Cole’s
Medical practice in New Zealand

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Preface to the 12th (2013) edition

This book is primarily for doctors beginning practice in New Zealand — graduating in New Zealand or educated elsewhere. You are welcome here: our country needs your services and we value your knowledge and skills.

The first editor of this book, Professor David Cole, wrote in his 1995 introduction,

"The aim has been to set down aspects of medical practice in this country that can loosely be regarded as concerned with professional medical conduct and practice. Most of this conduct is established by law, codes or by guidelines but in some instances the essentially dynamic standards are established by accepted practice or from case experience of disciplinary tribunals… Not only does the text outline various medical professional practices — what should be done — but also what should not be done, and the consequences."

A profession is a group that regulates itself, but self and state regulation must run side by side. The public interest must always take precedence over vested interest; competence must be maintained, ethical standards upheld, the regulatory process carried out by competent people, the processes transparent, fair, effective, flexible and responsive. In New Zealand, society permits self regulation by doctors but requires accountability in return, an accountability that doctors acknowledge by good medical practice in terms of demonstrable performance, and maintaining good health and proper conduct.

Quality is enhanced by competition among providers only when consumers are knowledgeable about the goods or services they buy. Competition works for bakeries, shoe shops and hairdressers, but it has limited and sometimes perverse results in the professions. Doctors do have special knowledge and skills, and thus inevitably, power, usually greater than that of their patients. Society allows them that power provided they use it for the common good. Doctors therefore have ethical guidelines and legal duties to use power properly, within boundaries that dissuade them from taking advantage of patients sexually, financially or emotionally, by lending spurious authenticity to quack methods, or by allowing their performance to slip.

Although doctors are intelligent, well motivated, self regulating professionals on the whole, they must also work within sometimes quite austere moral and ethical boundaries defined by their colleagues. The chapters here traverse what may be complex law, and they refer to further guidelines and ethical statements made by the Medical Council and other bodies over recent years.

The book’s main purpose is to introduce new entrants to medical practice in New Zealand to the main legislative and ethical standards and guidelines. Laws and even ethics change over time. What is permitted now may have been unacceptable not long ago: what can be contemplated now was never imagined longer ago: there is a good deal in here to interest the established New Zealand doctor too.

There are gaps and overlaps, of course, but I hope the book will be informative, especially to those entering or returning to medical practice in New Zealand.

Ian St George, February 2013
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CHAPTER 1

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Patients are entitled to good doctors. Good doctors make the care of patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy and act ethically.

**About Good Medical Practice**

Under section 118(i) of the Health Practitioners Competence Assurance Act 2003, a function of the Medical Council is to set standards of clinical competence, cultural competence and ethical conduct for doctors. Under Right 4 of the *Code of Health and Disability Service Consumers’ Rights* patients also have “the right to have services provided that comply with legal, professional, ethical and other relevant standards.” The Council has developed *Good Medical Practice* to be the foundation document for these standards.

The standards detailed in *Good Medical Practice*, and in other Council statements, are those which the public and the profession expect a competent doctor to meet and have been developed through discussion with the public and the profession. Where relevant, *Good Medical Practice* also provides guidance to assist doctors understand, and comply with, the requirements of legislation.

*Good Medical Practice* is not intended to be exhaustive. There may be obligations or situations that are not expressly provided for. In such circumstances, a doctor’s first priority should always be the care of his or her patient.

*Good Medical Practice* is not a Code of Ethics — it does not seek to describe all the ethical values of the profession or to provide specific advice on ethical issues, ethical frameworks and ethical decision-making. This type of advice is provided by the New Zealand Medical Association.

*Good Medical Practice* is addressed to doctors, but is also intended to let the public know what they can expect from doctors.

**How Good Medical Practice applies to you**

- For medical students, *Good Medical Practice* identifies the basic duties of a good doctor and serves as a source of education and reflection.

- For doctors, *Good Medical Practice* serves as a basis for you to monitor, and reflect on, your own conduct and that of your colleagues. The Health Practitioners Disciplinary Tribunal, the Council’s Professional Conduct Committees and the Health and Disability Commissioner may use *Good Medical Practice* as a standard by which to measure your professional conduct.

- For patients, *Good Medical Practice* provides guidance for assessing the minimum ethical and clinical conduct expected of doctors.
The directives outlined in *Good Medical Practice* are usually duties and must be followed. However, we recognise that not all duties will apply in all situations. Sometimes there are factors outside a doctor’s control that affect whether or not, or how, he or she can comply with some standards. Throughout this resource we have used the term “you should” (rather than a more directive term such as “you must”) to indicate where this is the case.

If you believe that a doctor is not meeting standards outlined in *Good Medical Practice*, you should raise your concerns with the doctor, draw that matter to the attention of the doctor’s employer, or report your concerns to the Registrar of the Medical Council¹ or the Office of the Health and Disability Commissioner², or in the event of matters related to health information privacy and security — the Office of the Privacy Commissioner³.

### Professionalism

Patients trust their doctors with their health and wellbeing, and sometimes their lives. To justify your patients’ trust, follow the principles outlined below and the duties outlined in the rest of this document.

**Caring for patients**

Make the care of patients your first concern.

Protect and promote the health of patients and the public.

**Respecting patients**

Aim to establish a relationship of trust with each of your patients.

Be aware of cultural diversity, and function effectively and respectfully when working with and treating people of different cultural backgrounds.

Treat patients as individuals and respect their dignity by:

- treating them with respect
- respecting their right to confidentiality and privacy.

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1 Telephone 0800 286 801 or email complaints@mcnz.org.nz. For more information, refer to the “Fitness to Practice” page of the Council’s website, [www.mcnz.org.nz](http://www.mcnz.org.nz).

2 Telephone 0800 11 22 33 or email hdc@hdc.org.nz. For more information, refer to [www.hdc.org.nz](http://www.hdc.org.nz).

3 Telephone 04 474 7590, or email enquiries@privacy.org.nz. For more information, refer to [www.privacy.org.nz](http://www.privacy.org.nz).
Working in partnership with patients and colleagues

Work in partnership with patients by:
- listening to them and responding to their concerns and preferences
- giving them the information they want or need in a way they can understand and ensuring they understand it
- respecting their right to reach decisions with you about their treatment and care
- supporting them in caring for themselves to improve and maintain their health.

Maintain the trust of colleagues, and treat them respectfully.

Work with colleagues in ways that best serve patients’ interests

Acting honestly and ethically

Be honest and open when working with patients; act ethically and with integrity by:
- acting without delay to prevent risk to patients
- acting without delay if you have good reason to believe that a colleague may be putting patients at risk
- never discriminating unfairly against patients or colleagues
- never abusing your patients’ trust in you or the public’s trust of the profession.

Work cooperatively with, and be honest, open and constructive in your dealings with managers, employers, the Medical Council, and other authorities.

Accepting the obligation to maintain and improve standards

Act in accordance with relevant standards.

Keep your professional knowledge and skills up to date

Recognise, and work within, the limits of your competence.

Be committed to autonomous maintenance and improvement in your clinical standards in line with best evidence-based practice.

Demonstrate reflectiveness, personal awareness, the ability to seek and respond constructively to feedback and the willingness to share your knowledge and to learn from others.

Accept a responsibility for maintaining the standards of the profession.

Remember that you are personally accountable for your professional practice — you must always be prepared to explain your decisions and actions.
**Areas of professionalism**

1. The Council expects doctors to be competent in:
   - caring for patients
   - respecting patients
   - working in partnership with patients and colleagues
   - acting honestly and ethically
   - accepting the obligation to maintain and improve standards

In the sections that follow, we outline the requirements of each of these areas of professionalism.

**Caring for patients**

**Principles**

*Make the care of patients your first concern.*

*Protect and promote the health of patients and the public.*

**Providing good clinical care**

2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
   - adequately assessing the patient’s condition, taking account of the patient’s history and his or her views, reading the patient’s notes and examining the patient as appropriate⁴
   - providing or arranging investigations or treatment when needed
   - taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient’s best interests.

3. In providing care you are expected to⁵:
   - provide effective treatments based on the best available evidence
   - consult and take advice from colleagues when appropriate
   - take steps to alleviate pain and distress whether or not a cure is possible.

**Safe practice in an environment of resource limitation**

4. Strive to use resources efficiently, consistent with good evidence based patient care, and balance your duty of care to each patient with your duty of care to the community and wider population⁶.

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⁴ See the Council’s statement on *Non-treating doctors performing medical assessments of patients for third parties*, which outlines the specific requirements for non-treating doctors performing medical assessments for other parties.

⁵ See the Council’s statement on *Telehealth* for information about providing services electronically or from a distance.

⁶ For more information, see the Council’s statement on *Safe practice in an environment of resource limitation*. 
Keeping records

5. You must keep clear and accurate patient records that report:
   - relevant clinical information
   - options discussed
   - decisions made and the reasons for them
   - information given to patients
   - the proposed management plan
   - any drugs or other treatment prescribed.

6. Make these records at the same time as the events you are recording or as soon as possible afterwards.

7. Take all reasonable steps to ensure that records containing personal data about patients, colleagues or others are kept securely.

Administrative systems

8. Your administrative systems must support the principles and standards contained within Good Medical Practice.

Prescribing drugs or treatment

9. You may prescribe drugs or treatment, including repeat prescriptions, only when you:
   - have adequate knowledge of the patient’s health
   - are satisfied that the drugs or treatment are in the patient’s best interests.

10. Before prescribing any medicine you should have a face-to-face consultation with the patient or, in the absence of a face-to-face consultation, discuss the patient’s treatment with another New Zealand registered health practitioner who can verify the patient’s physical data and identity. When neither of these options is possible or practical, it may be reasonable practice to:
   - Complete a prescription for a patient if you are providing cover for an absent colleague or are discharging a patient from hospital and review the patient’s notes.
   - Renew a prescription of a patient you, or a colleague in the same practice, have seen previously, following a review of its appropriateness for the patient. When the prescription has potentially serious side effects, you should regularly assess the patient.
   - Complete a prescription when you have a relevant history and there is an urgent clinical need to prescribe, provided that you inform the patient’s regular doctor as soon as possible.

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7 See the Council’s statement on The maintenance and retention of patient records
8 See the Council’s statement on Good prescribing practice.
9 For example, when a public health physician prescribes prophylactic medicines for family members of a patient, after that patient has been diagnosed with a serious communicable disease.
Providing care to yourself or those close to you\textsuperscript{10}

11. Other than in exceptional circumstances you should not provide medical care to yourself or anyone with whom you have a close personal relationship.

Treating people in emergencies\textsuperscript{11}

12. In an emergency, offer to help, taking account of your own safety, your competence, and the availability of other options for care.

Treating patients who present a risk of harm

13. If a patient poses a risk to your own health and safety or that of other patients or staff, you should take all reasonable steps to minimise the risk before providing treatment or making suitable arrangements for treatment.

Respecting patients

Principles

Aim to establish a relationship of trust with each of your patients.

Be aware of cultural diversity, and function effectively and respectfully when working with and treating people of different cultural backgrounds.

Treat patients as individuals and respect their dignity by:

\begin{itemize}
\item treating them respectfully
\item respecting their right to confidentiality and privacy.
\end{itemize}

Establishing and maintaining trust

14. 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.

15. Make sure you treat patients as individuals and respect their dignity and privacy.

16. Be courteous, respectful and reasonable.

\textsuperscript{10} See the Council’s statement on \textit{Providing care to yourself and those close to you}.

\textsuperscript{11} See the Council’s statement on \textit{The doctor’s duties in an emergency}. 
Cultural competence

17. New Zealand has as its founding document the Treaty of Waitangi. You should acknowledge the place of the Treaty, and apply the principles of partnership, participation and protection in the delivery of medical care. You must also be aware of cultural diversity and function effectively and respectfully when working with and treating people of all cultural backgrounds. You should acknowledge:

- that New Zealand has a culturally diverse population
- that each patient has cultural needs specific to him/her
- that a doctor’s culture and belief systems influence his or her interactions with patients
- that one’s culture may impact on the doctor-patient relationship
- that a positive outcome for patient and doctor is achieved when they have mutual respect and understanding.

18. You must consider and respond to the needs of all patients. You should make reasonable adjustments to your practice to enable them to receive care that meets their needs.

Personal beliefs and the patient

19. You must not refuse or delay treatment because you believe that a patient’s actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to affect your relationship with them.

20. Your personal beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right.

21. Do not express your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.

Treating information as confidential

22. Treat all information about patients as confidential and sensitive.

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12 See the Council’s Statement on cultural competence. For specific guidance on providing care to Māori patients, see the Council’s Statement on best practices when providing care to Māori patients and their whānau and Best health outcomes for Māori: Practice implications. For advice on providing care to Pacific patients, see Best health outcomes for Pacific peoples: Practice implications. See also Cole’s Medical practice in New Zealand for advice on providing care to Asian people in New Zealand.

13 New Zealand is a signatory to the United Nations Convention on Persons with Disabilities. This convention is intended to protect the rights and dignity of persons with disabilities. The convention includes provisions to ensure that persons with disabilities receive care appropriate to their needs, and at the same standard as others.

14 See the Health Information Privacy Code.

15 Rule 10 (1)(d) of the Health Information Privacy Code, allows you to disclose information about a patient in a limited range of circumstances, including when “disclosure [is] necessary to prevent or lessen a serious and imminent threat to public health or public safety or the life and health of an individual.”
Supplementary guidance — Sharing information in public

When sharing information in any public forum (including, for example, chatting in a hospital cafeteria or posting to a social networking site), do not disclose information about yourself that might undermine your relationship with patients. Similarly, do not disclose information that might identify and cause distress to colleagues, patients or their families.

Supplementary guidance — Sharing information with parents, caregivers or next of kin

When working with patients under 16 years, you should determine their competence to understand their condition and make decisions about their treatment. If they are competent, they are entitled to confidentiality. In the absence of a concern that the young person is at risk of harm, you should only share information with parents and caregivers with the patient’s consent.

When working with adult patients who have an intellectual disability or communication difficulties you should make a judgement as to whether you are acting in the patient’s best interests by sharing information with family or caregivers. Whenever possible you should seek the permission of the vulnerable adult to share information about their condition and treatment with others.

When an adult patient has died, advise the patient’s partner or next of kin, unless you know that the patient would have objected. When a patient under 16 has died, explain to the parents or caregivers to the best of your knowledge why and how the patient died.

Involving relatives, carers and partners

23. Actively involving relatives, carers and partners in a patient’s care is inherent to cultural competence and a positive doctor-patient relationship, and is often part of good clinical care. When appropriate you should seek the patient’s permission to involve relatives, carers and / or partners in their care. You must always be courteous, respectful and reasonable to relatives, carers, partners and others close to the patient. Make sure you are sensitive and responsive in providing information and support, for example, after a patient has died.

Supplementary guidance – End of life care

As a doctor you play an important role in assisting patients, families/whānau and the community in dealing with the reality of dying and death. In caring for patients at the end of life, you share with others the responsibility to take care that the patient dies with dignity, in comfort and with as little suffering as possible. You should take care to communicate effectively and sensitively with patients, their families and support people so that they have a clear understanding of what can and cannot be achieved. You should offer advice on other treatment or palliative care options that may be available. You should ensure that support is provided to patients and their families, particularly when the outcome is likely to be distressing to them.

Supplementary guidance – Euthanasia

You must not participate in the deliberate killing of a patient by active means. Euthanasia is an offence under the Crimes Act 1961 and illegal in New Zealand.
Dealing with adverse outcomes

24. If a patient under your care has suffered serious harm or distress you should act immediately to put matters right. You should express regret at the outcome, apologise if appropriate, and explain fully and without delay to the patient:

- what has happened
- the likely short-term and long-term effects
- what you and your health service can do to alleviate the problem
- what steps have been or will be taken to investigate what happened and (if possible) prevent it from happening again.
- how to make a complaint.

25. Patients who have a complaint about the care or treatment they have received have a right to a prompt, constructive and honest response, including an explanation and, if appropriate, an apology.

26. Do not allow a patient’s complaint to prejudice the care or treatment you provide or arrange for that patient.

Reporting of alleged abuse

27. If you have any concerns about alleged or suspected sexual, physical or emotional abuse or neglect of vulnerable patients, you should report this to the appropriate authorities without delay. You should inform the patient, and if the patient is under the care of another person, his or her caregivers of your intention to report your concerns, taking into account that such action might endanger you or the patient. Giving information to others for the protection of a patient may be a justifiable breach of confidentiality and, where a vulnerable adult is at risk of injury, is a legal duty.

Ending a professional relationship

28. In some rare cases, because of a lack of trust and confidence, you may need to end a professional relationship with a patient. If you do so, you must be prepared to justify your decision. You should tell the patient — in writing if possible — why you have made this decision. You should also arrange for the patient’s continuing care and forward the patient’s records without delay.

Working in partnership with patients and colleagues

Principles

Work in partnership with patients by:

- listening to them and responding to their concerns and preferences

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16 Refer to the Council’s statement on Disclosure of harm.
17 As outlined in the Privacy Act and the Health Information Privacy Code.
18 As outlined in s.151 of the Crimes Act 1961.
19 See the Council’s statement on Ending a doctor-patient relationship.
• giving them the information they want or need in a way they can understand and ensuring they understand it
• respecting their right to reach decisions with you about their treatment and care
• supporting them in caring for themselves to improve and maintain their health.

Maintain the trust of colleagues, and treat them politely and considerately.

Work with colleagues in ways that best serve patients’ interests.

Assessing patients’ needs and priorities

29. The care or treatment you provide or arrange must be made on the assessment you and the patient make of his or her needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.

Supporting self care

30. Encourage your patients and the public to take an interest in their health and to take action to improve and maintain their health. Depending on the circumstances, this may include:

• advising patients on the effects their life choices may have on their health and wellbeing and the outcome of treatments
• offering patients appropriate preventative measures, such as screening tests and immunisations, that are appropriate to their particular health status and consistent with guidelines and best practice
• encouraging patients to stay in, or return to, work or engage in other purposeful activities.20

Information, choice of treatment and informed consent21

31. You must familiarise yourself with the:

• Code of Health and Disability Services Consumers’ Rights22
• Health Information Privacy Code23.

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20 The Royal Australasian College of Physicians’ Consensus Statement on the Health Benefits of Work outlines the evidence that work is generally good for health and wellbeing, and that long-term work absence and unemployment generally have a negative impact on health and wellbeing. A copy of this paper can be downloaded from http://www.racp.edu.au/page/policy-and-advocacy/occupational-and-environmental-medicine.
21 See the Council’s statement on Information, choice of treatment and informed consent.
23 For a copy of the Health Information Privacy Code go to http://privacy.org.nz/health-information-privacy-code/
32. With rare and specific exceptions you should not provide treatment unless:

- the patient has received all the information that a reasonable patient, in that patient’s circumstances, would expect to receive about their condition and treatment options, including the expected risks, side effects, costs and benefits of each option; and

- you have determined that he or she has an adequate understanding of that information; and

- you have provided the patient with an opportunity to consider and discuss the information with you; and

- the patient has made an informed choice; and

- the patient consents to treatment.

33. In order that you can appropriately advise patients on their treatment options, you should have a reasonable knowledge of the range of evidence based treatments that are available to treat their condition, and of how patients can access those that you yourself do not provide.

34. You must respect and support the patient’s right to seek a second opinion or to decline treatment, or to decline involvement in education or research.

**Supplementary guidance — Informed consent in specific situations**

You should obtain separate written consent for research, experimental procedures, general or regional anaesthesia, blood transfusion or any procedure with a significant risk of adverse effects.

You should pay careful attention to the process of informed choice and consent when a proposed treatment is expensive or in any way innovative. If a patient is choosing between evidence based medicine and innovative treatments for which there is no scientific evidence, you should attempt to present to the patient a clear and balanced summary of the scientific information available.

Before providing treatment you should seek the advice of a senior colleague, or obtain legal advice, if you are unsure whether the patient is competent to make a particular decision, and:

- the patient’s wishes, or the wishes of a parent, guardian or caregiver, conflict with your assessment of the patient’s best interests; or

- the treatment is risky or controversial.

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24 Additional requirements apply in certain circumstances, such as where the patient is a minor or not competent to make an informed decision. In addition, there are several pieces of law that can override the requirements of the Code of Rights. The Council’s statement on *Information, choice of treatment and informed consent* outlines these requirements.
Supplementary guidance — Use of interpreters

When treating patients whose English language ability is limited, you should arrange to use a competent interpreter. When an interpreter has been used to assist in obtaining the patient’s informed consent you should note this in the records, along with the interpreter’s name and status (professional interpreter, family member etc) and, if possible, a note signed by the interpreter to certify that they believe the patient understands the information provided.

Advance directives

35. An advance directive is a formal document that clearly and specifically outlines or describes the patient’s wishes. Advance directives have legal standing in the Code of Health and Disability Services Consumers’ Rights. There may be exceptional circumstances in which it may not be appropriate to comply with the wishes outlined in an advance directive, however you must always respect and consider those wishes. If a patient has an advance directive that is relevant to their care you should, where possible, confirm that it is consistent with their current views before providing treatment.

Support persons

36. Patients have the right to have one or more support persons of their choice present, except where safety may be compromised or another patient’s rights unreasonably infringed.

Advertising

37. Make sure that any information you publish or broadcast about your medical services is factual and verifiable. It must not put undue pressure on people to use a service, for example by arousing ill-founded fear for their future health or by fostering unrealistic expectations. The information must conform to the requirements of the Council’s Statement on advertising, the Fair Trading Act 1986 and the Advertising Standards Authority guidelines.

Use of titles

38. Patients can find medical titles confusing. To reduce confusion, you should not use a title such as “specialist” or “consultant” that refers to an area of expertise unless you are registered with the Council in an appropriate vocational scope.

Working with colleagues

39. You must be aware of the impact of your conduct on members of your practice team and colleagues, and how that may affect quality care and treatment for patients.

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25 For example, where the patient is being treated under specific legislation such as the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1992 or when significant changes in the patient’s circumstances or condition or available treatments arising since the advance directive was made appear to counteract its validity or relevance.

26 This right is outlined in Right 8 of the Health and Disability Services Consumers’ Rights.

27 See the Council’s Statement on advertising.

28 Colleagues are those you work with, including doctors and other health professionals.

29 For more information, refer to the Council’s statement on Unprofessional behavior in the healthcare team.
40. You should respect the skills and contributions of your colleagues.

41. Treat your colleagues courteously, respectfully and reasonably. Do not bully or harass them. You must not discriminate against colleagues.

42. Do not make malicious or unfounded criticisms of colleagues that may undermine patients’ trust in the care or treatment they receive, or in the judgement of those treating them.

**Management**

43. You must always strive to work with managers and administrators in a constructive manner to create and sustain an environment that upholds good medical practice. If you are working in a managerial or leadership role you should adhere to the guidance contained in the Council’s statement on *Responsibilities of doctors in management and governance*.

**Being accessible**

44. Be readily accessible when you are on duty. Depending on the situation, this may mean you are accessible to patients, or it may mean that you are accessible to colleagues or a triage service.

**Going off duty**

45. When you are going off duty, make suitable arrangements for your patients’ medical care. Use effective handover procedures and communicate clearly with colleagues.

**Supplementary guidance — Shift handover**

In an environment where doctors work in rotating shifts, you should insist that time is set aside for the sole purpose of organising appropriate handover.

**Supplementary guidance — Arranging a locum**

Whether in private or public practice, you must take particular care when arranging locum cover. You must be sure that the locum has the qualifications, experience, knowledge and skills to perform the duties he or she will be responsible for.

**Sharing information with colleagues**

46. You should ensure that patients know how information is shared among those who provide their care.

47. You should seek the patient’s permission to, and explain the benefits of, sharing relevant information with other health practitioners and agencies involved in their care, including their principal health provider (who will usually be their general practitioner).

48. Once you have the patient’s permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay.
49. In most situations you should not pass on information if the patient does not agree. Some situations exist in which colleagues should be informed even if the patient does not agree (for example where disclosure is necessary to ensure appropriate ongoing care). Under the Health Act 1956 you may share information in these situations when a colleague is providing ongoing care and has asked for the information.

**Continuity of care**

50. Work collaboratively with colleagues to improve care, or maintain good care for patients, and to ensure continuity of care wherever possible.

51. Make sure that your patients and colleagues understand your responsibilities in the team and who is responsible for each aspect of patient care.

52. If you are the patient’s principal health provider, you are responsible for maintaining continuity of care.

**Supplementary guidance — Transferring patients**

Transfer of care involves transferring some or all of the responsibility for the patient’s ongoing care. When you transfer care of a patient to another practitioner, you must ensure that the patient remains under the care of one of you at all times. You should also provide your colleague with appropriate information about the patient and his or her care, and must ensure that the chain of responsibility is clear throughout the transfer. Where the transfer is for acute care, you should provide this information in a face-to-face or telephone discussion with the admitting doctor.

You must appropriately document all transfers.

You should ensure that the patient is aware of who is responsible for their care throughout the transfer, and how information about them is being shared.

**Supplementary guidance — Referring patients**

Referring involves transferring some or all of the responsibility for some aspects of the patient’s care. Referring the patient is usually temporary and for a particular purpose, such as additional investigation, or treatment that is outside your scope of practice. When you refer a patient, you should provide all relevant information about the patient’s history and present condition.

You must appropriately document all referrals.

When you order a test and expect that the result may mean urgent care is needed, your referral must include one of the following:

- your out-of-hours contact details
- the contact details of the another health practitioner who will be providing after-hours cover in your absence.

You must also have a process for identifying and following up on overdue results.

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30 Cole’s Medical practice in New Zealand contains some useful advice in the chapter on The management of clinical investigations.
You should ensure that the patient is aware of how information about them is being shared and who is responsible for providing treatment, undertaking an investigation and reporting results.

Supplementary guidance — Delegating patient care to colleagues

Delegating involves asking a colleague to provide treatment or care on your behalf. When you delegate care to a colleague, you must make sure that they have the appropriate qualifications, skill and experience to provide care for the patient. Although you are not responsible for the decisions and actions of those to whom you delegate, you remain responsible for your decision to delegate and for the overall management of the patient.

You should pass on complete, relevant information about patients and the treatment they need.

You should ensure that the patient is aware of who is responsible for all aspects of their care, and how information about them is being shared.

Supplementary guidance — Prescribing and administering of medicines by other health practitioners

You should support any non-doctor colleagues who are involved in prescribing or administering medicines as outlined below.

When other health professionals have prescribing rights

Some other health professionals have legal and independent prescribing rights. If you are working in a team with other health professionals who have prescribing rights, you should offer appropriate advice when needed to help ensure patient safety.

When non-doctor colleagues are supplying or administering medicines

Some teams delegate to non-doctors the responsibility for initiating and/or changing drug therapy. If a colleague is working from standing orders that have been issued under your authority, then you are responsible for the effects of the medicine being supplied or administered. You should be available to give them advice, and should regularly review how the standing order arrangement is working.

Supplementary guidance — Planning for transfer of care

You should have a plan in place to ensure continuity of care if you become unexpectedly ill.

If you are thinking of retiring or reducing your patient list, you should put transfer arrangements in place and let your patients know before these arrangements take effect. With the patient’s consent, all relevant medical records should be sent to the health practitioner taking over the care of the patient.

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31 Refer to the Ministry of Health’s Standing Order Guidelines. You can view or download a copy of these guidelines at http://www.health.govt.nz/publication/standing-order-guidelines
**Acting honestly and ethically**

**Principles**
Be honest and open when working with patients; act ethically and with integrity by:

- acting without delay to prevent risk to patients
- acting without delay if you have good reason to believe that a colleague may be putting patients at risk
- never discriminating unfairly against patients or colleagues
- never abusing your patients’ trust in you or the public’s trust of the profession.

Work cooperatively with, and be honest, open and constructive in your dealings with managers, employers, the Medical Council, and other authorities.

**Integrity in professional practice**
53. You must be honest and trustworthy in your professional practice and in all communications with patients.

**Sexual and emotional boundaries**
54. Do not become involved in any sexual or inappropriate emotional relationship with a patient. In most circumstances you should also avoid becoming sexually or inappropriately emotionally involved with someone close to a patient, or a former patient.

**Writing reports, giving evidence and signing documents**
55. If you have agreed or are required to write reports, complete or sign documents or give evidence, you should do so promptly, honestly, accurately, objectively and based on clear and relevant evidence.

**Supplementary guidance — Providing objective assessments of performance**
Be honest and objective when appraising or assessing the performance of colleagues, including those whom you have supervised or trained. Patients may be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

**Supplementary guidance — Writing references and reports**
Provide only honest, justifiable and accurate comments when giving references for, or writing reports about, colleagues. When providing references do so promptly and include all relevant information about your colleagues' competence, performance and conduct.

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32 See the Council’s guidance on *Sexual boundaries in the doctor-patient relationship.*
33 See the Council’s statement on *Medical certification.*
Financial and commercial dealings

56. Be honest and open in any financial or commercial dealings with patients, employers, insurers or other organisations or individuals.

57. Act in your patients’ best interests when making referrals and providing or arranging treatment or care. You must not allow any financial or commercial interests to affect the way you prescribe for, treat or refer patients. In particular:

- do not ask for or accept any inducement, gift, or hospitality that may affect, or be perceived to have the capacity to affect, the way you prescribe for, treat or refer patients. The same applies to offering such inducements
- do not exploit patients’ vulnerability or lack of medical knowledge when making charges for treatment or services
- do not encourage patients to give, lend or bequeath money or gifts that will benefit you
- do not put pressure on patients or their families to make donations to other people or organisations
- do not put inappropriate pressure on patients to accept private treatment.

Conflicts of interest

58. If you have a conflict of interest, you must be open about the conflict, declaring your interest. You should also be prepared to exclude yourself from related decision making.

Openness and investigatory or legal processes

59. You must cooperate fully with any formal inquiry or inquest (although you have the right not to give evidence that may lead to criminal proceedings being taken against you). When you provide information you must be honest, accurate, objective and the information provided must be based on clear and relevant clinical evidence.

60. You must not withhold relevant information from any formal inquiry or inquest, or attempt to contact or influence complainants or witnesses except where directed by the relevant authority.

Supplementary guidance — Giving evidence

If you are asked to give evidence or act as a witness in litigation or formal proceedings, be honest in all your spoken and written statements. Make clear the limits of your knowledge or competence.

61. You have additional responsibilities if you are involved in management or governance. In particular, you must ensure that procedures are in place for raising and responding to concerns.
Raising concerns about patient safety

62. Protect patients from risk of harm posed by a colleague’s conduct, performance or health.

63. If a colleague behaves in a manner which is inappropriate or unprofessional you should speak to them and raise your concerns in a constructive manner.

64. If your colleague does not respond to your concerns and continues to act inappropriately or unprofessionally, raise your concerns with a manager, appropriate senior colleague or the relevant external authority. Your comments about colleagues must be made honestly and in good faith. If you are not sure how to raise your concerns, ask an experienced colleague for advice.

65. If a colleague is concerned about the conduct, competence or health of another practitioner, or about a problem in the workplace, you should treat their concerns with respect and support them in taking action to address the concerns and in notifying the relevant authorities. You may need to provide less experienced colleagues with additional support to ensure that they have the confidence to raise concerns.

66. If you have reasonable grounds to believe that patients are, or may be, at risk of harm for any reason, do your best to find out the facts. Then you should follow your employer’s procedures or policies, or tell an appropriate person or organisation straight away. Do not delay taking action because you yourself are not in a position to put the matter right.

67. Under the Health Practitioners Competence Assurance Act 2003 you must tell the Council if you have reason to believe that a doctor’s ill-health is adversely affecting patient care.

68. You should also tell the Council about:
   - concerns you have that another doctor is not fit to practise or is not providing an appropriate standard of care
   - behaviour by another doctor that risks causing harm to patients.

69. If a colleague raises concerns about your practice, you should respond constructively.

Concerns about premises, equipment, resources, policies and systems

70. If you are concerned that patient safety may be at risk from inadequate premises, equipment or other resources, policies or systems, put the matter right if possible. In all other cases you should record your concerns and tell the appropriate body.

Your health

71. You should register with an independent general practitioner so that you have access to objective medical care. You should not treat yourself.

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37 See the Council’s statement on Raising concerns about a colleague.
38 Refer to the Council’s statement on Providing care to yourself and those close to you.
72. Protect your patients, your colleagues and yourself by:
   • following standard precautions and infection control practices
   • undergoing appropriate screening
   • being immunised against common serious communicable diseases where vaccines are available.

73. You must tell the Council’s Health Committee if you have a condition that may affect your practice, judgement or performance. The Committee will help you decide how to change your practice if needed. You should not rely on your own assessment of the risk you may pose to patients.

74. If you think you have a condition that you could pass on to patients, you must consult a suitably qualified colleague. Ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary.

**Disclosing concerns to the Council**

75. You must inform the Council without delay if, anywhere in the world:
   • you have been charged with or found guilty of a criminal offence
   • you have been suspended or dismissed from duties by your employer
   • you have resigned for reasons relating to competence
   • another professional body has made a finding against you as a result of ‘fitness to practise’ procedures.

**Being open about concerns and restrictions on your practice**

76. If you are suspended from working, or have restrictions or conditions placed on your practice because of a concern about your competence, conduct or health, you must inform without delay:
   • any other persons, or organisations, in which you are in partnership or association, or for whom you undertake medical work
   • any patients who would have a reasonable expectation to receive that information.

77. You must also give patients honest and accurate answers to any questions they have about restrictions or conditions on your practice.

**Supporting colleagues**

78. You should support colleagues who have problems with performance, conduct or health.

**Accepting the obligation to maintain and improve standards**

**Principles**

Act in accordance with relevant standards.

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39 See *The HRANZ joint guidelines for registered healthcare workers on transmissible major viral infections* (a statement developed by the Council with other regulatory bodies).
Keep your professional knowledge and skills up to date.

Recognise, and work within, the limits of your competence.

Be committed to autonomous maintenance and improvement in your clinical standards.

Demonstrate reflectiveness, personal awareness, the ability to seek and respond constructively to feedback and the willingness to share your knowledge and to learn from others.

Accept a responsibility for maintaining the standards of the profession.

Applying your knowledge and experience to practice

79. You must be competent in each professional role you hold. You must follow relevant guidance, including the guidance published by the Council, and continue to develop your knowledge and skills. This applies to all doctors, and to all aspects of your medical practice including management, research and teaching.

80. Recognise and work within the limits of your competence.

Research

81. When designing, organising or carrying out research:

- make sure that a properly accredited research ethics committee has approved the research protocol, and that the research meets all regulatory and ethical requirements
- do not allow payments or gifts to influence your conduct
- do not make unjustified claims for authorship when publishing results
- report any concerns to an appropriate person or authority
- be honest and accurate in reporting the results of your research.

Maintaining and improving your professional performance

82. Work with patients and colleagues to maintain and improve the quality of your work and promote patient safety. In particular:

- take part in audit, peer review and continuing medical education
- respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary
- contribute to inquiries and sentinel event recognition, analysis and reporting
- report suspected drug reactions using the relevant reporting scheme
- cooperate with legitimate requests for information from organisations monitoring public health
- participate in regular reviews and audit of the standards and performance of any teams of group in which you are a member, taking steps to remedy any deficiencies identified.

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40 See the Council’s guidelines on Continuing professional development and recertification
Keeping up to date

83. Keep your knowledge and skills up to date throughout your working life:
   • familiarise yourself with relevant guidelines and developments that affect your work
   • take part regularly in professional development activities that maintain and further develop your competence and performance
   • adhere to and keep up to date with all laws and codes of practice relevant to your work.

Mentoring, teaching, training, appraising and assessing doctors and students

84. Teaching and the passing on of knowledge is a professional responsibility. When you are involved in teaching you should demonstrate the attitudes, awareness, knowledge, skills and practices of a competent teacher.

Supplementary guidance — Providing supervision

Make sure that all staff for whom you are responsible and who require supervision, including locums, less experienced colleagues, and international medical graduates who are new to practice in New Zealand are properly supervised. If you are responsible for supervising staff, you should make sure you supervise at an appropriate level taking into account the work situation and the level of competence of those being supervised.

Related documents

The guidelines contained in Good Medical Practice do not cover all forms of professional practice or discuss all types of misconduct that may bring your registration into question.

You should familiarise yourself with the series of statements and other publications produced by the Council. The Council’s statements expand on points raised in this document. Some statements also cover issues not addressed in this document, such as internet medicine and alternative medicine.

Standards set by the Council

Below we list relevant Council statements and other publications.

Definitions

Clinical practice and non-clinical practice

Fitness to practise

Practice of medicine

41 See the Council’s publication Education and supervision for interns.
42 See the Council’s booklet on Induction and supervision for newly registered doctors.
43 For the most recent versions of the statements, go to www.mcnz.org.nz under the heading News and Publications. New and updated statements are sent to all doctors with the Council’s newsletter.
Administrative practice
Non-treating doctors performing medical assessments of patients for third parties
Raising concerns about a colleague
Responsibilities of doctors in management and governance
Safe practice in an environment of resource limitation

General subjects
Advertising
Complementary and alternative medicine
Confidentiality and the public safety
Cosmetic procedures
Disclosure of harm following an adverse event
A doctor’s duty to help in a medical emergency
Ending a doctor-patient relationship
Good prescribing practice
Information, choice of treatment and informed consent
The maintenance and retention of patient records
Medical certification
Doctors and health related commercial organisations
Use of the internet and electronic communication
When another person is present during a consultation
Sexual boundaries in the doctor-patient relationship, a resource for doctors

Health
HRANZ Joint guidelines for registered health care workers on transmissible major viral infections
Providing care to yourself and those close to you

Cultural competence
Best practices when providing care to Māori patients and their whānau
Cultural competence

Other Council publications
Best health outcomes for Māori: Practice implications
Best health outcomes for Pacific peoples: Practice implications
Legislation and standards set by other agencies

The Code of Health and Disability Services Consumers’ Rights gives rights to consumers, and places obligations on all people and organisations providing health and disability services, including doctors.

Traditionally the Code of Ethics for the medical profession in New Zealand is that of the New Zealand Medical Association.

The Health Information Privacy Code 1994 governs the collection and use of health information. A plain English edition has been published by the Office of the Privacy Commissioner and is available from www.privacy.org.nz

New Zealand is a signatory to the United Nations Convention on Persons with Disabilities. This convention is intended to protect the rights and dignity of persons with disabilities. The convention includes provisions to ensure that persons with disabilities enjoy full equality under the law, and have their rights and dignities protected.

Legislation places further legal obligations on doctors — consult your lawyer if you need advice about your legal obligations.
CHAPTER 2
The organisation of medical services in New Zealand

John Adams is Chairman of the Medical Council and Dean of the Dunedin School of Medicine.


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Organisation of medical services in general practice 34
Introduction

New Zealand has a proud history of social reform and innovation, including health service provision. New Zealand trained doctors have contributed significantly on the international stage over decades, in spite of the country’s small size, highlighting the high standard of medical practice. There are strong structures in place to protect patient rights and ensure that people receive the highest level of medical care possible within the available resources.

Health service structure

Medical Services in New Zealand are primarily delivered through publicly funded services. Public funding accounts for about 80 percent of service provision. Twenty District Health Boards (DHBs) are largely responsible for dispersing the public funds, and purchasing required medical and disability services from public hospitals, general practitioners and nongovernment organisations. Care in public hospitals is free, general practice visits and most pharmaceuticals are subsidised.

The governance of the DHBs lies with a board for each region that is partially elected at local body elections and partly appointed by the Minister of Health. Boards are responsible to the Minister of Health through the Ministry of Health, by contract. Each Board has a chief executive who is responsible for operations and management. Many have held the view that there are too many Board areas for a country of New Zealand’s size, and active collaboration and combination between Boards is occurring, supported by the government.

Doctors who work in public hospitals are employed by the DHBs, mostly under the terms of national industry employment agreements covering senior doctors (SMOs) and registered medical officers (RMO) separately.

Many senior doctors also work in private settings, charging patients the full fee for their services. Private hospital services are also full charge to the patient. Several companies provide private health insurance with differing reimbursement plans.

General practitioners predominantly own their practices, although some employment models are emerging, including some DHB primary care services in hard to staff areas. Urban areas may also be serviced by accident and medical clinics owned by conglomerates who employ doctors to staff the centres.

General practice services are organised into Primary Health Organisations (PHOs), governed by Boards. Through the DHBs, PHOs receive capitated government funding, which is passed to general practices and provides varying levels of subsidy for patient visits. All patients need to be registered with a practice. Most general practitioners charge most patients a fee for service.

Similarly to the moves to merge DHB operations, there have been clear directions that the number of PHOs around the country is to be reduced.

New Zealand has a “no fault” accident compensation scheme which pays for a portion of treatment for accidents in primary care and in some specialist services, particularly surgery. The Accident Compensation Corporation (ACC) also pays public hospitals bulk amounts for their treatment of accident victims.
The “no fault” scheme includes injury caused by medical treatment. Because of this there is only a right to sue in New Zealand for recompense of injuries that fall outside the scheme, or in cases of severe negligence where exemplary damages can be sought. Doctors are therefore seldom sued.

Ministry of Health and National Health Board

The Minister of Health has overall responsibility for the health system and the Ministry of Health is principal adviser to the Government on health and disability policy, and is responsible for leading and supporting the sector. The Ministry has recently undergone significant changes and restructuring, with reductions in staffing levels and the creation of a National Health Board within its structure.

The National Health Board is responsible for planning analysis and funding, performance monitoring, workforce, purchasing of national services, information strategy and delivery and business services in the Ministry.

Changing models of care

Whilst general practice care had been the foundation of medical care in New Zealand, until the last decade, general practice had become less well remunerated and less attractive as a specialty. Significant additional funding has reversed this trend, and moves are currently underway to further emphasise primary care delivery as the focus of patient care. There are initiatives to expand the services delivered by general practitioners and reduce barriers in the primary/secondary interface. There is also a project to redevelop general practitioner training, and attract more trainees into general practice.

Registration of doctors

Registration and regulation of health practitioners is legislated by the Health Practitioners Competence Assurance Act 2003, which sets up responsible authorities for each health profession, and prescribes processes for assuring standards of competence, conduct and fitness to practise. Regulatory authorities set scopes of practice for each registrant.

Medical vocational or specialist registration is recognised after the attainment of appropriate Australasian or New Zealand specialist college qualifications, or qualifications and training that are deemed to be as satisfactory as this. Doctors can practise independently with general registration, but require a collegial relationship to oversee their work.

International medical graduates can apply for registration under several pathways according to their planned work arrangements in New Zealand. Both provisional general and vocational registration require a period of supervision. The Medical Council (see below) engages with Branch Advisory Bodies to assess whether doctors from overseas applying for vocational registration have equivalent or as satisfactory training as New Zealand trained specialists.
Details of registration for international medical graduates are available on the Council website (www.mcnz.org.nz).

The Medical Council of New Zealand

The Medical Council of New Zealand (the Council) is the regulatory authority for medical practitioners. Its statutory role is to protect the health and safety of the public in New Zealand by ensuring that doctors are competent and fit to practise. The Council registers doctors and issues practising certificates, deals with issues of competence when they arise and may institute remedial competence programmes, refers conduct issues for further assessment if required, and assesses and monitors the health of sick doctors.

It is not a disciplinary body, although it manages some complaints to do with professional conduct. All patient complaints in New Zealand are channelled initially through the Health and Disability Commissioner’s Office (see Chapter 29).

The Council is also responsible for accrediting educational programmes for doctors including medical schools, vocational training programmes and the intern (PGY1) year. In practice, much of the accreditation of medical schools and Australasian colleges is done in collaboration with the Australian Medical Council (AMC).

Workforce

Future workforce issues have been a major discussion topic for over a decade. There have been several reports indicating the need for concerted action to provide enough doctors in New Zealand as the demands increase with an aging population and changing workforce patterns. A series of recent reports led to the creation of Health Workforce New Zealand as a committee to advise both the Minister of Health and the Director General of Health on a workforce plan and its implementation. The committee is working quickly and has established a workplan and several initiatives, including redeveloping the general practice training and piloting physician assistants in the New Zealand context.

Education and postgraduate training

There are two medical schools in New Zealand, at Auckland University and the University of Otago, which has campuses for medical training in Dunedin, Christchurch and Wellington. The government has recently increased student numbers in both schools. There are placements for undergraduate students in all major hospitals and increasingly in provincial and rural hospitals. General practices throughout the country are also involved in undergraduate experience and teaching. Both medical schools have established rural programmes.
Training in the first postgraduate year (PGY1 or probationary registration year) is managed by the hospitals who are accredited by the Medical Council to provide an adequate supervision and training experience. Vocational training is the responsibility of the colleges in association with the employers and the universities. The training programmes are set and supervised by the specialist colleges, and purchased from the health providers through Health Workforce New Zealand. Specialist qualifications in New Zealand are Fellowships of the specialist colleges, gained after meeting their training and examination requirements.

All doctors in New Zealand must participate in a continuing professional development (CPD) programme in order to gain their practising certificate. The Medical Council accredits these programmes and audits compliance by doctors.

Generally registered doctors not in training programmes or engaged in nonclinical work, must now join an online CPD programme delivered by BPAC New Zealand.

**Medical liability**

Whilst doctors are rarely sued in New Zealand, there are numerous ways in which their conduct and competence can be investigated including by employers, the Health & Disability Commissioner, Coroners inquiries, the Medical Council, etc. Indemnity cover is recommended and required by most employers. It is usual for employers to reimburse fees. Indemnity organisations provide legal advice to individual doctors.

**Drug purchase and prescribing**

Medicines are purchased in New Zealand on behalf of the government by a central purchasing agency called PHARMAC. PHARMAC establishes a schedule of subsidised medicines which details the various restrictions and availability of medicines. Some drugs are only available for prescription by specialists, and others require a special authority to be prescribed.

**Medical research**

New Zealand has an international reputation for the quality of its medical research. Increasingly, research is also performed outside the universities, in DHBs and primary care. Funding for medical research is tight, but available from many sources for good projects. The predominant purchaser of medical research in New Zealand is the Health Research Council, which distributes more than $70 million annually of public funds.
**Doctors’ associations**

The major professional association in New Zealand is the New Zealand Medical Association (NZMA), which has Specialist, General Practitioner and Doctors in Training Councils. The NZMA publishes the New Zealand Medical Journal, deals with medicopolitical issues and generates the Code of Ethics. Smaller special interest associations such as Te ORA (the Māori doctors’ association) and the Pasifika Medical Association cater in addition for the needs of some specific groups of doctors. Industrial organisations for senior doctors (Association of Salaried Medical Specialists), and house surgeons and registrars (Resident Doctors’ Association), are responsible for negotiating with health providers for salaried doctors terms and conditions.

