Bioethics for New Zealand/Aotearoa

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Abstract

The New Zealand Medical Association (NZMA) is reviewing its Code of Ethics. The current Code is predominantly an individual patient-focused, doctor as independent practitioner and monocultural document, based substantially around the four principles of Beauchamp and Childress.

This paper discusses the limitations of this approach and describes three groups who have developed ethical codes that depart substantially from the NZMA; the Public Health Association, The New Zealand Nurses Organisation (NZNO) and the Putaiao Writing Group “Guidelines for Maori Research Ethics”. All of these put much greater emphasis on trusting relationships as a foundation for ethical behaviour, which the current NZMA Code of Ethics pays little attention towards.

This paper argues that the emphasis on the universality of the four principles is incompatible with the development of trusting relationships with diverse individuals and groups and is a barrier to culturally competent practice, public health practice and collaborative interdisciplinary practice.

The New Zealand Medical Association (NZMA) Code of Ethics is currently being revised. The draft revised Code acknowledges that changes to the health care environment have led to some additions to the Code. The Preliminary Statement notes that “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”. Section 70 addresses the need for doctors to have a responsibility toward society in matters relating to “health and safety, health promotion and education and legislation affecting the health or wellbeing of the community”. Proposed sections 71 and 72 add the importance of applying efforts to achieve health equity, and advocating for resources for patients and populations.

However despite the increasing acceptance of New Zealand/Aotearoa as a Bicultural nation and the Preliminary Statement noting recognition of the principle of partnership, there is no reference at all to Maori values such as the importance of relationships, nor to our increasingly diverse population.

The Health Practitioners Competence Assurance Act (2003) (HPCA Act) Section 118 requires registration authorities to set standards on just three things: clinical competence, cultural competence, and ethical conduct, and yet this document completely ignores the concept of cultural competence. In addition the draft Code does not address the need for mandatory health promoting practices necessary for safe public health.

The Code remains a predominantly individual patient-focused, doctor as independent practitioner and monocultural document. In this paper I will argue that more
widespread amendments are needed to meet the societal and health changes that we are currently facing.

The problem of autonomy

The current Code relies heavily upon the four principles (justice, beneficence, non-maleficence and autonomy) of Beauchamp and Childress particularly the principle of autonomy, both in relation to patient autonomy and physician autonomy. The primacy of this principle reflects its origin from the USA which is a highly individualistic society. This is not a good foundation upon which to respond to the challenges we face. Developing collaborative practice is very difficult if doctors behave autonomously.

The principle of autonomy has limitations for Māori and Pacific people who are traditionally collectivist societies. It is also problematic for Public Health practice where many activities are based on the “Wellbeing of the Collective”.

Doing the right thing

The NZMA Code is based around Principlism, substantially depending on the approach of Beauchamp and Childress. In summary they argue there is a Common Morality that has core tenets that are “not relative to cultures, groups or individuals.”, and that ethical problems should be analysed against this moral code in order to decide what is ‘right’ which consequently determines how to act. The underlying premise is that there is a “right” answer to most ethical problems and once found it is clear what should be done.

This premise can be questioned on several grounds. Autonomy is not unanimously accepted as a primary universal principle and other groups have adopted different principles which conflict with this such as “Guardianship of the environment and its resources”. More importantly this approach is in direct conflict with the concept of Cultural Competence.

The Medical Council Statement on Cultural Competence is explicit in section 13(c) “Attitudes A preparedness not to impose your own values on patients.” Despite their assertion that their Common Morality is not relative to cultures, groups or individuals, Beauchamp and Childress clearly hold some values that are distinctively American: “It is extremely difficult for morally compelling social objectives to outweigh basic rights.”

Increasing attention is being paid in New Zealand to the importance of process or “doing”; the development of the relationships required to achieve good ethical outcomes.

