



Statement on safe practice in an environment of resource limitation

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 doctors¹. Doctors who are unable to provide the preferred treatment because of resource limitation must inform the patient of the preferred treatment and must furthermore advocate for its provision.

Background

The rationing of health services is becoming more explicit. 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 asked 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 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.

Ethical principles

- 01 In clinical work, a doctor must make the care of the patient his or her first concern².
- 02 Doctors have a responsibility to try to provide the best standards of service possible with the resources available.
- 03 Resource limitation should be recognised as an important part of the environment of medical professional practice.
- 04 Doctors have a responsibility to the community at large to foster the proper use of resources and must balance their duty of care to each patient with their duty of care to the population. In particular this involves making efforts to use resources efficiently, consistent with good patient care.
- 05 Doctors working as managers, medical administrators or public health physicians must endeavour to allocate resources in the way that best serves the interests of a community or population of patients.
- 06 In all roles, doctors should use evidence from research and audit to endeavour to make the best use of the resources available.
- 07 Acting on these ethical principles in an environment of resource limitation will involve health professionals making and communicating prioritisation judgements to the 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.

Medical practice where available services are restricted

- 08 Doctors must support research, study and discussion so that the allocation of health resources is rational, based on need and evidence of benefit.
- 09 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.
- 10 Doctors must try to ensure that services are provided in a timely manner.

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

² Good medical practice, published by the Medical Council in October 2008.

11 Doctors who are managers or employers have a responsibility to both managers and staff to try to ensure that sufficient appropriately trained staff, suitable equipment and other resources are available to provide adequate care.

Dealing with acute patients

12 Every effort should be made to avoid withdrawing or not providing treatment when this would involve significant risk for the patient and the only justification for doing so is resource limitation.

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

14 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.

15 Always inform the patient about the decision being made and the reasons for it.

Dealing with outpatients

16 A service has a duty to ensure that only those referrals that can be seen within the resources available (including time, staffing and physical resources) are accepted.

17 As far as possible assessment should fairly establish the patient's priority for treatment compared to that of other patients. For example, a doctor working in both public and private practice should only be able to shift patients from his or her private practice to the public system if those patients are subject to the same priority assessment criteria and are not seen before more needy patients in the public booking 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 his or her assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based and transparent.

19 Doctors making a referral to a service he or she knows to be constrained should try to ensure that the referral contains all the information needed to ensure a fair assessment of the patient's priority.

20 A doctor who receives a referral which does not contain the information required to make a fair assessment, 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 he or she is awaiting treatment.

23 A service or team making a decision about the management of a patient is responsible for the effects of making that decision.

24 A doctor who has a patient in a booking system for treatment, should advise that patient, to the best of their ability, how long they could expect to wait for treatment and must notify the patient if his or her 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 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 this next best option 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 to their employer and/or the agency funding 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 decisions 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.

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 16-29).

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

32 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 where services may be obtained privately.

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

Doctors with excessive workloads

34 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.

35 Doctors can be at risk of burn-out. Burn-out is particularly likely when a doctor's excessive workload lasts for an extended period of time. Doctors should be aware of the warning signs of burn-out in themselves and their colleagues³.

36 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 or Primary Health Organisation (PHO) before taking any other action and should also seek advice from an appropriate agency such as a peer, their College, Association of Salaried Medical Specialists, New Zealand Medical Association, or the Rural GP Network.

Note

The Medical Council has prepared these guidelines as an expression of the standard expected of the profession at the present time. This is a rapidly changing area which involves difficult choices and if doctors are concerned then they should discuss their concerns with their colleagues.

Approved by Council October 2005

This statement is scheduled for review by October 2010. Legislative changes may make the statement obsolete before this review date.

³ The American Counseling Association has some guidance on recognising burn-out available at http://www.workplaceblues.com/mental_health/recognizing.asp