**Organisation of medical services in hospital practice**

The 6th year of medical school in New Zealand is known as the “Trainee Intern” year, where students participate in medical teams in a junior capacity whilst maintaining their student learning. After graduation, the intern or PGYI year is a probationary registration year with requirements from the Medical Council having to be met before general registration (a general scope of practice) is approved. Most young doctors complete a second house surgeon year before entering formal training programmes in their chosen specialty.

Once in a vocational training programme, registrars (residents) come under the auspices of the relevant college, and are supervised by college accredited supervisors. After fulfilling the required training experience and exams, registrars become fellows of the appropriate college, gain vocational registration (a vocational scope of practice) with the Medical Council and are employed as Senior Medical Officers with the DHB. The medical structure of health delivery teams on a service usually consists of a SMO, registrar, house surgeon and possibly trainee intern.

**Organisation of medical services in general practice**

General practitioners in New Zealand are both vocationally registered and generally registered practising under the supervision of a collegial relationship (ie, practising in a general or a vocational scope). Trainee interns also contribute in general practices, where they are under the supervision of the general practitioner. In recent years, some funding has been made available for house surgeons to experience attachments in general practices. General practice registrars are employed by general practitioners to provide services as a part of training. Most general practitioners own and run their own practices as small businesses either individually or more commonly in groups.
CHAPTER 3

The doctor patient relationship

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The doctor patient relationship is central to the practice of medicine and to achieving effective clinical outcomes. While it has also been considered as the seventh element of quality in general practice settings, all practitioners can derive a deep sense of satisfaction through good doctor patient relationships.\(^1\) Many relationship skills can be learned through role modelling, but specific educational interventions are required for higher levels of competence.\(^2\) Clinical relationships need to be understood and developed effectively, as they can also be a source of great discomfort and even harm to both patients and doctors.

This chapter outlines the underlying principles of the doctor patient relationship, and how listening is essential to good medical care. We will then discuss two approaches to clinical practice called patient centred clinical method and whole person care. Reflection on practice is essential if relationship skills are to be improved. Finally, we will discuss more challenging interactions, including how to end the doctor patient relationship.

**Qualities of an effective doctor patient relationship**

Professionalism is the basis of medicine’s relationship to society and can be viewed as a social contract.\(^3\) As part of this contract, doctors have an obligation to maintain their competence.

In addition, doctors are expected to be trustworthy, moral, honest, accountable, and compassionate. They need to work in the best interest of the patient while preserving their confidence.

Although the clinical context is rapidly changing, what patients want from their doctor is clear — caring, kindness, courtesy and compassion.\(^4\) General practitioners also focus on a “holding relationship” which maintains a trusting, constant and reliable relationship with ongoing support, often without the expectation of a cure.\(^5\)

Doctors will interact with patients from a wide range of ethnic, cultural, social, and economic backgrounds. Patients may have lifestyles which include different underlying values to the doctor’s own; it is essential that respect for all patients and whanau is upheld. This is also mandated in New Zealand’s Code of Health and Disability Services Consumers’ Rights.

Confidentiality can only be broken in extreme cases of imminent harm to the patient or others. It is the doctor’s responsibility at all times, and through the systems that they work in, to maintain confidentiality and privacy of all patient information.

Trust is an important quality in the therapeutic relationship, yet it is often not explicitly negotiated with the patient. Patients may be quite vulnerable when they are making a decision to trust their doctor, sometimes within only a brief interaction. Trust can be developed and deepened if doctors show an early interest in the patient, display sensitivity to patient emotion, give time, build alliances and for short periods of time step outside their prescribed role (for example using shared humour).\(^6\) Doctors who encourage patients to talk, check understanding, provide information, and use humour are less likely to receive complaints.\(^7\) At the heart of each relationship is effective and culturally competent communication. Listening is a key ingredient.
CHAPTER 3 THE DOCTOR PATIENT RELATIONSHIP

The importance of listening

Many older doctors in clinical practice have developed their own style of consulting over time, largely through trial and error. While many have an effective bedside manner, the research on consulting skills indicates that good communication can be taught and learned and that it is not necessarily an innate or intuitive skill. For these reasons, most medical schools now include consultation training as part of their clinical skills programmes. Students are taught about the structure of each consultation and how to use “microcommunication skills” (introductions, open and closed questions, exploring the patient’s ideas, minisummaries, and so on). The outcome of this training is better listening, which in turn, improves the doctor patient relationship.

The three major functions of listening are to help make an accurate diagnosis, to develop and maintain the doctor patient relationship, and to act as a healing and therapeutic agent. Adler for example, has researched the “sociophysiology of caring”, where empathic listening can cause physiological changes in muscle tension and blood pressure. It can be profoundly helpful if the doctor is fully present and engages with the patient’s story and situation. “Being heard” in this way can help the patient make better sense of their illness. These undergraduate training programmes are usually embedded in what is known as a “patient centred” approach to clinical practice.

Patient centred clinical medicine

The underlying knowledge basis of modern practice is known as biomedicine, a relatively new approach to individual illness that emerged in the sixteenth and seventeenth centuries. This particular medical model has of course, been very powerful, affording an advanced understanding of the problems of the human body. In the last 50 or so years, there is also increasing evidence that communication skills in each consultation will improve the health outcomes of patients. Such evidence is the rationale for emerging models of clinical practice such as the patient centred clinical method.

This clinical model differentiates between the “disease” (symptoms, pathophysiology, diagnosis, investigations, and treatment) and the “illness” (the patient’s ideas, feelings, effect on daily life, the meaning of being unwell, any anguish or suffering), or in other words, the personal experience of illness. While the patient’s disease is never really “separate” to that person, this conceptual differentiation is useful as it affords some objectivity for both doctor and patient. The doctor has a body of knowledge about each disease that usually helps to predict the clinical course. The patient’s concerns are validated and justified as he or she has a legitimate problem.

In the patient centred clinical method, doctors weave between the disease and the illness in each consultation, attending to relevant disease details while also eliciting the patient’s concerns and illness experience. This approach leads to a better negotiation of the outcome of the consultation where the patient’s ideas and expectations often impact on decision making. Being patient centred does not imply giving patients what they want; instead, the name emerged as a reaction against older more paternalistic styles of biomedical practice where doctors made unilateral decisions. The patient centred model of consulting has been very influential, even if most senior doctors have not been explicitly trained in its use.
Whole person care

The whole person care model further explores the implications of being patient centred. Hutchinson has usefully noted that the doctor really has two relationships to consider: his knowledge and skills in relation to disease (the details or “content” of medical work); and the doctor patient relationship (Figure 1). Each relationship has a different set of characteristics requires a specific approach. The goal with the former is cure, or at least modification of the disease process. The goal with the latter is modification of the illness experience through relief of suffering, professional guidance, support and long term care. The goal of this interpersonal relationship is to help the patient gain greater tolerance and equanimity in the face of disease.

Figure 1. The two relationships and tasks in medical practice

When the doctor and patient focus on cure of acute illness, the patient’s goal is usually to regain full function. In chronic disease however, disease is never fully cured. It is even more important here for the doctor to attend to the illness experience and any potential suffering caused by disease. A caring, long term relationship is required where the doctor stands alongside and supports the patient. Identifying and attending to suffering is crucial for many patients.

The whole person care model is a helpful reminder to the medical profession of the two main tasks of doctoring: identifying and managing disease on the one hand, and attending to the person of the patient on the other. This is the essence of the doctor patient relationship.

Monitoring your consultation style

Another feature of modern undergraduate medical training is the emphasis on careful review of clinical work. Reflection involves “thoughtfully considering one’s own experiences in applying knowledge to clinical practice, while being coached by professionals in the discipline.” Most medical students are now required to analyse and review their consulting skills as well as to write about or discuss their seminal learning experiences. These activities are known as “reflection on action”, as they usually occur after the event. The overall goal is “reflection in action”, the capacity for increased awareness of the ebb and flow in each consultation, whether in hospital practice or in primary care.
Modern methods of reflection include peer groups, video analysis, Balint groups, mentoring and supervision. Peer groups have been well developed in New Zealand and are included as part of general practitioners’ requirements for recertification. These groups started in the 1980s and are self run by small groups of doctors who meet regularly to discuss their clinical work.

Video analysis of a series of consultations is now required by general practice trainees. Many report that such analysis has enabled a better understanding of their own style of consulting. Balint groups emerged in the United Kingdom in the 1950s when Dr Michael Balint ran general practitioner groups to discuss their more “difficult” or troubling patients. Some medical schools in Europe now use these groups in undergraduate training. The method itself has since evolved considerably and Balint groups are now becoming more popular, especially using multidisciplinary groups.

Mentoring and supervision are one to one methods of clinical review and support. Mentoring is usually with a more senior colleague who can help a junior enter their chosen field, provide support when doctors are under stress, or help a doctor start work in a new country. Supervision is usually with a psychotherapist and is more focused on the nuances of the doctor patient relationship. Because the therapist does not have medical training, there is less chance of becoming side tracked by biomedical details. Doctors can also improve their psychological understanding of patients through this ongoing method of professional support. All these methods are aimed at better understanding of the quite diverse doctor patient relationships in modern clinical practice.

**Challenging situations**

These methods of reflective practice are useful when clinical situations or particular patients are challenging to the doctor. There is an interesting literature from the UK on the “heartsink” patient, where the doctor’s heart “sinks” to floor when consulting with or even thinking about a particular patient. Most doctors will admit to having several such patients, where they feel quite challenged or even inadequate. While a few patients will prove problematic for almost all doctors, most patients who are labelled in this way are simply illustrating specific problems in the doctor patient relationship. Identifying and analysing why each patient is “difficult” can be extraordinarily helpful, both for the doctor and for the patient.

Some patients however, are problematic for many doctors. “Challenging” patients tend to confront the doctor’s assumed authority, while “cling” patients make unrealistic demands on the doctor’s time or potential effectiveness. “Self destructive” patients include those with alcohol, drug and gambling problems. Many doctors find it difficult to acknowledge that they are relatively powerless to intervene. Cultural barriers or other factors preventing adequate communication can also induce feelings of frustration and impotence. All these patients can be troublesome because they don’t conform to the doctor’s own expectations of feeling competent and effective, or because they are not displaying the “proper” behaviour expected of patients.
Balint groups and supervision are particularly useful methods of reflection and support, as they focus directly on the doctor patient relationship. Acknowledging that some patients are challenging and disruptive to the doctor’s self esteem and equilibrium is helpful, as without the benefit of such insight, some doctors avoid engagement. While this can lead to poor outcomes for patients, the doctor also misses out on his or her usual sense of purpose and meaning that emerges from productive therapeutic relationships. In this way, reflective practice about these challenging or “heartsink” patients can also help avoid burnout and compassion fatigue.

Patients with somatisation can be particularly challenging to the doctor patient relationship. Such patients usually present with multiple somatic complaints but no underlying organic pathology is found. While many can be educated about links between their stress and their symptoms “facultative” somatisation), there is a small group of “obligate” somatisers who are much more difficult to manage. Unnecessary investigations often emerge from these unsatisfactory consultations, illustrating what is known as “somatic fixation” by both doctor and patient. Learning how to approach the somatising patient is an important clinical skill in all areas of medical practice.

Other challenging situations are in relation to maintaining appropriate professional boundaries and when ending a therapeutic relationship.

**Sexual boundaries**

Given the power imbalance between doctor and patient, setting and maintaining appropriate professional boundaries is the responsibility of the doctor. A sexual relationship with a patient is never acceptable, as it violates the trust in the relationship and is harmful to both parties. The Medical Council provides clear guidelines about sexual boundaries and any doctor who is sexually attracted to a patient is strongly advised to seek help from a trusted colleague. As professional role boundaries are complex, both medical students and doctors need ongoing education and support in this area of professional practice.

**Ending a relationship**

Occasionally, the therapeutic relationship may become too damaged to continue. The patient and the doctor must be clear about the reasons for ending the relationship and the transfer of care needs to be managed carefully. In some situations, expert medical and legal advice is helpful, but termination of care cannot occur if acute or emergency care of the patient is required. Further models around ending a relationship in the general practice setting are described by Stokes.

In depth guidance is outlined by the MCNZ.

In summary, the doctor patient relationship is central to the practice of medicine. Clinical relationships require as much focus and attention as technical competence and biomedical details. The outcomes of this focus on relationship are improved clinical outcomes, enhanced practitioner satisfaction and a greater sense of professional wellbeing.
References


CHAPTER 4

Cultural competence and patient-centred care

Jean Hera was a lay member of the Medical Council from 2001—2009 and has a background in consumer health issues, social and community work.


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Cultural competence and patient-centred care — a consumer perspective

As a patient I feel vulnerable and I find it hard to feel empowered even as a knowledgeable and assertive person. Although I was born in this country, have always lived here, and I am from the “dominant” culture, the health environment often still feels strange and alienating to me even though I know a lot about it, including my rights as a health consumer and how to follow up on any concerns that I may have. I feel nervous about what I don’t know and also what I do know from my own past experiences and the stories I have heard from others. I have also personally experienced and heard about many excellent health experiences but somehow the not so good ones are often more prominent in my mind. I am aware that it can be far more difficult for patients with less education, whose culture is far removed from the context they are in, for those who feel judged because of how they look, act or because of their lifestyle, for those who don’t have English as a first language or who barely speak English at all, and for many of those who can no longer speak or act for themselves.

What then is important to myself and other patients in receiving culturally competent patient-centred medical care? This is not an easy question to answer simply, and certainly not on behalf of others in all their diversity. It is questionable whether I should even attempt to speak on behalf of others. However in my roles as a lay member or health consumer representative I am attempting to bring a strong and inclusive (but reasonable) consumer voice. Therefore I will attempt to do this.

We patients need you, our doctors, to develop a general and interconnected set of attitudes, behaviours, knowledge and skills that enable you, to be nonjudgmental and show us respect and understanding, to be approachable, and to communicate well. We want you to behave in ways that make us feel safe, assist us to ask questions and give feedback about any concerns we have, and we want to be listened to. If our requests cannot be accommodated we want you to be honest with us about why this is. It is helpful when you are friendly, and pronounce our name correctly or at least talk with us so that you can learn how to do this. We appreciate it when you show humility and assist us to tell you if there is any cultural need we may have that you are not aware of. If it is possible, help us to ensure that any important cultural requirements we have are accommodated.

As a general rule we want to be active partners in our health care decision making however in some cultural contexts we may not want this and we may not find it easy to communicate this to you. If we do not understand you we may find it hard to tell you this and in some cultural contexts even nod as if we do understand. We hope that you do not label us as noncompliant or difficult but work to find ways to understand our reality and adapt to this.

We also need doctors to engage well and in a culturally competent way with our family and other support people when this is appropriate. We hope that our doctors are culturally sensitive in all aspects of their work with us, not just to our face, and when we are conscious. Cultural competence also needs to extend beyond the patient to apply to interactions with colleagues and others encountered in the health environment to help ensure safe, collaborative and supportive health systems are in place around us. Cultural competence involves the heart as well as the intellect. We can teach you a lot if you are open to this.
General cultural competencies must be recognised as significantly more important than developing a range of cross-cultural knowledge about specific ethnicities and cultures. If you manage to achieve this as well it could be very helpful unless you embarrass and undermine us by knowing more about our culture than we do — but then this would not be our lived culture. If you are not able or are too busy to meet absolutely all these need is we hope you will help to develop and support health systems that can. Is this too much to ask?

Cultural competence and patient-centred care — the requirements

The Health Practitioners Competence Assurance Act 2003

One of the additional provisions for health registration authorities introduced under the Health Practitioners Competence Assurance Act 2003 (HPCAAs) is that of setting the standards of cultural competence to be observed by health practitioners. This is included under section 118(i) of the Act.¹

The Medical Council of New Zealand

The Medical Council sets the overarching standards of medical practice in Good medical practice.² An important theme throughout is that of working in partnership with patients and what this entails. This provides important guidance for patient-centred care. The Council released a general statement on cultural competence in 2006,³ alongside a statement on best practices when providing care to Māori patients and their whānau.⁴ A resource booklet prepared for the Council by Māuri Ora Associates on practice implications with Māori patients and their whānau⁵ was also released at this time. These statements provide guidance to the profession in developing cultural competence both as individual practitioners and in their broader contexts, for example, through practitioner groupings such as the specialist branch advisory bodies. In 2010 the Council published a resource booklet to assist doctors when providing services to Pasifika patients and their families.⁶

The Council defines culture broadly — extending beyond ethnicity and recognising that patients identify with multiple cultural groupings. These include (but are not limited to) gender, spiritual and other belief systems, sexual orientation, disability, lifestyle, age and socioeconomic status.

The definition of cultural competence in the Council’s statement is:
“Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population.
- That a doctor’s culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor patient relationship.
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.”

The Council is currently reviewing advice and resources for patient centred care and cultural competence.

The Code of Health and Disability Consumers’ Rights

The Code outlines requirements that are important to patient centred care and cultural competence. Right One is about patients (or consumers) being treated with respect and includes the statement that services should take into account your cultural, religious, social and ethnic needs, values and beliefs. Right Two states that as a consumer you should be free from discrimination on the grounds of age, gender, race, beliefs, marital or family status, employment, sexual orientation or disability. Right Five states that information should be given in a form, language and manner in which you can understand and that a competent interpreter should be available if you need one and if it is reasonably practicable. Right Seven includes a statement that you may make decisions about body parts or bodily substances and this is of particular significance to some cultures including Māori.

The Health Quality and Safety Commission

The Health Quality and Safety Commission (HQSC) was established in 2010 as an independent agency to lead initiatives to improve health quality and safety. It recognises the importance of working at the individual, population and systems level, and the need for consumer and provider partnerships to improve health quality and safety. Although the HQSC has not developed requirements for cultural competence and patient centred care it is developing relevant resources and guidelines. Partnership between providers and consumers is recognised as critical and this aspect is being developed in their “Partners in Care” Framework. This framework gives recognition to meeting the challenge of balancing the mix of evidence based medicine with the unique sets of values and experiences of consumers to produce treatment plans that meet both standards of clinical best practice and individual need. A free online course on cultural competency is available.
Cultural competence and the context of New Zealand society

Recognition of the importance of bicultural heritage and development

The establishment of cultural awareness and competency concepts and training in Aotearoa New Zealand have usually incorporated an understanding of our bicultural heritage as a key understanding. This bicultural emphasis recognises Māori iwi (tribes) as the indigenous or first nation peoples (tangata whenua), and the people from the other (originally predominantly British) cultures (tauiwi), as the later colonisers.

Te Tiriti o Waitangi, the Treaty of Waitangi of 1840, is recognised as the founding document between Māori iwi and the British crown on behalf of the later arrivals. Māori is an official language in Aotearoa New Zealand. Māori protocols and rituals of encounter have been incorporated into many health workplaces. Māori/iwi health services have been established throughout the country as have Māori policy, advisory and cultural services in District Health Boards and Primary Health Organisations. Treaty of Waitangi and Tikanga Māori training is ongoing and expected in many health workplaces in Aotearoa New Zealand. Māori cultural practices vary between tribal groups and understanding this assists respectful interactions.

Research concerning health disparities for Māori, and ways to address these, is important in the ongoing development to assist culturally competent practice with Māori.

Encountering New Zealand society

There are numerous new challenges for overseas doctors in understanding the peculiarities of New Zealand society, and the context and processes involved with health care delivery. In addition to learning about Māori culture there are Aotearoa New Zealand colloquialisms, humour and other shared cultural understandings to make sense of. There are cultural patterns to be aware of, for example, many New Zealand men have a tendency to understate illness and may be reluctant to consult their doctor when unwell. It is important to recognise that illnesses, for example depression, may manifest differently for people of different cultures in the way symptoms are presented.

Aotearoa New Zealand is increasingly becoming more diverse with the number and range of different ethnicities and cultures increasing and with some groups, such as Asian immigrants, growing rapidly. Pasifika communities are scattered throughout, are more prominent in certain areas and from 22 separate Pacific nations who have their own distinctive language, culture and history. Significant additional differences are also evident between Pasifika peoples who have been born in Aotearoa New Zealand and those who have immigrated. These and many other aspects influence the make up and expression of New Zealand as a society.
Is cultural safety a better term for a patient-centred approach?

Although similar concepts, nurses, some academics, educationalists and doctors assert that kawa whakaruruhau/cultural safety, the term introduced by Irihapeti Ramsden and adopted by the nursing profession, is preferable to the term cultural competence.\(^{10, 11, 12}\) Both terms concern the relationship between the helper (health professional) and the person being helped (the patient) however cultural competence is frequently described as being more centred on the health professional’s experience while cultural safety centres on the experiences of the patient. It is therefore argued that cultural safety fits better with a patient centred stance. That is, the patient can and should determine what is culturally important to his or her needs.

It is argued that health consumers are then able to become full partners in health care interactions, active in their treatment and are assisted to feel safe, respected and empowered. However the development of culturally safe practice requires health practitioners to establish, maintain and develop cultural competency. It can be argued then that these terms are intertwined. Competency requires safety and safety requires competency. A patient centred approach needs to be central to both.

Concepts of cultural competence and cultural safety both also recognise the importance of culturally appropriate and respectful professional relationships with colleagues and staff and the responsibility health professionals have in challenging cultural bias in health care systems where this brings negative impacts for patients. Cultural competence involves working effectively with interpreters to enable and improve communication, and developing networks with individuals and organisations who can provide expertise to assist in better understandings of patients’ cultural needs.

Cultural competence: patient-centred and family-centred approaches

Patient centred care places the needs of patients at the centre of health care interactions.\(^{13}\) It means being truly “present” with patients, aware of the values, biases, assumptions and expectations you bring and being able to question these while at the same time trying to imagine what it is like in your patients’ situations. It involves engaging with difference, having the ability to listen without interrupting and with a willingness and ability to extend your understanding to assist your patients.\(^{14}\) The ability to look back on your patient/doctor interactions, review these, consider how they might be improved, and develop awareness and knowledge for the future is important. This self reflection (reflective practice) is an important ongoing activity when working for ongoing improvement in cultural and other competencies.

For many cultures and contexts family centred approaches are important also as it is not possible to consider the patient without the wider unit of their whānau/family and extended family. In some cultures patients and their families may prefer a family centred approach to care and this can mean family members taking the lead in decision making.\(^{15}\) There may be a preference for a paternalistic approach where doctors are expected to be the decision makers.
This preference is somewhat at odds in the modern health care environment influenced by for example the Code and Good medical practice and creates tensions that need careful management. If the cultural context indicates a family centred approach, it is important to establish that this is what the patient genuinely wants and that they are not unwillingly being dominated by others. Some families are not a positive environment for patients and may instead be a danger to them. Traversing this can be fraught with tensions and difficulties. It is important to remember that each patient context is different and assumptions are never helpful.

Cultural competence and patient-centred care — an ongoing journey

The two concepts of cultural competence and patient centred care are from separate traditions but share many core features. Both are central to improving health quality and safety across the individual, family, community, population and health care systems levels. Cultural competence and patient centred care involves an ongoing journey — there is always more that can be learned. The key is being committed to the journey alongside patients, their whānau/families and other support people, and also when appropriate in the wider context of reducing disparities and working alongside communities and health consumers to improve both the quality of services and health outcomes.
References


CHAPTER 5

Māori and health

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Introduction

Māori are indigenous to Aotearoa New Zealand and a significant proportion of our society, comprising some 624,000 people (at census 2006) with expatriate communities in Australia (estimated 150,000) and Britain (estimated 15,000). Māori peoples are essentially a tribal society constructed from small family based units (whānau) organised into subtribes (hapū) which contribute to larger tribal entities (iwi).

Providing culturally competent care for Māori increases the likelihood of Māori engaging with health professionals and health services, improves adherence to treatment plans, and ultimately improves overall Māori health status. This chapter recognises that culturally competent practice should include consideration of Māori needs, values and preferences across all domains of practice. Readers should familiarise themselves with the relevant Medical Council statements on cultural competence and resources to support culturally competent care. Chapters on other ethnic groups and on the principles of culturally competent care are also included in this book.

Māori history and the Treaty

Traditional and modern scientific knowledge concur that Māori arrived in Aotearoa New Zealand from Hawaiki, the east Polynesian homeland at least 500 years before contact with European explorers. After the late eighteenth century, an increasing number of traders, whalers, sealers and settlers came to New Zealand. The British Government appointed James Busby as British Resident in 1833 to protect British trading interests and counter the increasing lawlessness amongst traders and settlers. By 1839, there were an estimated 2,000 Pākehā and 150,000 Māori living in New Zealand.

A Declaration of Independence was signed in 1835 by 52 Māori chiefs at the instigation of Busby and later tabled in the British Parliament. As a result the British Crown could make no claim on New Zealand without Māori agreement. In 1840, the British Government sent out Captain William Hobson to sign a treaty with the Māori chiefs. Hobson carried instructions from Lord Normanby of the Colonial Office to secure sovereignty over the independent state of New Zealand.

Consequently, in 1840, a treaty was drawn up and translated into Māori by Henry Williams, an English missionary, prior to being debated at Waitangi.

After a single day of debate the Treaty was signed on 6 February 1840, at Waitangi in the Bay of Islands by 43 Northland chiefs. Over the next eight months, the Treaty was signed at more than 40 other locations by more than 400 Māori chiefs including some women. However many important chiefs refused to sign the Treaty.

Both the English and Māori versions of the Treaty contain three articles but the Māori translation differs significantly from the English version, resulting in two documents with different meanings and interpretation.
The first article covers sovereignty. The English version states that Māori give up “sovereignty” to the British Crown, describing it as a complete transference of power to the Crown. By contrast, the Māori version implies a sharing of power and uses the word “kawanatanga”, an improvised word which did not mean a transfer of authority from Māori to British hands, but implied the setting up of a government by the British. The nearest Māori equivalent to the English term would have been “mana” or “rangatiratanga”.

The second article, mainly about the protection of property rights, also concerns “tino rangatiratanga” or chieftainship. The English version specifically gives Māori control over lands, forests, fisheries and other properties, but the Māori version implies possession and protection of cultural and social items such as language and villages and promises much broader rights for Māori in regard to possession of existing properties.

Explanations given at the Treaty signings support the conclusion that Māori expected that rangatiratanga would be enhanced not eroded, with the Queen or her representative having the power of governorship alongside their sovereignty as chiefs.

The third article promises Māori the same citizenship rights as British subjects.

Both versions of the Treaty of Waitangi are legitimate as both versions are signed. However, despite the promises and protection offered in the Treaty of Waitangi, the document was ignored in spirit and disregarded materially for many years. Many of the rights guaranteed to Māori were violated, and Māori lost most of their land through the nineteenth and twentieth centuries. The manner in which the land was lost was often questionable, and led to considerable protest from Māori. These protests largely fell on deaf ears until the establishment of the Waitangi Tribunal in 1975.

In 1896, the Māori population reached its lowest point, estimated at 42,000 while migration of non-Māori accelerated.

The cultural and political structure of New Zealand in 1840 was still essentially Polynesian, and all European residents absorbed Māori values to some extent. During this period, Māori commercial enterprise prospered. For instance in 1857 Te Arawa and Tuwharetoa Māori (connected tribes descended from the Te Arawa canoe and covering the Bay of Plenty, Taupo and Rotorua areas) consisting of approximately 8,000 people — had an estimated 3,000 acres of land in wheat, 300 acres in potatoes, nearly 2,000 acres in maize, and 1,000 acres of kumara. In addition they owned some 100 horses, 200 cattle, 5,000 pigs, 4 water powered mills, 96 ploughs, and 43 coastal vessels averaging nearly 20 tonnes each.

Māori were actively and purposefully organising successful commercial ventures and exporting from their tribal estates to the growing settler communities in New Zealand and New South Wales. Māori demonstrated a clear determination to gain the literacy skills of the Europeans. Māori tribes actively sought missionaries to settle in their areas to acquire these skills.

During the twentieth century, the Māori population has recovered and at over half a million is now larger than ever before. However, social and economic disparities continue to exist.
The Waitangi Tribunal was established in 1975 to rectify past breaches of the Treaty by the Crown. Claims cannot be made against private organisations or individuals. The Tribunal considers both English and Māori versions of the Treaty when making decisions and is also instructed to have regard for the principles of the Treaty rather than the precise words. In this way, some of the difficulties of conflicting texts (English and Māori) can be avoided. Since its establishment, the Waitangi Tribunal has ruled on many claims brought by Māori, and many others have been settled through direct negotiation between the Crown and claimant tribes. In many cases, compensation has been granted, often including return of land and financial recompense, which is vested in the tribal authorities for economic development.

The Treaty and health

The Government has identified three principles derived from the Treaty and relevant to Māori health in key statements and policies.2

The principles are:

- Partnership — working with Māori communities at all levels to develop strategies for the community’s health care,
- Participation — involving Māori at all levels of the planning and delivery of health care services, and
- Protection — working to ensure that Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values, and practices.3

The Treaty of Waitangi can be seen to apply to Māori health in numerous ways. Most importantly, the Treaty should have ensured that Māori retained their land, forests and fisheries. In addressing land rights, loss of language and social disruption, compensation can help to address some of the social determinants of health. Further, in the Māori version, the Treaty ensures that “taonga”, or precious possessions, would be protected and retained. In this context, health is sometimes considered a taonga. In addition, the New Zealand Public Health and Disability Act 2000 recognises the Treaty of Waitangi, by requiring District Health Boards to improve the health outcomes of Māori and other population groups.

Māori health and inequalities

Māori, the indigenous population of New Zealand make up approximately 15 percent of the New Zealand population, yet Māori have the poorest health of any New Zealand group. Māori have a higher mortality rate than non-Māori, as well as higher rates of illness, Māori infants die more frequently from SIDS and have lower birth weight than non-Māori4 5 as well as higher rates of illness.6 7 Māori infants die more frequently from SIDS and have lower birth weight than non-Māori children.8
Avoidable death rates are almost double for Māori than for other New Zealanders, and Māori die, on average, eight to ten years earlier.\textsuperscript{5, 10} New Zealand has a higher rate of death from cancer than Australia, with Māori accounting for two thirds of the excess male cancer deaths and one quarter of the excess female cancer deaths.\textsuperscript{11} Māori women have rates of breast, cervical, and lung cancer that are several times those of non-Māori women.\textsuperscript{12}

There is a higher incidence of obesity in the Māori community (27 percent vs 16 percent), which contributes to the higher incidence of diabetes (8 percent vs 3 percent) and the younger age at diagnosis (43 years vs 55 years).

This is compounded by lower rates of diagnosis and lesser access to effective treatment.\textsuperscript{13}

In summary, Māori are sicker, for longer periods, but have less access to care and die earlier than Pākehā. These disparities in overall Māori health persist even when factors such as poverty, education and location are accounted for, demonstrating that culture is an independent determinant of health status.\textsuperscript{14, 15}

These lower standards of health lead to suboptimal outcomes for individual Māori and influence the Māori community’s negative perceptions of the health system as a whole.\textsuperscript{16, 17, 18} These negative experiences can also reinforce stereotypes in the practitioner community if a provider does not understand a Māori patient’s dissatisfaction and thus cannot prevent similar experiences with other patients.\textsuperscript{19}

**Differential approaches to treatment**

Studies have consistently demonstrated that some doctors treat Māori differently from non-Māori. Examples of this include the findings of the 2001—02 National Primary Medical Care Survey (NatMedCa) where it was observed that doctors spent 17 percent less time (2 minutes out of a 12 minute consultation) interviewing Māori than non-Māori patients.

Once age is taken into account, Māori turn up for general practitioner appointments at the same rate as non-Māori, but obtain fewer diagnostic tests, less effective treatment plans and are referred for secondary or tertiary procedures at lower rates than non-Māori patients.\textsuperscript{20}

Analysis of the National Minimum Database over the period 1990—99 by Tukuitonga suggests bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke,\textsuperscript{21} obstetric intervention,\textsuperscript{22} heart failure,\textsuperscript{23} and asthma.\textsuperscript{24} These studies point to unconscious bias by providers rather than frank racism in health service delivery.

However the impact is that Māori patients are less likely to receive adequate care or adequate and understandable health information. This will in turn compromise the ability of Māori patients to adhere to treatment recommendations and the effectiveness of any treatments offered.

There is evidence too of the impact of racism on Māori health status. Harris et al reviewed the New Zealand Health survey data and made adjustments for sociodemographic factors and deprivation, and identified that the remaining differences in self perceived health status between Māori and non-Māori could be accounted for in terms of self perceived experiences of racism. These effects appeared to be dose related: that is the greater the number of experiences of racial discrimination, the lesser was self perceived health status.
The impact of culture on health

Culture plays an important role in health because culture influences behaviours through customs, traditions, beliefs and values. In the Māori world view, there is a fundamental belief that understanding and being connected to the past are important for both the present and the future. This is demonstrated by the importance placed on tūpuna (ancestors) and whakapapa (genealogical connections over many generations). In addition, the importance of a healthy environment, which impacts both community and individuals, is incorporated into the world view of many Māori.

Culture of the doctor

Like other cultures Māori value highly effective communications with health professionals. However cultural misunderstandings, unconscious bias and unfounded beliefs about Māori by practitioners contribute to problems in communication between non-Māori doctors and Māori patients.

All these problems have been demonstrated in studies of general practitioners and psychiatrists in New Zealand.

It is expected that improved integration of cultural and clinical competence should lead to better outcomes through improvements in communication, acceptability of treatment, adherence to treatment plans, and through measurements of doctor performance in delivery of services to Māori.

Māori concepts and Māori health values

Māori beliefs, customs and values are often expressed as tikanga. Tikanga Māori describe a guide for living, support Māori social systems and reflect Māori knowledge and traditions.

Doctors may have opportunity to recognise or come into contact with many Māori values, including tapu and noa (a pervasive stative dichotomy of restricted and ordinary or normal), mana (reflecting authority, status and control), wairua (reflecting spiritual elements and power), whānaungatanga (relationships interpersonal and familial) and manaakitanga (the duty and obligations of care).

Tapu and noa

Although tapu is often described as a state of sacredness, it also has the more general meaning of being special or restricted. Noa is the absence of tapu and denotes the state of being normal, ordinary or safe. All things to do with death or the body are tapu, while anything related to cooked food is noa.
Many Māori feel that keeping tapu items separate from noa items is very important and find it distressing when this division is not observed. For example, in the case of a patient’s death the whānau will likely wish to spend time in the room with their loved one. The presence of the dead body (tūpāpaku) makes the room tapu, and therefore food cannot be brought in. There will of course be wide variation in how strictly such controls are practiced and how observance of the traditional practice might be amended for practical reasons.

**Whānaungatanga**

Māori culture emphasises familial and community connections to the past and to the present. The extended family or whānau is the basic unit of Māori social organisation. Familial relationships and responsibilities are central to Māori identity and are often expressed in the Māori term whānaungatanga. Māori patients will often bring family members to medical visits and may consult with them before considering or accepting treatment. Māori usually prefer face to face interactions with their doctors, and until relationships are established may prefer formality.

**Tangihanga**

The rituals and customary practices that surround death are regarded as very important in Māori communities. The familial and community obligations to the deceased and the bereaved family are extensive. The tangihanga is a coordinated set of formal procedures that recognise the relationships of the deceased with the ancestors and with the living relatives. Many Māori recognise very strong imperatives to attend tangihanga of anyone in their extended family and friends, and will often travel great distances to fulfil their obligations in this regard. A person may be grieved over for three or more days, at their home or at a marae and often returned to their traditional tribal home for burial. Death itself however may not be feared so much as the manner and circumstances of dying, with many Māori preferring to die at home with the attention and support of their family.

**Manaakitanga**

The obligations and responsibilities to demonstrate care for your family and for visitors is expressed in the Māori term of manaakitanga. This customary value will involve the process of welcoming and caring for visitors to one’s home or marae, as well as the provision of food and accommodation. Food (kai) has a central importance in these practices. A guest (manuwhiri) has a complementary obligation to accept and receive this hospitality.

There are many useful texts that can provide deeper insight into Māori customary practices, and Māori patients are generally happy to educate a provider who seeks guidance about their preferences.
Rongoā and traditional healers

Māori patients may seek assistance from traditional healers like people from other cultural backgrounds. For Māori this may include consulting people with special skills (tōhunga) in herbal preparations (rongoā rakau), massage therapies (mirimiri), prayers and incantations (karakia).

There are few absolute contraindications to the use of traditional healing techniques alongside western therapies. However knowing about all the nonprescribed therapy a patient is using will assist the doctor and patient to monitor and adjust medications or to make appropriate choices. The key then is to maintain open and nonjudgmental communication with the patient, allowing or encouraging them to share information with you.

Māori language

There are several general introductory Māori language courses and a small number of dedicated Māori language phrasebooks for the health sector.

Welcome everybody.

*Kia ora tātou.*

I would like to acknowledge the family.

*Ka mihi atu ki te whānau.*

Greetings all.

*Tēnā koutou.*

Let’s introduce ourselves and get to know each other.

*Tēnā, me whakamōhio atu ko wai rā tātou.*

How can I help you?

*Ka pēhea taku āwhina i a koe?*

How can I help your family?

*Ka pēhea taku āwhina i tō whānau?*

How much alcohol do you drink?

*He pēhea te nui o te waipiro ka inumia e koe?*

Do you drink every day?

*Ka inu waipiro koe i ia rā?*

How many days a week do you drink alcohol?

*E hia ngā rā o te wiki e inu waipiro ana koe?*

How many days a week do you drink no alcohol?

*E hia ngā rā o te wiki kāore koe e inu waipiro ana?*

Do you have pain anywhere?

*He wāhi anō kei tō tinana e mamae ana?*
How long have you had that pain?
_Kua pēhea te roa e mamae ana?_

Where did the pain start?
_I tīmata mai tēnā mamae ki hea?_

What were you doing when the pain started?
_I te aha koe i te wā i tīmata ai te mamae?_

What makes it worse?
_Ka nui atu te mamae i te aha?_

What makes it better?
_Ka whakaeaeatia te mamae ki te aha?_

Have you been vomiting.
_I te ruaki koe?_

Do you have diarrhoea?
_I te torohī koe?_

What is the diagnosis?
_He aha te whakataunga?_

Does Hēmi have epilepsy or diabetes?
_Kua pā mai te mate huka, te mate ruriruri rānei ki a Hēmi?_

What medications do you take?
_Kua pā mai te mate manawa, te toto pōrutu rānei ki a koe?_

Do you have heart disease or high blood pressure?
_He aha ōu rongoā?_

My name is Richard. I am a doctor.
_Ko Richard ahau, he rata ahau._

My job is to listen to your concerns and support you.
_Ko tāku, he whakarongo ki ō āwangawanga, he tautoko hoki i a koe._

What are the main issues for you?
_He aha ngā tino take ki ōu whakaaro?_

How would you like me to help?
_Me pēhea taku āwhina atu?_

Where are you from?
_Nō whea mai koelkoutou?_

What is your tribe, your subtribe?
_Ko wai tō iwi, tō hapū?_

Tell me about your marae, your community.
_Tēnā, kōrero mai mō tō marae, tō papakainga._
Where did you grow up?
I tipu mai ai koe i whea?

Where did you go to school?
I kuraina ai koe i whea?

How old are you?
He aha tō pakeke? E hia ō tau?

How many children do you have?
Tokohia āu tamariki?

Tell me about your family.
Kōrero mai mō tō whānau.

How many brothers and sisters do you have?
Tokohia ō teina/tuakana, ō tuahine/tūngane?

Tell me about your health.
Kōrero mai mō tō hauora.

Tell me about any illnesses you have.
Kōrero mai mō ō māuiui, ō mate.

Tell me about any illnesses in your family.
Kōrero mai mō ngā māuiui, ngā mate rānei o tō whānau.

What medicines do you take? How often? When?
He aha ngā rongoā e kainga ana e koe? E hia ngā wā? Āheua ka kainga?

Do you use traditional medicines or herbal remedies?
Ka kat koe i ngā rongoā mai i te rākau, ngā rongoā Māori?

Do you have access to a traditional practitioner?
Ka toro atu koe i tētahi tōhunga?
Ngā Whakahua pronunciation guide

Vowel Sounds

a as in car, far  
ed as in Ed, bed  
i as in eel  
o as in awe, or, saw  
u as in chew, moo

Consonants

wh pronounced much like “f” (whā pronounced far)  
ng pronounced like the “ng” in singer (nga sing a)

Macrons

The vowels may take a short or long form. This is indicated by the macron over the vowel;  
ā, ē, ī, ō, ū. This is the method preferred by the Taura Whiri i to Reo Māori: Māori Language Commission), although others occasionally use a double vowel to indicate the long form; aa, ee, ii, oo, uu. The long vowel is pronounced in the same way as the short vowel but the length is extended and has a significant effect on the sound and meaning of a word. Knowing the length of each vowel is important in establishing correct pronunciation.

Otāhuhu O — ā — huhu  
Waitematā Wai — te — ma — ī

Ngā Mihi greetings

Tēnā koe Hello (literally “there you are”) formal greeting to one person  
Tēnā korua Hello (literally “there you are”) formal greeting to two people  
Tēnā koutou Hello (literally “there you are”) formal greeting to three or more people  
Kia ora Hi (literally “be well, good health”). Less formal greeting, and widely used affirmation, salutation  
Kia ora koutou Greetings to you all  
Kia ora tātou katoa Greetings to us all (inclusive of the speaker)  
E noho rā Goodbye (literally “stay there”) said as one is leaving.  
Haere rā Goodbye (literally “go forth”)
Glossary

hauora health
hinengaro psychic dimension
hongi press noses, share breath
karakia prayer, incantation, invocation
koha gift, donation
mana power, authority, prestige
manuhiri visitor, guest
mihi greet, greetings
mihimihi introductions
noa normal, profane
oranga wellbeing, health
pōwhiri formal welcome
reo language
tāngata whenua people of the land
tapu restricted, reserved, sacred
tinana physical body
waiata song, to sing
wairua spirit, spiritual dimension
whānau family
whānaunga relations
whānaungatanga relationships
whare house
References


16. Tipene-Leach David 1981. Māoris: our feelings about the medical profession; in Primary health care and the community. Note — this article is also available at: http://www.bopdhb.govt.nz/insideout/Forms/Culture_PreRead.pdf.


CHAPTER 6

Pacific people in New Zealand

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CHAPTER 6 PACIFIC PEOPLE IN NEW ZEALAND

Introduction

This chapter describes the health status of Pacific people in New Zealand, health service availability and usage and factors that may affect the interactions between health professionals and patients. Guidance is provided on additional sources of information, advice and support for health practitioners, their patients and their families.

Background

There are more than 300,000 Pacific people in New Zealand (NZ). The population grew rapidly during the 1950s through to the 1970s as a result of work related migration. The Pacific population is currently among the fastest growing groups in NZ, but most of the recent growth is due mainly to births in NZ. Two thirds of the population are now born in NZ and approximately one quarter of all births in Auckland claims a Pacific heritage. The Pacific population is projected to make up approximately 10 percent of the NZ population in 2026. Pacific people will form an increasing share of the consumer and voter base, school age population as well as an increasing share of an ageing and shrinking NZ workforce. Pacific people form a significant share of the patient/client base in selected urban neighbourhoods in NZ.

In NZ, the term “Pacific” or “Pasifika” usually refers to people who have a Pacific heritage. Samoan people make up half of the total Pacific population, Cook Island Maori one quarter, Tongans about one fifth, Niueans one tenth and smaller numbers from other island groups. Successive census has shown that an increasing proportion of Pacific people who claim origins from more than one ethnic group with unique sociocultural characteristics combining elements from their heritage cultures with significant Maori and palagi/pakeha (European) influences. Approximately, one in five individuals claim both Pacific and Maori heritage.

There is very little reliable literature on the health needs of the young, NZ born, urban Pacific people. This is an important and urgent area for research in order to improve policy development and service delivery. Much of the literature about health and illness among Pacific populations refer to older adults who were born in the islands.

The Pacific population is very young with 38 percent under 15 years of age compared with 22 percent of the total population. The mean age of the Pacific population at the 2006 Census was 21 years compared with 36 years in the total NZ population. Less than 5 percent of the Pacific population are over 65 years of age but the cultural importance of the elderly in most Pacific societies often means that the needs of the elderly take precedent over the needs of younger people.

Respect for the elderly is an important aspect of all Pacific societies in NZ, and this fact has a major influence on how Pacific families live.
Two thirds of the Pacific population live in Auckland, mostly in South and Central Auckland. Significant pockets of Pacific people live in Wellington, Porirua, Hutt Valley, Waikato and Canterbury. Studies have shown that nine out of ten Pacific persons live in low decile areas with significant social and economic disadvantage. Socioeconomic disadvantage is closely correlated with poor health and access to health services. It is also important to note that increasing numbers of Pacific people are not connected to their extended family and many need support from outside the family. Further, while most Pacific adults are regular church attendees, an increasing proportion of young people are less religious in their outlook compared with their parents. For most Pacific people, the church remains a significant influence on their lives, attitudes to health, illness, death and dying.

Health Status and Influences

Pacific people have some of the worst health and social indicators in NZ and there is considerable unmet health needs in these communities. Several reports show little improvement in the socioeconomic circumstances of Pacific people and little change in their overall health status. Prevailing disease patterns largely reflect the socioeconomic conditions under which they live and poverty is a major contributor of ill health among Pacific families. It appears that the most important factors that adversely affect their health are low educational achievement and health literacy, high unemployment rates, crowded, cold and damp houses and inequities in access to and quality of health care provided. While socioeconomic factors are the main underlying factors that contribute to poor health in Pacific people, not all of the ethnic disparities in health are attributable to socioeconomic factors.

However, Pacific cultures and practices rarely ever contribute to poor health, although attitudes to health and illness can influence health outcome mainly as result of the delay in seeking health care. Traditional tattooing using traditional methods has on occasion caused serious infections and even death.

