Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

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Safe practice in an environment of resource limitation

- Resource limitation is an important part of the environment of professional medical practice.
- Rationing decisions require clinical input and leadership, and doctors through their training and experience bring particular expertise to decisions on resource allocation.
- Resources should be allocated in a way that is equitable and that best serves the interests of a community or population of patients.
- Doctors must balance their duty of care to their patient with their duty of care to the wider population by making efforts to use resources efficiently and equitably, consistent with good patient care, and in accordance with guidelines and pathways where these apply.
- Doctors must endeavour to provide services in a timely manner and that are appropriate to the patient's needs. This includes evaluating whether a test, treatment or procedure is necessary before recommending it to the patient.
- It is important to support the patient to make an informed decision about their treatment. Changes to the patient's treatment including the inability to provide or continue the treatment must be discussed with the patient and documented.

If the state, an agency of the state, or an institution limits the services made available to the public, the responsibility for the consequences of these decisions must largely rest with the state or the institution. Such institutions are encouraged to make such decisions with the help and advice of doctors.[1] Doctors who are unable to provide the preferred treatment because of resource limitation must inform the patient of the necessary and appropriate treatment and advocate for its provision.

Background

The rationing of health services is becoming more explicit. Because it has wide-ranging implications, rationing decisions require clinical input and leadership. Doctors, through their training and experience, bring particular expertise to decisions on resource allocation and should be fully involved in making rationing decisions.

Conflicts may arise when doctors are called upon to make decisions about the use of resources and about a patient's (or patients') treatment, when the needs of an individual patient and the needs of a population of patients cannot both be fully met. Dilemmas of this kind have no simple solution. When making such decisions, doctors should take into account the priorities set by funding agencies and their employer, but they should also be clear as to their professional responsibilities to the patient and the wider population.

[1] The Ministry of Health has indicated that resource allocation and rationing decisions cannot be made without the full involvement of doctors.

Ethical Principles

1. In clinical work, a doctor must make the care of the patient their first concern.[2]

2. Doctors must not allow their own commercial interests or those of an employer or funding agency, to override their ethical responsibility to their patients.[3]

3. Doctors have a responsibility to try to provide the best standards of service possible with the resources available.

4. Resource limitation should be recognised as an important part of the environment of medical professional practice.

5. A doctor's culture and world view influence how they interact with patients, their understanding of health, healthcare and wellness, and the clinical decisions they make. Doctors have a responsibility to the community at large to foster the proper use of resources and must balance their duty of care to their patient with their duty of care to the wider population. In particular, this involves making efforts to use resources efficiently and equitably, consistent with good patient care, and in accordance with guidelines or pathways where these apply.[4]

6. Doctors working as a managers, medical administrators or public health physicians must work in partnership with patients, and endeavour to allocate resources in the way that best serves the interests of a community or population of patients.

7. In all roles, doctors should use evidence from research and audit to endeavour to make the best use of the resources available, and in a culturally competent manner.[5]

8. Acting on these ethical principles in an environment of resource limitation will involve health professionals making and communicating prioritisation judgements to patients and populations for whom they have duties of care. Doctors might also be involved as managers and policy-makers whose decisions determine the overall level of resource limitation and funding allocations.

Medical practice where available services are restricted

9. Doctors must support research, study and discussion to ensure the allocation of health resources is rational, equitable, and based on need and evidence of benefit.

10. Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for their patients' care and report any deficiencies to the appropriate authorities. Where these deficiencies are serious, the report should be made in writing.

11. Doctors must try to ensure that services are provided in a timely manner and are appropriate to the patient's needs. This includes evaluating whether a test, treatment or procedure is indicated before recommending it to a patient, and assessing whether the patient should be seen in-person or reviewed through other means such as a video consultation.[6]

12. Doctors who are in leadership roles have a responsibility to both management and staff to try to ensure that health funds are used wisely, and that sufficient appropriately trained staff, suitable equipment and other resources are available to provide adequate care.

Care of acute patients

13. Every effort should be made to avoid withdrawing or not providing treatment when this would involve significant risk for the patient and where the only justification for doing so are resource limitation and/or budget constraints.

14. If a patient is discharged or transferred early to allow a sicker patient to take the bed, the impact of the less ill patient's recovery should be minimised by alternate arrangements, such as properly organised community care.

[2] *Good Medical Practice.*

[3] Refer to *Doctors and health related commercial organisations.*

[4] See also Chapter 14 'Choosing Wisely – more isn't always better' in *Cole's Medical Practice in New Zealand* for a discussion on avoiding low-value care and inappropriate clinical interventions, and the need for well-informed conversations around the patient's treatment options.