Change in burden of disease

The largest part of our work now is in managing chronic conditions: Mismanagement of chronic conditions is the leading cause of hospitalisations, accounts for 80 percent of all preventable deaths and is estimated to consume a major proportion of our health care funds. Chronic conditions account for a higher proportion of illness and deaths among Māori, people on low incomes and Pacific peoples than among the general population.
Effective management of patients with these conditions is not possible without effective collaboration between the clinicians involved in their care\textsuperscript{12}. As with smoking related chronic conditions, there will need to be a significant public health response to affect the obesity epidemic: bariatric surgery for all obese people is not a viable option.

**Collaborative practice**

Collaborative care between disciplines is one aspect of a move to better integrate care within and between health and social agencies. The National Patient Safety Foundation in the USA produced a substantial document looking at how to accelerate care integration. They view physician autonomy as a barrier to care integration:

> The principle of the autonomous physician…..is ill-suited to address the problems that many patients have today, where optimal solutions require collaboration, shared decision making, and cooperative care management. Continuing to inculcate in medical students the concept of the autonomy of the physician is a formidable barrier to preparing them for the collaborative activities and interactions required in an integrated care process for the patient. In fact, we believe it may be the largest single barrier that stands in the way of successful care integration going forward.\textsuperscript{13}

In New Zealand the Health and Disability Commissioner expressed similar views about the importance of integration in a submission to the review of the Health Practitioners Competence Assurance Act:\textsuperscript{14}

> …care integration is an important factor in quality service provisions and quality and safety are becoming increasingly dependent on how multidisciplinary teams and clinical networks operate. Failure or inadequacy in care integration is a recurring theme in complaints….which often result in consumers receiving a poor standard of care.

The current NZMA view that “some ethicists” think that in “some circumstances” doctors merely “recognise the need to work in collaborative groups” significantly downplays this imperative. In many circumstances doctors must work collaboratively with other clinicians to be able to address the needs of patients.

> The days of the brilliant solo operator in medicine are gone. From primary to tertiary care, healthcare is delivered by (interdisciplinary) teams, and the ability to be a team player is essential for the team to function well for the benefit of patients. Yet we still see the old medical hierarchy at play, with junior doctors, nurses, pharmacists and technicians feeling unable to speak up and question the treatment being provided to the patient.\textsuperscript{15}

Intuitively you might expect that nurses and doctors would share similar ethical codes, particularly if you believe in a “Common Morality”. However Hall\textsuperscript{16} believes the cultures of Medicine and Nursing have differing values and that compared with nurses, “The culture of physician training has focused on action and outcome more than on relationships.”

The New Zealand Nurses Organisation Code of Ethics\textsuperscript{3} has relationships as a central feature. Like the NZMA Code it is based around principles, but has expanded beyond Autonomy, Justice, Beneficence and Non-Maleficence to include Confidentiality, Veracity, Fidelity, Guardianship of the Environment and Being Professional. Each of these nine principles is examined as they apply to the different relationships nurses have: with clients, colleagues, organisations and society.

The question of adopting uniform codes of ethics was addressed in the recent review of the Health Practitioners Competence Assurance Act\textsuperscript{14} “the majority of submissions
agreed that there was sense in at least a degree of standardisation [of codes of ethics]”.
It stands to reason that if doctors and nurses shared a Code of Ethics, collaborative practice might be easier to develop and the process of collaborative practice may be more effective.

Diversity of the New Zealand population

New Zealand is the fourth most diversely populated country in the world as measured by proportions of people born outside of the country. Since 1996 the percentage of New Zealand residents born overseas has increased from 17% to 25%. In the seven years between the 2006 and 2013 censuses the Chinese population grew by 16%, and the Indian population by 48%.

Asia is the most common region of birth for the overseas born. The proportion of people from non-English-speaking backgrounds is also increasing; Hindi and Samoan are the most widely spoken languages in New Zealand after English and Māori.

New Zealand’s immigrant population is disproportionately concentrated in the Auckland region. In 2013, over half (52%) of the overseas-born population lived in Auckland, which was home to 33% of the country’s total population. Of the children cared for by the Auckland District Health Board, 13% are Māori, 20% are Pacific, 26% are Asian and just 40.5% are European and other.