Older Pacific people who were born in the islands have a socioecological approach to health with strong spiritual dimensions to their beliefs about illness, healing, death and dying. Death, disease and disability are often attributed to the will of God and/or superior being. Mental disorders in particular are often regarded as possession by evil spirits or deceased relatives as retribution for wrong doing by the affected individual or members of his/her family. As a result, health care practitioners often have difficulty understanding the apparent fatalism that can be seen in some Pacific patients. These beliefs can lead to much “shopping around” with different health care practitioners, including traditional healers. There is anecdotal evidence that older members of Pacific families commonly use traditional healers and complimentary therapies in addition to or in place of conventional remedies.

Attitudes to health and illness among younger members of the Pacific communities are less clear. It is likely that young people are less likely to hold traditional attitudes and views about health and illness.
Morbidity and Mortality

Pacific people experience significant premature mortality and preventable morbidity mainly due to chronic noncommunicable diseases (NCDs), such as diabetes and heart disease. In the adult population, cardiovascular diseases are the leading cause of death and disability. Coronary artery disease mortality rates have declined in line with the decline in CVD mortality in the total NZ population but the decline has been less rapid among Pacific people. However, stroke incidence and mortality has not declined in line with other New Zealanders and stroke tends to affect younger adults in their most productive years in Pacific people. Ethnic differences in CVD mortality and morbidity are attributable to differences in risk factor prevalence and access to health care services.\textsuperscript{2, 3}

The prevalence of smoking has declined in the Pacific population but still remains higher than the smoking rate in other New Zealanders. Youth smoking rates, especially among Pacific girls, remain much higher than their peers. An additional challenge is the low uptake of smoking cessation services that have been proven highly effective in other groups in NZ. Preventing uptake of smoking and increasing uptake of smoking cessation programmes are important priorities for health care practitioners, especially in primary health care settings in NZ. Smoking remains one of the most important and preventable causes of morbidity and premature mortality among Pacific people in NZ.

Type 2 Diabetes is more prevalent among Pacific people in NZ due in part to the higher prevalence of overweight and obesity among them. The prevalence of diabetes is 2—3 times higher in Pacific people compared with the total NZ population. Several surveys have shown that approximately 90 percent of the adult Pacific population were overweight or obese compared with 60 percent of the total NZ population. Furthermore, the prevalence of obesity in young Pacific boys and girls was 55 percent compared with 29 percent other young New Zealanders respectively. High prevalence of obesity in Pacific people is attributable to the “obesogenic environment” that exists in urban areas in New Zealand. Consumption of highly processed food items and reduced physical activity levels are the most direct influences on obesity but there is a complex web of interrelated factors that lead to the unhealthy diets and low physical activity levels. Studies have shown that Pacific people are more likely to consume diets high in fats, sugar and salt, more likely to have takeaway meals and less likely to cook at home.

Young Pacific boys consume sugar sweetened soft drinks (SSSD) more often than their peers. Excessive consumption of SSSDs is closely associated with increased prevalence of obesity. Preventing and managing obesity in Pacific people is the most urgent priority for the NZ health system. Demand for services such as renal dialysis as a result of renal failure due to diabetes is already reaching a point where health services are struggling to meet demands.
Pacific children experience significant preventable morbidity. The most prevalent conditions largely reflect the socioeconomic circumstances of their families, including overcrowded, damp and cold housing, unhealthy diets and difficulties accessing health care services. The Children’s Commission estimated that 22 percent of NZ children were living below the poverty line, and Pacific children were more likely to be below the poverty line.\textsuperscript{6,7} Several studies have shown that respiratory disorders and skin infections are very common and hospital admissions are higher than other NZ children.\textsuperscript{2} Acute Rheumatic Fever and Rheumatic Heart Disease (ARF/RHD) are three times more common among Pacific children and young people compared with other NZ children and young people. ARF/RHS is widely regarded as a disease of poverty and a good indicator of the socioeconomic conditions under which children live. Increased government funding recently allocated to the prevention and management of ARF/RHD in priority groups is a promising development although action on the wider determinants of health is equally important. Unless effective action is taken to address poverty, interventions directed as specific diseases are unlikely to be sustainable.

The 2006 NZ Mental Health Survey (Te Rau Hinengaro) showed that the prevalence of mental disorders among Pacific people in NZ is similar to Maori and other New Zealand populations except psychotic disorders where the prevalence of schizophrenia is higher among young Pacific men.\textsuperscript{8} The study showed similar prevalence of suicide across all population groups in NZ but much higher prevalence of suicide ideation among Pacific people. Survey findings showed that only one quarter of Pacific people with severe mental disorders were receiving recommended care.

**Access to and quality of health care**

Pacific people are known to have low uptake of preventive and primary health care services for example, low uptake of cervical and breast cancer screening and low immunisation coverage rates. These observations are supported by high rates of Ambulatory Sensitive Admission (ASH) among Pacific people.\textsuperscript{2} ASH admission rates are generally accepted as a reasonable indicator of the quality and effectiveness of primary health care services. A recent review of the primary health care for Pacific people in NZ showed a potential disconnect between PHC providers and Pacific patients. General practitioners were less likely to record high levels of rapport with Pacific patients, and Pacific patients had low uptake of subsidised care, high use of Accident and Medical (A&M) clinics, and lower levels of satisfaction with their experiences of PHC.\textsuperscript{4} The report also concluded that the top three barriers to primary health care for Pacific people were cost, transport and language.

Reforms of the health sector and changes to the funding and delivery of PHC in NZ as part of the NZ Primary Health Care Strategy and the Pacific Health Strategy has resulted in some improvements for Pacific people. Information from Primary Health organisations (PHOs) has shown high enrolment rates for Pacific people. Furthermore, the NZ Health Surveys have shown that the per capita general practitioner consultation rates for Pacific people is comparable to other New Zealanders, although the level of consultation may not be appropriate for the level of health needs in these communities.\textsuperscript{9} Immunisation coverage rates among Pacific children are now among the best in the country.
Despite these improvements, it is clear that Pacific people continue to receive variable quality of health care. Studies of almost all health conditions have shown that Pacific people continue to receive lower levels of care, especially at the primary health care level. Health practitioners who work in health settings in communities need to ensure that best practice is normal practice at all times. Additional support, education and information for patients and their families will assist in improving the consistency and impact of primary health care for Pacific people. Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people. It is also worth noting that “free” health care in hospitals will continue to be a factor influencing Pacific people’s decisions about where to seek health care services.

Community controlled PHC

The emergence of Pacific owned community health services in NZ has contributed to the overall improvements in access to and quality of health care provided to Pacific patients and their families. However, it is estimated that 90 percent of Pacific patients continue to receive health care from mainstream providers and this situation is likely to continue. Many Pacific patients and their families also receive care from Maori service providers, especially in Auckland in view of the similarities in service delivery ethos of Maori providers to Pacific providers. Most Pacific community owned services are located in areas with high Pacific population in urban centres. Informal feedback confirm that Pacific patients report positive interactions with Pacific owned providers although there has been no independent evaluation of these services. In general, Pacific owned clinics have distinct advantages over conventional care models, such as lower fees, clinical staff who speak a Pacific language and good community support for patients and their families.

Getting assistance

The Ministry of Health (MOH) has a well developed strategy for improving the health of Pacific people and funds service delivery by selected District Health Boards (DHBs) which serve large numbers of Pacific people. The key MOH strategy is the Ala Moui Pathways to Pacific Health and Wellbeing 2010—2014, which outlines government priorities, programmes and major contributors to health. Much of the actual service delivery and support for health care providers is funded and coordinated by selected DHBs, mainly in urban centres. Pacific teams in DHBs are well placed to provide an overview of service delivery in their districts and advise on how best to support health care professionals. In addition, there are several Pacific owned health care providers in most urban centres throughout NZ. These providers have well developed networks that can assist with advice and support. Le Va is a national coordination service and workforce development programme for Pacific mental health, addictions, disabilities and general health (www.leva.co.nz).
The Pasifika Medical Association (www.pacifichealth.org) is the leading Pacific organisation dedicated to improving the health status of Pacific people, both in NZ and the Pacific region. Membership includes doctors, nurses, other health workers and community leaders. PMA provides professional support to its members, delivers health workforce development in schools and advocates for better policies and services for Pacific people. Most of the senior and experienced clinicians of Pacific descent in NZ are members of PMA. Most Pacific nations also have associations and community groups with an interest in health such as the Tongan, Samoan Nurses Association, the Cook Islands Health Network.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies that impact on health and health care provision and specific advice on how best to manage Pacific patients. Pacific Heartbeat at the National Heart Foundation has been providing information and training for health and community workers for several years. Their focus is on improving nutrition and physical activity as well smoking prevention and cessation information service. The NZ Stroke Foundation has recently established a service dedicated to preventing stroke in Pacific communities.

Resources
1. MPIA/Stats NZ Pacific Population Report 2010
2. MOH Tupu Ola Moui Pacific Health Chartbook 2012
3. MPIA/Stats NZ Pacific Report Health 2010
4. Pacific Perspectives Primary Care for Pacific People 2011
5. MSD Social Report 2010
6. A Fair Go for All Children — Children’s Commission 2008
8. The NZ Mental Health Survey 2006 (Te Rau Hinengaro)
9. MOH The NZ Health Survey
10. MOH Ala Moui Pathways to Pacific Health and Wellbeing 2010—2014
CHAPTER 7

Asian people in New Zealand

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Catherine Hong is an intercultural promoter. She worked in general practice in Auckland for 10 years serving the local immigrant Korean community. Additionally she held the position of National Asian Development Manager in ACC from 2007 to 2009. She was also the Manager of Cultural Services from 2009 to 2011.

Nagalingam Rasalingam is a retired general practitioner; Dr Rasalingam is a long time advocate and champion for Asian health in Auckland and across the nation.


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The Asian population is expected to grow to almost 16 percent of the national population by 2016. The increasingly diverse immigration to New Zealand caught momentum following the changes to legislation in 1987 and 1991 which removed a bias in favour of British and West Europeans who were considered “preferred sources” of migrant population. The migrant population of Aotearoa New Zealand has increased significantly over recent years. Between 1997 and 2001 the Asian population increased by 140 percent (Statistics New Zealand, 2000), at that time accounting for 6 percent of the country’s population. According to the 2006 statistics, Asians make up the fourth largest major ethnic group after European, Māori and other ethnicity totalling 354,552 people (9.2 percent) in 2006.2

For discussion on the use of the term “Asian” please refer to the work by Rasanathan, Craig, and Perkins.3 The increase in the Asian population has resulted mainly from large migration gains. Chinese (46 percent) and Indian (29 percent) are the major contributors in the increasing trend of Asian population along with populations from other Asian communities (for example, Korean, Filipino, Japanese, Sri Lankan, Cambodian and Thai). Many of them born overseas (30—40 percent) and some (15 percent) do not speak English.

This growth will impact on the host population, particularly the health delivery system, because of its rapidity, and because of possible language and cultural barriers between clients and health services and health workers.

**Specific health needs of Asian patients**

Asians in New Zealand are very diverse in religion, culture, language, education and socioeconomic experiences. It is therefore difficult to generalise the needs of the Asian population as a whole. Nonetheless, during the past years, four large scale reports about the health of Asian New Zealanders were published:

- Asian Health in Aotearoa: An Analysis of the 2002—2003 New Zealand Health Survey (The Asian Network Inc.)
- A Health Profile of Young Asian New Zealanders who attend Secondary School: Findings from Youth 2000 (The Youth 2000 project at the University of Auckland)
- Asian Health Chart Book 2006 (Ministry of Health)
- The health needs assessment of Asian people living in the Auckland region — August, 2012 (Written by S. Mehta, commissioned by the Northern DHB Support Agency).

The reports also indicate that whilst Asian peoples in New Zealand are relatively healthy overall, much of this result is due to the so called the “healthy immigrant effect”. That is, most migrants, need to be in good health to be allowed to immigrate to a new host country and many have high socioeconomic status in their countries of origin. These migrant groups also have high levels of education which are associated with better health status. However this positive effect on health gradually disappears with increased length of residency in the new host countries.
Rasanathan, Ameratunga and Tse provided a useful summary of the key health issues concerning the Asian New Zealand population. The pattern of low levels of health care service utilisation for example, primary health care and cancer screening, is seen across most areas for Asian people in New Zealand, particularly for Chinese New Zealanders. In the Youth2000 study, 15 percent of young Chinese New Zealanders reported accessing no health care at all which was over three times the rate reported by their European counterparts.

Primary Health Organisations (PHOs) are playing a pivotal role in New Zealand health care system; every Asian must be advised to register themselves and their families with these organisations. Another key issue is cardiovascular disease and diabetes for South Asian people. Indian people show the highest rates of self reported diabetes of any ethnic group in New Zealand and they also show high levels of cardiovascular disease, similar to Māori.

Levels of physical activity and mental health problems particularly in young people remain a concern.

Other cultural and social factors are also relevant to the health and wellbeing of Asian New Zealanders such as experiences of racism and difficulties in finding employment. Recent studies showed that the experience of racism by Asian New Zealanders is rather common. Māori reported the highest prevalence of “ever” experiencing any of the forms of racial discrimination (34 percent), followed by similar levels among Asian (28 percent). Racial discrimination included experience of ethnically motivated attack (physical or verbal), or unfair treatment because of ethnicity for example, by a health professional, in workplace or when seeking paid employment. Asian people in New Zealand are more likely than nonasian New Zealanders to have tertiary qualifications, but have higher levels of unemployment. Unemployment or under employment are often associated with negative health effects, particularly in terms of mental health. According to a local survey conducted by the Asian Public Health Project Team, Asian patients themselves have identified the following areas as their main health concerns.

**Mental health:** depression and psychosomatic illness are frequently seen and have a complex interplay among social isolation (from migration), language barrier, underemployment or unemployment. Stigmatisation and “taboo” of psychiatric illness compound the problem further resulting in a reluctance by Asian patients and their families to seek early intervention or treatment. Other mental health issues identified in New Zealand include problem gambling and alcohol abuse. Furthermore, the New Zealand Mental Health Commission’s Report on Asian mental health mentioned several specific concerns:

- The high mental health needs of women and refugees from smaller ethnic communities for example Vietnamese, Indonesian
- Mental health needs of older people
- Refugees because of premigration traumas and postmigration stressors in adapting to a new culture.
Refugee health: refugees enter New Zealand under three categories:

- Quota refugees — recommended by UNHCR (United Nations High Commission for Refugees)—700 yearly called “mandated refugees”
- Asylum seekers — termed as “Convention refugees”—those who conform to and satisfy the United Nations convention on refugees
- Family reunification.

All in the above are “health screened” for immigration purposes. Primary health care plays a significant role as individuals with refugee background have had very limited health care in their respective countries before fleeing to New Zealand. Conditions prevalent in their respective geographical zones include sickle cell anemia, malaria, Hepatitis B carrier state and gastrointestinal infections. With regard to services for refugee mental health, a mobile health team employed by Refugees As Survivors (RAS) is already functioning in Auckland and is of great help to individuals and families from refugee backgrounds.

Cardiovascular diseases and diabetes: lifestyle changes from Westernisation of diet and the relative lack of physical activities.

Sexual health: Asian women seem reluctant to use safe and reliable contraceptive methods; for example, some Chinese women believe that the pill will impair their fertility. Abortion is often seen as a de facto form of “contraception” as it is a common practice in many Asian countries. Such beliefs may have contributed to the steady rise of the abortion rate among Chinese women in the past decade. Another concern is the rapid rise of sexually transmitted illnesses such as chlamydia, gonorrhoea and syphilis among Asian patients. Contributing factors include ease of international travel and unsafe sexual practices.

Communicable diseases: tuberculosis and chronic hepatitis B infection are particularly common among Asian patients.
Ways to engage Asian migrant patients

In order to provide practical suggestions to engage Asian migrant patients the following material will be useful for those working with Korean and Chinese patients as examples.

Appreciate health beliefs

Chinese patients in general are rather health conscious even though they appear to be less knowledgeable in human anatomy or the scientific basis behind Western medicine. The fundamental belief of good health among Chinese people is the ability to maintain a peaceful state of mind and to be in harmony with the surroundings. It stems from the philosophy that everything in this universe is interrelated and is forever changing with the life force/energy (known as “Qi”) flowing through all matter continuously. “Qi” is the fundamental substance and its movements produce everything that constitutes the universe. The concept of “Yin and Yang” describes the dynamic and oscillating relationship of the flow of “Qi” between these two extreme states. “Yin” represents cold, dark, inactive, negative and female like, whereas “Yang” represents hot, bright, active and male like. Everything in the universe has an element of both “Yin and Yang”. On an individual level, good health is about having a balanced flow of “Qi” between the “Yin and Yang” organs.

An example of misunderstanding resulting from differences in health beliefs is the Chinese patient who said, “I’ve too much heat in my body.” From a Western medicine perspective, most doctors would tend to think that the patient is implying that he/she has a fever. However it is often not the case, as the patient is trying to say he/she has too much “Yang” in his/her body. It is therefore important to clarify with the patient about his/her concerns by asking something like, “What do you mean by having too much heat in your body?”

Understand health practices

Chinese patients often use folk medicine or “tonics” in the early stages of illness. In addition, self medication with Chinese medicine and consultation with a Traditional Chinese Medicine (TCM) doctor, and concomitant use of both Chinese and Western medicine is not unusual. It is also very common for both Chinese and Koreans to be taking vitamins, propolis, calcium supplements, and royal jelly as a regular daily supplement. Always ask specifically what health supplements they are taking, otherwise you will get a “no” answer to questions about medication. It is therefore important to seek a full drug taking history especially inquiring about the use of TCM or alternative health supplements. Chinese and Korean patients will often request injections as they perceive it as a more direct and potent route of delivery with a more rapid onset of action than the oral route.

A perceived imbalance of the “Yin and Yang” forces can be influenced by many factors including dietary intake. It is therefore common for a Chinese patient to ask the health practitioner about food avoidance in times of illness. For those health practitioners who are not familiar with the “Yin and Yang” concept, it would be best to advise the Chinese patient to seek dietary advice from a TCM doctor or suggest the patient eat whatever he/she feels comfortable with or accustomed to.
CHAPTER 7 ASIAN PEOPLE IN NEW ZEALAND

Realise Asian people’s use of medication

Noncompliance or miscompliance is an issue with any group of patients. It is more of an issue with Koreans as they have been used to easy access to most medications from their local chemist until a few years ago. Drugs like antihypertensive and antibiotics were freely available leading to resistance and misuse problems. Doctors in New Zealand need to emphasise the correct use of medication and check for compliance at each visit.

It is helpful to use medication cards with name of medicine and times to be taken on it. This improves understanding and compliance. Also, state clearly to the patient the duration of treatment—for example two weeks or lifelong. Make sure they come back for repeat prescriptions if necessary.

Be aware of patients’ expectations

The “family doctor” is a rather foreign concept as it is not a common practice in many Asian countries for a patient to have a family doctor. In their own country, when they are unwell, they tend to present to the first available doctor or whoever is the most reputable in treating the condition. Walk in without appointment and self referral to specialists is the norm. Medical consultation in many Asian countries is relatively short in duration and often conducted in a rather “doctor centred” manner. Some Chinese patients are used to doctors who give quick and authoritative diagnosis whereas some are used to asking for tests and medicines that they want. In addition, some expect to be told what to do and expect the doctor to do something concrete—for instance, writing out a prescription. Speaking of prescription, it is also a foreign practice for Chinese patients to fill a prescription at the chemist. Asian patients are also used to having a one stop shop system of health care where everything is done on the spot such as consultation, blood tests, radiology tests and treatment prescription.

Many Chinese and Koreans are familiar with the “total body checks” which are performed in many hospitals in South East Asia. They will often ask for one, which does not exist here in New Zealand. This may cause anxiety and frustration for the patient. They are used to being investigated extensively with a whole batch of routine blood tests, Xrays, ultrasounds and endoscopy of the gastrointestinal tracts. Doctors may need to explain that in New Zealand, we only request blood tests or investigations that we feel are necessary or pertinent to the problem involved.

Despite of all the patients’ various expectations, it is important to remember that as a doctor in New Zealand, the practice of patient centred care is crucial in the provision of good medical services. In short, it is important to seek patients’ ideas, concerns and treatment expectations of their illness regardless of their ethnicity.

Have effective communication

Even simple things such as making an appointment with a general practitioner can be a huge obstacle for some Asian patients with little English. For example, when answering phone calls from Asian patients, one has to speak slowly, clearly and in short simple English. Offer appointment times that are easy to understand for example, “Two o’clock” not “Fifteen to four”. Repeat and check for understanding. Asian patients with limited English will often make appointments through friends or family members, so make sure you have the right person’s details.
Know your patients’ names and dates of birth

Getting this right is tricky. When Asian people come to New Zealand, they often take on an English name, so they end up with more than one name. For women, it is further complicated by adopting the Western culture of taking on the husband’s surname. This results in a possibility of four names for the one person. It is recommended that medical practices use the name on the patient’s passport to simplify matters.

Date of births are also tricky because Koreans and some elderly Chinese people use two birthdays; one according to the solar calendar and the other according to the lunar calendar. There is no simple solution around such idiosyncrasy but it is important to find the right information.

Work with guardians/support persons

Some Asian patients are used to having a “guardian” or support person with them in consultations, similar to the whānau in Māori culture. It is appropriate to allow at least one person to accompany the patient into the consultation room, especially if they need help with interpreting.

Beware of the fact that the guardian or support person often speaks on behalf of the patient, and try to encourage the patient to speak for himself/herself if at all possible.

Deal with sensitive issues

It has been suggested that Confucian teaching which discourages open displays of emotions in order to maintain social and family harmony is contributing to the higher rate of psychosomatic illness among Chinese patients. Regardless of the reason, sensitivity and tact is important when dealing with the psychosocial aspect and sensitive issues like suspected abuses of all patients.

Work with individuals from a refugee background

This subgroup of Asian patients has been inadequately treated and needs complex follow up. Patients tend to use the emergency services as their last resort because they have limited understanding of the New Zealand health system or they can’t afford visiting their family doctor. Thus patients are often admitted to hospital acutely with serious presentations. Past histories are difficult to ascertain and the lack of interpreters to help the health team can lead to wrong diagnoses, unnecessary investigations and referrals to tertiary care.

The mental health of refugees needs special care in view of their history of torture. Torture methods adopted and the consequence of their sufferings have to be carefully understood for treatment to be successfully pursued. Referrals to expertise in rehabilitation of these torture trauma victims are essential. Building a good rapport with refugee patients is a useful strategy in addressing their health needs.
Working with interpreters

For the patient this is highly anxiety provoking. They are faced with putting their trust in a doctor or health professional with a different language and culture to their own. Thus it is vital to employ an experienced interpreter who has been trained in medical terminology and concepts. In reality, the use of trained interpreters is often not possible because of lack of access and the high cost. Hence, friends and family members are frequently used as de facto interpreters for the patient.  

Some doctors will be more experienced than others at adjusting their consultations to the presence of interpreters. Some may feel uncomfortable when faced with patients with no English skills, and indeed feel culturally incompetent of the patient's health beliefs and practices.

No doctor is expected to be fully competent in the many cultures that exist in New Zealand, especially the many different Asian cultures. They key is to approach the Asian patient with genuine concern and interest. Nonverbal messages of reassurance like smiles and good eye contact along with a clear, kind tone of voice go a long way. Sentences should be short, in simple English, and not spoken too quickly. Allow more time than other consultations when using an interpreter, as it is more time consuming to consult through an interpreter.

Some basic ground rules should be set and agreed on before the consultation begins.

**Introductions/ briefing**

It is important if the interpreter can be briefed as to the problem. This will enhance the quality of the interpretation. In an ideal situation, the doctor might like to find out some do's and don'ts of the particular Asian culture before the consultation for example, red colour is good luck in China, and bad luck in Korea. Number four is symbolic of death in both cultures.

**Agreement on type of interpreting**

In the medical setting, it is recommended that the doctor speaks in one or two sentences followed by interpretation. Interpreting big chunks of speech (longer than two or three sentences) is less conducive to understanding and flow of conversation or consultation.

**Seating arrangements**

Where possible, the doctor, patient and the interpreter should be seated in a triangle formation with the doctor and the patient sitting in direct and full view of each other. This enhances communication. The interpreter should be seated in between the doctor and the patient, slightly out of view from both. The doctor should look and talk directly to the patient instead of talking through the interpreter.

Interpreters services are being made available to Asian migrants from nonenglish speaking background at a PHO level. Further enquires can be made at the local practices.
Conclusions

The cultural beliefs of people’s countries of origin still prevail in their initial settlement period, and have to be considered by health practitioners. Efforts must be made to get Asian patients integrated to the health systems in New Zealand and this will require ongoing education for both patients and doctors.

Availability, accessibility and affordability are three important criteria in measuring how well Asian people’s health needs are met in New Zealand. Common diseases listed here need to be considered in the final diagnosis and treatment. Mental health is a challenging area because of the degree of stigma attached to such illness in many Asian cultures resulting in treatment delay and possibly worsening of prognosis. The follow up of patients should consider the life styles, financial situation, the roles family and community play and the barriers to successful resettlement. Health interpreters play a major role in addressing health needs, and careful use of these experts is critical in the management of these patients.
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CHAPTER 8

The use of interpreters

Ben Gray is a general practitioner and Senior Lecturer in the Department of Primary Health Care and General Practice, University of Otago, Wellington.


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Diversity

Increasing numbers of New Zealand residents are born overseas — since 1996 the percentage has increased from 17 percent to 22 percent or nearly one in four people living in New Zealand. Between 2006 and 2026 the Asian, Māori and Pacific populations are all projected to grow faster than the New Zealand population overall,¹ and net migration will become an increasingly significant contributor to population growth.² The proportion of people from non-English speaking backgrounds is also increasing; people of Chinese origin are now the second most common group of migrants after those of English origin, and Chinese 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 2006, over half (52 percent) of the overseas born population lived in Auckland, which was home to 32 percent of the country’s total population.

New Zealand has three official languages, English, Maori and New Zealand Sign Language (for which there are 24,000 users).³

Right to communication

Right 5 of the Health and Disability Commissioner’s Code of Rights, “Effective Communication”, includes a right to a competent interpreter.⁴ Without an interpreter many of the other “Patient Rights” are not available to a person with “limited English proficiency” (LEP).

Is any interpreter satisfactory?

Accurate complete interpreting is a difficult professional job that requires significant training. In addition good interpreting is founded on trust; the patient must trust the interpreter to hold any information confidential and trust them to accurately interpret their communication, the doctor has to trust the interpreter to be accurate, and to signal if there is any doubt as to how a phrase should be translated. The further apart culturally two languages are the more likely that concepts do not translate. For example, there is no equivalent term to schizophrenia in Somali. It requires significant practice to be able to recall all that is said in English and then accurately translate it into another language.

It is common practice for clinicians to use ad hoc interpreters: family members, friends, bilingual colleagues to aid communication with LEP patients. Table 1 lists the important linguistic and ethical problems with this approach.
Table 1

<table>
<thead>
<tr>
<th>Linguistic problems</th>
<th>Ethical problems</th>
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<tbody>
<tr>
<td>Accuracy of interpreting, degree of English fluency</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>Unfamiliarity with medical terms</td>
<td>Difficulty with talking about sensitive matters</td>
</tr>
<tr>
<td>Incomplete interpretation</td>
<td>Role conflict (e.g. abusing husband interpreting for abused wife)</td>
</tr>
<tr>
<td>Adding in advice or opinion of interpreter</td>
<td>Disrupting family dynamics; in particular the use of young children as interpreters for their parents is unacceptable.</td>
</tr>
</tbody>
</table>

In judging the likelihood that a professional interpreter is needed, the following issues should be considered:

- Complexity of anticipated clinical content
- Language ability of the patient
- Language ability of available *ad hoc* interpreter
- Degree of ethical risk: e.g. is the patient vulnerable with mental health issues? Is the available *ad hoc* interpreter a child? does the available *ad hoc* interpreter have a position of power over the patient?
- Sensitivity of clinical content: e.g. gynaecology, family discord
- Legal need for informed consent
- Urgency of presentation: in emergency use the best available
- Wishes of the patient
- Ability to pay for an interpreter.

It is useful to think of there being a continuum in degree of need to use a professional interpreter.

For example looking at clinical complexity, at one end it is essential: e.g. explaining a new diagnosis of cancer, gaining informed consent for a major procedure. At the other end a family member may be satisfactory: doing a repeat prescription for hay fever medication.

**Every doctor must have the ability to employ a professional interpreter if caring for a Limited English Proficiency patient**

If a patient has LEP then there will be times when care cannot be provided without a professional interpreter.
Professional interpreter: telephone vs face to face

Many organisations prefer to use telephone interpreting, predominantly because of cost. Table 2 contrasts the risks and benefits of telephone and face to face interpreting.

Table 2

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Telephone interpreter</th>
<th>Face to Face Interpreter</th>
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<tbody>
<tr>
<td>Anonymity of interpreter</td>
<td></td>
<td>Relative ease of communication including non verbal</td>
</tr>
<tr>
<td>Availability (for smaller language groups or at short notice)</td>
<td></td>
<td>Easier if needing to consult with a family group</td>
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<tr>
<td>Cheaper</td>
<td></td>
<td></td>
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<tr>
<td>Relative ease of communication including non verbal</td>
<td>Easier if needing to consult with a family group</td>
<td></td>
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<tr>
<td>Easier if needing to consult with a family group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disadvantages/Risks</td>
<td>Distancing effect of the phone</td>
<td>Possible issues with confidentiality/comfort the patient and interpreter are socially acquainted or part of a small ethnic community</td>
</tr>
<tr>
<td>Possible background noise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty in gauging quality of interpreter</td>
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<tr>
<td>Lack of continuity (more likely)</td>
<td></td>
<td>More costly</td>
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<tr>
<td>More costly</td>
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</table>

Organisational systems required to care for LEP patients

Doctors work in organisations and there are many things at a system level that will facilitate communication with LEP patients:

- Routine collection of ethnicity, preferred language and need for interpreter data on registration
- Organisational policy on use of interpreters
- Provision of a budget for employing interpreters
- Register kept of available interpreters
- Speaker phones available (telephone interpreters are commonly used and available)
- Staff training on managing LEP patients including reception staff
- Look at all communications from the organisation to patients through the eyes of an LEP patient: do any of them need translating?
- Patient safety Incident management system flagging when language barrier may have been a factor.
Skills required

Assessing English fluency

If the patient speaks no English it is easy to work out that you need an interpreter. It is rarely helpful to ask someone if they speak English. Better is to ask open ended questions, or ask the patient to repeat back in their own words what they have understood you to have said. Even if someone has sufficient English for conversation at work they may still have insufficient for discussing complex health issues.

Working with an interpreter

Organisations providing interpreter services all offer brief advice or training on how to work with an interpreter. Some basic points are:

- Speak as if you are talking to the patient (“how do you feel” not “how does she feel”)
- Sit in an equilateral triangle so patient doctor and interpreter can easily see each other
- Speak in small “chunks”. The longer you speak without a break for interpreting, the harder it is to interpret accurately
- Avoid colloquialisms and medical jargon. Jokes are often hard to explain and risk being misunderstood.

Communicating with deaf people

Past prohibition of the use of sign language in schools means that there are significant numbers of deaf people with low levels of literacy. Written communication is not a suitable or reliable substitute for communicating with many deaf people. If you have deaf people in your practice there is a detailed guide on managing this at: http://www.odi.govt.nz/resources/guides-and-toolkits/working-with-nzsl-interpreters/index.html

Funding for interpreters

All public hospitals in New Zealand have policies and a budget for the use of interpreters, although anecdotally the budgets are constrained. Any public sector organisation can join “Language Line” (see below) which provides subsidised telephone interpreting. This includes PHOs. The three Auckland DHB’s have a fully funded primary care interpreting service. Many PHOs provide some funding through “Services to Improve Access” funding.
CHAPTER 8 THE USE OF INTERPRETERS

Availability of professional interpreters

Language Line is a partially subsidised telephone interpreting service that is provided from the Office of Ethnic Affairs. http://www.ethnicaffairs.govt.nz/oeawebsite.nsf/wpg_url/language-line-Index. They provide interpreters in 43 languages, and are available Monday to Friday 9am—6pm and Saturday 9am—2pm.

Auckland has its Primary Health Interpreting Service http://watis.org.nz/info/Primaryservice.php available to primary health services in Auckland, Waitemata and Counties Manakau. The New Zealand Society of Interpreters and Translators keep a database of interpreters: http://www.nzsti.org

Interpreting New Zealand provides interpreters in 70 languages from Wellington and Christchurch, face to face, and by telephone to other regions. http://www.interpret.org.nz

Uptake of professional interpreters is poor

Two New Zealand studies document that the use of interpreters is inadequate and clinical harm is likely to be happening as a result of impaired communication.5,6 Cost can be a significant barrier to using professional interpreters. Doctors working for organisations who care for LEP patients where there is no budget for interpreters have a responsibility to lobby for funding to be found.

However even if the service is free there can be a low uptake. This has particularly been noted in Australia where despite a comprehensive free interpreting service uptake is significantly lower than anticipated.7

The main identified barriers to uptake identified were training of clinical staff and particularly training and attitudes of reception staff.8 A toolkit has been developed for use in primary care in New Zealand to address this need.9

Summary

New Zealand has an increasingly diverse population with significant numbers of people who are not English proficient, particularly in the Auckland region. It is not possible to provide good care for an LEP patient without an interpreter, and there are some situations where a professional interpreter is essential. Current use of interpreters in New Zealand is such that it is very likely that LEP patients are being exposed to increased clinical risk. Attention to the systems in which doctors work as well as the skills and knowledge of clinicians is needed to improve this problem.
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CHAPTER 9

The psychiatric patient and the law

David Chaplow is a forensic psychiatrist and former Director of Mental Health and Chief Adviser at the Ministry of Health Wellington.


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In a typical day a general practitioner will assess and treat people presenting with psychological symptoms and illness. They will present either with a clear psychiatric illness (e.g., “I am depressed doctor...”) or with symptoms which need explanation, (e.g., “I haven’t been able to sleep properly for ages…”). Up to 30 percent of patients present with such symptoms.

The World Health Organisation estimates that over one in five persons will present with mental disorder over their lifetime. Many presentations will be dealt with in a social context (e.g., counselling by a priest), never coming to medical notice. Of those who do present to services, most will be assessed and treated by a general practitioner. Up to three percent will be referred, assessed and treated to/by secondary (or psychiatric) services. People with presumed mental illness and marked behavioural disturbance may need assessment and treatment under the Mental Health Act (Mental Health [Compulsory Assessment and Treatment] Act 1992).

This chapter defines and discusses mental disorder and practical aspects of using the Act, including giving evidence in court.

**Why have an act?**

Mentally ill patients are vulnerable because of their impaired judgment and autonomy and because of their capacity to harm themselves, harm others or to be unable to ensure self care. The Mental Health Act (The Act) protects the mentally disordered person, ensures assessment and treatment and upholds their rights.

Other associated protective legislation includes the Protection of Personal and Property Rights Act 1988

**The Mental Health (Compulsory Assessment and Treatment) Act 1992**

The Act:

- defines mental disorder
- specifies rights and protections for “patients” and
- ensures a framework of accountability for their care.
How is “mental disorder” defined?

This is given in sections 2 and 4 of the Act. There is a core definition,

Mental disorder in relation to any person, means an abnormal state of mind (whether of a
continuous or an intermittent nature) characterised by delusions, or by disorders of mood or
perception or volition or cognition.

…and threshold criteria: that their behaviour

(a) poses a serious risk of danger to the health or safety of that person or of others; or
(b) seriously diminishes the capacity of that person to take care of himself or herself.

Section 4 states that the above definition should not apply to the following categories,

(a) a person’s political, religious or cultural beliefs; or
(b) a person’s sexual preferences; or
(c) a person’s criminal or delinquent behaviour; or
(d) substance abuse; or
(e) intellectual handicap.

Abnormal state of mind refers to a qualitatively different presentation, distinct from people of
similar cultural or religious backgrounds.

Continuous or intermittent acknowledges that most mental illnesses and disorders follow a
fluctuating course. This is why both “cross sectional” and “longitudinal” histories are necessary.

Delusions are defined as fixed false beliefs out of keeping with the patient’s ethnic or
religious culture.

Disorder of mood refers to a pervasive and sustained feeling state. It can be “low” as in
depression, or “high”, as in hypomania. True depression or hypomania comprise mood states
that affect world view, judgment and ability to function adaptively. Abnormal mood states
can occur secondarily to other illnesses such as personality disorder and schizophrenia.

Disorder of perception include hallucinations and usually occur in psychotic illness.

Disorder of volition is a reference to disorders of the “will” and may be affected in
depressive stupor,

catatonia, and disinhibited states or in the “frontal lobe syndrome” following a head injury.

Disorder of cognition refers to disorders of the process of thinking. The disorder covers the
isordered thoughts of the psychotic disorders (such as the disorder of “thought form”), the
increased rate of thought in mania and the slowed process of thoughts as seen in depression.
The *threshold criteria* mean that people can only be committed under the Act if their disorder is so severe that it endangers themselves, others, or seriously impairs their ability for self care. Assessment of risk must encompass the following points:

- the nature and magnitude of the harm
- its imminence
- its frequency
- circumstances and conditions that increase the likelihood of harm
- balancing the alleged harm on one hand and the nature of society’s intervention on the other.

*Section 4 exclusion criteria* mean that compulsory assessment and treatment should only be applied to those with major mental disturbance, not to those who disagree with the state or those whom we dislike or disagree with.

**How do I initiate civil commitment under the Mental Health Act?**

Compulsory assessment is initiated by contacting a Duly Authorised Officer (DAO) at the local District Health Board (DHB). This is usually by a member of the public (usually a family member) or by a medical practitioner. Both need to complete a Section 8 application certificate (of the Act.)

The DAO reassesses to determine the grounds for further assessment and arranges for a further assessment by a psychiatrist, informing the patient (section 9).

A psychiatrist (or a senior training registrar) will complete the assessment (section 10) stating that there are grounds for suspecting that the person may be mentally disordered (or the contrary).

If the assessment finds that the person may be mentally disordered, a period of five days’ compulsory assessment begins. This is usually in a mental health inpatient unit but could be in the community. The patient’s assessment and treatment fall under the responsibility of a Responsible Clinician (RC), usually a psychiatrist.

Before the end of five days a patient can be released, or a further 14 day period of assessment will commence (Section 12). At the end of this period the patient must be released or an application made for a Compulsory Treatment Order (CTO).

This order is made by a Family Court Judge at a hearing arranged for the purpose. The Judge must determine whether or not the person is mentally disordered, if an order is necessary, and what type of order should be made (i.e., to the community or to an inpatient unit).

The CTO is initially of 6 months duration and patients must be regularly reviewed by their RC and by a District Inspector (DI), a lawyer appointed by the Minister of Health. Patients can appeal their compulsory detention (to the High Court, Section 16 of the Act) or to the Mental Health Review Tribunal (MHRT).

All services under the Act are the responsibility of the Director of Area Mental Health Services (DAMHS), often the same clinician as the Director of Clinical Services.
**Issues in civil commitment**

Under an inpatient CTO a patient is obliged to take their medication and reside where directed. They can request a second opinion from a psychiatrist of their choice. The viewpoint of the family and other carers is important and the Act now mandates consultation with the “family” (section 7a) unless there is good clinical reason not to do so or it is not practicable to do so.

Ordinarily the doctor patient relationship would prevent disclosure of confidential information to a third party. However if there is a known, serious and imminent risk to a third party, doctors have a common law and ethical responsibility to warn them of such a risk and take appropriate action. When in doubt you should discuss with a colleague, with your medical defence organisation or with the local DAMHS.

**Guardianship Order (Protection of Personal and Property Rights Act 1988)**

This provides for people who are impaired in their competence to make certain decisions about their health, welfare and property. It can be invoked in respect of any persons who:

> lack, wholly or partly, the capacity to understand the nature, and to foresee the consequences of, decisions in respect of matters relating to (his or her) personal care and welfare (section 6(1)(a)).

It provides for the least restrictive orders necessary to address the issues of care and welfare. It can apply to the mentally disordered but more commonly is applies to the care and welfare of the intellectually disabled and/or to those with acquired cognitive impairment (as in head injuries or dementia). Application of the act involves the appointment of a “welfare guardian”.

**Criminal matters**

For those persons before the court for any matter, provision is made in law (Criminal Procedure [Mentally Impaired Persons] Act 2003) in order to assess:

- fitness to stand trial
- mental status at the time of committal of the alleged crime (“insanity defence”)
- matters concerning sentencing and disposal.

**Disability**

Natural justice demands that a person understand what he/she is charged with, know the plea options and their consequences, understand the legal process and be able to work with a lawyer in order to defend him or herself.
Insanity

This defence is defined in section 23 of the Crimes Act and concerns those who:

...when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable — —

(i) Of understanding the nature and quality of the act or omission; or

(ii) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

The term applies only to the period immediately surrounding the period of commission of the crime.

Contrary to popular belief only a few people per year are acquitted on the grounds of insanity. For this to occur the jury must hear all of the evidence, including the testimony of defence and crown psychiatrists and be satisfied on the grounds of the balance of probability that the defendant was not only mental ill at the time but either didn’t know what he/she was doing, or didn’t know that their action were morally wrong. It must be emphasised that the court makes the decision as to insanity with the assistance of the psychiatrist/medical practitioner.

Special patients

There are four categories of Special Patient:

• short term remandees
• remand and sentenced prisoners who require assessment and treatment in hospital
• those who are under disability
• those who juries assess as “not guilty by reason of insanity”.

The statute governing their leaves, reviews and release to the community are rigorous and set down in the Act.

What happens if you are asked to testify in court?

There are three types of witness:

• witness to fact (when the witness sees or hears something relevant to case)
• the clinical witness who becomes involved by virtue of the doctor/patient involvement (e.g., has made notes about the case)
• the expert who has special knowledge and experience in a defined area.

Most general practitioners will be asked to present in court by virtue of having assessed and treated a patient. As a witness in court you:

• need to know why you are being called
• how your testimony will be used; and
• what procedure is required (e.g., will you need to supply a report?)

If your professional relationship with the patient may be compromised you are best to request a subpoena. This makes your obligations (to the court and to the patient) clear. You are also advised to discuss the issue with your medical protection insurer.

The medical witness is in court for two reasons:
• to assist the court to come to a sound decision
• to explain complex issues which are often outside the province of the ordinary person.

Most doctors feel uncomfortable in court. It is because the evidence needs to be tested and the court need to be sure of the facts on which it makes its decision. For these reasons it is important to:
• be clear why you are there as a witness. Request written instructions as to what role you have
• prepare carefully. Make sure you have your notes. Be able to define what words you use
• know that you don’t have to “take sides”. You are not on trial. Nor do you have to prove anything.

You are there to assist the jury:
• be relaxed and nondefensive. Don’t give your opinion beyond your expertise. If you don’t know, say so. Use plain words.

**Resources**


CHAPTER 10

Informed consent

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Informing and obtaining consent

Informed consent is more than getting a patient to sign a consent form. The consent form is merely the written acknowledgment of a process that provides the patient with sufficient information in order to make an informed decision about their treatment. It is a two-way communication process between a doctor and patient which results in the patient feeling confident that they have enough information to agree to undergo a specific medical intervention. It is also more than a one-off action. It is a process throughout all stages of treatment or procedure.

Informed consent to medical treatment has long been an ethical obligation, and more recently a legal requirement. It is a fundamental patient right. The process of obtaining informed consent acknowledges the independence of the patient and the fact that the interaction between the doctor and the patient is for the patient’s benefit.

In the modern world of medical practice much is known about the risks, benefits and costs of treatments. Most of these risks, benefits and costs have been quantified to the degree that meaningful information can be given to patients, enabling them to make an informed choice. However, this informed choice can be made only to the level of comprehension and competence that the patient possesses. It is therefore necessary to be aware of this level of understanding in your patient. There can be no suggestion of coercion and the patient must make choices voluntarily. Patients will sometimes need time after the consultation to consider matters and possibly discuss these matters with family/whānau or others who are near to them before they can make a decision. Sometimes, after considering all of the information, patients can still be unsure about what to do. They may ask their doctor what he or she would do if he or she were the patient. It is reasonable in this circumstance to give an honest answer to this question.

In addition patients may waive the right to discuss the details of a treatment. You should record this decision. Sometimes patients maintain that they do not want a lot of detail about possible complications from the proposed treatment. In this situation, you must decide whether or not the patient has in fact received sufficient relevant information to make an informed choice. If not, then you may need to consider declining to perform the procedure under discussion. In such circumstances it is vital to seek collegial support or refer the patient to another doctor.

In some areas of medical practice, the concepts involved in treatment are complex and most patients will be able to grasp only some of the considerations surrounding the recommended treatment or procedure. In these areas of treatment or investigation, it is wise for the doctor to make a specific recommendation based on his or her experience. The final choice about whether to accept or reject such a recommendation is the patient’s.

In addition to discussing the risks and benefits of any proposed treatment, the patient has the right to know of alternative treatments and their risks and benefits. This does not mean that a doctor must know of every single possible alternative treatment, but they should know about a range of treatments that their colleagues would judge to be reasonably known by a doctor in their position. This includes informing the patient of treatment options that might be available outside of the publicly funded health service.
Patients sometimes raise the possibility of a treatment that the doctor does not agree with or does not know about. This is especially true of “alternative therapies” (see chapter 24). In these circumstances the doctor should advise the patient of the evidence base for the respective treatments as far as they know them, and give the patient clear reasons why they recommend one treatment over another.

It is not necessary to have a signed consent form for every treatment; this would be impractical, for example, for every prescription written in general practice. However, the more invasive the procedure, or the more risks it involves, the more prudent it is to have the patient sign a consent form.

In the absence of a signed consent form, you should include an annotation in the patient record that the patient has consented to this treatment. You should do this in every case because it provides evidence that you engaged with the patient in an appropriate discussion. When an interpreter or other third party has been used to assist in obtaining the patient’s consent you should note this in the patient record. Other than in extreme emergencies it is a requirement of the World Health Organisation Patient Safety Checklist to ensure a written and signed consent form is completed prior to any operative procedure. The checklist is likely to be introduced into all New Zealand hospitals.

If a treatment is part of research or is experimental, or the consumer will be under general anaesthetic, or there is significant risk of adverse effects to the consumer, then the consent must be in writing.

Doctors have a special duty of care when enrolling apparently healthy asymptomatic persons in screening programs. Particular attention must be paid to explaining the uncertainties and limitations of the screening and implications of false positive and false negative findings for their patient. This must be explained prior to obtaining consent.