[5] Refer to the statement on *Cultural competence.*

[6] See also the statement on *Telehealth* that outlines Council's expectation when care is provided to patients by telehealth.

15. When deciding whether to change or withdraw one patient's treatment to make way for another, doctors should consider the expected benefit or potential harm to each patient.
16. Always inform the patient about the decision being made and the reasons for it. Document such discussions.

Care of outpatients

17. As far as possible, assessment should fairly establish the patient's priority for treatment compared to that of other patients. For example, a patient receiving private care can at their request transfer to the public system but must do so based on the same priority assessment criteria as that applicable to patients in the public system.

18. Doctors have a responsibility to ensure that the process of assigning priority is appropriate. Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with their assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based and transparent.

19. Doctors making a referral to a service they know to be constrained should try to ensure that the referral contains all the information needed by the service provider to facilitate a fair assessment of the patient's priority.

20. A doctor who receives and assesses a referral must be appropriately qualified to do so. Where the referral does not contain the information required to make a fair assessment, a doctor should request the relevant information or return the referral to the referrer with a request for more specific information.

21. All referrals must be met with a timely and appropriate response.

22. It is good practice for the referrer and the service provider to keep each other informed of changes in a patient's priority while the patient is awaiting treatment.

23. While a service or team making a decision about the management of a patient is responsible for the effects of that decision, a doctor is still accountable for the doctor's actions within the team.

24. A doctor who has a patient in a booking system for treatment, should, to the best of their ability, ensure a patient is advised how long they could expect to wait for treatment and must ensure the patient is notified if the patient's priority changes. It is acknowledged that managing acute services in conjunction with elective services can sometimes make this difficult. The booking system must be accurately portrayed and must not be misused to shift patients from a doctor's care.

Where a decision has been made by the funder not to fund a specific service

25. Doctors cannot be held responsible in any forum for not providing what is not in their power to provide.

26. It is important to support the patient to make an informed decision about their treatment.[7] Doctors who are placed in a position where they are unable to provide a preferred treatment are advised to inform the patient what the preferred treatment involves, what the next best option is and what that involves. This discussion should be documented.

27. Where possible, doctors should outline the rationale for treatment being limited or denied. Where the reasons have dimensions that go beyond the technical expertise of the doctor to resolve, the doctor should instead refer the patient to the funding or responsible agency for an explanation.

28. Before making public statements about less than ideal services, doctors should first advocate for the provision of preferred services with their employer and/or agency funding or providing the service as appropriate.

29. Doctors working as medical directors may be expected to make decisions for their employers on whether or not procedures are medically necessary. Such decisions are both funding and medical decisions. Such medical directors are required to hold a current practising certificate and as such are subject to all provisions of the Health Practitioners Competence Assurance Act 2003.

[7] Refer to *Information, choice of treatment and informed consent.*

Managing elective procedures

30. Doctors should manage resource limitation issues concerning elective procedures in the same manner as they manage those concerning outpatient referrals (see points 17-29).

31. Where there are delays in the publicly funded health system and the public system is not the only avenue for treatment, the doctor should also advise the patient if services may be obtained privately.

32. Where a doctor has made a referral and is concerned about the subsequent management of that patient, they should discuss the case with the consultant, advocate for the patient and notify the consultant if the situation changes.

Managing workload

33. Doctors, like everyone else, have a right to reasonable quality of life outside their profession and to participate fully in the lives of their families. Within this context, it is reasonable for doctors to strive for efficiency so that they can provide more services, but not at the expense of lowering the quality of those services or putting their own health and quality of life at risk.

34. Doctors can be at risk of burn-out. Burn-out is particularly likely when a doctor's heavy workload lasts for an extended period of time. Doctors should be aware of the warning signs of burn-out in themselves and their colleagues.[8]

35. When doctors are unable to provide services that are both safe for themselves and safe for their patients, they should bring their concerns to the attention of management in their workplace or Primary Health Organisation (PHO), and should seek advice from an appropriate agency such as a peer, their College, New Zealand Resident Doctors' Association, Association of Salaried Medical Specialists, New Zealand Medical Association, the Rural GP Network, or their medical indemnity insurer.

Related resources

- ***Good medical practice***
- ***Cole's medical practice in New Zealand***
- ***Doctors and health related commercial organisations***
- ***Responsibilities of doctors in management and governance***
- ***Information, choice of treatment and informed consent***
- ***Telehealth***
- ***New Zealand Medical Association's* Code of ethics for the New Zealand medical profession**

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This statement is scheduled for review by June 2023. Legislative changes may make the statement obsolete before this review date. The contents of this statement supersede any inconsistencies in earlier versions of the statement.

[8] The American Counseling Association has some guidance on recognising burn-out available at http://www.workplaceblues.com/mental_health/recognizing.asp