20 July 2010

Barbara Moore
Professional Standards Advisor
Pharmacy Council of New Zealand
PO Box 25 137
WELLINGTON 6146

Dear Ms Moore

Consultation on the Code of Ethics for the pharmacy profession

Thank you for the opportunity to comment on the Pharmacy Council of New Zealand's (the Council) revised Code of Ethics (the Code).

I acknowledge the Council's function under section 118(i) of the Health Practitioners Competence Assurance Act 2003 is "to set the standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession". It is therefore important that the Code reflects the principles and values the New Zealand public expects pharmacists to have when acting in their professional roles.

I commend the Council on ensuring that the Code stays relevant, applicable, and instep with the public's expectations.

I have made some specific comments and suggestions below for your consideration. I have also included valuable comments made by Judi Strid, Director of Advocacy.

General comments

I understand that during its revision of the Code, the Council has been influenced by professional standard statements from other jurisdictions. While it is useful to be aware of overseas developments, it is important that the Code sits comfortably in the New Zealand context. One way of achieving this is to use the terminology of New Zealand.

The terms "patient" and "healthcare provider" can be limiting and do not align well with the terms used in the Code of Health and Disability Services Consumers' Rights (the HDC Code). Furthermore, it is helpful to use terminology that is consistent with what is used across the health and disability sector.

I consider that where "patient" appears in the Code, it be replaced with "consumer". In my view, 'Patient' does not adequately reflect who a pharmacist may encounter in their work.

For example, a person may take preventive or regular medication (eg, the contraceptive pill or the elderly take aspirin as a precaution against blood clots), but do not consider themselves a ‘patient’.

In a similar vein, I also suggest that rather than using the term “healthcare provider”, the Code refer only to a ‘provider’. An aged care provider is likely to be a significant user of pharmaceutical products, yet may not be considered a “healthcare provider”.

Preamble
I suggest that the following be added to the section titled: *Additional references that directly or indirectly impact on the professional practice of pharmacy include*:

- New Zealand Disability Strategy 2001
- United Nations Convention on the Rights of Persons with Disabilities (ratified by New Zealand in 2008)

Principle 3
Sub-principle 3.6 has the potential to cause confusion, as some may wrongly construe this to mean that it is a pharmacist’s role to lobby for resources to meet a consumer’s needs (ie, the pharmacist is required to advocate to Pharmac). I recommend that this be clarified to accurately reflect the Council’s intended meaning.

To further complement Principle 3, I recommend adding a sub-principle that ensures pharmacists recognise the status of people with disabilities. I suggest the following:

> 3.4 Recognise the United Nations Convention on the Rights of Persons with Disabilities and endeavour to ensure people with disabilities receive services appropriate to their needs, and in a way that respects and acknowledges their cultural values and beliefs.

Principle 4
I suggest that sub-principle 4.7 requires an example of “exceptional circumstances”. By giving an example, it would help to give context to what constitutes an exceptional circumstance and act as a guide to a pharmacist querying whether they are required to disclose confidential information without the consumer’s consent.

Principle 5
Under Principle 5, I suggest including a reference to pharmacists actively participating in medicine safety initiatives. This could be either as a sub-principle, or combined with sub-principle 5.2. As you are aware, this Office receives numerous complaints a year regarding labelling and dispensing errors made by pharmacists. By adding such a reference, it would promote the importance of pharmacists engaging in medicine safety initiatives. Such an endorsement in the Code by the Council would highlight the importance of such safeguards, which in turn could help to reduce errors, and complaints.

Principles 5 and 6
Sub-principles 5.4 and 6.5 seem to address the same issue of a pharmacist’s requirement to comply with the standards issued by the relevant authorities. To ensure that the Code is not repetitive, I suggest that these sub-principles are combined. I consider that the most appropriate place for the combined sub-principle to appear is under Principle 5.

Definition
In keeping with my proposal to change “patient” to “consumer”, I also suggest that a definition of “consumer” be added in place of the current patient definition. I submit the following as a possible definition of consumer:

> Consumer means a health consumer or a disability services consumer, and includes hospital patients and residents in residential care and any person receiving any health or disability service from the pharmacy (or other place from which services are provided by the pharmacist).

Conclusion
Once again I commend the Council on its commitment to producing a Code of Ethics that accurately reflects the current climate pharmacists are practicing in. Overall, the ethical principles that are being promoted in the Code are consistent with the HDC Code. I trust my comments are of assistance, and I would appreciate receiving a copy of the final version of the Code when it is published.

Yours sincerely

Nicola Sladden
Chief Legal Advisor