Where medical trainees are involved in the treatment or care of a patient the patient should be informed about the extent of the involvement of the trainee and the trainee’s experience. Consent should be obtained from the patient if the care or treatment is part of the trainee’s education.

There are rare occasions when a doctor does not wish to discuss a particular treatment with a patient because that treatment conflicts with the values or beliefs of the doctor. An example of this might be termination of pregnancy. In this case the doctor must inform the patient of this conflict and refer the patient forthwith to a doctor who can discuss all the currently recommended and accepted treatment options.

When a proposed treatment is expensive or in any way innovative, particular care should be taken to ensure that the patient is aware of this.

In summary, there must be a discussion with your patient about the proposed treatment, during which the patient must be given the opportunity to ask questions and gain a better understanding, and you, (and not a delegated representative) should disclose and discuss with your patient:

- The diagnosis as far as it is known
- The nature and purpose of the proposed treatment or procedure
- The risks and benefits of the proposed treatment or procedure
• Alternatives to this treatment or procedure (regardless of their cost or availability in the New Zealand public health system)

• The risks and benefits of the alternative treatment or procedure as far as you know them; and

• The risks and benefits of not receiving or undergoing a treatment or procedure.

The patient has the right to:

• Consider the information given

• Ask for clarification and ask for time to consider the information

• Consult with family and others

• Give consent or decline to give consent

• Waive the right to discuss the details of treatment

• After having given consent, change his or her mind and withdraw the consent.

The standard for informed consent is that which a reasonable patient might expect rather than what a reasonable doctor might think (Rogers v Whitaker 1992), and failure to fulfil requirements may be considered as professional misconduct. All doctors must be familiar, and comply with, the Code of Health and Disability Services Consumers’ Rights.

The Code of Health and Disability Services Consumers’ Rights 1996

There are legal requirements for doctors to undertake the informed consent process prior to beginning treatment. The Code (see chapter 29) makes explicit reference to informed consent, especially in Rights 5, 6, and 7. It is important that every practitioner working in New Zealand is fully conversant with this Code. Among other things the Code makes it clear that the patient must be informed of any proposed research or teaching associated with their treatment, and whether such research requires and has received ethical approval. The Code says that the patient must also be informed about the estimated time in which a health service will be provided, the results of any tests, and the results of procedures. The patient has the right to know the identity and qualifications of the providers of the service, how to obtain an opinion from another provider, and the results of the research.

The Code is also explicit that health services can be provided to a patient, only if that patient has made an informed choice and given informed consent. General consent may be given by a patient in advance of the knowledge that any treatment will be necessary. This can be in the form of an advance directive and must be in writing and is covered by common law. Retention and or storage of body parts or bodily substances can be done only with the informed consent of the patient.

Many of the complaints made under the Code are essentially about the lack of proper communication between doctor and patient.
When informed consent is not necessary

There are rare occasions when it is not necessary to get informed consent and the health practitioner has immunity. Some of these occasions are covered by statutory provisions which take precedence over the Code. These situations are detailed in the Medical Council’s statement Information, choice of treatment and informed consent which can be found on its website, www.mcnz.org.nz. The well-known examples are under the Mental Health (Compulsory Treatment) Act 1992 (see chapter 9), and under the Health Act 1956—to prevent the spread of infectious disease. Other examples are the Alcoholism and Drug Addiction Act 1966, the Land Transport Act 1998, Criminal Investigations (Bodily Samples) Act 1995, Criminal Procedures (Medically Impaired Persons) Act sections 36 to 38 Care of Children Act 2004 and the Children, Young Persons and Their Families Act 1989 (see chapter 28). Right 7 (4) of the Code specifies other circumstances when it is possible to proceed with treatment without consent. This section involves a patient’s competence, but remember that every patient must be presumed to be competent unless there are reasonable grounds for believing that they are not. The common circumstances where a patient is not competent are where they are a young child, where they are unconscious, or where they are suffering from dementia, or have an intellectual disability.

If in emergency, immediate action must be taken to preserve the life or health of a patient, then you can provide the key services without consent. Only those treatments that are necessary to preserve life or health should be done at this time. Any procedure that can reasonably be delayed should be delayed until an opportunity can be given for the patient to consent.

Occasionally, when a patient is unable or refuses to consent to treatment, a legal opinion should be sought with a view to seeking authority from the High Court.

Who can give consent on behalf of another?

The only individuals who are entitled to grant consent on behalf of a patient are legal guardians (welfare guardians under the Protection of Personal and Property Rights Act, or parents/guardians under the Care of Children Act 2004 or someone with enduring power of attorney). A spouse or next of kin cannot consent to or refuse medical treatment on behalf of an incompetent person unless they hold enduring power of attorney or are their welfare guardian. The individual with that authority can make all health care decisions, except they do not have the legal ability to refuse consent for lifesaving treatment or medical experimentation. Section 18(1) (c) of The Protection of Personal and Property Rights Act 1988 specifically forbids the person who has enduring power of attorney from refusing consent “to the administering … of any standard medical treatment or procedure intended to save [the patient’s] life or to prevent serious damage to that person’s health” (see chapter 28). It is important to ask someone who has enduring power of attorney, if they have powers in relation to property, or personal care, or both. Personal care is the applicable authority in regard to giving consent for health care.
Care of Children Act 2004

This Act came into force on 21 July 2005 and replaced the Guardianship Act 1968. It states that all persons over the age of 16 are regarded as adults for the purposes of determining competence to give informed consent. People under the age of 16 are not automatically prohibited from consenting to medical, surgical, or dental procedures so judgment is needed in each instance. This Act has changed the way a court order may be sought in cases where the parents or guardians refuse to consent to treatment for children in circumstances where the child’s life is at risk.

It also covers how the consent of children should be obtained for medical procedures and the right of doctors to administer blood transfusions to children without consent in certain conditions (to save life being the principal condition). Section 38 of the Act addresses the issue of obtaining consent for abortion for children (a female of any age has the right to consent to or refuse to consent to any medical or surgical procedure for the purpose of terminating her pregnancy).

Ethical dilemmas

Doctors need to be aware of decisions made by the Courts. Decisions are made on a case by case basis and are circumstance dependent. While a particular medical act may be considered ethical in one situation in another situation a similar act can be unethical and illegal.

Not all the issues surrounding consent for the treatment of children have been settled and doctors will still face dilemmas. New Zealand has had three high profile cases since 2000 when parents withheld consent for medical treatment for their children under circumstances that resulted in all three children dying of their diseases. The way the police and the courts treated these cases was inconsistent and in the first of these cases, the lack of a police prosecution followed intense nationwide public support for the parent’s decision to decline to accept conventional medical treatment. In the other two cases the parents were prosecuted. The courts imposed a suspended sentence on the parents in the second case, and sentenced the parents in the third case to 5 years in prison. It would appear, for the time being at least, that the ability to persuade the court will be the most significant factor in determining outcomes. Doctors should regard court orders against parents as an absolute last resort, and all other means to persuade parents should be exhausted first.

Professor Don Evans, director of Otago University’s Bioethics Centre has stated “There is a huge price to be paid for that last step. It pretty well destroys any collaboration for the future between parents and health carers”. If you are likely to find yourself in conflict with a child’s guardian about the treatment of serious life threatening conditions, you should read this legislation and seek advice from your medical protection insurer, lawyers, or employers. There are situations where doctors and caregivers may jointly seek a court order for consent, for example to terminate treatment to allow a patient to die peacefully, or sterilisation of a patient who is unable to consent but for whom the family and other carers, supported by medical opinion, request the operation to enhance the quality of life or to prevent deterioration in physical or mental health.
CHAPTER 10 INFORMED CONSENT

Current legal authority “consent” decisions

In *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL) it was held that “parental rights” did not exist other than to safeguard the best interests of a minor (under 16). In some circumstances a minor could consent to treatment, and that in those circumstances a parent had no power to veto treatment. The test is can the child fully understand the medical treatment proposed and give consent. This is referred to as “Gillick competency”. A child who is deemed “Gillick competent” is able to prevent parents viewing their medical records.

In *Rogers v Whitaker* (1992) 175 CLR 479 High Court Australia the decision affirmed that a doctor has a duty to warn a patient of any material risk involved in a proposed treatment. A risk is considered material if a reasonable person in similar circumstances would attach significance to the risk, or if the doctor is, or should be, cognizant that the particular patient would express concerns about the risk. This approach is similar to the standards which the Medical Council of New Zealand has set. The “mature minor” principle is considered and discussed by the Supreme Court of Canada in *Manitoba (Director of Child & Family Services) v C (A)*. 2009.

In *B v Medical Council of New Zealand* [2005] HC 3NZLR 810 the High Court stressed the importance of assessing the adequacy of information conveyed by a doctor to a patient from the viewpoint of the patient and warns that inadequate information will almost always be professional misconduct.

In conclusion, informed consent, long an ethical obligation, is in New Zealand a legal requirement. It is one of the cornerstones of good patient care, and recognises that the doctor patient relationship is for the benefit of the patient. Informed consent begins with the patient’s first appointment and continues until the procedure is completed. Not all issues in informed consent have simple solutions. It can be a matter of what is reasonable under the circumstances and the reasonableness is from the point of view of the patient rather than the doctor. It is advisable to consult with other doctors and professional advisers when you are uncertain. The Medical Council’s statement *Information, choice of treatment and informed consent* is a reliable primary source.

Resources

Disclosure of harm

Ian St George is a Wellington general practitioner and has been an elected member of the Medical Council, Chair of its Education Committee, and Chair of the International Physician Assessment Coalition (IPAC).

Poison is in everything, and no thing is without poison. It is the dosage that makes it either a poison or a remedy — Paracelsus.

Disclosure of harm is a subset of informed consent, so is dealt with here. We know now that Hippocrates’ “First do no harm” is not going to work all the time. Nearly all treatments carry the potential for harm, and all of us will do harm, so an honest doctor should talk openly about it — before (informed consent) and after (open disclosure).

Open disclosure is the discussion of incidents that result in harm from health care. The elements of open disclosure are:

• an apology or expression of regret
• a factual explanation of what happened
• an opportunity for the patient to relate their experience of the incident
• a discussion of the potential consequences of the adverse event
• an explanation of the steps being taken to manage the incident and prevent recurrence.

In New Zealand open disclosure is a right under the Code of Health and Disability Services Consumers’ Rights and is a requirement of the Health and Disability Service Standards.

Principles

The patient and their support people should be told about adverse events in a timely, open and honest manner. Further information should be provided as it emerges.

There should be an early apology or expression of regret for any harm that results from an adverse event. An apology or expression of regret should include the words “I am sorry” or “we are sorry”, but should not contain speculative statements, admission of liability or apportioning of blame. The patient and their support people should be fully informed of the facts surrounding an adverse event and its consequence, treated with empathy, respect and consideration and supported appropriately.

Staff should be encouraged to report adverse events, educated to participate in open disclosure and supported through the process. A staff member must not become a “second victim”.

Investigation of adverse events and harm should be conducted through good clinical governance covering risk management and systems improvement. The information obtained should be used in quality improvement.

Procedures should consider privacy and confidentiality for patients, support people and clinicians, fully, and in compliance with privacy law.
Resources


CHAPTER 11

End of life issues

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Introduction

As the population ages end of life issues are becoming more frequent. As a doctor, you play an important role in assisting patients, families and the community in dealing with the reality of death. In caring for patients at the end of life, you share with others the responsibility to take care that the patient dies with dignity, in comfort and with as little suffering as possible.

You should take care to communicate effectively and sensitively with patients and their families so that they have a clear understanding of what can and cannot be achieved. You should offer advice on other treatment or palliative care options that may be available to them. You should ensure that support is provided to patients and their families, particularly when the outcome is likely to be distressing to them.

Two vital ingredients of end of life care are the assessment of capacity (competence) and communication. When difficulties do arise in end of life care it is often due to inadequate communication so it is important to spend time with the patient and family and document contacts fully and accurately in the patient’s notes. For a person with a speech impairment, dysphasia after stroke for example, the assistance of a Speech Language Therapist (SLT) may be invaluable in determining a patient’s wishes or capacity.

Great care must be exercised in recognising and respecting different cultural beliefs. These may influence decisions about treatment, who is consulted and arrangements for handling the body after death.

Assessment of capacity

Many decisions in end of life care depend on whether the patient has “capacity” for decision making, also referred to as “competence”. Competence is always presumed present until proven otherwise. Courts quite rightly take the stance that an individual’s liberty is their most important possession and they should only be deprived of it for compelling reasons.

Doctors should feel confident about assessing the capacity of their patients, but it is wise to seek a second opinion if there is doubt or if the matter is likely to be contentious. The basic guidelines are:

• Competence is always assessed regarding a particular question, and tests of competence will vary according to the issue at hand
• Competence can change
• It is assessed on a “balance of probabilities”
• It is a medical duty to enhance competence.

In addition to testing cognition by a tool such as the Mini Mental State Examination (MMSE) there are three competence “subskills” to be considered. They are communication, insight and judgment.
CHAPTER 11 END OF LIFE ISSUES

Communication
• Can the person perceive what I am telling them clearly enough?
• Can the person let me know what they are thinking clearly enough?

Insight
• Can the person comprehend what I am telling them about the issue at hand?
• Can the person believe the facts about the situation at hand?
• Can the person understand the consequences of the choices open to them regarding the situation at hand?

Judgment
• Can the person retain the necessary information and maintain attention enough to form a judgment based on all the relevant data?
• Has the person made a decision about the issue at hand?
• Can the person outline a process of reasoning for their decision which takes into account the likely outcomes?

There are three major pitfalls in competency assessment. These are:
• Serving team/family goals rather than the person’s goals wrongly interfering with a person’s sovereign right to competently make a bad decision about themselves
• Mistaking competence now for competence forever; basing a decision on the current picture situation rather than the wider picture
• Hurrying.

It therefore follows that if a person is deemed to have capacity (competence) they are entitled to make autonomous decisions even if others consider them ill advised. The exception to this is if the health and safety of others is endangered.

If the person is judged to have lost capacity, i.e. is not competent, and has an enduring power of attorney (EPOA), this can be activated with a doctor’s letter which should outline the reasons why capacity is deemed to be lost and the likelihood that it might be regained. An EPOA has two parts; personal care and welfare, and property and finance. Some people nominate a different person for each part.

If a person without capacity does not have an EPOA application must be made to the Court for a guardian under the Protection of Personal Property and Rights Act (PPP&R) 1988. This can take time so it is a good idea for doctors to encourage their patients, particularly older ones, to obtain an EPOA.

See also: Section on legal guardianship in chapter 9 “The psychiatric patient and the law”.
Do not resuscitate (DNR often now DNAPR) orders

DNR orders refer to Cardiopulmonary Resuscitation (CPR) only and not to other issues of care. It is quite appropriate to actively treat other problems in patients with DNR orders, particularly if they are causing pain or distress (a chest or urinary tract infection, for example). The patient or their proxy should be consulted about vigour of treatment of other health problems. Many District Health Boards now call DNR orders, DNAPR (do not attempt cardiopulmonary resuscitation) orders to denote their limitation and to avoid confusion.

CPR is the default option in all health care facilities in New Zealand unless an advance decision is made that CPR should not be attempted. Most rest homes will ask the resident’s wishes on admission and this, together with other treatment wishes, is usually filed with the medication chart. If the resident is then admitted to an acute hospital then the information about DNR status should be sought. Patients and relatives can find repetitive questioning about DNR and treatment status upsetting if their wishes have already been clearly conveyed. Most hospitals require the DNR status to be clearly displayed in the patient’s notes.

Cardiac arrest is frequently the final event in the dying process and for many patients with advanced illness CPR has virtually no prospect of success and may leave the patient worse off. Unfortunately public expectations of the success of CPR are greatly inflated compared to reality. It is appropriate to accurately inform patients and relatives about the low success rate of CPR in relevant clinical situations.

Where possible the patient’s wish for CPR should be sought. If CPR is being withheld on the grounds of multiple comorbidities (so called futility) the patient should be informed. If the patient is unable to give an opinion a proxy should be consulted about the person’s probable wishes, but it is important to remember that under the law a Power of Attorney (POA) cannot withhold CPR — only give an indication as to what the patient would have wished.

Advanced directives or “living wills”

Advanced directive or “living wills” are instructions which people make about their health care at some future time. These advanced directives are to be used if the person loses the ability to make their wishes known. When this occurs the advance directive guides the person’s substitute decision makers (Darzins et al 2000).

A person may have made an advanced directive many years earlier so may have changed their mind about some issues. It is also impossible for an advanced directive to cover all medical contingencies. It is therefore important to check with the patient or their proxy as to whether the advanced directive still holds good in the present situation. It may be necessary to complete a competence assessment or to determine whether the patient has an activated enduring power of attorney (EPOA) in considering the provisions of the advanced directive.

Advanced directives have legal standing in the Code of Health and Disability Services Consumers’ Rights. There may be circumstances in which it may not be appropriate to comply with the wishes outlined in an advanced directive, however, you must always consider and respect those wishes.
Terminating life sustaining treatments or “instituting palliative care”

A common end of life care decision that has to be made is the cessation of vigorous or life extending or sustaining treatment recognising that the patient is dying. The expression “ceasing active treatment” is sometimes used but this is an inaccurate term as providing good quality palliative care is a very active process requiring frequent review of the patient to ensure symptom control. Terminating life sustaining treatment is often referred to as “passive euthanasia”. A further term that is used is “indirect euthanasia” defined as “administering narcotics or other medications to relieve pain which may have the incidental consequence of hastening death by, for instance, respiratory depression” (Emanuel 1994). Definitions of “active euthanasia” are given in the next section. The main reason for distinguishing between these terms is differences in their ethical status. There is general agreement that so called passive euthanasia and indirect euthanasia are both ethical and legal where treatment is futile and merely prolonging death. However it should be remembered that patients and families have widely differing view on this subject and great care must be taken to explain the change in management goals.

The decision to terminate life sustaining treatment must be made with the patient’s permission where possible, and if not, by reliable proxy such as family members and whānau or power of attorney. The doctor should try and ascertain as reliably as possible what the patient would have decided had they been able to communicate. The patient may have an advanced directive or living will to assist in this regard.

Good communication and documentation is vital at these times. Clear communication extends beyond doctor, patient and family as other members of a health team may have differing opinions and people’s own beliefs must be respected. All concerned must know the reasons for the change in plan and a “debrief” after the patient’s death is wise practice.

The paper entitled “Reducing the uncertainties of withdrawing and withholding treatment” by Logan and McKenzie (2002) provides valuable advice for dealing with these complex situations.

Euthanasia

Strictly speaking the term “euthanasia” means a “good death”, however like many words in the English language the meaning of the word has changed with time. The word is also heavily emotionally charged. As commonly used “euthanasia” is understood to mean “active euthanasia” which is defined as “intentionally administering medications or other interventions to cause a patient’s death” (Emanuel 1994). Active euthanasia can be further divided into “voluntary” (at the patient’s request), “non voluntary” (when the patient is incompetent and mentally incapable of requesting it) and “involuntary” (where the patient is competent but without the patient’s explicit request). Regardless of one’s personal views it is difficult to imagine a situation where involuntary active euthanasia, in particular, or nonvoluntary active euthanasia could be morally justified.

“Physician assisted suicide” is defined as “a physician providing medications or other interventions to a patient with the understanding that the patient intends to use them to commit suicide” (Emanuel 1994).
The Palliative Care Australia position statement on *Euthanasia and Physician Assisted Suicide* provides the following relevant statements:

- Euthanasia and physician assisted suicide are not part of palliative care practice.
- Every Australian at the end of life should have timely and equitable access to quality, needs based and evidence based care.
- Dying is a natural part of life, and declining or withdrawing aspects of treatment is acceptable if it aligns with the informed wishes of the patient. This does not constitute euthanasia or physician assisted suicide.

These statements reflect what is accepted practice in New Zealand.

You must not participate in the deliberate killing of a patient by active means. Euthanasia is illegal, and an offence under the Crimes Act.

**Conclusions**

Dealing with end of life situations can be challenging for the doctor but can also be very rewarding. Clear communication is paramount so that patients and their advocates understand their condition and the implications of treatment or nontreatment. Assessment of capacity or competence is central to decision making. Good documentation of discussions and decisions is essential. Some form of counselling or debriefing for family or team members after death is usually beneficial.

Active killing of a patient is both unethical and criminal.

**Resources**

1. Darzins P, Molloy DW and Strang D. Who can decide? The six step capacity assessment process.
CHAPTER 12

Accident compensation

Peter Jansen is a general practitioner and Senior Medical Adviser for the Accident Compensation Corporation.


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Overview

The Accident Compensation Corporation (ACC) has provided comprehensive, no fault cover for people injured from accidental causes since 1974. Levies from workers, employers, vehicle registrations and taxpayers are applied to facilitate the recovery of those injured and to fund the future needs of those injured long term.

The scheme applies to all New Zealand residents and temporary visitors to New Zealand. New Zealanders who are ordinarily resident may also be covered if they are injured while overseas. ACC, a crown entity, administers the scheme according to the Accident Compensation Act 2001 (the Act).

The right to take legal action for personal injury covered by ACC is removed other than for exemplary damages.

Once a claim is approved by ACC the injured person may have access to a range of entitlements from treatment and rehabilitation aids, to weekly compensation and lump sum compensation, depending on the person’s injury and circumstances. The information that follows relates to current legislation and new claims. Changes to legislation since 1974 mean that the criteria for continuing cover and entitlements on existing claims may vary from that available on new claims.

Accident claims to ACC

Most of the approximately 1.8 million ACC claims made each year are lodged through general practitioners. Other health providers such as osteopaths and physiotherapists also lodge claims alongside their role in providing treatment or assisting in the rehabilitation of those who are injured. ACC has a network of call centres, branch offices and specialist units to assess claims and administer entitlements.

Once a claim has been approved by ACC, the injured person may be entitled to a range of assistance such as contributions toward the costs of treatment by doctors and other providers. These contributions are usually claimed by the treating practitioner on the client’s behalf (bulk billing) under the treatment costs regulations which specify the amount ACC will contribute. This may not equate to the full cost of treatment so the treatment provider may request a copayment from the patient.

ACC also contracts for a range of services from elective surgery, to psychological services and rehabilitation. In general these contracts are intended to meet the full cost of the service and no copayment can be charged.

The legislation also supports good clinical practice — stating that ACC should fund services that are necessary and of the quality required to achieve a return to independence. To ensure that the health services ACC purchases meet these legislative requirements, it monitors the delivery of health services.
Personal injury

Accident cover is available for “personal injury” that is caused by:

- an accident
- a work related gradual process, disease or infection (WRGPD1)
- treatment provided by or at the direction of a registered health professional (treatment injury).

Personal injury is defined in the Act as:

- death
- physical injury
- damage to dentures or prostheses that replace a part of the human body.

With limited exceptions wear and tear is not covered by ACC. One example where cover may be available is a work related gradual process.

Mental Injury

Cover is also available for mental injuries that result from:

- a physical injury
- sexual abuse or assault (sensitive claims)
- first hand experience of sudden traumatic events in the workplace (WRMI).

A mental injury is a clinically significant behavioral, cognitive or psychological dysfunction. It does not include emotional effects such as hurt feelings, stress or loss of enjoyment.

When a mental injury is caused by a physical injury, the claim will usually be lodged by a doctor or nurse practitioner. However, the disorder must be diagnosed by a registered psychiatrist or psychologist.

Definition of accident

The definition of an accident is important if claims are to be lodged appropriately. Those definitions include a specific event (or series of events) that:

- involves the application of a force (including gravity) or resistance external to the human body, or involves the sudden movement of the body to avoid such a force or resistance external to the human body
- is not a gradual process
- involves inhalation or oral ingestion of any solid, liquid, gas, or foreign object on a specific occasion, except for inhalation or ingestion of a virus, bacterium, or protozoan, unless it is as a result of criminal conduct by another person
• involves a burn or exposure to radiation on a specific occasion (other than exposure to the elements)

• involves the absorption through the skin of any chemical for a period of not more than one month

• involves exposure to the elements or to extreme temperatures for a defined period (not exceeding one month), where the exposure results in death or an inability for more than one month to perform an activity in a normal manner.

Specifically excluded by legislation as neither accidents (unless work related) nor personal injuries are:

• any ectoparasitic infestation

• contraction of a disease through an arthropod as the active vector

• cardiovascular and cerebrovascular events

• conditions caused wholly or substantially by the ageing process.

**Hearing loss**

Cover for hearing loss may be available where it is:

• a personal injury caused by accident

• the result of a work related gradual process, disease or infection (WRGPDI)

• a treatment injury.

For hearing loss claims lodged after 1 July 2010 the person must have suffered at least a 6 percent hearing loss from accidental causes for the claim to be approved. Ear, nose and throat specialists are engaged by ACC to assess claims including the apportionment of accidental and nonaccidental causes for the loss of hearing.

**Complex claims**

AC legislation describes some claims for cover as “complicated”. Generally these claims require additional information before ACC can make a cover decision, and ACC may take more time to assess the claim. These claims are for:

• mental injuries caused by certain criminal acts (sensitive claims)

• personal injuries caused by work related gradual process, disease or infection (WRGPDI)

• personal injuries caused by treatment (before 1 July 2005 this was called medical misadventure)

• claims that are lodged more than 12 months after the date the personal injury occurred

• work related mental injuries as a result of witnessing a traumatic event while working.
When assessing complicated claims ACC may contact treatment providers seeking additional information. This is done with the consent of the patient. By responding in a timely fashion and providing all relevant information the patient’s claim can be processed quickly including arranging any expert assessments that are required.

**Sensitive claims**

Sensitive claims are mental injuries caused by sexual assault or sexual abuse. The events which amount to sexual abuse/assault are included in a list of crimes contained in Schedule 3 of the Act. Claims approved as sensitive claims have entitlement to the full range of ACC services, although the main treatment offered is counselling or psychotherapy for the mental injury suffered as a consequence of the criminal activity.

Sensitive claims are managed by ACC’s Sensitive Claims Unit in a confidential process. When a mental injury is caused by sexual assault or abuse, the person can lodge their claim through either a doctor, nurse practitioner or an ACC registered counsellor. Once ACC receives the claim a case manager will contact the client to facilitate the collection of relevant information or to arrange for any ACC funded assessments that may be required. Any information collected is treated as highly confidential and is only seen by the Sensitive Claims Unit staff or the expert independent assessor.

Further information and guidance can be obtained from the Sensitive Claims Unit on 0800 735 566.

**Work related mental injury**

Since 1 October 2008, claims for work related mental injury can also be considered, providing the injury was first treated on or after this date and the mental injury:

- was caused by a single, sudden traumatic event
- has been directly experienced, seen, or heard during the course of their work
- resulted from an event which could reasonably be expected to cause mental injury in people generally.

**Treatment injuries**

A treatment injury is a physical injury caused as a result of treatment from a registered health professional — but some exclusions apply. There is no requirement to find fault, although in some cases the cause of the injury will be treatment that is inappropriate in the circumstances. Both the underlying disease and other pre-existing diseases are not covered, although a significant worsening of disease might attract cover. Also excluded are:

- a necessary part, or the ordinary consequences of treatment (for example hair loss following chemotherapy or radiotherapy burns would be unlikely to be covered)
- injury caused solely by decisions about allocating health resources
- injury caused because a patient unreasonably delayed or refused to give consent for treatment.
The fact that treatment did not achieve the desired result does not in itself constitute a treatment injury. Examples of treatment injuries could range from a wound infection to operating on the wrong limb.

ACC must report to the Director General of Health and may report to the Medical Council when the investigation of the claim leads to a conclusion there is a risk of harm to the public. All claims, approved and declined are reviewed for reporting of harm.

**Work related gradual process (WRGP) claims**

From 1 July 2010 claims for WRGPDI return to the provisions in effect before 1 August 2008.

There are two types of claims under this heading:

1. A person is exposed at work to one of the substances or agents listed in Schedule 2 of the ACC Act and then develops the listed occupational diseases.

2. Other work related gradual process claims that meet the 3 part test, namely:
   - there must be a particular property about the person’s work task or work environment which has caused or contributed to the injury
   - the property or environment must not be found to any material extent outside the workplace
   - the risk of suffering the injury must be significantly greater for people who perform that task or work in that environment.

To investigate these claims ACC will collect additional information from the client, their employer and their treatment provider. The client may also be assessed by an occupational medicine specialist before a decision is made.

**Lodging a claim with ACC**

Only registered treatment providers can lodge a claim with ACC. This simply involves completing an ACC45 Injury Claim Form and submitting this to ACC. The form is available in both paper and electronic format.

Electronic forms can be submitted from a patient management system or via the web.

Once the ACC45 information is processed by ACC a decision is made as to whether or not cover is granted or if further investigation is required. In most cases the decision takes no more than two days.

If more information is needed ACC may contact you as the treatment provider lodging the claim, the client or their employer, or arrange for further assessment. Complicated claims require investigation, so the Act allows ACC more time to make decisions in some circumstances.

Once the claim is approved ACC will pay the treatment provider’s invoices and give appropriate entitlements to the client. If cover is declined you and your patient will not receive any payments. In that event you are entitled to bill the patient for services provided.

It is important to complete the ACC45 as completely and as accurately as possible.
Remember to record the Read codes for the patient’s injury on the ACC45. Where there are multiple injuries record the Read code for each injury. For manual forms ACC has produced a quick reference guide to the most commonly used codes. Electronic practice management systems will automatically help you assign the correct Read code.

The ACC45 also acts as a “sick note” for the client and this part should be filled in as accurately as possible. Only a registered doctor or a nurse practitioner can certify work incapacity.

Each ACC45 has a unique number which is then assigned to that injury.

The completed ACC45 should be posted in the reply paid FastPost envelopes or electronically lodged as soon as possible. Treatment injury, work related gradual process and sensitive claims each have specific processes. Information on these is available from the ACC website.

**Entitlements**

Patients who suffer injuries that are covered by the Act may be entitled to a number of financial, treatment and rehabilitation benefits depending on their injury and circumstances.

Types of assistance include:

- rehabilitation — treatment (including pharmaceuticals, imaging, elective surgery, public health acute services), home based care, transport, equipment, consumables and other services aimed at restoring the client to maximum health and independence
- compensation for lost earnings — clients may be eligible for weekly compensation forearnings lost as a result of their injury
- death benefits such as funeral grants and payments to dependants
- an independence allowance for injuries that occurred before 1 April 2002
- lump sum compensation for injuries that happened on or after 1 April 2002.

**Criminal injuries and self inflicted injuries**

ACC is required to disentitle clients whose injuries are sustained after 1 July 2010 during the course of committing a serious offence. The circumstances require that the offence is punishable by a maximum term of imprisonment of 2 years or more, and the client is sentenced to a term of imprisonment or home detention. In such cases ACC is only permitted to contribute to the cost of treatment. Special provisions apply to surgery.

From 1 July 2010 similar levels of disentitlement apply to those who commit suicide or a wilfully self inflicted injury. This provision does not apply to those whose injury is the result of a covered mental injury.
Time off work — work incapacity certificates

Patients who require time off work because of their injury will need a medical certificate from a medical provider. Some injuries necessitate time off work. The certificate used by a registered doctor or nurse practitioner (the only treatment providers who can issue these certificates) is:

- ACC45 for the first visit
- ACC18 medical certificate if an ACC45 has already been lodged.

This form should be filled in carefully with regard to the person’s work capacity, the tasks involved in their job and the alternative tasks they might still be able to do at their work. At times it may be appropriate to talk, with the patient’s consent, to their employer.

For that reason it is preferable, when completing the forms, to focus on the capacity of the client to undertake work, whether that means their usual tasks or alternative duties or limited hours.

All patients should be examined before they are issued with a new medical certificate. The patient should be asked relevant questions such as:

- the type of work they do and the tasks involved
- how long they have been doing that job
- what their working conditions are like
- any problems or injuries they had before the accident
- any concerns or fears they have about returning to work
- the tasks they are still able to do.

Use this information and other findings to estimate the time in which you expect your patient to be fit for normal work, and the range of tasks they can do now as well as the number of hours the patient can attend work.

A certificate that reports on fitness to work (work capacity) helps case managers to negotiate with employers on behalf of the patient, and to develop rehabilitation programmes that best suit their needs.

The maximum time off work allowable on the first certificate (usually the ACC45) is fourteen days. After that the maximum time off you can certify is thirteen weeks before another certificate is due. Many clients will return to work sooner, and guidelines are available for expected time off related to specific injuries.

Note: retrospective certification is not good practice.
Obligations of treatment providers

Before you can lodge claims for, or treat under, ACC you must register with ACC and maintain relevant practising certificates. Information about registering, including application forms, is available online at www.acc.co.nz in the “For Providers” section. Once accepted you can claim and treat under the ACC scheme.

All treatment must:

• be necessary and appropriate
• match the quality required
• be given the appropriate number of times
• be given at the appropriate time and place
• normally be provided by your type of treatment provider.

ACC has policies and procedures designed to ensure appropriate treatment and rehabilitation. Treatment providers are monitored and ACC can investigate if there are any concerns about the treatment being provided.

Resources and where to go for more information

ACC has produced several publications to assist you, including:

• the Treatment Provider Handbook, a comprehensive guide to working with ACC
• Treatment Profiles which provide a guide to managing individual injuries.

This and additional information is available on the ACC website www.acc.co.nz and through the Provider helpline: 0800 222 070.

I acknowledge Dr Jonathon Fox who wrote the chapter on ACC in a previous edition. This chapter is based on his work with updates in line with new legislation and policies introduced since 2007. Thanks also to my ACC colleagues for their advice: Dr Kevin Morris, who was Director of Clinical Services; Mike Mercier of Legal Services; and Greg Palmer, Acting Communications Manager.
CHAPTER 13

Medical records and patient access to information

Robert Stevens is an Auckland barrister and a consultant in the management of personal information and privacy.

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Dr D’s documentation in relation to the consultation on 21 June was inadequate and, accordingly, he breached Right 4(2) of the Code.

Health and Disability Commissioner’s Decision 10HDC00753.

Purpose and content of the record

An all too common finding of bodies with statutory rights to investigate doctors is that of inadequate clinical records. The clinical note is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many practices as well as in hospitals. To fulfil these tasks, the record must be comprehensive and accurate. A good medical record can also be helpful for the doctor if there is any question or complaint about the care of the patient.

There is a long established tradition in medicine that the “notes” that form the main part of the record contain something about the patient’s symptoms, signs, diagnosis and treatment plans. It is useful to differentiate between what is reported, what is observed, and what is diagnosed. These different features of a record entry are often abbreviated as (S) subjective, (O) objective, (Dx) diagnosis and (P) plan. It is also important that the notes can be ascribed to the appropriate patient (so the name, date of birth or other identifying details must be recorded accurately), at an identifiable time and by a recognisable author.

There are some useful principles that apply to clinical notes:

• write legibly
• write the date and time
• sign legibly
• do not use ambiguous abbreviations
• do not alter notes or disguise additions
• do not use offensive or humorous comments
• check what you have written.
Consider the difference between a record on one day which says “Repeat meds Metoprolol 47.5 daily 3/12” and one which says “Repeat meds, well, 130/80, pulse reg 64/min, Metoprolol 47.5mg daily 3/12, buying Cartia”. Although not a lot longer, the second form shows considerably more of the process the doctor is going through and records important findings for monitoring the patient’s health and the results of the doctor’s interventions. Sometimes, on reviewing an earlier record entry, a doctor may feel that it is inaccurate, incomplete or potentially misleading. It is appropriate to augment a record in such cases, making it clear when and by whom the augmentation or annotation was added. The earlier entry should never be deleted, obliterated or changed, if only because such amendments might later raise suspicion of covering up an error in treatment or diagnosis.

With modern computer systems in both primary and secondary care, test results such as bloods and imaging are an important part of the clinical record. Although the principles of management of tests will be discussed in chapter 14, it is useful to think of such results as part of the record.

**Legal and ethical obligations**

The management of all personal information is covered in New Zealand by the Privacy Act 1993. Where health information is concerned, a special code of practice issued under the Privacy Act adapts the usual rules at the centre of the Privacy Act to health care. It is called the *Health Information Privacy Code* 1994 (HIPC). It has the force of law. The rules of the HIPC are designed to ensure that people retain a degree of autonomy when others are dealing with health information about them. A good rule of thumb is that there should be no surprises for the individual in how information about them is collected, is used, and is passed to others. The rules generally reflect good ethical medical practice.

**Electronic records**

The obligations around medical records exist regardless of the form in which they are kept. Medical records are very often made and held in electronic form, and existing paper records converted to electronic media. To the extent that an electronic record captures everything which was in the original paper version, there is no need to retain that original. However, if scanned copies of images would miss detail of potential significance, the original films should not be destroyed inside of the normal minimum retention period.
The rules of the Health Information Privacy Code

The HIPC provides rules for health agencies, including doctors working on their own account or for others, on their handling of health information that is about identifiable individuals. “Health information” covers everything from consultation notes through to medical test results, and also includes the incidental information used in conducting the business side of health care such as address and billing details. A brief outline of the twelve rules at the heart of the HIPC is given in this chapter, but in case of any doubt doctors should refer to the words of the HIPC itself, or obtain advice from someone else who is more familiar with the HIPC. The HIPC is published with accompanying commentary by the Privacy Commissioner; the commentary is not legally binding, but contains a wealth of practical pointers and observations which will answer many a query.

Rule 1 — Purpose of collection
You must collect health information only where the information is needed for a lawful purpose, and the collection is necessary for that purpose. You may be asked to justify having collected individual items of health information.

Rule 2 — Source of the information
Wherever practicable, you should collect health information directly from the individual concerned. One exception is where the individual has authorised you to collect the information from someone else. It is good practice to record the source from which you have obtained health information.

Rule 3 — Collection of health information
When you collect health information directly from the individual concerned, you must take all reasonable steps to ensure that the individual is aware that the collection is taking place, is aware of who is doing the collection, for what purpose, and with what intentions of passing the information to others.

You should also see that the individual is told the name and address of the agency which will be keeping the information, and that they have a right of access to it. If it is practicable to do so, these steps should be taken before the health information is collected. Many health care agencies find it convenient to communicate these matters by the use of leaflets, and by notices on the forms which the individual uses to give the information.

Rule 4 — Means of collecting health information
You must collect health information by means which are lawful, fair, and do not intrude unduly on the individual’s personal affairs. Medical professionals become used to dealing with very sensitive personal information, but must remain mindful of its importance to the individual concerned.
Rule 5 — Storage and security
Anyone holding health information must take the steps which are reasonable in the circumstances to ensure that it is guarded against loss or unauthorised access and use. Amongst other precautions, this means that the more personal information should not be voiced where others can hear it if those others have no business to know it.

As with several other rules of the HIPC, the test of what steps are “reasonable in the circumstances” calls for a proportional approach — the more sensitive the information, the greater should be the safeguards applied. Transfers, archive storage, or destruction of medical records, all require particular care as to confidentiality. Computers should have passwords, and records should be accessible only in areas where access is limited to staff.

Rule 6 — Right of access
Individuals have the right to have access, on request, to health information about them. Access should usually be given without charge, and in the form that the individual prefers. A request for access must be responded to promptly, and certainly within twenty working days. The health agency should verify the individual’s identity before giving the information to them.

There are circumstances in which the request for access may be refused, but these are exceptional cases and the only valid reasons for refusal are those set out in the Privacy Act. Any doctor making records should do so on the assumption that they may be seen by the individual concerned.

It sometimes happens that a doctor is given information about a patient by someone else, and the source of the information may ask that the patient is not to be told that the doctor has the information or who gave it. However, no matter what the doctor promises, the right of access under the Privacy Act still exists, so doctors should never give unqualified promises of confidentiality if they receive information about a patient from third parties.

Rule 7 — Correction of health information
Every individual has the right to request correction of health information about them if they believe it to be wrong. The agency keeping this information may refuse to make the correction if the agency feels that it would not be appropriate to do so, but in such a case the agency must if so requested attach a note to the contested information showing the patient’s assertion of the error. Quite apart from any request, if you become aware of an error in health information held you should yourself take steps to correct it. Any corrections made should be communicated, if practicable, to every other person or agency to which the erroneous information has been previously passed.

Rule 8 — Check before use
You must not use health information without first taking reasonable steps to ensure that it is accurate and not misleading. The steps taken will depend on the use to which the information is to be put: the more important that item of information is in the proposed action, the more rigorous should be the steps to ensure that it is accurate, up to date, complete, relevant and not misleading.
**Rule 9 — Retention of medical records**

This HIPC rule states that health information is not to be kept for longer than it is required for those purposes for which it may lawfully be used. Given that health information is normally kept for purposes which include future diagnoses and care, the rule itself will not often impose a limit on retention. Furthermore, there are specific regulations — the Health (Retention of Records) Regulations 1996 — requiring that health information relating to an identifiable individual must be retained for a minimum of ten years from the day after the last treatment or care of that individual by the agency holding the information.

Unless the accuracy of certain health information is being questioned, the most likely form of complaint in relation to retention is that it has not been retained for long enough. The Medical Council’s guideline, and the advice of several colleges, is that records are retained for more than ten years.

**Rule 10 — Limits on use**

Health information obtained for one purpose cannot be used for another purpose. There are some exceptions to this rule.

**Rule 11 — Limits on disclosure**

Disclosures which were anticipated and intended when the information was obtained can proceed as planned. Other disclosures can be made with the authorisation of the individual. A further group of exceptions applies to allow other disclosures where it is not desirable or practicable to obtain the individual’s authorisation, and the situation fits into one of the limited exceptions set out in the full rule. Examples of this group are where the disclosure is directly related to the purpose for which the information was obtained, where the disclosure is for a professionally recognised accreditation or quality assurance programme, or where the disclosure is for statistical or approved research programmes. The rule against disclosure applies to health information about individuals until twenty years after their deaths.

**Rule 12 — Unique identifiers**

You can use another agency’s unique identifier only where your use of it is part of the purpose for which that identifier was assigned. A case in point is the National Health Index number, where its recording and use by your agency is for the purpose of making the claims and reports which are required to be indexed by that common identifier.

**Health research**

Most health research in New Zealand has to be approved by an official ethics committee, which will inquire into any privacy issues apparent in the scope and conduct of the proposed programme and may set limits in those areas. Health information can then be used in, and disclosed for, a research programme which has received ethics committee approval, but even so any disclosure for the purpose of such a research programme can only go ahead in the absence of the individual’s authorisation if it is not practicable or not desirable to obtain that authorisation.
It should be noted that there is no prohibition on the use or disclosure of statistical information which is not identifiably about any individual. Where information about an identifiable individual is to be disclosed for use in statistical surveys, but nothing will be published in a form that could be expected to identify the individuals covered, this can proceed without the individual’s authorisation if it is not desirable or practicable to obtain that authorisation.

Other requested disclosures

There are a number of other provisions in legislation under which information can be requested from, and supplied by, a doctor. The bodies which make such requests should make it clear what statutory authority they are relying on. A doctor can and should ask the requesting body to clarify in writing exactly what information is sought, the reason for the request, and the statutory provision which might permit or require the doctor to provide that information.

Certain protected disclosures

There are provisions under the Children Young Persons and their Families Act 1989 which allow and protect the reporting to Police or to a social worker of suspected neglect or abuse of a young person. There is a duty on a doctor under the Land Transport Act 1998 to report to the Director of Land Transport Safety any person they know of who is likely to drive a vehicle but whose mental or physical condition makes it unsafe for them to do so. In those cases the legislation allowing or requiring the disclosure will protect the doctor who made the disclosure in good faith from any legal or disciplinary action being taken against the doctor on account of that disclosure.

Transfer of patient records to another doctor

A doctor leaving a partnership has no automatic right to remove any records, and legal advice should be sought where the partners do not agree on what should happen to the records.

When a patient’s medical records are to be transferred to another doctor, medical defence organisations strongly recommend the doctor keeps a copy, especially if there has been any suggestion of complaint. Such transfers must be made at the request of the patient, either received directly or through the request of the new doctor. Transfers should be made promptly on request, and the existence of outstanding accounts is no excuse for refusal or delay.

The record to be transferred would usually be the whole folder of notes or print out of the electronic file, but at the minimum should consist of a brief factual summary of what records the doctor has along with a note of the present state of the patient’s health.

The agency holding the record should generally wait for a request by the patient or by the new health care provider before transferring the records; this allows for agreement on what records are to be transferred and by what means.
CHAPTER 14

The management of clinical investigations

Ian St George is a Wellington general practitioner and has been an elected member of the Medical Council, Chair of its Education Committee, and Chair of the International Physician Assessment Coalition (IPAC).


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The management of clinical investigations is a contentious issue in New Zealand practice. There is no clear agreement on the level of responsibility that should be held by doctors, patients, and those conducting the investigations. However, the failure to manage test results appropriately has the potential to cause harm and there are a number of basic principles that may assist you in protecting your patients.

The Commissioner’s view

In a paper in *New Zealand Doctor* the previous Health and Disability Commissioner expressed his view about the key principles that should apply when managing clinical investigations:

1. At the time any test is proposed, patients have a right to be told by their doctor why the test is recommended and when and how they will be informed of the results.

2. If a doctor or medical centre has a standard practice of not notifying normal test results, patients must be informed and their consent obtained to not notifying in such circumstances.

3. It must be made clear to patients that they are entitled to be notified of all test results, and, even if they agree to be notified only of abnormal test results, they are welcome to call the medical centre and check whether their results have been received and what they are.

4. In the absence of any other such arrangement being made, when results are received by a medical centre, the patient must be informed. This is especially important if the results raise a clinical concern and need follow up.

5. A doctor is responsible for having an efficient system for identifying and following up overdue test results.

A review of other cases has identified a number of principles which the Commissioner applied when assessing complaints:

1. Doctors responsible for reporting test results to the patient should have a system to audit and manage patient test results. This system should not rely on the patient taking the first step in the notification process. However, patients should be able to enquire about their results as a backup to the notification system.

2. Patients should be appropriately informed of the system for notification of test and procedure results, and arranging follow up.

3. Where significant pathology is suspected, doctors should ensure that the notification system tracks the request or referral and the outcome, and manages this in an appropriate and timely manner.

4. A clear policy should be developed to ensure that staff and colleagues are aware of the system. This policy should cover the role of the test initiator, notifications, locums and follow up.
Case 1: The District Court looked at a case involving a patient who presented to a hospital emergency department. The first doctor to assess this patient ordered tests, but neglected to inform a colleague of this before going off duty. The court made a finding of medical error, relying heavily on the advice of an expert adviser who stated, “It is the responsibility of the doctor ordering tests to review, interpret and act on results. When test results are ordered but the doctor goes off duty before the results are known — it is that doctor’s responsibility to alert the incoming doctor that there are test results outstanding. Policies vary from one hospital to another on how abnormal laboratory or radiology results are alerted to treating clinician or team.”

Case 2: A woman had a slightly painful breast mass that could not be aspirated. She had a history of fibrocystic disease and recurrent breast mass. Her general practitioner was suspicious of “other pathology” and referred her to a hospital radiology department for mammography and ultrasound. She attended the hospital and was told that her general practitioner would inform her of the test results. The general practice had a policy that patients would be contacted if their results were abnormal, but patients should also contact the practice if they did not hear about their result. The woman was not made aware of this policy. The practice did not receive the report. The woman phoned the practice nine weeks after the mammogram. The practice nurse contacted the radiology department and requested the report, but the results were not forwarded and the practice nurse did not follow this up. One month after the first call, the woman rang the practice again. The practice nurse was able to access the results that same day. The Commissioner found that general practitioners should not be responsible for system failures outside their control, but he also found that tests ordered when a doctor has a reason to suspect a cancer diagnosis do require proactive follow up. The general practitioner was found in breach of Right 4(4) of the Code of Rights, which states that patients must be provided with services in a manner which minimises potential harm to, and optimises the quality of life of, that patient.

The previous Commissioner also made his view clear about the patient’s responsibilities. He stated “clearly, general practitioners are subject to resource constraints (time and money), labs must have efficient systems, and patients have some responsibility for their own health care. But patients who have tests taken should surely be able to look to their primary care provider to follow up results in appropriate cases.”

The devil, of course, is in the detail.
The Royal New Zealand College of General Practitioners resource

After considering the Commissioner’s reports and the case heard at the District Court the RNZCGP developed a resource called *Advice on minimising error in patient test result management*, which included these principles:

1. General practice is encouraged to develop a system to audit and manage patient test results.
2. This system should not rely on the patient taking the *first* step in the notification process. However, patients should be able to enquire about their results as a backup to the practice’s notification system.
3. Clear information on the practice’s system for notification of test and procedure results should be made available and explained to patients.
4. In specific cases, where the general practitioner suspects significant pathology, the practitioner needs to ensure the practice system tracks requests and return of the results to the practice and manages the result in an appropriate and timely manner.
5. A clear policy is required covering the test initiator, notifications, locums and follow up.

The paper acknowledged that different organisational structures and procedures among general practices and patient populations made it difficult to provide easy solutions to managing patient test results, and identified a number of issues and challenges.

Other views

At a meeting with the different branch advisory bodies (BABs), the Medical Council asked whether guidance on the subject of managing patient test results was needed for the entire profession (and not just general practitioners). Comments in response to this suggestion included that:

1. A statement should not be developed for doctors, but instead the Council should look at “how it can help patients to take responsibility for their own health”.
2. Good computer systems and software may be the best way to improve outcomes.
3. Care should be taken not to put too great a burden on doctors and systems that are already overburdened.
4. Provisional and final imaging reports need to be married and differences flagged.
5. In hospitals it is often difficult to identify who ordered a test. Doctors should always use a stamp with their name and Medical Council number on it.
6. Laboratories should notify high priority results by telephone, as well as by post.
7. Test results might be copied to the patient as a matter of course.
Issues

Case 3: A semiurgent radiology referral for barium enema was made for a patient, but no appointment was received seven months after the referral despite the fact the hospital had received the referral. The general practitioner was not aware of this waiting time.

Case 4: After a seizure a patient had had a CT head scan one week before seeing a general practitioner. The doctor asked that the results be sent to him. Eight days later he had not received the results and the patient had another seizure. The doctor phoned to find the specialist was on holiday with the results on his desk indicating a brain abscess.

Case 5: The Commissioner considered a case where errors resulted in a woman not receiving the cervical screening programme’s recommended follow up. The programme followed normal recall procedures but the woman did not receive the recall letters as she had moved. He found the general practitioner alone in breach for failure to ensure the patient had a repeat smear.

As can be seen in the comments made at the BAB meeting, many consider the responsibility and right to follow up test results should remain with the patient. There is a view that practitioners should advise all patients of their right to seek confirmation of test results and how these requests are managed in their practice. This view states that doctors should then be responsible for following up the results only when the patient goes for the ordered test; the results are received by the practice or department; and failures are within their control.

A further problem is that current computer systems for tracking test results may not suffice. A computer system should be able to track individual tests for the results, including when several tests are ordered from one sample, or when the patient did not have the test. It should track tests based on a criterion such as a suspicion of cancer; and it should include a follow up function which alerts the doctor when either the patient does not attend a test (or delays attending) or when the results have not been received in a timely manner.

In addition, even good systems can fail: an example of this occurred in three weeks during August and September 2001 when some general practitioners did not receive electronic results of Xray examinations. This anomaly was discovered only from a patient call to one such practice. Clinicians should not be blamed for system failures beyond their control.

Practising doctors have signalled a number of other concerns about the principles outlined by the former Commissioner, and the cases on which the principles are based. They include:
1. Infantilisation of patients by doctors who assume a paternalistic relationship
2. Vicarious liability for employees’ actions
3. The responsibility of general practitioners who are employees, especially when the practice is owned and governed by other than general practitioners and the doctors have little control over the systems they are required to use
4. The cost of developing systems to minimise error
5. The term “suspicion of serious pathology” is open to wide interpretation
6. The ongoing fragmentation of health providers and services poses challenges to the provision of continuous care
7. There is some debate about when a referral for a specialist procedure should regarded as a request for “clinical investigation”. For example, should a referral for colonoscopy be included in that definition?

8. What are a general practitioner’s responsibilities when results are copied to them from an accident & medical clinic?

**Conclusion**

There is a gap between what frontline doctors think is practical and reasonable and what the previous Commissioner, as consumer advocate, believed is proper. The debate has so far largely involved general practice, but all clinical disciplines should consider their position.

Nonetheless, despite these debates there are some common principles which most parties can agree on and which you should consider following to ensure patient health and safety.

1. If you request a clinical investigation, you should tell your patient why the clinical investigation is recommended and when and how they will learn the results.

2. All the relevant parties should understand their responsibilities clearly.

3. If you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are appropriately communicated to those in charge of conducting follow up and keeping the patient informed.

4. If you are responsible for informing the patient, you should:
   - Inform the patient of the system for learning test and procedure results, and arranging follow up.
   - Ensure that staff and colleagues are aware of this system.
   - Inform patients if your standard practice is not to notify normal results and obtain their consent to not notifying.
   - If other arrangements have not been made, inform the patient when results are received. This is especially important if the results raise a clinical concern and need follow up.

5. Identifying and following up overdue results is an essential, but difficult, office management task. Your system should ensure that test results are tracked successfully. Such a system might be a paper file or computer database that identifies:
   - high risk patients
   - critical clinical investigations ordered
   - dates of reports expected
   - date of expected or booked follow up patient visits.

6. The patient’s medical chart itself might be flagged in some way to aid this tracking process.
7. It can sometimes be difficult to contact a patient by telephone, and sometimes they do not attend planned follow up appointments:

- The number and intensity of efforts to reach the patient by telephone should be proportional to the severity and urgency of the medical problem. All attempts to contact the patient should be documented.

- If the patient fails to attend an appointment, or you have been unable to speak to them directly about test results which raise a clinical concern, then send a letter to the patient advising them of the action they should take.

8. If you order investigations it is your responsibility to review, interpret and act on the results. If you go off duty before the results are known, you should alert the incoming doctor that there are results outstanding. Further, you should check the results when you are next on duty.
CHAPTER 15

Medicine and the Internet

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NZ’s health information technology (IT) plan

New Zealand is still in the process of developing its IT infrastructure and further information on the proposed national IT plan. Significant changes to national and local systems, including patient management systems, are likely to occur over the next four years. In the past 12—24 months initiatives that prepare the ground for improved information and data sharing, such as the New Zealand Universal List of Medicines (NZULM) and the New Zealand Formulary have been released and are being built into patient management systems. Initiatives such as GP2GP records transfer, and the trials of systems of eMedications Management in several District Health Boards are further indicators of the direction of travel for health IT in New Zealand and the distance still to travel.

These initiatives are all happening in the health intranet, where there are existing facilities for streamlined sending and receiving patient data like referrals to specialists, test results, National Health Index (NHI) number, referrals from Healthline and making claims from funding agencies. Privacy, confidentiality, data security and verification of the identity of users of the system have been resolved in the New Zealand health intranet and as described above, advances are being made to increase the number of services being delivered electronically.

Outside of the health intranet the internet is essentially an unsecured network and unless you take adequate precautions, the data on your computers, and computer terminals themselves, can be captured (hacked) and read by persons outside of your medical practice. Before you embark on any process that involves you, or your practice, sending or receiving information about patients over the internet, especially if you intend to operate outside of the health intranet, you should consider whether the system you are using is secure and able to maintain patient confidentiality and privacy.

The website of the Privacy Commissioner (http://www.privacy.org.nz) sets out the requirements for data security. You should seek professional advice if you are not sure about the security of your system or network.

Emailing patients

The use of email as a means of communicating with patients significantly increases the problems of confidentiality, privacy, and data security. How do you determine that the person asking the question is actually the patient named on the email and not some other member of the household who has access to the family computer?

What can you do to be assured that any results sent by email will be read by the patient only? and is this information so sensitive it is inappropriate to send it by email?

Some subjects and test results are more confidential and sensitive than others, so before deciding to use email routinely as a communication tool with patients, it is worth identifying in advance what data you are comfortable sending to patients and what data or subjects you would only discuss with a patient as part of a consultation. You can then discuss your internet information release policy with your patient before seeking their consent to send data to them by email. You can also use this opportunity to discuss with them your schedule of charges for responding to questions or requests for comment via email.
As with all other forms of communication with patients, email communication must comply with the Code of the Health and Disability Services Consumers’ Rights.

**Prescribing for New Zealand based patients**

If you are asked to prescribe by email for one of your own patients, a telephone script to a pharmacy followed by faxing, and sending a written prescription to that pharmacy is required.

It is illegal for a patient to be in possession of a prescription medicine other than that obtained by filling a prescription written by a registered doctor. Prescription medicines purchased over the internet are therefore likely to be stopped at the border and the patient asked for proof that they have a prescription.

If you are asked to write a prescription to allow your patient to obtain a medicine they have bought over the internet, you should consider a number of ethical and practical questions. Most medicines purchased on the internet are counterfeit products. Are you prepared to facilitate patient access to such medicines? is the medicine available in New Zealand? does the patient actually need the medicine? are you satisfied that the medicine being imported meets the necessary standards of safety, quality and efficacy of locally available medicines, or in fact even that the product actually contains the stated active ingredient? there are legal liabilities if harm is caused by the use of medicine purchased on the internet.¹,²

**Video consultations**

Video consulting is now quite widely practised. It can be two way (doctor and patient), or three way (general practitioner, other specialist and patient). Australian and Canadian papers cover the latter;³,⁴,⁵ there are few commentaries on the former, but the issues are somewhat similar.

The advantages seem obvious: for the patient less travel, better access to health services, improved timeliness of care, less need to take time off work, less need to make family or day care arrangements, less time away from home — and all of these perhaps greater in rural communities. For the specialist, the possibility of providing specialist services in rural communities, more frequent clinics, less travel to rural clinics, provision of a new method of communication with rural medical staff and the opportunity to upskill them in different specialties.

There are advantages for the health system too. Video consulting helps to enable fair and equitable access to care and that may apply particularly to rural, Māori and Pacific patients. It may actually improve the quality of care. Because it is efficient it may support the sustainability of the New Zealand health care system, reduce the cost of care and make better use of the contemporary specialist workforce.
There are, of course, ethical issues, though perhaps strangely teleconsulting is not mentioned in the NZMA Code (Chapter 22). “Standards” are covered in the Royal Australian College of General Practitioners’ papers referred to above. The Medical Council statement dated 2006 (Statement on use of the internet and electronic communication) has recently been updated but is being challenged in the courts.

We are thus left to seek our own balance between profit and professionalism, between altruism and entrepreneurialism, and must, as always, consider what we are doing in terms of beneficence, nonmaleficence, autonomy and distributive justice.

Consider this...

1. Lowering barriers to care is good for the patient and good for the doctor.
2. In about a third of general practice consultations no physical examination is necessary.
3. New Zealanders are highly computer literate, and that includes older people.
4. Nearly all laptops have a camera.

Current advice is that doctors should only prescribe for patients under their care, when they have previously seen or examined the patient and the doctor is confident that a physical examination would not add critical information about the management of the patient.

Skype is not secure, but good secure systems are now available to connect patient and doctor in video consultation (eg, “Anywhere, Anytime”). We can look forward to a kind of practice where, for (say) an hour or two a day, patients have the choice to consult online by secure video, from the comfort and privacy of our home computer rooms or workplaces, both of us tapping into the clinical record.

Joe White makes an online follow up hypertension appointment, and tells the doctor his home recordings. He looks healthy and happy. Routine enquiry elicits no problems. It is time to recheck his bloods so the doctor sends him a form electronically, as well as his prescription and instructions that next time will be his annual face to face check.

Brian Pink comes online and tells the doctor he has a mole that has changed colour, and moves so that the lesion on his shoulder is in front of the camera: the doctor is not reassured by its appearance (actually she rarely is, and certainly never online), and asks him to come in for a closer look; the treatment room will be ready for possible excision biopsy.

Jack Black manoeuvres his red hot swollen 1st MTPJ in front of his laptop camera; it is his 3rd attack of gout in 5 years, triggered by a dietary indiscretion on a familial hyperuricemia; the doctor introduces the idea of allopurinol and they discuss the pros and cons, but he opts for the short sharp course of naproxen that has promptly settled it in the past, understanding it may not be his last.

None of these has phoned for an appointment, taken a taxi to the surgery, or two hours off work, or negotiated their way past a protective receptionist, or sat inadvertently in a small puddle of vomit or picked up influenza in the waiting room. There is nothing second rate or unsafe about the care they receive. It is also cheap green care: the doctor does not need a high rent well equipped consulting room for these meetings, so the room at the practice is, for the time, free for another doctor to do face to face work.
Practising “virtual” medicine

The emergence of “virtual” medicine doctors is a different matter altogether and is of highest concern. Virtual medicine describes the situation where the consultation, including the writing and dispensing of a medicine, is conducted often without the knowledge of the patient’s regular doctor. These services are being supplied by a number of doctors around the world and the quality of the advice offered and the professional standards applied vary enormously.

Virtual medical practice creates a number of new problems in addition to those identified above for prescribing — confirming the identity of the patient requesting advice, the accuracy of the data presented in any case history, the need for a physical examination, and assessing the validity of the request for the medication all need to be resolved. There are in addition significant ethical questions about patient safety, professional responsibility and duty of care, and the legality of prescribing for patients in another country (where the prescribing doctor is not registered to practise medicine).

The Medical Council has developed a Statement on the use of the Internet. This statement clearly says that under the Medicines Act it is illegal for doctors to prescribe medicines for patients unless the patient has had a face to face consultation with the doctor, or another doctor who can verify physical data and patient identity.

Internationally medical licensing authorities such as the Medical Council and the Federation of State Medical Boards of America, and regulatory authorities such as Medsafe, have indicated that they are prepared to prosecute doctors involved in virtual medical practice.

Medsafe has already successfully prosecuted a pharmacy that was supplying prescription medicines to consumers in the United States, and has investigated several cases where doctors are signing, or countersigning, prescriptions for patients overseas to allow medicines to be dispensed from New Zealand pharmacies. This activity is contrary to best medical and pharmacy practice. The Medical Council’s Statement on use of the Internet, and the recent decision by the Pharmacy Council to add a new clause to its code of ethics to prohibit pharmacists from selling medicines intended for the treatment of chronic diseases to patients outside of New Zealand, are examples of how the professions are no longer prepared to tolerate these activities.

Practitioners of virtual medicine are subject to prosecution and disciplinary action in New Zealand for all activities they undertake in their “virtual medical practice” irrespective of the country of residence of their patients. However, it is now reasonably clear that virtual medicine doctors are also likely to be liable for prosecution and action against them in the Courts in the patient’s country of residence.

Before embarking on any scheme to prescribe over the internet you should take legal advice on your potential liabilities in both New Zealand law and in the law of the countries where your patients reside. You should also check that the terms of your medical practice (malpractice) insurance would cover you for care of patients in other countries.
While authorities have taken a conservative position on New Zealand based doctors undertaking virtual medicine activities for patients located overseas, the Medical Council in January 2010 introduced a teleradiology special purpose scope of practice designed to allow suitably qualified radiologists located overseas to provide services to New Zealand based health providers. This newly introduced scope of practice limits access to radiologists whose qualifications and registration are recognised by the Council and who are employed by a fully credentialled health care provider in New Zealand.

Oversight of the teleradiology practitioner by the clinical director of the employing organisation is a prerequisite for inclusion in this scope of practice; as is the creation of a complaints resolution process in the provider’s organisation that will report complaints to the relevant authorities in both countries and will allow these authorities to investigate a complaint. The controls placed around this scheme which is designed to allow New Zealand health care providers to gain access to diagnostic radiology skills located overseas give an indication of the range of protective and oversight systems that need to be in place to protect the safety of patients in New Zealand. It is an act of hubris if New Zealand based doctors involved in practising virtual medicine in other scopes of practice think that patients in other locations do not deserve the same degree of protection.

Information from the Internet

Information technology has provided the general public with the tools needed to find, collect, and analyse medical information. The internet has decreased the asymmetry of information that existed between doctors and patients and forever changed the nature of the relationship between the two parties by allowing the ideal of informed discussion and consent to emerge for the first time.

As with all revolutions increased availability of medical information challenges the status quo and creates a number of threats and opportunities for doctors.

Doctors cannot know everything. An essential skill is therefore the ability to access good information efficiently. The internet contains a vast number of useful medical information resources; unfortunately they are hidden amongst a sea of opinion, conjecture and misinformation. Many sites are not peer reviewed and are not subject to the publishing and review rules that we expect of evidence based medical information. To determine the value of information you find on the internet, you therefore have to check each article you review for the basics of quality evidence based medicine, namely:

- Who authored the article? What are their qualifications?
- Have they disclosed any potential conflicts of interest?
- Is the article appropriately referenced and are these references from acceptable peer reviewed sources?
- Where is the article published? Is the journal subject to adequate peer review?
- Does the website disclose any potential conflicts of interest, such as who has paid for the site to be maintained?
The Health on the Net Foundation (HON) has developed a Code of Conduct and has developed databases of health information resources that have been assessed as meeting the requirements of their Code. Doctors intending to publish information on the internet should follow the HON Code of conduct when writing and publishing.

As with any form of medical literature review, when searching the internet it is best to stick to mainstream, peer reviewed, evidenced based information resources. The availability of electronic copies of a number of the mainstream medical journals makes internet literature review easier, and abstracts of some of the lead articles in these journals can be obtained free of charge from their websites.

Another key information resource is Pubmed; this database contains all articles and letters published in over two hundred peer reviewed medical journals from around the world. Abstract data can be obtained free from Pubmed, and you can purchase copies of complete articles from the website; alternatively you can use Pubmed to identify the key references and then search them out at your local medical school library.

The Ministry of Health, PHARMAC, Medsafe (the New Zealand Medicines and Medical Devices Safety Authority) and the Health and Disability Services Commissioner all maintain websites that contain information relevant to medical decision making. For example, the Medsafe website contains the latest medicines safety and prescribing information for over a thousand of the most commonly used medicines in this country, as well as an electronic version of its publication Prescriber Update and information for consumers. The Ministry of Health and PHARMAC have also funded the supply of a series of decision support and reporting tools for integration into general practice management systems.

Continuing professional development

Just as the internet has changed the asymmetry of information between doctor and patient, it has also created the means to address the asymmetry between generalist and specialist medical practitioners. It is now relatively easy for any doctor to identify and contact specialists anywhere in the world with an interest in a particular medical condition.

Despite the reservations many practitioners have about the role of information technology in medical practice, the internet has become an important source of continuing professional development (CPD) in New Zealand. Resources to obtain CPD points can be found at a number of local sites including the Goodfellow Unit and the Royal New Zealand College of General Practitioners.

Integration of the internet into day to day practice

Creating a website for your practice to inform your patients of your opening and closing times, after hours arrangements, charges and privacy and email policy, is a start to establishing a healthy partnership. Constructing your website to encourage your patients to use it to obtain information from good evidence based health resources should improve the quality of your interaction with patients.
References


CHAPTER 16

Interdisciplinary collaboration: working in teams for patient care

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New Zealand health care relies on the skills of many health and other professionals. For those with chronic or complex needs, collaboration between a range of disciplines is needed. Doctors have a key role in enabling a collaborative approach, with growing agreement that the “pitcrew” interdisciplinary model of care results in safer, higher quality care for patients, providers and systems rather than a unidisciplinary “solo operator” model.

**Collaboration: always needed?**

While necessary for patients who have chronic or complex conditions, interdisciplinary fully collaborative care is not always appropriate, needed or cost effective: for example the diagnosis and treatment of a sore throat in an otherwise well person is generally and appropriately undertaken by one health professional. The spectrum of collaboration (see Figure 2) best explains this continuum.

*Figure 2. The spectrum of collaboration*

![Image of the spectrum of collaboration](image)

**What is collaboration?**

Collaborative interdisciplinary care is enshrined in the Health and Disability Code of Consumers’ Rights in Right 4: Right to Services of an Appropriate Standard, which requires in point 5 that: Every consumer has the right to cooperation among providers to ensure quality and continuity of services.

While the terms “team work” and “collaboration” are often used in the same breath — they are not the same. Individuals of different disciplines may provide care to the same patient without considering they are part of a team. However, for teamwork to be effective there must be collaboration.

We all recognise collaborative team work when it’s working well. The experienced Emergency Department (ED) team undertaking resuscitation is a good example. The team train together and know and trust each other. Each person has a particular role and yet there is flexibility, with some skills (chest compressions, cannulation) able to be undertaken by a range of health professionals and others such as intubation which are discipline specific.
Collaborative interdisciplinary teams explicitly commit to cooperate in order to meet shared goals. Members allow their activity to be directed through shared decision making or by the team leader. These sorts of teams are “characterised by a greater interdependence, jointly defined goals and client centred plans”, as giving recognition and value to the expertise and perspectives of other disciplines. Like the ED team, all are reliant on the skills of others to achieve the necessary goals of treatment or care.

The specialist skills of each discipline are well utilised and common values and skills affirmed for all. Communication equity means all disciplines are able to contribute to care and speak up with safety concerns. Different disciplines take the lead or share leadership in a distributed model which acknowledges “no one leader can provide all the leadership in any complex situation”. A bonus of this model is that the burden of caring is shared between all disciplines and burnout reduced.

In contrast, in some so called multidisciplinary teams (MDTs), clinicians from different disciplines are each involved in the patient’s care but report back on referrals solely to the senior doctor leader, who then unilaterally directs patient care. The limitation of this model is not that the senior doctor is the team leader per se, (they may indeed be the best person to lead the team at a particular time) but that there is little or no opportunity for shared wisdom or shared decision making. This might be appropriate in some settings (perhaps in the consultation/referral stage in the Spectrum of Collaboration) but has significant limitations wherever ongoing complex care is needed. Not only does it inadvertently restrict possible alternative quality options for patients but it also tends to easily disempower junior staff, making it hard for them to contribute to care or speak up, even about issues of basic safety.

**Roles and skills**

Knowing what your own role is in a team (e.g. leader, or the person responsible for a particular task), is just as important as knowing what others’ roles are. Roles may be defined by the specific skill sets you possess but where skills are held in common (communication or clinical skills), roles need to be negotiated. It is only by discussing and practising how the different team members each contribute to patient care that role clarification is achieved. Role clarification is one of the most important requirements of a well functioning team. Once it is achieved, the team is well placed to swing into action in any given situation, often with just a few well chosen words, as each member anticipates and trusts in each other’s respective roles.
The patient as a member of the care team

There are many benefits of involving patients in the care team. Involvement increases patient motivation to change behaviour, enhances concordance with health care advice and leads to greater adoption of self management skills. Patients are empowered by becoming more knowledgeable about their conditions and are more able to participate in decisions about treatment. Wherever possible patients also need to be able to both establish and revisit their role in the team; some may choose at some times to be passive receivers of proffered treatment, but at other times to reject or substantially alter management recommendations.

That is not to say that patients either need or should be expected to take sole responsibility for all care decisions. Patients and families are entitled to hear clearly expressed, thoughtfully considered recommendations for care from health professionals, particularly in complex situations where there is no one right answer.

Benefits of collaboration

The Health Quality & Safety Commission has found that interdisciplinary collaboration reduces medical error as well functioning teams make fewer mistakes than individuals. More timely referrals occur with better use of disciplinary skill sets and holistic care provision and patients are less likely to fall between services. Taken together patients have higher levels of satisfaction and are more likely to have better access to health care and improved self management skills. Staff also enjoy higher levels of work satisfaction and cost savings are likely to occur. This approach benefits not only our patients, but health professionals and health organisations.

We also know that collaborative teams do not happen by chance. In New Zealand a number of factors have been shown to contribute to successful interdisciplinary teams including: skilful leadership in each discipline, readiness for an interdisciplinary culture, commitment to change, interdisciplinary respect and opportunity for trust to develop between individuals and across the team.

Organisational structures have supported institutional change as well as “alterations to existing health professionals values, socialisation patterns and workplace structures”. Interdisciplinary competencies can be taught at undergraduate level and this is happening in New Zealand. Similarly experienced doctors and other health professionals can achieve these competencies through intentionally learning about roles and skills of others and engaging in interdisciplinary programmes of study.

Doctors have had a key role in supporting this change by fostering professional respect for and trust in other disciplines and leading a willingness to use different forms of clinical decision making.
Barriers to collaboration

Even though the evidence points to the benefits of collaborative approaches in health care delivery for chronic and complex patients, the application of these models is variable and far from being universally adopted. Meeting in teams can be time and resource intensive with organisational and funding support being necessary. Professional regulation and legislation are also given as reasons to limit collaboration. Entrenched attitudes about scopes of practice, professional “turf” and historical power structures can sabotage the essence of what good teamwork is.

A common concern when a team of disciplines is involved is the issue of who is ultimately responsible for the patient’s care. In the past doctors have assumed varying degrees of responsibility for the practice of other clinicians involved in patient care. The regulatory framework is now clear that each professional is responsible for their work in their scope of practice.

Student health professionals (including medical students) hold a limited responsibility for patient care, as they are working under the direct supervision of a more experienced colleague. Once junior staff are registered, they must work in a scope of practice commensurate with their qualification and level of experience, reporting to more senior colleagues, but still responsible for their own practice in their expected scope. Adequate communication and collaboration with all health professional colleagues is also expected and essential practice. The Health and Disability Commissioner reports more frequently on a breakdown of collaboration between professionals than on the responsibility of the individual clinicians being deficient.

Nevertheless, there is still a need to ensure that good communication and good team processes are followed by everyone in the team; part of the leadership role. Teams need good leaders and teams need good members. Knowing when it is appropriate to take the leader role and when it is time to be a supporting member of a team is a key skill in being a good team player. For example, in the ED resuscitation situation, a resuscitation nurse specialist may take the lead to ensure good communication and that all essential tasks are undertaken, while the more junior nurse does chest compressions and the ED physician concentrates on intubating the patient.

Interdisciplinary collaboration in primary care

In NZ we know that great gains can be made in reducing inequalities in health care if health disciplines as well as other professionals work collaboratively in primary care services. Collaborative service delivery models can enable best use of other disciplines’ skill sets in a time when general practitioners are dealing with increasingly complex patients in the community.

This means patients may not access general practitioners for all health presentations but can receive excellent and appropriate care from nurses, community pharmacists or other health professionals working in primary care services.

The care of someone with diabetes requires a team approach which includes the patient and family. Likely others in the team are: community dietician, community pharmacist, diabetes educator, practice nurse, general practitioner and endocrinologist, as well as other professionals such as exercise or sports instructors and self management trainers.
Some factors may need to be changed when developing new collaborative teams or enhancing existing teams. Limited geographical colocation of services, mixed capitation/fee for service funding and the owner operated business model of many NZ general practices can make collaboration more difficult. Thought needs to be given to increase opportunities to meet together, develop processes for equal access to funding and ensure equality in decision making.\textsuperscript{14}

**Shared care**

The management of people with long term conditions is often shared between primary and secondary services and is an area where more attention to effective team work can reap dividends. This means “sharing responsibilities for maintaining and improving health and includes making and carrying out a collaborative plan to do so. Care can be shared by two or more agencies and the individuals in those agencies”\textsuperscript{15}

A well described New Zealand example of effective shared care comes from South Auckland with chronic obstructive pulmonary disease patients who had frequent winter time hospital admissions. A concerted collaborative effort between primary and secondary care health professionals was developed and for the intervention group this significantly decreased inpatient bed days.\textsuperscript{16}

An approach which is being increasingly adopted is the use of a care plan developed in primary care by the general practitioner and practice nurse, oriented around the needs and goals of the patient and available electronically across sectors and agencies. In collaboration with the patient, the care plan can be accessed and edited by the hospital specialists, specialist nurses, physiotherapist, community pharmacist and others. There is facility for electronic messaging and tasking between all the professionals involved to facilitate necessary changes in care. Patients can also access summary information (including medications and goals of care) through an electronic portal.

**Conclusion**

In New Zealand, doctors are increasingly working in collaborative interdisciplinary teams, particularly in the management of patients with chronic and complex conditions, and have an important role in supporting the further development of these models. Increasingly we are seeing models of shared care between disciplines, across health sectors and including a range of professional groups. There is a particular need to see further development of these models of care in primary care settings. In teams, role clarification is being recognised as necessary together with the building of professional trust in other disciplines’ specialist skills.

Current regulatory processes enable shared decision making and shared leadership however institutional policies and funding mechanisms may not and these need to be worked on. Champions are also needed to support collaborative processes wherever these are appropriate for best patient care, regardless of tradition or discipline.
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CHAPTER 17
Doctors in other roles

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In the course of a medical career a doctor may become involved in roles other than that of being a clinician. Most of the roles will fall under the jurisdiction of the Medical Council.

The Council definition of the practice of medicine is broad. The Council defines the practice of medicine as: advertising, holding out to the public, or representing in any manner that a person is authorised to practise medicine in New Zealand, the signing of any medical certificate, the prescribing of medicines and the assessing, diagnosing, treating, reporting or giving advice in a medical capacity.¹

A doctor is engaged in clinical practice if they assess, diagnose, give advice, treat or make reports, whether face to face or otherwise, with a patient, or with a group of patients or a population. A doctor is practising nonclinical medicine if he or she is not engaged in clinical practice.²

The clinical role is well understood and the parameters of the role established through the apprenticeship that doctors have served in their training years. The call to “Consider the health and wellbeing of the patient to be your first priority” is well known as the first point in the New Zealand Medical Association code of ethics. However when working in other roles, the last two points in the code of ethics are relevant:

“Accept a responsibility for assisting in the allocation of limited resources to maximise medical benefit across the community” and “Accept a responsibility for advocating for adequate resourcing of medical services”.³

The need to accept responsibility across the community and to look to resourcing means that the health and wellbeing of the patient must be looked at in the wider context of the health and well being of the population as a whole.

This wider context was recognised when the NZMA, in 2011, developed with input from a wide range of doctors a consensus statement on the “Role of the Doctor in New Zealand”.⁴

This statement recognised doctors as scientists, health professionals, leaders, health advocates and teachers and learners. It also noted:

- Doctors have diverse roles, in and outside of the health sector, in the promotion and maintenance of both individual and population health
- Doctors accept their ethical responsibilities to act in the best interests of their patients, and the population as a whole, and undertake this in a caring, compassionate, competent, and trustworthy manner
- Doctors work in partnership with patients in the delivery of their health care and serve as advisors and interpreters in the pursuit of optimal health outcomes using evidence based medicine and in accordance with available resources
- Doctors work effectively as leaders. As members of health care teams, doctors recognise and respect skills and attributes of other practitioners.
The CanMEDS initiative that began in the 1990s by the Royal College of Physicians and Surgeons of Canada developed the CanMEDS roles framework that recognises seven roles for doctors:

- Medical expert
- Communicator
- Advocate
- Scholar
- Professional
- Collaborator
- Manager

**Doctors as leaders and managers**

Doctors are increasingly involved in both leadership and management roles.

The purpose of clinical leadership is to bring about movement and constructive change, while the role of medical management is to provide stability, consistency, order and efficiency.6

“Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients.”7

It is the clinical skills and knowledge inherent in medical training that separate clinical leaders from health service executives. In making day to day management decisions the clinical leader is applying their medical knowledge to assess the impact, risk and clinical outcome of decisions. It is the role of the medical leader to apply clinical medicine to the development of policy, strategy, service design, behaviour change and effective clinical processes. The clinical leader is uniquely responsible for ensuring patient safety and monitoring both service and individual outcomes.

To be an effective clinical leader requires a different set of skills from those required to be a good clinician. Clinician leaders need to be able to develop a cohesive team, work across disciplines, and work in an organisational culture and communicate the impact of change to executives and senior managers.

The clinician leader bridges the cultural divide between clinicians and managers.

**Notifying poor performance**

In effectively fulfilling their clinical governance role, the clinical leader often becomes aware of performance issues amongst their colleagues.

Clinical leaders may become aware of poor practice when undertaking their audit or advisory role. This poor practice may relate to doctors working in the organisation or who are providing a service to patients of the organisation.
The enquiry into clinical issues at the Bristol Royal Infirmary highlighted that the clinical leader has a responsibility to identify and report failing performance, even when that clinical leader is not in active clinical practice.\(^8\)

A doctor has a mandatory requirement to report to the Registrar of the Medical Council another doctor whom they believe is not fit to practise medicine because of some mental or physical condition (see chapter 18).\(^9\)

As an employee the clinical leader has a duty to work in their organisational governance structures. Every clinical leader should clarify their organisation’s expectations and processes around their reporting of fellow employee’s and other colleagues performance to the Medical Council.

### Disagreement about clinical decisions

When a clinical leader becomes concerned about a decision that an organisation has made and believes that it will compromise patient outcomes, lead to serious harm or constitutes serious wrongdoing, they must follow the procedures outlined in the Protected Disclosures Act 2000. Where the doctor follows these procedures they have the right of complete confidentiality.

Serious wrongdoings may include inappropriate use of public funds, gross negligence or mismanagement by a public official, and acts or omissions that constitute serious risk to public safety or constitute an offence.

The clinical leader must put their concerns in writing and ensure they are addressed to the appropriate person. Where their concerns are not adequately addressed they may raise the issue with the Director General of Health, the Health and Disability Commissioner, or the Medical Council. It is strongly advised that they seek legal advice before raising the issue with an external party or the media.

### Providing opinions about patients or other doctors

A clinical leader may be asked to provide an opinion on the adequacy or appropriateness of another doctor’s report. This opinion is usually based solely on information recorded in the patient’s file. The nontreating doctor must ensure they have access to all the necessary information and that they can provide an opinion based on the information to hand.\(^10\)

Where additional information or a clinical examination is required, the nontreating doctor should either refrain from providing an opinion or note the need for further information in their report.
Working in a resource constrained environment

The New Zealand government allocates a defined amount of money for the provision of health services each year.

The distribution of this money has to balance the needs of the population with the needs of the individual patient. This can be a particularly vexing dilemma for the clinical leader who is asked to provide advice on the marginal benefit of two competing priorities.

Clinical leaders will also be asked to provide advice on whether certain expensive procedures are medically necessary or appropriate. Such decisions are both funding decisions and medical decisions.

In all roles, doctors should use evidence from research and audit to inform their decisions and advice on the best use of the resources that are available in their organisation.

Doctors have a responsibility to ensure that the process of assigning priority is appropriate and that patients referred to a service with limited resources are adequately assessed and consistently receive treatment in accordance with the clinical priority criteria. Prioritisation systems should be fair, systematic, consistent, evidence based and transparent.

If a patient is discharged or transferred early to allow a sicker patient to take the bed, the clinical leader has a responsibility to ensure that appropriate arrangements are in place to optimise the discharged patient’s recovery.

Where a patient is unable to access the preferred treatment due to funding constraints, they should be informed what the preferred treatment involves and what the available options are. This discussion should be documented.

Doctors in advisory roles

Doctors are often engaged to serve on advisory committees to government agencies, DHBs or nongovernment organisations.

When invited to serve on a committee, the doctor should determine if they are invited as an individual with a desired set of clinical skills or as the representative of an organisation or industry body. Where they are engaged as a representative they should ensure they have a mandate from the nominating body before proferring an opinion or providing endorsement to a planned strategy or process.

It is good practice to distribute an agenda and briefing papers well in advance of a meeting to allow representatives to seek advice from the nominating body on issues that are to be discussed. Failure to do so compromises the value of the meeting. Where inadequate time has been allowed for consultation or consideration of an issue, the doctor may need to withhold their advice. In such cases it is helpful to indicate when advice will be forthcoming.

Cabinet Guidelines set out a framework for government agencies engaging expert advisors. Amongst other things they currently preclude the payment of locum fees to a doctor who is required to be absent from their practice.
Expert witness

The High Court publishes a set of rules to guide expert witnesses. These provide a sound basis for any doctor who is providing an expert opinion, be it to a court, insurance company or medical review panel.

These rules note that the expert witness has an overriding duty to impartially assist the court on relevant matters within the expert’s area of expertise. The expert witness must not act as an advocate for the party who engaged them.

When giving evidence as an expert witness, the doctor should:

• clearly state their qualifications as an expert and indicate how the evidence they provide lies within their area of expertise

• provide the facts and assumptions on which their opinions are based. This should include any literature or other material they have used in forming their opinions. They should also describe any examinations, tests, or other investigations which helped them reach their conclusions. When these were undertaken by a third party, they should provide the qualifications of the person who carried out the tests or examinations

• give the reasoning behind their opinions.

The expert witness must also clearly indicate any provisos that would make their evidence incomplete or inaccurate. They also need to make it clear if they have been unable to reach an opinion because of insufficient research or data or for any other reason.

I acknowledge the work of Dr David Rankin who wrote this chapter for the last edition. This chapter is based on his work with updates drawn from recently published documents and materials.


**References**

1. Medical Council of New Zealand Glossary  

2. Ibid


5. Royal College of Physicians and Surgeons of Canada.  
   [www.royalcollege.ca/portal/page/portal/rc/canmeds](http://www.royalcollege.ca/portal/page/portal/rc/canmeds)


12. Fees framework for members appointed to bodies in which the Crown has an interest.  

CHAPTER 18

Doctors’ health

Kate O’Connor is a radiologist in Auckland, and was an elected member and deputy Chairperson of the Medical Council and was Chairperson of its Health Committee.

Joanna MacDonald is a psychiatrist and senior lecturer at the Wellington School of Medicine: she was a member of the Council’s Health Committee from 2002 to 2008, and its Chairperson for 6 years.


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As doctors we are constantly exposed to stresses and hazards that can impair our relationships and ourselves: working long hours, fatigue, sleep deprivation, consumer demands, secondary traumatic stress, consequences of mistakes, debt, demands of external bodies (including the Council and colleges), fear of complaints and litigation, infectious diseases, radiation, noxious chemicals. In addition we are vulnerable to the same physical and psychological disorders as the rest of the community. The incidence of these disorders in doctors is comparable to that in the general population and in some cases considerably higher (e.g., suicide, liver cirrhosis and accidents). The British Medical Association’s working group on the misuse of alcohol and other drugs reported in 1998 that, in a lifetime, about one in 15 doctors in the United Kingdom may suffer from some form of dependence on alcohol or other drugs.

Being a patient

Doctors are often poor at seeking help and attending to their own health needs. A survey of the health practices of New Zealand general practitioners found that only 71 percent claimed to have their own family doctor and only 10.9 percent said that they visited their doctor for regular checkups. Of women, 27.5 percent had not had recommended cervical screening.

Some factors that make it difficult for a doctor to become a patient are:

- a sense of being indispensable
- fear of moving from a position of power in the medical system to a position of powerlessness
- fear of breaches of confidentiality or of being recognised in the waiting room
- fear of having a serious condition
- shame or embarrassment particularly with respect to substance abuse or sexual issues
- a misperception that we lack time to see to our own health needs
- reluctance to impose on a busy colleague
- a belief we should be able to heal ourselves
- our ready access to a wide range of medication
- financial pressures to maintain high levels of income
- shame at having “let myself down”, and also your family and the profession at large
- a fear of disciplinary action and deregistration.

We often fail our colleagues by not confronting them when it is clear they are sick and impaired. Some of the reasons for this failure include:

- the “there but for the grace of God go I” syndrome
- lack of knowledge of the notification process and the consequences of notification
- fear of the reaction, especially if the doctor is in a position of power
Being a doctor’s doctor

Being a doctor to a colleague can be challenging for a number of reasons. These include:

- fear of being seen as inadequate
- fear of offending a colleague
- role confusion
- hierarchy
- difficulties if you disagree with your doctor patient’s self diagnosis
- identifying with the doctor patient
- boundary issues
- difficulties saying “no” to a colleague
- issues of privacy and confidentiality
- difficulties challenging a colleague particularly with respect to lifestyle issues.

Dr Hilton Koppe who works in the area of doctors’ wellbeing, suggests a six step consultation model when seeing a colleague as a patient. The principles are those used in any consultation — the key issue being to retain these principles and your usual professionalism in this unusual encounter.

Connection — as part of the process of agreeing to see a colleague, you should make a formal appointment in your rooms. You may need to discuss whether the doctor is comfortable to wait in the waiting room or elsewhere and whether an appointment at a quieter time of day would be easier. At the first appointment issues of confidentiality, notes, payment and your expectations of each other (including how to address each other) should be clarified.

Information gathering — you will need to walk the tightrope of acknowledging your colleague’s knowledge while taking a thorough, and if necessary challenging, history as you would with any patient. It is important not to make assumptions, for example that the doctor would tell you of symptoms without your needing to ask specifically. You will need to clarify what he or she thinks is the diagnosis then take the history and examine the patient to establish the diagnosis for yourself, rather than accepting that diagnosis.
Exploring thoughts and feelings — at this stage you may need to reaffirm confidentiality and the difficulty of being a patient. You will need to explore the doctor’s fears and look for any other issues. It is particularly important to be aware of the dangers of self disclosure and identification or collusion. Keep the focus on the doctor who is here as a patient and avoid discussing mutual patients or experiences.

Education — Again you will need to walk a tightrope between assuming your colleague has specific knowledge, and causing offence by imparting that knowledge. It can help to explain that hearing information about yourself is different from giving it to others, so you will explain it as you would to any patient. Acknowledge his or her fear if relevant, and admit the limits of your own knowledge. As with any patient it will be important to negotiate the choice of treatment.

Safety net — you should give clear instructions about follow up and after hours contact. Ask whether the doctor patient wishes to receive copies of test results and negotiate about minor procedures e.g. removal of sutures.

Closure — is just as important as starting the consultation. Check that everything has been dealt with and reinforce your commitment to them, and agree on how to book the next appointment.

Maintaining good health

Doctors are in the vanguard of illness prevention and health promotion and should lead by example. Sadly this is not often the case with respect to our own health and we often fall into unhealthy work patterns. This may begin during medical student years and then persist into vocational practice. One study found the prevalence of depressive symptoms among medical students was 12.9 percent (significantly higher that the general population), and an earlier study showed that at that stage of their careers, medical students were reluctant to seek help if stressed or distressed. The practice of medicine can place huge physical and emotional demands on practitioners. In recent years this has been increased further by administrative and reporting pressures as well as by the exponential rise in knowledge and literature in all medical fields. Increasing pressures, coupled with the subtly induced ethos of “doctors must always cope” can be a very toxic mixture.

Doctors should be informed about stress management and how to stay healthy despite these demands. Each doctor must find his or her own solutions but some simple guidelines are:

- establish good health habits early
- set aside time each day to maintain your own fitness and health, and to pursue other interests outside of medicine
- deal with your own reluctance to seek help and identify the barriers, both real and imaginary, which prevent help seeking behaviour
- have your own general practitioner — someone who is comfortable treating doctors
- avoid corridor consultations about your own health
- if you are feeling stressed consider contacting support groups from your professional body, College or insurer
• you should not prescribe for yourself as you lose the benefit of objective care and insidious illness may ensue
• when you visit your general practitioner leave your “medical mantle” at the surgery door
• do not become isolated. Join professional bodies, a peer support group, and attend meetings regularly. Isolation is not always geographic and can occur even in the biggest cities
• plan holidays and recreation and make sure work does not intrude on them
• remind yourself often that you are “responsible to” your patients, not “responsible for” them. (Responsible to your patients to provide the best care you can for them, which may mean from time to time organising somebody else to care for them)
• when ill health strikes seek help early (as you would like your patients to)
• consider income protection so financial pressures are not a consideration in preventing you from taking sick leave if it is necessary
• consider planning for your retirement so you do not feel you have to keep working for financial reasons.

The future is perhaps a little rosier with a greater emphasis on promoting health, wellness and coping skills in the undergraduate programme, improvement in working conditions for those in training and a greater recognition and assistance for some groups with particular stresses: rural, isolated doctors; women doctors; the older doctor.

The law: fitness to practise

The Council states, “A doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine”. These functions would include:
• the ability to make safe judgments
• the ability to demonstrate the level of skill and knowledge required for safe practice
• behaving appropriately
• not risking infecting patients with whom the doctor comes in contact
• not acting in ways that impact adversely on patient safety.

The most common disorders that impair doctors’ ability to practise are:

Psychiatric disorders
• substance use, abuse and dependence (both alcohol and drugs)
• mood disorders — bipolar disorder and severe depression
• dementias
• eating disorders
• anxiety disorders
• adjustment disorders, personal and professional stress and situational crises.

**Medical disorders**

• head injury

• neurological diseases

• malignancy

• eyesight and hearing difficulties

• communicable diseases.

