "efficiently and equitably"; however, it finds that what Council may be interested in identifying in this Principle is equality rather than equity. To achieve equal outcomes across a population, limited resources must be delivered according to need; moreover, this means that resources will need to be allocated disproportionately to address inequities. The RACP recommends that Council adds definitions to this Principle, to clarify if it intends to refer to equity or equality.

In relation to Principle Four, the RACP welcomes reference to Choosing Wisely, which seeks to reduce waste and inefficiencies in the health system by discouraging the use of tests, procedures and interventions which are ineffective, not based on evidence, are resource-intensive and may cause patient harm. The RACP has been working closely with its affiliated specialty societies to identify a top 5 of low-value interventions as part of its EVOLVE Project. At time of writing, there are 20 published EVOLVE lists, with more in development[2].

4. **What other changes, if any, should Council include in the section on 'Ethical principles'?**

As noted above, the statement may benefit from additional definitions to clarify Council's intention regarding equity versus equality.

Proposed changes to the section 'Medical practice where available services are restricted'

5. **Do you agree with the proposed changes to the section 'Medical practice where available services are restricted' as outlined above and set out in the draft?**

The RACP posits that as resources undergo further rationing and are increasingly limited, it is difficult to practice ethically. If resources are continuously subject to greater and greater constraint, so much so that it is difficult to ascertain whether or not the patient will benefit, doctors will not be able to practice ethically, and ethical standards towards individual patients will be challenged. In this scenario, there is a risk that medical practices considered unethical will gradually be labelled and perceived as ethical, (the 'slippery slope' argument) because it is "meeting the best standard of service possible", in an environment of resource

[2] The Royal Australasian College of Physicians. Evolve. Sydney: The Royal Australasian College of Physicians; 2018. https://evolve.edu.au/.

limitation, while consequently placing doctors under pressure and placing strain on the doctor/patient relationship.

6. **What other changes, if any, should Council include in the section on 'Medical practice where available services are restricted'?**

The RACP has no further recommendations on this section.

Proposed changes to the section 'Care of acute patients'

7. **Do you agree with the proposed changes to the section 'Care of acute patients' as outlined above and set out in the draft?**

The RACP welcomes the reference to doctors documenting clinical decisions that impact on a patient's treatment, management or care. Doctors are frequently in positions of leadership within a multidisciplinary team. Recording decisions accurately and ensuring that the patient is informed is essential to providing a continuity of care, and a record of events in a busy, often complex environment.

8. **What other changes, if any, should Council include in the section on 'Care of acute patients'?**

Statement 16 in the draft document states that doctors must "always inform the patient about the decision being made and the reason for it. Document such decisions." The RACP recommends Council amends this statement to include "and the patient's family/whānau" in line with our comments on the summary box at the outset of the document.

Proposed changes to the section 'Care of outpatients'

9. **Do you agree with the proposed wording in paragraph 20 that a doctor who receives and assesses a referral must be appropriately qualified to do so?**

The RACP notes the proposed changes to this section of the document and agrees that the proposed changes provide clarity around referrals. The change to patient-centred and people-first language (from 'dealing with outpatients' to 'care of outpatients') in this section and in the section above are supported.

The proposed changes to paragraph 20 ensure the process of receiving and assessing a referral are distinct from the process of requesting additional information from the referrer. The RACP supports this change to assist readability and clarity, particularly where the second sentence specifies a doctor requesting the relevant information from the initial referrer. The greater definition in this sentence sets out expectations of roles within the team environment.

10. **Do you agree with the proposed clarification in paragraph 23 that a doctor working in a service or team setting is still accountable for the doctor's actions within the team?**

The RACP finds that while the proposed clarification in paragraph 23 is appropriate, there could still be perceptions of ambiguity as to accountability, particularly where there are multiple doctors working within a clinical team. In the proposed change, the RACP believes Council intends:

1. A doctor is accountable for *their* actions within the team; as opposed to
2. A doctor is accountable for the actions of all doctors within a team.

In the instance that paragraph 23 is noted verbally, there is no way of discerning between "the doctor's actions" and "the doctors' actions". While the RACP contends a verbal reference to the paragraph would be unusual, further clarification to prevent confusion regardless of how the information is disseminated may be beneficial.

Proposed changes to the section 'Where a decision has been made by the funder not to fund a specific service'

11. How could the wording in paragraph 26 (about supporting patients to make an informed decision about their treatment, and discussing the next best option where doctors are unable to provide a preferred treatment) be more effective?

The RACP strongly supports the addition of "and their family/whānau" to paragraph 26. As the delivery of health care in hospitals and community contexts has evolved to be provided by members of a multidisciplinary team, health practitioners, including doctors, should expect to interact and have discussions with a patient's family and whānau (the patient's team), particularly in discussions around a variety of available treatment options.

12. What other changes, if any, should Council include in the section on 'Where a decision has been made by the funder not to fund a specific service'?

While the RACP acknowledges that the document is intended to be situated within an apolitical environment, it can be difficult to extract the challenges of a resource constraint or limitation from the distribution of resources and politically-motivated decision-making that has (directly or indirectly) contributed to the status quo. This is particularly relevant in the section "where a decision has been made by the funder not to fund a specific service'.

Statement 28 includes a reference to "preferred services". The RACP suggest Council amend this to read "doctors should advocate for the provision of services which meet best practice and available evidence", as "preferred" has an implication of subjectivity. Moreover, it is difficult to discern if "preferred" is referring to the preferred option of the doctor or the patient.

Proposed changes to the section 'Managing workload'

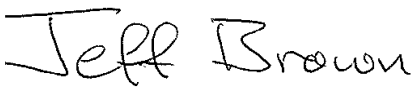
13. Are there any other changes that Council should consider including in the section 'Managing workload'?

The RACP is supportive of the proposed changes to this section. The RACP has taken an active approach to supporting its members' health and wellbeing by providing a range of resources on its website on workload and burnout, including supporting a colleague or trainee, supporting oneself, and descriptions of members' own experiences with workload, burnout and managing stress[3].

Conclusion

The RACP thanks Council for the opportunity to provide feedback on this consultation, and looks forward to receiving the finalised version of the Statement. The RACP is interested in meeting with Council in person to discuss the implications of critical decision-making in an environment of resource limitation. To discuss this opportunity further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Yours sincerely



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[3] The Royal Australasian College of Physicians. Physician health and wellbeing. Sydney: The Royal Australasian College of Physicians; 2018. Available from https://www.racp.edu.au/fellows/resources/physician-health-and-wellbeing.