Ethnic diversity brings a rich variety of ethical viewpoints and communities may not share a common view of ethical behaviour. The Kaiwhakahaere (Māori director) from the Health and Disability Commissioner noted:

“The cultural norm for Pacific Island people makes it difficult for them to complain and the concept of the Code of rights is hard to accept.”

Harding notes that Chinese approaches to ethics are significantly different “…Confucianism emphasises virtue, duty and context. The self in Chinese culture is subordinate to relationships with others”.

The Medical Council of New Zealand has a comprehensive Statement on Cultural Competence, but the only references in the draft NZMA Code are (clause 9) proscribing discrimination, and (clause 71) supporting efforts to achieve health equity. This fails to address many of the issues raised in the Medical Council Statement, and thus is at odds with the HPCA Act

Māori ethics

Te Ara Tika Guidelines for Māori Research Ethics demonstrates a different way of approaching ethics. The ethical principles in this document focus on relationships or “Doing”:

The Māori ethics framework references four tikanga based principles whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility), and mana (justice and equity) as the primary ethical principles in relation to research ethics. The outer quadrant relates to what has been termed minimum standards. The minimum standards are expected to have been met by researchers before ethics committee members consider ethical approval for the research project. The middle quadrant refers to good practice which indicates a more Māori responsive approach to the research project. Best practice extends the ethical consideration to align with expectations of behaviour within Te Ao Māori.
An important feature of the model is the stages of transition from the guiding principles on the outer circle, moving inwards to the highest level ethical obligations (figure 1). Researchers who operate at the centre are obligated not to deceive, manipulate or harm. Such an obligation cannot be fully carried out without a significant relationship with both parties trusting in each other, understanding respective values and goals, and reaching agreement by collectively working together.

This approach is not incompatible with the “Principles” approach. The document notes that:

The Māori ethical framework should be used in conjunction with the [Health and Disability Ethics Committee] Operational Standard\(^6\) and the majority of the concepts and issues identified within the Māori ethical framework can be referenced back to the Operational Standard.\(^4\)

What it does is change the emphasis of activity from analysis of the best option to developing a relationship between researcher and subject, who then analyse the problem together. They then agree on the most acceptable option.
Although the focus of this document is on ethical principles as applied to research, it also has application to clinical ethics. Research ethics is largely based on “Doing the right thing”, predominantly not causing any harm to research participants whilst gathering research data.

The conventional approach is to analyse the proposal in detail, anticipate ethical problems and determine ways to mitigate them. The participant can then either consent or refuse to participate. This process is based on the presumption that there is one “right” way to do the research. The Māori approach depends on developing a trusting relationship with rights and obligations for both parties and analysing the proposal together.

A presumption is made that if there is a good relationship then a way that both parties agree to will be found. Such an approach does not require full agreement on what the “right” thing is, they may not have congruent values, but on negotiating an agreed approach that is sufficiently cognisant of the important values of both parties. My contention is that a similar change of focus is needed for clinical ethics to greater highlight the importance of relationship and on negotiating an agreed approach, rather than the current focus on seeking the “right” approach.

**Pacific health and relationships**

The importance of relationship is also high in Pacific communities. In a report looking at a Pacific approach to Primary Care one of the four main results of the study was around the importance of relationship:

> Significantly, Pacific people judged the quality of their health care by their sense of whether or not the va [sacred space] was being respected. Consultations are more than just a commercial transaction in which doctors provide a service and patients pay; when the relationship between patient and health professional respects the va, then, to the Pacific person, there is a completely different quality to the relationship.