The Health Practitioners Competence Assurance Act 2003 (the Act) provides for notification of any mental or physical condition affecting a doctor’s fitness to practise medicine. Part 3 section 45 sets out the steps that must be taken when there is reason to believe a doctor is unable to perform the functions required for the practice of medicine because of some mental or physical condition. There is a mandatory requirement for registered health practitioners, their employers, medical officers of health and persons in charge of a hospital or other organisation that provides health services to notify the Council Registrar promptly in writing.

Persons in charge of health professional education programmes (eg, deans of medical schools) are similarly required to give written notice to the Registrar if students who are completing a course would be unable to perform such functions. People considering making a notification are entitled to seek medical advice to assist them in forming an opinion and must state whether such advice has been obtained when giving notice to the Registrar.

These provisions extend across, and between, all registered health practitioners and their professions.

Any person making a notification is protected from civil or disciplinary proceedings unless the person acts in bad faith.

**The Council’s Health Committee**

The Council’s Health Committee is currently authorised by the Council to exercise the functions, duties, and powers contained in sections 45—51 of Part 3 of the Act, except for those relating to registration.

The Health Committee is comprised of at least four members of the Council, including one public member. The Council’s health manager is responsible for the functioning of the Health Committee and keeps close liaison with the committee chairperson.
How the Health Committee deals with notifications

When the Council Registrar receives notification of the possible impairment of a doctor or graduand, the notice is passed to the Health Committee, which considers the notification and its potential implications. If necessary, and pending a full review, there is provision to suspend a doctor’s practising certificate temporarily, or alter a doctor’s scope of practice in ways it considers appropriate. However, this course of action is rarely required. An important aim of the Health Committee is to keep the doctor working.

Usually the notice is discussed immediately by the chairperson of the Health Committee and the health manager, and then the health manager, contacts the doctor. If appropriate, a report might be requested from the doctor’s general practitioner and other treating specialists. Sometimes the doctor may be asked to make an agreement which limits his or her practice of medicine in particular ways, to ensure public safety while an expert examination is arranged.

The Act gives the Health Committee, acting under the Council’s delegation, the power to order a doctor to attend a medical examination at the Council’s expense. The examination is by a specialist relevant to the suspected (health) condition, and the Council would consult with the doctor about the specialist. The doctor receives a copy of the report. Failure to attend for such an examination may mean the Council suspends the doctor’s registration. If the circumstances warrant, the Council can impose restrictions on a doctor’s scope of practice.

If an examination has been arranged and the examining doctor’s report received, any initial limitations are reviewed in light of the report. If the examining doctor’s report indicates that a mental or physical condition is affecting the doctor’s ability to practise, the doctor will usually be invited to attend a meeting of the Health Committee to discuss the report and implications, with a support person if desired. The doctor is also entitled to make written submissions, and to be represented.
If the doctor’s ability to practise is affected by a mental or physical condition, the Health Committee usually decides on one or more of the following:

- ask the doctor to sign a voluntary agreement
- conform to appropriate restrictions on practice to ensure public safety in light of his or her condition
- undertake specific treatment or counselling according to the advice in the examining doctor’s report
- recommend to the Council that conditions be placed on the doctor’s scope of practice or that registration is suspended, for example while the doctor attends a rehabilitation or treatment programme.
The agreement is underpinned by the acknowledgment that conditions may be placed on the doctor’s practice if the agreement is breached in any material way. In doing this, the Health Committee’s intention is to help the doctor to regain and maintain health so that he or she can continue to practise, subject to appropriate limitations, and also ensure the health and safety of the public are protected.

A typical agreement may include:

- limiting the doctor’s scope of practice such as the place or places of work, the types of work to be undertaken, the workload, for example hours of work
- supervision of the doctor’s practice
- treatment to be undertaken and the names of the treating doctors, therapists and agencies who may be involved in the doctor’s treatment programme, with some indication as to the frequency of consultation. There may be provision for each to communicate with the Health Committee if problems arise eg, noncompliance or relapse
- where relevant, provision for a key person in the doctor’s workplace to be aware of the condition
- some monitoring by the Health Committee for example where the problem has involved abuse of drugs or alcohol, random testing will also form part of the agreement
- restricted access to prescription drugs and medicines
- prohibition on self prescribing
- regular assessment of progress by a Health Committee nominated doctor.

Doctors monitored by the Health Committee may meet with its members at intervals to discuss their progress, current state, and to make changes to the agreement. When the situation has stabilised and the doctor’s recovery is firmly established, the doctor may be monitored by an annual exchange of letters and then, if all is going well, the doctor is finally discharged from Health Committee monitoring.

It should be stressed that the Health Committee does not become involved in treatment decisions directly but ensures the appropriate treatment is taking place and the doctor’s health is maintained at the most satisfactory level possible. The doctor chooses his or her own treating team.

This process has been designed to separate matters of impairment from matters of professional misconduct and discipline. The assumption is that with treatment of the impairment a doctor should be able to return to the medical workforce. The process is intended to be rehabilitative, not punitive.
Infection with transmissible major viral infections (TMVIs)

As with any illness that may pose a risk to patients, doctors who are — or may be — infected with one of the transmissible major viral infections (hepatitis B, hepatitis C and Human Immunodeficiency Virus) must take all necessary steps to minimise the possibility of transmission. Health Regulatory Authorities of New Zealand (HRANZ), has, with the Medical Council, developed guidelines for health care providers. Key points are:

- learning and awareness must start early, in students’ training
- doctors should be tested if they may have been exposed to the viruses
- doctors should advise patients who may have been exposed to be tested
- doctors who perform exposure prone procedures have a responsibility to know their HBV, HCV and HIV status and notify the Council if they are infected
- being infected does not, by itself, justify either refusing registration of the doctor or limiting their practice — such decisions are always case by case
- doctors who know, or think, they may be infected with any of the viruses must seek advice and then act on it — a doctor should not continue practising based on her or his own assessment.

Conclusion

“Physician heal thyself” is not a policy the Medical Council endorses. Doctors are a valuable asset. We must take responsibility for maintaining our own health as much as is possible and seek professional help when we are ill. While the Act gives the Medical Council powers to restrict doctors’ practice when necessary to protect public safety, it is preferable if the Council can reserve the use of these powers and assist doctors to continue to work as appropriate and recover from their illnesses. This is best achieved by early notification and early intervention.
Resources


2. Health Committee via health manager phone 04 384 7635 or 0800 286 801.


References


CHAPTER 19

Maintaining competence

Steven Lillis is a general practitioner in Hamilton, and Medical Adviser for the Medical Council.


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Like all professions medicine is granted professional autonomy by society under the assumption that its practitioners will be deemed competent on entry into practice and will maintain competence for as long as they practice.¹

**Evidence based education**

Although no one would negate the importance of lifelong learning, there has been considerable debate as to how to ensure that useful learning occurs. The principal purpose of the Health Practitioners Competence Assurance Act 2003 (the Act) “is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions”. The Council currently requires all doctors to participate in approved continuing professional development (CPD) activities in order to recertify, but there is disquiet that the currently practised CPD, with its emphasis on continuing medical education, does not necessarily identify or improve underperformance, and therefore cannot “ensure” doctors are competent.

Traditional continuing medical education (CME) employed planning models that were devised 50 years ago. The effectiveness of such methods has been substantially questioned and it is generally accepted that such techniques have little to offer modern complex professional practice. CPD comes somewhat closer to the needs of doctors but is generally deficient in its ability to understand learning deficits. Alongside these limitations is increasing awareness of the dangers inherent in self assessment of learning need where inadvertent self deception can colour objectivity.² A body of research on educational effectiveness has revealed the following:

**Of marginal value**

- Formal CME meetings or conferences
- Didactic sessions
- Self assessment of educational needs
- Large group teaching
- Cross discipline teaching sessions
- Self assessment.

**What works well**

- Interactive programs between doctors and educators
- Comparison between optimal and actual care
- Academic detailing
- Outreach programs
- Providing learners with access to their own data
- Teaching integrated with clinical practice
- Multifaceted approach to education
- Individualised educational initiatives.
The task of good education is to understand where learning needs exist and meet those needs in the most effective and efficient way. The outcome should be either a positive change in doctor behaviour or better patient outcomes and preferably the change should be measurable. Practice visits offer a solution to many of the problems inherent in delivering good education for practising doctors; the assessment of need is undertaken on the real work of the doctor rather than a theoretical construct, the process is individualised and the assessment is objective. Practice visits embody many of the most effective methods of educating doctors.

**Practice visits**

The Council envisages a system of practice visits being part of CPD. It will be formative (designed to assist learning) rather than being summative (designed to test minimum standards). The professional bodies rather than the Medical Council will administer the scheme to ensure that it is in line with professional need in various disciplines. There will be a focus on developing the concepts to ensure they are acceptable and feasible to the profession.

**Resources for educational effectiveness**

The following references provide useful information on the effectiveness or otherwise of various educational opportunities.


References


CHAPTER 20

Credentialling

Kenneth Clark is the Chief Medical Officer at MidCentral DHB, the chair of the national CMO Group, and is a specialist obstetrician and gynaecologist.

Don Mackie is Chief Medical Officer at the Ministry of Health and is a specialist in medical administration.

Joan Crawford is the Strategic Programme Manager at the Medical Council.


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**Definition of credentialling**

Credentialling is a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice in a defined context. This context includes the particular service provided, and the facilities and support available in the organisation.

— The Credentialling Framework for New Zealand Health Professionals (2010), Ministry of Health

Credentialling is a continuous process that commences on a doctor’s appointment, with determination of clinical responsibilities, and then extends for the length of employment.

Credentialling reviews take place in a number of ways:

- an annual confirmation of credentialled status, often undertaken in conjunction with a performance review
- a periodic formal review by a credentialling committee
- nonroutine reviews for events such as the introduction of a new treatment or service or when there is reason to confirm a doctor’s competence across a range of specific clinical responsibilities.

**The interface with medical regulation**

The Medical Council is responsible for ensuring that doctors maintain high standards of practice. Doctors working in New Zealand are respected for the high standard of care they provide, however the public’s expectations have increased and patients are more questioning of the medical advice they receive. The profession and the Council need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted.

The Health Practitioners Competence Assurance Act 2003 (the Act) prescribes the responsibilities of registration authorities for each professional group. Council is responsible for defining scopes of practice, prescribing the qualifications for registration, ensuring doctors are competent and fit to practise, and registering doctors in a broad scope of practice. Credentialling processes undertaken by service providers define the clinical responsibilities for individual doctors in the scope in which they are registered and in the context in which they work.

Credentialling is part of clinical governance, and responsibility for credentialling lies with organisational governing bodies. However, credentialling processes must be owned by the profession and quality improvement will only occur if there is clinical leadership of the process.
Consumer input

Credentialling aims to improve outcomes for patients. Effective credentialling processes can provide assurance to the public of the quality of care they can expect from their doctor. Consumers play an important role in credentialling processes primarily as a member of the credentialling committee. A consumer representative is also often involved in credentialling during the process of appointment of doctors.

Benefits of credentialling

Effective credentialling systems for the medical profession:

- help to ensure patient safety
- promote professional practice development among doctors
- improve risk management in provider organisations
- support clinical improvement activity
- improve public confidence in the health system.

The focus of credentialling is on quality improvement. Credentialling can identify system errors and can also identify patterns of poor performance by individual doctors.

Fair process and transparency

Credentialling processes must follow due process and be procedurally fair. It is important that policies document the process, and these are adhered to. The process must be fair, unbiased and transparent. Credentialling processes must follow the tenets of natural justice and there must be a documented and robust appeal process.

There is a public interest in the outcome of credentialling processes. Policies need to identify what information is made available to patients. The credentialled status of a doctor should be made available to the public, however the information generated during the credentialling process may be confidential.

Credentialling information should also be shared among service providers. This includes public and private hospitals and service providers. It is essential that the doctor is informed if such information is to be shared between providers.
Standards for credentialling

There is a need for consistent processes to be followed to ensure effective credentialing across all health service providers. *The Credentialling Framework for New Zealand Health Professionals (2010), Ministry of Health* lays out general principles with a purpose of promoting a nationally consistent credentialling system. In medicine credentialling is reasonably well established in hospital settings but in contrast is yet to be introduced to any extent in primary care settings. This is a significant challenge for the profession and one that the Council and the national Chief Medical Officer group is keen to see taken up.

Even where credentialling is routinely practised in New Zealand the overall standard needs to be raised in order to truly aid in the assurance of high quality care and patient safety. A set of national standards for credentialling, monitored by an external accreditation system would result in an improvement in the current high standards of practice of doctors in New Zealand.
CHAPTER 21

Error in medical practice

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On one hand, mistakes are inevitable. On the other hand they are to be avoided… This fundamental paradox creates the moral challenge of accepting our fallibility and at the same time struggling against it.

Error is common

The incidence, cause and prevention of medical error has attracted considerable interest in both the public and professional domains. Two research papers highlighted the extent of the problem by quantifying the number of patient deaths caused by error in the United States.\textsuperscript{2,3} The results indicated that somewhere between 44,000 and 98,000 people die each year as a result of medical error in the U.S.A. A further study based on Australian hospitals revealed similar statistics.\textsuperscript{4} New Zealand data indicate 13 percent of hospital admissions are associated with an adverse event and 15 percent of these adverse events are associated with permanent disability or death.\textsuperscript{5} All practising doctors are aware of error in their day to day work.

Causes of error

A useful concept is to look at error as a failing of processes and systems. An individual may be at the sharp end of this failure but should not be blamed for its defects. Reason describes the “Swiss cheese” concept of error. High technology systems such as medicine have many defensive layers. Well trained professionals, procedures, guidelines and computerisation all can be considered defensive layers against error and can be likened to individual slices of Swiss cheese; mostly intact but with some holes. The presence of a hole in one slice doesn’t necessarily cause an error, as it is probable that the next slice in the series will prevent the error. When holes in successive slices line up momentarily, error occurs.

Preventing error

The study of error in medicine would indicate that solutions range from the very simple to the complex.\textsuperscript{6} Prescription errors are a common and serious cause of error in both hospital and community based medical practice. Better systems for safe prescribing can have significant impact on the rate of prescribing error.\textsuperscript{7,8} Utilising error reporting systems to better understand what has gone wrong has also shown effective in reducing error.\textsuperscript{9} There is, however, a common underlying theme to the continued high prevalence of medical error; blaming the individual rather than the process. Failure of medicine as a profession and health care as an industry to recognise the negative effect of dealing with error by “naming, blaming and shaming” the person involved in the mistake has led to disappointing results in reducing error rates.\textsuperscript{10} Medical culture has proved quite resistant to change.\textsuperscript{11}
Many other industries face similar work environments as medicine where real time decisions have to be made, there is constant interaction between humans and technology, the processes are complex and the end result of error can be catastrophic in human and resource costs for both those receiving the service and those providing it. Common themes that emerge from these industries as to methods of reducing error include systematic reporting systems, collecting data on “near misses”, confidential reporting systems and developing a culture of safety. Not all error results in an adverse outcome. However, collecting information on “near misses” — events that could easily have led to an adverse outcome if not discovered — allows better understanding of what processes are deficient and how to fix them. The key to collecting information on things that go wrong is effective communication. This in turn requires a culture in medicine that encourages and supports open communication and recognises that it is a defective system and not an individual that is responsible for the vast majority of errors that occur.

**Clinical governance**

The National Health Committee defines clinical governance as “A framework through which New Zealand health sector organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” A more concise way of thinking about it is “Taking responsibility for clinical outcomes at a locality level.” The five components are:

- Clear lines of accountability for the overall quality of clinical care at practice level
- A comprehensive programme of quality improvement systems in each practice
- Supporting and applying evidence based practice
- Clear policies aimed at managing risk
- Procedures to identify and remedy poor performance integrated into practices.

**Responding to error**

It is an inevitable part of professional practice that all doctors will make mistakes and that some of these mistakes will result in patient harm. Most doctors who are involved in patient care where error has occurred are significantly affected by it, particularly if the error results in harm to the patient and formal complaint. Reactions include anger, shame, guilt, depression and reduced enjoyment of the practice of medicine. However, the importance of effective emotional support during a time of professional crisis is also being recognised.
Communication would seem to be a strong predictor of the outcome of medical error. Not all litigation and complaint is occasioned by medical error and only a small proportion of error results in complaint. An American study looking at why a decision to pursue litigation was made by patients suggested that failure of communication was a crucial factor in the majority of cases. Good communication between doctor and patient is crucial should error occur. The majority of patients whom have suffered from medical error want disclosure of error, truthful explanations, understanding of what has happened and reassurances that the “system” has been fixed so that the error will not happen again. Failure to meet these expectations is more likely to result in the patient seeking such explanations in a court or through disciplinary processes.

A common question asked when error occurs is “Should I apologise?” The uncertainty as to what to do is usually driven by fear of disclosure to the patient and colleagues, fear of complaint, the threat to ones own sense of professional competence and the desire to avoid compromising a legal situation. Clearly, if working as an employee, the institution in which a doctor is employed should be notified at the earliest opportunity should error occur and the appropriate indemnity insurance company notified. Once such notification has occurred, the error should be disclosed.

Acknowledging and apologising for the error places the incident in an interpersonal framework rather than the impersonal and distant hierarchy of an institution. It is an important step in the process of recovery for both the patient and the doctor concerned. It empowers patients as they have both understanding and involvement whereas nondisclosure disempowers patients. Disclosure may lessen the likelihood of formal complaint and allows a transparent process of understanding what went wrong and how to prevent it from happening again. A 2006 study undertaken in New Zealand reported that 86 percent of hospital doctors surveyed believed that disclosure of error to patients would decrease the likelihood of a complaint being filed against them.

Conclusion

Developing a culture of safety in medicine requires effective communication and trust between team members and acknowledgement of the failure of processes rather then individuals as the cause of the majority of errors in medicine. If and when error occurs, effective communication and transparency can lessen the emotional, physical and financial cost for both the patient and the doctor involved. Like many things in medicine, effective communication is the key to improving outcomes. Errors are to be avoided. When they occur, the learning that can be found in them is invaluable in ensuring they don’t happen again. The opportunity for learning should not be overlooked.
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CHAPTER 22

The New Zealand Medical Association code of ethics


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Preliminary statement

The profession of medicine has a duty to maintain and improve the health of the people and reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community. In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients. This document represents a further stage in that evolutionary process.

This document does not purport to set out rigid, immutable rules. It revises the Code of Ethics and provides guidelines endorsed by the Council of the New Zealand Medical Association. The Code will be reviewed at regular intervals and, to this end, comment and feedback is invited.

The basis of the moral framework for medical practice has been developed gradually over several thousand years, and is therefore well established, whereas guidelines for professional behaviour must reflect the changing social and cultural environment in which doctors practise. The moral basis for practice has its expression through what is commonly termed medical ethics. Integral to an ethical basis for professional practice is the overriding acceptance of an obligation to patients, and recognition of their autonomy.

Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, non-maleficence, and justice. Autonomy recognises the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognising resource constraints. Non-maleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources.

In New Zealand today there is also an increasingly wide recognition of the principle of partnership - between doctor and patient; profession and society; and different cultures as an important aspect of the ethos of professional practice.

The concept of the autonomy of doctors also needs to be considered, although this principle has always been tempered with common sense and recognition of the duty to act within the limits of one’s own capabilities. 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, sharing their skills, experience and judgement with others. In today’s world, doctors have an increased ethical responsibility to participate in reviewing formally their own and others’ work to maintain standards of practice.

44 Comments should be sent to: New Zealand Medical Association, PO Box 156, Wellington.
45 The NZMA strongly favours retention of the word “patient” because it reflects accurately the nature of the relationship between a doctor and the person seeking help.
46 The NZMA recognises no distinction, in terms of accountability, between conventional and alternative medicine when practised by a registered medical practitioner. All treatments should be subject to the same standards in respect of the rigour with which they are subjected to scientific testing and the ethics applicable to their use.
The concept of accountability, as applied to the medical profession, needs to encompass a widening set of relationships and contexts. An increasing number of statutory and commercial organisations interact with doctors in relation to issues of accountability. Increasingly, doctors are experiencing difficulty in balancing the requirements of their primary obligation to individual patients and families with their responsibilities to the wider community. Many commercial concepts, including that of intellectual property and that of contracting with various funding bodies, are challenging aspects of medical organisation and professional practice.¹

Changes in the context of medical practice are reflected in new sections on Medical Responsibilities in Prioritising Care and on Medicine and Industrial Action to address the exquisite dilemmas that doctors find themselves in as participants in the tension between the welfare of the individual patient and the good of all other patients.

Faced with this complex and changing situation, the New Zealand Medical Association affirms its adherence to certain ethical principles. Patients have a legal right (under the Code of Health and Disability Services Consumers’ Rights) to services that comply with ethical standards such as this Code of Ethics. The Association accepts responsibility for delineating standards of ethical behaviour expected of doctors in New Zealand and has consulted widely in the development of this Code.

The NZMA urges Members and all doctors to follow the standards set out below:

¹ The concept of intellectual property and its protection is relatively recent. The patenting of inventions based on an individual’s thinking and research is becoming widespread. The ethical issues related to this are at present being defined and the present code cannot encapsulate any established pattern.
Principles

All medical practitioners, including those who may not be engaged directly in clinical practice, will acknowledge and accept the following Principles of Ethical Behaviour:

1. Consider the health and well being of the patient to be your first priority.
2. Respect the rights, autonomy and freedom of choice of the patient.
3. Avoid exploiting the patient in any manner.
4. Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.
5. Protect the patient’s private information throughout his/her lifetime and following death, unless there are overriding considerations in terms of public interest or patient safety.
6. Strive to improve your knowledge and skills so that the best possible advice and treatment can be offered to the patient.
7. Adhere to the scientific basis for medical practice while acknowledging the limits of current knowledge.
8. Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient.
9. Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease.
10. Accept a responsibility to assist in the protection and improvement of the health of the community.
11. Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.
12. Accept a responsibility for maintaining the standards of the profession.

Recommendations

Given the complexities of doctor-patient relationships, and the increasing difficulties brought about by the need for rationing of resources and direct intervention of third-party providers of funding, no set of guidelines can cover all situations. The following set of recommendations is designed to convey an overall pattern of professional behaviour consistent with the principles set out above in the Code of Ethics.

Responsibilities to the patient

1. Doctors should ensure that all conduct in the practice of their profession is above reproach. Exploitation of any patient, whether it be physical, sexual, emotional, or financial, is unacceptable and the trust embodied in the doctor-patient relationship must be respected.
2. Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power. Sexual relationships between doctors and their patients or students fall within this category. The NZMA is mindful of Medical Council policy in relation to sexual relationships with present and former patients or their family members, and expects doctors to be familiar with this. The NZMA considers that a sexual relationship with a current patient is unethical and that, in most instances, sexual relations with a former patient would be regarded as unethical, particularly where exploitation of patient vulnerability occurs. It is acknowledged that in some cases the patient-doctor relationship may be brief, minor in nature, or in the distant past. In such circumstances and where the sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred. Any complaints about a sexual relationship with a former patient therefore need to be considered on an individual basis before being considered as unethical.

3. Doctors should ensure that every patient receives appropriate available investigation into their complaint or condition, including adequate collation of information for optimal management.

4. Doctors should ensure that information is recorded accurately and is securely maintained, with due regard to the challenges of the modern electronic era.

5. Doctors should seek to improve their standards of medical care through continuing self-education and thoughtful interaction with appropriate colleagues.

6. Doctors have the right, except in an emergency, to refuse to care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and that the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.

7. When a patient is accepted for care, doctors should render medical service to that person without discrimination (as defined by the Human Rights Act).

8. Doctors should ensure that continuity of care is available to all patients, whether seen urgently or unexpectedly, or within a long-term contractual setting, and should assure themselves that appropriate arrangements are available to cover absence from practice or hours off duty, informing patients of these.

9. Doctors should ensure that patients are involved, within the limits of their capacities, in understanding the nature of their problems, the range of possible solutions, as well as the likely benefits, risks, and costs, and should assist them in making informed choices.

10. Doctors should ensure that patients are promptly informed of any adverse event or error that occurred during care for which the doctor has individual or direct overall responsibility.

11. Doctors should recognise the right of patients to choose their doctors freely.

12. Doctors should recognise their own professional limitations and, when indicated, recommend to patients that additional opinions and services be obtained, and accept a patient’s right to request other opinions. In making a referral to another health professional, so far as practical, the doctor should have a basis for confidence in the competence of that practitioner.
13. Doctors should accept the right of a patient to be referred for further management in situations where there is a moral or clinical disagreement about the most appropriate course to take.

14. Doctors should keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient or in those unusual circumstances when it is clearly in the patient’s best interests or there is an overriding public good, including the risk of serious harm to another person. If there is any doubt, doctors should seek guidance from colleagues or an appropriate ethics committee.

15. When appropriate, doctors should communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information. Patients should be made aware of this information sharing which enables the delivery of good quality medical care. Where a patient expressly limits possession of particular information to one practitioner, this must ordinarily be respected. Patients should be made aware in advance, if possible, where there are limits to the confidentiality which can be provided.

16. Where a doctor is performing an assessment on behalf of a third party, the patient must be clearly informed of who the third party is, the purpose of the assessment and the limits of confidentiality. Where the assessment occurs in the context of a treating relationship, the patient should be made aware that the doctor is ethically obliged to provide a complete and professional report.

17. When it is necessary to divulge confidential patient information without patient consent this must be done only to the proper authorities, and a record kept of when reporting occurred and its significance.

18. Doctors should recommend only those diagnostic or screening procedures which seem necessary to assist in the care of the patient and only that treatment which seems necessary for the well being of the patient.

19. When requested or when need is apparent, doctors should provide patients with information required to enable them to receive benefits to which they may be entitled.

20. Doctors should be aware of statutory provisions and the codes of the Privacy Commissioner, the Human Rights Commissioner and the Health and Disability Commissioner, and the requirements of the Medical Council of New Zealand.

21. Doctors should accept that autonomy of patients remains important in childhood, chronic illness, ageing, and in the process of dying.

22. When patients are not capable of making an informed choice or giving informed consent, doctors should consider any previously expressed preferences from the patient, the wishes of the family, guardian or other appropriate person, and consult colleagues before making management decisions, which may include recourse to the courts for determination.

23. Doctors should bear in mind always the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. In such inevitable terminal situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.
24. Doctors should be prepared to discuss and contribute to the content of advance directives and give effect to them. In the case of conflicts concerning management, doctors should consult widely within the profession and, if indicated, with ethicists and legal authorities.

25. In relation to transplantation and requests for organ donation, doctors should accept that when death of the brain has occurred, the cellular life of the body may be supported if some parts of the body might be used to prolong or improve the health of others. They should recognise their responsibilities to the donor of organs that will be transplanted by disclosing fully to the donor or relatives the intent and purpose of the procedure. In the case of a living donor, the risks of the donation procedures must be fully explained. Doctors should ensure that the determination of death of any donor patient is made by doctors who are in no way concerned with the transplant procedure or associated with the proposed recipient in a way that might exert any influence upon any decisions made.

Professional Responsibilities

26. Doctors have both a right and a responsibility to maintain their own health and well being at a standard that ensures that they are fit to practise.

27. Doctors should seek guidance and assistance from colleagues and professional or healthcare organisations whenever they are unable to function in a competent, safe and ethical manner. When approached in this way doctors should provide or facilitate such assistance.

28. Doctors have a responsibility to assist colleagues when they are unwell or under stress.

29. Doctors have a general responsibility for the safety of patients and should therefore take appropriate steps to ensure unsafe or unethical practices on the part of colleagues are curtailed and/or reported to relevant authorities without delay.

30. Doctors have a responsibility to participate in reviewing their own practice and that of others.

31. When appropriate doctors should make available to colleagues, with the knowledge of the patient, a report or summary of their findings and treatment relating to that patient.

32. When working in a team environment, doctors have a responsibility to behave cooperatively and respectfully towards team members.

33. Doctors should recognise that the doctor/patient relationship has a value and should not be disturbed without compelling reasons. Disruption of such a relationship should, wherever possible, be discussed in advance with an independent colleague.

34. Doctors should avoid impugning the reputations of colleagues. In normal circumstances, information about colleagues divulged as a part of quality assurance exercises (including peer groups) should remain confidential.

35. Doctors should accept a share of the profession’s responsibility toward society in matters relating to the health and safety of the public, health promotion and education, and legislation affecting the health or well being of the community.
36. Doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Where doctors are working within a health service they should first raise issues in respect of that service through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly.

37. Doctors should not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty.

38. Doctors should recognise the responsibility to assist courts, commissioners, commissions, and disciplinary bodies, in arriving at just decisions. When doctors are providing expert opinions, the doctor has a duty to assist the body impartially on relevant matters and to confine such opinion within their area of expertise.

39. Doctors should certify or give in evidence only that which has been personally verified when they are testifying as to circumstances of fact.

40. Doctors should not allow their standing as medical practitioners to be used inappropriately in the endorsement of commercial products. When doctors are acting as agents for, or have a financial or other interest in, commercial organisations or products, their interest should be declared. If endorsing a product, doctors should use only the proper chemical name for drugs, vaccines and specific ingredients, rather than the trade or commercial name. Any endorsement should be based on specific independent scientific evidence, and that evidence should be clearly outlined.

41. Doctors should not use secret remedies.

42. Advances and innovative approaches to medical practice should be subject to review and promulgation through professional channels (including ethics committees) and medical scientific literature. Doctors should accept responsibility for providing the public with carefully considered, generally accepted opinions when presenting scientific knowledge. In presenting any personal opinion contrary to a generally held viewpoint of the profession, doctors must indicate that such is the case, and present information fairly.

43. Doctors should accept that their professional reputation must be based upon their ability, technical skills and integrity. Doctors should advertise professional services or make professional announcements only in circumstances where the primary purpose of any notification is factual presentation of information reasonably needed by any person wishing to make an informed decision about the appropriateness and availability of services that may meet his or her medical needs. Any such announcement or advertisement must be demonstrably true in all respects and contain no testimonial material or endorsement of clinical skills. Qualifications not recognised by appropriate New Zealand statutory bodies should not be quoted.

44. Doctors should exercise careful judgement before accepting any gift, hospitality or gratuity which could be interpreted as an inducement to use or endorse any product, equipment or policy. Doctors must not allow gifts to influence clinical judgement. In all cases of doubt, advice should be sought from relevant professional organisations.
Research

45. Before initiating or participating in any clinical research, doctors should assure themselves that the particular investigation is justified in the light of previous research and knowledge. Any proposed study should reasonably be expected to provide the answers to the questions raised. There must be an assessment of predictable risks and burdens in comparison with foreseeable benefits to the participants or to others. All studies involving patients should be subject to the scrutiny of an appropriately constituted ethics committee which must be independent of the investigator and the sponsor, and any kind of undue influence.

46. Doctors should be assured that the planning and conduct of any particular study is such that it minimises the risk of harm to participants. When comparing active treatments, the control group should receive the best currently available and accepted treatment, in accordance with a reasonable body of medical opinion.

47. A placebo-controlled trial may be ethically acceptable, even if an established therapy is available for a certain condition, under the following circumstances:

• The established treatment has never been demonstrated to be effective by evidence-based criteria; or

• Where for compelling and scientifically sound methodological reasons its use is necessary to determine the efficacy or safety of a prophylactic, diagnostic or therapeutic method; or

• Where a prophylactic, diagnostic or therapeutic method is being investigated for a minor condition and the patients who receive placebo will not be subject to any additional risk of serious or irreversible harm;

There must be a robust mechanism for curtailing the trial should at any stage the treatment group be demonstrated (by adequate statistical methods) to be different from the placebo group.

48. Patient consent for participating in clinical research (or permission of those authorised to act on their behalf) should be obtained in writing only after a full written explanation of the purpose of that research has been made, and any foreseeable health hazards outlined. Opportunity must be given for questioning and withdrawal at any time. When indicated, an explanation of the theory and justification for double-blind procedures should be given. Acceptance or refusal to participate in a clinical study must never interfere with the doctor-patient relationship or access to appropriate treatment. No degree of coercion is acceptable.

49. Boundaries between formalised clinical research and various types of innovation have become blurred to an increasing extent. Doctors retain the right to recommend, and any patient has the right to receive, any new drug or treatment which, in the doctor’s considered judgement, offers hope of saving life, re-establishing health or alleviating suffering. Doctors are advised to document carefully the basis for any such decisions and also record the patient’s perception and basis for a decision. In all such cases the doctors must fully inform the patient about the drug or treatment, including the fact that such treatment is new or unorthodox, if that is so.
50. In situations where a doctor is undertaking an innovative or unusual treatment on his or her own initiative, he or she should consult suitably qualified colleagues before discussing it with, or offering it to, patients. Doctors should carefully consider whether such treatments should be subject to formal research protocols.

51. It is the duty of doctors to ensure that the first communication of research results be through recognised scientific channels, including journals and meetings of professional bodies, to ensure appropriate peer review. Participants in the research should also be informed of the results as soon as is practicable after completion.

52. Doctors should not participate in clinical research involving control by the funder over the release of information or results, and should retain the right to publish or otherwise release any findings they have made. Doctors involved as principals in research should not participate if they do not have access to the base data. Negative as well as positive results should be published or otherwise made publicly available. Any dispute or ethical issue which may arise in respect of the research should be considered openly, e.g. by consultation with the appropriate ethics committee.

Teaching

53. Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors.

54. Teaching involving direct patient contact should be undertaken with sensitivity, compassion, respect for privacy, and, whenever possible, with the consent of the patient, guardian or appropriate agent. Particular sensitivity is required when patients are disabled or disempowered, e.g. children. If teaching involves a patient in a permanent vegetative state, the teacher should, if at all possible, consult with a nursing or medical colleague and a relative before commencing the session.

55. Wherever possible, patients should be given sufficient information on the form and content of the teaching, and adequate time for consideration, before consenting or declining to participate in clinical teaching. Refusal by a patient to participate in a study or teaching session must not interfere with other aspects of the doctor-patient relationship or access to appropriate treatment.

56. Patients’ understanding of, or perspective on, their medical problems may be influenced by involvement in clinical teaching. Doctors should be sensitive to this possibility and ensure that information is provided in an unbiased manner, and that any questions receive adequate answers. It may be appropriate for the doctor to return later to address these issues.
**Medicine and Commerce**

57. Commercial interests of an employer, health provider, or doctor must not interfere with the free exercise of clinical judgement in determining the best ways of meeting the needs of individual patients or the community, nor with the capacities of individual doctors to co-operate with other health providers in the interests of their patients, nor compromise standards of care or autonomy of patients in order to meet financial or commercial targets.

58. Where potential conflict arises between the best interests of particular patients and commercial or rationing prerogatives, doctors have a duty to explain the issues and dilemmas to their patients. Doctors should state quite clearly what their intentions are and why they advocate particular patterns of diagnosis, treatment, referral or resource use. Commercial arrangements that have the potential to impinge on the patient’s care should be declared to the patient.

59. Doctors who provide capital towards health services in the private sector are entitled to expect a reasonable return on investment. Where there may be a conflict of interests, the circumstances should be disclosed and open to scrutiny.

60. Like all professionals, doctors have the right to fair recompense for the use of their skills and experience. However, motives of profit must not be permitted to influence clinical judgement.

61. Doctors should insist that any contracts into which they enter, including those involving patients, be written in clear language such that all parties have a clear understanding of the intentions and rules.

62. Doctors who find themselves in a potentially controversial contractual or commercial situation should seek the advice of a suitable colleague or organisation.

**Medical Responsibilities in Prioritising Care**

63. Doctors have a primary responsibility to the individual patient, but also a concurrent responsibility to all other patients and the community. Doctors therefore have an ethical responsibility to manage available resources equitably and efficiently.

64. Rationing of resources must be open to public scrutiny and points of conflict identified and presented in a rational, non-biased manner to the public.

65. Patients must be able to trust their doctor to deal with their needs fairly and honestly. Doctors should, within reason, provide adequate information to their patients about their assessment and available treatments, including those not readily available.

66. In an environment of resource constraint, priorities need to be assigned to achieve the wisest use of limited resources. Doctors have a duty to work with others in developing rules to set priorities. Doctors also have a duty to abide by such rules, provided the rules conform to ethical principles. The rules should be just, open, valid, and reliable.
Medicine and Industrial Action

67. It is recognised that certain extreme circumstances may lead to consideration of industrial action by doctors. Such action is not always unethical, even if it compromises care to individual patients, which is contrary to one of the ethical principles. However, a decision to take industrial action must be based on a reasonable expectation that the desired outcome will result in improved patient care and safety. A doctor’s primary duty is to their patient, but the secondary duty to all other patients may mean that action has to be considered. In the case of industrial action, doctors should take care to minimise any detrimental effect on patient care. Services to preserve life and prevent permanent disability must always be provided. Self interest alone by individuals or the profession is not an ethical basis on which to take action.

This code will undergo major review by May 2013. However, minor changes may be introduced before then in response to further alterations in the environment in which medicine is practised. To this end, the NZMA welcomes feedback and comment on this code at any time.
CHAPTER 23

Advertising

Steven Lillis is a general practitioner in Hamilton, and Medical Adviser for the Medical Council of New Zealand.


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Patients are not consumers in search of a commodity. There is a unique vulnerability that comes for want of relief from disability and disease, and patients are unlikely therefore to be capable of defending themselves with the incredulity they may normally bring to other forms of advertising.\(^1\)

### Introduction

Medicine has had a difficult and tense relationship with advertising. There have been a significant number of formal complaints upheld against doctors in New Zealand over advertising in recent years. This suggests a poor understanding of advertising in a medical context as well as a degree of naivety over the consequences of advertising that breaches guidelines.

Perceived problems with advertising led to American physicians being prohibited from advertising for 130 years, change occurring only in 1975. The change was brought about by positioning health care as a business no different from any other and therefore a prohibition on advertising was seen as a restraint of trade. The contrary view is that good decision making in medicine represents a very different interaction from the majority of consumer decisions.

There are convincing ethical views that support tight control on advertising. The ethical considerations centre around three themes: the vulnerability of those with illness and disease, the power implications of an imbalance in knowledge and the commitment of health practitioners to use limited health resources wisely. Mark Yarborough cautions that advertising may transform the doctor/patient relationship “primarily into a means of making money rather than a means of serving and promoting the best interests of the patient as determined by the patient”.\(^2\)

Those who perceive themselves as ill may be frightened, vulnerable and powerless. They seek health care professionals who profess to have specialised knowledge and who profess to act only in the patient’s best interest. The purpose of advertising is to generate income. It does so by providing limited but alluring information about a product or service that will meet a real, perceived or generated need. There is an assumption in such a transaction that the consumer is a free agent. This is, of course, incorrect concerning medical treatment. Aside from the vulnerability that goes hand in hand with many illnesses, there is an imbalance of knowledge between doctor and patient. The limited and potentially biased information given in advertising may give rise to unrealistic expectations in those considering treatment. These expectations may have adverse consequences in subsequent interactions between doctor and patient.
“Statement on advertising”

The Medical Council has produced several publications that act as guidelines for those wishing to advertise their medical services and these are available from the Council website. The most important of these is the Statement on advertising. The statement covers legislation for health related advertising set by the Advertising Standards Authority but also describes additional requirements the Council has described regarding advertising. Some principles from that statement are:

**Responsibility** — you are responsible for the content even if you delegate the task to another person. Responsibility exists for advertorials in media such as TV and radio as well as more traditional newspapers and magazines.

**Content** — the key words are truthful and balanced content. Should complaint occur, the claims made in an advertisement may well be examined with a close eye on the medical and research evidence to substantiate those claims. The use of images must also be balanced and fair. This especially applies to “before and after” photos.

**Qualifications** — the term “specialist” has special meaning under Council’s guidelines and refers to a doctor who has vocational registration. If advertising, you should not claim to have specialist knowledge or be a specialist in a particular area of medicine unless you hold vocational registration in that area.

**Discounting** — advertisements that offer discounts are not acceptable. Such incentives are aimed at inducing “reflex” decisions about buying a product or service. Decisions regarding medical care are not served well by promoting quick decisions. In particular, advertising that promotes limited time offers runs contrary to many of the principles of informed consent and good decision making. Offering medical services as prizes or gifts is inappropriate when this is done to promote a commercial service for financial gain.

**Endorsing products** — the Medicines Act prohibits the endorsement of medical products, treatments or medicines. Any other endorsements need to be evidence based.

More comprehensive descriptions of these principles are available from the Statement on Advertising and this information is not intended to be a replacement for the statement. The Advertising Standards Authority also provides useful information on standards relevant to therapeutic products or therapeutic services. Doctors responsible for poorly considered advertising can be investigated by a number of bodies including the Health and Disability Commissioner, the Medical Council and the Commerce Commission.

Legislation relevant to advertising includes:

- The Code of Health and Disability Services Consumers’ Rights
- The Fair Trading Act 1986
- The Consumer Guarantees Act 1993
- The Medicines Act 1981
- The Therapeutic Services Advertising Code
- The Therapeutic Products Advertising Code.
References


CHAPTER 24

Doctors who use complementary and alternative medicine

Shaun Holt holds pharmacy and medicine degrees and is an Adjunct Professor at Victoria University of Wellington where he teaches courses on clinical trials and evidence based natural therapies.


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What is complementary and alternative medicine (CAM)?

Treatments that are not commonly used in mainstream medical practice have been given a number of names over the years, from quackery to unproven to unorthodox to unconventional. The most widely used current description is “complementary and alternative therapies and medicines”, shortened to CAM. Complementary therapies are health care and medical practices that work alongside traditional medical treatments, but are not currently an integral part of conventional medicine, whereas alternative therapies are used instead of standard medical treatments.

There are hundreds of CAM therapies and The National Centre for Complementary and Alternative Medicine, a United States government agency that carries out scientific research on complementary therapies, classifies them into five categories:

- **Alternative medical systems** have a completely different theory and practice to the conventional “Western” way of understanding and treating medical problems. Some of these systems were developed in the Western world, such as homeopathy, but most originate in other parts of the world, particularly in the East, such as acupuncture. In addition to homeopathy and acupuncture, they include ayurvedic medicine from India and traditional Chinese medicine.

- **Manipulative and body based systems** are methods of treating a person by way of moving part(s) of the body, or by using substances on/in the body for their physical properties (for example water, heat or oxygen) rather than for their pharmacological properties. Such systems include acupressure, Alexander technique, chiropractic, colonic irrigation, craniosacral massage, cupping, ear candling, Feldenkrais technique, hyperbaric oxygen, iridology, massage therapy, osteopathy and reflexology.

- **Mind body interventions** harness the undoubtedly powerful but currently poorly understood power of the mind to influence a person’s physical health. A good example of such an intervention would be the placebo effect, which can lead to improvements in 90 percent of people with some medical conditions. Other examples, some of which have proven benefits while others do not, include aromatherapy, art therapy, biofeedback, hypnosis, hypnotherapy, meditation, music therapy, psychic surgery, qigong, reiki, shiatsu, spiritual healing, t’ai chi and yoga.

- **Biologically based therapies** fit most closely with modern medical practice in Western countries, whereby medicines are often taken to relieve symptoms or even cure medical conditions. They include herbs, supplements, vitamins and diets, which are considered to be complementary therapies if they have not been fully accepted by the majority of traditional health care professionals.

- **Energy therapies** aim to harness invisible energy fields in order to improve health. There is a wide range of credibility in this category, ranging from measurable, proven energy therapies such as transcutaneous electrical nerve stimulation (TENS), through to implausible and unproven ones such as crystal healing and magnetic therapy.
CAM use is increasing and there are now more visits to CAM practitioners than there are to primary care or family doctors in many developed countries. An interesting aspect of CAM use is that it is almost totally patient driven. Proponents and consumers of CAM will often say that they are worried about the safety of conventional medicines and medical procedures, that the doctor patient relationship is unsatisfactory for them in terms of the perceived power disparity, and that traditional Western medicine treats them as a disease to be cured rather than a person to be healed.

The vast majority of New Zealanders take dietary supplements or use CAM.\textsuperscript{1,2} Despite this, health professionals receive little if any training on this subject and often the patient may know more than the health professional they are consulting with. Studies investigating the knowledge of health care professionals show that they mostly rate their knowledge in this area as inadequate and are not confident in answering patient enquiries, but they do want to learn more.\textsuperscript{3}

**How CAM can harm**

There is a widespread misconception that CAM is safe because it is natural. Not only is this not true, but CAM can harm in a number of ways that may not be immediately apparent.

1. **Direct harm**

   Adverse events from CAM can range from a trivial stomach upset from a herbal preparation to serious injury, disfigurement or even death. Many of the drugs that are used in everyday medical practice are of course extracts from plants themselves. Many more are closely related to plant extracts — in other words, natural products can be every bit as powerful (and harmful) as prescription medications. CAM proponents argue that severe side effects are rare and to a large degree they are correct. However, it is also likely that side effects are more common than is claimed, because unlike for conventional medicines, there are no good systems in place to monitor side effects from CAM therapies.

2. **Indirect harm**

   (i) **Delay.** In general terms, the earlier a disease is detected and treated the better the outcomes will be. Delays in using conventional, proven, effective treatments, due to decisions to try CAM therapies first, can lead to much worse outcomes including death.

   (ii) **Substitution.** A real danger arises when CAM is used as an alternative to proven medical treatments. This can lead to delays in seeking medical treatment, as described above, or even not seeking medical treatment at all. Although homeopathy, for example, can not cause any direct harm, harm can result in other ways, including if it used as a substitute for proven medical treatments or if it delays medical therapy.
3. **Bad advice**

Most CAM practitioners are not trained health care professionals. They have little or no training in anatomy, physiology, pharmacology, microbiology and many other areas of knowledge that health care professionals must have in order to give sound advice, diagnose and treat patients effectively. Without this training many CAM practitioners give out bad advice which can of course be dangerous in itself or cause harm in other ways. There is a whole spectrum of advice quality, from excellent to appalling, and the problem for laypeople is knowing which advice can be relied on.

4. **Psychological harm**

People with cancer and other serious diseases are often emotionally and psychologically very vulnerable. Extravagant claims for unproven therapies can give a patient false hope. Denial is one of the stages in the grief process that occurs with a diagnosis of a serious disease. Bad advice leading to false hope, from misguided or deliberately dishonest CAM practitioners, reinforces this denial stage, interfering with the natural process of grief (which leads to the acceptance phase) and therefore causes psychological harm.

5. **Financial harm**

It has been estimated that around US $1 billion per year is wasted on CAM therapies for cancer that do not work, around the same amount that is spent each year on cancer research. Any money spent on a CAM therapy that does not work is wasted and there are many sad reports of people who, not wanting to leave any stone unturned, have spent all their savings or even lost their family home, trying a variety of expensive and ineffective treatments.

**Evidence based CAM**

Most CAM therapies are not supported by robust clinical trial data, but instead by some or all of: word of mouth, anecdote, inaccurate media reports and exaggerated and inaccurate marketing claims. There are three main reasons why people may think that a treatment, CAM or orthodox, works when in fact it does not.

1. **Placebo effect** — this is a beneficial effect, an improvement in health or a reduction in symptoms, that occurs when a treatment is administered but is not due to the treatment itself, but instead, is a result of complex mind body interactions whereby the expectation of a benefit from a treatment actually results in real benefits. Depending on the condition, up to 90 percent of patients can have an improvement in their health when taking a placebo, which is usually an inert substance such as a sugar pill that looks like a real treatment. Up to 30—40 percent improvements are common in clinical trials in participants who are in the placebo group.

2. **Natural history** — the role of the natural history of the illness when looking at whether a treatment works is often overlooked. Natural history refers to the likely course of events of an illness if it is not treated. For example, symptoms of the common cold will generally last 3—4 days and a cold sore will generally last 5—6 days without specific treatments. In other words, many illnesses will simply get better by themselves over time as the body heals itself.
3. Additional measures — often when a person is ill they will do several things to get better at the same time, but they may attribute the recovery to a single therapy. For example, a person with chronic fatigue syndrome may think that they got better because of the homeopathic remedy that they used, whereas the real reason (if not placebo effect or natural history) could be that they also changed their diet, started doing more exercise or some other lifestyle change.

Controlled clinical trials factor in these and other sources of error as, although they will still be present to some degree, they will be present to around the same level in both the active and control groups, and therefore the difference between the two groups will be due to the treatment under investigation. This of course applies equally to the investigation of orthodox medical treatments as well as CAM.

The New England Journal of Medicine summarised the requirement for CAM therapies to be supported by robust research as follows:

*There cannot be two kinds of medicine — conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. … But assertions, speculation and testimonials do not substitute for evidence. Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatments.*

Some recommended sources of reliable information on CAM are listed in the resources section.

### Medicolegal guidance

The Medical Council issued an updated statement on CAM in March 2011 and it is strongly recommended that doctors who recommend or practise CAM therapies are familiar with the contents. The statement was written to inform doctors of the standards of practice that are expected of them by the Council should they choose to practise CAM or if they have patients who use CAM. It may be used by the Health Practitioner’s Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which a doctor’s conduct is measured.

The key points are that when CAM therapies have demonstrated benefits for the patient and have minimal risks, and patients have made an informed choice and given their informed consent, the Council does not oppose their use, and that no doctor:

* …will be found guilty of a disciplinary offence under the Health Practitioners Competence Assurance Act 2003 merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith.*

Therefore the key issue is the strength, if any, of research evidence that supports the practice, as this underpins whether it has “demonstrated benefits”.

Previous decisions by the Medical Practitioners Disciplinary Tribunal also provide important guidance as to what is expected of doctors in this regards. For example decision 02/89D stated:

*Whilst section 109(4) recognises that a practitioner is not to be found guilty “merely” because he has adopted or practised a theory of medicine or healing, it does not follow that his adoption and practice of any theory of medicine or healing is by itself a sufficient answer.*
In another case the Tribunal stated, among other things:

Where a registered medical practitioner practises “alternative or complementary” medicine, there is an onus on that practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which it is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners. The Tribunal recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are more readily exploited. The faith which such persons place in practitioners offering alternative remedies largely depends on the credibility with which such practitioners present themselves. Where such remedies are offered by a registered medical practitioner, it is difficult to escape the conclusion that the patient derives considerable assurance from the fact that the practitioner is so registered. It follows, therefore, that a registered medical practitioner cannot discharge his or her obligation to treat the patient to the acceptable and recognised standard simply by claiming the particular treatment was “alternative or complementary” medicine.

In assessing complaints or concerns related to the practice of a doctor who has adopted or advocated CAM investigations or treatments, the Medical Council will apply the standards that have been developed for reviewing the competence of any practitioner. In the case of CAM practices it will particularly consider the above comments.

The Health Practitioners Disciplinary Tribunal will also consider whether:

• the methodology promoted for a diagnosis is reliable
• the risk/benefit ratio for any treatment is acceptable
• the treatment is extrapolated from reliable scientific evidence or is supported by a credible scientific rationale
• there is a reasonable expectation that the treatment will result in a favorable outcome compared with placebo
• the practitioner is excessively compensated for the service (i.e., is there any suggestion of exploitation?)
• informed consent has been adequately documented in the medical record.

In assessing the performance of a doctor practising CAM, the Council will not attempt to evaluate the alternative therapy itself, although the critical appraisal skills of doctors may be of concern. The usual domains of competence are assessed, rather than the principles of CAM practice.
Resources

Web
Scientific evidence for popular supplements —
http://www-informationisbeautiful.net/play/snake-oil-supplements

Mayo Clinic — http://www.mayoclinic.com/health/alternative-medicine/PN00001

National Centre for Complementary and Alternative Medicine (NCCAM) —
http://www.nccam.nih.gov

Books


Journals
Focus on alternative and complementary therapies (FACT) —

Complementary therapies in medicine —
http://www.elsevier.com/wps/find/journaldescription.cws_home/623020/description

New Zealand Training course
8 hour RNZCGP CME approved DVD course — http://cammasterclass.weebly.com
References


CHAPTER 25

Doctors and interventions with well people

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**Introduction**

Increasingly, doctors are becoming involved in procedures and interventions sought by people for lifestyle or image reasons, where there is no medical condition, no improvement in health results and there is a charge directly to the person not covered in the health system. Examples are interventions requested to improve appearance, cosmetic surgery without medical indication and some alternative medicine interventions.

Sometimes these interventions are delivered by doctors in organisations that are not primarily medical (beauty clinics for example), and by personnel working alongside doctors who have no “medical” training.

These developments highlight important issues for the profession and for the regulation of these activities.

**Issues**

Doctors being involved in these interventions, raises ethical, resource and regulatory issues. Involvement in nonessential treatments can be attractive to doctors. In many circumstances, there are few complex diagnostic or investigative issues to be grappled with, the people are well, they are generally grateful for the intervention, there is limited ongoing responsibility, and it can be lucrative.

Having a doctor associated with some services lends credibility to the service and promotes the doctor. Especially for appearance medicine, this seems to be uncomplicated work, with limited responsibility and reasonable revenue.

However, there are questions to be asked about doctors using their medical skills in this way. For instance, is it reasonable ethically when medical skills to treat patients are in short supply elsewhere?

The capacity for this field to “medicalise” everyday problems and exploit people is obvious. Offers to “Europeanise” facial features or alter genitals to what is considered the norm, walk a fragile line that it is easy to tip over from into prejudice and discrimination.

Advertising in an ethical way is a prominent issue. Competition promotes interprofessional rivalry. Many of the problems that arise are driven by income and financial concerns, which appear to strike at the heart of the altruism that is expected as a part of professional practice.
Discussion and recommendations for doctors

Some doctors feel that because they are working at a beauty therapy clinic, or outside their normal practice, that they are absolved from the kinds of professional and regulatory expectations that apply elsewhere. But as Daniel Sokol reminds us, “you are a doctor, not a tattoo artist”.

A doctor is always a doctor. When working with people in any context the professional, including ethical, principles that guide our profession continue to apply. Adequate followup of treatments, communications with someone’s usual doctor and adequate records, are some of the usual professional obligations that continue to apply, whatever the nature of the practice. The Medical Council will expect that doctors always practice within the standards and guidelines it sets down.

A recent comprehensive report on cosmetic medical and surgical procedures prepared under the auspices of the Australian Health Minister’s Conference, pointed out that safe interventions for consumers involved five interdependent elements “the procedures, the promotion of the procedures, the practitioner, the patient and the place.”

Procedures need to be safe. The use of drugs, chemicals and technology, including laser is expanding. As a doctor there is an ongoing responsibility to ensure that procedures have been adequately researched and that any harm they may cause is within acceptable limits. Even apparently simple interventions like face peels can cause problems.

Advertising must meet the Council’s guidelines. If a doctor is associated with a service, particularly if that doctor’s association is used to increase the credibility of the organisation, the doctor has a responsibility to make sure that standards are met. This includes offering discounts, “specials” or prizes. People must have the freedom to reflect on decisions about nonessential treatments, without being driven to decide something by time limits for reduced prices.

The Council expects that doctors have adequate training in procedures they perform, have systems to maintain that competence, adequate supervision and recognise their limits. Titles are important. People should not be misled. The Council has taken steps to regulate some aspects of cosmetic practice and has a comprehensive statement on the issue.

Because performing elective procedures may involve a conflict of interest, informed consent is central to doctor’s responsibilities in this area. Health consumers need to know potential outcomes, risks and costs fully and recommendations for expensive treatments have to be put in context of their necessity and alternatives. Doctors have to make sure that the person’s expectations about outcome are realistic. Sometimes this might mean that you need to persuade your patient that a cosmetic procedure is not the solution.

There should be sufficient consultation time for the patient and thoroughness from the doctor, for a complete history and relevant examination to be undertaken.

Facilities need to support a doctors’ work. Simple issues like the provision of privacy for consultation, examination equipment and a couch for examination if needed can be of crucial importance if a doctor is asked later why they did not perform appropriate examinations and investigations.
Doctors are also capable of being exploited. Organisations set up to profit from nonessential interventions want doctors involved to add credibility and deliver their product or intervention. The systems that such organisations have in place do not always meet the professional and medical practice standards that will be expected of doctors. Doctors need to be sure that they are adequately supported and that the systems are robust and safe. Once you are associated with an organisation, you share some of the responsibility.

In the transition from caring for the unwell patient who needs care, to caring for the well patient who chooses to have care, it is easy to slip into business mode. The “patient” becomes the “client” and your relationship with them changes. But it is important not to lose sight of your role as a doctor, your duty to protect patients from harm, and the conflicts that arise when you are rewarded for providing such services.

References
CHAPTER 26

The pharmaceutical industry and the profession

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Inevitably there is a close relationship between doctors and the pharmaceutical industry. Doctors prescribe drugs, design and execute drug trials, advise individual drug companies, are employed by drug companies, and receive drug company sponsorship for a range of activities. While some pharmaceutical companies adhere to codes of ethics, others do not.

This coupled with the susceptibility of some doctors to accept pharmaceutical company generated data as their sole source of information about a drug, has led to serious patient harm including deaths.

Intense media interest in such cases has brought the relationship between doctors and pharmaceutical industry into sharp relief, and the public and patients are no longer excluded from the debate.

As a starting point there is a fundamental difference in the focus of the two players in this; the doctor’s primary focus must be on the well being of the patient; the pharmaceutical company’s primary focus is on profit. It is not a level playing field; pharmaceutical companies have vastly more resources available to influence the way doctors work than doctors have to resist them.

Medicines New Zealand — a voluntary organisation, which has as members all the large pharmaceutical companies) — has a code of ethics which recognises the potential for patient harm and covers many aspects of the pharmaceutical industry interactions with doctors. For example, in the section on Direct to consumer advertising, it contains this advice, “Information directed to consumers should be accurate, balanced, not misleading and due consideration should be given to the role of the health care practitioner.” New Zealand and the United States are the only two OECD countries in which direct to consumer advertising is legal. Other countries have chosen to mitigate the risk this activity presents to patients, by making it illegal.

A handful of medical colleges worldwide have also responded to public criticism by writing codes for their members. The American Psychiatric Association (APA) has eliminated all industry sponsored symposia at its annual meeting. The Royal Australasian College of Physicians (RACP) has a code of conduct for its members giving advice on member interactions with the pharmaceutical industry.

The “marketing techniques” of pharmaceutical companies have successfully influenced prescribers, and have resulted in patient harm.

In 2012 Glaxo Smith Kline (GSK) will pay $3 billion to the United States Department of Justice in the largest fraud settlement in US health care history. It is alleged that GSK promoted “off label” uses of drugs and failed to report safety risks. In one example it promoted (by the creation of a medical journal article) the use of the antidepressant paroxetine as being safe in paediatrics when several previous journal articles had refuted this. GSK has also pleaded guilty to failing to report safety data around cardiovascular risks with the use of the diabetic drug rosiglitazone.

If the sum of $3 billion seems eye wateringly large, note that the US pharmaceutical industry as a whole expects to pay a total of $8 – 9 billion in fines in 2012 and that GSK had a taxable profit of $44 billion in 2011.
Is this an isolated case? Sadly no. Almost every major pharmaceutical company in the US has paid millions of dollars in fines or reached a settlement with the US Department of Justice over fraud cases in the last decade. In 2010 the pharmaceutical industry reached the dubious distinction of passing the notoriously corrupt defence contracting business in the dollar value of fines paid. A cynical view might be that the cost of the fines has simply been factored in to the cost of doing business for these companies because the fines do not come close to the additional profit made from the fraud.

Terfenadine and rofecoxib (Vioxx) are just two recent examples of widely prescribed drugs that caused serious morbidity and death before being withdrawn from the market.

Advertisements for drugs for mild to moderate depression do not allude to the studies showing that regular physical exercise is as effective an antidepressant for many (not all) patients as tricyclics and SSRIs.

Doctors should exercise good judgment and not look to a company for impartial critical education about any product it sells.

**Prescribing**

After diagnosis, there are a number of steps that should precede the writing of a prescription. What are the available options for altering the natural history of this disease? What is the best choice of an appropriate drug, or nondrug therapy. It is this last step that the pharmaceutical industry has an intense interest in influencing. In the most affluent countries in the world the prescribing of pharmaceuticals is tightly regulated and the “sales” are determined almost exclusively by the medical profession. Therefore a pharmaceutical company will do considerable work to persuade doctors that:

- drug therapy is superior to nondrug therapy, and
- a particular agent (theirs) is superior to all other agents.

Changing doctors’ prescribing behaviour is not easy. Sustained effort on a number of fronts is necessary. Thus there are advertisements in medical journals, and other publications, direct to doctor mailings and incentives offered to doctors to prescribe specific agents. Pharmaceutical company personnel will arrange general practitioner access to specialists who will endorse prescriptions for restricted drugs. “Detailing” by company representatives is common, as are sponsored medical education sessions, and sponsorship of medical conferences. If a doctor fails to manage successfully the inherent conflicts of interest which arise from these interactions with the industry, then best patient care will be compromised.

This will occur if the doctor:

- allows his relationship with a pharmaceutical company to result in a prescription that is not the best treatment for his patient
- allows the clinical trial data the pharmaceutical company has presented to him to be his sole source of education
- allows biased or incomplete trial data to influence his prescribing.
Many doctors claim that their relationships with the pharmaceutical industry do not influence their prescribing. The pharmaceutical industry does not share this view and has data to prove it. Relationships between health care professionals and industry can lead to confusion about goals.

Both health care decision making and the conduct of research have been profoundly affected by pharmaceutical companies, in ways that are not beneficial to patients. There are a number of objective studies that show that the pharmaceutical industry is successful in influencing doctors’ prescribing. In addition, pharmaceutical companies themselves track sales (ie, prescriptions written) figures by region.

Drug promotion is a sophisticated commercial activity with the intention of overtly and covertly altering doctors’ thinking. Considering the level of investment they make, it is not surprising that pharmaceutical companies promote their products with the most effective marketing tools available. One area of very high risk is where pharmaceutical companies seek to be involved in the production of educational material for doctors. Doctors need to recognise that, like other consumers, they are susceptible to marketing and should actively seek unsponsored objective education about new drugs so that patient care is not compromised.

Finally the “medicalisation” of conditions formerly viewed as lifestyle or behavioral matters and, as noted previously, the expansion of existing diagnostic criteria to make increasing numbers of patients eligible for drug therapy, are areas where the pharmaceutical industry takes a keen interest. The recent proposed expansion of the DSM IV criteria for Attention Deficit Hyperactivity Disorder and the influence that the industry is exerting to promote these proposed changes is a case in point. There is clear ambiguity in the advantage to those currently (and those who will be) diagnosed, and the long term effects of current drug therapy are unknown.

Research

There are number of areas of potential conflict of interest for doctors here:

- Doctors who are researchers can have a direct financial interest in the design or the conduct or the outcome of a clinical trial
- Individual researchers are increasingly becoming involved with the commercialisation of their own work
- Individual researchers sometimes retain the intellectual property to their own work
- Financial compensation for doctors who are investigators in clinical trials sometimes appears to be at a level that is not commensurate with the work performed
- Researchers sometimes stand to gain in nonprofit ways from the results of clinical drug trials
- Researchers sometimes have to make a decision about whether to publish unfavourable results, as a result of which future financial rewards, and future employment with the pharmaceutical company may be lost.
Doctors who are researchers need to be aware that, unless these risks are managed properly, the results of their research will be seen as neither reliable nor impartial. There are documented cases where patient care has been compromised (including death) by the implementation of the results of such research. At the trial design stage, the doctor must consider whether the proposed study sets out to answer questions which are sufficiently important to justify the study, whether the risks to which the patients are exposed are reasonable, considering the likely benefits, whether the study design is appropriate, and whether patients will be able to consent freely with appropriate levels of informed consent.

When a doctor is involved in research he must declare apparent conflicts of interest to the ethics committee which is involved in approving the trial. The doctor must allow others to determine whether the apparent conflicts are potential or real, and must take steps to separate the conflicts by withdrawing from or curtailing certain activities and by delegating these functions to others. He must communicate these decisions to fellow researchers and to the participants in the research.

**Summary**

In spite of widely held notions by doctors of immunity to their influences, the activities of the pharmaceutical industry do affect the behaviour of doctors in ways that are not always conducive to providing the best patient care. Unless these risks are managed appropriately doctors will be breaching ethical and sometimes legal boundaries. The Code of Health and Disability Services Consumers’ Rights makes reference to patients who are subject to research (right 9). When considering whether or not to interact with the pharmaceutical industry doctors should ask themselves, “Might there arise a conflict of interest in this activity which could compromise my ability to provide impartial and best quality patient care?”
CHAPTER 27

How medical practice standards are set by legislation 1: the Health Practitioners Competence Assurance Act

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The regulation of health professionals in New Zealand is governed by the Health Practitioners Competence Assurance Act 2003 (the HPCAA 2003). The principal purpose of the HPCAA 2003 is to protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise medicine. This provides the framework for the policies, procedures and standards applied by the Medical Council of New Zealand (the Council) to the regulation of doctors.

The intention of the HPCAA 2003 is to increase consistency, transparency and efficiency in the regulation of health professionals. In applying the mechanisms under the Act, the Council applies the principles of natural justice, with the Council striving to make well informed and reasoned decisions.

The HPCAA 2003 details a number of important functions that the Council is required to perform, including but not limited to:

- determining scopes of practice and qualifications required for registration
- registering doctors in specific scopes of practice
- requiring doctors to demonstrate competence at registration and maintenance of competence when applying for practising certificates
- conducting competence reviews (performance assessments) and requiring programmes for up-skilling or retraining of doctors who are not practising at the required standard
- receiving notifications of any mental or physical conditions affecting the fitness of a doctor to practise medicine (referred by Council to its Health Committee where necessary for expert assessment and follow up)
- setting standards of cultural and clinical competence, and ethical conduct
- accrediting branch advisory bodies,1 medical schools and intern runs.

**Registration**

Under the HPCAA 2003, Council is required to define what falls within “the practice of medicine” in New Zealand in terms of one or more “scopes of practice”. These “scopes of practice”, define aspects of the practice of medicine and the health services that a doctor may provide within the scopes.

The HPCAA 2003 requires that each doctor must be fit to practise, hold a relevant qualification “prescribed” by the Council, and be competence to practise within the scope of practice applied for. These prescribed qualifications will vary between the different scopes of practice. In many cases, a “prescribed” qualification will be an identified medical degree, or fellowship of a medical college, but in some cases the Council will require a combination of a medical degree, and additional training, or approved experience. In such cases, the doctor will be required to meet all these requirements before he or she will be recognised as holding the “prescribed” qualification.
In assessing an application for registration, the Council may consider placing one or more conditions on a doctor’s scope of practice. Examples include conditions requiring a period of supervision in a specified position or identifying a form of assessment that must be completed upon which the limitation may be removed. Such conditions do not necessarily suggest an identified competence, conduct or health concern. Instead, they enable a doctor to be registered in a practice context that best corresponds to the areas that the doctor has previously worked in, or been formally assessed in.

Practising certificates

A doctor must hold a practising certificate to practise medicine in New Zealand. The practising certificate is valid for a period of time, up to 1 year. The certificate records the doctor’s registered scope(s) of practice, place of work, supervision requirements and/or conditions (if applicable).

Scopes of practice

General scope of practice (and provisional general scope of practice)

New Zealand and Australian medical graduates who have completed their internships in either country are eligible for registration in a general scope of practice after a year of provisional registration and supervised practise. These graduates will have a year of provisional registration first (which is the internship).

International medical graduates (IMG) who apply for registration in New Zealand in a general scope of practice must first be eligible or become registered in a provisional general scope of practice. This allows Council to determine whether a doctor is able to work at the required standard required in the New Zealand health system.

Doctors registered in a provisional general scope of practice are required to work satisfactorily under supervision in an approved position or positions for 6-12 months consecutively to qualify for registration in a general scope of practice. Once the doctor has satisfied the Council that all conditions have been met under their provisional general scope of practice, they can then apply for registration within a general scope of practice.

Vocational scopes of practice (and provisional vocational scopes of practice)

The vocational scopes of practice are the scopes for specialised medical practice. There are currently 36 different vocational scopes of practice. Each scope has an accredited postgraduate training programme and prerequisite (‘prescribed’) Australasian postgraduate qualification.
International medical graduates who hold a postgraduate qualification (but not the prescribed Australasian qualification) and who wish to apply for registration within a vocational scope practice, must first be registered within a provisional vocational scope of practice. In deciding whether to register IMGs in a provisional vocational scope, the Council seeks advice from the branch advisory bodies. The BAB will advise Council whether the doctor has training, qualifications and experience equivalent to, or as satisfactory as, that of a doctor trained in New Zealand who holds the prescribed qualification. The Council considers this advice in making its final decision.

**Special purpose scopes of practice**

The Council provides special purpose scopes of practice for short-term registration. Registration in these scopes of practice is limited in duration and is for a range of defined purposes. They provide registration options for doctors wishing to teach, train, conduct research, work as a locum specialist, assist in an emergency or pandemic scenario in New Zealand or provide teleradiology to New Zealand health services.

Doctors may work as a postgraduate trainee registered in a special purpose scope of practice for a maximum of 2 years. This registration option is specifically designed to allow IMGs to work in New Zealand and gain skills and experience that they can take back to their countries of origin. Time registered in a special purpose scope of practice as a postgraduate trainee will not be counted toward gaining registration in any other scope of practice.

**Recertification**

To maintain the right to practice doctors must meet ongoing recertification requirements. For the general scope of practice, this is achieved by maintaining a collegial relationship. Doctors must also meet other continuing professional development (CPD) requirements, including audit of medical practice, peer review and CME. Within a vocational scope of practice, doctors must participate in an approved recertification programme.

**Professional standards**

**Competence and performance**

The Act permits the Council to review the competence of a doctor to practise medicine at any time, whether or not there is a reason to believe the doctor’s competence may be deficient. Commonly, however, such reviews follow formal notification to the Council of potential competence concerns. The HPCAA 2003 refers to “competence” (ability) and “standard of competence” (performance). This distinction means that the ability to practise well is not enough; any assessment also needs to show whether the doctor is actually practising well (ie at the required standard of competence”).
A competence review (also known as a performance assessment) is a broad-based assessment of how the doctor is practising, using a variety of assessment tools (including notes reviews and peer assessment). The process is thorough, and is ultimately intended to be educative. If following the assessment, the Council has reason to believe that the doctor does not meet the required standard of competence, the Council must make one or more of the following orders:

- that the doctor undertakes a competence programme (also known as an educational programme)
- that conditions be placed on the doctor’s scope of practice
- that the doctor sits an examination or assessment
- that the doctor is counselled or assisted by a named person.

In most cases the Council orders a 12-month education programme, with specific, targeted standards for the doctor to achieve.

**Conduct**

The HPCAA 2003 enables the Council to appoint a professional conduct committee (PCC) to investigate complaints about conduct, or to investigate the circumstances of offences committed by doctors.

Most complaints about a doctor’s conduct the Council receives must first be referred to the Health and Disability Commissioner (the Commissioner) and may not be referred to a PCC until the Commissioner informs the Council that:

- the matter is not being investigated by the Commissioner; or
- the matter has been resolved by the Commissioner; or
- the Director of Proceedings will not be considering or proceeding with the matter.

If a doctor is convicted of an offence punishable by imprisonment for a term of 3 months or more, the Council will be notified and is required under the Act to refer the matter to the PCC for an investigation (regardless of the actual sentence ordered by the Court).

For other matters, the Council has residual power to refer the matter to a PCC if the Council considers that information in its possession raises one or more questions about the appropriateness of the practice or conduct of the doctor.

After considering a case the PCC may make a number of recommendations to the Council, including recommending that Council review a doctor’s competence or fitness to practise, or scope of practice (including placing conditions on their scope of practice), and in some cases referral to the police. The PCC may, alternatively, make its own determinations, independent of the Council. These include laying a charge before the Health Practitioners Disciplinary Tribunal (HPDT).
Interim suspension or imposition of conditions

In association with a review of a doctor’s competence or conduct, Council has powers in more serious cases to suspend a doctor’s right to practise, or impose conditions on a doctor’s scope of practice, for an interim period. The processes differ, depending on whether the core concern relates to matters of competence or conduct.

Conduct

Council may also place an interim suspension on a practising certificate or place conditions on a doctor’s scope of practice, where Council believes on reasonable grounds that a conduct issue casts doubt on the appropriateness of the doctor’s conduct in their professional capacity.

The Act does not always require that a matter be before a PCC before action can be taken. The Council may also consider imposing an interim suspension or conditions when a doctor’s alleged conduct is relevant to a pending criminal proceeding or is being investigated by the Commissioner.

Competence

Where a doctor’s competence is being or has been reviewed, and the Council considers it has reasonable grounds for believing the doctor poses a risk of serious harm to the public by practising below the required standard of competence, the Council may propose conditions or suspension for an interim period. The condition or suspension will remain in effect until the performance assessment is completed or the doctor has passed an examination or assessment required by Council.

However, in either situation, Council adheres to natural justice principles and the specific provisions in the Act. Council will first propose its decision and give the doctor the opportunity to provide submissions and be heard by Council before finalising any proposed interim suspension or conditions.

Health Practitioners Disciplinary Tribunal (HPDT)

The HPDT hears and determines charges brought by the Director of Proceedings or by a PCC. The main purpose of the HPDT is to protect the health and safety of the public from incompetent and improper conduct by doctors by ensuring that doctors conform to standards reasonably expected from them.

A doctor can be charged with ‘professional misconduct’. Should the doctor be found guilty then the gravity of the doctor’s offence is reflected in the nature of the penalty imposed by the HPDT. Penalties could include the cancellation of a doctor’s registration, suspension for a period of up to 3 years, imposition of conditions, a fine not exceeding NZ$30,000, and censure.

Decisions of the HPDT may be appealed to the High Court. The High Court decision is final and can only be appealed to the Court of Appeal on points of law.
References

1. Section 12(2) of the HPCAA 2003 lists the aspects that may form part of a prescribed qualification, which include training, educational qualification and experience. Once a doctor is registered, their authorised scope of practice is entered on the publicly-available medical register, along with any conditions.

2. Council has a system of accrediting and reaccrediting the postgraduate training and recertification programmes associated with each vocational scope.

3. See 2

4. The Office of the Health and Disability Commissioner was created under the Health and Disability Commissioner Act 1994, to promote the rights of the health and disability services consumers and facilitate the fair, simple, speedy and efficient resolution of complaints.

5. The Director of Proceedings (DP) is a lawyer appointed under the Health and Disability Commissioner Act. When the Commissioner has found a breach of consumer rights, he may refer the provider to the DP. The DP reviews the case and makes an independent decision on whether or not to take any further action.
# CHAPTER 28

How medical practice standards are set by legislation 2: other legislation

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Introduction

Medicine is a risky business, and where there is risk, governments usually like to enact laws. Many of these laws have a direct impact on the way you practise medicine. Some grant you protections and powers, others place limits on what you can do. It is important that you have a basic understanding of these laws before they have an impact on your practice.

Other chapters in this book deal with specific areas of medical law in detail. The Council also provides a variety of statements, which discuss how aspects of the law apply in particular situations. This chapter aims to provide a brief overview of aspects of the law not discussed elsewhere in this book and discuss how they apply to your practice. Much of the law is complex and this chapter is unlikely to answer all of your questions. If you are unsure about something, ask a colleague or an adviser from your medical indemnity insurer.

The Acts and regulations mentioned below can all be read online at www.legislation.govt.nz.

Prescribing medicines

The Medicines Act 1981, the Misuse of Drugs Act 1975 and the Medicines Regulations 1984 provide controls over the manufacture, storage, prescribing, dispensing and advertising of medicines. Medicines Control, a regulatory team in the Ministry of Health, is responsible for monitoring and administration of medicines and controlled drugs and staff can provide you with advice on the legislation and your responsibilities. The Council has also issued a portfolio of statements on Good prescribing practice which outlines its expectations in the context of these laws.

Good prescribing practice

The issuing of prescriptions for prescription medicines is legally restricted. In particular, you should be aware that while a doctor can generally prescribe from the full range of approved medicines, he or she is only permitted to prescribe for a patient “under his or her care” and “within and in accordance with all conditions (if any) stated in, [his or her] scope of practice...”. The Regulations require that your prescriptions be “legibly and indelibly printed” and include: your signature (not a facsimile or stamp); the date; your full name, your address; the name and address of the person for whom the prescription is given (and date of birth if they are a child under 13 years); the name and strength of the medicine; the total amount to be dispensed; dose and frequency (and method of delivery in some cases); the number of occasions on which it may be supplied; the interval between each date of supply; and the period of treatment. You should also include a contact phone number and medical registration number. Prescriptions for some controlled drugs must be written on a prescribed form and require additional information.
You should also ensure that your prescriptions include all the information needed for appropriate dispensing and compliance with subsidy requirements. It is wise to avoid using any abbreviations that could be misunderstood. Mistakes, missing information or illegibility can have serious consequences. It is not permissible to issue prescriptions by email or other electronic means. Faxed or telephone prescriptions are permitted, but only in cases where a medicine is needed urgently. In such cases the original prescription must be forwarded to the pharmacist within 7 days. Be aware that the Medicines Act and Regulations are currently under review, and the requirements may well change in the following months. The Council will advise you of any relevant changes, and will update Good Prescribing Practice to incorporate any legislative amendments.

Approved medicines and their uses are outlined in MIMS New Ethicals, and you should keep a copy on hand. If you prescribe an unapproved medicine (or a medicine for a purpose for which it has not been approved) you should advise the patient of the unapproved status of the medicine and be frank about the standard of support for the use of the medicine and any safety concerns. You are also required to pass certain details relating to the supply of that medicine to the Director General of Health.

**Drugs of abuse**

The Misuse of Drugs Act classifies some medicines as “controlled drugs”, and further classifies these according to the risk of harm they pose. “Class A” controlled drugs are very high risk (for example cocaine, heroin and methamphetamine) and these are almost unprescribable. “Class B” controlled drugs (high risk) include methadone, morphine and pethidine, while “Class C” controlled drugs (moderate risk) include codeine, diazepam and temazepam.

Inappropriate prescribing of drugs of abuse is unacceptable, both clinically and ethically. It is usually also against the law. In particular you should be aware that it is illegal to prescribe controlled drugs to any person deemed a “restricted person” by a Medical Officer of Health. If you prescribe drugs that have the potential for abuse you should make sure you are aware of any restricted persons living in your area. Lists of restricted persons are maintained through prescriber updates and peer review processes. If you have any doubts about the appropriateness of a request for drugs, especially controlled drugs, it is wise to discuss your concerns with an adviser from Medicines Control.

Section 48 of the Medicines Act 1981, section 23 of the Misuse of Drugs Act 1975 and the Health Practitioners Competence Assurance Act 2003 empower the Medical Council to inquire into the prescribing of any doctor to consider and determine whether he or she is prescribing inappropriately. If the Council has concerns then it can recommend to the Minister of Health that a doctor be prohibited from prescribing all, or specific classes of, prescription medicines.

Under section 24 of the Misuse of Drugs Act it is an offence to prescribe, administer or supply a controlled drug to a person you believe is dependent on that drug for the purpose of treating dependency, unless you are an authorised person (or working for an authorised facility).

If you hold or dispense controlled drugs then you are required to keep a controlled drugs register. You are also required to keep “Class A” and “Class B” controlled drugs and your controlled drug prescription pad in a secure cupboard or compartment, which is of metal or concrete construction.
Standing orders

The requirements for initiating and using standing orders are set out in the Medicines (Standing Order) Regulations 2002. These only allow medicines to be administered or supplied to patients by way of a standing order if certain conditions are met. If you delegate the administration or supply of medicines to a nondoctor colleague by means of standing orders, then you need to make yourself familiar with these conditions and with the Ministry of Health’s Standing Orders Guidelines. If you sign a standing order, then the responsibility for the effects of the medicines administered or supplied under that standing order rests with you, and you must also countersign the charted treatment or record and put in place a process to monitor and review the correct operation of the standing order.

Crimes Act 1961

The Crimes Act 1961 imposes a legal duty on those who “undertake... to administer surgical or medical treatment” to have and to use reasonable knowledge, skill, and care. An omission or failure to discharge this duty without lawful excuse will leave you criminally responsible for the consequences. However, the law also provides you with a degree of protection from prosecution in circumstances where you do administer treatment in accordance with this duty.

If you perform a surgical operation with reasonable care and skill on any person for that person’s benefit, then the Crimes Act provides you with protection from criminal responsibility. This section applies if the performance of the operation was reasonable, having regard to the patient’s state at the time and to all the circumstances of the case. You are also protected if you perform a surgical operation with reasonable care and skill when you have the patient’s consent and the operation is for a lawful purpose.

So long as you comply with either of these sections, you cannot be charged with a crime such as manslaughter if something goes wrong. The common law also contains “Good Samaritan” principles which may protect you from legal action if you perform a procedure in an emergency.

Withdrawal of care and euthanasia

Section 151 of the Crimes Act places legal duties on any person “who has actual care or charge of a person who is a vulnerable adult” to provide himself or herself with necessaries. Under this section, you are required to supply a sick person in your charge with “the necessaries” and to take reasonable steps to protect that person from injury. Although not defined, “necessaries” could include medical and hospital treatment. However, the law also recognises a distinction between “active killing” and merely allowing someone to die by the withdrawal of life support. The New Zealand Court of Appeal has upheld the withdrawal of treatment in circumstances where the court was satisfied that treatment was futile and merely prolonging death.

Under the New Zealand Bill of Rights Act 1990, withdrawal of care necessary to keep someone alive is also permitted if the patient refuses it.
In a recent incident a severely physically disabled patient refused to accept nourishment needed to keep her alive. In this case her carers made sure that they offered her treatment every day, ensured that she was well informed about the consequences of her decision and documented these discussions.

Euthanasia, the provision of treatment when the primary aim is to assist a patient to die, is illegal. When a medical or surgical treatment is not for the patient’s benefit or where it is not “reasonable”, then a patient death may result in a conviction for murder (if deliberate) or manslaughter. In 2001 a doctor was convicted of manslaughter of his mother who was nearing the end of her life. He injected her with a cocktail of drugs in significant quantities that she might die and he also strangled her.

Protecting vulnerable patients

You have a responsibility to report suspected child abuse, or abuse of a vulnerable adult patient, as part of your responsibility to patients and the community. A change to the Crimes Act 1961 in March 2012 made this ethical obligation a legal one. Section 195A states that a staff member of a hospital, institution or residence where a child or vulnerable adult resides commits an offence if he or she knows that the person is at risk of death, grievous bodily harm, or sexual assault and fails to take reasonable steps to protect that person.

Section 15 of the Children, Young Persons, and their Families Act 1989 allows you to report ill treatment or neglect of children and young persons to the Police or a social worker. You do not need to seek authorisation from a child or parent before making this disclosure and section 16 provides you with protection from civil, criminal or disciplinary proceedings for doing so (although this protection does not apply if the disclosure is made in bad faith).

Public health

The Health Act 1956 is intended to improve, promote and protect the public health. It covers a range of issues, such as ensuring the safety of drinking water and giving certain officials the power to quarantine ships or aircraft. It also outlines the statutory duties and responsibilities of Medical Officers of Health and sets out when and how doctors must notify infectious and notifiable diseases.

Section 74 states that if a doctor has a reason to believe that a patient is suffering from a notifiable disease then he or she must advise their local Medical Officer of Health. The local authority must also be informed in some cases. If the notifiable disease is infectious, then the doctor must also “inform the occupier of the premises and every person nursing or in immediate attendance on the patient of the infectious nature of the disease and the precautions to be taken”.

The list of diseases and infectious diseases which must be notified are set out in Schedule 1 and Schedule 2 of the Act. Under the Tuberculosis Act 1949 you must also notify your local Medical Officer of Health of cases of tuberculosis.
Cervical screening

The Health (National Cervical Screening Programme) Amendment Act 2004 established a national cervical screening programme intended to reduce the incidence and mortality of cervical cancer. Under the Act you must tell a woman about the screening programme whenever you take a specimen from her for the purpose of a screening test, or perform a colposcopic procedure. If this is the woman’s first screening test or you are performing a colposcopic procedure, you must also tell her about the importance of having regular screening tests; the objectives of the screening programme; who has access to information on the programme’s register; and how that information might be used. For colposcopic procedures you must also tell the woman that she will be automatically enrolled on the programme, but may withdraw at any time.

Section 112ZB of the Act also states that you must make health information and specimens available to a screening programme evaluator, but the evaluator is bound by strict confidentiality rules to ensure that the patient’s privacy is protected.

Contraception, sterilisation and abortion

The Contraception, Sterilisation and Abortion Act 1977 and section 174 of the Health Practitioners Competence Assurance Act 2003 outline the duties of doctors in respect of reproductive health services. If you are likely to be approached for contraception, sterilisation or abortion services you should be familiar with the requirements of these complex pieces of law.

Assisted human reproduction

The Human Assisted Reproductive Technology Act 2004 regulates assisted reproductive procedures, prohibits some unacceptable procedures (such as sex selection of human embryos) and prohibits commercial transactions relating to human reproduction. Organisations that wish to perform assisted reproductive procedures or conduct research into reproduction are required to first obtain the written approval of a specially designated ethics committee.

The Act also establishes an information keeping regime to allow people born from donated embryos or donated cells to find out about their genetic origins.

Advance directives and enduring powers of attorney

Advance directives and enduring powers of attorney are methods that patients can use to ensure that their treatment wishes are met, even after they are no longer able to communicate those wishes to you.
An advance directive is also sometimes referred to as a living will. Right 7(5) of the Code of Health and Disability Services Consumers’ Rights says that “every consumer may use an advance directive in accordance with the common law”. The Code goes on to define an advance directive as “a written or oral directive

• by which a consumer makes a choice about a future health care procedure; and
• that is intended to be effective only when he or she is not competent.”

This means that a person can make an advance choice about receiving or refusing services. In some countries there is specific legislation setting out requirements that need to be followed and met before such a directive is legally valid. There is no equivalent legislation in New Zealand, and the validity of an advance directive under common law is currently unclear.

Although the law is not clear, there are some steps that it would be prudent for you to take before acting in accordance with a patient’s advance directive or living will. You should ensure that the advance directive was made without undue influence and that the patient was competent and fully informed about the consequences of their decisions.

You should also be satisfied that the patient intended the advance directive to apply to the current situation and that they reviewed the advance directive recently.

The Protection of Personal and Property Rights Act 1988 allows a patient formally to nominate someone else to make personal care and welfare decisions on his or her behalf should he or she become mentally incapable. If a patient has appointed someone to act as an “enduring power of attorney” with respect to their personal care and welfare and has been assessed as lacking capacity, then you should generally treat the lawyer as the patient for most information and consent purposes. However, section 18(1)(c) of the Act specifically forbids the lawyer from refusing consent “to the administering... of any standard medical treatment or procedure intended to save (the patient’s) life or to prevent serious damage to that person’s health.” In making decisions about the patient’s personal care and welfare the attorney must consult, as much as possible, with the patient and with other people named and must have regard for any advance directive expressed by the patient. If you are concerned that an lawyer has made a decision which is not in the patient’s interest, then section 103 empowers you to ask a court to review that decision.

**Fitness to drive motor vehicles**

The Land Transport Act 1998 requires you to report to the Chief Medical Adviser of the New Zealand Transport Agency when:

• in your judgment a patient is not medically fit to drive
• you have advised the patient not to drive
• you believe or know that the patient is continuing to drive despite this advice.
Some drivers (for example, drivers over the age of 75 and bus drivers) are required to regularly obtain a medical certificate to state that they are medically fit to drive a motor vehicle. When assessing such a driver and completing a certificate, you are required to consider the information contained in the booklet entitled *Medical aspects of fitness to drive*. This can be downloaded from the Agency website.

At some point you might be called on to take a blood specimen for evidential purposes from a person who is suspected of an offence relating to alcohol or drug involved driving. The Act allows you to take a blood sample without a person’s consent if they present as a result of a motor vehicle accident, or when an enforcement officer asks you to. When taking a blood sample you must be satisfied that doing so would not be prejudicial to the person’s proper care or treatment and must tell him or her (unless they are unconscious) that the blood specimen is being taken for evidential purposes.

### Deaths and medical certificates of causes of death

The requirements for the issuing of a “Medical certificate of causes of death” are outlined in the Burial and Cremation Act 1964. This Act states that a doctor attending a patient who dies as a result of an illness must sign such a certificate “immediately after the doctor learns of the death”. Urgency is often important in such situations, because the body cannot be released for burial or cremation until you have issued the certificate.

If you were not the last doctor to attend the patient during the illness you may only complete the certificate if you are satisfied that the death was a result of the illness and:

- the doctor who last attended the person during the illness is unavailable; or
- less than 24 hours have passed since the death, and the doctor who last attended the person during the illness is unlikely to be able to complete a certificate within 24 hours after the death; or
- 24 hours or a longer period has passed since the death and the doctor who last attended the person during the illness has not completed a certificate.

In such situations you are required to consider the patient’s medical records and the circumstances of their death; and to examine the body before completing a certificate.

You should be as precise and specific as possible when completing a certificate of causes of death. The information you provide not only appears on the official death certificate issued by the Births, Deaths, Marriages and Relationships Registration Office, but is also used in the national cause of death statistics that are reported to the World Health Organisation.

You should pay particular attention when specifying the underlying cause of death. Often it can be a combination of a number of serious conditions that leads to the death of the person. In such cases you should record the condition which you believe is most likely to have initiated the train of morbid events leading to the death. There are a range of specific provisions that apply to issuing death certificates in different circumstances (for example stillbirths, or where an elderly patient dies as a result of an accident).

There are some circumstances when you should not issue a certificate, and must instead report a death to the police. These circumstances are outlined in section 13 of the Coroners Act 2006 and include when:

- death appears to be without known cause, suicide, unnatural or violent
- death occurs during or apparently as a result of some medical, surgical, dental or similar operation or procedure
- death occurs while a person was affected by an anaesthetic or the result of the administration of the anaesthetic
- death occurs while the woman was giving birth, or that appears to have been the result of the pregnancy or giving birth
- death occurs in certain types of institutions or custody, including police or prison custody, or treatment facilities for mental illness or alcohol or drug addiction.

Once you have notified the Police they will usually make some enquiries and then notify a coroner. The coroner might then contact you, and in some situations might require you to complete a written report. If you are uncertain about your obligations in these circumstances or how to go about completing a report then you can contact a coroner directly and a 24 hour phone service has been set up to facilitate this. The number for this service is (04) 910 4482.

References

1. Refer to Appendix A.
2. Telephone: Northern Region (09) 580 9088, Central Region (04) 496 2437 or Southern Region (03) 474 8492
3. These are Good prescribing practice, Prescribing drugs of abuse, and Prescribing performance enhancing medicines in sport.
4. For more information, refer to the Council's statement on Good prescribing practice.
5. Although there are often separate subsidy requirements which must be met, and the Council requires that you only prescribe “within the limits of your competence”.
6. Medicines Regulations 1984. Regulation 39. Refer to Good prescribing practice for a discussion on how “under the care” should be interpreted.
9. For more information, refer to the Council’s statement on Good prescribing practice.
10. Unless special dispensation has been obtained. Contact the Ministry of Health for information on how to obtain such dispensation.
12. Subscription details are available from www.mims.co.nz or 0508 464 676.
14. For more information, refer to the Council’s statement on Prescribing drugs of abuse.


16. Please call Medicines Control on 0800 163 060.

17. “Inappropriate prescribing” can include indiscriminate, excessive or reckless prescribing. See the Council’s statements on Good prescribing practice and Prescribing drugs of abuse for more information.


20. These can be downloaded from www.health.govt.nz/publication/standing-order-guidelines


26. A “vulnerable adult” is defined in the Act as a “person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person”.


28. Clause 23 of the NZMA Code of Ethics advises you to bear in mind always the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. In such treatment situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.


32. Refer to Chapter 29.


CHAPTER 29

The role of the Health and Disability Commissioner and the Code of Rights

Anthony Hill has been New Zealand’s Health and Disability Commissioner since July 2010.


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The role of the Health and Disability Commissioner (the Commissioner) is to:

- promote and protect the rights of consumers who use health and disability services; and
- facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringement of those rights.

As a consequence of the Crown Entities Reform Act 2012, the advocacy and monitoring functions in the mental health and addictions sector were transferred to the Health and Disability Commissioner.

The Commissioner enforces the Code of Health and Disability Services Consumers’ Rights (the Code). The Code confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

HDC supports the successful expression of a consumer centred system. Culture is critical — the “the way we do things around here” should successfully engage the whole team caring for the consumer. Consumer centred care involves sharing information and understanding, engagement between provider and consumer, quality and continuity of care, a supportive and transparent environment — all of which are underpinned by respect for the consumer and their values and preferences, and the role of the consumer’s family.

The Commissioner aims to achieve resolution, as well as safety and quality improvement through continuous learning, and protection of the public. A key aspect of successful resolution involves ensuring that the provider, the organisation, and the system identify what went wrong and successfully learn from it, and that the system is strengthened as a result.

**The Code of Rights**

The Code became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act 1994 (the HDC Act).

Application of the Code is very wide and includes public and private services, paid and unpaid services, hospitals, and individuals. The Code covers all registered health professionals, such as doctors, nurses, and dentists, and can also cover other providers such as naturopaths, caregivers, and even people who care for family members with a disability.

The Commissioner can consider systems issues as well as individual actions.

The rights set out in the Code are not comprehensive. For example, the right to patient confidentiality is affirmed in separate privacy legislation (see chapter 13 on medical records), and the Code does not extend to funding decisions or confer entitlement to any particular service. The Code does not override duties or obligations established in other legislation.

Nor are the rights absolute. It is a defence for a provider to show that he or she took “reasonable actions in the circumstances to give effect to the rights, and comply with the duties in [the] Code”. “The circumstances” are defined to include the consumer’s clinical circumstances, the provider’s resource constraints, and any other relevant circumstances.
In summary, there are ten rights.

1. Consumers should always be treated with respect.

2. No one should discriminate against consumers, pressure them into anything, or take advantage of them.

3. Services should help consumers to live dignified, independent lives.

4. Consumers should be treated with reasonable care and skill and receive well coordinated services.

5. Service providers should listen to consumers and give them information in a way they can understand and that makes them comfortable to ask questions if they don’t understand. This may require the services of an interpreter.

6. Consumers should have any treatment explained to them, including benefits, risks, alternatives, and costs, and have any questions answered honestly. They must receive information that a reasonable consumer, in that consumer’s circumstances, would expect, and information needed to receive to give informed consent.

7. Consumers can make their own decisions about treatment, and are free to change their mind.

8. Consumers can have a support person with them at most times.

9. The Code rights apply if consumers are asked to take part in research or teaching.

10. Consumers have a right to make a complaint and have it taken seriously.

All doctors should be familiar with the Code, and should take action to inform consumers about the rights in the Code. Copies of the Code, as well as other educational materials, can be obtained from the Commissioner’s website (www.hdc.org.nz) or by phoning 0800 11 22 33.
Complaints resolution

Any person (including the consumer, a family member, or even another provider) may complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code. Complaints made to an advocate that remain unresolved after advocacy assistance must be referred to the Commissioner. If the Medical Council receives a complaint about patient care, it must refer the complaint to the Commissioner in the first instance.

The Commissioner is responsible for ensuring that each complaint about health care and disability services providers is dealt with appropriately.

On receipt of a complaint, the Commissioner is required to make a preliminary assessment of the complaint to decide what course of action, if any, is appropriate. The Commissioner may, among other things:

- refer the complaint to another agency or person, including a regulatory authority such as the Medical Council, ACC, the Director General of Health, or the person who provided the services about which the consumer has complained
- refer the complaint to an advocate
- call a mediation conference
- formally investigate the complaint
- take no action on the complaint.

The HDC Act supports resolution of complaints at the lowest appropriate level.

In the 2011/2012 financial year, around 65 percent of the complaints HDC received were about doctors. Recurring themes in those complaints were failures to get the basics right, such as:

- reading the notes
- asking the questions
- talking to the patient
- listening to the patient and the patient’s family
- ensuring continuity of care
- taking responsibility.

No further action

At any time after completing a preliminary assessment of a complaint, the Commissioner may, at his discretion, decide to take no action on a complaint if he considers that any action is unnecessary or inappropriate. This may occur when, for example:

- the length of time that has elapsed between the incident and the making of the complaint is such that an investigation is no longer practicable or desirable
- the subject matter of the complaint is trivial
- the complaint is frivolous or vexatious
• the consumer does not want action to be taken
• there is an adequate remedy which it would be reasonable for the complainant to exercise
• the matter has been fully investigated and reviewed, any recommendations of the review have been implemented, and an HDC investigation is unlikely to shed further light on the matter.

In some circumstances, the Commissioner may decide to take no further action but will make recommendations for improvement to systems and practices. The Commissioner will then follow up the recommendations to ensure any changes are appropriately implemented. In cases where the wider health sector may benefit from the learnings revealed by the assessment of complaint, the Commissioner may publish an anonymised case note on the HDC website.

Case study

Parents complained about the care provided to their eight year old son when he died following an anaphylactic reaction to nuts. In particular, they were concerned with the quality of information provided by a paediatrician about his nut allergy, resulting reactions, and links between asthma and nut allergy. They were also concerned about the lack of planned follow up or review when their son was discharged from paediatric overview.

The parents were concerned that their son’s general practitioner did not adequately review or update the management of their son’s nut allergies, or take the allergy into account when considering treatment for asthma.

The parents also complained that the health authorities did not provide national standards or consistent national delivery of advice and treatment on food allergies. They were concerned about the availability of immunology services and direct links between paediatricians and immunologists. The parents considered that advice on when to prescribe and administer adrenaline autoinjectors was unclear and inconsistent across the country.

The Commissioner obtained a response from the paediatrician and general practitioner concerned. He then requested preliminary expert advice from an expert general practitioner and an expert general paediatrician, both of whom advised that the care provided was appropriate and reasonable in the circumstances.

Overall, the Commissioner was satisfied with the clinical decisions made, and the care provided by the general practitioner and the paediatrician. However, the Commissioner suggested to the general practitioner and the paediatrician that they reflect on the expert paediatrician’s comment that the boy’s long term conditions, including his nut allergy, should have been under ongoing review. He recommended that the general practitioner and paediatrician keep abreast of ongoing developments in this field, including the issue of health professionals working more closely together, with families, to ensure quality and continuity of services, and cooperative monitoring of long term conditions.

The Commissioner published a case study on the HDC website for educational purposes, and brought the case to the attention of the Royal New Zealand College of Practitioners, the Paediatric Society, Coronial Services, the New Zealand Clinical Immunology and Allergy Group, the Ministry of Health, Pharmac, the National Health Board, and the Health Quality and Safety Commission.

This case can be accessed in full at http://www.hdc.org.nz/media/192449/10hdc00458casenote.pdf
Provider resolution

Often the quickest and most satisfactory way of dealing with complaints is for the consumer to deal directly with the provider. A health or disability service provider who respects, listens to, and involves the consumer (and family and whānau where appropriate) is more likely to deliver a better service and be able to resolve any concerns at an early stage. The Code requires providers to have a complaints procedure, and sets out minimum requirements for keeping consumers informed about the progress of their complaint. Consumers are entitled to the assistance of a support person or an independent advocate when making a complaint.

The Commissioner may refer a complaint to the provider for resolution if the complaint does not raise public safety issues and can be appropriately resolved by the provider. In some cases, the provider may not have been aware of the complaint and may be well motivated to resolve the complaint directly with the consumer. All referrals to a provider are accompanied by reporting requirements back to the Commissioner. This enables the Commissioner to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues are addressed, and independent oversight is maintained. The Commissioner may take further action if not satisfied with the reported outcome.

Case study

The Commissioner received a complaint relating to a woman’s care over a year or more by providers from many disciplines, all in one District Health Board. The woman complained of her “year of hell”. She acknowledged that taken in isolation the matters she complained of could appear trivial, but in total they had had a serious effect on her health. After discussion with the District Health Board’s chief executive officer, and with the woman’s agreement, the complaint was referred to the District Health Board. The District Health Board looked into the complaint, met with the patient, and achieved a speedy resolution which satisfied her. She reported the positive outcome to the Commissioner before the District Health Board had reported back.

Advocacy

Free independent advocacy services are available throughout New Zealand. Advocates promote awareness of the Code and HDC Act, providing free education sessions to consumers and providers. They assist consumers to resolve complaints at an early stage and encourage self advocacy as well as providing more support as needed.

Advocates do not make decisions on whether there has been a breach of the Code. Rather, their role is to give consumers information about their rights, and to support them to make decisions and take action to attempt to resolve the complaint. Most complaints that advocates handle are received directly rather than via the Commissioner, but in some cases the Commissioner may decide that a complaint made to his office should be referred to an advocate to enable the parties to resolve the matter. The majority of complaints referred to advocacy are successfully resolved, often by face to face meetings with providers. Advocates must report back to the Commissioner with the results of a referral to advocacy, and may also report on any matter concerning the rights of consumers that they consider should be brought to the Commissioner’s attention.
The nationwide health and disability service is provided by an independent national advocacy trust through a contractual arrangement with the Director of Advocacy. The advocacy service can be contacted by freephone on 0800 555 050, free fax on 0800 2787 7678 or at advocacy@hdc.org.nz.

Case study

Mrs D was provided with verbal and written information about advocacy and the Code after relaying the following information: on a number of occasions she and her doctor had discussed the probability that she would need to start an antihypertensive. At a consultation her blood pressure was noted, yet again, to be high, and the doctor advised that it was now time to start the treatment. They again discussed her reluctance to commence the treatment, but she agreed to do so. Mrs D was told the name of the medication being prescribed and she asked about possible side effects. The doctor told her she would know if she experienced any and she should return if she did. Mrs D then requested the same information from the dispensing pharmacist, who advised that it is not the pharmacy’s normal practice to provide such information about the medication.

Mrs D was very disturbed about not being able to get the information and contacted the local advocate to find out her rights. As a result of her concerns and discussions with the advocate, Mrs D decided to seek a second opinion from a specialist, and contacted her general practitioner’s nurse to organise a referral letter. Within the hour her doctor had telephoned her, having recognised her distress, and asked to meet with her later the same day. Mrs D’s advocate offered to support her, but Mrs D felt able to proceed alone.

She reported back to the advocate that the meeting had gone well and she had received the information she required. The doctor apologised for the distress caused and assured her that he would support her in obtaining a second opinion.

Other advocacy case studies can be found online at http://advocacy.hdc.org.nz

Mediation

The Commissioner may call a mediation conference at any stage. Mediation is often a very effective way of resolving complaints, and provides an opportunity for the parties to agree to a fair outcome with minimum delay and cost.

The parties meet across the table, with or without support persons, to discuss their concerns. Although the parties may have a lawyer present, this is not necessary. An impartial mediator assists the parties to define the issues in dispute, explore options for resolution of the complaint, and find their own solutions to the dispute. All statements made during mediation are confidential and, if a deed of settlement is signed, it is a full and final settlement of the issue.

If a complaint is not resolved by mediation, the Commissioner will decide what, if any, further action to take.
Case study

Mr E was admitted to a hospital Emergency Department after injuring himself in a car accident that morning. On assessment, his main complaint was abdominal and back pain. Xrays of his back and neck showed no fractures, and he was discharged around 5pm. Mr E’s condition deteriorated and he was readmitted to the Emergency Department at 10pm with pain in the kidney region and symptoms of shock. He was reassessed and discharged home with pain relief and treatment for a urinary tract infection. Four days later he deteriorated markedly, with disorientation, increased abdominal and back pain, and weakening of his legs. He was admitted to Intensive Care and received treatment for a contusion of the small bowel. Mr E continued to complain of intermittent back pain, but another Xray showed no fracture. However, a further Xray and CT imaging taken a few days later indicated a fractured spine. Mr E experienced increasing heaviness in his legs and subsequently developed paraplegia.

This serious complaint concerned the standard of care Mr E received at the hospital. The primary issue was the failure of hospital medical staff to diagnose the fracture, which left Mr E paralysed. The complaint also concerned pain management, nursing care, and communication.

The Commissioner commenced an investigation and, after reviewing the hospital’s response, referred the matter for expert orthopaedic advice. The advisor considered that, overall, the care Mr E received was satisfactory. Mr E’s fracture was not displaced at the time of initial Xray investigation and was therefore hidden from view. The advisor stated that this was an exceptionally complex case, and that Mr E had received good management and well documented, compassionate care.

In light of the expert clinical advice, and the unresolved communication concerns, the matter was considered appropriate for mediation. As Mr E’s family was Māori, the Commissioner engaged a Māori mediator with knowledge of cultural issues. The family and the District Health Board were provided with a copy of the expert advice prior to the mediation conference, to guide them in their discussions.

The mediation conference resulted in a successful outcome. This included a written apology by the Board to Mr E and his whānau, as well as the instigation of a process to restore his mana. In its letter of apology, the Board commented that the mediation was a learning experience for all involved, and that the knowledge gained would be applied for the benefit of all patients.

Investigations

Some complaints, for example those involving allegations of serious professional misconduct, sexual impropriety, complex systems issues, or public safety issues, are not appropriate for low level resolution and proceed to a formal investigation. The Commissioner may commence an investigation in response to a complaint or on the Commissioner’s own initiative.

The investigation process is independent and impartial. Providers are informed of the investigation, given a copy of the letter of complaint, and asked to respond to the complaint. The provider’s response is very important in informing the Commissioner’s understanding of what occurred, and his opinion as to whether there has been a breach of the Code.

Registration authorities, such as the Medical Council, are notified of any investigation.

Where the appropriate standard of care is in issue, expert independent clinical advice is obtained to assist the Commissioner to form an opinion. Relevant professional groups, such as the Royal New Zealand College of General Practitioners, nominate expert advisers, and the advisers are named in the Commissioner’s reports.
The HDC Act gives the Commissioner wide powers to gather relevant information. This includes the ability to summon witnesses, to take evidence under oath, and to require the production of relevant documents. It is an offence to obstruct or hinder the Commissioner or any other person in the exercise of their powers under the HDC Act, or to give false or misleading information.

Most investigations end in a written report from the Commissioner to the parties. Before forming a final opinion, the Commissioner sends a provisional report to the parties. If any adverse comment is made about a person, that person is given an opportunity to respond to the adverse comment before the Commissioner’s report is published. The Commissioner considers responses to the provisional report, and sometimes seeks further expert advice, before issuing a final report. The reports are usually published in an anonymised form on the HDC website.

An investigation can be a lengthy process, depending on the complexity of the issues under consideration and the number of people involved.

**Relationships with other organisations**

Complaints may be referred to other agencies or persons involved in the health and disability sector. For example, a complaint of a breach of patient confidentiality will be referred to the Privacy Commissioner, and a complaint of discrimination will usually be referred to the Human Rights Commission. Concerns about the conduct or competence of a registered health practitioner will usually be referred to the appropriate registration authority, such as the Medical Council.

Working with other agencies is an important part of promoting and protecting the rights of consumers. Where necessary, the Commissioner shares information with a number of other agencies and persons, so that relevant information can be analysed and acted on to identify public safety concerns, and so that duplication can be minimised.

The Commissioner has wide discretion to refer a matter to an appropriate person or authority. For example, the Commissioner may contact ACC if it appears that the consumer may be entitled to compensation for a personal injury, and concerns about inappropriate prescribing may be referred to Medsafe.

The Commissioner must inform the appropriate authority or person if he becomes aware that the practice or systems of a health care provider may pose a risk of harm to the public.
Options where there is a breach of the Code

Where an investigation reveals a breach of the Code, the Commissioner has a number of options. Usually, the Commissioner’s final report makes recommendations to improve systems or practices, and help ensure that a situation similar to that which led to the breach of the Code does not recur. For example, the Commissioner may recommend that the provider offer the consumer a written apology, review his or her practice in the light of the Commissioner’s report, undertake further education, or implement appropriate systems to prevent a recurrence. The Commissioner cannot order compensation, but occasionally may recommend that a provider refund money paid for substandard services.

The Commissioner’s opinion is reported to the relevant registration authority and, in the case of a doctor, the Medical Council may be asked to consider the need for a competence review. Copies of the report may also be sent to the Minister of Health, funders, or any other appropriate agency, to enable them to take further action if necessary.

Reports with significant educational value are distributed to the appropriate colleges and posted on the Commissioner’s website (www.hdc.org.nz) in an anonymised form. The Commissioner is empowered to name individual providers publicly. While he will usually name group providers such as a DHB or a rest home, he only names individual providers in exceptional circumstances (eg, where the provider poses a risk of harm to the public). The Commissioner’s naming policy can be accessed at www.hdc.org.nz.

The Commissioner uses individual complaints to promote wider systemic improvements. For example, in the cases below, the Commissioner investigated complaints involving deficiencies in the coordination of care (including handover) and supervision.

Case study

A woman complained about the care provided to her 79 year old father, who had Parkinson’s disease, by a public hospital. The man was referred to the hospital’s emergency department with acute pain in his left leg and a cold, blue left foot. He was diagnosed with impending ischaemia and admitted to hospital.

The man was initially under the care of a general surgeon. The hospital’s vascular surgeon was on leave at the time the man was admitted. The vascular surgeon’s registrar gave the general surgeon ambiguous information about the vascular surgeon’s return, which led to a delay of ten days before the man was seen by the vascular surgeon.

Eight days later, the vascular surgeon performed a bypass of the aneurysm behind the man’s knee.

Over the next few days, the man’s condition deteriorated. The vascular surgeon again went on leave, and did not handover care of the man to the on call consultant, relying instead on the registrar. The registrar and a house surgeon reviewed the man, whose foot was pale, cool and his pulses faint. The registrar did not take further action or contact the on call consultant.

Five days after surgery the man was reviewed by the on call surgeon, who concluded that the bypass graft was blocked. The man was transferred to a larger DHB, where acute ischaemia following an acute thrombosis of the graft was diagnosed. Removing the clot did not improve the condition of the man’s foot and he underwent an above knee amputation. The family told the Commissioner that despite raising concerns on several occasions, they were reassured that “it should be alright”.


The Commissioner found that the general surgeon should have checked the roster to determine exactly when the vascular surgeon was back from leave. The delay of ten days to see a vascular surgeon was unacceptable. The general surgeon breached Right 4(1) of the Code (the right to have services provided with reasonable care and skill).

The Commissioner found that the registrar should have taken more care in informing the general surgeon about the vascular surgeon’s return from leave. He also found that the registrar failed to recognise that the man’s condition was deteriorating and seek appropriate specialist advice from the on call consultant. The registrar also failed to document all his examinations and findings. The registrar breached Right 4(1) of the Code.

The vascular surgeon failed to adequately handover the man’s care to the on call consultant when he went on leave. No specific instructions were left in the clinical records to cover his absence, particularly in the event of the man’s deterioration. The vascular surgeon breached Right 4(5) of the Code (the right to cooperation among providers to ensure quality and continuity of care).

The Commissioner made adverse comment about the DHB. The medical record demonstrated that the nurses and the medical officer were concerned about the man’s deterioration, however, there was a lack of action at the stage when the registrar’s management should have been questioned and when concerns about the care being provided should have been raised and escalated to the on call consultant. The Commissioner emphasised that DHBs and senior practitioners need to encourage a culture where it is acceptable and commonplace for questions to be asked, to and from any point in the hierarchy, at any time.

Case study

A woman complained about the services provided to her husband by DHB1. The man consulted a respiratory physician at DHB2, who arranged for tests, including an exercise tolerance test (ETT), which showed the man had significant coronary artery disease that required urgent attention. The respiratory physician telephoned DHB1, then faxed a referral and the ETT results to DHB1. The respiratory physician did not detail the ETT results in the referral letter but mentioned in the letter that the results were accompanying the letter.

The referral was triaged by a cardiologist at DHB1. He told HDC the ETT results were “too faint to read” and that he did not follow up a legible copy. He triaged the man’s priority as “semiurgent” but later advised HDC that if he had seen the ETT results he would have assessed the man’s priority as “urgent”. Appointment dates were assigned in accordance with the “semiurgent” priority but, sadly, the man died of a heart attack before the first of those appointments.

The Commissioner found that a system, designed to ensure that patients who require either immediate hospitalisation or an urgent assessment are assessed in a timely way, failed to deliver.

DHB1 was found in breach of Right 4(1) of the Code because staff did not obtain sufficient information to determine whether it was necessary to refer the respiratory physician’s call to the on call registrar or consultant, did not seek a legible copy of the ETT results, and did not appropriately acknowledge the referral. It also failed to communicate effectively with DHB2 and breached Right 4(5). DHB1 also failed to provide the man with adequate information about his referral and breached Right 6(1)(c).

Adverse comment was made about the cardiologist’s failure to ensure that a legible copy of the ETT results were obtained and reviewed. The Commissioner also criticised DHB2 for its failure to ensure the referral was received and actioned.
**Proceedings**

Following a finding of a breach of the Code, the Commissioner may refer a provider to the independent Director of Proceedings, to decide whether legal proceedings will be issued against that provider. Before referring a provider, the Commissioner must give the provider an opportunity to comment on the proposed referral. The Commissioner must also have regard to the wishes of the consumer and complainant and the public interest (including any public health or safety issues).

The Director of Proceedings may take proceedings before the Human Rights Review Tribunal and/or the Health Practitioners Disciplinary Tribunal, or may decide to take no further action. An aggrieved person may themselves bring proceedings before the Human Rights Review Tribunal where the Commissioner, having found a breach of the Code, decides not to refer the matter to the Director of Proceedings, or where the Director of Proceedings decides not to take proceedings.

The functions of the Health Practitioners Disciplinary Tribunal are outlined in chapter 30.

**The Human Rights Review Tribunal**

Where proceedings are brought before the Human Rights Review Tribunal, the Tribunal has the power to award a number of remedies, including:

- a declaration that the provider’s action is in breach of the Code
- an order restraining the provider from continuing or repeating the breach
- an order that the provider perform any specified acts with a view to redressing any loss or damage suffered by the consumer as a result of the breach
- damages of up to $200,000 (including damages awarded in respect of loss suffered, expenses reasonably incurred, humiliation, loss of dignity, injury to the feelings of the consumer, and punitive damages for any action that was in flagrant disregard of the consumer’s rights), and
- any other relief the Tribunal thinks fit.

An important limitation is that where a person has suffered personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, no damages other than punitive damages (where the provider’s action was in flagrant disregard of the consumer’s rights) may be awarded.

**Conclusion**

The Commissioner promotes resolution of individual complaints and systemic improvements in health and disability services. The Commissioner’s focus is on a consumer centred system, and HDC aims to achieve such a system through resolution, protection and learning.
CHAPTER 30

The disciplinary process: the Professional Conduct Committee and the Health Practitioners Disciplinary Tribunal

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Part 4 of the Health Practitioners Competence Assurance Act 2003 (the Act) sets out the complaints procedures which apply to doctors and establishes the Health Practitioners Disciplinary Tribunal (the Tribunal) which hears and determines disciplinary charges brought against doctors (and other health professionals).

One of the principal purposes of the complaints and disciplinary process is public protection; to protect the public and the profession from persons who are unfit to practise. Another purpose is to enable the profession to ensure the conduct of its members conforms to the standards generally expected of them.

Complaints about doctors may be made to the Medical Council or the Health and Disability Commissioner (the Commissioner). The Council must refer all complaints it receives to the Commissioner.

The Commissioner has the power to refer complaints back to the Council and if a complaint is referred back then the Council must promptly assess the complaint, and consider what action should be taken in response. The Council may decide to refer the matter to a professional conduct committee (PCC) for investigation.

The Commissioner must notify the Medical Council of any investigation under the HDC Act that directly involves a doctor and the Medical Council may take no action while the matter is under investigation by the Commissioner.

**Professional Conduct Committees**

PCCs deal with complaints referred from the Commissioner and with referrals after convictions in a court of law. In addition, if the Medical Council considers information in its possession raises questions about the conduct or the safety of a doctor’s practice, then it may refer those questions to a PCC. Further, if while a matter is under consideration by a PCC, the Council thinks a further matter concerning that doctor should form part of the PCC’s consideration, it may refer the further matter to the PCC.

A charge brought by the Director of Proceedings goes directly to the Tribunal and bypasses the PCC process.

**Membership**

PCCs comprise three members appointed by the Medical Council. Two are doctors and one is a lay person. One member coordinates the investigation process and presides at PCC meetings. This member is usually known as the Convener. Both the doctor and the complainant are advised of the intended composition of a PCC and have an opportunity to request changes in membership.

Usually, where possible, one of the doctors on the PCC practises in the same vocational scope of medicine or a similar vocational scope as that in which the doctor being investigated practises. The other doctor is usually selected from a more general area (for example, general practice). This ensures there is an appropriate mix of general medical knowledge and specialised knowledge on the committee.
If there are multiple complainants involving one doctor the same PCC generally deals with all the complaints.

**Process**

The PCC may investigate however it sees fit. Care is taken to ensure the parties are informed about the progress of the investigation and that the investigation is carried out fairly and in accordance with natural justice principles.

The PCC has wide powers to receive evidence and may receive any statement, document, information or matter that in its opinion, may assist it to deal effectively with its investigation (even if the evidence would not be admissible in a court of law). The PCC has the power to call for information or documents from any person and in the event of refusal or failure without reasonable excuse to comply with a request for information (or knowingly or recklessly providing false or misleading information), that person is liable to a fine not exceeding $10,000. In respect of patients, consent is normally obtained in writing before the PCC obtains medical records.

The PCC must give the doctor who is under investigation a reasonable opportunity to present evidence about each matter that is the subject of the PCC’s investigation. The PCC may hear oral evidence and receive written statements and submissions from any or all of the following persons: the doctor; the doctor’s employer; any person in association with whom the doctor practises; the complainant and any clinical experts. The PCC usually gives the complainant and the doctor an opportunity to meet with the Committee in person.

Complainants may bring a support person (patient advocate, family or whānau member, friend or counsellor) to a PCC meeting. This is important particularly if the complainant is disabled or if the complaint concerns sensitive issues like sexual impropriety.

The PCC usually appoints a legal assessor to advise it on matters of law, procedure, and evidence. It is also entitled to appoint an investigator to collect information and to investigate complaints. However, neither the legal assessor nor the investigator may be present during any deliberations of the PCC.

**Recommendations and determinations**

The PCC’s role is to determine whether the issues it has investigated are matters of competence or discipline and then to recommend and/or determine an appropriate course of action.

The PCC may recommend the Council should:

- assess the doctor’s performance
- review the doctor’s fitness to practise medicine
- review the doctor’s scope of practice
- refer the subject matter of the investigation to the police
- counsel the doctor.
The PCC may also make one of the following “determinations”: that no further steps be taken in relation to the complaint or conviction; a disciplinary charge should be brought against the doctor before the Tribunal; or a complaint should be submitted to conciliation.

The PCC must make its recommendations and/or determination within 14 days after the completion of its investigation. Written notice of any recommendations and/or determination, and the reasons on which they are based, must be given to the Registrar of the Medical Council, and the doctor concerned (and in the case of a complaint, the complainant). The Council must “promptly” consider any recommendations.

It is not the responsibility of the PCC to reach a view on the guilt of the practitioner if the matter is considered to be a disciplinary matter. If the PCC determines to lay a disciplinary charge then the Tribunal will determine the outcome and whether or not the established conduct is professional misconduct.

If the PCC decides the complaint or conviction should be considered by the Tribunal it must frame an appropriate charge and lay it before the Tribunal in writing. Where a charge is laid against a doctor before the Tribunal, the chairperson of the Tribunal is required to convene a hearing of the Tribunal to consider the charge as soon as reasonably practicable.

If the PCC determines the complaint should be the subject of conciliation, it must appoint an independent conciliator to help those concerned to resolve the complaint by agreement. If the complaint has not been successfully resolved by agreement, the PCC must promptly decide whether it should lay a charge against the doctor before the Tribunal, or whether to make any recommendations to the Council about the doctor; or whether no further steps should be taken in relation to the complaint.

Health Practitioners Disciplinary Tribunal

Function

The Tribunal’s principal function is to hear and determine charges brought against doctors (and other health professionals) by the Director of Proceedings or by a PCC.

Membership

The Tribunal has a legal chairperson, one or more legal deputies and a panel of health practitioners and laypersons. The panel is maintained by the Minister of Health. For each hearing the Tribunal must comprise a legal chair and four other persons selected by the chair or deputy from the panel, three of whom must be professional peers. One member must be a lay person.

Procedures

The Tribunal controls its own procedures in accordance with the Act, and has wide powers to summon witnesses and records. Refusing to attend or to cooperate, or acting in contempt are offences punishable by fine.
Charges

The Tribunal must notify the doctor in writing of the charge and provide enough particulars to inform the doctor clearly of the substance of the allegations against him/her. A provisional hearing date is set between 20 and 60 working days from the date of the notice. In most cases the hearing dates are rescheduled once the availability of the parties and their counsel has been ascertained at a Directions Conference. On occasions hearings are adjourned.

Once a doctor has been notified of a charge they must advise the Tribunal within 10 working days whether or not they wish to be heard by the Tribunal. Doctors can be heard personally or they may be (and usually are) represented by a lawyer.

Interim suspension

The Tribunal has the power pending the hearing of a charge, to suspend the doctor or impose conditions on his or her practice if the Tribunal is satisfied it is necessary or desirable to protect the health or safety of the public. The Tribunal does not have to give notice to the doctor that it intends to make such an order but it must advise the doctor of the order once it has been made, the reasons for it, and their right to apply for variation or revocation of the order. The Tribunal must also serve a copy of the order on the doctor’s employer, and on the Council. Any application for revocation has to be heard within 10 working days after it is received by the Tribunal.

Public hearings

Although the Tribunal has the power to restrict publication and hold hearings in private, the emphasis is on public hearings. The Tribunal can make various orders restricting the public nature of the hearing including ordering that the whole or part of the hearing be heard in private and suppressing the publication of the name or particulars of any person, including the doctor.

Applications for private hearings are rarely granted. Applications for name suppression are usually supported by affidavit evidence of the reasons why an order is sought and the Tribunal is required to balance the respective interests of the doctor, the complainant and the public interest before exercising its discretion.

Witnesses are given special protection if their evidence relates to a sexual matter, or relates to another matter that may require the witness to give intimate or distressing evidence. Only certain people may be present during evidence of this nature including a news media reporter, any person the witness chooses, and any person the doctor chooses. The witness may object to the presence of a person of the doctor’s choice.

The Tribunal has the power to order that a witness be permitted to give their evidence from behind a screen, if necessary (Tribunal Decision No. 7/Med04/03P).
In sexual cases no person may publish the name of the complainant or any particulars likely to lead to the complainant’s identification, unless the complainant is 16 years or older and the Tribunal makes an order permitting the publication. However, if the complainant is 16 years or older and applies to the Tribunal for an order and the Tribunal is satisfied the complainant understands the nature and effect of the application the Tribunal must make an order. The Tribunal may restrict publication of any evidence relating to the sexual acts. If the Tribunal makes a privacy order any person can apply for it to be revoked, including representatives of the media.

**Procedures**

The Tribunal can regulate its own procedures however the procedures must accord with the rules of natural justice. Each party must be given a fair opportunity to put their evidence and call relevant witnesses. The Tribunal may receive as evidence any statement, document, information, or matter that may help it deal effectively with the matters before it, whether or not it would be admissible as evidence in a court of law.

Witnesses usually read out their evidence from a written statement. They are then cross examined by opposing legal counsel and questioned by members of the Tribunal. The evidence is recorded by a stenographer. The hearings are either heard in the Tribunal’s hearing rooms in Wellington or in the closest major centre to the events in suitable conference venues where there are facilities for hearing and waiting rooms.

The prosecution has the burden of proving the charge. It must prove the doctor’s guilt. The Tribunal has to be satisfied to the civil standard of proof (“on the balance of probabilities” rather than “beyond reasonable doubt”) that a doctor is guilty of the charge. The civil standard of proof is applied flexibly depending on the seriousness of the allegations (*Z v Dental CAC* ([2008] NZSC 55)).

**Findings**

The Tribunal may find that the doctor:

- Has been guilty of professional misconduct because of an act or omission that amounted to malpractice or negligence in relation to the doctor’s registered scope of practice when the conduct occurred; or
- Has been guilty of professional misconduct because of an act or omission that has brought or was likely to bring discredit to the medical profession; or
- Has been convicted of an offence that reflects adversely on the doctor’s fitness to practise (convictions for offences against relevant health acts including Contraception, Sterilisation and Abortion, Coroners, Medicines, the Injury Prevention, Rehabilitation and Compensation, and Misuse of Drugs; or for an offence punishable by a term of three months’ imprisonment or longer); or
- Has practised his or her profession while not holding a current practising certificate; or
- Has performed a health service without being permitted to perform that service by his or her scope of practice; or
- Has failed to observe any conditions included in his or her scope of practice; or
• Has breached a penalty order of the Tribunal.

The charge of professional misconduct has been part of New Zealand’s medical disciplinary regime for many years.

A two step process is involved in testing what constitutes professional misconduct under the Act.

The first step involves an objective assessment of whether the doctor’s acts or omissions in relation to their practice can reasonably be regarded as constituting malpractice or negligence; or otherwise meets the standard of having brought or was likely to bring discredit to the profession. The second step (often referred to as “threshold”) involves the Tribunal being satisfied the doctor’s acts or omissions require a disciplinary sanction for the purposes of protecting the public or maintaining professional standards or punishing the doctor (that is, that the conduct was sufficiently serious to justify the imposition of a sanction).

Malpractice involves immoral, illegal or unethical conduct or neglect of professional duty (improper professional conduct). Negligence generally involves breach of a doctor’s duty in their professional setting. Bringing discredit to the profession involves bringing harm to the reputation of the profession and involves an objective assessment of whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the profession was lowered by the behaviour of the doctor concerned.

The test recognises that not all acts or omissions which constitute a failure to adhere to the standards expected of a medical practitioner will constitute professional misconduct.

**Who sets the standard?**

Whether or not there has been a breach of the appropriate standards is generally measured against the standards of a responsible body of the doctor’s peers (Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635). In Tizard v Medical Council of New Zealand (Full Court, Auckland, M 2390/91, 10 December 1992) the Full Court stated:

“Professional misconduct” is behaviour in a professional capacity which would reasonably be regarded by a practitioner’s colleagues as constituting unprofessional conduct. It... is an objective test judged by the standards of the profession: Ongley v Medical Council of New Zealand [1984] 4 NZAR, 369, 374. (p16).

However, when assessing a doctor’s conduct the Tribunal cannot lose sight of the fact that the Tribunal’s role is partly one of setting standards (including the expectation that professional standards should not be permitted to lag) and that in some cases patient interests and community expectations may require the Tribunal to be critical of the usual standards of the profession (B v The Medical Council of New Zealand (Unreported, High Court, 11/96, Elias J). The Tribunal’s deliberations now rely on both public as well as professional opinion; and it is that mix of opinion which sets the standard.

The Tribunal usually issues a fully reasoned written decision once it has determined the charge. The Tribunal posts its decision on its website (www.hpdt.org.nz).
Penalties

When fixing a reasonable and proportionate penalty the Tribunal balances the aggravating and mitigating factors in the case. To ensure there is consistency in the penalties imposed the Tribunal also considers previous relevant cases.

The penalties available to the Tribunal if a doctor is found guilty are cancellation of the doctor’s registration; suspension of the doctor for up to three years; the imposition of conditions on practice for up to three years; censure; and a fine of up to $30,000.

The Tribunal cannot impose a fine in dealing with an offence for which the doctor has been convicted by a court. In all other cases the full range of penalties (including cancellation of registration) is available. Before determining to cancel a doctor’s registration the Tribunal Cole’s must consider the alternatives available to it short of doing that. If the Tribunal decides to order that the doctor’s registration be cancelled it must explain why the lesser options have not been adopted in the circumstances of the case (Patel v PCC (High Court, Auckland, CIV 2007—404—1818 Lang J, 13 August 2007).

After cancelling the doctor’s registration, the Tribunal may impose one or more conditions which the doctor must satisfy before applying for registration again. The conditions may include any or all of the following conditions requiring the doctor:

• to undertake a specified course of education or training
• to undergo a medical examination and treatment or psychological or psychiatric examination, counselling or therapy
• to attend a course of treatment or therapy for alcohol or drug abuse (the doctor must consent to these)
• any other condition designed to address the matter that gave rise to the cancellation of the doctor’s registration.

The Tribunal also has the power to order that the doctor pay a percentage of the reasonable costs and expenses incurred by the prosecution (either the Director of Proceedings or the PCC (for its investigation and the prosecution) and by the Tribunal (hearing costs).

There is no power to order costs to be paid to a doctor acquitted of a charge.

The Tribunal has no power to award compensation or costs to a complainant.
Appeals must be filed within 20 working days from the date of the Tribunal’s decision. Unless a Court orders otherwise, the penalties imposed by the Tribunal stay in force pending the outcome of an appeal. Appeals against decisions of the Tribunal are to the High Court, whose decision is final on all matters except points of law, which may be appealed to the Court of Appeal. Instead of determining an appeal, the High Court may direct the Tribunal to reconsider the whole or any part of its decision or order, and when reconsidering, the Tribunal must take the Court’s reasons into account and give effect to the Court’s directions.

Appeals are generally conducted by way of a rehearing on the record of the Tribunal, following the approach outlined in Austin, Nicholls & Co Inc v Stichting Lodestar [2007] NZSC 103 (see for example Harman v Director of Proceedings (High Court, Auckland, CIV 2007—404—3732) and Dr G v Director of Proceedings (High Court, Auckland CIV 2009—404—000951, 13 October 2009, Duffy J)). The High Court must form its own assessment of the merits of the case, having regard to the expertise of the Tribunal members who heard the charge but not approaching that expertise with undue deference. If the High Court is of a different view of the merits from the Tribunal and is therefore of the opinion that the Tribunal’s decision is wrong, the High Court must act on its own view. The appellant bears the onus of satisfying the appeal court that it should differ from the decision under appeal.
APPENDIX A

Medical Council publications

Medical care
Complementary and alternative medicine (March 2011)
A doctor’s duty to help in a medical emergency (August 2006)
HRANZ Joint Guidelines for registered health care workers on transmissible major viral infections (November 2005)
Cosmetic procedures (October 2011)
Safe practice in an environment of resource limitation (August 2008)

Good prescribing practice
Good prescribing practice (April 2010)
Prescribing drugs of abuse (April 2010)
Prescribing performance enhancing medicines in sport (April 2010)

Communication and informed consent
Information, choice of treatment and informed consent (March 2011)
Ending a doctor patient relationship (March 2011)
Use of the internet and electronic communication (October 2012 — provisional date)*george*
Telehealth (October 2012 — provisional date)*george**
Maintenance and retention of patient records (August 2008)
Disclosure of harm following an adverse event (December 2010)
When another person is present during the consultation (March 2004)
Statement on advertising (August 2010)

Cultural competence
Cultural competence (August 2006)
Best practices when providing care to Māori patients and their whānau (August 2006)
Best health outcomes for Māori: practice implications (October 2006)
Best health outcomes for Pacific peoples: practice implications (May 2010)
Management
Responsibilities of doctors management and governance (March 2011)
Employment of doctors and the Health Practitioners Competence Assurance Act 2003 (December 2005)

Professionalism
What to do when you have concerns about a colleague (December 2010)
Unprofessional behaviour and the health care team. Protecting patient safety (August 2009)
Medical certification (December 2007)
The importance of clear sexual boundaries in the patient doctor relationship. A guide for doctors (October 2009)
Providing care to yourself and those close to you (June 2007 — currently under review, a new edition may be published in late 2012)
Nontreating doctors performing medical assessments of patients for third parties (December 2010)
Doctors and health related commercial organisations (July 2012)

For patients
What to expect from your doctor when you have a cosmetic procedure (June 2008)
You and your doctor (March 2008)
The importance of clear sexual boundaries in the patient doctor relationship. A guide for patients (October 2006)
APPENDIX B

Cite this as St George IM 2013. Take our word for it: New Zealand slang expressions.
Appendix B in St George IM (ed.). Cole’s medical practice in New Zealand, 12th edition.
Medical Council of New Zealand, Wellington.

When Kiwis (New Zealanders) talk, they may use slang words that you do not understand.
Here are a few that may be used in a medical context. Be warned, however: don’t try these at
home; many of these words and expressions are considered vulgar, rude or offensive: do not
use them until you are sure you will not offend.

anklebiter: infant, toddler, kid, small child.
arise over tit: head over heels, as “he fell arise over tit”.
arise: buttocks, anus, rear end, butt.
beaut: great, well, as “I’ve been feeling beaut”.
bloke: usually a man, often referring to a stranger: “Seems a decent bloke”.
bludge: to sponge off other people or the government, as “Dole bludger”.
Bob’s your uncle: it’s all fixed, as “I put the ointment on, and Bob’s your uncle”.
bonk: (= bang) to have sex with.
box of birds: well, as Q: “How are you feeling now?” A: “A box of birds”.
braces: suspenders.
brassed off: disappointed, annoyed.
brilliant: excellent; great; wonderful — or even OK, satisfactory, or “thanks”.
bugger all: not much, very little, as Q: “Are you any better?” A: “No; bugger all”.
buggered: exhausted.
bun: buttocks, rear end, butt. As a verb, means to bludge.
bun in the oven: pregnant.
bust a gut: make an intense effort.
cackhanded: left handed, southpaw.
cardie: cardigan; woollen button up the front jersey or sweater.
carked: died, kicked the bucket. Like “croaked”.
cheerio: good bye (also a small red sausage).
cheers: goodbye, thanks.
chemist: pharmacy, drug store.
chilly bin: sealable, usually polystyrene insulated box, for keeping beer and food cold. Like Australian “eskie”.
chippy: builder, carpenter.
chips: french fries.

choc-a-block (chocker): full to overflowing.

choice: used when something is desirable, eg, “That’s choice!”

chook (chick): chicken, girl.

chuffed: pleased.

chunder: vomit.

colly wobbles: a feeling of nausea usually associated with nervousness; as “Just thinking about the operation gives me the colly wobbles”.

corker: very good.

cot: child’s bed.

cotton buds: Q tips.

crook: sick, unwell (but to “go crook” may mean to complain or tell off).

ding: a small dent in a vehicle; any hit on the body, as “Her knee took a bit of a ding early in the game”.

dodgy: bad, unreliable, spoiled, as “The knee’s a bit dodgy”.

dole: unemployment benefit; income support for the unemployed.

dreaded lurgy: alternative name for the flu, a head cold, any febrile illness.

dressing gown: bathrobe.

dummy: pacifier.

dunny: toilet, bathroom, lavatory.

duvet: quilt.

eh: often used at the end of sentences whether or not expecting a response to a statement which is not a question, eg, “I took all the pills, eh”.

face cloth: flannel: wash cloth.

fag: cigarette.

fagged out: see knackered.

fanny: “fanny” refers to female genitalia; fanny does not mean buttocks! a warning to Americans.

football: rugby.

french letter (frenchie, frog, joey, rubber): condom.

full on: intense.

go bush: become reclusive, “get away from it all”.

good as gold: a good job well done, not a problem, an affirmative answer, or well, as Q: “How has your sore knee been?” A: “Good as gold”.
half pai (half pie): sort of, not completely; as Q: “Are you feeling any better?” A: “Well, only half pai”.

hard yakka: hard labouring work.

heaps: a lot, as “Give it heaps”, means to push it to the limit.

hottie: hot water bottle; sexually available potential partner.

hunky dory: everything’s fine, as “My life is hunky dory now”.

jersey: sweater.

john: lavatory.

jumper: woollen sweater.

kapai: fine, excellent.

kai: food.

kia ora: hello, greetings.

kick the bucket: die, cark it, croak.

knackered: tired or broken; stuffed; fagged out; rooted; as “I’m knackered.” (origin: the “knacker’s yard” is where surplus farm animals were sent to be slaughtered).

loo: bathroom, toilet.

nana: female grandparent.

nappy: diaper.

no worries: not a problem, yes, certainly; as Q: “Thanks for your help;” A: “No worries!”

off (his) face: completely drunk.

pack a sad: become morose, ill humoured, moody, broken, eg, “He packed a sad and went to bed.” or “The fridge packed a sad”.

pike out: to give up when the going gets tough.

piker: one who gives up easily.

piss: beer, urine. (“Take the piss” = tease).

piss around: waste time or effort in a futile manner, fart about.

pissed: drunk, inebriated.

pissed off: angry, as “I’m really pissed off!”

pissing down: raining heavily.

piss up: social gathering with alcohol.

plaster: see sticking plaster.

plastered: drunk.

PMT: premenstrual tension.
pong: bad smell.
pottle: small container (eg, for sputum — but also for strawberries in the S. Is.)
pram: baby carriage, stroller. A small dinghy.
prang: minor vehicle smash.
pushing up daisies: dead and buried.
randy: horny, feeling sexy.
right as rain: OK, perfect.
ing: phone somebody; as “I'll give him a ring”.
root: to have sex. An American woman visitor: “My first time in New Zealand I said I liked to root for the football team. One of the boys said, ‘What, the whole team?’”.
rooted: feeling tired.
round the bend: going crazy.
shultz: not a problem, it'll be OK (may disguise some deficiencies).
shufti: a look, as “I'll just take a shufti at that”, meaning “I'll have a look at that”.
sickie: as “Throw a sickie”; to take time off work; also used for sickness certificate.
singlet: undershirt.
snarky: mixture of sarcastic and nasty.
snotty: condescending, snooty; or ill humoured, packing a sad.
sook: someone timid, or behaving over cautiously. As “you’re being a sook” or “just a big sook”.
spew: to throw up.
spit the dummy: to throw a tantrum or get mad.
sprog: a child.
squiz: as “Have a squiz” to take a look at something. “Giz a squiz” ask for a look at something.
sticking plaster: band aid.
stuffed: really tired.
suss: to figure out.
sweet as: really good. Q: “How would you rate the service?” A: “Sweet as.”
ta: thank you.
take aways: New Zealand term for take outs or food to go. Prêt à manger.
tata: goodbye, often when speaking to a child.
the tatas: anxiety.
tinned food: canned food.
trots: diarrhoea, as “I’ve got a dose of the trots”.

undies, underpants: undershorts, grundies.

up the duff: pregnant, in the family way, with a bun in the oven, sprogged, etc.

whinge: complain, grizzle.

wicked: energetic, well; as “I feel wicked after a week off work”.

wobbly (pack a wobbly): become angry, get snotty.

yonks: forever, a long time, ages; as “I haven’t been right for yonks”.

zambuck: St John Ambulance officer.

zit: acne lesion.

**Resources**

This material was gleaned from several general websites on New Zealand colloquial words.

1. www2.vuw.ac.nz/international/studentlife/glossary_nz.html.

2. www.chemistry.co.nz/kiwi.htm#quite_nice.


5. www.urbandictionary.com