**Public health ethics**

Almost everything that a public health worker does affects the autonomy of individuals, from quarantining infectious people, limiting supply of tobacco to adults or adding fluoride to water supplies. Internationally and in New Zealand following the SARS scare there was much focus on public health ethics in a pandemic. Baylis argued that a relational framework for public health ethics works best for managing pandemics. The title of the New Zealand pandemic planning document was “Getting Through Together” and included values of:

> Neighbourliness/whanaungatanga helping and caring for our neighbours and friends helping and caring for our family/whanau and relations working together when there is a need to be met

And

> Respect/manaakitanga recognising that every person matters and treating people Accordingly, supporting others to make their own decisions whenever possible supporting those best placed to make decisions for people who cannot make their own decisions restricting freedom as little as possible, but as fairly as possible, if freedom must be restricted for the public good

The Public Health Association of New Zealand has developed a Code Of Ethical Principles For Public Health in Aotearoa New Zealand that extends these principles to apply to all public health practices. It retains many of the ethical principles in other
codes, although it omits autonomy. The important difference is the inclusion of Māori Principles such as Manaakitanga and Whanaungatanga that focus on the quality of relationships rather than the content of decisions. Like the Māori research ethics this is not incompatible with a “Principles” approach but again adds the importance of relationships and the quality of the decision making process.

**Relationships and trust**

An important element of a functional relationship is trust. The New Zealand Medical Council standard on medical practice in New Zealand “Coles Medical Practice in New Zealand” states:

> You should aim to establish and maintain trust with your patients. Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs.

Despite this the only sections in the NZMA Code of Ethics that refer to trust or relationship are

> “Preliminary Statement “In return for the trust patients and the community place in doctors, Ethical Codes are produced to guide the profession and protect patients”

1. Exploitation of any patient…..is unacceptable and the trust embodied in the doctor-patient relationship must be respected.

12. Patients must be able to trust their doctor to deal with their needs fairly and honestly”

> “37. Doctors should recognise that the doctor/patient relationship has a value and should not be disturbed without compelling reasons.”

There is nothing in the draft Code that addresses the importance of developing a trusting relationship and there is a presumption that the patient and community already trust doctors. It might be argued that this is a matter for “Professionalism” and should be limited to a statement in Cole’s Medical Practice. I would argue that in fact trust is central to ethical practice and that it was betrayal of trust by Professor Green at National Women’s Hospital that stimulated the development of the discipline of Bioethics in New Zealand, In her commentary following the Cartwright Inquiry Paul addressed trust explicitly:

> The revelations of the inquiry have damaged this trust and good faith not only in the National Women’s Hospital but also elsewhere in New Zealand. Many doctors are extremely perturbed about the new lack of trust. Those doctors need to stop and think. The trust that existed has been shown not only to have been misplaced but to have been dangerous to the women concerned.”

> “Inevitably, new consent procedures will be recommended, especially for patients concerned in research and teaching…… Patients will welcome more information and a greater chance to make informed decisions about their treatments, but I suspect that both doctors and patients will continue to worry about the lack of trust. People who are ill need to be able to trust their medical advisers, but that trust is not bestowed with a higher degree; if it has been abused it will need to be earned again.

Lewis subdivides trust into three types: cognitive, emotional and behavioural, although noting that they usually combine together. Rousseau adds the idea that people can also trust institutions (such as the hospital or the profession of medicine). Paul refers to providing patients with more information and being able to make
informed choices, an approach which is analogous to enhancing cognitive trust. The trust that ill people need to have in their medical advisors that is not “bestowed by a higher degree” is emotional trust; trust that has been built through a developing relationship.

Conclusion

Building and maintaining a relationship is a central ethical activity. The proposed updated NZMA Code of Ethics is still overly dependent on the “Four Principles” approach. The Principles approach particularly the emphasis on autonomy is the antithesis of good Culturally Competent care. Autonomous physicians preclude good collaborative care; individual autonomy is problematic for public health practice. Codes of Ethics have been developed by Public Health practice, Māori Research and Nursing with each proposing alternative models which combine the traditional ‘Principles’ with the importance of clinician – patient relationships. It is time that the NZMA ethical Code paid more attention to the quality of relationships.

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References:


